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Men have yet to take it seriously

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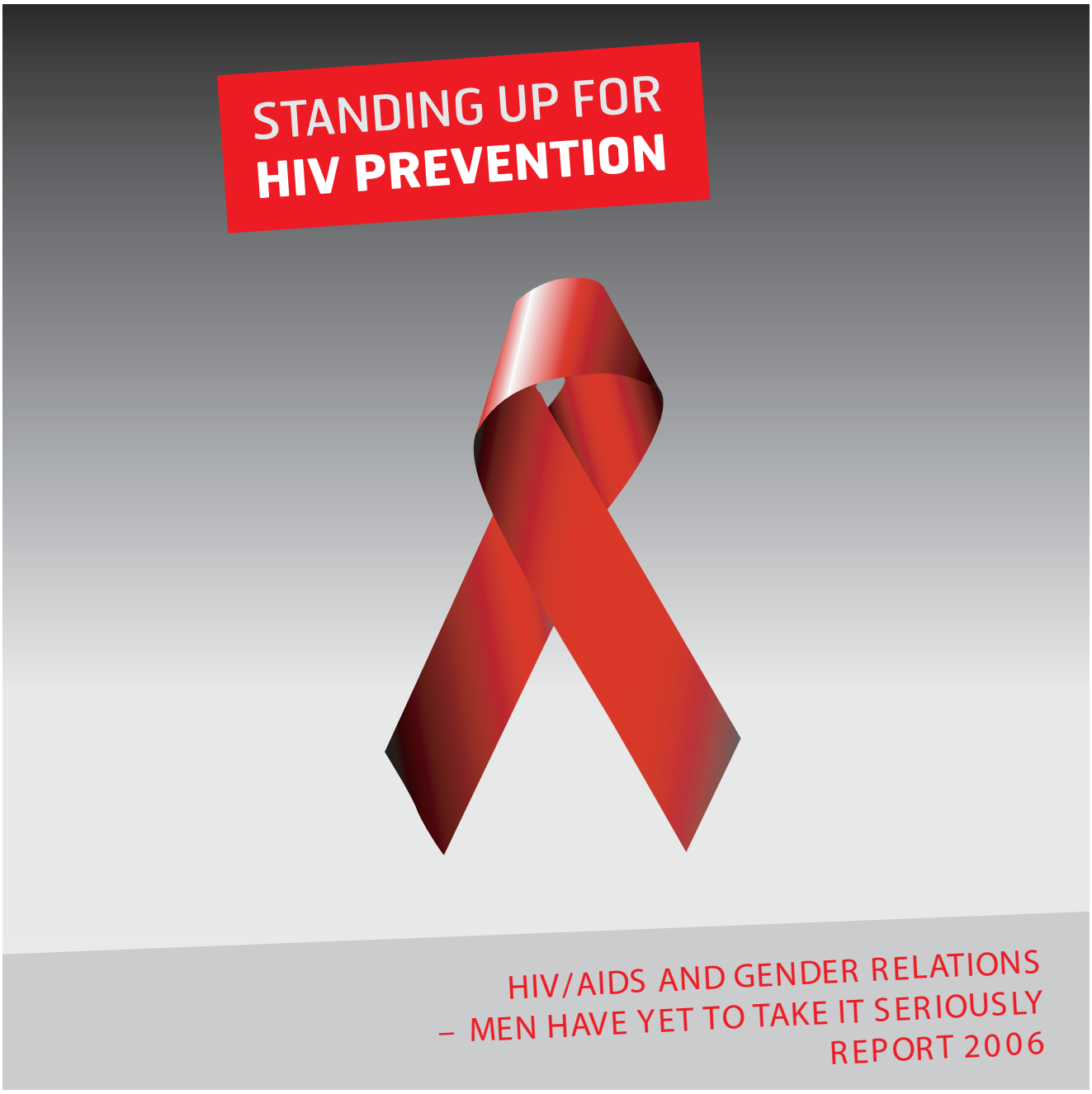
HIV/AIDS and gender relations



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1. Introduction:

"Gender blindness"— a principal issue in HIV/AIDS prevention

"Gender differences are at the root of a number of the social, economic and political factors that drive the epidemic. Without an understanding of the complex relationship between gender and HIV/AIDS, strategies devised to tackle the epidemic will fail". (UNAIDS 1999)

After more than 20 years of struggle against HIV/AIDS, there are still an estimated 4.1 million new infections annually and 8000 AIDS-deaths daily (UNAIDS 2006a). This clearly shows that the pandemic is far from under control and that responses have been insufficient and possibly even misdirected. It also reminds us of the enormous obstacles to be overcome in reaching the Millennium Development Goal of halting and reversing the spread of HIV, and the new global UN goal of universal access by 2010 to HIV/AIDS prevention, treatment, care and support services for all in need (UNAIDS 2006b, WHO 2006a).

The understanding of what drives the epidemic has moved a long way since the 1980s, when first homosexual and bisexual men and injecting drug users, and later female and male prostitutes[1] and their clients, were the targets, while condom use was the recommended behaviour change (UNAIDS 1999). In the 1990s, reports on rising rates of infection among women in stable relations created a need for more 'women's empowerment' and the defence of their sexual and reproductive rights were among the conclusions, as highlighted in the final Programme of Action of the International Conference on Population and Development, in Cairo (United Nations 1994). These issues at that time were seen as distant from HIV/AIDS programmes and policies, but since then the broad spectra of gender-related violence, and wider homosexual, bisexual and transgender issues, in that order, have been added to the HIV/AIDS agenda.

A new chapter was opened when research on men and boys showed that gender norms not only restrict women's sexual autonomy, but also "exaggerate men's sexual freedom, thereby putting both women and men at risk of infection" (Rao 2002). Another important step was the recognition that due to women's usually inferior social and economic position their exposure to unsafe and unwanted sexual relations increases, especially in connection with armed conflicts and war, when trafficked or when living as migrants or refugees. In short, gender was seen as a central element of both individual and societal vulnerability.

At the XIV International AIDS conference, held in Barcelona in 2002, the phrase "AIDS has a woman's face" gained currency. In 2003, the particularly distressing effects of HIV/AIDS on women in sub-Saharan

[1] Sweden officially uses the term 'prostitute' to include conditions like trafficking. UNAIDS, on the other hand, employs the term 'sex worker'. This is intended to be non-judgmental, focusing on the conditions under which sexual services are sold. Alternate formulations are: 'women/men/people who sell sex'. Clients of sex workers may then also be called 'men/women/people who buy sex'. (UNAIDS editors' notes, May 2006)

Africa led the United Nations Secretary General to set up a Task Force on Gender and AIDS in southern Africa. Funding for the Task Force was, however, only first made available in April 2005.

