

Gender and **AIDS** Almanac



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The *Gender & AIDS Almanac* was created to be an easy-to-use resource on the various factors that contribute to the HIV/AIDS pandemic, focusing special attention to the role that gender plays in contributing to the vulnerabilities of women, men, adolescents, and children.

The term “gender” is used to describe the various characteristics assigned to women and men by a given society. The term “sex” refers to the biological characteristics of women and men. Gender roles reflect the behaviours and relationships that societies believe are appropriate for an individual based on his or her sex. Gender roles are learned, rather than inherent, and vary from culture to culture and from generation to generation. They can change over time due to a variety of factors such as economics, education, technology, religion, and political structures. Gender roles are a powerful feature of social organisation, not only describing how men and women are expected to behave, but also influencing power relations, decision-making authority, and individual responsibility.

The *Gender & AIDS Almanac* adopts a gender-based approach to the study of HIV/AIDS in order to examine how socially defined gender roles influence HIV/AIDS prevention, transmission, and care. Such an approach can provide insight into the factors that contribute to the spread of HIV/AIDS either directly or indirectly.

Although this almanac was designed specifically for use by development practitioners and policy makers, it can also be useful to a variety of audiences. This almanac begins by describing HIV and AIDS, explaining how HIV is transmitted, and discussing the populations that are most severely affected. The issues of prevention and care are presented, with a particular focus on how efforts are targeted to specific genders. The final section of the almanac looks at the various factors that contribute to the spread of HIV/AIDS, such as social status, poverty, politics, culture, violence, and sex exploitation. In addition, the impact that HIV/AIDS has on society is also discussed, including how the lives of young people have been affected.

HIV/AIDS is no longer a disease of someone else. The pandemic leaves no lives untouched. This almanac provides the reader with an understanding of the broader, global implications of HIV/AIDS and the relationship between gender and HIV/AIDS.

Glossary of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral drugs
CSM	Condom social marketing
CSW	Commercial sex worker
FGM	Female genital mutilation
GDP	Gross domestic product
GNP	Gross national product
HIV	Human Immunodeficiency Virus
HIV+	HIV positive or infected with HIV
IDUs	Injection drug users
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency of International Development
WHO	World Health Organization



What is HIV? What is AIDS?

AIDS, the Acquired Immune Deficiency Syndrome, is a disease caused by the Human Immunodeficiency Virus (**HIV**). A virus is a tiny piece of biological material that attaches to the cells of another creature and uses them to help it make copies of itself. HIV attaches to one of the important types of cell* that make up the human immune system. These cells make many copies of HIV and then die, releasing those copies to attach to other cells. When enough of these cells are dead, the immune system is weakened and can no longer fight off diseases as well as it could before. At this point, many diseases that would not normally be a problem become very dangerous. These diseases eventually stop the body from working correctly and the infected person becomes seriously ill and dies.

There are two types, or strains, of HIV:

- ◆ **HIV-1, which has nine sub-types. Each of these subtypes is most common in one or more specific parts of the world. For example, 93% of a sample of HIV+ people from Western Africa were infected with subtype A, and less than 1% were infected with subtype C. Conversely, 94% of a sample of HIV+ people from Southern Africa were infected with subtype C, and less than 1% with subtype A.¹**
- ◆ **HIV-2, which is less infectious and is found primarily in West Africa.**

Most of the research on HIV has been done using HIV-1 subtype B, which is found mostly in industrialised nations. There may be important differences between the different subtypes, but research into these differences is not yet very advanced.

The way that a disease develops in a person is called **progression**. The progression of HIV/AIDS has three phases:

Phase I: *Acute Infection.* A person who has just been infected with HIV may experience flu-like symptoms as her/his body reacts to the virus. The symptoms normally go away in 1-3 weeks.²



Phase II: *Asymptomatic Infection.* During this phase, which usually lasts 8-10 years, the infected person will not appear to be ill, even though HIV is destroying the cells in the immune system faster than the body can replace them.



Phase III: *Clinical AIDS.* During this phase, the immune system becomes very weak and the infected person catches diseases and eventually dies.

Research has shown that women who are infected with HIV often have fewer copies of the virus in their bodies than men do for at least the first five years of phase II (asymptomatic infection).³ Despite having fewer copies of the virus in their bodies, women are more likely than men to progress quickly to phase III (clinical AIDS) and die.⁴ This may be because women in many parts of the world have poor access to medical care and receive lower quality care than men even when they do have access. (Refer to “Care” for more information.)

* These cells are called CD4+ T-cells.

Means of transmission

HIV is present in the body fluids (such as blood, semen and vaginal fluids) of an infected person. People who are infected with HIV are sometimes referred to as “HIV positive,” or “HIV+.” An uninfected person can become infected with HIV through:

- ◆ **having unprotected sexual intercourse** with an infected person;
- ◆ **sharing syringes** or other drug-injection equipment with an infected person;
- ◆ **receiving a blood transfusion** that contains HIV-infected blood (or receiving a medical injection using medical equipment that has not been properly cleaned and sterilised); and
- ◆ **being exposed to HIV while still a baby** in the HIV+ mother’s uterus, during birth, or through breastfeeding.

The risk of infection per contact (i.e., having sexual intercourse one time, sharing a syringe once, receiving one transfusion, or being born to an infected mother) varies among the different means of transmission.

Sexual intercourse

Sex between an infected person and an uninfected person is the most common means of transmission worldwide.

- ◆ About three-fourths of HIV infections are caused by sexual intercourse.⁵
- ◆ Three-fourths of these are caused by heterosexual intercourse (sex between a man and a woman).⁵
- ◆ Women are far more likely to become infected through heterosexual intercourse than they are through any other means of transmission.⁶

During vaginal or anal intercourse, tiny cuts and scrapes can open up on the skin of the penis, vagina or anus. Researchers believe that HIV enters a person’s body through these cuts or scrapes. Women who have sex with men are more vulnerable to HIV infection during intercourse than their partners are because:

- ◆ the vagina and anus have larger areas of exposed, sensitive skin;
- ◆ the virus has an easier time surviving in the vagina and anus than it does on the surface of the penis;^{4,6} and
- ◆ there are more copies of the virus in a man’s semen than there are in the fluids of the vagina or anus.⁶

The more cuts and scrapes occur during vaginal or anal intercourse, the more likely it is that the woman will become infected. Cuts and scrapes are especially likely:

- ◆ during anal sex;²
- ◆ during violent or coerced sex;⁶ and

- ◆ when the woman is very young. Young women are especially vulnerable to HIV infection during sexual intercourse, because a young woman's cervix is not fully developed, and the skin is more likely to rip or tear during intercourse.^{6,7}

If either the infected or uninfected partner has a sexually transmitted infection (STI), especially an STI that causes open sores or lesions on the penis or vagina, the risk of HIV transmission to the uninfected partner is greater because:

- ◆ open sores or lesions on the skin of the uninfected person allow HIV to enter the body more easily;²
- ◆ open sores or lesions on the skin of the infected person increase the amount of HIV that is "shed" during sexual intercourse;² and
- ◆ people with sexually transmitted infections usually have more of the immune cells that HIV attaches to concentrated near their penises or vaginas.^{2,7}

Sexual intercourse between men who have sex with men also contributes to the spread of HIV, especially in North America, South America and Western Europe. Intercourse between men is thought to be responsible for a very small percentage of HIV infections in Asia, Africa and the Caribbean, but new studies in sub-Saharan Africa suggest that sex between men is far more common than previously estimated.⁸ In addition to the higher risk of infection associated with anal intercourse, men who have sex with men are often at very high risk of becoming infected because:

- ◆ government officials and the general public may refuse to admit that homosexual transmission occurs and allocate no funds for HIV/AIDS prevention among men who have sex with men;

- ◆ homosexual intercourse is highly stigmatised and in some cases illegal, forcing men who have sex with men in industrialised nations and developing nations alike to keep their relationships secret; and
- ◆ men who have sex with men often face great marginalisation and discrimination and are unlikely to have equal access to health care and prevention services, even if such services exist.^{5,8,9}

Injection drug use

When a person uses a syringe to inject drugs into her or his body, some blood leaks out into the syringe. An uninfected person who uses the same syringe without first sterilising it thoroughly with bleach may become infected. Sharing syringes* is much more likely to cause infection than sexual intercourse,² because the syringe injects infected blood directly into the blood stream of the uninfected person. Transmission through syringes and other equipment used for drug injection is the

*Blood from the infected person sometimes leaks onto other drug-injection equipment as well, and anyone else who shares this equipment is in danger of contracting HIV.

second most common means of transmission:

- ◆ 6-10 million people in the world are thought to use injection drugs.¹⁰
- ◆ Four-fifths of injection drug users worldwide are men.¹¹
- ◆ High rates of HIV infection among people who inject drugs have been found in countries all over the world, including Brazil, India and Myanmar.¹⁰ Injection drug use is also among the most common means of HIV transmission in Eastern Europe and Central Asia, as well the United States and other industrialised nations.
- ◆ Injection drug use is the primary means of transmission in China and South-East Asia (except Thailand).²
- ◆ HIV can spread through a population of injection drug users very rapidly: during 1985-1987, about 1% of injection drug users in Bangkok were infected. By the end of 1988, 40% were infected.¹²
- ◆ Injection drug use plays a critical role in spreading the virus to people who do not use injection drugs: men who

use injection drugs spread the virus to their sexual partners, starting a new pattern of infection through heterosexual transmission.

Blood transfusion and medical equipment

Because HIV is present in the blood of an infected person, any blood that that person donates or sells for medical use can infect another person. Unless the blood supply is thoroughly screened for HIV, anyone who receives a blood transfusion is at risk of HIV infection.

- ◆ Although infected blood may represent a very small portion of the blood supply, anyone who receives a transfusion of infected blood is almost certain to become infected.
- ◆ In the early 1980s, blood transfusions were a major source of new HIV infections in the industrialised world.
- ◆ Since the late 1980's, nations that can afford to screen their blood supplies have virtually eliminated this means of HIV transmission within their borders.
- ◆ Transmission through blood transfusion contributes to the spread of HIV mostly in developing nations that do not have or cannot afford to establish mechanisms to screen their blood supply: it has been estimated that 5-10% of the new HIV infections in developing nations are caused by transfusions of infected blood.¹³
- ◆ Women are more likely than men to need blood transfusions, especially anemic and malnourished women who need transfusions after childbirth.¹⁴

People may also become infected from medical equipment that has not been properly sterilised. This is especially likely in developing nations, which may not have proper facilities for sterilising medical equipment or sufficient funds to replace old equipment or equipment that is intended to be thrown away after each use.

- ◆ Medical injection is often seen as more effective than pills or liquid medicine, and many people

prefer to receive their medication through injection.¹⁵

- ◆ One behavioural study found that more than one-third of all adults surveyed in eight out of nine developing countries had received a medical injection in the year prior to the survey.¹⁶
- ◆ Research shows that medical injection using non-sterile syringes has been responsible in the past for the spread of other disease such as hepatitis and malaria, which are also present in the blood.¹⁷

Mother-to-child transmission

If a pregnant woman is HIV+, she may transmit HIV to her child before or during birth (through the baby's exposure to the mother's infected body fluids) or after birth (through breastfeeding).

- ◆ Because a baby can only be infected with HIV by the mother if the mother is HIV+, mother-to-child transmission is most common in places where women are likely to be HIV+.
- ◆ Most HIV+ women are infected through heterosexual intercourse, so mother-to-child transmission is generally widespread in regions where heterosexual intercourse is the most common means of transmission: in sub-Saharan Africa, 15-20% of all new HIV infections occur in babies born to HIV+ mothers.²
- ◆ Studies show that breastfeeding increases the risk of transmission from mother to child,¹⁸ but ceasing breastfeeding can risk a baby's life by depriving him or her of important nutrients and weakening its immune system. In the absence of healthy alternatives, it is not always advisable for women to avoid breastfeeding their children.

