People unlimited HIVOS

# Women, gender and HIV/AIDS
# Where are we now & where are we going?

Maria de Bruyn

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## Contents

# PREFACE

The Stop AIDS Now! Initiative (SAN) in The Netherlands is preparing to expand its attention to issues of gender, women and HIV/AIDS. In that context, SAN member Hivos commissioned this background paper to examine how gender-based factors are currently influencing women's and girls' vulnerability to the HIV/AIDS pandemic and how these factors can be addressed in the next five years. While recognizing that gender also plays a role in determining men's susceptibility to HIV infection and its effects, a particular concern held by Hivos and SAN is the identification and promotion of interventions that will ultimately lower women's and girls' risks of contracting HIV and lessen the burdens they face in dealing with its consequences. While Hivos will continue to focus on other types of HIV/AIDS-related interventions (e.g., programmes for MSM), this paper examines interventions that can complement Hivos' overall goals of increasing women's self-reliance and contributing to greater societal gender equality and equity.

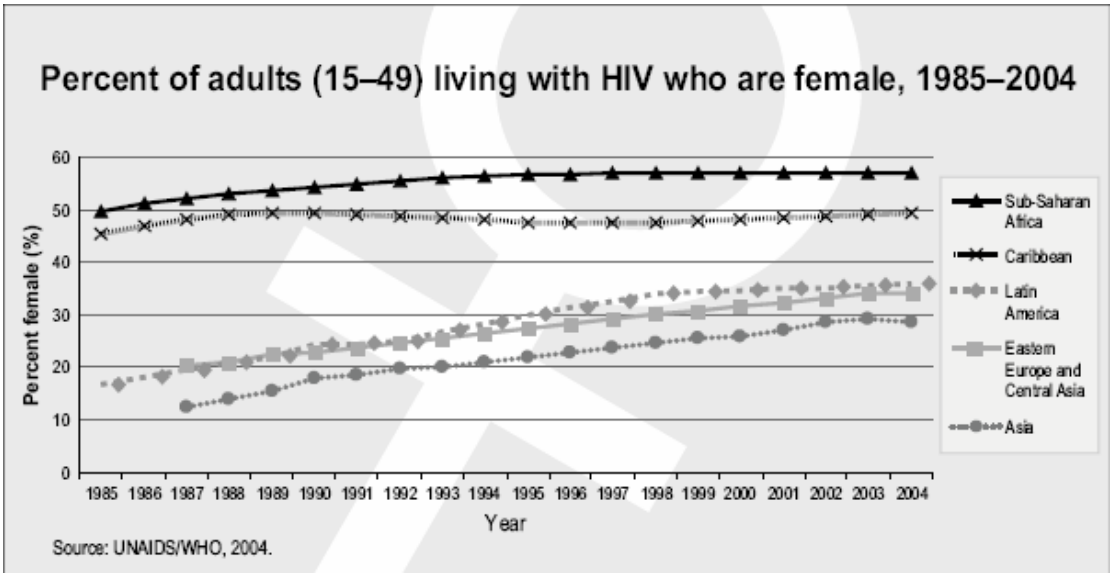
The paper is primarily intended to serve as a resource for Hivos' staff and SAN partners; hopefully, it will provide useful information for their counterparts in developing countries as well. While the author recognizes Hivos' choice to focus mainly on capacity-building, human rights, advocacy and policy-making, some of the recommendations touch on treatment and care issues that could be of interest to the SAN partners.

The topic of this paper is quite broad and a comprehensive overview of the issue could fill volumes. Given the wealth of documentation that most readers must absorb in their daily work, a decision was made to restrict this briefing/position paper to 35 pages of text. Consequently, many details and nuances have been left aside in favour of highlighting particular points of interest and salience.

The paper is organized as follows. The first section provides some epidemiological information about the situation at the global level, as well as in different regions of the developing world. This is followed by an overview of factors that increase women's and girls' vulnerability to the HIV/AIDS epidemic. The third section focuses on some gender-based interventions that have been used thus far, while the fourth section describes key challenges that are currently making gender-based approaches more difficult. The last chapter concludes with recommendations and ideas for the types of programmes and interventions that Hivos and SAN could consider supporting as part of a Gender, Women and HIV/AIDS Programme.

# 1. GENDER AND THE HIV/AIDS EPIDEMIC

UNAIDS, WHO and other organizations now speak about feminization of the HIV/AIDS pandemic, because an increasing proportion of people affected by HIV/AIDS around the world are female (Figure 1) [1]. They include adolescent girls, women of reproductive age and post-menopausal women, although most of the new infections are occurring in young adults. As increasing numbers of HIV-positive people gain access to antiretroviral therapy (ART), we may expect to see more and more youth who were infected perinatally surviving into adulthood, so that HIV/AIDS programmes will need to more explicitly address the needs of young people who begin puberty already living with HIV [2].




The percentages of infected women are substantially lower than the percentages of men in some regions, such as Eastern Europe and much of Latin America. This has led advocates working on behalf of men who have sex with men (MSM) to take issue with claims that the HIV/AIDS epidemic is becoming more feminized.[1] They argue for more nuanced portrayals of how HIV is spreading so that programmes and interventions focused on MSM do not lose attention, momentum and funding. Their point is well taken: interventions to reduce HIV infection and deal with its effects among MSM — and heterosexual men! — must certainly continue and receive funding that is proportionate to the numbers of men being infected in certain areas. That said, however, a focus

[1] There is a great deal of debate among organizations that work with men on what kind of terminology to use when referring to men who engage in sexual contacts with other men (e.g., homosexual, gay, MSM, etc.). For purposes of simplicity, the author acknowledges this debate but chooses to use MSM in this paper to denote all kinds of men who have sex with other men.

on women and girls remains warranted because women everywhere are highly vulnerable because of sex- and gender-based factors that are strikingly similar across most regions. The paragraphs that follow present some statistics and factors of particular relevance per region; a broader discussion of the conditions that place women in jeopardy is presented in section 2.

## Africa

Epidemiological estimates indicate that women are most greatly affected by the HIV/AIDS epidemic in sub-Saharan Africa, where they constitute almost 57% of those infected [1]. Young women are at particular risk; those aged 15-24 years appear to be three times more likely to be infected than their male peers. While overall HIV prevalence remains relatively low in Northern African countries, women are infected there by husbands who contract HIV through homosexual contacts; the stigma attached to homosexuality and the lack of attention to protecting female partners in MSM interventions are risk factors over which women have no control.

Other factors that increase women's vulnerability include high levels of domestic and sexual violence, high levels of poverty, multiple areas of civil conflict resulting in high numbers of displaced persons and refugees, and a lack of protection through laws.

## Asia and the Pacific

In Asia, the number of infected girls and women is growing. In East Asia, they account for 22% of HIV-positive adults and 28% of those aged 15-24 years with the virus; in South and Southeast Asia, the corresponding figures are 30 and 40%. Depending on their areas of residence, transmission may be predominantly through unprotected heterosexual intercourse with mainly steady or sole partners, through sex work or injecting drug use [1].

Factors that particularly affect women in this region include a burgeoning sex trafficking industry, high levels of violence against women, high levels of poverty, and widespread injecting drug use in certain areas. Women living with HIV in several countries have reported pressure or coercion to undergo sterilization and abortions.

## Eastern Europe and countries in transition

In Eastern Europe and Central Asia, women have been estimated to account for 34% of people living with HIV/AIDS. Many of them acquired the virus through injecting drug use, sexual contacts with infected partners who inject drugs, or through unprotected sex during sex work [1].

Women's vulnerability in some countries is partly related to the fact that relatively few women have been infected compared to men. General societal attitudes therefore assume that women are not at risk and do not need to take measures to prevent HIV infection. Sex trafficking is a problem and women living with HIV here have also reported coercion to undergo abortions and sterilization.

## Latin America and the Caribbean

In the Caribbean region as a whole, nearly equal numbers of women and men have been infected with HIV in the past; now, young women aged 15–24 years are two times more likely than their male peers to have contracted the virus [1]. In Latin America, the epidemic was largely confined for many years to injecting drug users and MSM; in all countries, the proportions of infected women have been rising, however, and they now constitute about 36% of those infected in the region [1].

Factors increasing women's vulnerability to the HIV/AIDS epidemic are similar to those seen elsewhere: high levels of domestic violence, large numbers of people living in poverty, stigmatization of homosexuality and a lack of protection for female partners of MSM. Although the influence of the Catholic Church is strong throughout all countries of Latin America, governments appear to pay more attention to Church leaders on issues such as reproductive choice (availability of contraceptives and abortion) rather than condom use. For example, in August 2005, the government of Venezuela launched a media campaign aimed at youth and women about the need for voluntary HIV counselling and testing (VCT); the campaign included the distribution of one million free female and male condoms to health facilities [3].

# 2. FACTORS AFFECTING WOMEN'S AND GIRLS' VULNERABILITY

Although much has been written over the past few decades about mainstreaming gender concerns into development assistance programmes, gender-based factors are still ignored or largely neglected in much HIV/AIDS-related research, policy-making and programming. However, that is not because we are unaware of how gender factors influence and are influenced by the HIV/AIDS epidemic [4].

> **"Many people know what the gender-based challenges facing women and girls are. However, the complexity of gender relations means that many find it difficult to focus on what exactly to do…Although girls and women represent the bulk of new infections, budgets, programmes, policies and human resource commitments do not reflect this. Many interventions continue to be aimed at an imaginary boy or man or a fictional gender-neutral public…Even organisations that are explicitly trying to address the problems of women and girls find it difficult to deal with the root causes of gender inequality. Because changes in gender relations occur slowly, not enough funding or attention is given to programmes that try to address the deeper connections between gender and HIV/AIDS."**
>
> **UN Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa [5]**

In general, recent research has elicited relatively little new knowledge or insights about gender-based risk factors and situations, although there are a few exceptions; for example:

- After years of debate about whether male circumcision affects men's risks of HIV infection, researchers finally carried out a prospective study that indicated this procedure may have a protective effect [6]. What remains to be done now are confirmatory studies and debate on whether male circumcision might be considered an indirect protective measure for women as well.
- While injecting drug use research has primarily focused on how risks might be lessened through harm-reduction strategies (needle and syringe exchange, sterilization of needles), some researchers are now examining differences in practices between female and male injectors that can increase HIV transmission risks. For example, in Tanzania, it was found that female injecting drug users created a new practice called "flashblood", in which blood is drawn back into a syringe until it is full and then passed to a female companion who injects the blood in the belief that this can help her avoid drug-withdrawal symptoms. The underlying (unproven and unlikely) rationale is that the first injector's blood contains heroin that is then passed to the second injector, who cannot afford to purchase drugs [7].

