

**GENDER AND HIV/AIDS:
LEADERSHIP ROLES IN SOCIAL MOBILIZATION**

**REPORT OF THE
UNFPA-ORGANIZED BREAKOUT PANEL
AFRICAN DEVELOPMENT FORUM**

**Addis Ababa, Ethiopia
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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
FAO	Food and Agriculture Organization of the United Nations
HIV	Human immunodeficiency virus
NGO	Non-governmental organization
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

INTRODUCTION

The United Nations Economic Commission for Africa, in partnership with the Joint United Nations Programme on HIV/AIDS (UNAIDS)¹ and other co-sponsors, organized the African Development Forum, which took place at the United Nations Conference Centre in Addis Ababa, Ethiopia, from 3 to 7 December 2000. The Forum's purpose was to address and heighten awareness of crucial aspects in the fight against HIV/AIDS, such as political will and leadership, adequate resources and multisectoral approaches.

In addition to the main plenary activities of the Forum, parallel breakout sessions were organized. The primary objectives of the breakout sessions were to:

- Examine the issues raised in the plenary sessions; and
- Facilitate the identification of concrete recommendations to address the fight against HIV/AIDS.

The United Nations Population Fund (UNFPA) was responsible for the breakout session on gender and HIV/AIDS, entitled "Gender and HIV/AIDS: Leadership Roles in Social Mobilization." Held on 5 December 2000, this session took the form of a panel group discussion chaired by Ms. Virginia Ofori-Amaah, Director, UNFPA Africa Division, New York. Panellists included Mr. Martin Foreman, Director, The Panos AIDS Programme, London; Ms. Ngozi Iwere, Nigeria; Ms. Jane Wambui Kiragu, Executive Director of the Federation of Women Lawyers, Kenya; Ms. Wariara Mbugua, Chief, UNFPA Gender Issues Branch, Technical Support Division, New York; and Ms. Marcela Villarreal, Chief, FAO Population Programme Service, Rome. The rapporteurs were Ms. Miriam Jato, Ms. Mere N. Kisekka and Mr. Opiya M. Kumah, Advisers, UNFPA Country Technical Services Team in Ethiopia. The session was well attended, and many in the audience actively participated in the discussions by sharing their experiences and providing suggestions to deal with the issues.

What follows is a summary of key points and recommendations that arose from the panel discussions on "Gender and HIV/AIDS: Leadership Roles in Social Mobilization", together with the presentations made by the panellists, which form the major part of this report. Also included is an outline of issues related to youth perspectives on gender and HIV/AIDS presented by a young participant from Liberia. Each of the presentations includes conclusions and recommendations.

¹ UNAIDS brings together seven United Nations system organizations to address HIV/AIDS-related issues: the United Nations Children's Fund (UNICEF); the United Nations Development Programme (UNDP); the United Nations Population Fund (UNFPA); the United Nations Drug Control Programme (UNDCP); the United Nations Educational, Scientific and Cultural Organization (UNESCO); the World Health Organization (WHO); and the World Bank.

SUMMARY OF KEY POINTS AND RECOMMENDATIONS ARISING FROM THE DISCUSSIONS

Key Points

- HIV/AIDS affects men and women differently, arising from differential infection rates and learned cultural values and norms, including early marriage, stereotypes, gender roles and power relations that impose a disproportionate burden of care and nurturing on women;
- Existing policies and programmes are inadequate for addressing gender inequalities in the area of HIV/AIDS;
- Traditional notions of masculinity lead men to engage in risky sexual behaviours, e.g., multiple sexual partners, and to assume positions of power vis-à-vis women, including negotiating for sex. This promotes the spread of the epidemic;
- Exploitative intergenerational sexual relationships, which are largely fuelled by poverty and economic powerlessness, are highly implicated in HIV transmission. Such relationships may be construed as one of the many forms of corruption that African societies must combat;
- Gender violence, which is prevalent -- and condoned -- in many African societies, is highly correlated with HIV transmission. Gender violence is exacerbated during civil strife and conflicts;
- In Africa, leaders in most spheres of life are men. Such positions of leadership confer power which facilitates men's access to sex and which is often abused;
- Existing legal frameworks are inadequate to deal with the reproductive rights and gender aspects of HIV/AIDS. Even where such laws exist, they are seldom enforced; and
- HIV affects men and women differently in the rural and agricultural sectors. When women are affected by HIV/AIDS, the impact on rural households is greater.

Recommendations

- Include a gender perspective in all policies and programmes;
- Sensitize leaders about the gender concept and the role that they can play in positively transforming gender relations within their communities;
- Promote new images of masculinity that emphasize male involvement, respect for women's reproductive rights, nurturing and negotiated conflict resolution;
- Promote research on masculinity and male sexuality in the African context;

- Promote the empowerment of women at household, community and national levels to enable them to assert their sexual and reproductive rights;
- Undertake coordinated action to eliminate gender-based violence;
- Promote equal educational opportunities for both boys and girls;
- Enable parents and other traditional socializing agents within the family and community (e.g., grandparents, aunts), through education and sensitization, to offer sexuality information and education to young persons;
- Ensure that family life education, in both school and out-of-school settings, covers sexuality and gender; and
- Review national legal frameworks to render them responsive to gender aspects of HIV/AIDS.

GENDER AND HIV/AIDS: SOCIAL MOBILIZATION AND THE ROLE OF LEADERS

**Wariara Mbugua
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The rapid spread of HIV/AIDS has created challenges for everyone who is involved in the fight against it. Many of the strategies to prevent the spread of the pandemic have focused on promoting condom use, reducing the numbers of sexual partners and treating sexually transmitted diseases (STDs). However, by failing to address the social, economic and power relations between men and women, such strategies have not been effective in tackling women's and men's risk of infection, their ability to protect themselves effectively and their respective share of the burdens of the epidemic. Some of the potentially most promising strategies are those that explicitly address the gender dimensions of HIV/AIDS, especially given the fact that in Africa HIV/AIDS spreads mostly through heterosexual contact. Taking into account the gender dimensions of HIV/AIDS is, therefore, a critical element of any social mobilization effort to address the pandemic.

HIV/AIDS has vastly different implications for men and women. Not only is the probability of transmission between men and women different, but so are the opportunities for diagnosis and the consequences for those who are seropositive. These differences can be attributed largely to the socially constructed gender roles that are assigned to men and women in every society. In Africa, the prevailing gender roles at the household, community and even at the national level have relegated women and girls to a subordinate status, which limits their abilities to protect themselves from infection by the HIV/AIDS virus. It is, therefore, not surprising that HIV/AIDS is fastest rising among women. The infection rates for young women in the age group 15 to 19 are sometimes five times higher than for boys in the same age group. Addressing the HIV/AIDS pandemic therefore requires social mobilization to remove the structural underpinnings of gender inequalities.

Few policies and programmes in response to HIV/AIDS are informed by the real-life situations of men and women: how they live and work in urban and in rural areas, and the complex network of relationships and structures that shape their lives. Yet, these experiences are all well known and well documented. Both men and women live in accordance with widely shared notions of what it is to be a man, or to be a woman. These ideas about typically feminine or masculine characteristics, abilities and expectations determine how men and women behave in various situations. Such ideas and expectations are learned from families, friends, schools, the workplace, religious and cultural institutions, the media and opinion leaders. Since these are learned responses, it is evident that leaders can and should play an aggressive role in changing those norms about femininity and masculinity that support the spread of HIV/AIDS.

Among the learned behaviours that make the response to the HIV/AIDS pandemic in Africa difficult are those related to power in relationships between men and women, and those

related to sexuality, as well as those related to the division of labour. These need to be addressed openly and transparently by leaders to halt the spread of HIV/AIDS.