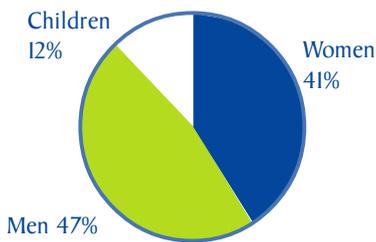


State of the Pandemic

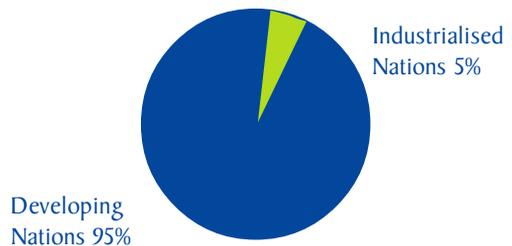
“The concentration of HIV/AIDS in the developing world and in the marginalised communities of the first world confirms that the HIV/AIDS pandemic mirrors the conditions of global inequality. Tracking the path of least resistance, HIV/AIDS flourishes in conditions of poverty, conflict and inequality, and in states with weak resources and capacity.”¹⁹

As of 2000, an estimated 21.8 million people have died of AIDS, including:	9 million adult women 8.5 million adult men 4.3 million children
There were estimated to be 36.1 million people living with HIV/AIDS in 2000, including:	16.4 million adult women 18.3 million adult men 1.4 million children
In the year 2000, 5.3 million people were newly infected with HIV, including:	2.2 million adult women 2.5 million adult men 600,000 children

Distribution of New HIV Infections²¹
(Year 2000)



Distribution of New HIV Infections²¹
(Year 2000)



In 1990, there were an estimated 10 million people living with HIV/AIDS worldwide.²⁰ More than half that many became infected in 2000 alone. 15,000 people are newly infected with HIV every day.²²

Adults and children estimated to be living with HIV/AIDS as of December 2000



Total: 36.1 million²¹

AIDS is the fourth leading cause of death in the world, and the leading cause of death in sub-Saharan Africa.²⁰

Who is affected—by region

(Figure source²¹)

	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult (15-49) HIV/AIDS prevalence rate	% of HIV-positive adults who are women	Important means of transmission
Sub-Saharan Africa	25.3 million	3.8 million	8.8%	55%	hetero
North Africa & Middle East	400,000	80,000	0.2%	40%	hetero, IDU
South & South-East Asia	5.8 million	780,000	0.56%	35%	hetero, IDU
East Asia & Pacific	640,000	130,000	0.07%	13%	hetero, IDU, MSM
Latin America	1.4 million	150,000	0.5%	25%	hetero, IDU, MSM
Caribbean	390,000	60,000	2.3%	35%	hetero, MSM
Eastern Europe & Central Asia	700,000	250,000	0.35%	25%	IDU
Western Europe	540,000	30,000	0.24%	25%	IDU, MSM
North America	920,000	45,000	0.6%	20%	hetero, IDU, MSM
Australia & New Zealand	15,000	500	0.13%	10%	MSM
Worldwide	36.1 million	5.3 million	1.1%	47%	

note: Hetero = transmission through heterosexual intercourse. IDU = transmission through sharing of equipment for injection drug use. MSM = transmission through sexual intercourse among men who have sex with men.

- ◆ In 2000, there were an estimated 3.8 million new infections in sub-Saharan Africa, compared to 4.0 million in 1999. This reduction in the number of new infections could be because of nationwide prevention programmes now active in some countries; it could also reflect the small number of uninfected people remaining in high prevalence areas. If countries which have shown low incidence rates in the past begin to exhibit higher rates, this progress could be reversed.²¹
- ◆ The Caribbean has the highest rates of adult HIV/AIDS prevalence outside of sub-Saharan Africa. As in sub-Saharan Africa, heterosexual intercourse is the predominant means of transmission in the Caribbean. Historically, the AIDS epidemic in the Caribbean differs from that in sub-Saharan Africa in that HIV/AIDS reached high prevalence rates first among Caribbean men who have sex with men, before crossing over to the larger heterosexual population through injection drug use and men who have sex with men and women.²¹
- ◆ Latin America’s pattern of HIV prevalence is similar to that of North America, with heterosexual intercourse, homosexual intercourse, and injection drug use all contributing to the region’s 1.4 million HIV infections.²¹
- ◆ Although HIV infections in Eastern Europe and Central Asia represent a small portion of the

total number of HIV infections worldwide, they are climbing at an alarming rate: conservative estimates place the current total for the year 2000 at 700,000, up from 420,000 in 1999—an increase of 40%.²¹

- ◆ 700,000 adults became infected in South and South-East Asia in the year 2000 alone.²¹
- ◆ The rapid spread of HIV in Eastern Europe and in Central, South, and South-East Asia is characteristic of regions where injection drug use is the most common means of transmission.²¹
- ◆ East Asia and the Pacific, although they have the lowest prevalence among any of the listed regions, could become the next focal point of the pandemic, unless prevention efforts are able to halt the rapid spread of HIV through injection drug use.²¹
- ◆ Prevention efforts in Western Europe and North America were unable to lower the number of new HIV infections in 2000. Overall prevalence has increased slightly in these regions, as new drug treatments for HIV/AIDS allow infected people to live longer.²¹

Who is affected—men and women

- ◆ Sub-Saharan Africa is the only region of the world in which more women than men are infected with HIV and dying of AIDS.¹¹ In sub-Saharan Africa alone, however, there are estimated to be 12.2 million women infected compared to 10.1 million men,²³ and 12-13 women become infected for every 10 men.⁶
- ◆ AIDS now ranks as one of the leading causes of death among women aged 20-40 in several cities in Europe, sub-Saharan Africa, and North America.²⁴
- ◆ Women account for 43%* of infected people in developing nations.²
- ◆ Roughly one in ten uninfected women in

sub-Saharan Africa becomes infected every year²⁵—in high prevalence areas, fewer women may become infected simply because fewer uninfected women remain.

- ◆ The percentage of adults living with HIV/AIDS who are women has been steadily increasing in recent years. In 1997, 41% were women—in 2000, 47% were women. (Refer to the graph on page 10.)
- ◆ The rate of HIV infection among women has rapidly increased in recent years. For example, only 1% of HIV+ people in Brazil were women in 1984; ten years later, 25% of HIV+ Brazilians were women.³¹

- ◆ In major cities in developing nations around the world (Argentina, Brazil, Cambodia, India, and Thailand), more than 2% of pregnant women who report to a prenatal clinic are infected. In some countries in sub-Saharan Africa, as many as 25% of these women are infected.²

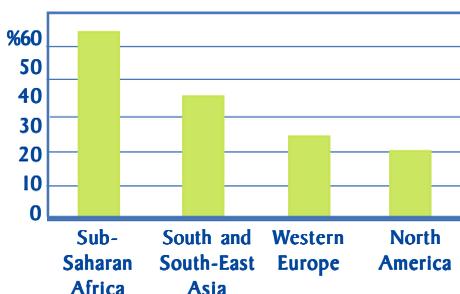
* This may be an underestimate: women in developing nations are usually diagnosed with HIV when they visit prenatal clinics, but infected women are less fertile on average, making them less likely to become pregnant and visit a prenatal clinic where they could be diagnosed.

- ◆ 32% of women worldwide receive no institutionalised prenatal care, so estimates of HIV/AIDS prevalence based on diagnoses in prenatal clinics should take into account that many pregnant women never have the opportunity to visit these clinics.²⁷
- ◆ In industrialised nations, the proportion of people living with HIV/AIDS who are women is relatively low, reflecting the importance of injection drug use and sex among men who have sex with men as means of transmission in these nations.²¹
- ◆ Studies have shown that women and men become infected with HIV at different ages. For example, in 1998 most HIV+ women in Namibia were in their twenties, while most HIV+ men were in their thirties—suggesting that women had become infected at an earlier age.²⁸
- ◆ In regions of the world where injection drug use is the most important means of transmission, newly infected people are overwhelmingly male (89% in Eastern Europe and Central Asia).²¹

Who is affected—young and old

- ◆ AIDS kills mostly prime-age adults—people who are at an age where they would generally be raising children and are at or near the peak of their income-earning potential.²
- ◆ To date, about half of all infections have occurred in young people less than 25 years old.²⁶
- ◆ Recent data indicate that up to 60% of all newly infected people are between the ages of 15 and 24, and that newly infected young women may outnumber their male counterparts two to one.²⁹
- ◆ 91% of children who have been orphaned by AIDS live in sub-Saharan Africa.²⁰
- ◆ AIDS has slowed or reversed the trend towards increased life expectancy in many developing nations. In some nations, life expectancy at birth has been reduced by a decade or more to levels that were last considered normal 40-50 years ago.²
- ◆ Although HIV/AIDS has already reached very high prevalence in some parts of the world, the full impact of the pandemic, as measured in projected mortality, will not be seen for some time.

Proportion of women among HIV-infected adults²¹



The strategies and methods used in the international effort to slow or stop the spread of HIV/AIDS have changed over the history of the pandemic. Early efforts often tried to apply scientific theories of behaviour change to different programmes that served people in different places without taking into account the social and economic factors that contributed to the spread of AIDS.¹ Newer prevention programmes have achieved greater success by choosing strategies that combine scientific theory with an awareness of the real-life conditions that women, men and children confront in their everyday lives.

Prevention Strategies

HIV passes from person to person through several different routes. Different prevention strategies have been developed to slow the spread of AIDS along each of these routes. The most common strategies are listed below, grouped into categories according to the route of transmission they normally address.

Preventing sexual transmission of HIV

Because most new HIV infections (75%) are transmitted via sexual intercourse, it is logical that the strongest efforts be focused on preventing sexual transmission of the virus. Targeted intervention strategies aimed at reducing the number of sexual partners, promoting condom use and treating STIs have achieved some success, but are insufficient to meet the needs of the most vulnerable.³² Comprehensive strategies that include prevention efforts for women, youth, migrant labourers and other vulnerable groups are needed to successfully combat HIV/AIDS on a national scale.

Efforts to prevent sexual transmission of HIV can be divided into two categories: biological

Sexual Transmission	Injection Drug Use
<p>Biological interventions:</p> <ul style="list-style-type: none"> - Sexually transmitted infection (STI) prevention and control - Vaccines and microbicides <p>Behavioural interventions:</p> <ul style="list-style-type: none"> - Formal HIV/AIDS and health education - Mass media campaigns - Social marketing of condoms <p>Targeted interventions</p>	<p>Provision of sterile drug equipment</p> <p>Outreach and peer education</p> <p>Access to health care, testing and treatment</p> <h3 data-bbox="532 1518 1149 1591">Blood Transfusion</h3> <p>Screening of blood donors</p> <p>Screening of blood supply</p> <h3 data-bbox="532 1728 1149 1801">Mother-to-Child Transmission</h3> <p>Prevention of HIV infection in women</p> <p>Use of antiretroviral drugs before birth</p> <p>Provision of healthy alternatives to breastfeeding</p>

interventions and behavioural interventions.

Biological interventions

Three types of biological interventions are currently considered in prevention efforts: treatment of non-HIV STIs; use of vaccines, which may be shown to provide immunity against the virus; and use of microbicides to prevent sexual transmission.