- Little attention has been given to the additional health risks that women living with HIV/AIDS may run when they undergo unsafe abortions because legal termination of pregnancy is highly restricted or unavailable. Research on this topic has undoubtedly remained scarce for two reasons. First, most interventions regarding pregnancy and HIV have focused on ensuring the right of HIV-positive women to bear children and to do so safely. Second, abortion is a highly sensitive topic that many policy-makers, programme managers and researchers would rather avoid. Even in countries where abortion services are legal, there may be few linkages with HIV/AIDS programmes. An analysis of HIV/AIDS services in KwaZulu Natal, South Africa, reported that in-service training of health-care providers neglected abortion; terminations were unavailable at community health centres and clinics, and only 4% of facilities had information materials on abortion for clients [8]. The University of Cape Town has begun studying abortion within the greater context of HIV-positive people's reproductive choices [9] and other international organizations such as the Guttmacher Institute are looking at this topic as well [10].

While the majority of observations regarding gendered aspects of the HIV/AIDS epidemic may be widely known, it is nevertheless useful to summarize them as a context for recommendations for future action.

## Physiological factors place women at more risk than men

It has been well-established that, because of their physiology, women are more at risk of contracting HIV during vaginal intercourse than men [1]. As mentioned above, the physiological intervention of male circumcision might prove protective for men and their female partners; according to the researchers involved, it appears to be "equivalent to a vaccine with a 63% efficacy" [6].[2]

There are no such interventions available to lower women's biological risks. Indeed, while male circumcision generally does not produce serious side effects, female genital cutting can lead to both short- and longer-term morbidity, infertility, pregnancy complications and sexual dysfunction. It offers no protective effect against HIV/STIs at all.

## Domestic and sexual violence against women

Women are by far the sex that is most often victimized in domestic violence and sexual assaults in

[2] Some activists in the United States immediately claimed that male circumcision is a human rights violation because it is often performed on boys without their informed consent [11]. WHO speeded up work on guidelines for ensuring the safety of male circumcision [12], while UN agencies stated that more research is needed "to determine whether male circumcision should be promoted as an additional public health intervention to reduce the risk of sexual transmission of HIV" [13].

all countries of the world [1, 14].[3] Surveys in various countries have shown that many women, as well as men, have internalized gender notions condoning men's violence against women [5, 15]. Penal codes also serve to reinforce such ideas. In many countries, marital rape is not yet considered a crime. In Nigeria, the Penal Code specifically allows husbands to physically punish their wives as long as they do not inflict serious harm [16]. In comparison to the United States, which has over 1200 shelters for battered women, Nigeria has only two.

Sexual violence against women not infrequently involves rough sex, in which the vagina or anus is traumatized, making it easier for HIV to enter the blood stream. Gang rapes involving multiple perpetrators, which are increasing in frequency in some countries, multiply the risks of trauma for women in certain areas [17]. In some African countries, myths have contributed to an increased number of rapes in which young girls and even toddlers and infants are victims. Such myths include beliefs that having sex with a virgin will cure a man of AIDS, prevent him from contracting HIV/AIDS or will cure impotence [18].

Poverty and lack of property rights can prevent women from leaving marriages characterized by domestic and sexual violence, which might lead to HIV infection [19-20]. In addition, violence or threats of violence can prevent women from seeking VCT or treatment once they have contracted the virus. HIV-positive women in South Africa have commented about husbands who force them to obtain antiretroviral drugs at clinics and then hand them over to the men, who do not want to be identified as HIV-positive [21]. Staff of a Zambian clinic that provides ongoing ART to women who test positive during pregnancy remarked that 60% of women eligible for the programme drop out due to fears of psychological and physical violence. Some women who did enrol were subsequently chased from their homes, cut off financially and assaulted. A counsellor commented: "I saw a woman with a CD4 count of 8 in need of treatment, and she'd withdrawn because of physical abuse" [22].

In areas of civil conflict, rape is used as a weapon of war (examples include Liberia, Kosovo, Rwanda, Sierra Leone, Sudan, Uganda). In most cases, the victims are female, leaving considerable numbers of women pregnant against their will. Where emergency contraception and safe legal abortion is restricted or services are unavailable (e.g., in refugee camps), some women will turn to unsafe abortions, placing their health and lives at risk [23]. For HIV-positive women whose health is already compromised, such unsafe abortions may increase their morbidity. Women who are raped in areas where HIV infection is endemic are at great risk of contracting the virus themselves.

Women living on the streets and sex workers are often subjected to sexual violence, not only from thugs and clients, but also law enforcement personnel. Female sex workers in Bangladesh who

[3] Men and boys who suffer sexual assault are obviously also at high risk of infection from HIV-positive perpetrators. These risks are not as generalized, however. **All** women, irrespective of age or socio-economic class, run a high chance of suffering violence in their lifetimes. It is MSM and men in institutional settings, such as jails and prisons, who are at most risk of being raped in the male population.

work as AIDS peer educators, for example, told of repeated instances in which they were raped and assaulted by police officers [24].

The sex trafficking industry mostly involves young girls and young women [25]. They often end up in brothels where they are unable to insist on condom use; when they become HIV-positive and ill, they face being tossed into the streets to fend for themselves. Young women are moved within a region (e.g., from Nepal to India), from developing to industrialized countries (e.g., the Dominican Republic to The Netherlands), as well as between developing countries (e.g., Belarus, Russia and the Ukraine to Thailand) [26-27]. It is poverty that allows some young women or their families to believe tales that they will be taken to work in legitimate businesses if they accompany the traffickers [28]. In some cases, they are indeed recruited for labour, for example as domestic maids, but here, too, they may be vulnerable to sexual exploitation.

Female migrants are at more risk of sexual exploitation and sexual assault than their male counterparts. Research has shown that the range of jobs open to them are more limited, driving some women to turn to sex work for an income. Female traders may be subjected to demands for sexual intercourse in return for transport of their goods, lower importation fees or other services needed for their business [29].

Finally, one place where young girls should feel safest may be the place where they are precisely at risk of sexual harassment and abuse: the school they attend [30]. Reports especially, but not only, from Africa indicate that not only the girls' male schoolmates but also teachers rape them [31]. Such assaults are not always violent in the case of the teachers; they may use psychological threats of low or failing grades, punishment or humiliation to coerce schoolgirls into having sex with them [5].

## Obstacles to women's sexual decision-making

In many societies, prevalent gender conceptions dictate that women are not expected to be decision-makers regarding sex. Research data and anecdotal information have pointed out time and time again that people assume men will decide when and how they will have sex and that it is women's duty to submit to their wishes, particularly if they are married. Considerable numbers of women have agreed in surveys, for example, that men are justified in beating them if they do not have sex with their husbands on demand. Men usually leave it up to their wives to take care of birth control, but it is the men who decide whether contraception can be used in the first place. Since condoms are still the only contraceptive method proven to protect against HIV/STIs — and since male condoms are much more widely available and affordable than female condoms — women must rely on men's cooperation to employ this HIV prevention tool.

It is well known that a considerable percentage of MSM have both male and female partners. In some cases, this is because they have a bisexual orientation. In other cases, particularly where homosexuality is heavily stigmatized, MSM marry women in order to conform to societal

expectations. Considerable numbers of these MSM do not reveal their homosexual activity to their female partners, however, either because they fear discrimination and violence when their homosexual encounters become known or because they feel it is none of the women's business. They do not broach condom use because it cause suspicion or would prevent them from fathering children. For example, a 2002 study of 150 married MSM in Bangladesh and India revealed that "in the main the feeling was that as long as they [MSM] performed their duty to the wife in terms of sex, money, and support, their behaviours and choices were not of concern to the wife…All the participants acknowledged the risks of STI/HIV infection for themselves and possible transmission to their wives. All also understood the need to use condoms with their male partners. However…condom use with their wives was another issue altogether. These issues reflected concerns that the wife may become suspicious if the husband uses condoms (why?), that this would interfere with the need for a son, and the whole issue of discovery" [32].

Since HIV transmission still persists within the MSM population throughout the world, those men who do not engage in protected sex will subsequently place their wives and other female partners at risk. Most MSM interventions still focus on educating men about their own risks of infection and encourage them to protect themselves and their male partners; little is said about their responsibility towards their female partners.

Women who do not have steady partners or who are not living under the daily control of men may appear to have more freedom to make decisions about sexuality. However, unless they are financially well off, this freedom may be largely illusory. Some schoolgirls may engage in transactional sex because they are enticed by the possibility of being able to receive and purchase luxury items. In some cases, the only pressures on them to sell sex come from peers and advertising about "the good life" [33]. Nevertheless, many young women submit to sex for money and goods because they need the income to pay for school supplies or to help their families subsist from day to day [5]. In July–September 2005 alone, there were news reports about such "schoolgirl sex" in Ghana, Liberia (with estimates of 60–80% of schoolgirls engaged in transactional sex), Niger and Togo [34–38]. Their partners are frequently older and the young women have limited possibilities for negotiating the conditions under which they have sex. They may even engage in sexual practices that they believe are safer but that pose more risks of HIV infection. A project worker in South Africa commented, for example: "…I read that more and more young girls are resorting to anal sex to avoid HIV infection and pregnancy. Apparently they request their older lovers to have anal sex as they are unable to say no to sex because often the older lover gives the young girl some money to meet her needs – whatever they are" [39]. It has also been noted that female orphans may be at increased risk because they do not have parents to protect them and guardians may be less concerned about their welfare [40].

Poverty increases adult women's vulnerability as well. Those with little education and who are unable to support their families through agricultural endeavours may have few economic opportunities open to them. Certain occupations may seem "legitimate" at first but can easily lead to sex work (e.g., restaurant work [41]).

When short- and long-term migration offer what seem to be the only or best possibility for gaining an income, many people believe the benefits of migration outweigh the potential drawbacks [1]. Women who are separated from their spouses without a regular income may turn to transactional sex to supplement household revenues. Not all of them feel strong enough to insist on condom use with their non-spousal partners. Their husbands, in the meantime, may engage in sex with other partners for various reasons: boredom, a belief that they are entitled to have multiple partners, a perceived inability to resist biological urges, or peer pressure. It is not uncommon for them to avoid condom use. Female and male spouses thus run the risk of infecting one another, both for the first time and with new strains of the HIV virus if they are already HIV-positive.