With regard to power, there is a perception in many cultures that a woman's sexuality is owned not by the woman herself but by other male members of the family. Bride wealth is often the symbolic manifestation of this perception. In too many instances, women do not exercise the choice, but are instead told, when to become sexually active, through various rites of passage, often at too early an age. They are told when and whom to marry; how to have sexual relations, which may involve using dangerous herbs; when to have children and whether or not they can use contraception; and even what to do about household expenditures. This type of male power is supported by tradition and social norms. So, women learn that their first loyalty is to kin and families, causing them to act in ways that reinforce rather than challenge their own subordination. Such control and power over women's sexuality and reproductive behaviour also leads to women's abdication of responsibility over their own sexual and reproductive health because of the powerlessness that they experience. This has dire consequences with respect to HIV/AIDS.

Prevailing ideas about sexuality contribute significantly to the spread of HIV/AIDS. Men are often made to believe that male sexual needs are strong and that because of this they can easily succumb to the seduction of women. Such notions make men appear to be governed by their instincts, unable to control their sexual behaviour, and the victims of female power. As a result, men are often excused for not behaving responsibly -- for example, not using condoms -- and women themselves are reluctant to buy or carry condoms because of their fear of being accused of wanting to entice or seduce men. At worst, such perceptions also condone aggressive sexual behaviour whereby men believe that coercing women into sexual intercourse, including rape, is part of normal masculine behaviour. In fact, social rules usually deprive women of the freedom to move about freely and lead to situations in which women, not their attackers, are blamed for sexual abuse. Women are also very reluctant to report sexual abuse because it may affect their position in society. The *June 2000 UNAIDS* report notes that the incidence of HIV/AIDS transmission in the context of coerced sexual intercourse is exceptionally high.

In many societies in Africa, women's primary role is still seen as that of bearing and nurturing children. Men's role, on the other hand, is perceived to be that of earning a living and dealing with the broader issues of society on behalf of the family. Responsible fatherhood, wherein the man takes an active role in looking after and nurturing his children, is not widespread. This division of labour is extended to other aspects of men's and women's lives. The expectation that women must care for children is extended to all household members needing support, that is, the elderly and those with long-term illnesses, including those living with HIV/AIDS, as well as orphans. Women's nurturing role also involves unpaid labour on family land. One of the major consequences of the prevailing division of labour is women's economic dependence on men as economies in Africa have evolved. This is at the heart of women's low social and economic status that is associated with their lack of opportunities, including those related to access to education and literacy. This contributes significantly to women's ignorance in obtaining information that can help to protect them against HIV/AIDS. Such economic vulnerability also fuels women's recourse to selling sex. In most cases, if selling sex enables them to survive today, long-term concerns remain out of focus.

The examples given above demonstrate some of the reasons why a gender-based response to the HIV/AIDS pandemic is essential. Such a response focuses on how different social expectations, roles, status and economic power of men and women affect, and are affected by, the pandemic. The dominance of male sexual needs and the denial of female needs impede open discussions between the sexes and limit people's chances of achieving a mutually trusting and satisfying relationship. Men's violence against women has now emerged as a major risk factor for HIV/AIDS and it is sustained by notions of, and about, men and women's behaviour that are learned through socialization. Women's economic precariousness, which feeds the sex industry, has its foundations in the gender division of labour and the opportunities, rewards and benefits that accrue.

Collective action is required to ensure wider development and implementation of gender-sensitive strategies. This is where the role of leaders is critical because they can mobilize people for the type of social change that challenges the deeply embedded cultural beliefs and practices about men and women that promote the spread of HIV/AIDS. To this end, leaders need first of all to create an environment in which dialogue about gender equality and the protection of women and girls can take place in a constructive manner. Such a dialogue would help to create a better understanding of how men and women define personal risk in different types of relationships which, in turn, could be used in the development of policies and programmes to decrease vulnerability to infection, reduce stigmatization and curb the socio-economic impact of the disease.

Leaders need to ensure that short- and long-term gender-sensitive strategies are developed, from the community level all the way to the national level. Short-term strategies may focus on people's immediate needs, especially those pertaining to obtaining information about HIV/AIDS, for both literate and illiterate populations, support to home-based care, and access to treatment of STDs and counselling services. Long-term strategies must address the underlying cultural and social structures that sustain gender inequality. They should promote mutual respect between men and women and equal access to opportunities and resources, and should empower individual men and women to exercise responsible choices about their own sexual behaviour.

MASCULINITY AND THE HIV/AIDS PANDEMIC (INCLUDING GENDER-BASED VIOLENCE)

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Men Drive the Epidemic

Men's behaviour and attitudes drive the HIV/AIDS epidemic.

- Men have more sexual partners than women, which means more opportunity to transmit the virus to others; and
- Men tend to decide the circumstances and form of sexual intercourse. Most women cannot insist that their partner wear a condom during intercourse and women cannot prevent their partners from having sex with other partners.

The Dynamics of HIV Transmission

Number of sexual partners

Men have more sexual partners than women (Figure One).

Figure One: Percentage of Adults Reporting More than One Sexual Partner in the Preceding Twelve Months

	Men	Women
Ethiopia	7%	2%
Togo	18%	1%
Lusaka	33%	9%
Guinea-Bissau	38%	19%
Lesotho	42%	29%

Statistics from M. Caraël and others, "Sexual behaviour in developing countries: implications for HIV control", *AIDS*, vol. 9 (1995): 1171-1175.

Two conclusions that can be drawn from Figure One and other studies of sexual behaviour are:

- Women tend to practise serial monogamy (they are faithful to one partner after another);
- Men also practise serial monogamy, but at some time in their lives most men also have casual sex.

Patterns of transmission

Figure Two represents a theoretical community at one period of time. Although one in four men but only one in ten women have more than one sexual partner, more women (150) than men (125) are at risk of contracting HIV or another STD, and two out of every three women who contracts HIV does so from their regular partner.

Figure Two: Risk of Transmission in a Theoretical Community			
Women	Intercourse	Men	Risk of transmission
300 partnered & faithful	↔	300 partnered & faithful	NO

100 faithful	↔	100 partnered & unfaithful	YES
50 unpartnered & casual sex	↗ ↘ ↔	25 unpartnered & casual sex	YES

50 unpartnered & abstinent	(none)	75 unpartnered & abstinent	NO

Figures One and Two demonstrate that men’s and women’s risk of contracting HIV is different.

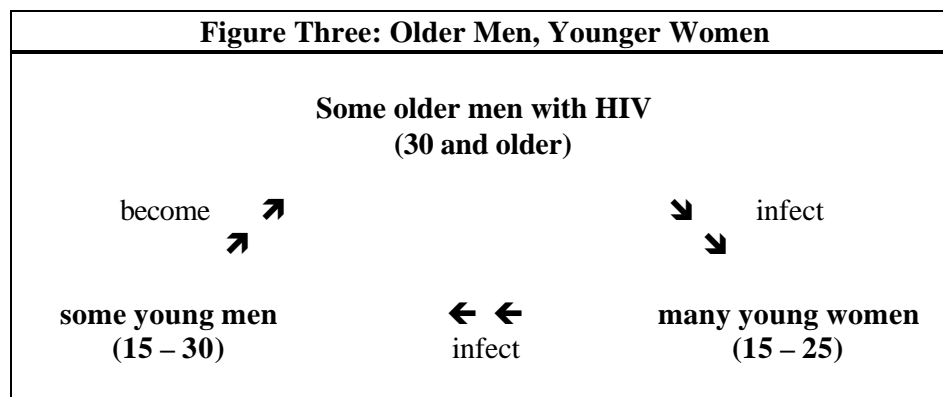
- Men’s risk generally comes from the numbers of partners they have;
- Women’s risk comes from their partners’ sexual behaviour.

In general,

- Most women with HIV transmit the virus only to their newborn children or to a regular partner following the partner they contracted it from;
- Men with HIV risk transmitting the virus to their regular partner and to other women. (Some men have sex with men and also risk contracting and transmitting the virus that way.)

Older men, younger women

In most parts of Africa, many more young women (15 – 25) are HIV-positive than are men of the same age. This is because one common pattern of transmission is that of an older man with HIV transmitting the virus to a younger woman. She is likely to pass the virus to her next partner, the man she marries or has a long-term relationship with. If her new partner has casual affairs, he then transmits the virus to other women.