Treatment of sexually transmitted infections (STIs)

In comparison to HIV, non-HIV STIs are extremely infectious, especially in women:

- ◆ An uninfected woman has about a 0.2% chance of being infected with HIV during vaginal intercourse with an HIV+ partner.²
- ◆ If her partner had gonorrhoea instead, she would have a 50-70% chance of becoming infected.¹

Studies indicate a relationship between non-HIV STIs and HIV infection, based on heightened biological vulnerability as well as greater likelihood of risky behaviour:

- ◆ People who already have an STI are more likely to become infected during sexual intercourse with an HIV+ person. People who are HIV+ and also have a non-HIV STI are more likely to transmit HIV

to their sexual partners.^{2, 7} (Refer to “Background” for more information.)

The most important biological intervention that is currently recommended to help prevent the spread of HIV/AIDS through sexual transmission is the treatment of non-HIV STIs:

- ◆ Multiple studies have shown that treating symptomatic STIs reduces HIV transmission in a high-risk population.²

Women, especially those with STIs or other reproductive health problems, are at greater risk of HIV infection than men:

- ◆ Women are far more likely than men to have a reproductive tract infection that is not related to disease—this type of infection also makes them more vulnerable to HIV infection.²
- ◆ Women are more likely than men to have asymptomatic* STIs which increase their risk of HIV infection.⁷

Certain cultural conditions also contribute to women’s vulnerability to STIs:³⁴

- ◆ Many cultures discourage women from learning about their own genitals and reproductive processes, making them less likely to realise when they are actually ill.
- ◆ Lack of health information and the stigma which is often associated with reproductive tract infections and sexually transmitted infections make women unlikely to seek treatment for a reproductive health problem even after they have realised that something is wrong.

Programmes that are designed to reduce the transmission of HIV/AIDS must be sensitive to women’s needs in order to be effective. STI

* An asymptomatic STI is a sexually transmitted infection with no obvious symptoms. Often, it is only possible to tell that someone has this type of STI through a thorough medical examination or blood test.

prevention and treatment programmes that are coercive in nature may achieve the opposite of what they intend, forcing women who are at high risk of HIV infection (such as sex workers) to avoid treatment rather than seek it out.

Vaccines and microbicides

Vaccines and microbicides, two methods of biological prevention that have yet to be developed, may be key elements in future HIV/AIDS prevention efforts.

Vaccines—injections, pills, or other medications that create some level of immunity from a particular disease—have been used with great success to combat the threat posed by diseases such as smallpox and polio. Multiple efforts, including some large-scale international efforts, are currently underway to create an effective vaccine for HIV. Unfortunately, the development and testing process for a vaccine takes many years. Because there are many types and subtypes of HIV, it is possible that a vaccine would only be effective against some, but not all, of these types. It is also possible that a vaccine would only reduce, rather than eliminate, a person’s risk of HIV infection.

A microbicide is a substance that, when inserted into the vagina or rectum, may help to prevent sexual transmission of HIV by killing or inactivating the virus. Given the gender dynamics in intimate relationships between men and women, a microbicide that could be used by women without the consent (and possibly without the knowledge) of their male partners could be an important tool for HIV/AIDS prevention. Because each microbicide must pass through many tests to make sure that it is effective against HIV and safe for the women who use it, it may be several years before one is widely available.

Behavioural interventions

This section discusses the context in which behavioural interventions take place, outlines three common strategies for promoting awareness, and highlights some of the populations targeted for behavioural interventions.

In analysing the success of past prevention efforts or planning for future ones, it is critically important to account for, or at least recognise, the social and economic conditions that facilitate HIV vulnerability. For example, prevention efforts that target women must recognise that reducing the number of sex partners or negotiating safer sex may be unrealistic for women who engage in sex to support themselves and their families and for youth from economically and socially underprivileged environments.³² Although much more research is needed, the following strategies have proven to be effective in changing HIV risk behaviours:

- ◆ provision of appropriate, accessible services and technologies to reduce women’s risk of HIV transmission;
- ◆ improvement of access to information, education, and skills regarding sexuality, reproduction, and HIV/AIDS among women, girls, men, and boys;
- ◆ adoption of a gender-sensitive approach which acknowledges the economic and social burdens placed on women and girls, particularly as a result of the pandemic; and
- ◆ adoption of a gender-sensitive approach which addresses men’s vulnerability.⁴

(Refer to “HIV/AIDS, Gender and Society” for a more detailed

discussion about the interplay between AIDS, gender, and society.)

Involving men, whose actions and decisions are determined by the same social norms, is critical to the success of prevention efforts:⁵

- ◆ Interventions intended to empower women must be coupled with interventions to sensitise, educate and otherwise involve their male partners. If men are not involved, they may view the interventions as outside interference and resent any perceived loss of power or control over their wives and households.
- ◆ If a man's extended family and peers are not also involved in education and sensitisation activities, they may make it harder for him to change by deriding what they perceive as a loss of authority on his part.

reduce their risk of HIV infection, they must be aware of the risk, and understand the choices available to them. Three of the most common strategies for promoting awareness and understanding are: formal AIDS/reproductive health education; mass media campaigns; and social marketing.

FWES, an example of successful male- and family-involvement strategy.⁶

Family Welfare Education and Services (FWES), in India, created a prevention programme that is a successful example of the ways men and other family members can be involved in improving the outlook for traditionally disempowered women. Prevention practitioners worked both with men and with their mothers, who wield considerable authority within the family structure. Mothers were taught to encourage sons to treat their wives better by pointing out that “only a healthy and happy mother produces a healthy child.”

Formal AIDS/reproductive health education

Sex education has been used in both the industrialised and developing world to help disseminate information regarding HIV/AIDS, reproduction, and human sexuality. Sex education is defined as formal education about HIV/AIDS and other reproductive health matters. Such education can be an effective way of providing information to help both adolescents and adults protect themselves from sexual related illnesses such as

HIV/AIDS. (Refer to “HIV/AIDS and Young People” for more information on sex education.)

Mass media campaigns

Governments confronting HIV/AIDS will often sponsor broad-based educational campaigns, attempting to use high visibility popular media to reach large numbers of people. These campaigns have the following specific aims:⁷

Before people can take action to

- ◆ to provide information, raise awareness and stimulate discussion;
- ◆ to inform people about the availability of further information and services;
- ◆ to encourage behaviour changes that minimise the risk of infection, usually through increased condom use, decreased number of sexual partners, and decreased incidence of sex with high-risk partners;
- ◆ to reduce misinformation about casual transmission; and
- ◆ to prevent discrimination against those infected with HIV.

In order to have the greatest chance of success, mass media campaigns should be developed through a careful planning process that includes the following:

- ◆ research to define the issues most relevant to the population; and
- ◆ pilot testing and revision of messages to ensure that they are clear and acceptable to their target audiences.³⁸

Both of these stages in planning should involve male and female representatives from the sub-groups of the population which the campaign is intended to reach.

Social marketing

Social marketing is the promotion of an item or idea using traditional commercial marketing strategies to improve public health. Social marketing that is focused on HIV/AIDS prevention usually promotes condom use, and is called Condom Social Marketing (CSM^{*}). CSM has the following objectives:³⁸

- ◆ to increase the availability of good-quality, low-cost condoms; and

- ◆ to increase the use of these condoms, both by the population in general and by specific groups that are at especially high risk of contracting or transmitting HIV.

Just like other types of mass-media campaigns, CSM must be carefully planned to be effective and avoid negative outcomes.

In order to overcome the obstacles of low availability, high cost, and negative perception of condoms, CSM attempts to simultaneously increase distribution and promote use through the following strategies:²⁹

- ◆ to create and promote recognisable condom brands;
- ◆ to sell condoms at reduced prices;
- ◆ to distribute condoms outside of stores, at places such as bars, beauty parlours, gas stations and brothels; and
- ◆ to use high visibility advertising campaigns which help to “normalise” condoms by countering widespread negative perceptions (e.g., dirtiness, untrustworthiness, disease).

^{*} This abbreviation is also used to refer to Contraceptive Social Marketing, which includes social marketing of condoms as well as birth control pills and other family planning supplies and techniques.

CSM programs have achieved considerable success, both in

distributing condoms and in encouraging their use:⁹

- ◆ Since the mid-1980s, when CSM was first used for HIV/AIDS prevention, CSM has expanded quickly and is now being used in many countries around the world. In 1996 alone, CSM programs distributed 783 million condoms and conducted culture-specific advertising campaigns in over 50 countries.
- ◆ Communication and condom-promotion campaigns, ranging from the use of traditional story-tellers to the production of radio shows and soap operas, have helped CSM programs increase condom use and improve attitudes about condoms in many countries.

Targeted interventions

Many HIV/AIDS prevention strategies are targeted at certain populations of people who are at high risk for HIV/AIDS and may play an important role in spreading HIV/AIDS to others

if they become infected. In the past, specific prevention strategies have been crafted for commercial sex workers, men who have sex with men, youth, migrant labourers, transportation and shipping workers and many others. UNAIDS has created other informational materials that describe and discuss these specific strategies.^{24, 26}

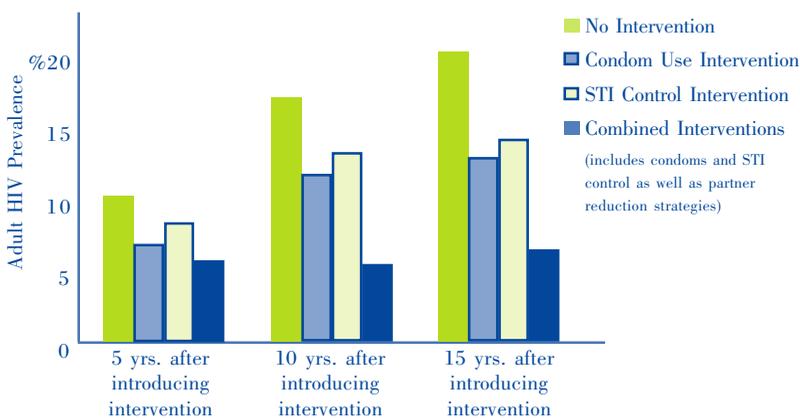
Interventions with combined strategies are more likely to be successful than any one intervention alone. (Refer to graph below.)

Preventing HIV transmission via injection drug use

The 6-10 million injection drug users (IDUs) throughout the world are often falsely considered to be a single group, despite the fact that injection drug use is prevalent in some countries on every inhabited continent except Africa.¹⁰ Although IDUs are mostly adult men, other groups who are also vulnerable to injection drug addiction include poor urban women, street children, sex workers, and migrant workers in drug-producing areas.¹⁰ Prisoners are especially vulnerable to HIV infection through injection drug use, since drug use in prisons is rarely acknowledged or addressed.²⁴

The principal risk for HIV infection among injection drug users stems from the fact that injection drug use is associated with great social stigma and is almost always illegal. People

The Effects of HIV/AIDS Interventions



Based on simulation modeling of typical high prevalence urban areas.

Note: Prevalence rates are projected to rise over time.

Source: Adapted from The Futures Group International. *AIM Presentation*. Glastonbury, CT: The Futures Group International.

who inject drugs may find it difficult to access health services and resources that might help them protect themselves from HIV infection. Legal restrictions on the sale and possession of equipment for drug injection are common in both developing and industrialised nations, forcing IDUs to share and re-use drug equipment, putting themselves and others at increased risk of HIV infection.^{10, 11}

Needle exchange is probably the best known of all HIV/AIDS interventions for IDUs, and is generally considered to be the most important single component of a comprehensive plan for HIV/AIDS prevention among IDUs. Needle exchange programs, which can now be found all over the world, allow IDUs to trade used syringes for sterile ones. Multiple research studies have shown that needle exchange is effective at reducing HIV infection rates but does not increase injection drug use.²⁴

People who inject drugs also spread HIV infection through sexual intercourse with their partners and spouses; therefore, all of the HIV/AIDS prevention objectives discussed under sexual transmission are also important for interventions focused on IDUs.