Marginalized women are also very vulnerable to sexual exploitation. For example, female injecting drug users who are desperate for money to buy drugs, as well as girls and women living on the streets who need to buy food, may see no other choice than to engage in transactional sex.

## Blame, stigma and discrimination

### Blame and discrimination within the family

Numerous studies in different countries have shown that women are “blamed for bringing AIDS into the family” [22, 42]. Large numbers of men who are tested and discover they are HIV-positive do not share this information with their spouses or other female sex partners. Their reasons vary; single men are afraid that they will be unable to find a spouse; some men do not want their female partner to discover that they were infected through homosexual practices; some men are ashamed or fear blame from their wives; others are irresponsible or uncaring.

When women are tested, their serostatus frequently becomes known before that of their partners or husbands. Women identified as HIV-positive may subsequently suffer stigmatization, loss of child custody, discrimination within the family, abandonment and even violence [43]. Fears of such negative consequences still lead women to avoid HIV testing or returning for their HIV test results. If women cannot count on a legal system that will protect their rights regarding violence, divorce, child custody, property ownership and inheritance, it is not unreasonable from them to believe it is better to remain unaware of their HIV status.

### Stigmatization and discrimination against marginalized women

Discrimination against women living with HIV may be related to ideas that they themselves are to blame for their infection. Judgemental attitudes towards sex workers and injecting drug users are still prevalent and influence how women (and men) are treated. In a report from Uzbekistan, one HIV-positive woman said: "I had problems with the police earlier as I was an injecting drug user. When they came to the house the police started insulting me loudly saying that I was infected with HIV. It was a shock for my parents — and the neighbours were watching." The representative of an NGO added: “"HIV positive people are often detained by the police. Many are injecting drug users

and or commercial sex workers. The police have many prejudices and denigrate them by telling whoever they want to about their condition." [44]. In Russia, where there is a shortage of ART, mothers and children are given priority for ongoing therapy unless the women are injecting drug users. As one physician said: "Giving ARV therapy to a drug user is the same as taking money and throwing it into a pit" [45].

## Stigmatization and discrimination within the health sector

Health-care providers, like other members of society, often feel that HIV-positive women are not interested in sex or they judge that they should not be [9, 46]. Considerable numbers also believe that it is better for people living with HIV not to have children, especially where ART is not yet widely available and/or where society is dealing with large numbers of orphaned children. For example, 60% of 373 health professionals surveyed in three states of Mexico thought that HIV-positive women should be prohibited from giving birth [47]. Attitudes denying HIV-positive women's sexuality may result in an emphasis on condom use for HIV prevention and a failure to provide information on other contraceptive methods that are more effective in preventing pregnancy [48-49]. Some providers may pressure HIV-positive women to undergo sterilization or abortion [45, 50].

On the other hand, in some places where provision of ART has become the norm to prevent perinatal transmission, providers may withhold information from women about possibilities of legal abortion in the case of unwanted pregnancy or they may deny them abortion-related care [51]. In both cases, HIV-positive women are being deprived of their right to make fully informed and voluntary decisions about childbearing and parenting.

> **"...the doctors also found out I was pregnant. I did not want to have a child at this stage and requested the pregnancy be terminated. The doctors only agreed to the termination on condition that I consented to sterilisation. I had no option."**
>
> **South African positive woman [52]**

The blame that is attached to women in the context of HIV has become somewhat institutionalized through interventions focused on preventing HIV transmission during pregnancy. In the early years of the epidemic, WHO, UNAIDS and other institutions spoke of prevention of perinatal or vertical transmission. This changed gradually, however, to prevention of **mother-to-child** transmission (PMTCT or PMCT). Though surely unintentional, this change in terminology ended up implicitly emphasizing women as a vector of transmission and identifying an innocent victim — the child. Whereas the earlier terminology was gender-neutral and carried no intimations of who was responsible, the PMTCT terminology does do this, ignoring the fact that the woman's

partner often also is HIV-positive and that she may not be in a position to do anything to prevent transmission. It would be much better if the HIV/AIDS field were to revert to the original terminology and speak of prevention of perinatal transmission or PPT.

There are reports from all around the world of women's rights being violated by health-care providers who test them for HIV without their knowledge and/or reveal their serostatus to family members (and third parties) without their permission [45, 48, 50-52]. This is one reason that some women avoid VCT.

Until recently, antenatal testing was usually offered to women and they could proactively choose to have an HIV test. Now routine opt-out testing is increasingly being introduced; that is, women must explicitly state that they do not want an HIV test. However, some women may not realize that HIV testing has become routine, especially if they are only informed about tests during pregnancy through a written form that they are asked to sign. This may be particularly the case for illiterate women or women who have not received pre-test counselling and raises questions about whether women's right to fully informed consent is being observed [53-54]. In addition, a newer recommendation, first made in the United States and now also by UN agencies [55-57], is being adopted by organizations in developing countries [58-59]: HIV testing of women during labour and delivery. Given the state of crowded labour wards in many places [60-61] and the fact that women in the process of giving birth are unlikely to be able to concentrate well on absorbing new information, even more questions can be raised about whether their rights to give fully informed consent, to privacy and to confidentiality can be fully observed [62].

The benefits of PPT programmes cannot be denied. It is in everyone's interests to prevent HIV infection of infants. But the focus of PPT programmes remains on the child, rather than the woman and child, since programmes that offer ongoing ART to parents are very limited in scope. These programmes are missing the mark unless they can help guarantee that women will not face negative repercussions of a positive HIV diagnosis. This will require much more work to offer adequate counselling and emotional support, combat breaches of confidentiality within the health system, more efforts to eliminate community- and family-based stigma and discrimination, more support for women to use either exclusive breastfeeding or replacement feeding, and availability of a steady supply of ART drugs to those women who need it.

Finally, it should be noted that women suffer violations of their rights to health, health care and freedom from discrimination through inhuman and degrading treatment and outright denial of care [43, 45, 50]. This is partly due to negative attitudes toward people living with HIV/AIDS and partly due to health-care providers' fears of becoming infected through occupational exposure. For example, 16 providers interviewed in Indonesia all stated that they were prepared to discriminate against HIV-positive patients, for example, by isolating patients or refusing them care. Providers said they could avoid treatment by claiming a shortage of medical supplies or equipment so that they needed to refer a patient elsewhere. An HIV-positive woman who needed a pap smear confirmed that she had undergone such reactions when physicians learned of her

positive serostatus [63]. Research in Thailand revealed instances in which pregnant women were told to go elsewhere to deliver their babies or denied a caesarean section due to provider fears [64].

## Inequality in treatment and care

### HIV/AIDS treatment

Given the enormous amount of attention and donor funding that has gone into promoting PPT programmes, one might assume that women have been given preference in testing and treatment. This is indeed the case for some women. In one study, 56% of drug recipients at ART sites were women [22]. However, this does not mean that women in general are more "privileged" than men regarding treatment access:

- In some areas, a greater proportion of HIV-positive people are female and accordingly a greater proportion of patients needing treatment are women.
- Many of the women enrolled in ART programmes learned their HIV diagnosis through a PPT programme. The vast majority of women who are not pregnant do not access VCT and thus many HIV-positive women remain unaware of their status and are not identified as candidates for ART. There is an urgent need to expand VCT services beyond the antenatal care setting and to encourage women to access testing, provided the health system has services to offer them such as treatment, care and support [48, 65].
- In many countries, a positive HIV diagnosis during pregnancy still means that a woman will only be offered ART for PPT, not for her own ongoing treatment and survival. Even where ART is theoretically available to all patients in need, supplies may be lacking or erratic and the infrastructure needed to supervise ART regimens may be absent. In South Africa, the Hlabisa Hospital in northern KwaZulu-Natal province recorded six maternal deaths within a two-month period: all were HIV-positive women who were not receiving ART [66].
- When women are able to access ART, they may be subjected to certain restrictions not imposed on men, e.g., a requirement to use provider-defined and controlled contraceptives such as IUDs or injectables [49, 67].

Where there are insufficient ART drugs available for all patients in need, women may be at a disadvantage in trying access the drugs. Even when ART is offered free of charge, for example, women may be less able to pay associated expenses such as transportation, additional laboratory tests or user fees because of poverty or the inability to decide on how household income is spent [68].

In countries with fairly well-functioning welfare systems, both women and men may face an unexpected disadvantage as their health improves with ART. Some countries give HIV-infected persons with certain illness markers disability payments; when their condition improves, the welfare payments cease. This is the case in South Africa: when a person's CD4 count exceeds 200, s/he no longer qualifies for a disability grant [69]. Since drug supplies are still erratic and ART

may be stopped from time to time, not only will a patient's CD4 count rise and fall, the patient may also develop drug resistance to the few ART drugs available. Patients whose disability status must be repeatedly be "reclassified" face bureaucratic obstacles; women may find it more difficult to deal with the bureaucratic procedures because of lower educational levels, lack of funds for transport, lack of childcare to enable them to visit the relevant offices, etc.

## Home- and community-based care for patients

In most societies, the care of household members, especially when they are ill, has largely been relegated to women and girls, since such care is considered a domestic chore that women are obliged to fulfil for the family. This also holds true when family members become sick with AIDS [1, 70]. When ART and drugs to treat opportunistic infections are absent, people fall ill more quickly and, as is well-known, providing home-based care for patients suffering from AIDS can be very time-consuming and labour-intensive. Women may be unable to devote as much time to farming and need to be absent from paid jobs relatively frequently [70].

This scenario holds true in all regions affected by HIV/AIDS. In poorer regions (much of Africa and Asia), young girls may be kept home to assist caregivers. Withdrawal from school jeopardizes their future education and employment in better-paid jobs. Moreover, links have been demonstrated between women's educational levels and their susceptibility to HIV infection [71].

## Care of orphaned children

Where the epidemic has existed for a longer time and there are high levels of HIV prevalence, it is especially older women who end up caring not only for their adult children with AIDS but also for their orphaned grandchildren [72-73]. Research by the Ministry of Agriculture and Cooperatives in Zambia revealed that female-headed households cared for three times more orphans than male-headed households in one province [74].

## The economic situation of widows, divorced and separated women

National AIDS Programmes may pay little specific attention to the needs of HIV-positive women other than through PPT programmes. In some countries, this is "because" the epidemic has primarily affected men and/or injecting drug users. In other countries, even where a large proportion of infected persons are female, gender biases conspire to overlook or even negate women's rights and concerns, including those of women living with HIV/AIDS.