Condoms and counselling

Condom use is increasing, but mostly in casual affairs. But much HIV transmission occurs within long-term or “serious” relationships. For example, the young women who have affairs with older men do not want to use condoms because they do not want to be considered casual relationships. The older men do not want to use condoms because they do not think their young partners are HIV positive, and they do not consider that they themselves might have the virus and should protect the young women. When two young people fall in love, they often do not want to talk about their sexual past.

- Unless both partners can prove they are negative with an HIV antibody test, condoms must be used in all sexual relationships;
- We have to change the image of condoms so that they symbolize trust and respect.

Condoms are not needed in relationships where both partners are proven to be negative and each can be sure that the other is faithful. Widespread free testing facilities are required to allow any member of the public to learn if he or she is HIV positive. This must include counselling before and after the test, so that the client has a full understanding of the implications of the result. Ideally, both partners in a relationship should be counselled and tested at the same time.

The role of poverty

In poor communities, sex is a valuable currency, and for many women it is the only currency they have. Fifteen-year-old girls in rich countries are not usually attracted to men in their thirties and forties, because there is little that these older men can offer them. In Africa, fifteen-year-old girls are seduced by the promise of luxuries they cannot afford -- clothes, cosmetics and even school fees.

As women grow older and find other means of earning a living, sex becomes more an expression of love and affection than of financial need. But as long as communities remain impoverished and as long as women are dependent on men, men will offer money or presents to get the sex they want and women will offer sex to get the resources they need.

Men, Women and Violence

Men and sex

Men's sexual behaviour is deeply rooted in the cultures they grow up in. Boys grow up believing that it is "natural" for men to have frequent sex and that having many sexual partners is a sign of virility. Girls grow up believing it is their "duty" to satisfy men. Both men and women perpetuate these attitudes -- men by the examples they give and women by accepting them.

Traditional polygamy gave men authority over their wives, but when it was respected, it limited the likelihood of transmission of disease. Today in many communities traditional polygamy has often given away to an informal version, where men's right to have more than one wife is often interpreted as a right to as many women as they wish.

Men and women

Women are still seen as second-class citizens by many men, and in a few countries they still do not have full legal rights. Women are often seen as property to be bought in marriage and thrown out of the house when no longer needed.

Violence towards women

Many men are violent towards women. They beat them or rape them and sometimes kill them. A half or more of all women say that they have suffered violence at the hands of their husbands or a sexual partner. Rape of strangers occurs, but most rape is either within a long-term sexual relationship (marital rape) or of a woman a man has recently met, when he believes she “owes” him sex because he has bought her a drink or a present or spent time with her.

Men and insecurity

Men who are violent towards women behave this way because they believe that control of women’s lives is an essential element of masculinity. They become angry or frustrated when they appear to be losing control. Abuse of alcohol and other drugs can increase that anger and frustration, often leading to rape and violence towards women and other men.

Although men have many advantages, their lives are not always better than women’s. On average, women live longer than men. Men are more likely to go to prison and die violently. Masculinity can be a burden to many men as they find it difficult to live up to the expectations of others.

Men’s desire to control their partners can conflict with deeper needs to have a more equal relationship with them. To break free of the demands imposed by masculinity, men need to express their doubts and uncertainties and to discover ways of leading happier, healthier lives.

Definitions of masculinity need to change. More emphasis should be placed on the positive aspects, such as responsibility and care for one’s family and partners, and less emphasis on the negative aspects, such as sexual prowess and risk-taking.

The Role of Leaders

Most political and religious leaders are men. Men in positions of power have many advantages, including increased access to sex. Men who are community and national leaders may be reluctant to promote policies that will enhance the status of women, because such policies appear to threaten the status of men.

Yet men also benefit from equal status with women. Most men who treat women as equals find that their lives are more rewarding and less stressed: at a personal level, instead of a servant, they have a partner for a wife, and at community level they benefit from the insights and strengths that women bring.

HIV/AIDS prevention depends on equal gender status, but equal gender status will result in much greater benefits.

Political leaders must have the courage to place the needs of their communities above their personal desires. Steps that political leaders can take include:

- Publicity campaigns discouraging sex between older men and young women;
- Support for explicit sex education, within a broader framework of life skills, within the national school curriculum;
- Support for policies and laws that enshrine gender equality;
- Publicity campaigns encouraging condoms within all relationships;
- Widespread provision of voluntary counselling and testing facilities for HIV;
- Establishment of a Ministry of Gender, responsible for examining practices in government ministries and implementing changes where necessary to ensure no discrimination against women; and
- Clear public support of women candidates in elections at all tiers of government.

Political and religious leaders should also set a clear example in their personal lives, by having no extramarital relationships. Ideally, leaders should make a public statement to such an effect, although it is recognized that this is an extremely difficult and sensitive area.

A GENDER PERSPECTIVE ON THE IMPACT OF HIV/AIDS ON FOOD SECURITY AND LABOUR SUPPLY: LEADERSHIP CHALLENGES

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The AIDS pandemic is not only a health problem. Development agencies increasingly regard it as an important, cross-cutting developmental issue which requires a multisectoral and multidisciplinary perspective to understand it and to intervene effectively. The work of the Food and Agriculture Organization of the United Nations (FAO) in the area of HIV/AIDS and agriculture has shown that the HIV/AIDS pandemic exacerbates obstacles to sustainable agricultural production and increases food insecurity.

The FAO Approach to HIV/AIDS and Gender

HIV/AIDS and gender issues are intrinsically linked to both environmental sustainability and food security. FAO's Population Programme is approaching gender and HIV/AIDS issues in their interactions with agricultural production and organization, land access and land tenure, environment and environmental issues, forestry and fishery. This approach is in line with the International Conference on Population and Development (ICPD) Programme of Action and the World Food Summit Plan of Action, both of which highlighted the importance of a holistic and interdisciplinary perspective on gender, population and development issues. In summary, HIV/AIDS and gender-related activities conducted by FAO focus on two main areas:

- **Assessing and understanding the impact of HIV/AIDS** on agricultural development, including land tenure and the gender division of labour; its impact on food security, sustainable livelihoods and nutrition of affected communities, households, male and female individuals; and, more recently,
- **Assisting rural people and rural institutions**, at local, national and international levels in coping with the HIV/AIDS pandemic, while taking into account the various effects on each gender according to the sociocultural and economic context.

AIDS, Food Security and Agriculture

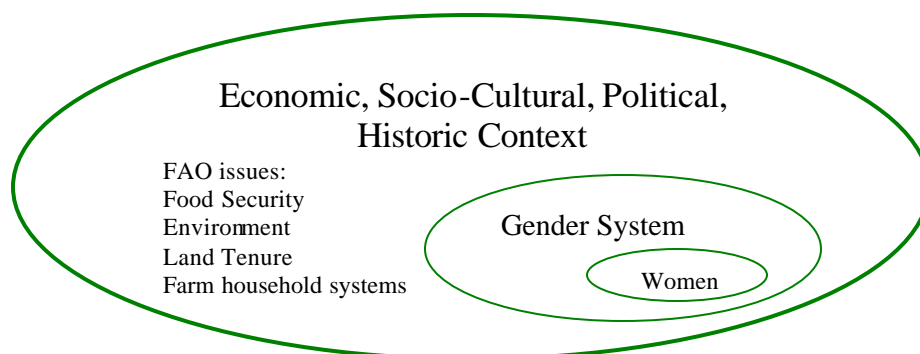
The AIDS epidemic can cause a major agricultural labour shortage, with 7 million agricultural workers already lost and at least 16 million more who could die before 2020 in sub-Saharan Africa,¹ and hence a potentially dire effect on food security. However, it is not only the deaths of labourers that contribute to the scarcity of labour. It has been estimated that

¹ Estimates by FAO's Population Programme Service, 25 most affected countries, based on United Nations population projections, International Labour Organization (ILO) labour statistics and UNAIDS prevalence rate estimates.

by the time a person dies of AIDS, two person-years of labour have been lost, due to the incapacitating nature of the illness and to the time others have to devote to take care of the sick.² In addition, by killing farmers, extension workers and teachers, AIDS can undermine the intergenerational transmission of knowledge and know-how and the local capacity to absorb technology transfers, which constitute pillars of sustainable rural development.