It is clear that the development of the epidemic to a large extent reflects a persistent gap between the need for and availability of prevention. However, the problem also appears to be a more profound lack of understanding of the concept of 'gender' and its importance for AIDS-related policy and intervention work.

The search for ways to improve the efficiency of HIV prevention will require the posing of unconventional and uncomfortable questions about gender issues in general and the needs of girls and women in particular. And this requires concessions and a change in behaviour from those with the resources and the power. Similar to all health interventions, there is also a need to recognise that *context* is essential in HIV/AIDS prevention. There is neither magic bullet nor one-size-fits all solution.

While there is broad agreement about women's greater biological vulnerability to HIV, it remains unclear how far gender relations go in explaining such important differences as the lower HIV prevalence levels in most of West Africa as compared to much of East and Southern Africa. Similarly, prevalence levels show no *simple* correlations with either the degree of gender inequity[2] nor with democratisation, as evidenced by the low levels reported in North African, West Asian and Middle Eastern countries. That there are correlations, however, will be discussed below.

This report starts with a brief review of recent evidence and trends, followed by epidemiological patterns from a gender perspective. To further clarify the issues, an analysis of the interface between HIV/AIDS and gender is presented, leading to a discussion of the current challenges with a special focus on low-income countries, notably sub-Saharan Africa.

[2] The United Nations definition of "Gender Equity" is: fairness of treatment for women and men, according to their respective needs. This may include equal treatment or treatment that is different but considered equivalent in terms of rights, benefits, obligations and opportunities. In the development context, a gender equity goal often requires built-in measures to compensate for the historical and social disadvantages of women. The United Nations definition of "Gender Equality" entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices. Gender equality means that the different behaviours, aspirations and needs of women and men are considered, valued and favoured equally. It does not mean that women and men have to become the same, but that their rights, responsibilities and opportunities will not depend on whether they are born male or female.

2. Current situation and trends from a gender perspective

Globally, an estimated 17.3 million out of 36 million (47%) HIV-positive adults are women, and the overwhelming majority of these women, more than 13 million, live in sub-Saharan Africa (UNAIDS 2006).

Table 1. Proportion of HIV-infected women 1997, 2003 and 2005 (% of adults 15–49 years)

	1997	2003	2005
Sub-Saharan Africa	50%	57%	59%
North Africa and Middle East	20%	50%	48%
South & South-east Asia	26%	25%	30%
East Asia	13%	17%	17%
Eastern Europe, Central Asia	21%	26%	28%
Caribbean	33%	50%	50%
Latin America	18%	32%	32%
Western/Central Europe	21%	27%	28%
North America	20%	25%	26%
Oceania	na	44%	47%

Sources: UNAIDS 1998, UNAIDS 2006a

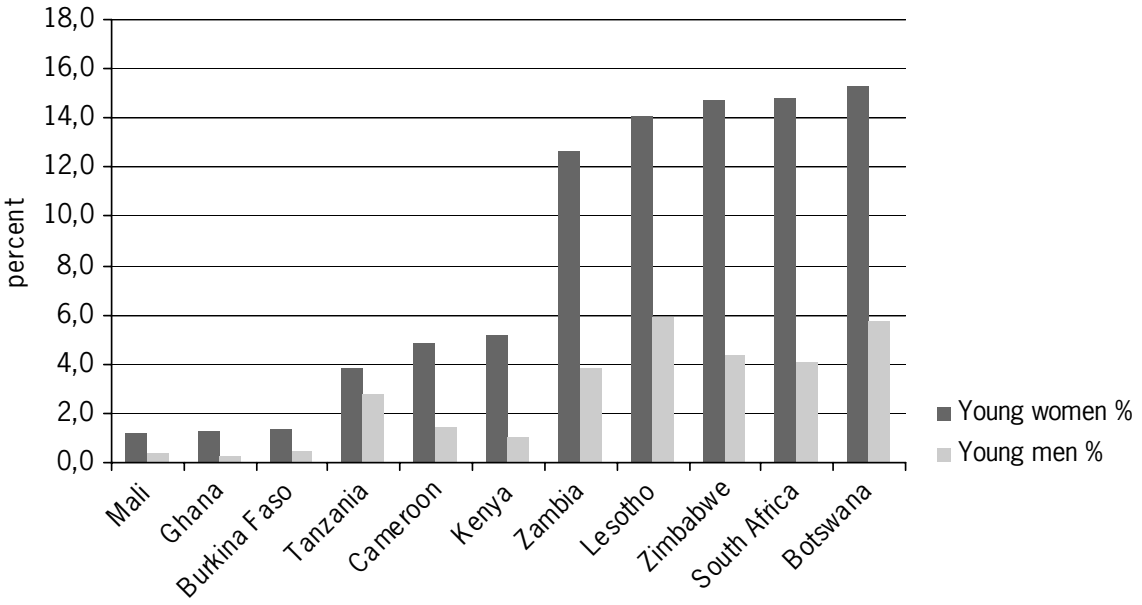
In sub-Saharan Africa the overall proportion of women living with HIV/AIDS is still rising and is now at 59%. Apart from sub-Saharan Africa, women in the Caribbean, Oceania and North Africa/Middle East also form about half or more of all people living with HIV. (See table 1). However, when looking globally at young people, the proportion of women among the newly HIV-infected, as well as of people living with HIV, is much higher

Young women – now the most affected

A recent World Bank report (2005) estimates that "In sub-Saharan Africa, there are nearly 10 million young men and women, ages 15–24, living with HIV/AIDS, of which more than 75 per cent are women, reflecting a worldwide feminization of the epidemic". A similar message emerges from South Africa: "Our youth prevention programmes are failing. HIV infection in girls aged between 15 and 24 has jumped by 5% to 17% in just three years…" (Cullinan 2005).

This is well reflected in the graph below where HIV-prevalence among young women is far beyond those of young men in a number of sub-Saharan countries (UNAIDS 2005). Such data should, however, never be read as 'hard statistics'. Virtually all information on HIV prevalence in poor countries comes from sentinel surveillance sites set up at antenatal clinics, which obviously only test pregnant women, few of whom are adolescents.

HIV-prevalence among 15–24 year old men and women, selected countries 2001–2005



Source: UNAIDS 2006

Such weaknesses in the basis for the estimates have led the UN recently to emphasise the need to treat its estimates with a great deal of caution and to refrain from making comparisons with previous or even future estimates (UNAIDS 2006; Walker et al 2004). Where infection rates are higher among young women than among young men – due to various factors, many related to the social vulnerability of young women – this may lead to young women also infecting same-age men (perhaps including "future husbands").