In India, few laws govern matrimonial property and women receive very little support upon divorce [75]; women who are abandoned when their HIV status is discovered therefore have little legal recourse. Human Rights Watch found that women's property and inheritance rights are routinely undermined and violated in Kenya, because civil laws permit gender discrimination regarding rights, customary laws privileging men are given more credence, male authorities ignore or deny women's rights and women who dare claim their rights face social retribution in the form of family abandonment and violence [19]. In Namibia, customary law is generally accorded the same

status as civil law and customary law limits or annuls the inheritance rights of widows and orphans [76].

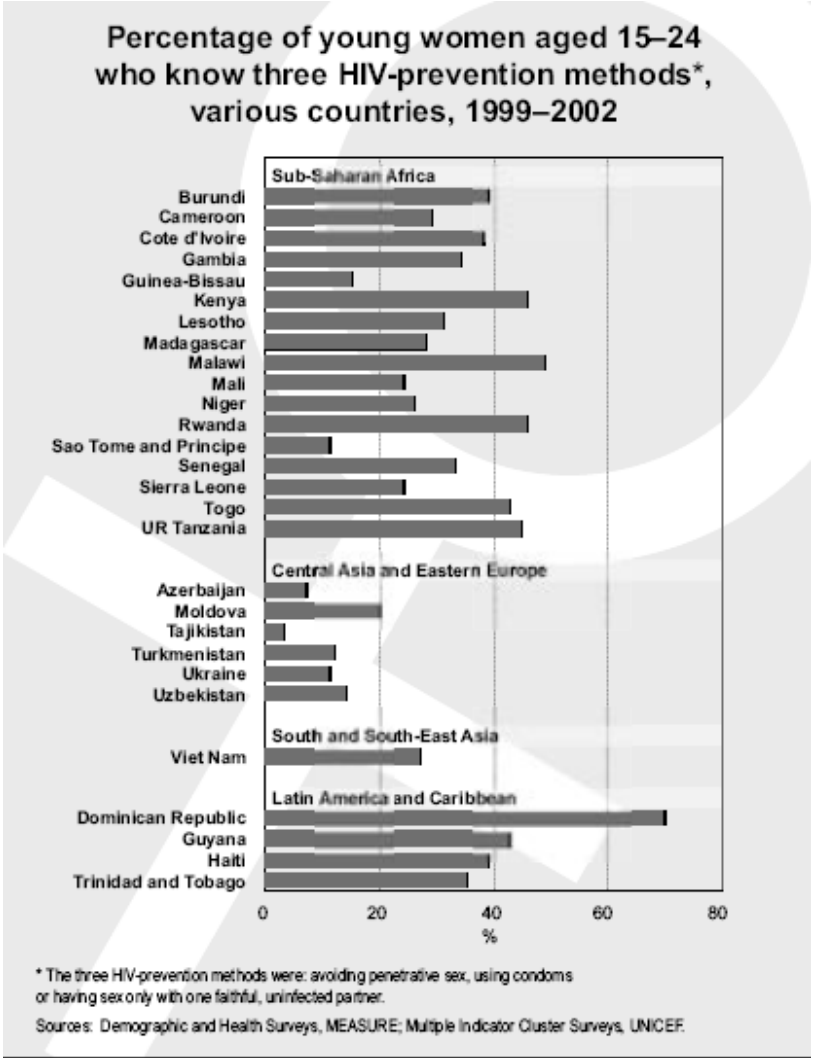
Particularly in Africa, it is not uncommon for women living with HIV to be robbed of their property while their spouses are alive, when they divorce and when they become widows. Without any resources, they are scarcely able to meet their own and their children's subsistence, educational and health needs. As the epidemic becomes more visible in Asia, it is likely that a similar scenario will be more commonly seen there.

# 3. GENDER-BASED RESPONSES THUS FAR

## HIV prevention for girls and women

### Information and education

Since the early 1990s, when the advocacy and scientific literature began paying attention to women and HIV/AIDS issues, many interventions focused on women and girls have centred around informing and educating them about HIV transmission and prevention methods. Reports of success often focus on smaller-scale projects, where IEC is offered in face-to-face situations by peer educators and others. The scale of such projects is necessarily limited and coverage often is mainly restricted to urban areas. It is thus perhaps not surprising that demographic and health surveys in various regions show considerable numbers of young women interviewed between 1999-2002 still did not know three ways to prevent HIV infection (Figure 2 [1]).




Expanding efforts to provide IEC through comprehensive sexuality education programmes, in both urban and rural primary and secondary schools, and integrating HIV prevention education into other programmes (e.g., agricultural extension and rotating savings schemes) remains necessary. Particular emphasis should be given in such education to the benefits of condom use, emergency contraception and post-exposure prophylaxis (PEP).

Much has been written about women's inability to force their male partners to use condoms. However, some women are able to influence their sexual partners' behaviours and some women themselves prefer not to use condoms or are insufficiently informed about the risks to their health if they do not do so.

Education for young people — both girls and boys — should therefore explain clearly why condoms are protective against HIV/STIs and that they can especially protect young women, who are physiologically more vulnerable to infection.

## Empowerment strategies

Recognizing that IEC is not a sufficient prevention strategy, programmes that promote women's empowerment have been developed. Many of these interventions seek to increase women's sense of self-esteem and self-worth and encourage them to "say no to sex" when they don't want it and yes to sex only when it is on their terms. "Saying no" can mean that women decide to only have protected sex, delay sex until they are ready, or only have intercourse when they are married. All three options are legitimate as long as they are made voluntarily by the women themselves and do not lead to stigmatization or derision of people who do not choose to —or cannot — say no until marriage. That danger has arisen, however.

It is not only in the United States that virginity pledges are being promoted. In Swaziland, the King instituted a traditional five-year chastity rite for teenage girls, in which they wore specially coloured tassels to denote their virgin status and vowed to refrain from sex. The families of men who still approached them for sex were expected to pay a fine. Some young women said the custom helped them avoid unwanted sex; others claimed that girls were forced to wear the tassels [77]. As one 18-year-old girl said when the rite was stopped a year early: "We are so happy that King Mswati ordered us to take off the woollen tassels…They were no use because some girls fell pregnant while wearing the same tassels" [78]. The director of Swaziland's National Emergency Response on HIV and AIDS confirmed that new teenage HIV infections and pregnancies had slowed, but he said that this was the result of vigorous prevention campaigns by NGOs rather than the tassels [78].

In South Africa and Zimbabwe, some have taken virginity pledges a step further, promoting virginity **tests** for young women [79]. King Goodwill Zwelithini, leader of the Zulus, vowed to promote the tests in defiance of the Children's Rights Bill that will ban the custom in South Africa [80-81]. The rationale that he and women employed as virginity testers advance is that girls and young adults who choose not to have sexual intercourse will remain free of HIV.

Abstinence is protective, of course, as long as a girl or woman is not sexually assaulted. Nevertheless, virginity testing has negative aspects that argue against its use as a prevention strategy:

- The tests are generally promoted only for women, reinforcing gender stereotypes that women should remain "pure" before marriage while it is acceptable for men to have multiple partners.
- There is no fool-proof medical method of "proving" that someone is a virgin as the hymen may be absent or broken for reasons other than sexual penetration. The criteria that are actually used to "determine virginity" are ridiculous: "certain lines below a girl's eyes, behind her knees

and on her breasts" [82]. Moreover, there are now reports of young girls engaging in riskier anal sex so that they can still pass the virginity tests [81].
- Such programmes imply that unwed women who are not virgins are somehow less moral or dignified or have less integrity than virgins. The Women's Action Group in Zimbabwe pointed out that this can be linked with sexual abuse: girls who have "failed" virginity tests have subsequently been raped [79].

Any prevention strategy that is associated with moral superiority, rather than responsibility and health protection, remains questionable.

Empowerment programmes that have avoided moral overtones have proved successful with varied groups, such as young women in Nepal and sex workers in India [83–84]. But it has become apparent that even women with higher self-esteem and enhanced decision-making skills have a difficult time carrying out their intentions without structural support. Increasing women's and girls' income-generating capacity — and ability to decide how to allocate earned resources — is a necessary component of empowerment strategies. Changing laws so that women are not penalized for undertaking prevention measures is also of vital concern. For example, peer educators sponsored by the Kerala Health Department and Sex Workers Forum Kerala in India faced a constant threat of arrest for soliciting because of laws criminalizing sex work [85]. Women must also be able to access prevention tools, such as PEP and steady supplies of male and female condoms at affordable prices. Condom promotion should not come at the expense of other needed SRH interventions, however. In Jamaica, some pharmacists opposed making emergency contraception widely available because they thought it would promote irresponsibility and lead to less condom use [86].

## Female-controlled prevention methods

The amount of research devoted to HIV prevention methods that women can control has slowly increased, particularly regarding the development of a microbicide that can prevent HIV/STI infection. Some attention is also being paid to issues that can affect the acceptability of microbicides. For example, some women might prefer an agent that is also spermicidal, while others might want a method that can permit pregnancy. Women in Africa have discussed whether preferred sexual practices might favour or impede microbicide use. In areas where men (and some women) prefer dry sex, a microbicide might be less accepted than in areas where wet sex is considered desirable [87]. While it may be some years before a microbicidal agent is available, preparatory research that examines such questions is needed to prepare the way for IEC and marketing campaigns.

A female-controlled prevention method that is already available — the female condom — has received nowhere as much attention as male condoms. Some say this is because female condoms are much more expensive than male condoms. Others have pointed out that efforts to inform and educate women on proper use have remained limited [88]. The Ghana Chapter of the Society for Women and AIDS in Africa (SWAA) reported success in promoting female condom use by tailoring

IEC messages to target audiences' immediate concerns: "With the secretaries, their concern was having a better career and taking care of their families. We explained how failure to use condoms can affect realization of their dreams" [89]. Following a technical consultation on female condom promotion and use, the Global Coalition on Women and AIDS and Global Campaign on Microbicides agreed to take steps to reinvigorate advocacy and programming that involves this prevention tool [88].

### Prevention methods after unprotected sex

Most countries do not yet make PEP available to rape survivors. Where governments and NGOs have taken steps to do so, such as South Africa, accessibility of PEP is still limited, especially in rural and more remote areas [90]. Advocacy, policies and interventions in this area need to be vigorously pursued.