Gender, AIDS and Agriculture

To address gender issues adequately, it is necessary to take into consideration the system of gender relations in which inequalities are generated, developed and reproduced. Gender is culturally ascribed through a system of social, economic, political and historic relations. The gender system shapes patterns of behaviour and the way people view the world and organize production and economic activity. It is intrinsically related to agriculture, food security and rural development. To be able to fully grasp gender relations, this broader system, as illustrated in the figure below, should be targeted:



This system of influence on gender is as important as gender relations themselves for interventions regarding population and development.

The gender system is at the core of the ways in which the HIV/AIDS epidemic spreads and is closely related to its impact. Among men, socially constructed ideals of masculinity are related to risk-taking behaviour and to acquiring wide sexual experience. Among women, a subordinate position or lack of economic autonomy may make negotiation for protected sexual intercourse difficult. Age differences between sexual partners, in which men are older, exacerbate the subordinate position of women and frequently result in higher infection rates among young women. These have been reported to be 35 times higher than among young men.³ Effective interventions to mitigate the spread of the epidemic should thus target both men and women, based on a gender perspective that seeks to understand the complex set of socially ascribed roles and relations between them.

The sickness and death of working adults affect the total labour available in a farm household and its division between adults and children, as well as between men and women. According to the gender system, women, who are the traditional caregivers, spend a considerable amount of time taking care of AIDS patients, and the supply of agricultural labour for specific tasks is significantly reduced.

²G. Rugalema, "AIDS and African rural livelihoods -- from knowledge to action", Keynote address, Conference on AIDS, Livelihood and Social Change in Africa, Wageningen University, 1999.

³UNAIDS calculations.

Access to productive resources, including land, credit, know-how, knowledge and technology transfer, is strongly determined along gender lines, with men frequently having more access to all of these than women have. With the death of the man, the wife may be left without the access she had gained through her husband or her husband's clan, and her livelihood can be immediately threatened. As shown in the examples below, the AIDS epidemic has a strong negative impact on women with an overall negative effect on agricultural productivity and, therefore, on food security.

Example 1: The HIV/AIDS pandemic and traditional institutions

In many patrilineal African communities, the cultural custom of *lévirat* dictates that if a woman becomes a widow, she has to remarry one of her husband's brothers. This custom allows the woman to continue having access to land and food security; otherwise she has to leave the lineage on the death of her husband. Land inheritance patterns are intrinsically related to the gender system. With the AIDS epidemic, this custom has become a risk multiplier, given that the husband might have died of AIDS. Addressing the inequalities in the access to land by men and women (and not only the *lévirat* custom) will have a positive effect on limiting the spread of AIDS.

An appropriate response to HIV/AIDS should thus take into consideration the gender system and the specific development context in which this system is generated, which, at least partially, determines the extent and nature of the impact of the pandemic. To reduce the vulnerability of rural populations and the effects of the pandemic on food security, sustainable development and rural development policies and programmes need to take into account sociocultural and economic factors such as land tenure patterns, inheritance practices and access to, as well as use and management of, productive and non-productive resources.

Example 2: HIV/AIDS and farming communities

A recent FAO study analysed the impact of HIV/AIDS on farming communities in Namibia according to the type of household. The results showed that for all types of households AIDS deaths meant severe labour shortages and loss of productive resources through the sale of livestock to pay for sickness, mourning and funeral expenses, as well as a sharp decline in crop production. The loss of farm labour also meant missing the ideal sowing periods, which are few and of short duration, and therefore sometimes resulted in the loss of the entire production for the season. Delayed weeding meant a higher labour demand, already scarce due to AIDS morbidity and mortality and a loss of crop productivity.

If all households suffer the consequences of the loss of a productive-age member due to AIDS, in matrilineal cultures the loss can be more significant, leaving at risk the survival of the entire family. The study showed that at the death of the husband, productive resources were almost completely depleted by the husband's relatives. As shown in Table 1, most or all of the livestock was taken away from the wife, and she and her children were left without means of livelihood. Evidence for some of the patrilineal societies showed that the death of the male spouse was comparatively less disruptive to the nuclear family's assets.

In all cases, AIDS deaths had the effect of undermining longer term development possibilities in favour of short-term solutions, but in matrilineal societies the death of the man left the family in immediate poverty.

Table 1: Percentage Change in Productive Resources after an AIDS-related Death of Head of Household, shown for five matrilineal communities in Namibia

	Widower (Death of wife)	Widow (Death of husband)	Orphan (Death of parents)
Cattle	-7	-95	-17
Sheep	16	-82	-14
Pigs	-72	-33	-50
Chicken	27	-57	-46
Area cropped (has.)	-16	0	-20
Grain produced relative to requirements	Severe shortage	Significant shortage	Significant shortage
Members employed off-farm	-8	-100	0
Income-generating activities	0	-100	0

Source: Calculated from FAO study “Impact of HIV/AIDS on farming systems in Namibia”, August 2000.

HIV/AIDS, gender and agricultural production are thus closely interrelated. An understanding of these complex interactions is a key to planning for sustainable development. They should be taken into account in order to develop effective interventions in any of the three areas.

Leadership Challenges

The AIDS epidemic is undermining the pillars of rural development and the possibilities of its long-term sustainability in sub-Saharan Africa. An integrated effort at all levels of leadership is needed to counter it and to avoid its further spread. Serious political commitment and adequate resource allocation are essential elements to save the lives of millions of persons and the economic viability of the societies involved. In addition, a more complete knowledge of the complex interactions of the various factors affecting the spread of the epidemic is urgently needed in order to develop appropriate prevention initiatives. AIDS issues cannot be addressed through any of its single factors in isolation.

Difficulties

Given that gender inequalities are at the core of the spread of the AIDS epidemic, gender issues have to be systematically addressed in any prevention strategy. The fact that Governments as well as non-governmental organizations (NGOs) and United Nations agencies are sectorialized and that there is frequently little coordination among sectors at both

central and field levels creates a significant obstacle to address a cross-sectoral issue such as gender in a systemic way.

Another difficulty stems from the fact that, in the same way that AIDS continues to be seen primarily as a health issue by many leaders, gender continues to be equated to women and addressed only as a women's issue by many. This stands in the way of developing an effective strategy to tackle unequal relations between men and women, which are the kernel of the spread of the epidemic.

To incorporate gender issues in development efforts, it is necessary to be able to monitor and evaluate the intervention through appropriate indicators. However, there are some measurement difficulties associated with the gender approach. In the first place, measuring *relations* poses practical problems, which are not unsolvable, but are more easily addressed through methods, such as qualitative methods, that are not widespread among the institutions in charge of promoting development. As a consequence, few indicators are available and fewer still are currently used. This makes comparisons and trends assessment difficult. In addition, few of the available studies are grounded on empirically sound evidence.

Evaluation of interventions is complex, not only due to the lack of adequate indicators but also because evaluations should tackle the gender system as a whole to be meaningful. Thus, a system approach is also required for evaluation.

Other measurement difficulties arise from the fact that changes in gender relations are only possible through a *process*, which takes place in the long term, or at the very least in the medium term, but in any case, usually longer than the span of most social development projects.

What Can Be Done?

All the actors in the development process should be actively involved, from State to civil society, NGOs, religious and social leaders, community and opinion leaders, as well as the academic community, in the efforts to counter the AIDS epidemic and mitigate its impact.