The higher male HIV prevalence in the beginning of the epidemic reflects men's and women's different lifestyles. Men are more likely to have temporary same-sex encounters, buy sex and have more occasional heterosexual contacts, than women. This may have equalled out the higher biological susceptibility of women in the first decades of the epidemic. The current feminization most likely indicates that women in stable relations are increasingly exposed to the risk of contracting HIV. A special factor is the tendency among men, also HIV-infected men, to seek out partners from among much younger women, including the so-called sugar daddy scenario in sub-Saharan Africa. In both cases, the trend is linked to patriarchal male behaviour, men's earlier risk-taking and their behaviour when living with HIV.

3. Epidemiological aspects of gender and HIV/AIDS

The understanding of the AIDS pandemic has increased slowly in the past 25 years. Simultaneously, gender issues have become increasingly prominent in national and international work, and notably as a development issue. It is now widely accepted that preventing HIV is linked with improving gender relations. While much evidence has been gathered on the linkages, action – and especially results – are lagging behind. This is perhaps not surprising considering the wide gender inequities in most countries.

3.1 Initial epidemic

During the initial phase of the epidemic in a country, HIV typically will infect people in one or several of four high-risk groups: prostitutes, injecting drug users (IDUs), men who have sex with men (MSM), or persons with sexually transmitted infections (STIs). In all these groups, and their respective settings, gender dimensions are prominent. Under certain circumstances, if transmission is not controlled when mainly within the aforementioned groups, it will spread further to become a generalized epidemic, as is the case in parts of Africa. This is often instigated or exacerbated through weak health care systems in which the blood supply may be contaminated or needles and syringes reused, and in prison settings.

Prostitution is an effect not only of poverty but also of gender inequality, and reflects the exposed situation of many women. They are often sole providers for their families and children. Low education, unemployment and unequal rights to ply a trade (e.g. open a business, sign a contract or own land) contribute to prostitution, which can take many different forms including so-called transactional sex. In parts of sub-Saharan Africa, prostitution was a major route for the spread of HIV in the initial phases of the epidemic. In Thailand, the "100% condom campaign" in the 1990s was directed towards this source of transmission – prostitutes and their male and female clients.

Injecting drug use, when needles and syringes are shared, is a very efficient way of spreading HIV. It is also sometimes linked to prostitution, i.e. women and men financing their drug use by prostituting themselves and/or beginning to take drugs when becoming a prostitute CEEHRN 2005). Much of the rapid HIV spread in Eastern Europe as well as in eastern and South-East Asia is currently associated with injecting drug use and intricately linked to prison settings. In e.g. most eastern Euro-

pean countries, more than 70% of injecting drug users are male (Lazarus et al 2006).

Same sex relationships among men are clearly also a gender issue. Many of these men also live in heterosexual relationships, and neglecting them as a group (or criminalizing them) risks contributing to the "bridging effect", i.e. HIV spreading from this population to women and thereby into the general population. This issue is discussed further below. HIV transmission among MSM was very common in the initial phases of the epidemic, especially in parts of the Caribbean, the USA and Western Europe during the 1980s, and still makes up a large part of transmission in many western countries and Latin America. Sweden and most of Western Europe have even currently experienced a slight increase in new HIV infections in this group (EuroHIV 2005). It should be noted that there is very little information about MSM in sub-Saharan Africa and Eastern Europe, where it is most often officially or *de facto* illegal and therefore driven underground.

Individuals with a sexually transmitted infection (STI) constitute a high-risk group for HIV, as STI greatly increases the transmission of the virus, especially if it is linked to any of the above populations, or where HIV is common. Dealing effectively with STIs in any stage of the epidemic is a very effective way to reduce the spread of HIV. One way to do this is to integrate such services with other health programmes such as family planning and maternal health programmes (WHO 1999, WHO 2005). Progress in such integration efforts has been quite mixed, however. For instance, services for men with STI symptoms are still in many countries much less accessible than reproductive health services for women.

Factors that can influence the possible "bridging" of HIV from the above groups to the general population include the frequency of male utilization of prostitutes; the sexual patterns in the general population (frequency of partner change and parallel relationships; frequency of homosexual relations and bisexuality), on frequent use of condoms, age differences between partners, the prevalence of STIs, the frequency of sexual violence, women's empowerment, the overlap between IDUs and prostitutes, access to ARV treatment and the capacity of the health-care system. In most of the bridging mechanisms, gender dimensions are prominent. Current epidemiological discussions in regions where the pandemic is still in its initial phase focus on all of the above, and the debate concentrates on how to contain and control the epidemic among the aforementioned groups (Matic et al 2006).

3.2 Mature epidemic

In a mature epidemic, the following factors and conditions will influence the evolution, all of which have significant gender dimensions:

Sexual patterns. In parts of sub-Saharan Africa sexuality is, to a large extent, influenced by male dominance, as often evidenced by large age differences between partners. This appears to be one of several major determinant of HIV spread in many countries in this region (Silberschmidt 2005). When, with whom and how to have sex is largely determined by men. In parts of South and South-East Asia patterns appear to be similar, as well as in Latin America and the Caribbean. In a recently released study by the World Bank/University of Manitoba (Canada)[3] it is suggested that there is a limited concurrent sexual partnership in Asia and that is one reason why Asia will not experience the same explosive epidemic as in Africa.

[3] HIV/AIDS in South Asia: Understanding and Responding to a Heterogeneous Epidemic

C*hildren/adolescents in vulnerable situations* (e.g. street children of both sexes, orphans, children in institutions and children with disabilities) risk sexual exploitation and are subsequently at a higher risk of contracting an STI including HIV. In mature stages of the epidemic, AIDS orphans in a country will also increasingly reach adolescence and often enter into the group of vulnerable youth. According to some indications (Atwin et al 2005), orphans reaching adolescence may have lower self-esteem and present more reckless behaviour. In this way adolescents, orphaned by HIV or otherwise, may end up acting as "drivers" of the epidemic. Studies from e.g. Zimbabwe suggest that orphaned girls are three times as likely to contract HIV as girls whose parents are alive (UNICEF 2005). The gender pattern of these mechanisms is of great importance for every affected country, and particularly where the percentage of orphans is very high or increasing as in some African countries. These emerging effects of the epidemic need to be studied carefully in order to design appropriate interventions (De Zoysa and Johnson 2001).