While PEP and emergency contraception are prevention methods worth pursuing, not every new prevention tool should be embraced. For example, in 2005, publicity was given in South Africa to "Rapex®", a device like a female condom or tampon that would latch on to a man's penis with fish tooth-like hooks [91].The inventor's intention is to create a method that will not only stop a rapist from completing his sexual assault but also identify him as a perpetrator since the device can only be removed by a surgeon. Besides overlooking the fact that a woman usually cannot predict when she will be raped (so that she can insert the device in advance), proponents also ignore the fact that a rapist "caught" in the device may become enraged and even more violent against his victim. As one rape crisis worker noted: "It's not empowering women, it increases their vulnerability to violence and murder" [91].

### Youth-friendly services (YFS)

An area where some strides have been made over the last decade is the design and development of youth-friendly SRH services. When it became clear that young people frequently prefer visiting health facilities where they feel comfortable and can address multiple SRH concerns at the same time, both NGOs and public health systems embraced the YFS concept [92-94]. Hallmarks of such services include: providers who have been especially trained to deal with youth, special attention to issues of privacy and confidentiality, provision of information through counselling as well as print and audiovisual media, and convenient opening hours. Some YFS services include peer educators among their staff, which can increase youths' receptivity to messages focused on prevention of HIV/STIs and unwanted pregnancies (which are frequently of greater concern to young women than HIV/STIs).

## Programmes focused on men and boys

As noted above, only a few projects for MSM appear to address these men's relationships with women. For example, a 2003 *Charter for Social Justice* focused on the needs and concerns of MSM in Asia did not mention such relationships at all [95]. While MSM projects must of course address

the rights, needs and concerns of MSM, they must also emphasize their responsibilities to all their partners, including women.

While HIV prevention outreach to men has been done for years (e.g., at bars, truck stops, workplaces, sporting venues) [96], more recent efforts have focused on SRH programmes for men and boys [97]. A major trigger was the recognition that women's ability to protect themselves against HIV infection will remain limited until gender biases are tackled. It was also acknowledged that men have received much less attention to their SRH needs such as genital tract cancers.

A number of these programmes have shown success. For example, the Program H Alliance in Latin America works with young men on gender, reproductive health, sexuality, fatherhood, violence and other issues through participatory weekly workshops. An evaluation at two sites showed that the young men developed better attitudes regarding women's household roles and violence against women; their rates of STIs decreased and reported condom use increased [98].

Campaigns and programmes to mobilize men's support for women's rights have emerged, often from organizations of men against violence, such as the worldwide White Ribbon Campaign [99]. In The Philippines, Population Services Pilipinas Inc. conducted an awareness-raising and educational campaign for policemen and village chairmen [100]. In South Africa, more than 25 member organizations in the Men as Partners Network have worked especially, but not exclusively, with younger men on opposing domestic violence and engaging in HIV prevention [101-102]. Such actions and organizations deserve much more support as important components in changing gender conceptions and working towards elimination of gender-based violence around the world.

## Support for female caregivers

It was already recognized in the 1990s that the care of patients and children affected by HIV/AIDS has fallen mainly on women: wives, sisters, mothers, older daughters who become de facto guardians of their younger siblings, grandmothers who sometimes must look after up to 10-15 children, and the large majority of home-base care programme staff. While there is acknowledgement that their unpaid labour has lessened the burden on health-care professionals, there have been few moves to consider reimbursing them in some way for the home-based care they provide.

It is generally agreed that it is best for orphaned children to remain in their own communities or with extended family members, because orphanages are a much more expensive solution (for governments and NGOs) and because there is some belief that the children are better off in families [73]. However, it has also been recognized that as numbers of orphans skyrocket, caregivers are becoming overwhelmed. This has contributed to neglect and an inability to meet orphans' needs, as well as unfortunate instances of orphan abuse [40]. A few governmental and NGO programmes offer economic aid. In South Africa, caregivers are entitled to foster-care grants

but bureaucratic requirements can delay or prevent access [103]. One study revealed that caregivers who could benefit from Child Custody Grants or Foster Care Grants face significant obstacles in accessing the stipends because they cannot provide children's birth certificates; it is estimated that over 50% of children in the country do not have these [104].

Most interventions to support caregivers have centred on a few approaches:

- Home-based care programmes: offer assistance with tasks such as bathing patients, tending their sores, fetching water and firewood, cooking and cleaning; provide supplies such as foodstuffs, bleach and soap; help arrange transport of patients to clinics when necessary [22, 73-74, 105].
- A few projects have focused on motivating youth (both boys and girls) and men to assist in home-based care [73, 106].
- Some projects have helped widows, child-headed households and orphans increase their ability to meet subsistence needs (through vocational training, income-generating projects) and to stay in school (e.g., subsidizing school supplies and eliminating schools fees) [20, 22, 73, 107].

Such projects should continue but innovative schemes need to be supported as well. For example, in South Africa, home-based care providers have been equipped with special mobile phones programmed with questions that help them monitor patients on ART. They send the answers by text to a database at the University of Cape Town where health professionals can respond to urgent requests and assess whether patients are taking their ART drugs correctly [108].

## Support for women living with HIV/AIDS

### Self-help and support groups

A welcome development over the past decade has been the promotion and development of organizations and programmes to support women living with HIV/AIDS. Internationally, three major driving forces were behind this movement: ICW (which was founded at the 1992 International AIDS Conference in Amsterdam), TASO in Uganda, and UNAIDS through its GIPA Principle (Greater Involvement of People Living with HIV/AIDS). It should be noted, however, that women may still find it difficult to find support groups that are receptive and understanding of their particular concerns, particularly in countries where the absolute numbers of HIV-positive women are low (e.g., Eastern European, Central Asian and Latin American countries).

International NGOs are active in supporting self-help and support groups, which may either be mixed-sex groups or associations exclusively for women. These groups give emotional support, offer women a space where they can discuss issues such as disclosure and sexuality, teach about nutrition, exercise and other supportive health measures, offer supplies of needed commodities such as condoms, help with home-based care, offer ideas for how women can prepare their children for their deaths (memory books), etc.

More recently, associations of HIV-positive women have become more active in advocacy and lobbying for their rights. ICW has published a series of position papers and guidance documents on issues such as the ethics of research on HIV-positive women and policy measures needed to address women's economic and reproductive health needs [52, 109-111]. NGOs are working with HIV-positive women in projects to build their skills in areas such as research, policy formulation, project monitoring and evaluation [49, 112-113].

## Integration of SRH services

Some HIV-positive women's health-care needs have been largely ignored, partly because of political reasons. These neglected issues include failed contraception, unwanted pregnancies and abortion-related care, screening and treatment of reproductive tract cancers, and obstacles to exclusive breast- or replacement feeding. Clinical trials may still place restrictions on women's participation that are not applied to men, even when women are willing to give informed consent regarding possible drawbacks or side effects.

The area in which the greatest integration of SRH services has been seen is prevention of perinatal transmission of HIV. Governments and NGOs are vigorously promoting and supporting the incorporation of VCT into antenatal care so that ART can be offered to stop transmission during late pregnancy, labour and delivery. Since considerable numbers of women still refuse HIV tests or fail to return for test results, some programmes are attempting to alleviate their fears of disclosure by conducting couples counselling and involvement of men in antenatal care and PPT programmes [114-115]. This has produced some successes. For example, at Kumasi South Hospital in Ghana, the introduction of community-based Daddy Forums, in which couples are counselled on reproductive health, contributed to a three-fold rise in women undergoing antenatal VCT [116].

An increasing number of NGOs and other agencies are advocating for and implementing the integration of HIV/AIDS messages into family-planning services and vice versa [117-118]. On a limited scale, integration of, or at least more linkages between, other SRH services is also occurring. For example, Liverpool VCT and Care in Kenya offers preventive medical care, VCT, treatment for opportunistic infections and ART, as well as counselling, PEP and emergency contraception for survivors of rape. In South Africa, Médecins sans Frontières has linked a rape crisis clinic to its HIV/AIDS programme [119].

## Efforts to combat stigma and discrimination

HIV-positive women and men have participated in public-education campaigns about HIV/AIDS for many years now. Studies indicate that their first-hand testimonials and sharing of experiences serve to humanize the epidemic and help combat stigma and discrimination. Public disclosure has also been shown to benefit the HIV-positive educators themselves, through increased self-esteem, relief at no longer having to hide their serostatus, and increased acceptance in their

communities [120]. More attention should be given to incorporating HIV-positive women's input in the design, rather than only the implementation, of campaigns.

Projects that target couples, rather than women and men alone or separately, may play a useful role in combating the tendency toward mutual blame that arises in the context of HIV/AIDS [121]. In Nigeria, Teachers Without Borders organized a meeting on HIV/AIDS for 40 couples of different ethnicities and religions that ended with a declaration of commitment to act in prevention and care [122]. While some of their conclusions could have been more nuanced (e.g., pledging to promote chastity before marriage for their children), some of their recommendations deserve emulation: "We, as couples also, condemn all forms of discrimination against Couples Living With HIV/AIDS, Children Living With HIV/AIDS and call on stakeholders to make available ARD [antiretroviral drugs] for all PLWHA." Adapting the methodology of such projects for replication in other places is a worthwhile idea.

There have also been some well-meaning, but ultimately questionable, projects to support HIV-positive women. Botswana began a beauty pageant for HIV-positive women in an effort to enhance their self-esteem and show the general public that they can still be attractive, strong and healthy [123]. A student group in Uganda wanted to institute a similar pageant but the Uganda AIDS Commission halted the event, stating that acceptance of HIV-positive people can be fostered in other ways [124-125]. Several male participants in an e-forum discussion protested that the beauty pageant was a good idea; as one man said, "We need to 'normalise' HIV and AIDS so that those who live with it, and their friends and colleagues and lovers can live in peace and harmony, just like those living with diabetes, cancer and genital warts" [126].

One might question, however, whether organizing a beauty pageant is truly a step towards normalization. When pageant winners participate in HIV education, for example in secondary schools, their "celebrity status" may indeed make the students sit up and take notice. But are the students taking notice because of the speaker's "Miss" title or because the pageant involved women living with a disease that is taboo, stigmatized and therefore somehow exciting? Would students react the same way if they were addressed by the winners of beauty pageants for Miss Diabetes, Miss Cancer or Miss Genital Warts?