Strong, effective and sustained national and international leadership efforts are needed to:

1. Promote a better understanding of the interactions between gender dynamics, HIV/AIDS and food security/rural development;
2. Create awareness among leaders at all levels of these interactions and about the need to incorporate them into all prevention and mitigation activities;
3. Ensure the political commitment necessary to undertake an integrated effort to combat AIDS and to sustain that effort over time;
4. Create awareness of the processional nature of the necessary interventions and make available the means to implement them and follow them through the process;
5. Ensure that every rural development and food security policy is gender- and HIV/AIDS-sensitive; and

6. Develop appropriate indicators for the monitoring and evaluation of interventions, including both process and impact indicators.

Leaders need to be trained, sensitized and provided with economic means and operational tools to implement the above. Within this broad framework, strong leadership is needed for the following priority areas:

1. *Elimination of gender disparities in the access to productive resources.* Addressing issues of land tenure and of access to other productive resources is an effective way to reduce one of the structural aspects of the spread of the epidemic. If, for example, women do not have to depend on the deceased husband's clan for their economic survival, the custom of wife sharing -- one factor associated with the spread of AIDS in rural societies -- loses its economic foundation and consequently tends to disappear. If, for example, women have easy access to education, they do not have to engage in relationships with older men, "sugar daddies" who leave them in a subordinate position where they cannot negotiate the use of a condom. If, for example, women have access to adequate formal-sector employment, they do not have to resort to commercial sex.

Elimination of gender disparities is an effective way of addressing some of the factors at the root of the dissemination of the epidemic. At the same time, it contributes to reducing food insecurity among the most vulnerable households. Women's economic empowerment is an effective means to contain the spread of the epidemic.

2. *Coordinated action to eliminate gender-based violence.* AIDS is transmitted through human behaviour. Behavioural changes are difficult to produce and may take a long time. Gender-based violence is closely associated with the spread of HIV/AIDS. Strong leadership from the State to the community level is needed to eliminate violent behaviour, including rape and domestic violence. Concrete and urgent action is needed to change socially constructed values of masculinity which are linked to violent behaviour, with special emphasis on the armed forces, the military and the police. Elimination of gender-based violence will greatly contribute to containing the spread of the AIDS epidemic.

3. *Development of innovative strategies to rebuild capacity from local to national levels.* The AIDS epidemic has implied the loss of local capacities and of the mechanisms for transmission of knowledge, including gender-based knowledge. New needs for information and skills have arisen, and they have to be understood in order to provide for them. Strong leadership is needed to rebuild capacities according to the new needs the epidemic is generating. For example, agricultural extension has to be modified to cater for the needs of labour-short rural households, widow- or widower-headed households, and orphan-headed households. New and appropriate mechanisms for technology transfer are essential, including extensive use of information technology.

4. *Rethinking of all sectoral policies and programmes.* All sectoral policies and programmes should incorporate gender and HIV/AIDS issues in their strategies, including appropriate monitoring and evaluation indicators.

LEADERSHIP CHALLENGES IN STRENGTHENING NATIONAL LEGAL INSTRUMENTS AND FRAMEWORKS TO ADDRESS THE CONSEQUENCES OF HIV/AIDS FROM A GENDER PERSPECTIVE

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This presentation is based on the situation in Kenya and focuses mainly on the legal instruments and frameworks that have been set in place to combat the HIV/AIDS pandemic. More specifically, it centres on those aspects of HIV/AIDS-control efforts from a gender perspective. It is hoped, however, that where similarities in challenges facing HIV/AIDS-control initiatives in different countries in this region emerge from this presentation, they will be highlighted in order to direct the process of developing recommendations that can guide Governments and private-sector and civil society leaders in efforts to combat the AIDS pandemic on the continent.

AIDS in Kenya: A Background

The AIDS situation in Kenya has progressed from one case in 1984 to about 14 per cent of all Kenyan adults. Approximately 2.2 million Kenyans are living with HIV infection and 1.5 million have so far died from AIDS, making Kenya one of the hardest-hit countries.¹ On average, close to 500 people in Kenya die daily because of AIDS, and about 80 per cent of them are between 15 and 49 years old. In economic terms, this age group is the most economically productive and translates to an economic loss of Kshs 210 million daily. According to *Sessional Paper No. 4 of 1997 on AIDS in Kenya*, in 1997, it was estimated that a total of 1.7 million Kenyans would be infected with HIV by the year 2000. The number of new cases reported was, by that time, averaging 12,000 annually since 1990. However, due to under-reporting, missed diagnosis and delays in reporting, the recorded cases represented only the tip of the iceberg. A more valid estimate, at that time, might have been three times the above figure, which translates to about 36,000 new infections a year, and possibly more.

Kenya has some achievements in the area of information provision. Almost everyone has heard of AIDS, how it spreads and the means of prevention. Condom use has increased: figures indicate that a total of 10 million condoms are used each month compared with 300,000 in 1990. Despite this, HIV/AIDS prevalence remains high and is still increasing.

In Kenya, two transmission mechanisms are most important: heterosexual contact and prenatal transmission.² The majority of infections, approximately 80-90 per cent, is transmitted through heterosexual contact. Many children are infected prenatally: that is, they receive the infection from their mothers during pregnancy, at the time of birth or through

¹ *The East African Standard*, 29 November 2000.

² National AIDS/STDs Control Programme, Ministry of Health, Nairobi, *AIDS in Kenya: Background Projections Impact Intervention Policy*, 5th Edition, 1999.

breastfeeding. About 30–40 per cent of babies born to infected mothers will themselves be infected. The rest will not be infected but are at risk of becoming orphans when their parents die from AIDS. Transmission through infected blood is not significant in Kenya because close to 100 per cent of blood used for transfusion is screened for HIV.

From the perspective of those who have worked outside of the Government and particularly within the civil society, the general perception has been that the Government of Kenya has not been quick enough to respond to the challenge posed by HIV/AIDS over the past decade and a half. For example, despite the fact that the first case of infection was reported as far back as 1984, it was not until 1997 that the Government formulated the first national policy paper on AIDS in Kenya, *Sessional Paper No. 4 of 1997 on AIDS in Kenya*. Until then, issues related to HIV/AIDS were left to a department of the Ministry of Health, the National AIDS/STDs Control Programme (NASCOP).

Clearly, therefore, the Kenyan Government took an inordinately long time to recognize HIV/AIDS as a multisectoral and not just a health challenge, thanks to the advocacy initiatives of non-governmental organizations (NGOs), particularly the Kenya AIDS NGO Consortium. Rather belatedly, *Sessional Paper No. 4 of 1997 on AIDS in Kenya* proposed the formation of a National AIDS Council. The rationale for the formation of the National AIDS Council was to expedite HIV prevention and control activities through the formulation of appropriate policies; establishment of an appropriate institutional framework for a multisectoral AIDS control programme; strengthening of institutional capacity at all levels; leadership in resource mobilization for AIDS control, including care of people affected; and coordination of all actors, including government departments, NGOs, community-based organizations, religious organizations, the private sector and donors, among others.

It was not until November 1999 that the Government, through President Daniel Arap Moi, declared AIDS a national disaster and called for the introduction of AIDS prevention education in the elementary school curriculum. Although HIV/AIDS prevention education has been taught in all institutions of learning since January 2000, the formal launching of the HIV/AIDS syllabus and curriculum took place on 28 November 2000 as one of the build-up activities of the 2000 World AIDS Day.

AIDS and Women in Kenya

Kenyan women, like those in other parts of Africa, are finding it difficult to cope with the heavy burden placed on them due to HIV/AIDS. The threat to women -- including married women and young girls who do not fit into traditional “high risk” groups -- is rising dramatically. The shift has come about not because women are taking greater risks in their sexual lives, but because of social and cultural inequality, economic marginality, restricted access to power in public and private life and legal systems that discriminate against women and deprive them of basic rights. Women also suffer from greater biological vulnerability to HIV infection.³ The fact that HIV affects everybody irrespective of sex makes heterosexual transmission an important factor when dealing with women and girls. Research continues to show that young girls become sexually active at an earlier age than boys. This is a key reason why prevalence rates peak earlier for women than men.

³ Jane Kiragu, “HIV Prevention and Women's Rights: Working for One Means Working for Both”, *AIDScaptions*, November 1995.