Most prevention activities for IDUs emphasise a hierarchy of prevention messages, encouraging IDUs to:¹²

- 1) stop using and injecting drugs;
- 2) not share equipment, if they continue to use and inject drugs; and
- 3) disinfect equipment to reduce transmission, if they share equipment.

UNAIDS recommends that the prevention strategies listed below be used in combination, since no single strategy provides a long term solution to the problem of HIV infection among IDUs. Strategies used to prevent HIV transmission among IDUs include the following:²⁴

- ◆ provision of sterile drug equipment;
- ◆ outreach and peer education among IDUs and their sexual partners;
- ◆ provision of health care and increase access to drug treatment; and
- ◆ distribution of condoms.

Preventing HIV transmission through blood transfusion

Although the technology exists to screen the blood supply for HIV, sufficient funds for such blood safety efforts are not always available, particularly in developing nations.¹³

In addition to screening of a nation's blood supply for HIV, the following blood safety measures are also recommended:⁴³

- ◆ comprehensive blood donor screening to reduce the chance that HIV-infected blood will be collected;
- ◆ screening of blood components for HIV before their use in treatment of haemophilia as well as in other conditions; and
- ◆ screening of the blood supply for other possible blood-borne pathogens, including hepatitis.

Where blood screening is not possible, blood-collection policies should promote voluntary donation instead of blood-selling, and encourage individuals who see themselves as high-risk

not to donate blood. In some regions, it may be possible for individuals to donate blood that they can use themselves at a later date. Finally, when the safety of the blood supply cannot be ensured, medical staff should avoid giving blood transfusions except when absolutely necessary.⁴³

Preventing mother-to-child transmission (MTCT) of HIV

It is estimated that of the 5 million infants infected with HIV since the beginning of the pandemic, about 90% were born in Africa. In the year 2000, an estimated 600,000 infants worldwide were infected with the virus, bringing the total number of young children living with HIV/AIDS to over 1 million.¹¹⁵ It is possible to prevent the transmission of HIV from mother to child in three ways:

- ◆ by preventing the mother from becoming infected;
- ◆ by ensuring that women have the right and are enabled to choose whether or not they wish to have children; and
- ◆ by reducing the risk of passing on the infection from the mother to the child, if the mother is infected, during late pregnancy (by using ARVs to prevent the baby from becoming infected), labor/delivery (by modifying obstetric practices to reduce risk of passing on infection, such as avoiding premature

rupture of membranes, avoiding unnecessary use of instruments, and planned caesarean sections when these can be done safely), and breastfeeding (where feasible, by providing safe, sustainable and acceptable alternatives to breastfeeding, so that the babies who are not infected at birth will not be infected through breastfeeding).

Antiretroviral Drugs (ARVs)¹⁴

Antiretroviral Drugs, also known as ARVs (Antiretrovirals), prevent HIV from reproducing and infecting cells inside the body of an HIV+ person. They are not a cure for HIV/AIDS, but when used correctly, they can help many (but not all) people with HIV/AIDS lead longer, healthier lives. ARVs can also be used in relatively small amounts to reduce the risk that a mother will transmit HIV to her baby. Because ARVs are expensive, most people with HIV/AIDS do not have access to them. Among those who do have access, many find it difficult to adhere to the complicated medication schedules. ARVs can also cause serious side-effects, such as nerve and liver damage. Some research suggests that ARVs may affect women and men differently, but more studies that take gender differences into account are needed.^{15, 16}

The first step toward preventing MTCT is providing women with access to general health care and pre- and post-natal services. For this reason, interventions to prevent MTCT are often combined with general efforts to improve health services for women and their children.²⁴ Once women have access to prenatal services, they should be offered an HIV test, and provided with information about the risks of HIV. Testing is of critical importance—it is estimated that 9 out of 10 HIV+ women in developing nations do not know that they are infected. Mandatory or coercive testing

is not appropriate, as it will discourage women from accessing care.²⁷

ARVs, which are used to treat HIV/AIDS in nations where citizens or governments can afford their cost, have been used in conjunction with HIV testing regimens to drastically reduce MTCT in many industrialised nations.^{27, 17}

- ◆ MTCT prevention using ARVs works in this way: a relatively small dose of one or more drugs temporarily lowers the amount of virus in the mother's body, making it less likely that the child will become infected before or during birth by providing the baby with ARVs as postexposure prevention.
- ◆ Studies suggest that this type of treatment does not typically harm the mother or child.

In addition to ARVs, other interventions exist to prevent MTCT. These interventions must also be used in conjunction with ARVs:

- ◆ voluntary testing and counselling for pregnant women and women contemplating pregnancy;
- ◆ provision of high-quality health care before, during and after birth; and
- ◆ creation of referral networks to help women access prenatal care.

If a pregnant woman is infected, she should be counselled on breastfeeding and alternatives to breastfeeding.

- ◆ Breastfeeding is normally the healthiest choice for mothers and children. It provides the child with excellent nutrition as well as support for its undeveloped immune system.
- ◆ If the mother is HIV+, however, breastfeeding increases the risk that the child will become HIV+.
- ◆ HIV+ women should only use alternatives to breastfeeding if they have access to clean water and breast-milk substitutes that provide their child with proper nutrition, and if alternatives are acceptable, sustainable and affordable.^{18, 19, 27}

Care of those Living with HIV/AIDS

Quality of care for HIV patients in most parts of the world remains low, despite increased efforts and expenditures in many countries. Cost is probably the greatest obstacle—providing proper care for both men and women with HIV/AIDS requires implementing a wide range of health services, including reproductive and child health, tuberculosis, STI and HIV/AIDS-specific services. Because HIV/AIDS is most prevalent in less economically prosperous regions of the world, most HIV/AIDS patients cannot afford to pay for their own health care. Already, the drain on health care caused by HIV/AIDS is reducing the overall quality of care in some places, and when resources are insufficient to offer care to all patients, it is typically women who have reduced access to health care and who receive lower quality of care when they do get access.¹

Traditional gender roles affect the ways in which men and women seek out health care:

- ◆ Within a family, men's illnesses are often perceived as more important because they often have a greater impact on wage-earning. The contribution of "women's work" to family survival is usually undervalued,⁴⁹ and women's illnesses may be ignored

until they are unable to perform daily tasks.³⁶

- ◆ Women are traditionally responsible for the well being and health of their families. Inability to care for their families often results in feelings of failure and decreased self-esteem. Low self-esteem, together with the higher priority placed on children's health, makes women less likely to seek out care for themselves.^{2,3}
- ◆ Traditional ideals of masculinity, which require men to endure pain rather than admit weakness, prevent some men from seeking care.³⁶

The stigma surrounding HIV/AIDS has a particularly heavy impact on women:

- ◆ Women in some regions of the world may not seek care out of fear that their children will be taken away from them if they are diagnosed with a severe illness.⁵⁰
- ◆ Women are often blamed for the spread of HIV/AIDS to their families.
- ◆ HIV/AIDS is incorrectly perceived as a “woman's disease” or “prostitute's disease” in many parts of the world, causing women to refrain from HIV testing and seeking out care in order to avoid being ostracised, abused, and viewed as promiscuous.^{19, 4, 5}
- ◆ Medical personnel in some parts of the world may refuse to treat women who are in-

fectured with HIV/AIDS or other STIs because of widespread beliefs that these women are dirty or promiscuous.³⁴

Some studies have shown that women with HIV/AIDS die more quickly (on average) than men with HIV/AIDS.⁴ This difference is likely to be a result of differing access to care and quality of care rather than the biology of HIV/AIDS:

- ◆ Research suggests that women whose HIV infections are detected early and who receive high quality care survive as long as HIV-infected men.⁶
- ◆ Even in areas where women have good access to HIV/AIDS care, there is evidence that they wait longer than men before seeking care and are less likely to seek care at all.^{49, 54}
- ◆ Women with HIV/AIDS in many countries are also more likely than men to suffer from malnourishment, which accelerates disease progression.⁴⁹
- ◆ Because women have limited economic opportunities and are considered to be lower priority than men within a family, their access to fee-based health care services is severely restricted.³⁶
- ◆ In areas where antiretroviral drugs (ARVs help people with HIV/AIDS live longer, healthier lives) are available, many doctors assume that women will have more difficulty adhering to complicated medication regimens, and may be less likely to offer treatment to women with AIDS, even though research has shown that women are just as likely as men to adhere to treatment.^{45, 53}

In previous sections we explored gender in relation to the prevalence, prevention and treatment of HIV/AIDS, with special emphasis on the physiological factors that increase men's and women's vulnerability to infection. In this section, we discuss the social factors that contribute to HIV/AIDS risk. While HIV is found in men, women, boys and girls, the causes and consequences of infection are different for each.

HIV/AIDS, Gender and Risk

In this section we will look at the relationship between HIV/AIDS and the social status of women, the impact of HIV/AIDS on social structure, the link between HIV/AIDS and poverty, the particular issues related to HIV/AIDS and adolescents, the connection between violence and HIV/AIDS, and the role of sex workers in the HIV/AIDS pandemic. In each of these cases, women's economic, political, and social positioning forms the backdrop for our discussion. Our purpose is to show how gender norms and expectations not only exacerbate women's and girls' risk of HIV infection, but also how these can contribute to infection in men and boys.

In most parts of the world, girls and women face particular risk of HIV infection because of the interplay between their economic positions and social status. These realities form a social context in which their abilities to make healthy choices are often diminished. Economic and social indicators representing literacy, income, and education each point to women's and girls' unequal status in these areas:

- ◆ Women make up almost two-thirds of the world's 876 million illiterates.⁵⁵
- ◆ Women receive an average of 30-40% less pay than men for the same work.⁵⁶
- ◆ Worldwide, there are 90 young women in secondary school for every 100 young men.⁵⁷

- ◆ In some countries, including Bangladesh, Yemen, Cambodia, Chad, and Niger, there are less than 60 young women in secondary school for every 100 young men.⁵⁷

Because of women's economic and social position, they often have difficulty controlling when, where, and how sex takes place. The impact of this inability to negotiate sex practices falls most heavily on women themselves. The state of women's sexual status is reflected in the following statistics:

*Each year worldwide, there are an estimated.*³⁶

- ◆ 80 million unwanted pregnancies
- ◆ 20 million unsafe abortions
- ◆ 500,000 maternal deaths (including 78,000 as a result of unsafe abortions)

Most HIV+ women have become infected with the virus through heterosexual intercourse. While popular perceptions of HIV/AIDS often depict it as an illness of "promiscuous" people, many HIV+ women acquired the virus from their husbands:

- ◆ An estimated 60-80% of HIV+ African women have had sexual intercourse solely with their husbands.⁵⁸
- ◆ A sampling of 400 women seeking treatment for sexually transmitted infections in Pune, India, discovered that 13% of them tested positive for HIV. 91% of them reported only ever having sex with their husbands.⁵⁹
- ◆ While women are often perceived as bearers of HIV/AIDS, it is usually men who bring HIV into a family or committed sexual relationship.¹⁹
- ◆ Women who submit to their partners' demands for risky sex in order to avoid abandonment and abuse may become the victims of both if they contract HIV from their partners. Research shows that women who are known to be HIV+ are more likely to be abused, abandoned, or even killed.¹⁹

Because heterosexual intercourse is the primary means of HIV transmission for women, and because many women acquire the virus through intimate relationships with their husbands and male partners, gender-based power relations within these relationships often

result in a heightened vulnerability for women. Economic dependence is one factor that makes it difficult for many women to discuss HIV and negotiate safer sex with their partners. Gender roles can also complicate matters by promoting behaviours for men and women that put both groups at risk, as illustrated in the next section.