Box 2. The sad situation of orphan girls

"Poverty, pregnancy at a young age and a lack of education have been problems for young women in Africa for a long time… but over the past 25 years the trends have confirmed that more African girls are receiving formal schooling and marrying later in life...However, the HIV/AIDS pandemic threatens to take away those hard-won gains especially among female AIDS orphans who are being propelled into sex at shockingly early ages to support themselves, their siblings and, all too often, their own children."

(New York Times, 3 June 2005)

Migrant work contributes significantly to both the national and international spread of HIV. One well documented group is male (labourer) migrants, who often engage in occasional sex and use prostitutes. The migration of prostitutes in West Africa is considered to have played a crucial role in the initial stage of the regional epidemic. Much less is known about the possible contribution of massive numbers of South Asian female migrant workers in inferior, vulnerable positions, often as domestic workers in foreign countries (UNAIDS/UNIFEM 2004). In central Asia, however, it is well known that many of the people documented to be living with HIV/AIDS acquired it outside of their home country, often while working abroad.

Widespread alcohol and other drug use, commonly among men, plays a major contributory role to the unsafe sexual and injecting patterns that are encountered in many countries and in *gender-based violence*, which is a prominent feature of gender inequality, and one that is intimately linked to the risk of HIV transmission (WHO 2004).

War and civil unrest are today often associated with forced sex and even systematic rape, sometimes linked to "ethnic cleansing". Young, unemployed men drawn in as soldiers risk becoming more insensitive to violence and brutality, not least against women (Barker *et al* 2005). Some members of peacekeeping forces (almost exclusively male) have also been documented to have been involved in unsafe sexual practices, including rape, sexual abuse and transactional sex.

Prisoners, mostly male, face an increased risk of unsafe sex due to high levels of coerced sex in prison settings. In many countries of Africa, coerced sex for favours between guards and prisoners is widespread,

Moreover, HIV rates in prisons tend to be significantly higher than in the general public (Jackson 2002, Stöver 2006). Another problem is that unsafe injecting practices often continue in prisons. In Lithuania, for example, almost one half of all people reported to be living with HIV were infected in prison.

HIV/AIDS home-based care entails that care for family members suffering from HIV/AIDS complications largely is the responsibility of women and girls, who thereby tend to lose opportunities for schooling or income-generating activities. This can increase their exposure to discrimination and poverty, adding to already existing gender inequity, and in turn an increased risk of exposure to HIV infection.

Human trafficking for sexual purposes is increasingly being given more attention; not least in Europe. To stem such trade requires much more comprehensive, upstream action; working both from a human rights, a reproductive health and an illicit drug perspective (Stafström and Liljestrand 2005). The significance of human trafficking when it comes to fuelling the AIDS epidemic, however, still remains unclear in most regions, as by nature trafficked women are "underground" and their health conditions poorly documented.

In short, aspects of gender are fundamental in all phases of the epidemic in a country, and the particular aspects need to be analyzed and taken into account for each individual national strategy. The mechanisms of transmission are dependant on multiple factors among both men and women, and some of these will be reviewed below.

4. The interface between gender relations and HIV transmission

Gender relations are a key element of how any society organises itself. They are not only apparent in direct woman/man relations, but – usually indirectly – in morals, values, institutions and practices throughout society. An overview of where gender meets HIV/AIDS is given in Table 2.

Table 2. Different types of gender relations of importance for HIV/AIDS

Type of relation	Expressions	HIV/AIDS-relevant examples
Area 1 **Primary relations, strong affection**	**"Private sphere inequalities"** • Pre-or extramarital "lasting love relations" • Marital relations (power, force, male violence)	• Rape in marriage • Male contraceptive control • Incest
Area 2 **Primary relations, weak or no affection**	**"Inter-personal power and dependence** relations" • Trafficking • Prostitution • Occasional sex • Rape • Certain community rituals, initiations and the like • Intergenerational sex • Paedophilia	• Infected men seek sex with virgin girls. • Religious leaders, teachers etc. misuse their position to get sex. • Resource-weak women accept transactional sex. • Orphaned children at increased risk.
Area 3 **Secondary contacts (mainly inter-personal)**	**"Public sphere inequalities"** • Male dominance in senior positions in governments, in international organisations and other agencies • Workplace relations • Services/discrimination • Community leadership	• Male perspectives dominate planning and priorities. • Women's voices suppressed. • "Men first" in e.g. bonuses, HAART to staff and promotions
Area 4 **Tertiary (no personal contact)**	**"An environment of inequality"** • Laws linked to gender inequality • (Poor) law enforcement • Macroeconomic priorities • Male morals (Some customary law and many religions)	• Male dominance slow down legal reform and/or law enforcement (World Bank, 2004) • Government budget reflects low priority to gender-relevant policies. • Inequality supported/accepted by public authorities.

Area 1 covers inequalities in relations with the family and in couples, as well as in the way children are treated by adults (e.g. discrimination of girls). Examples are gender-differential access to health-promoting resources (e.g. food, health care, relaxation and education). A predominantly anti-equality culture in certain parts of (South and East) Asia is also reflected in premature death of girls and women. Inequalities within couples are also linked to forced sex and other male violence.

Area 2: public sphere social relations, including sex for employment/promotion. It covers (male) teachers' demand for favours, employers' negotiations for sex, but also differential wages and/or access to higher posts in the formal economy, and preferential treatment of men in the health sector and of boys in the educational sector. The cost and scarcity of antiretroviral therapy entails a grave potential for inequitable access, e.g. by employers being more interested in keeping male staff healthy, or by health centres more easily accepting those with money (most often men).

That sex – unlike many other personal services – can be used as a tool to access resources, including income, is a key issue. Girls' economic dependence on men, women's dependence on their husbands and poor women's use of sex as a means to gaining income are all examples of the articulation of differential access to resources.

Area 3 covers power and discrimination in the public sphere (e.g. the workplace and health services). This has received considerable attention both in general efforts to reduce gender inequalities, and in HIV/AIDS-related interventions. While changes in, for instance, legal institutions pave the way for improved gender relations, they do not guarantee such change. Reforms in state legislation might be resisted on the basis of customary law, or simply meet (male) social resistance such that little real change takes place. Work in this area is important as it also entails a confrontation with inequality — preserving values and norms in society, and opens for debates that contribute to social change.

At the international level, many well intentioned policies developed by men have lacked a female perspective or adequate "buy in" from women's organisations. This was clearly experienced during the UN five-year review of the Declaration of Commitment on HIV/AIDS in May/June 2006. Important aspects of the final document, supported by women's and other groups, were rejected by many African countries, the US and the Vatican.