Gender inequity of all kinds increases women's vulnerability to HIV infection in three closely linked ways. First, lack of economic opportunity for women, enshrined in sociocultural practices and reinforced by the legal system, leads to dependence on men, whose interests do not always coincide with women's needs to protect themselves. Second, depriving women of the right to control their own bodies also deprives them of their right to refuse sex and to demand safer sex practices by men. Third, some cultural practices, many of which are protected by the law, are directly and immediately dangerous and can lead to HIV infection. The situation is worsened by deteriorating economic conditions, which make it difficult for women to have access to health and social services.

A Gender Perspective on Legal Instruments, HIV/AIDS

So far, Kenya does not have specific statutes dealing with HIV. However, existing laws/statutes and regulations touch on some aspects. The *Sessional Paper No. 4 of 1997 on AIDS in Kenya* identified key areas in which legislation needs to be formulated in order to ensure that persons with HIV/AIDS are adequately protected by the law. Highlighted below are areas in which the need to formulate laws seems even more urgent now than it was in 1997.

***Human rights.** All forms of discrimination against people with AIDS need to be outlawed as enshrined in the Constitution*

While the Constitution outlaws discrimination, it does not address the emergent discrimination due to the social stigma associated with HIV/AIDS. As an instrument that provides the framework for other statutes, it is important for integration of this component. At this point, it is also crucial to note that in Kenya, despite the Constitutional Amendment 1997 in Section 82 to include "sex" as a basis of non-discrimination, there is the claw-back clause in Section 82(4) that provides for discrimination in matters pertaining to personal law, succession, inheritance, burial and devolution of property. This relegates women to be subjected to customary laws that invariably affect their rights to decide when and whom to marry, and also their rights to negotiate safe sex. Non-discrimination for persons infected with HIV/AIDS would and should specifically include the right of access to health services to ensure that those seeking medical services due to HIV infection are treated the same way as those who are not.

The challenge is to ensure that there is legislation against all discriminatory practices that have implications for HIV/AIDS, including regulating the age of consent. Leaders in civil society and in policy-making organs, and parliamentarians, need to ensure harmonization of the provisions of the Constitution so as to guarantee women their full non-discrimination rights. Further, laws regulating health institutions should provide a framework that will ensure that health facilities are not discriminating in the delivery of services.

The girl child is highly susceptible to HIV infection due to the age when they become sexually active, in addition to the type of partners they have, who are often older men who have been influenced by "high risk" behaviour in cultural norms such as labour migration, alcohol use, plural marriages and other social behaviour.⁴ The law needs to articulate clearly

⁴ *Daily Nation*, 1 December 2000.

the age of marriage and harmonize the various legal regimes on marriage to reduce the vulnerability of the girl child.

Other emerging draft bills need to integrate the HIV/AIDS component, e.g., the Domestic Violence Bill, which should ensure that infection by a person in a domestic relationship falls within the ambit of the Act. Undoubtedly, this should correspond with various criminal penal codes to include those who knowingly infect their partners with HIV/AIDS, who should be penalized not purely for assault but for manslaughter. The immediate challenge here is that Kenyan penal laws and other Commonwealth legal regimes recognize murder or manslaughter if the person dies within a year of such infection. The time lag between infection with HIV and subsequent death due to AIDS-related illness is typically longer than one year; therefore, conviction for murder or manslaughter is precluded from the law. Young girls who are often forced into sexual relations with men as a cleansing exercise fall squarely within this bracket as well. In order to effectively address the continued spread, there is need for legal instruments that will monitor and shape sexual behaviour.

***Testing for HIV.** Legislation needs to be formulated to ensure that testing for HIV is voluntary, with informed consent, except for authorized research where protocol has been approved by the National AIDS Committee.*

For women, the potential for non-compliance with voluntary testing is high, particularly for women in their reproductive ages. Post-natal clinics that carry out testing on all mothers should clearly adhere to the guided principles and ensure that informed consent is obtained as well as that efficient pre-testing and post-testing counselling is undertaken. Without sufficient legislative and policy direction on this aspect, women find themselves subject to involuntary testing, which is trespass and battery.

Other legal questions on HIV/AIDS testing also emerge in the area of laws and policies:

- Should persons intending to get married undergo compulsory testing to provide them with sufficient information on whether or not to get married? Should prospective employees undergo compulsory testing before they are employed?
- Should insurance companies insist on compulsory testing before issuing insurance policies?
- Should testing be a requirement for travel across borders and for visa applications?

How do these questions fit in with the constitutional provisions of non-discrimination? These challenges need to be addressed in the wake of HIV infection by the provision of a facilitative legal framework that will ensure that the gains made in removing the stigma surrounding HIV pandemic are not eroded.

***Confidentiality.** Confidentiality must be maintained in line with existing professional medical ethics. However, health care providers should be allowed to disclose the HIV status of their patients to persons considered to be at risk of infection after the individual has been provided with opportunities to disclose their HIV status to those concerned.*

As stated elsewhere in this paper, married women find themselves at great risk in their sexual lives due to the social and cultural inequities, with accompanying legal sanctions. On the other hand, men's "high risk" behaviour is influenced by cultural norms of labour migration, alcohol use, plural marriages and other social behaviour.⁵ If for a moment it is assumed that within an intimate partnership either a man or a woman is responsible for bringing the infection to the home, and that this forms a basis for the confidentiality rules to be relaxed, the question remains on how to deal with the consequences thereof. The law will be legislating sexual behaviour within marriages; how does this fit within the context of guaranteed rights under the Constitution, specifically the right to privacy? On the other hand, how does it fit within the medical workers' responsibility to ensure that they provide their patients with sufficient information to lead healthy and productive lives? This remains a delicate question and a challenge for leaders and activists in the area of HIV/AIDS.

Medical ethics. *Whereas existing ethical practices have served the country well in the handling of AIDS and HIV infection, legislation still needs to be formulated in order to ensure enforcement. In the interest of the public, all people diagnosed with HIV infection must be informed of their status and be encouraged to take precautions for themselves and those with whom they are likely to have sexual relations.*

In Kenya, the Public Health Act clearly outlines the measures to be taken in instances of the spread of STDs.⁶ STDs are defined as infectious notifiable diseases. The Act was envisioned to respond to STDs and other infections that are treatable; hence, measures to safeguard the spread of infection bear results in terms of reducing prevalence. HIV is not curable and, consequently, legislation needs to be developed cautiously to ensure that there is sensitivity in the mechanisms for HIV/AIDS counselling for prevention. The current enforcement measures proposed in the Act are not applicable to HIV/AIDS and may present a great challenge in the interpretation of the law.

Research. *Different departments of the Government without legal authority currently handle the coordination of research in Kenya. A legal body with a clearly defined mandate will be established to coordinate AIDS/HIV/STDs and related research.*

The major legal concern, which is yet to be provided for, is the lack of legal procedures relevant to the carrying out of research on HIV/AIDS. The use of human subjects in research and the implications of their rights *vis-à-vis* the public obligation to undertake measures that may lead to finding a cure, present a great challenge.

Religion and culture. *Because of the diversity of Kenyan culture and religion, written laws and ethics must be applied within the context of specific communities. Research on these issues needs to be undertaken to shed more light on what is involved in each community. Religious and cultural practices and utterances which undermine HIV/AIDS control measures must be censured for the public good.*

There is a need to address whether some aspects of culture that undermine HIV/AIDS-prevention strategies should be legislated against, e.g., wife inheritance, early marriage and

⁵ Ibid.

⁶ Medical officers have a right to inspect premises where inhabitants may have been exposed to infectious diseases and they may medically examine such persons. They also have wide powers of cleansing and disinfecting the buildings, isolating and detaining carriers of infectious diseases.

female genital mutilation. At the same time, in recognizing that formal law is not the ultimate solution to the issue, there is a challenge to identify positive use of culture and traditional medicines and indigenous religions for the combat of HIV/AIDS.