Gender roles

Gender roles—society's expectations of how males and females should look, feel, behave, and live—often increase the risk of HIV for both women *and* men. In this section, we explore the influence of gender roles and gender expectations on HIV/AIDS risk in three main areas: knowledge (particularly sexual knowledge), sexual passivity and aggression, and promiscuity.

Women and the Burden of HIV/AIDS

◆ While women accounted for only 47% of the 36.1 million people living with HIV/AIDS at the end of 2000, more than 50% of the 17.5 million adults who have died of AIDS since the beginning of the epidemic are women.²¹

◆ The economic burdens presented by HIV seem to fall most heavily on the shoulders of women, who already make up 70% of the world's poor.⁵⁶

◆ Among AIDS orphans (children who have lost one or both parents to AIDS), female children are more likely to be withdrawn from school than their male counterparts.¹¹⁴

◆ Research in Africa shows that women are less likely to be admitted to the hospital and less likely to get the benefit of family resources when sick than male family members.¹¹⁴

Sometimes, gender roles bear directly on HIV/AIDS risk. For example, in many countries women are under great pressure to demonstrate their fertility and become mothers.³⁴ The goal of producing children is directly incompatible with safer sex practices. Women who seek to become pregnant may have no real options to protect themselves against HIV/AIDS.

Gender roles can also bear indirectly on HIV/AIDS risk, as when unhealthy or unattainable norms are set which may inadvertently put people into situations of risk. For example, men who live in conditions of poverty may be unable to provide for their families—an important gender role that many men feel obligated to fulfill. Studies show that men who are unable to live up to such expectations may respond by becoming dependent on alcohol or inflicting violence or sexual control on those who are weaker and more disempowered than they are.³⁶

Knowledge

The need for correct knowledge about HIV/AIDS is paramount. Insufficient or incorrect information is a risk factor for many people. Research shows that many people—particularly young people—do not have correct knowledge about the transmission, prevention, and risks associated with HIV/AIDS.

- ◆ In a study of Cambodian seafarers who visit commercial sex workers, most reported that they did not use condoms because they did not perceive themselves to be at risk for HIV/AIDS.⁶¹
- ◆ A study of poor married women in Bombay, India revealed that many women had received no information about sex prior to their own experience of it.³⁵
- ◆ The myth that sex with a virgin girl can cure HIV has prompted some men—particularly in eastern and southern Africa—to seek out young girls as sex partners.⁶²
- ◆ One quarter of female university students in Nigeria agreed with the incorrect statement

“young people cannot get AIDS.”²⁹

Knowledge of HIV/AIDS is an important feature of efforts to prevent transmission. Yet, knowledge becomes useful only when people have the ability to protect themselves from the virus. Gender roles and expectations can make this difficult. For example, in many societies, it is considered improper for a woman to demonstrate sexual knowledge. Thus, even when women are provided with knowledge about HIV/AIDS, its transmission, and how they can protect themselves, they may feel unable to share this knowledge with their partners. The HIV prevention methods usually offered to women—abstinence, mutual fidelity, or condom use—may not be within their power to control.

Equally a problem is the gender expectation that men are knowledgeable about sex. Evidence from Thailand suggests that the notion that men “know what to do” in regard to sex is consistent with society’s ideal of what it means to be a man.⁶¹ This can make men feel uncomfortable about admitting what they do not know, limiting their ability to access correct information about HIV/AIDS. Men, too, may be expected to make reproductive health decisions within the family, leaving them with the burden of managing HIV/AIDS risk.

Young people—particularly young girls—can also find it difficult to access correct

information about HIV/AIDS due to societal expectations that they are not sexually active. Research in Brazil, Mauritius, and Thailand revealed that young women are hesitant to seek information on sexual health for fear of appearing sexually active.²⁹ Further, studies show that even where access to correct information is possible, young women rarely have the power to demand condom use by their partners.⁶³

Sexual passivity & aggression

In many societies, women are expected to display sexual passivity. This means that women are not supposed to initiate sexual encounters, and that within sexual encounters women should defer to the sexual pleasure of men. A study of Zimbabwean girls and boys found that while boys expected to initiate sexual encounters, girls did not.²⁹ Even when equipped with the correct information about HIV/AIDS, women may be tacitly discouraged from taking active steps to protect themselves. In societies where social and cultural norms support the man's right to determine the type and timing of sex, women may be unable to negotiate.³⁴

For men, the gender stereotype is sexual aggression. This often implies pursuing a number of sexual partners and being “in control” of sexual interactions. Stereotypical characteristics of men include dominance, physical strength, virility, and risk-taking. The pressure to

prove one's possession of these characteristics can sometimes push young men to engage in unsafe sex practices.⁶¹ Drug and alcohol use—in many countries, a “male” activity—often play a factor in diminishing inhibitions, which can lead to unprotected sexual intercourse, and can also be a contributing factor to sexual violence.³⁵

Male aggression is also related to the occurrence of sexual violence, coercion, and rape of women. Researchers in diverse settings such as Guatemala, India, Jamaica, and Papua New Guinea have found cases in which women were reluctant to raise the issue of condom use with a partner because of the threat of violent retaliation.³⁵

*A study of young women in South Africa revealed that.*³⁵

- ◆ 30% reported that their first sexual intercourse was forced.
- ◆ 71% reported having sex against their will.
- ◆ 11% reported being raped.

Violent and coerced sex can also increase a woman's *biological* vulnerability to HIV because of damage to membranes of the genital area.⁵⁹

Promiscuity

In many cultures where female virginity is valued, young women are expected not to engage in sexual intercourse until married. While the standards may be the same for young men, male “experimentation” with numerous sexual partners may often be tolerated. After marriage, this “double standard” often continues to punish women for sexual transgressions while indulging the same in men.

These gender roles are particularly important for young women and men, girls and boys, who face additional pressure to conform to gender roles:

- ◆ A study undertaken in Guatemala revealed a widely-held perception that having numerous sexual partners was a necessary feature of a young man's physical and mental development.²⁹
- ◆ Another study found that in Nicaragua, boys who failed to conform to such expectations faced ridicule.⁶³
- ◆ Anecdotal evidence in Thailand suggests that 15-year-old youths are not considered "real men" until they have visited a commercial sex worker.⁶⁴
- ◆ Focus group discussion among Zimbabwean high school students revealed popular perceptions that boys should have many girlfriends while girls should "stick to one boy."³⁵

When it comes to HIV, this "double standard" can put both males and females at risk. Where virginity is valued, young women may engage in risky sexual behaviour (namely, anal sex) in order to "protect" their virginity. Older men may seek out younger female partners on the belief that they are virgins and free from HIV.⁶⁵ A study in Zimbabwe revealed that schoolgirls are often approached by older men who offer money and gifts in exchange for sex. Girls who began relationships with these men (known as "sugar daddies") pointed to the need for money (often for school fees) as an incentive.²⁹

Some stereotypical ideas of manhood reveal an underlying belief that men "need" multiple sexual partners, that "sexual variation is essential to men's nature."³⁵ While stereotypes dictate that these partners be women, sometimes men have sex with other men. Research in India revealed that 90% of the male clients who frequent male sex workers were married.³⁵ This practice is often regarded with secrecy and shame—and in some countries, illegality. Men who have sex with men are often at risk of contracting and transmitting HIV. The

stigma and denial of homosexual behaviour may make men reluctant to take measures to protect themselves from HIV, particularly when clandestine sexual encounters are rushed.

The popular notion that HIV/AIDS is an illness that affects "promiscuous" people has repercussions on women who become HIV+. Because of the association between HIV and promiscuity, women who are HIV+ may be particularly stigmatised.⁶⁶

Some successful prevention efforts have addressed local gender roles and expectations. A recent study of young female factory workers in Thailand found that a peer education HIV prevention programme which included discussion about how dominant ideas of masculinity and femininity influenced safer sex choices resulted in a significant improvement in knowledge and HIV prevention skills. Further, the study found that women were often reluctant to talk about sex for fear of appearing promiscuous to others. Rewarding participants with certificates and "peer educator" status upon completion of the course gave them the ability to talk openly about sex without worrying about compromising their reputations.⁶³



Enabling Environment

The term “enabling environment” describes the economic, cultural, social, and political circumstances that contribute to HIV/AIDS risk. Not only may an enabling environment facilitate the spread of HIV/AIDS, but high incidence of HIV infection may worsen the conditions of the enabling environment, creating a “vicious cycle” in which increasing numbers of people become infected. This section examines the enabling environment, focusing on the economic, social, cultural, and political factors that contribute to, and are affected by, HIV/AIDS.

Economic factors

HIV/AIDS tends to affect the most impoverished. At the same time, HIV/AIDS can lead to poverty within affected families, communities, and even nations.

Poverty and HIV/AIDS

- ◆ 95% of all AIDS cases have occurred in developing countries.⁶⁷
- ◆ Sub-Saharan Africa, the region where GNP per capita is the lowest (\$520), has the highest prevalence rate of HIV infection (8.57%).⁶⁸
- ◆ Among urban adults, low income and unequal income distribution are strongly

associated with high HIV infection.²

Poverty contributes to the HIV risk of individuals or communities:

- ◆ Poverty means a day-to-day struggle for life in which individuals may be unable to afford the “luxury” of worrying about HIV/AIDS.
- ◆ In developing countries, 45% of women of childbearing age are unable to eat the recommended number of calories each day.⁶⁹ When shortage of food is a prime concern, managing HIV risk may not be a priority.
- ◆ In a recent study of street children in Rio de Janeiro, young people explained that they worried more about dying of hunger or violence than HIV/AIDS.⁶³

AIDS medications—which can slow the course of the epidemic and help people with HIV live longer—are too expensive in places where poverty is widespread:

- ◆ AIDS medications can cost \$400 a month in regions of Africa where 290 million people live on less than one dollar a day.⁷⁰

Poor women are particularly at risk of HIV/AIDS because economic inequality and social disempowerment may influence their abilities to control the timing and safety of sexual intercourse.²⁹

Local conditions of poverty may prompt individuals to search for jobs elsewhere. Such labour migration can create increased susceptibility to HIV infection across social networks:

- ◆ Men who engage in labour migration may be vulnerable to HIV if they have unprotected sex with sex workers or with multiple partners.
- ◆ The unequal ratio of men to women—common in a number of migratory contexts—can also foster the spread of HIV when infected

sex partners are shared.³⁵

Labour migration can also be a means through which young women become involved in the commercial sex trade. Young women may find themselves conned into joining the trade after taking up offers of work in urban areas. For example, it has been revealed that young Burmese women seeking paid work in Thailand have been unknowingly sold into the sex trade by employment agents.³⁵ Sex workers, because they may have unprotected sex with multiple partners, may be at an extremely high risk of HIV/AIDS and other sexually transmitted infections. Because of the illegality of sex work in most places, sex workers may be reluctant or unable to seek medical care and treatment for existing infections. (Refer to “HIV/AIDS & Sex Work” for more information.)

HIV/AIDS: Contributing to poverty

Not only is poverty an enabling environment of HIV, but HIV/AIDS can also *lead to* poverty, particularly for women and young people:

- ◆ When the primary breadwinner becomes infected with HIV/AIDS, household income can falter, causing hardship and the need for child labour.
- ◆ Where women are customarily unable to own and inherit land, the wife and children of a man who has died from HIV/AIDS may lose access to productive resources.