Events like "Miss HIV/AIDS Stigma-Free" also reinforce gender stereotypes in which the focus is primarily on women's physical beauty (and therefore attractiveness as potential marriage partners), rather than on their roles as decision-makers, income earners, household managers and valuable community members. As one female e-forum participant pointed out: "Is there a Miss HIV Activist in Mother to Child Transmission?" [127]. If we want to appeal to young people, inviting speakers who are celebrities for other reasons (e.g., athletes, movie stars, musicians) or HIV-positive activists who are contributing to research, policy-making and programmes might be a better approach than honouring young women simply because they happen to be HIV-positive and attractive.

## Legal strategies as part of a supportive and enabling environment

There is a fourth area in which efforts have been made to support women affected by, and living with, HIV/AIDS: legal literacy projects and the enactment and enforcement of laws designed to create a supportive and enabling environment for prevention and care.

NGOs and associations of people living with HIV/AIDS have been instrumental in some countries in helping women (and men) write wills to provide for their children. Some NGOs have provided assistance in taking cases of discrimination to court [1]. It should be noted here that it may be easier for women to pursue rights violations in areas such as housing and employment rather than health care. This is because they may be able to find another residence or job without too much trouble, whereas a fear remains that they may be jeopardizing their future health care if they make complaints about health-care providers. For example, one HIV-positive woman in Mexico was treated very badly by a gynaecologist during her pregnancy and was willing to submit the case for consideration by the Human Rights Commission in her state. However, when informed that the Commission could not discuss the case with the hospital anonymously, she was unwilling for her identity to become known to the hospital staff for fear of retribution when she needed future care [128]. Such fears have also been noted by women in South Africa [21].

A number of actions have been taken regarding laws and rights. Associations of people living with HIV/AIDS have taken governments to court to enforce compliance with the human right to health by making ART available through the public health system (e.g., in Costa Rica, South Africa and Venezuela). In some cases, groups are using the law to ensure quality of care. The Argentinian chapter of ICW challenged the government in court to prove that they are using good-quality antiretroviral drugs [129].

Some women's groups have lobbied for laws that they hope will offer all women more protection, such as additions to the Penal Code that make marital rape a crime. Such initiatives should be encouraged, but parliamentarians and women's groups should also be helped to seek advice from rights organizations about the formulation of legislation [130]. In Kenya, the Federation of Women Lawyers (FIDA), the Centre for Abused Women and the League of Kenya Women Voters backed proposed legislation that will impose penalties of 15 years to life imprisonment on any person who knows s/he is HIV-positive and who "intentionally, knowingly and wilfully does anything or permits the doing of anything which he or she knows will or is likely to infect another person…whether or not he or she is married to that other person…" [131]. The same bill would impose a prison sentence of 20 years on those who have sexual intercourse with a young person aged 10-16 years and 30 years for rape of children nine years and younger. While one intention of the bill's backers is to protect wives who are infected by their husbands, the opposite could also occur. Given prevailing gender relations, it is conceivable that a woman who learns of her HIV-positive diagnosis during pregnancy will then be accused by her husband of infecting him. One ICW member told of an instance in which an HIV-positive woman who was raped was later accused by the rapist's and her own family of infecting him [109].

# 4. CHALLENGES IN CREATING GENDER-BASED RESPONSES

There are currently three major obstacles that can impede progress in implementing responses to HIV/AIDS that will benefit women and girls. Development assistance workers have been dealing with two of them for generations —societal gender biases and poverty — and will need to continue doing so for generations to come. The impact of the third obstacle — fundamentalism— could be lessened in the shorter term through concerted action by a coalition of agencies worldwide.

## Societal gender biases and poverty

The two longer-term obstacles to empowering girls and women to protect themselves against HIV are interconnected: societal gender biases and poverty. In the majority of societies worldwide, men continue to have more power and privilege than women in all spheres of life — sexuality, education, employment, politics, health care, sports, etc. Even in countries where women and men have achieved gender equity in some areas, women rank second to men in others. In many developing countries, despite different life opportunities for lower-, middle- and upper-class members, most women of all socio-economic classes remain subordinate to men of their own class and above.

This implies that working towards greater economic security for poorer women and eliminating gender biases in society will be essential for achieving equality between the sexes in their ability to prevent HIV infection. It does not mean that nothing can be accomplished in the interim. Steps towards eliminating gender biases can contribute to more decision-making power for women, for example regarding sexuality. As stated before, this will require working with all men who have sexual relations with women, including MSM, who must recognize that their own victimization does not absolve them of taking responsibility for the welfare of all their sexual partners and any children they may father.

Increasing girls' and women's educational opportunities is vital for increasing their ability to protect themselves and cope with the effects of the AIDS epidemic. Education can help them better understand IEC messages and the relevance of prevention to their own lives and those of their children. Higher education can help women obtain (or create) better-paying jobs; more economic independence can empower them to have sex with male partners on their own terms (including condom use). And better incomes can help women access services and goods that will enable them to better care for others and prolong their own lives and those of their children, whether infected with HIV or not.

## Faith-based, "women-unfriendly" fundamentalism

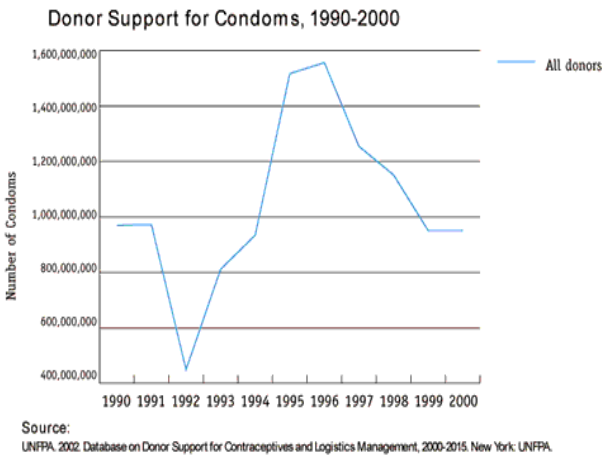
Extremists of various religious persuasions have long promoted a brand of fundamentalism that seeks to "keep women in their place" by restricting their freedom and continuing to promote their subordination to the authority and will of men. The influence of these social conservatives has

varied in different countries. For example, where conservative Roman Catholic and Muslim clerics have been able to wield a great deal of political power, laws and regulations can prevent women from exercising decision-making authority over their own bodies and lives. In such places, legislation prevents women from being able to easily access affordable contraceptives, including emergency contraception (e.g., the Philippines and Poland), makes it impossible for women to vote for legislators who might pass laws that promote women's rights (e.g., Saudi Arabia), makes it almost impossible for women to legally separate from abusive and unfaithful spouses while retaining at least some rights to communal property and custody of children (e.g., Iran) and greatly restricts safe, legal termination of pregnancy (e.g., completely outlawing it, even to protect a woman's life, in countries such as Chile and Costa Rica).

> **"Focusing programmes on persuading girls to abstain from sex until marriage is of little help to many young women. In some places, the main HIV risk factor for a woman is the fact that she is faithful to a husband with previous or current other sex partners…. Choosing to abstain or have safer sex is not an option for the millions of women around the world who endure rape and sexual violence."**
>
> **UNAIDS/WHO [1]**

Fundamentalists of various religions agree on a number of SRH issues:

- They condemn sexual intercourse outside of marriage, which they define as a union between a man and a woman. This means that they favour HIV/STI prevention messages of abstinence until marriage (or forever in the case of people who want sexual contacts with people of the same sex) and faithfulness for married couples. Such measures not only impose a particular worldview on everyone else but are also not feasible or realistic for many youth, people with a non-heterosexual orientation, women who marry a partner who may already be infected, women who are faced with an unfaithful spouse, or women who are sexually assaulted, both within and outside marriage.
- They generally oppose condom promotion and are willing to countenance it only for "high-risk groups", who they basically define as immoral persons who are unable to practice the moral choices of abstinence and fidelity. Such a stance increases stigmatization and marginalization of certain social groups, such as sex workers (most of whom are women) and people living with HIV. In Uganda, where the government withheld distribution of millions of condoms in 2005, Beatrice Were, an ICW member, commented: "There is a new wave of stigma. AIDS is now being treated as a moral issue. There is now stigma attached to the use of condoms. Those of us that are promoting condoms are looked at as immoral people. For those of us who are infected with HIV, this is a painful thing" [132].
- Such attitudes have contributed to reductions in funding for condom purchases and distribution in developing countries. PEPFAR funding requires at least one-third of prevention funds to be spent on abstinence-only education [133] and donor support for condoms has




decreased (Figure 3 [134]). While the Ministry of Health in Uganda said that the above-mentioned refusal to distribute condoms was due to quality concerns, many believe that it was a response to pressure from religious conservatives who favour abstinence-only and fidelity prevention strategies rather than condom use [135-136].

- The fundamentalists not only oppose safe, legal abortion but may also oppose promotion of family planning, although there is some variation among religious conservatives in this area. Some are willing to accept contraceptive use by married women and men, although not for single persons; some oppose emergency contraception because they erroneously identify it as an abortifacient. Yet others oppose all forms of modern contraception because they again erroneously state that these are in some way abortificaient or because they consider these methods interference with a supreme being's will. Such a stance can make it very difficult, if not impossible, for women to use condoms or for HIV-positive women to avoid unwanted pregnancies.

The influence of these fundamentalists has grown with the emergence of a conservative, faith-based government in the United States. The Bush Administration and conservative-dominated Congress have been able to impose their ideology at the international level to some extent. Their coalitions with other conservatives (e.g., the Vatican) have led to restrictions in the terminology used in international policy guidance documents and thereby in the frameworks that might be developed to implement assistance work. For example, UN General Assembly agreements have limited use of the phrases "reproductive health care" and "reproductive health services" because the United States and its allies fear acceptance of the terms would permit easier access to abortion services.

The US government has further tried to impose its ideology through restrictions on development assistance funding that directly affects women and their ability to cope with the HIV/AIDS. The global gag rule prevents US State Department and family-planning funds from going to foreign NGOs that do not agree to refrain from talking about, advocating for, or providing abortion care, even when it is legal and done with their own (rather than US) funds. Though this rule does not apply to HIV/AIDS funding, many NGOs in developing countries work both on HIV/AIDS and other areas of reproductive health. Those that refuse to sign the gag rule have lost money for condom distribution and STI treatment. Others that have signed the rule can no longer offer integrated or comprehensive SRH services and have had to curtail some HIV/AIDS-related programmes [137].