Criminal sanctions. *Criminal sanctions against people who deliberately and irresponsibly infect others with HIV must be upheld.*

Under the current laws in Kenya, where another has infected a person with HIV intentionally, the legal interpretation would be that one would have a case to answer. No legal precedent has been set in Kenya as no prosecution has been undertaken. The practical enforcement of this legal provision poses a great challenge as in cases of sexual offences. The evidence required to prove a case is awesome, and it further places the sufferer in an open court to testify on sensitive issues regarding his/her sexuality. The need for a campaign for the judiciary to specify that certain cases be held in camera is evident. Perhaps the proposed establishment of family courts and provisions to handle sexual violence cases in camera would fall into this category.

While not mentioned in the *AIDS Sessional Paper*, there is a need to address the situation of children orphaned by HIV/AIDS. A great number of children have been orphaned, and they have had to give up their childhood and take on parental responsibilities. Many of the children have been disinherited by greedy relatives, leaving them with little support. The procedures governing the administration of estates of the deceased persons need to be addressed so that they are simpler, friendlier and more protective of widows and orphans. The new legislative initiatives started in Kenya, such as the Children's Bill and the establishment of family courts, are hoped to be more accommodating and sensitive to handle such matters.

In conclusion, there is a need to re-emphasize the call for action by leaders. The many questions left unanswered in this presentation indicate that there are many legislative gaps in the context of HIV/AIDS.

The scourge of HIV/AIDS is greatly undermining the development of our countries. Prevention efforts need to be accompanied by clear legislative and policy frameworks that will strengthen efforts at community levels. It is only then that we shall see our continent emerge as one that has comprehensively addressed the rights of those infected with HIV/AIDS and the rights of all others who are affected by HIV/AIDS. For leaders, we call for greater commitment and political will. It can be done.

COMMUNITY-LEVEL INTERVENTIONS ON HIV/AIDS FROM A GENDER PERSPECTIVE: THE ROLE OF LEADERS

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Nigeria

AIDS in Sub-Saharan Africa

This paper is informed by the situation in sub-Saharan Africa, which accounts for about 70 per cent of global infections and where the gender implications of HIV/AIDS are compounded by peculiar sociocultural realities.

Total Adults and Children Living with HIV/AIDS as of 31 December 1999

Worldwide	34.5 million
Sub-Saharan Africa	24.5 million
South and South-East Asia	5.6 million
Latin America	1.3 million
North America	900,000
East Asia and Pacific	530,000
Western Europe	520,000
Eastern Europe and Central Asia	420,000
Caribbean	360,000
North Africa and Middle East	220,000
Australia and New Zealand	15,000

(UNAIDS, June 2000)

The latest figures released in November 2000 show the following:

Total adults and children with HIV/AIDS	36.1 million
Sub-Saharan Africa	25.3 million

The gender dimensions of HIV/AIDS are glaringly obvious at the community level. Women bear the major burden of HIV/AIDS because of their traditional roles within the family and the community. Since caregiving and domestic chores are still predominantly women's responsibilities, an increase in the prevalence of HIV/AIDS in the society directly and indirectly increases the burden on women. Women's subordinate status, especially in sexual decision-making, is another factor that makes women more vulnerable to HIV/AIDS

infection. Coupled with these are negative and harmful sociocultural beliefs and practices, which vary from community to community.

Paradoxically, women's emerging and emancipating roles within the family and the community also increase the burden of HIV/AIDS on them. The fact that women are taking on men's traditional role of breadwinning is worsening the situation for women. The combination of productive activities outside the home with domestic work, including caregiving to the infected, puts additional strain on women's physical, mental and emotional health. Many women have to divert a significant part of their financial resources into caregiving. When the infected woman who heads a household herself becomes ill and unable to earn a living, the situation of the household could become hopeless.

Poverty is a key consideration in community-level interventions on HIV/AIDS from a gender perspective. It constitutes a great challenge indeed for leaders everywhere, at international, national and local levels. Poverty is a major driving force of HIV/AIDS. It is both a motive force and a consequence. Poverty leads to migrant labour, mostly from the rural areas to the cities, separating couples and increasing the incidence of multiple and casual sexual relationships. It also forces women to trade sex for material gratification.

The situation is compounded by the feminization of poverty occasioned by so-called Economic Recovery Policies or Structural Adjustment Programmes. The cut in public spending on social services, health education, transportation, etc., and the retrenchments and the introduction of costs for medical care and education cause more unemployment, insecurity in family relations, more school drop-outs and poorer reproductive health, increasing the burden of poverty on families and communities. Naturally, women who are among the poorest of the poor are the worst hit. More girls are denied the opportunity for education, and more women are forced to trade sex for survival. Secondly, the strain put on the health care system and the introduction of costs further increase the burden on women who are mostly responsible for caregiving. The social unrest that ensues creates a climate of political instability, encouraging dictatorships and undemocratic coercive governance and driving away investors whom the "austerity measures" were meant to attract in the first instance -- a vicious cycle.

The plight of women in the face of HIV/AIDS requires strategic responses. Interventions at the community level need to effectively address both the vulnerability of women as well as the impact of HIV/AIDS. To do so, there is a need for a shift in paradigms. Policies and programmes need to move beyond reaching women alone. A gender perspective needs to become much broader than the feminization of interventions. In addition to direct assistance to women to ensure livelihoods for them, access to treatment and reduced burden of caregiving, and bold, fresh responses are needed by leaders and other stakeholders to proactively address root causes and the unjust structures which perpetrate the vulnerability of women to HIV/AIDS.

The recent international conferences -- for example, the International Conference on Population and Development and the Fourth World Conference on Women, as well as the World Summit on Social Development -- all make poverty alleviation a key factor in improving the status of women. Governments all over the world have also recognized the need to alleviate poverty. HIV/AIDS is, however, extending a new challenge -- the need to tackle poverty as a human right and a women's rights issue, and to put on the front burner the

issue of a more just and equitable economic order. So far, leaders and stakeholders everywhere have adopted a rather timid attitude to the issue of eradicating poverty in the developing world and even within rich countries. Poverty “alleviation” is a short-term palliative that is daily proving elusive. How do we “alleviate poverty” while the structures and forces that breed it are left intact?

The leaders of the rich and powerful countries of the world, especially those with previous colonial ties and current neo-colonial ties with developing countries, have a moral obligation to ensure that resources are equitably distributed globally. In this regard, terms of trade need to be reviewed.

In terms of HIV/AIDS prevention and control, there is an increasingly greater political will on the part of leaders to acknowledge HIV/AIDS as a serious development issue. The focus on HIV/AIDS by the Special Session of the United Nations Security Council in January 2000 is evidence of this. This political will has not always been translated into concrete actions, nor has HIV/AIDS prevention and control received the kind of priority attention it deserves.

With all the attention that HIV/AIDS is receiving as a development and security issue, world leaders and heads of Governments have fallen short of treating HIV/AIDS as a natural disaster. The fact that the millions of people infected and affected are dispersed in relative obscurity in their respective families and communities has encouraged a rather leisurely approach to HIV/AIDS interventions.

The devastating effect of HIV/AIDS on families, communities, and the productive workforce, and the gruesome reality of 13.2 million orphans and 18.8 million deaths (cumulative), ought to precipitate a massive emergency relief response. But that has not been the case. Why have heads of Governments, especially of the rich industrialized countries, not dispatched direct relief? Why is nobody flying in food supplies, nutrient supplements, medicines and caregiving kits to the “disaster areas”? Could it be because those most affected are women, children and the poor? When one compares this rather lukewarm approach with the frenzy with which sophisticated military hardware and legions of troops are flown and shipped across regions in order to protect economic interests, “human rights” and “freedom and democracy”, one can only begin to raise fundamental issues about human values and about the priorities of our world leaders.