Economic indicators show how HIV/AIDS may lead to greater poverty in the years to come:

- ◆ The economic impact of AIDS in sub-Saharan Africa could cut the wealth of some countries by up to 20%, deepening existing poverty and drying up resources available to fight the epidemic.⁷¹
- ◆ Researchers estimate that by 2010, South Africa’s GDP will be 17% lower than it would be without the pandemic. In South Africa, approximately one in five people are HIV+.⁷²
- ◆ In Botswana—where 36% of people are

HIV+—the poorest households of those affected are expected to be 13% worse off financially than without HIV/AIDS.⁷²

Yet, economic indicators can be deceptive: while HIV/AIDS causes a decrease in productivity because of the loss in work force, the vast numbers of AIDS deaths may cause the GDP per capita of a country to actually *increase*.²

Cultural & societal factors

While some cultural and social practices may facilitate the transmission of HIV, widespread incidence of HIV infection is also changing the face of society and culture. Some traditional practices that relate specifically to sex and sexuality may bear directly on HIV vulnerability, such as the customary marrying of young or virginal women to older, more sexually-experienced men. At the same time, long-standing family structures and social networks can deteriorate in regions where HIV/AIDS has had a devastating impact.

Traditional practices

In some societies where men’s sexual pleasure is paramount, women may be encouraged to engage in risky behaviour in order to please their partners. For example, in parts of Africa, women have been known to insert herbs, roots, or scouring powders into the vagina in order to dry and tighten the

vaginal passage, on the belief that this makes sex more pleasurable for men.³⁵ Evidence suggests that these practices of dry sex may be associated with increased HIV infection:

- ◆ Dry sex can cause a woman to bleed, providing a direct passageway for HIV to enter the bloodstream.
- ◆ Drying agents can also cause inflammations or lesions on a woman's genitalia.
- ◆ Dry sex can increase the risk of HIV infection for men who have not been circumcised because a man's foreskin is susceptible to tearing, creating a pathway for HIV infection.⁷³

Female genital mutilation (FGM) is another traditional practice that may facilitate the spread of HIV. When female genital cutting is performed on a number of young women in a group initiation ceremony with shared razors or knives, there is a risk of transmitting HIV via the blood on unsterile instruments.⁶³ The traditional practice of male circumcision can also result in HIV transmission where shared cutting instruments are used.⁶³

Under some customary or religious laws, women have no legal right to household resources through inheritance. This can

mean that the wife of a man who has died of AIDS loses the ability to provide for herself and her children:

- ◆ Women own only 1% of the world's land. Where access to land is the primary means for sustaining a livelihood, lack of access to it can be deadly.⁵⁹

The changing social and family structure

The demographic changes that are occurring due to HIV/AIDS, such as increased parental mortality as well as increased death among children, have many impacts on social and family structures.⁷⁵ For example, a family's finances may not withstand the immense pressure that HIV infection can pose—particularly if the primary breadwinner is living with HIV/AIDS.² Because AIDS tends to affect those in the most productive years of their lives, the impact on families can be considerable:

- ◆ Where older relatives, such as grandparents, step in to care for younger ones who are infected with HIV, the burden of income-generation may fall on the shoulders of children. This “role reversal” can contribute to child labour.⁷⁶
- ◆ Research shows that as members of a household become infected, children are often taken out of school.⁷⁷

There is evidence that the effects of HIV infection in the family are more than a matter of economics:

- ◆ The social stigma associated with HIV/AIDS may prevent affected families from discussing their situation with others.⁷⁴ They may be unlikely to rely on social networks of support for help, as they would do otherwise.
- ◆ Because many developing countries lack the resources of public assistance, the burden of care of HIV/AIDS victims often falls on families. In some regions, up to two-thirds of adults who die of HIV/AIDS are cared for by a parent sometime during their illness.⁷⁸

- ◆ Older people who care for their grown HIV+ children may experience physical strain from caregiving, the disruption of social relations where stigma is associated with HIV infection, and the emotional strain of caring for a dying child.⁷⁸ These consequences are harsher in developing countries where there is an expectation that children will provide for their own ageing parents.⁷⁸
- ◆ The impact of HIV/AIDS can be particularly hard on ageing parents. In Thailand, where only 2% of people are infected with HIV, more than 10% of people in their 50s can expect to lose a child to AIDS.⁷⁸

The AIDS deaths of many people of reproductive age has resulted in the phenomenon of AIDS orphans—children who have lost a mother or both parents to HIV/AIDS:

- ◆ UNAIDS estimates that more than 13.2 million children under the age of 15 have lost a mother or both parents to HIV/AIDS.²²
- ◆ There are more than 12 million AIDS orphans in Africa alone.⁷¹

The challenges of AIDS orphans include the following:

- ◆ AIDS orphans can be particularly susceptible to discrimination: both because of the stigma attached to their parents' death, and because a third of them are themselves infected with HIV.²
- ◆ A Ugandan study showed that foster children often are given the smallest share of a family's resources, including food, school fees, healthcare, and bedding.⁷⁴

Efforts to Support AIDS Orphans

Church groups in Zimbabwe have tried to improve the lives of orphans by organising community members who agree to visit orphans in their homes—whether they live with grandparents, foster parents, other relatives, or are heads-of-household themselves. These weekly or twice-weekly visits help give orphans emotional and material support. Volunteers bring blankets, money for school, and seeds and fertiliser as needed. With over 180 volunteers, the programme is cost-effective: they have helped over 2,700 households with orphans, at a cost of under US\$10 per family.²¹

- ◆ Children who lose a parent suffer measurable declines in nutritional status and schooling opportunities.²
- ◆ In Zambia it was found that 65% of households where a mother had died were dissolved.⁷²

Caring for and raising the growing number of AIDS orphans has become a priority among NGOs and the governments of highly-affected countries. The institutionalisation of these young people (into orphanages) is a costly solution—and one that may not be in the best interests of orphans themselves:

- ◆ Orphanages rarely prepare young people for future lives as adults.²¹
- ◆ In Ethiopia, the cost of keeping a child in an orphanage for one year is between US\$300 and US\$500 a year. This is over three times the per capita national income.²¹

Political factors

Politics play an important role in the enabling environments for HIV/AIDS. At the same time, political instability (particularly in the form of war or armed conflict) can create situations that place individuals at increased risk of HIV infection.

Women’s access to political power

The political will to establish HIV/AIDS policies is lacking in many countries, especially those policies that help women and girls. For example, in countries where women do not have access to decision-making, or do not have representation in the government, their lack of formal power may mean that HIV/

AIDS policies are ill-suited to meet their needs. Today, women make up only 13.8% of the seats in national parliaments.⁷⁹

The impact of instability

Political instability can contribute to the spread of HIV/AIDS. War and social upheaval can result in the disintegration of the family, the loss of local social systems, and mass migration, creating an enabling environment for the transmission of HIV. Rape and atrocities often accompany the violence of war. (Refer to “HIV/AIDS and Violence” for more information.)

Prevention Efforts

An enabling environment is made up of a variety of social, economic, cultural, and political factors. This means that prevention measures must take into account a broad spectrum of social realities. Uganda, which had runaway HIV infection rates until the early-1990’s, has used a multi-sectoral approach to curb the high rates. In addition to widespread public information campaigns, Ugandan officials have promoted the participation of state, local, non-governmental, and community-based agencies in the fight against HIV/AIDS. Ugandan rates of HIV infection among girls aged 13-19 dropped from 4.4% in 1989-1990 to 1.4% in 1996-1997.⁸⁰ Reports also indicate that in the capital city of Kampala, the number of HIV positive pregnant women—which peaked at three in 10 in the early 1990’s—has also fallen sharply.⁸¹

Nordic countries	38.8%
Americas	15.6%
Asia	14.9%
Europe - OSCE member countries (excluding Nordic Countries)	13.8%
Pacific	13.6%
Sub-Saharan Africa	12.5%
Arab States	3.6%



HIV/AIDS and Young People

The HIV/AIDS pandemic is radically changing the lives of many young people (aged 10-24). In some regions of the world, young people face a greater risk of HIV infection than any other age group. Moreover, young people are particularly affected by the occurrence of HIV/AIDS in those who play important roles in their lives, such as teachers, parents, and other family members. When people close to them become infected with HIV, young women and men are faced with new responsibilities and challenges—dramatically altering what it means to be a young person. This section looks at the affect HIV/AIDS has on the lives of young people, the factors that place them at risk, and the prevention efforts that have been proven successful at lowering their rates of infection.

The effect of HIV/AIDS on young people

HIV prevalence among youth

- ◆ Every minute, six people under the age of 24 become infected with HIV.⁸²
- ◆ According to UNAIDS, 1.7 million young Africans are infected with HIV each year.⁸³
- ◆ In countries where 15% of adults are HIV+, a third of today's 15-year-olds are projected to become infected with HIV/AIDS.⁶⁷
- ◆ In South Africa and Zimbabwe, one-half of 15-year-olds are expected to die of HIV/AIDS.⁶⁷
- ◆ Half of all people who acquire HIV become infected before the age of 25.²⁶

The special vulnerability of young women

In countries with low prevalence levels, young men often have higher rates of infection than young women. In some places with higher HIV-infection rates, young women surpass young men of the same age in HIV infection rates:⁸⁴

- ◆ In Peru, where rates are relatively low, 0.4% of young men aged 15-24 and 0.2% of young women in the same age group are HIV+.
- ◆ However, in Lesotho, where HIV rates are high, 12% of young men and a full 26% of young women are infected.

Worldwide statistics point to the escalating HIV infection rates in young women:

- ◆ In sub-Saharan Africa, young women aged 15-24 experience HIV prevalence rates two to three times the rates of young men. Among young people aged 15-19, the gender discrepancy is even more extreme.⁶⁷
- ◆ In Botswana, among 15-24-year-olds, one in three young women, and one in seven young men have HIV.⁸⁵

Evidence shows that HIV+ females are less likely than males to be given their family's support and resources.⁶³

The effects of widespread HIV infection

Young people are tremendously affected by the HIV/AIDS pandemic not only because of the prevalence of HIV within their age group, but also because of HIV infection among those closest to them, their parents and teachers:

- ◆ Young people whose parents have died of HIV/AIDS may find it difficult to get support and care from adults—especially when they are

themselves HIV+.⁶³ (Refer to “Enabling Environment” for more information about AIDS orphans.)