Area 4 includes male-dominated ideologies, macro-level decision-making and priorities that have an effect on access to resources – often expressed in institutionalised inequalities – legal inequities, including those embedded in customary law or differential access to financial or other institutions; and so on. Although most of these issues rarely if ever appear in discourses on HIV/AIDS and gender, they are important development forces. For instance, high-income countries rarely live up to financial commitments such as those agreed on in the ICPD Programme of Action (Sinding 2003) or in the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Despite increased attention recently, the poverty/debt traps of many of the countries worst affected by AIDS have not been resolved or have at best been given inconclusive solutions. Protective trade policies, the influence of multinational companies and the financial politics favoured by the International Monetary Fund are other issues that have not yet been fully considered in the light of the AIDS pandemic.

Box 3. Widow cleansing and widow inheritance

'Widow cleansing', practised in some communities in Africa and Asia, generally involves a widow having sexual relations either with a designated village cleanser or with a relative of her late husband. It has traditionally been a way to break with the past and move forward — as well as an attempt to establish a family's ownership of the husband's property and provide new safety for his wife and children. In cases where a husband died of AIDS, this practice is just as risky for the men who are chosen to 'cleanse' as the women who are 'cleansed'.

These traditions reflect customary regulations that prevent women from inheriting property that has been their family's main source of support. Women have been thrown out of homes they helped pay for and lost all their property because they refused to have relations with a cleanser. Because of conditions like these, Human Rights Watch has called the problem of property rights in sub-Saharan Africa 'catastrophic', leading to women ending up "homeless or living in slums, begging for food and water, unable to afford health care or school fees for their children, and at grave risk of sexual abuse or exploitation."

Gender inequalities in relation to ownership and inheritance of land and other property is a longstanding target for serious reform efforts. The AIDS epidemic has increased pressures for reform.

Human Rights Watch (2003), UNFPA, UNAIDS and UNIFEM (2004)

The battle against HIV/AIDS presupposes a financially solid state machinery, with access to qualified human resources to tackle not only HIV/AIDS but its roots – including mass poverty and young people's lack of trust in their future. These basic issues underline the necessity of including *Area 4* in strategies to reduce the further spread of HIV, nationally and internationally.

4.1 HIV versus national gender equity indices

How do the statistics on HIV prevalence and the indicators on gender development correlate, if at all? While UNDP's Human Development Index measures average achievement, the Gender Development Index, GDI (UNDP 2005) adjusts the average achievement to reflect the inequalities between men and women in the following areas:

- "a long and healthy life" (the differences in life expectancy at birth);
- "knowledge", measured by the adult literacy rate, and the combined primary, secondary and tertiary gross enrolment ratio (differences between men and women);
- standard of living, measured by estimated earned income (differences between men and women).

These three component indices combined give a gender development indicator and 140 countries have been ranked according to their GDI. Comparing the 30 countries with the highest HIV prevalence with the 30 countries at the bottom GDI ranking gives the result that *19 of the high-prevalence countries also are the worst off with regards to basic gender equality*. All of these are in sub-Saharan Africa (see Appendix 1).

The only country at the bottom GDI ranking list that does not have a documented HIV problem is Yemen. It should also be noted that the top-

prevalence countries Botswana, Namibia and South Africa have only a slightly better GDI than the 30 bottom countries, while the Caribbean countries have a better position. This is not to say that gender inequality automatically leads to a higher prevalence of HIV, but the supposition that "gender inequalities fuel the epidemic" appears to hold water when measuring inequalities in this way. It should be noted though, that the general human development in these countries is very low, which is to say that poverty is a key factor here as well.

A completely different picture emerges when gender inequalities are measured using other indicators we are accustomed to, like percentage of seats in parliament held by women and female legislators. In UNDP's "Gender Empowerment Measure (GEM)", 80 countries have been ranked according to the above indicators and two additional ones. No sub-Saharan countries are found at the bottom of the GEM. Instead, we find countries like Egypt, Saudi Arabia, Bangladesh, Iran, Cambodia and (again) Yemen, while Namibia holds 31st place.

Although not many sub-Saharan countries are on the GEM list, a conclusion can probably still be drawn: While a lot of the high prevalence countries in sub-Saharan Africa are performing quite well with regard to women in politics, the main gender inequality problems that have an impact on the AIDS pandemic concern basics like equitable access to health facilities and schooling, and assets to ensure a better living standard. Women's growing presence in legislative institutions and even the executive management of international agencies is apparently not always sufficient to change this state of affairs. Alternatively, the effects of affirmative action, promoting female political participation, may take longer than hoped for.

5. Men have yet to take it seriously

In the many reports on gender and HIV/AIDS available today, the plight of women is repeatedly emphasised. Since the late 1990s, attention has also increasingly been turned to how heterosexual men's identities are formed, particularly among boys and young men, (Melendez and Tolman 2006) and how their attitudes and behaviour can be influenced to contribute to a reduction in exposure to infection – for themselves and their partners.

This is a demanding agenda. As summarised in a recent report (World Bank 2005), different studies add weight to the perception that gender role norms are among the strongest of the social factors that influence sexual behaviour. Some widespread norms related to masculinity and sexuality, for instance those that link masculinity to multiple partners, may influence young men and women to expose themselves to the risk of HIV infection.

Gender norms, whether for women or for men, are constructed and mediated by both sexes. That women in Africa's Horn make sure their daughters undergo genital mutilation to avoid social exclusion is well-known. Women everywhere also take part in shaping their sons' identities as men, and young women influence their male partners by their expectations on what manhood means.

We agree with the World Bank (2005) that: "lasting changes in gender norms will be possible only when it is widely recognized that gender is relational, that it is short-sighted to seek to empower women without engaging men, and that is difficult if not impossible to change what manhood means without also engaging young women".

Such insights hold across age or socio-economic groups and localities, be they urban or rural, wealthy or poor. They hold for women and men in marriage, in the workshop and the office, at school, in the boardroom, in parliament and in international organisations. But they are compounded by inter-generational tensions, and most have witnessed the conservatism of religious or other institutions in relation to changes in gender roles. Although seldom mentioned in reports on gender and HIV/AIDS, this is an essential dimension of the gender-HIV/AIDS issue.[4]

[4] A report on gender and AIDS in India (AIDS Alliance 2004) states: "The links between poverty, patriarchy and women's vulnerability to HIV/AIDS have never been clearer. [In] the Human Development Report (2004)... India is ranked 103rd (out of 144 countries) in the gender/development index (GDI), which captures inequalities in achievements between men and women. Despite ... laws prohibiting early marriage, half of all women aged 20 to 24 are married by 18 years and a quarter by the age of 15." The report however fails to clarify the workings of 'patriarchy' and what is required to reform gender relations on that level

Further, a predominantly male elite – senior position holders, the wealthy, decision-makers – may constitute role models for many young aspiring people. Further, this elite commands the resources and thus sets the priorities. In a rare reference to this problem, the World Bank (2005) is very clear about the implications. Change in gender norms is everywhere a slow process, made even slower by the fact that those who make programme and policy decisions often have their own deep-seated biases about gender that they are unwilling to question. This could be seen as a lack of awareness, of understanding or of willingness to change.