When it comes to HIV/AIDS intervention at the community level, women, the community and religious organizations have demonstrated a great deal of leadership. They have sought to respond by harnessing their often meagre financial and material resources to meet the basic needs of the infected and affected. Most of the community interventions are initiated by women or are being implemented by them. Some examples are:

- The CINDI project in Lusaka, Zambia, launched by Catholic women in collaboration with other religious women’s organizations and other community people, to provide care for orphans and for people living with HIV/AIDS. These women work to ensure that orphans have shelter, food, medical care and clothes and that they go to school or learn skills;
- The WAMATA and the KIWAKKUKI projects in the United Republic of Tanzania, which are also involved in the care and support of people living with HIV, counselling

and home-based care, as well as preventive education, including promoting sexuality education for young persons and tackling sociocultural issues pertaining to HIV/AIDS;

- The Community-based Counselling Project of the Ugandan AIDS Control Programme, which uses Voluntary Community Counselling Aides to provide HIV/AIDS education and counselling to families and communities and to engage them in dialogue on how to adopt healthier sexual behaviour;
- The ZINATHA programme in Zimbabwe, which, in collaboration with the Ministry of Health, has mobilized traditional healers for preventive education, care and support, and promoted the adoption of safe medical practices and treatment of opportunistic infections;
- The INDENI HIV/AIDS workplace intervention in Zambia, which provides preventive education, and support for treatment of opportunistic infections for workers. Under this programme, wives of workers were also organized around HIV/AIDS issues;
- The TASO project in Uganda, launched by Noreen Kaleeba and her friends, is well known and has received wide acclaim for its dynamism in providing care and support for people living with HIV/AIDS; and
- The Community Life Project in Lagos, Nigeria, which provides a unique example of how synergistic partnerships between activists, community and religious organizations, and local institutions, involving men, women and children simultaneously, can help to effectively break the silence on sexuality issues and place sexuality education on the community's agenda, thereby creating a supportive environment for advancing women's reproductive and sexual health.

Leaders at international, national, state and local levels have a major role to play in community-level interventions from a gender perspective. Without their leadership, women and community organizations are bound to exhaust their own resources -- human and material. The task of social mobilization for community-level interventions should be that of Governments and political leaders.

Recommendations for Leaders

1. *Make community-level interventions the focal point of national response.* It is important that leaders adopt a strategic outlook and make community-level interventions the main thrust of their national response. This strategy will help to ensure that a truly holistic and integrated response becomes a reality. It will address the issue of livelihoods, food security, preventive education, care, the status of women, discrimination and stigmatization, and the implementation of a multisectoral approach. It will also help to ensure that sociocultural factors which make women vulnerable are effectively addressed and that women's rights are guaranteed.

To this end, leaders need to:

- Decentralize HIV/AIDS-prevention and control activities and strengthen the primary health care systems. Fully functional HIV/AIDS units at the primary health care level should provide HIV/AIDS screening, treatment of opportunistic infections, diagnosis and

treatment of sexually transmitted infections (STIs) and tuberculosis. This should be complemented with a free voluntary testing policy to encourage more people to come for testing. Strengthening the blood safety mechanisms and diagnostic capacities at all levels of the health care system is also important;

- Ensure that a multisectoral approach is adopted;
- Undertake the social mobilization of their populace for community-level interventions by:
 - Breaking the silence. Government officials, politicians and other influential people who are infected should lead the way and be positive role models for the governed, by publicly acknowledging their HIV-positive status;
 - Building on local initiatives, especially those run by women and community people; and
 - Building a systematic, sustained and synergistic partnership with religious and community organizations, men's associations and clubs to promote the active participation of men in caregiving and to review sociocultural practices which are harmful to women, which make them more vulnerable or increase the burden of HIV/AIDS, including such issues as property inheritance and other basic rights.
- Involve women and communities in policy formulation and in the design of interventions; and
- Implement grass-roots political education on governance and democracy and on human rights.

2. Mobilize private-sector commitment. Governments and leaders should take responsibility for mobilizing private-sector commitment to HIV/AIDS. To this end, leaders need to initiate HIV/AIDS workplace intervention.

There is need to enforce a compulsory workplace intervention policy involving all employers of labour (including the public sector), labour unions and other stakeholders, which will involve:

- Basic HIV/AIDS education on modes of transmission, prevention, factors driving the epidemic, the gender dimensions of HIV/AIDS, promotion of STI treatment, and the benefits of voluntary testing; and
- The integration of HIV/AIDS prevention and care into companies' health policies.

Workplace intervention is strategic for several reasons:

- It is a viable medium for reaching millions of men;
- It provides a unique opportunity to sensitize men to gender dimensions of HIV/AIDS;

- It will help to reduce stigmatization and discrimination of infected workers, thereby helping to protect the rights of infected people;
- It will help employers of labour ensure a healthier workforce and increase productivity by reducing the loss of their productive workforce to HIV/AIDS; and
- It is highly cost-effective, as it will be reaching the staff where they are.

3. *Negotiate and guarantee access to drugs.* Leaders, especially in developing countries, should be the principal negotiators with drug companies for access to drugs for antiretroviral therapies and should take responsibility for putting the necessary infrastructure in place to support availability and accessibility of antiretroviral drugs. South-to-South collaboration and subregional initiatives should be encouraged.

4. *Invest more in social services.* There is a need for leaders to invest more resources in order to provide social services. Economic policies such as Structural Adjustment Programmes, which impoverish masses of people, should be reviewed and restructured to make them more people-centred.

5. *Give special focus to rural communities.* Another strategic response that needs to be undertaken by leaders is to give special focus to rural communities by implementing and supporting rural-based HIV/AIDS prevention and care activities. Since many terminally ill widows and orphans end up with extended families in rural communities, these communities have become effective intervention points for prevention and care, and for guaranteeing food security and responding to the cultural norms which worsen the plight of women.

In addition, promoting infrastructural and business investments in rural areas in developing countries so as to reduce poverty and migration, which increase women's vulnerability, is vital. Policies to improve the quality of life in rural areas and to control rural-urban drift constitute a key strategic response with far-reaching implications for food security and social security in general. Rural development will keep families together and provide women with support and security.

6. *Redistribute resources.* Leaders all over the world have the responsibility to ensure that resources are more equitably distributed between the "haves" and the "have-nots" of the world. In addition, within countries, there is need for a shift in funding priorities. Such a shift demands that less money is spent on the military and more be invested for HIV/AIDS prevention and care.

Conclusion

Leaders everywhere are challenged to treat HIV/AIDS as a priority, a global catastrophe and holocaust. The time for words is over. Governments everywhere should learn from local communities and women about what needs to be done and proceed to do the will of the people.

YOUTH PERSPECTIVES ON GENDER AND HIV/AIDS

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The challenges of gender and HIV are related to issues of poverty and should be addressed together. Issues that need urgent attention include:

- **Poverty:** Girls and boys turn to commercial sex work because of boredom and the lack of employment. They use their bodies to earn money and sustain themselves;
- **Early marriage:** In some African settings, parents force their children into early marriages instead of sending them to schools to become productive citizens. These practices should be stopped;
- **Sexual violence:** Rape and forcing children to have sex with adults are very bad practices, which prevent the development of the children;
- **Multiple sexual partners:** For young boys and girls, it is time to stick to one partner instead of having two or more older men and women and even having sexual relations with mothers and fathers. Adults should stop the sexual exploitation of young girls and boys under the pretence and pretext that they are their goddaughters and gods ons. Adults should focus on supporting their wives, husbands and children instead of being "sugar daddies" and "sugar mummies" to youths and sexually exploiting them;
- **Girls supporting homes:** It is time for parents to send their girls to school instead of making them breadwinners. Education can make a great difference in a girl's life, and she can in turn help her parents in the future; and
- **Social mobilization:** Young people need to be mobilized through peer education, the use of friendly approaches and mass media such as TV, radio and theatre performances in rural areas.

Recommendations

- All government leaders and parents should ensure that girls as well as boys are sent to school;
- Governments should provide employment and job opportunities for young men and women;
- Governments should establish schools for children who have dropped out of school. For example, vocational and technical schools should be created for these young people;

- Parents should be open about sex with their children;
- Government officials, church leaders, teachers and parents should be role models for young people; and
- Youths should be part of decision-making at all levels.