- ◆ Between 1996-1998 HIV/AIDS killed five teachers each week in Côte d’Ivoire.⁷⁷
- ◆ 1,300 teachers died in Zambia in the first 10 months of 1998 due to AIDS.⁷⁷
- ◆ As many as 860,000 primary school children are believed to have lost their teachers to HIV/AIDS in the worst affected areas of Africa.⁸⁵
- ◆ When a male head-of-household becomes ill, women are likely to divert household resources to care for him. This is often at the expense of children, who may be taken out of school. Girl children are usually the first to be taken out of school.¹⁹

Why young people are at risk

Sexual activity

Young people have sex for a number of reasons, including love and sexual desire. Abuse, economic necessity and social pressure can also contribute to sexual activity:²⁹

- ◆ Girls and young women may initiate relationships with older men in order to exchange sex for material benefit. Of 168 sexually active young women in Malawi, two-thirds reported exchanging sex for money or gifts. 18% of 274 sexually active

female university students in Nigeria reported the same.⁶³

- ◆ Adolescent girls are more likely to consent to sex in order to prove their love and obedience towards their partner.⁶³
- ◆ There are documented cases of young men engaging in commercial sex work in order to support their families in Thailand, Mexico, Peru, and Sri Lanka.⁶³
- ◆ A recent study of 141 street children in South Africa revealed that more than half exchanged sex for food, money, or protection.⁶³
- ◆ Two million girls between the ages of five and 15 are introduced into the commercial sex market each year.³⁶
- ◆ In Jakarta, Indonesia, street children reported frequent incidents of rape and sexual abuse.⁶³

Young women are especially vulnerable to HIV infection through sexual intercourse because:

- ◆ The immature genital tract of girls is more likely to tear during sexual activity, creating a higher risk of HIV transmission during acts of unprotected sex.
- ◆ Young women tend to have older, more experienced sexual partners. Such partners are more likely to have sexually transmitted infections (STIs) due to their previous sexual experiences. The power imbalances between young women and their older partners may make it difficult for young women to request condom use or control sexual encounters.⁶⁷

Knowledge

Despite high levels of sexual activity, young people often do not know the basic facts about HIV/AIDS, which puts them at risk:

- ◆ A recent study found that nearly half of African young women aged 15-19 thought that a person’s HIV status could be discerned just by looking at them.⁸⁵
- ◆ In Thailand, 65% of sexually-active youth said

they did not use condoms because they did not think they were at risk of infection.⁸⁷

- ◆ Sexual health knowledge is withheld from young women in many countries on the erroneous belief that discussion of sexual health promotes sexual activity.⁶³
- ◆ 8% of young unmarried men (aged 15-21) in Lucknow, India are sexually active—but reports indicate that most know nothing about STIs.⁸⁸
- ◆ In 17 countries of Africa, more than half of young people were found not to know how to protect themselves from HIV.⁸⁵

Studies show that when young people lack sex education—knowledge about their own bodies, body processes, and the risks of various sexually transmitted infections—they are more at risk of contracting HIV.⁸⁶ Some young people get their sexual health information from unreliable sources, which also places them at risk:

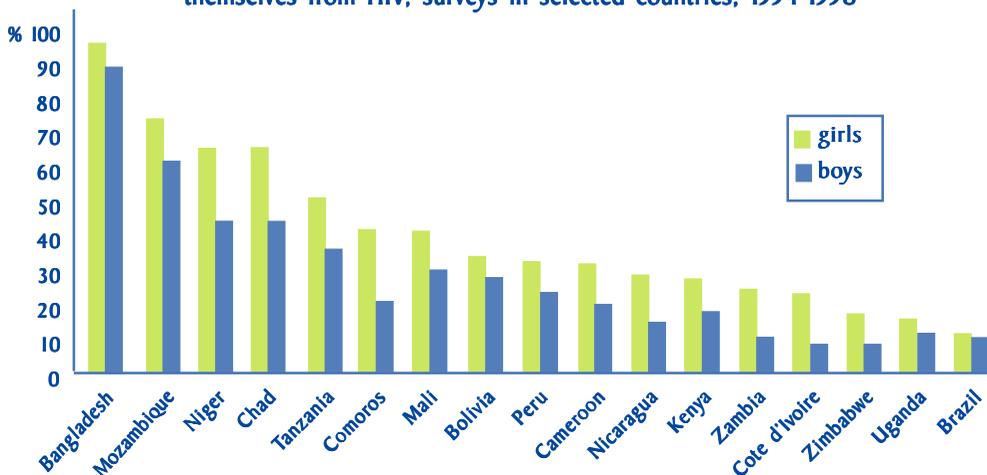
- ◆ Young people often rely on their peers, not their parents, for information and guidance about sex.⁶³

◆ Studies in Costa Rica, Cameroon, Zimbabwe, and the Philippines reveal that while parents often provide young women with a small amount of sexual health education (usually relating to menstruation and reproduction), young men rarely receive any.⁶³

In cases where young people have sexual health knowledge, they may still be at risk:⁶³

- ◆ Even when young people want to protect themselves, they often have a hard time obtaining or affording condoms.
- ◆ Young people may not seek out appropriate health care, even when they are knowledgeable about the risks of unprotected sex. Young people in Tanzania told researchers

Proportion of girls and boys, aged 15-19, who do not know how to protect themselves from HIV, surveys in selected countries, 1994-1998



Source: UNAIDS. Report on the Global HIV/AIDS Epidemic: June 2000. Geneva: UNAIDS, 2000.

that they treated themselves for STIs with over-the-counter medicines, rather than going to the health clinic.

- ◆ The stigmatisation and illegality of commercial sex work can make it difficult for young sex workers to negotiate condom use with their clients or to obtain treatment of STIs.
- ◆ Research in Nigeria, Egypt, and Mexico revealed that young women rarely have the power to negotiate safer sex with their partners, even when they know the facts about HIV/AIDS and the best ways to protect themselves.

Gender roles

Gender inequalities and socially-prescribed gender roles can contribute to young people's risk of HIV infection. Adolescent girls are at risk from gender roles that emphasise innocence, virginity, and submission to male prerogative:

- ◆ Where traditional ideologies place high value on virginity and sexual inexperience among young, unmarried women, adolescent girls who exhibit too much knowledge of sex and reproduction may be seen as promiscuous.
- ◆ In Thailand and Guatemala, young women report hiding knowledge of sex in order to protect their public reputations.⁶³
- ◆ Social expectations of virginity may lead adolescent girls

to engage in anal sex to preserve their virginity.²⁹

- ◆ Young women are often socialised to allow men to take control of sexual encounters, and to relinquish their own ability to influence how and when sex takes place.⁶³
- ◆ The gender expectation that young women are not sexually active may lead older men to seek them out as sexual partners—on the belief that they are not infected with HIV. Young women may be at risk from male partners who have extensive sexual experience and do not support condom use.⁶³

Adolescent boys are constrained by gender roles which call for aggression and sexual risk-taking:

- ◆ Boys are often expected to experiment with sex during their adolescent years. In many societies, sexual experience among boys and young men is encouraged by peers and seen as a matter of prestige.⁸⁸
- ◆ In South Africa, social popularity among adolescent boys is usually associated with sexual experience.⁶³

Prevention efforts

Because half of all people who acquire HIV become infected before they turn 25 years old,²⁶ interventions designed to educate young people and protect them from HIV could have greater long-term impact than any other type of focused intervention. In many countries opponents of sexual health education believe that:

- ◆ Children and young people receive important information on sexual health from family sources.
- ◆ Educating young people about sex and health issues related to sex will encourage them to become sexually active earlier than they would have otherwise.

Yet, research has shown that young people are often unable to speak to their family members about sexual issues and that sex education does not lead

to increased sexual activity among children and young people.⁸⁹

- ◆ A review of 19 studies from around the world provided no evidence that sexual and reproductive health education (“sex education”) leads to earlier or greater amounts of sexual activity among young people.
- ◆ Some sex education programmes have succeeded in delaying students’ first intercourse, reducing students’ frequency of intercourse, and increasing the chances that sexually active students will adopt behaviours that reduce their risk of HIV infection.
- ◆ Sex education programmes that emphasise skills (such as condom use) and address the social conditions under which students live are more likely to be effective in reducing student’s risk of HIV/AIDS.

In some societies, there is no precedent for school-based sex education. When introducing this type of education, it is critical to work with teachers to increase their comfort discussing topics related to sex to enhance the potential effectiveness of school-based sex education.²⁹

Interventions designed to reach young people typically have the following objectives:²⁴

- ◆ increase knowledge and understanding about HIV/AIDS, including personal risk assessment;
- ◆ increase acceptance of abstinence and safer sexual behaviour;
- ◆ delay first intercourse for young people who are not yet sexually active;
- ◆ increase condom use among sexually active young people; and
- ◆ decrease number of partners among sexually active young people.

Many interventions use peer educators to convey

important prevention messages. Peer education can be very effective at encouraging young people to discuss issues related to sex and HIV/AIDS.⁹⁰ Other strategies include the following:²⁴

- ◆ improve access to youth-friendly health and prevention services;
- ◆ condom distribution;
- ◆ group discussion, workshops, and classes held outside of school settings;
- ◆ youth groups and support networks to encourage healthy behaviour;
- ◆ the meaningful involvement of young people in programme planning and implementation;
- ◆ information dissemination through printed materials, performances, and other media; and
- ◆ drop-in centres and refuges that provide safety and critical resources to disadvantaged youth.

Effective Prevention Efforts for Young People

The *Women/Life Collective* in Brazil focuses on girls in two age groups (young girls, ages 7-12, and adolescents, ages 12-18) with a special emphasis on girls who live or work on the streets and are involved in or at risk of joining the sex trade. Adolescents meet in weekly support groups to discuss topics related to family, work, school, drugs and sexuality. An adult monitor refers girls with specific problems to specialised social services. After participating in the programme for some time, adolescent girls are offered enrichment and professional courses. None of the 850 adolescents who have gone through the programme have returned to street gangs or become sex workers. Young girls are offered safe housing, healthy food and academic enrichment activities, while their mothers are invited to participate in a literacy programme and given support to pursue professional courses. Young girls who have participated in the programme demonstrate higher self-esteem and improved academic performance.²⁴

The *Save Your Generation Association* in Ethiopia was started by a group of young men who wished to do something about Ethiopia's rising HIV/AIDS prevalence rate. The original group of young men provided education materials, produced puppet drama performances, helped their peers seek economic opportunity, and promoted condom use. They also trained other peer educators to continue their work. As a direct result of the Association's activities, 230,000 condoms have been given away or sold, and over 25,000 people have been reached by the puppet drama performances and other activities.²⁴



HIV/AIDS and Violence

In this section we look at how violence contributes to the spread of HIV/AIDS. While violence in its many forms can increase risk of HIV transmission for both males and females, in this section we pay particular attention to how gender-based violence (including violence between intimate partners, rape, and sexual assault) contribute to HIV infection in women and girls. We also look at how violence on a large scale, as in the case of war or armed conflict, creates situations of increased HIV risk for both males and females.

Rape & sexual assault

HIV can be transmitted directly through rape and sexual assault, usually from a male attacker to a female or male victim. Rape and sexual assault can increase the risk of HIV transmission because:²²

- ◆ The walls of the vagina and anus as well as the genital area are more susceptible to tearing during a violent attack, creating passageways for HIV to enter the bloodstream.
- ◆ Condoms are rarely used in situations of rape.
- ◆ Repeat rapists can put many individuals at risk.