Policies and programmes designed to tackle gender inequalities may not always focus on the underlying forces that make those inequalities so resistant to change. It is important, for example, to work with young people, not least with young men. Much has also been learnt about ways and methods in recent years, even if "some program initiatives and research on HIV/AIDS are prescriptive and represent outside-in approaches in which foreigners are attempting to change African men and cast them in a negative light. Some of these efforts have only generated defensiveness" (World Bank 2005).

Box 4. Education not always enough

A recent UN report shows that formal education is only one of several measures required o reduce gender inequities:

"Despite the many benefits of education, there are also challenges. The environment in which girls and boys learn is as important as the fact that they are in school…In the Caribbean, which has the second highest HIV prevalence rates after sub-Saharan Africa, girls outperform boys throughout the education system, including at the university level where there are many more women graduates. Nevertheless, the rate of new infections among girls aged 15 to 19 is five times higher than that of boys of the same age group.

This paradox between higher education levels and higher rates of HIV incidence appears to be linked to young women's inability to advocate for themselves despite their longer education. The skills and knowledge women acquire in the formal education system are not sufficient to enable them to take control over other parts of their lives, or it may come too late to prevent them from being the victim of unwanted or transactional sex as adolescents. A study showed in fact that fully half of all young women in the Caribbean report that their first sexual encounter was forced or coerced."

This emphasises the importance of discussing gender norms in connection to HIV/AIDS at an early stage in the school system – and not only for girls. Limited studies in Brazil (Horizons Report 2004) indicate that repeated group discussions on manhood, sexuality, violence and fatherhood with young men resulted in both increased condom use with primary partner as well as new critical thinking on traditional views on manhood and sex.

(UNFPA/UNAIDS/UNIFEM 2004)

Generally, however, these policies and programmes have failed to address the gender issues in institutions such as aid organisations, government and donor agencies, multilateral organizations, parliaments and

professional bodies. In post-industrial countries as well as in transitional and 'developing' countries, these are the locations where gender inequalities are near-universal and highly resistant to change. It is within these bodies that desired changes are promoted – or stalled. Summarised above in the framework in Table 2, such bodies generally constitute a "pro-inequality environment" where highly needed reforms, if they make the print, have difficulties in becoming practice. In many cases, it is not the lack of laws and regulations, but rather the lack of active enforcement that act as a hurdle to gender equality.

Men tend to be the decision-makers and those in control of priorities. Male identities are reinforced through systems of promotion and other rewards. Here, motivation to learn about and address gender inequalities is often low, even where such reforms would be reflected in better goal achievement.

One clear exception is Stephen Lewis, the UN Secretary-General's Special Envoy for HIV/AIDS in Africa. Lewis recently emphasised how miserably the UN system performs when it comes to addressing gender inequality – within the UN system itself, and as a consequence in its work overall. Lewis identifies this failure as one major reason why effective measures to control HIV in Africa are not in place (Lewis 2005).

In sum, male empowerment is expressed not only in direct personal exchanges with women, but also in the running of institutions and management of resources, all of which affect the choices for women and men to handle the risks of HIV in everyday life. On the most indirect level, it is expressed in macro-level decisions that give higher priority to trade protection, military expenditure, cheaper energy and space exploration than to health sector budgets and fulfilling the eight Millennium Development Goals.

6. Redressing HIV-related gender inequality

As gender inequality is a major root of HIV spread, it is important to define strategies for primary and secondary HIV/AIDS prevention. To start with, working definitions of primary and secondary prevention in the HIV/AIDS context can be seen in Box 5.

Box 5. Primary and secondary prevention

Prevention is commonly understood by dividing it into three areas: primary, secondary and tertiary prevention

Primary prevention means prevention from getting a certain condition.

Secondary prevention means preventing it from becoming worse, in that individual, by curing it or managing it, to prevent complications.

Tertiary prevention implies treating manifest complications, rehabilitating and mitigating. Some experts do not really see this as prevention at all, and it can therefore partly be left aside here.

In the area of HIV/AIDS, **primary prevention** includes actions such as, condom use, sexual education, redressing gender inequity and inequality, sexual abstinence or preventing sexual coercion and violence/rape in addition to the provision of clean needles and syringes to injecting drug users and in hospital/clinic settings.

Secondary prevention means helping people living with HIV/AIDS (PLWHA) to not get sick from their disease, through voluntary, confidential counselling and testing (finding out their HIV status and getting to know about the infection), good nutrition, a healthy lifestyle, condom use to prevent contracting an additional strain of HIV, early detection and treatment of opportunistic infections, and antiretroviral therapy when the immune system starts to weaken. It is worth noting that secondary prevention in PLWHA also may lead to some primary prevention in the sexual partner: if PLWHA know their HIV status and use condoms or clean needles to avoid further complications; or are on antiretroviral therapy, the partner will be at a lower risk of becoming infected.

It is also worth noting that in countries with a low HIV prevalence, i.e. a concentrated epidemic, primary prevention of HIV may entail secondary prevention of other sexually transmitted infections, e.g. detecting and curing a case of gonorrhoea, syphilis or Chlamydia leads to a reduced risk of HIV infection – particularly if it is combined with good counselling on safer sex practices.

From the above epidemiological definitions, one can derive a broader societal understanding of HIV/AIDS prevention: everything that prevents individuals from getting HIV is primary prevention. All actions that prevent the further spread from PLWHA, be it to vulnerable groups or the general population, can be seen as secondary prevention.

6.1 Strategies for redressing gender inequities within primary and secondary HIV/AIDS prevention

Certain priorities as regards redressing gender inequity within HIV prevention strategies have been identified. The following paragraphs summarize ways of redressing gender inequity in the field of HIV/AIDS, in a "medium-term" perspective, arbitrarily set at 5–20 years. Continuous, fundamental moves to the redressing of gender inequity in a "long-term" (>20 year) perspective go beyond the Millennium Development Goals, and also beyond the scope of this paper. Priority strategies will clearly be different for different regions and national settings.