Organizations that even mention the word abortion in their publications are singled out for attacks and suggestions that their work should not be funded. For example, ICW was highlighted in a letter to the US Administration by a conservative senator who erroneously accused them of promoting abortions for HIV-positive women [138]!

In June 2005, the US government expanded its restrictions on NGOs. Not only foreign NGOs but US organizations that provide technical assistance and funding must sign an "anti-prostitution and sex trafficking pledge." The USAID directive states: "No funds…may be used to promote or advocate the legalization or practice of prostitution or sex trafficking…. No funds…may be used to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking" [139]. More than 200 US groups wrote the White House to say that the policy is "undermining promising interventions" to fight AIDS [140].

DKT International, a social-marketing organization, sued USAID for requiring it to sign the pledge, arguing that a requirement to endorse the Bush Administration's "political viewpoint on prostitution" violates its free-speech rights and undermines the battle against AIDS by forcing groups to condemn the very people they seek to help — commercial sex workers at high risk of catching HIV [141]. Specifically, DKT stated: "The U.S. government's "anti-prostitution" policy does a grave disservice to international AIDS-prevention programs and to those who carry them out. The policy does no good, and is clearly doing considerable harm" [142]. Their action was echoed by the Open Society Institute and Alliance for Open Society International in another lawsuit against USAID that states: "We believe the pledge requirement undermines efforts to provide life-saving services and information to sex workers and flies in the face of evidence-based public health practice. Making health workers condemn those people most at risk for HIV will intensify stigma and fears among this vulnerable population, driving them further underground and away from health and social services" [143].

Civil society organizations in the United Kingdom have noted the influence of US funding restrictions on their own work. They, too, are losing funds when they refuse to comply with US government requirements. As one group stated: "In the context of expanding EU international assistance, both bilateral and collective, there may be further necessity for the EU to pick up projects that are too sensitive for US support…" [144].

The United States is the single largest country donor; they have given 43% of development assistance related to family planning, maternal and child health care, and HIV/STIs [145]. Dutch and other EU governmental and NGO donors have an important role to play in counteracting their current detrimental actions [146]. On the one hand, they can speak out more forcefully in international arenas about the harmful effects of conservative policies on women and girls exposed to HIV/AIDS and affected by restrictions on comprehensive SRH services. Such support would be welcomed not only by NGOs and associations of people living with HIV that receive European funding, but also by agencies involved in restrictive programmes. For example, it was recently noted that many people involved in PEPFAR programmes recognize that the ABC approach

to prevention is unrealistic and "reflects different moral standards for boys and girls" [22]. At the very least, Dutch endorsement of resistance to questionable restrictions can give moral support to those opposing the imposition of ideology (e.g., Brazil, which rejected USAID funding because of the anti-prostitution pledge [147]. If such endorsements are accompanied by funding, other groups may be encouraged to resist as well.

> **"…a major partner, the United States government, enthusiastically promotes abstinence until marriage as the main way for young people to avoid H.I.V. infection. Abstinence is one critical prevention strategy, but it cannot be the only one. Focusing on abstinence assumes young people can choose whether to have sex…. In Nigeria, we are painfully aware that girls and women typically cannot negotiate when, where or with whom they have sex; that far too few have access to affordable health services; and that sex education is not available or accessible to many girls. When dealing with AIDS, we must address these realities and use a multipronged approach to improving education and health systems, one that can reach all of our people."**
>
> **Babatunde Osotimehin, Chair,**
> **National Action Committee on AIDS, Nigeria [148]**

In the spirit of pragmatic compromise that characterizes much policy-making in The Netherlands, Dutch agencies can also support more nuanced approaches to HIV prevention that acknowledge the complex social circumstances in which women and girls, and men and boys, find themselves. Given the apparent fondness for acronyms in the field of HIV/AIDS, a number of examples can be considered. CAFOD advocates giving abstinence, being faithful and condom use equal consideration, while also embracing a second ABC strategy [149]:

- **A**dvocacy for changes in laws, attitudes and practices that promote power imbalances
- **B**reaking down the silence that sustains denial, stigmatization, isolation or discrimination
- **C**hallenging discrimination and injustices that occur in the legal, cultural and attitudinal spheres.

IPPF and partners suggest a different ABC strategy [150]: **A**cceptance of young people's sexuality; **B**eing realistic and a real partner for young people; **C**hoices to offer and support young people to make well-informed decisions.

A DEF approach has also been advanced [151]: **D**isclosure in safety; **E**ducation for economic independence; **F**emale-controlled prevention methods (female condoms and microbicides).

And Youth Incentive suggests promotion of a three R approach: Rights, Respect and Responsibility [152].

# 5. RECOMMENDATIONS AND POSSIBILITIES FOR ACTION

The foregoing description of how women and girls are affected by the HIV/AIDS epidemic can lead to numerous recommendations for action. The brief review of some key responses indicates that donors, developing country governments and civil society organizations are collaborating in at least some areas to implement programmes and interventions to address women's needs and concerns. To increase the efficiency, thoroughness and effectiveness of Dutch responses, it would be wise to continue a policy of selecting a limited number of key areas for support.

Below are some suggestions for the Dutch government, NGOs and communities in The Netherlands regarding the guiding principles that should underlie their work, as well as the types of interventions that they could support to enhance a gender-based approach to reducing women's vulnerabilities regarding HIV/AIDS-related prevention, treatment and care. It would be useful to organize a consultation with key developing country partners to determine their opinions and insights regarding the recommendations below. This could perhaps lead to the formulation of concrete action plans.

## Guiding principles

- Stipulate that developing country partner organizations publicly commit to honouring the international guidelines on HIV/AIDS and human rights issued by UNAIDS and the UN Office of the High Commissioner on Human Rights [153] and the *Barcelona Bill of Rights* [112].
- Consider all proposed interventions from a gender perspective, delineating both possible positive and negative repercussions for women and girls. Speak out against interventions whose negative aspects ultimately outweigh possible benefits (e.g., Miss HIV/AIDS Stigma-Free beauty pageants, virginity testing, the Rapex® device).
- Allow partner organizations in developing countries to take the lead in defining which strategies and approaches would work best. However, do not hesitate to point out where their suggested approaches could be less than beneficial. For example, counter arguments that certain interventions would be "against our culture or tradition" or would "sustain our cultural heritage" (e.g., virginity testing) by reminding partners that no culture is static and all cultures have changed throughout history in response to internal and external influences. Do not hesitate to criticize statements that are gender-biased or "woman-unfriendly".
- Provide not only project- or intervention-specific funding but also multiyear grants for organizations' core operational needs. When developing country partners must scramble about from year to year submitting numerous proposals to cover their overhead costs, they lose valuable time and resources that could be devoted to their work for beneficiaries. Such an approach would be in line with Hivos' recognition of the need to provide support "in the areas of organisational and institutional development, e.g. management, leadership, finance and planning" as well as coordination and networking among organizations [154].
- Agree to share evaluation exercises with other donors so that developing country partners are not overburdened with multiple, repetitive evaluations.

## Create and sustain an enabling environment

### Link programmes, projects and interventions that focus on gender, economic development and HIV/AIDS

Both the Dutch government and donor NGOs can ensure that all the projects they support address the interconnectedness of gender biases, economic issues and HIV/AIDS. For example, feminist organizations around the world have been notoriously slow to incorporate attention to HIV/AIDS into their research and advocacy agendas. Dutch funders can encourage them to do so and facilitate networking with organizations working on HIV/AIDS. Suggestions can be made to partners that implement and support micro-credit and savings schemes for women that they add education about HIV/STI prevention and care into skills-building sessions. AIDS projects benefiting women in particular can be helped to establish links with economic development and resource programmes (e.g., Heifer International). By promoting and facilitating such links, steps will be taken to give women more economic independence so that they are in a better position to undertake prevention measures and access treatment and care for themselves and their families.

### Provide a counter-balance to conservative forces at the international and national levels

One obvious way to counter the deleterious effects on HIV/AIDS programmes posed by conservative ideologies and restrictions is to fill the resource gap suffered by developing country partners who lost money when the United States withdrew or withheld some of their funding. When NGOs know that their programmes will not have to be curtailed because they refuse to sign anti-prostitution, anti-harm reduction or anti-abortion pledges, they can better plan and implement programmes that respect rights and provide more comprehensive approaches to meeting women's needs.

Dutch donor NGOs can also consider providing financial support to enable developing country partners to speak out on the sensitive issues. This can include enabling them to gather relevant information so that they can write op-ed pieces for the media and participate in TV and radio broadcasts, lobby their governments on proposed legislation relevant to women living with HIV/AIDS, carry out media campaigns to ensure that governments do not block measures that can protect women (e.g., the campaign in Uganda to restart distribution of subsidized condoms), and prepare shadow reports for Treaty Monitoring Committees that evaluate governmental compliance with various international human rights treaties.

Such support can help fund the travel of partner representatives to UN General Assembly sessions that consider HIV/AIDS (e.g., the upcoming UNGASS on HIV/AIDS in September 2006) and to international conferences where the topics of women and HIV/AIDS may need more attention (e.g., the AWID Conference, People's Health Assembly, International AIDS Conferences). And it can involve funding civil society organizations — especially associations of women living with

HIV/AIDS and human rights groups — to have sufficient computer equipment and high-speed Internet connections (with all attendant maintenance and subscription costs) so that they can participate in e-mail list serves, electronic forum discussions and phone conferences (using low-cost computer telephone possibilities) where international and national advocacy and other actions for the benefit of women affected by HIV/AIDS are designed, promoted and implemented.

## Provide support to interventions for heterosexual men and MSM that focus on respecting women's rights, protecting female partners and (future) children from HIV/STI prevention

While IEC efforts targeting men, such as condom promotion and distribution at bars and truck stops, are important, they do not produce lasting change in male-female relationships. A gender-based perspective requires SRH programmes that both meet men's needs and offer an avenue to change biased gender concepts so that men become more gender-equitable and respectful of their partners' and children's rights and well-being.

This focus could generate resistance from some feminists, who fear that this will result in fewer resources for women's programmes, and from men who are reluctant to give up their privileges. To achieve fairer societies, however, we must challenge gender stereotypes of men being unwilling to share power and decision-making. We need to embrace models that pay attention to women's and men's needs separately, as well as in conjunction with one another.