The scope of the problem:

- ◆ Studies show that in many countries, a young girl's first act of intercourse is often forced.⁹¹
- ◆ Researchers estimate that the reported number of rapes in some countries represent only a fraction of the real number of rapes that occur each year.³⁶
- ◆ Between 12% and 25% of women in population-based studies report attempted or

completed forced sex by an intimate partner or ex-partner.⁹²

- ◆ Young women may be particularly susceptible to abuse. The percentage of sex crime victims 15 years old or younger is: 58% in Malaysia; 62% in the United States; 58% in Chile (Santiago); and 40% in Papua New Guinea.⁹³ In Botswana, more than two-fifths of all rape cases that reach the courts involve girls under 16 years of age.²²

Impact on HIV:

- ◆ In Harare, Zimbabwe, as many as 12% of 13-16 year olds at a sexual abuse clinic tested positive for HIV.²²
- ◆ 10% of rape victims in Thailand, and as many as 30% of rape victims in the United States contract a sexually transmitted infection (STI) from their attacker.⁹³ STIs increase susceptibility to HIV infection.⁹⁴
- ◆ Studies in the United States show that women who are abused as children are twice as likely to have unprotected sex with multiple partners—putting them at greater risk of HIV infection.³⁶

Violence between intimate partners

Violence between intimate partners is defined as physical, emotional, psychological, or sexual abuse among intimate partners. Violence between intimate partners

contributes to HIV risk because:

- ◆ When a woman is afraid of violent retaliation by her intimate partner, she is less likely to discuss HIV risk-reduction with him.⁹⁵
- ◆ Violence between intimate partners is often connected to marital rape, coerced sex, or other forms of abuse that lead to HIV risk.³⁶

Rape Prevention and Response Efforts Around the World:⁹³

- ◆ *El Salvador: Hospitals with rape crisis rooms can examine and treat victims of rape and sexual abuse in privacy.*
- ◆ *Bangladesh: Women police officers are trained to work with rape victims.*
- ◆ *Jamaica: School-based theatrical performances increase awareness of rape and sexual abuse.*
- ◆ *United States: Rape crisis hotlines provide anonymous counselling and support to victims.*

The scope of the problem:

- ◆ Between 10% and 50% of all women worldwide report being physically abused by an intimate partner.⁹²
- ◆ Every 15 seconds a woman in the United States is battered, most often by an intimate partner.³⁶
- ◆ 18% of urban married women in Papua New Guinea have sought hospital treatment for injuries inflicted by their intimate partners.⁹³
- ◆ A survey of court records in Zimbabwe revealed that 59% of female homicide victims were killed by their intimate partner.⁹³
- ◆ In Ghana, almost 50% of women and 43% of men agreed that a woman deserved to be beaten if she used contraception without telling her husband.³⁶

Impact on HIV:

- ◆ Fewer than 25% of Zambian women agreed that a woman could refuse to have sex her husband, even if he was known to be violent, unfaithful, or HIV+.²²
- ◆ A 1991 study in Ghana revealed that 60% of women did not believe that they had the right to refuse sex with their husbands, even if their spouses had been unfaithful, and possibly at risk for HIV.⁹⁶
- ◆ HIV+ women are more likely to suffer violence, abandonment, and neglect.⁹⁷
- ◆ A study in Tanzania showed that women specifically avoided raising the issue of condoms with their husbands, for fear of violent retaliation.⁹⁵

War & armed conflict

War and armed conflict contribute to HIV risk in two ways: first, by creating situations of social upheaval which place both males and females at greater risk, and secondly, through rape and other atrocities which may directly put individuals into contact with the AIDS virus. How war contributes to HIV risk:

Violence Between Intimate Partners Prevention and Response Efforts Around the World.⁹³

- ◆ *India: Support groups for battered women to share experiences.*
- ◆ *Belize: Community involvement in the shaming and reporting of violent husbands.*
- ◆ *Throughout Asia: Women's police stations, where women can report abuse.*
- ◆ *Jamaica: Conflict resolution and non-violent parenting classes.*
- ◆ *Uganda: Legal literacy programmes, where battered women can get free legal advice.*
- ◆ *Zimbabwe: Gender sensitivity training for health professionals and the police.*
- ◆ *Egypt: Safe-houses and shelters for battered wives.*

- ◆ War is often associated with increased violence against women. Mass rape, military sexual slavery, gang rape, and the rape of young girls have all been known to accompany war.⁹³
- ◆ During war or armed conflict, women may need to offer sex for survival—in exchange for food, shelter, or protection.⁹³
- ◆ The movement of military personnel is linked to the spread of HIV, both through commercial sex with civilians and wartime rape.²²
- ◆ Rates of violence between intimate partners often increase dramatically in countries devastated by war.⁹⁸

- ◆ Health services may be more concerned with primary care of war casualties than with routine treating of STIs, which make individuals more susceptible to HIV infection.⁹³
- ◆ During times of war, HIV prevention is almost never a government priority.⁹¹

The scope of the problem:

- ◆ During the 20th century, hundreds of thousands of women are believed to have been raped in war.²²
- ◆ Since the 1980s, the rape of women by military personnel has been reported in Sri Lanka,²² Jammu and Kashmir, Peru, Bosnia and Herzegovina, Rwanda, and Myanmar.⁹⁹
- ◆ Women and girls make up 75% of the world's 18 million refugees.¹⁰⁰ Refugees are at particular risk of rape and abuse.²²
- ◆ In 1998, women fleeing Burundi reported rape in Tanzanian refugee camps.⁹⁸
- ◆ Studies show that soldiers who rape almost never fear being punished for their acts, which increases the likelihood of repeat offences.⁹⁸

Impact on HIV:

- ◆ Militarisation correlates with higher rates of HIV infection: countries with larger numbers of soldiers tend to have greater prevalence of HIV.²

Military personnel tend to have rates of sexually transmitted infections—which can increase the risk of HIV—two to five times higher than those of the civilian population.²² High rates of STIs may be related to the use of sex workers within a lifestyle of frequent migration.¹⁰¹



HIV/AIDS and Sex Work

In this section we look at the role of sex workers in the HIV/AIDS pandemic. After describing different types of sex workers, we examine the factors that place them at risk of HIV/AIDS, including the impact of legal regulation. Finally, we address current approaches in HIV prevention with sex workers, and the unique role they can play in the prevention of HIV worldwide.

What do we mean by “sex worker”?

Sex workers are often portrayed as a single, homogeneous group, but in reality they can be male or female, young or old. Some sex workers live in absolute poverty, while others are able to live in more comfortable conditions. Sub-populations of sex workers include the following:²⁴

- ◆ full-time sex workers who work in brothels or on the street;
- ◆ “indirect” or “informal” sex workers, who exchange sex for food or money in order to survive, and often do not consider sex work to be their primary employment; and
- ◆ individuals who are forced into sex work and kept in bondage.

In many cases, there is no clear division between “formal” and “informal” sex workers. Among full-time sex workers, there are differences based on varying rates of payment, sub-populations of clients, and locations of work.⁹⁶

Although sex workers have been shown to be no more likely to become HIV+ than the general population, there are regions of the world where sex workers face higher rates of HIV infection:

- ◆ In Dakar, Senegal, the rate of HIV-1 infection among pregnant women and blood donors is

1.7%, while among female sex workers the percentage of infected individuals is 10.1%.¹⁰³

- ◆ Studies in Nigeria have revealed HIV infection rates among female sex workers as high as 36%.¹⁰⁴
- ◆ In 1999, the HIV infection rate among pregnant women in Vietnam was 0.12%. Among commercial sex workers, rates reached as high as 13.2% in some provinces.¹⁰⁵
- ◆ Rates of HIV infection among commercial sex workers in northern Thailand are thought to be as high as 44%. In regions of Cambodia, these rates may be as high as 60%.¹⁰⁶

Vulnerability of sex workers

These high rates of infection may not be due to the fact that sex workers have multiple partners, but rather due to a combination of factors that put them at risk. These factors include demographics, drug use, knowledge of HIV/AIDS, access to healthcare services, and condom use. Some of these factors are discussed below.

Demographics:

- ◆ Sex workers in most developing nations are typically poor and lack formal education.²⁸
- ◆ Male sex workers are often victims of multiple discrimination that may hinder their ability to access prevention resources.²⁴
- ◆ Studies in Indonesia have shown that young people—including sex workers—who are most at risk for HIV are also usually the hardest groups for prevention programmes to reach.¹⁰⁷
- ◆ Studies show a correlation between income level and HIV prevalence among sex workers, possibly due to the inability of poorer sex workers to negotiate condom use.⁹⁶
- ◆ A study in Belize revealed that 91% of sex workers in brothels use condoms compared to only 35% of women working on their own.¹⁰⁸
- ◆ Some commercial sex workers in Indonesia consider HIV/AIDS to be an inextricable part of

sex work, whereby higher earnings are linked to higher risk of infection.¹⁰⁷

- ◆ In Thailand, some clients of sex workers seek out young, virgin girls on the assumption that they will not be infected with HIV. These young girls may be more likely to experience tissue tearing during intercourse—putting them at greater risk for HIV.⁹⁹

Drug use:

- ◆ Studies show that sex workers who use drugs have a greater risk of HIV infection.
- ◆ A study of six cities in the United States revealed that injection drug use was the primary factor contributing to HIV risk for female sex workers.¹⁰⁹
- ◆ Some researchers suggest that the use of crack cocaine may raise the dangers of HIV infection from unprotected oral sex when the user has experienced damage to the mouth from smoking the drug.¹⁰⁹

Knowledge of HIV/AIDS:

- ◆ When sex workers do not know the causes and consequences of HIV infection, they may inadvertently put themselves and others at risk.
- ◆ Studies in China reveal that most commercial sex workers are young and poorly educated. In addition, sex workers are likely to be uninformed about HIV transmission.¹¹⁰

Access to healthcare services:

- ◆ Where sex work is illegal and stigmatised, sex workers may be unwilling or unable to access healthcare services. Untreated sexually transmitted infections (STIs) can increase the likelihood of HIV infection.⁹⁴
- ◆ According to studies in Abidjan, Côte d'Ivoire, only those sex workers serving wealthy clients have access to modern forms of contraception and STI prevention. Most other sex workers rely on douching or ritual scarring to prevent both STIs and pregnancy—methods which have shown to be ineffective, and may even increase risk.⁹⁶

Condom use:

- ◆ Sex workers may be at risk from HIV as much from their intimate partners as from their paying clients.
- ◆ While 94% of American sex workers have ever used condoms with their clients, only 25% have used condoms with their domestic partners.¹⁰⁹
- ◆ Among commercial sex workers in Glasgow, United Kingdom, 98% use condoms with clients while only 17% use condoms with an intimate partner, even among frequent drug users.¹¹¹

Sex work & the law

The widespread illegality of sex

work can heighten HIV/AIDS risk:

- ◆ Because sex workers are often outside the protection of the law, they are particularly vulnerable to coercion and rape.²⁶
- ◆ Stigma and legal status may make it difficult for sex workers to access relevant health services.
- ◆ In areas where sex work is against the law, a woman may be arrested and fined for carrying a large number of condoms.²⁶

Where commercial sex work is legal and regulated, sex workers may still be at risk:

- ◆ In places where sex work is legal and licensed, diagnosis of an STI may cause a sex worker to lose her license—and with it, her means of supporting herself. As a result of this and similar programmes, sex workers may avoid health care facilities and go underground to escape rules and restrictions that threaten their welfare.³²

Prevention efforts

Interventions designed to prevent HIV infection among sex workers must take into account the context in which sex workers are working, and the specific practices of individual sex workers.⁷

Prevention interventions often include the following:^{24, 26}

- ◆ distribution or promotion of condoms;
- ◆ provision of health services, especially to treat STIs;
- ◆ discussion groups or classroom-based HIV and sexual health education;
- ◆ networking to promote better laws, working conditions and health services for sex workers;
- ◆ dissemination of information through printed materials and street theatre; and

- ◆ economic development programmes for sex workers seeking other types of employment.

Innovative HIV prevention programmes for sex workers include the following:

- ◆ interventions taking place in a variety of settings, including bars, clubs, brothels, the street, truckstops, and prisons;²⁶
- ◆ targeted interventions that also deal with drug addiction;¹⁰⁹
- ◆ interventions directed towards the male clients of female sex workers;¹⁰³ and
- ◆ emphasis on the power of sex workers to help stop the spread of HIV through the promotion of condom use with clients.¹¹²

100% Condom Programme

S u c c e s s f u l programmes to stop the spread of HIV through sex work may need to take economic concerns into account while working with brothel owners, clients, and sex workers. Thailand's 100% condom programme, first implemented in 1991, mandates condom use with all customers in all brothels.¹¹³ This has prevented brothels from competing for customers who want condom-free service, and helped raise condom use from 15% (1989) to over 95% (1997). The programme is being exported to nearby countries, including Cambodia, the Philippines, and Vietnam.

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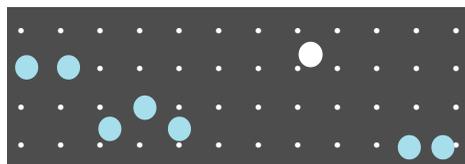
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