6.1.2 Early risk groups

In the early stages of an HIV/AIDS epidemic in a country – as in some eastern European and central Asian countries – the needs of high-risk groups must be addressed with an explicit gender perspective, based on local data. Injecting drug users, prostitutes and men who have sex with men all have different needs and these must be met by a coherent effort to satisfy them, using a gender lens. This is essential for such groups and for society as a whole. In this work one must also highlight issues that intersect with human rights vis-à-vis HIV/AIDS. In addition to the aforementioned groups, one also needs to focus on men who may become a "bridge" to the general population: clients of prostitutes, men in prisons and young people who may start using illicit drugs (WHO 2004).

Actions targeting these three risk groups – potential entry-points for HIV into the general population – need to include antiretroviral therapy for those living with HIV/AIDS and in need of it. In the provision of such services a gender lens is also necessary, making sure that there will be no unintended gender difference in access to treatment; and that a gender analysis precedes interventions (e.g. focused sexual and reproductive health services, and harm reduction programmes such as needle and syringe exchange).

A number of specific actions (micro-credits, education for girls/women, legal rights reforms, and poverty reduction – in general but also in particular for women) help reduce the need to turn to prostitution. Criminalization of prostitution unfortunately tends to drive it underground and not reduce it. Current trends in human trafficking for prostitution risk contributing to the spread of HIV, but this is still rarely measurably significant (Stafström and Liljestrand 2005). Interventions targeting (potential) clients of prostitutes have been effective in a few countries, e.g. Thailand.

6.1.3 Later in the epidemic

When HIV has started to spread among the general population, all the aforementioned interventions targeting high-risk groups need to continue with full force; as well as long-term efforts to reduce gender-based inequity and poverty. In addition, gender-sensitive interventions now also need to emphasize primary and secondary prevention among sexually active age groups in the general population.

6.1.4 Recommendations applicable in various stages of the epidemic:

ADEQUATE EDUCATION FOR GIRLS AND BOYS Young people need adequate, age-specific, culturally appropriate information on sexuality, reproductive health and rights, and HIV/AIDS; they also need health care that provides them with access to counselling and the provision of services

related to contraception, sexually transmitted infections and HIV (WHO 2004). Both information and services need to be gender sensitive – girls and boys have different physical and communication needs (Bott *et al* 2003).

Such education is labelled sexual education and in some countries life skills education, family life education or health education. Both education and services also need to be accessible to out-of-school youth who often represent the most vulnerable group.

An additional, important dimension of such programmes is helping boys and girls learn about gender roles, how to become a "good man", challenging traditional gender roles in the respective society. This has been introduced on a small scale in some countries, e.g. Brazil, with the specific purpose of starting early in life, when interest is high and gender roles are being shaped, to help develop more equitable gender roles.

A NEW MALE ROLE Supporting girls and women in their striving for gender equality and protecting them from abuse and sexual dominance must be matched by conscious and strategic efforts to help develop a new male role, a new masculinity. This will entail different options in different societies. What they will have in common is the need to, among influential men, decision-makers, trendsetters and leaders, inspire a willingness to recognise and act on "the problem" and to seek new ways of self-fulfilment that also will contribute to a healthier, more productive, safer and more just society. WHO, for example, is currently developing a gender strategy for all its work, and one major direction of that strategy is to promote changed fatherhood roles as a vehicle to which most men can subscribe (Wallstam, WHO 2006, personal communication). In a recently released report by SADC[5] it is suggested to explore possibilities for mass campaigns or social movements with strong political, religious and community leadership in order reduce concurrent partnership.

STRATEGIES AGAINST GENDER-BASED VIOLENCE Gender-based violence is a well-know public health problem that needs to be addressed comprehensively, with strategies that aim at both prevention and support for victims (PAHO 2003). While violence between men is a well know problem, violence against women is increasingly recognised as a cause of ill health in many different areas. In 1993, the United Nations defined violence against women as:

> *"…any act of gender-based violence that results in, or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life".*
>
> – UN Declaration on the Elimination of Violence against Women.

Widespread public discussion and awareness raising, and improved care of rape victims (including post-rape HIV prophylaxis), are necessary elements to curb and mitigate effects of violence against women. Effective strategies to control and reduce gender-based violence can also include legislation, effective legal enforcement, female police stations, supporting women's shelters through non-governmental organisations and formative and operational research.

NON-DISCRIMINATION Currently, HIV testing in seriously affected countries is most common among women, often in connection with pregnan-

[5] SADC Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa

cy as a step towards preventing mother-to-child transmission (UNAIDS/WHO 1998). One effect of testing during pregnancy is often the disclosure of HIV infection to the partner/family with ensuing severe consequences, such as blame and eviction. Discrimination, related to HIV in a wide sense, needs to be systematically combated. This includes not only discrimination of people with HIV/AIDS, but also those who are already vulnerable such as prostitutes, injecting drug users, MSM, victims of human trafficking and sexual exploitation/abuse of e.g. street children and orphans, the incarcerated, people with disabilities and ethnic minorities, especially as victims of ethnic violence during wars/civil unrest. The potentially very important role of working actively with people living with HIV/AIDS, also in the reduction of stigma, is currently being emphasized by their key role in speeding up and improving quality and compliance, in antiretroviral programmes in many countries (Global Network of Peoples Living with HIV/AIDS).

LEGAL PROTECTION The vulnerable groups mentioned above need systematic steps to improve their legal protection: adequate legislation and policy; and the systematic introduction/implementation and monitoring of these legal instruments. It involves increasing judicial capacity, implementation capacity, and raising public awareness. Without proactive interventions, women usually have a much weaker *de facto* legal status than men, and extra efforts are therefore needed to heighten their legal protection in many areas.

LABOUR, MIGRATION In heavily hit countries, human resources are dwindling, constituting a serious threat to work towards controlling the epidemic and, generally, to reaching the MDGs (WHO 2006). Realistic human resource planning needs to take the projected losses into account; women will otherwise risk either a double burden or double exclusion effect from being both caregivers for diseased family members and overworked staff.

Only now are a few heavily hit countries starting to develop and implement HIV/AIDS policies in their public institutions, such as government offices and universities, where sexual harassment and abuse of women, misuse of superior status (in relation to junior women), and discrimination are often commonplace. Work to develop and implement gender-sensitive in-house HIV/AIDS policies needs to accelerate, in public and private work places.

In many low and middle-income countries, migrant labourers provide important financial incomes for families and the government. Improving the protection of these groups is a wise measure, and as indicated earlier has several gender dimensions.