As the Young Women and Leadership Programme of the Association for Women in Development (AWID) has pointed out: "Men are part of the equation that will ultimately lead to gender equality. Involving men is therefore a pragmatic measure within efforts to achieve women's rights and is also a tactical measure towards the goal of human rights for all. By working only with women, we may be trying to improve the lives of women while actually having little effect on the overall institutional, societal and structural transformations needed to achieve true gender equality" [155]. And as the Executive Director of Zimbabwe's Padare/Enkudleni/Men's Forum on Gender has written: "Most men experience strong unwillingness to disturb some aspect of traditional gender notions in conscious dialogue with others…. The challenge in our gender discourse…is to find what kinds of activities and discussions encourage flexibility and openminded reflection, in contrast to approaches that confirm inflexibility and rigidity in men's thinking. Gender discussion processes that encourage movement in critical thinking are the ones that can best inform personal agency and new consensus for social changes that this era of HIV/AIDS so urgently needs" [156].

Dutch agencies can help disseminate lessons learned from such programmes to partners in developing countries and provide technical assistance and funding so that successful interventions can be adapted and replicated. One way to help disseminate information is to enable representatives of men's programmes to visit key NGOs in other countries to share their experiences. Alternatively, gender-sensitive men from a variety of organizations in one country

can be funded to participate in a study tour where they visit organizations of men against violence or a series of clinics for men to see first-hand how they function.

## Directly address HIV/AIDS prevention, care and support

### Pay special attention to programmes and projects that promote human and legal rights in connection with HIV/AIDS

There are a variety of interventions and organizations that deserve new or increased support:

- Legal literacy programmes for women living with HIV/AIDS and orphans should not only focus on property and inheritance rights, formulation of wills and ensuring that children have birth certificates, but also teach them how to lodge complaints on human rights violations to Commissions on Human Rights, the health sector, the courts, etc.
- NGOs that work on advocacy, literacy/education and complaints/lawsuits in the human rights and legal arenas should be brought together with associations of women living with HIV/AIDS for a technical consultation to exchange experiences and ideas for action, promote networking and foster the emergence of innovative actions (see Appendix 1).
- The Athena Network: Advancing Gender Equity and Human Rights in the Global Response to HIV/AIDS is a new initiative uniting individuals and organizations that endorse the *Barcelona Bill of Rights* as a basis for action [157]. Athena members are willing to address sensitive and taboo topics such as reproductive choice, harm-reduction strategies, and comprehensive sexuality education instead of abstinence-only sex education. In 2005-2006, Athena will focus on helping integrate women's issues into the 2006 International AIDS conference and on offering sessions that deal with human rights, women and HIV/AIDS.[4]
- Work can be done to integrate HIV/AIDS issues into the Right to Decide Initiative supported by the Dutch government. The Right to Decide Initiative is promoting NGO involvement in advocacy related to sexual and reproductive health and choice but has not yet included HIV/AIDS as a theme [158].
- Foster collaboration between civil society organizations that are working on different types of gender-related rights. Feminist and HIV/AIDS groups have especially worked to promote women's reproductive choice, while LGBTI groups have mainly focused on decriminalization of homosexuality or sodomy, freedom from the right to discrimination, marriage, and the right to adopt children. There are interconnections between these rights [159] that can be highlighted in relation to HIV/AIDS. Dutch organizations can help increase recognition of these linkages and foster connections between the organizations that work on them. The *Causes in Common* manifesto published in the USA contains a statement of principles regarding gay rights, comprehensive sexuality education and reproductive choice that can serve as a model mission statement for such work [160]. Once such linkages are established, a supportive environment

[4] Please note that the author of this report is one of the founding members of the Athena Network.

for addressing MSM's responsibilities towards their female partners and (future) children regarding HIV/STI prevention can also be developed.

## Promote linkages between HIV/AIDS and other aspects of SRH in advocacy and programmes

Both the Dutch government and donor NGOs fund and support numerous health projects and health institutions in developing countries (e.g., mission hospitals, district hospitals, HIV/AIDS projects, family planning associations). Donors in other countries are already focusing on PPT programmes, so Dutch funding could centre on some relatively neglected areas. These would include interventions to:

- Develop and disseminate information and counselling to HIV-positive women on contraceptive methods and parenting in the context of HIV/AIDS. This could include not only information on the advantages and potential drawbacks of various contraceptive methods but also projects that address concepts of motherhood, fatherhood, assisted conception (e.g., in vitro fertilization with donor sperm, sperm washing), foster care and adoptive parenting. If associations of people living with HIV/AIDS express an interest in legal adoption, lobbying to ensure that laws and regulations permit adoption by HIV-positive people could be supported.
- Promote the availability of screening and diagnostic tests and treatment tools for reproductive tract infections, including cervical cancer which is a marker illness for AIDS in HIV-positive women.
- Promote the availability of PEP and emergency contraception to survivors of rape. This can include lobbying lawmakers to make emergency contraception available in hospital emergency rooms and as an over-the-counter drug and mass-media campaigns to inform the general public about these services.
- Create linkages between HIV/AIDS programmes and abortion-related care: most HIV/AIDS programmes have focused on promoting respect for HIV-positive women's right to bear children and on combating coerced abortions and sterilization — while such interventions must continue, women living with HIV/AIDS should also be enabled to access safe, legal abortions if they have been unable to prevent unwanted pregnancies.

## Support programmes and interventions to enhance HIV-positive women's capacity and skills to participate in research, advocacy and policy-making

A recent study in Argentina, Kenya, Lesotho, Mexico, Poland, South Africa and Swaziland indicated that, while NGO staff and health-care providers value insights from women living with HIV/AIDS, they — and the women themselves — believe that HIV-positive women often do not participate in research and policy-making in a meaningful way [49]. HIV-positive women among the study respondents emphasized that their place at the decision-making table should not be tokenistic. They need capacity-building to become partners in research and training in advocacy-related skills and support to carry out their roles as representatives of people living with HIV/AIDS in various policy-making bodies.

> **"...I was a member of the CCM of the Global Fund project. I was with them for two years and I realized that...one needs to be well prepared regarding why one is participating there, because the system absorbs you and you end up supporting and endorsing things that are not fundamental objectives for HIV-positive people nor things that we want. And you have to pay for this with your body [health], by receiving criticisms, with ignorance. We left the CCM...we think that our best strategy was to train ourselves as leaders of the network so that we could take such positions later in a better prepared way."**
>
> **HIV-positive woman, Argentina [ 161]**

Dutch government and NGO programmes can facilitate the provision of such technical assistance, as well as fund ongoing advocacy activities carried out by HIV-positive women and their allies (e.g., policy-relevant research, preparation and dissemination of position papers and press releases, logistical costs involved in gathering input from their "constituents" and feeding back information from policy-making exercises). Again, such an approach would fit well with Hivos' aim to provide "support for capacity-building and organisational development of women's organisations aiming at strengthening their organisational performance and institutional impact" [154].

## Support programmes and interventions that increase financial resources for women living with HIV/AIDS

In many countries, HIV-positive women are playing an important role in prevention and care by acting as unpaid, volunteer educators, counsellors and caregivers. Dutch agencies can insist that partner organizations employ these women as paid (part- or full-time) staff rather than continue to exploit their services given for free [115].

Dutch NGOs and communities can also explore possibilities of giving ongoing support to associations of women living with HIV/AIDS, for example, by establishing permanent partnerships similar to the scheme where Dutch municipalities adopt "sister cities" in developing countries. Such a programme would not have to be restricted to municipal development groups; secondary schools and university groups could also be encouraged to "adopt" an association.

Representatives of the Dutch groups could discuss with representatives of the HIV-positive women what they want and need, but the support given could include goods and services such as monthly financial contributions, school supplies, bicycles, a scholarship fund for the women's children, and/or the guaranteed purchase of a certain amount of handicrafts that the Dutch community members can give as gifts for Sinterklaas or celebrations related to Ramadan and Hannukah. Such partnerships would benefit both the HIV-positive women and the Dutch citizens who feel they are actually doing something concrete.

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# Appendix: Possible participants in a technical consultation on gender, women and human rights

## Human rights and legal NGOs

- Canadian HIV/AIDS Legal Network
- Lawyers Collective, HIV/AIDS Unit, India
- Human Rights Law Network, India
- Federation of Women Lawyers (FIDA), Kenya/Uganda
- Women in Law in Southern Africa, Mozambique chapter
- AIDS Law Unit, Namibia
- Legal Assistance Centre, Namibia
- AIDS Law Project, University of Witwatersrand, South Africa
- Centre for AIDS Rights, Thailand
- Center for Reproductive Rights, USA
- Human Rights Watch, USA
- Amnesty International, United Kingdom
- Justice for Widows and Orphans Project, Zambia
- Proyecto Acción SIDA de Centroamérica
- PAHO-Western Hemisphere Region

## Associations of women living with HIV/AIDS

- International Community of Women Living with HIV/AIDS: regional representatives

## Other relevant parties

- Athena Network, international representatives
- World Health Organization
- Paul Hunt, UN Special Rapporteur on Health
- Yakin Erturk, UN Special Rapporteur on Violence against women
- Silvia Pimentel, member of the CEDAW Treaty Monitoring Committee
- Evelien Herfkens, UN Special Representative on MDGs

# ABBREVIATIONS

| | |
|---|---|
| ART | Antiretroviral therapy |
| ARV | Antiretroviral |
| AWID | Association for Women in Development |
| EU | European Union |
| FIDA | Federation of Women Lawyers |
| GIPA | Greater Involvement of People Living with HIV/AIDS |
| ICW | International Community of Women Living with HIV/AIDS |
| IEC | Information, education and communication |
| IUD | Intrauterine device |
| LGBTI | Lesbian, gay, bisexual, transsexual and intersex persons |
| MDG | Millennium Development Goal |
| MSM | Men who have sex with men |
| NGO | Non-governmental organization |
| PEP | Post-exposure prophylaxis |
| PEPFAR | US President's Emergency Plan for AIDS Relief |
| PLWHA | People Living with HIV/AIDS |
| PMTCT/PMCT | Prevention of mother-to-child transmission |
| PPT | Prevention of perinatal transmission |
| SAN | Stop AIDS Now! Initiative in The Netherlands |
| SRH | Sexual and reproductive health |
| STI | Sexually transmitted infection |
| SWAA | Society for Women and AIDS in Africa |
| TASO | The AIDS Support Organisation |
| UK | United Kingdom |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNGASS | United Nations General Assembly Special Session |
| UNICEF | United Nations Children's Fund |
| US | United States |
| USAID | United States Agency for International Development |
| VCT | Voluntary HIV counselling and testing |
| WHO | World Health Organization |
| YFS | Youth-friendly services |