RESEARCH Formative, action-oriented, social science research in key areas is essential in order to bring hidden issues related to gender inequity and HIV to the fore in society: e.g. violence and rape, sexual exploitation, the situation of high-risk groups and the mechanisms of discrimination. Of major interest is the studying of intervention efforts directed at young people; the shaping of new male roles; and "ecological" studies of implemented country strategies.

IMPROVE/INCREASE GENDER AWARENESS IN POLITICAL RESPONSES To have any chance to move in the direction of fulfilling the Millennium Development Goals, many countries, and notably the hardest hit in sub-

Saharan Africa, need very significant and consistent international support to reduce poverty through debt relief, fair trade and development cooperation. Poverty reduction will increase possibilities to improve gender equity but effective poverty reduction also requires systematic "engendering of development". Starting to control HIV/AIDS, also through gender-focused approaches, will act in synergy with such poverty reduction efforts.

6.2 Communicating prevention – a new "alphabet" is needed

For over 25 years, much HIV communication has been simplistic, in that it has ignored gender relations. One set of messages has been the ABC of Abstinence, Be faithful and Condom use. Replacing "A-B-C" with a broader, gender-sensitive understanding of HIV/AIDS prevention would be timely. As reflected in Box 6, the overly simplistic ABC message largely disregards the gender dimensions of the pandemic. Development of a better language, "alphabet" or other main messages needs to better reflect the gender dimensions, e.g. as the suggested new alphabet below.

Box 6. Why "ABC" is inappropriate, also from a gender perspective.

"ABC", meaning Abstinence, Be faithful and use a Condom, is a much used expression in HIV prevention work. Ever since the 1980s, this way of speaking about HIV prevention has been used, even before the acronym itself was invented. It has appeared fully logical to recommend abstinence/later sexual debut; faithfulness, "zero grazing", and the reduction of sexual partners; and to use a condom with one's occasional partners.

Currently, a global debate is raging as to the "C" in ABC, with the Catholic hierarchy in Rome opposing condoms and Catholics for a Free Choice proclaiming that "Good Catholics use Condoms": To date, the Holy See is consistently against all condom use, even among HIV-discordant, monogamous couples, although an increasing number of priests and bishops are in opposition to this policy, arguing the necessity of condom use as the lesser of two evils, the other being the spread of HIV. This opposition to condom use is also supported by the US government and some Muslim governments. The debate, unfortunately, tends to dominate over the even more important issue as to whether "ABC" is actually the most appropriately formulated intervention at all.

Decisions on abstinence, faithfulness and condom use are all, in the majority of situations and countries, taken mainly by males, and reliance on the simple "ABC messages" is therefore "gender-blind". Males in the vast majority of cultures have more sex partners than women, are less faithful, and usually take the decision on condom use. "ABC" disregards the subjugated position of women in general in negotiating sex during intimate encounters, and ignores the multitude of encounters that take place under (male) alcohol influence, or are connected with gender-based dominance and/or violence.

A more appropriate alphabet has been suggested as a help to come away from the promotion of "ABC messages":

- Accept sexuality and sex as something good for both men and women of all ages
- Be realistic
- Choose and be allowed to choose
- Delay sexual debut
- Empower
- Financial autonomy

7. Growing opportunities for social change

A slow-motion tsunami of rising adult mortality is currently underway in countries hit early by the AIDS epidemic and where in the foreseeable future only a minor part of those in need will receive ARV treatment. Insufficient little attention has so far been given to the impact of this rapidly rising adult mortality, which indeed threatens both HIV prevention and poverty reduction and thus also undermines efforts to improve gender equality.

The capacity of the pandemic to impede the very efforts made to contain it underlines that affected societies are in the midst of a very real crisis. Is there a way out? Yes, the dramatic nature of the crisis holds the potential of change, but only when it is fully acknowledged.

In the African context, one commentator points out that: "…through its impact on virtually all aspects of development…the HIV/AIDS epidemic may force an opening for policy attention to women's property and inheritance rights as a vital element of poverty reduction strategies; these strategies already recognize and respond to links between HIV/AIDS and agricultural development, democratic governance, health, and education" (Strickland 2004).

This prediction can be read as a challenge and a recommendation. The HIV/AIDS catastrophe offers a window of opportunity to make real progress in reducing gender inequities and inequalities. To capture this opportunity requires that all actors assume a new perspective: gender issues and HIV/AIDS issues are not competitors in development cooperation, but twin issues not to be separated. The real challenge is to bring this message, made clear in the Millennium Development Goals, home in the high echelons of power as much as among men and women, both young and old, in their local communities. The conclusion of this review is that – wherever the efforts to provide prevention, treatment, care and support services for HIVAIDS will lead to – the many gender dimensions of the pandemic at all levels of society need urgent and serious attention.

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Appendix 1:
Comparison: HIV-prevalence and ranking in the Gender Development Index

30 countries with highest HIV-prev 2003	**% 15–49 years**
Bahamas*	3.0
Ghana	3.1
Trinidad and Tobago	3.2
Guinea*	3.2
Angola	3.9
Togo	4.1
Uganda	4.1
Congo, Dem. Rep. of the	4.2
Burkina Faso	4.2
Ethiopia	4.4
Chad	4.8
Rwanda	5.1
Nigeria	5.4
Haiti	5.6
Burundi	6.0
Kenya	6.7
Cameroon	6.9
Côte d'Ivoire	7.0
Gabon*	8.1
Tanzania, U. Rep. of	8.8
Mozambique	12.2
Central African Republic*	13.5
Malawi	14.2
Zambia	16.5
Namibia	21.3
South Africa	21.5
Zimbabwe	24.6
Lesotho	28.9
Botswana	37.3
Swaziland	38.8

* = not GDI ranked

Source: UNAIDS 2005

30 countries with the lowest GDI-ranking (country ranking 1–140, 2003)	
Zimbabwe	111
Togo	112
Cameroon	113
Lesotho	114
Swaziland	115
Madagascar	116
Kenya	117
Mauritania	118
Gambia	119
Senegal	120
Yemen	121
Rwanda	122
Nigeria	123
Angola	124
Eritrea	125
Benin	126
Tanzania, U. Rep. of	127
Côte d'Ivoire	128
Malawi	129
Zambia	130
Congo, Dem. Rep. of the	131
Burundi	132
Mozambique	133
Ethiopia	134
Guinea-Bissau	135
Mali	136
Chad	137
Burkina Faso	138
Sierra Leone	139
Niger	140

Source: UNDP 2005

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