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WOMEN AND AIDS: AGENDA FOR ACTION

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SUMMARY

The Fourth World Conference on Women is taking place at a time when women are increasingly becoming infected with HIV, the virus that causes AIDS. From being almost absent from the AIDS epidemic in the 1980s, women infected with HIV now number more than six million -- with another one million women becoming infected this year. By the year 2000, over 13 million women will have been infected and 4 million of them will have died. Women worldwide are asking why a virus that infects both men and women is increasingly affecting women in a disproportionate manner.

The bleak reality is that the sexual and economic subordination of women fuels the HIV/AIDS pandemic. In order to break the cycle of neglect which affects women across their life span and across generations, it is essential to undertake actions which will allow women to make informed choices and enable them to improve the quality of their lives. Women must empower themselves by networking, forming alliances, and advocating for change. Top-level political commitment is needed to reduce the social vulnerability of women to HIV infection by improving their health, education, legal and economic prospects. Effective HIV/AIDS prevention and care efforts along with sound policies and programmes targeting women affected by HIV/AIDS need to be developed and integrated into existing national structures, particularly at the community and family level. Because such social vulnerability cannot be effectively challenged by women as individuals alone, or even as groups, building effective alliances between women and men based on mutual respect, remain the greatest challenge, but also the best hope, for the lives of tomorrow.

THE UNIVERSITY OF CHICAGO

WOMEN AND AIDS: AGENDA FOR ACTION

I. INTRODUCTION

1. In the space of just one decade, AIDS has turned into a pandemic affecting millions of men, women and children on all continents. WHO estimates that 4 million AIDS cases had occurred by mid-1994 and foresees that this cumulative total will triple by the year 2000. The number of people infected with HIV --- the virus that can lead to AIDS --- is much greater. According to WHO's conservative estimates, as of mid-1994 more than 16 million adults and over one million infants have been infected with HIV since the start of the pandemic (Figure 1). By the year 2000, there will be an estimated 30-40 million infections.

2. To what extent has the epidemic affected women? Enormously. A decade ago women seemed to be on the periphery of the epidemic. Today they are at the centre of concern. WHO estimates that almost half of all newly infected adults are women. This means that the number of women acquiring HIV each year cannot be counted in the thousands, or even in the hundreds of thousands. Last year alone, more than 1 million women were newly infected. Already, more than 6 million women have been infected with HIV worldwide (Figure 2) and this figure is rapidly growing. Estimates are that over 13 million women will have become infected with HIV by the year 2000, and about 4 million of them will have died.

3. Among both men and women, the hardest-hit group is youth. WHO estimates that half of all infections to date have been in 15-24-year-olds. However, in nearly all parts of the world, the peak age of infection is lower in girls than boys. In many countries, 60 % of all new HIV infections are among 15-24 year-olds, with a female to male ratio of 2 to 1. An analysis of reported AIDS data from several African and Asian countries suggests that young women under 25 account for nearly 30% of female AIDS cases and young men for approximately 15% of male cases.

4. As infections in women rise, so do infections in the infants born to them. To date, these total about 1 million, of whom more than half a million have already developed AIDS. Overall, about one-third of babies born to HIV-infected mothers become infected themselves.

5. The route of transmission to women is overwhelmingly through heterosexual intercourse (see Annex). In most developing countries, heterosexual transmission has predominated from the outset. In industrialized countries, where homosexual contact and needle-sharing used to account for nearly all infections, there is an ominous rise in heterosexual transmission. The result is a growing AIDS burden in women. Everywhere, people who have unprotected sex with many partners are at especially high risk. But it is important to remember that as local epidemics mature, the net of infection is cast wider and wider, drawing in women with only one sex partner. In many countries throughout the world, pregnant women attending antenatal clinics are showing a high prevalence of infection. Studies of women attending antenatal clinics find that many are monogamous and have been infected by their one partner --- their husband.

6. The sexual and economic subordination of women fuels the HIV/AIDS pandemic. In order to break the cycle of neglect which affects women across their life span and across generations, it is essential to undertake actions which will allow women to make informed choices and enable them to improve the quality of their lives. Given the growing dimensions of the HIV/AIDS pandemic, the need for change is literally a matter of life or death.

II. HOW HIV/AIDS IS SPREADING AMONG WOMEN

Sexual Subordination Leads to HIV Vulnerability

7. In many societies, there is a significant power differential between men and women, supported by social and cultural systems that posit the control by males. Males are expected to initiate relationships, and sexual assertiveness in women is often stigmatized or punished. The gender power differential is compounded by age differences. Women typically marry or have sex with older men, who have been sexually active longer and hence are more likely to have become infected themselves. In countries with high HIV infection rates, men justify the selection of young adolescent girls, even female children, on the grounds that they are less likely to be infected with HIV/AIDS.

8. Many countries which promote monogamy and mutual fidelity, and discourage multiple casual partners as a societal norm, have also encouraged these values as a primary AIDS prevention strategy. Some societies, however, expect women to adhere strictly to this norm while tacitly condoning male deviation from it. Women are expected to have one lifetime sex partner while men are expected, or even encouraged, to have more than one partner. As a result, women are more likely to be monogamous than men and to have fewer lifetime partners. Reliance on "monogamy" or "mutual fidelity" as a principal solution can be misleading for women, as fidelity protects against HIV/AIDS only if it is completely mutual and lifelong. It creates an illusion of safety for individuals who are monogamous but who cannot be certain about their partners.

"For example, a situation like this develops. If your man comes home at 3 a.m. smelling of a perfume you don't recognize, that's the time he's going to ask for sex because he's trying to clear his conscience by making you think he hasn't already had it. But if he goes out drinking with the boys, he comes home and goes straight to sleep peacefully. You have to go along with whatever he asks, even if you're smelling this strange perfume, because you can't say 'no'."

9. In some cultures, women don't have the "permission" to talk about sex with men, or to negotiate safer sex practices. To do so may have serious repercussions, ranging from stigma to fear of violence or abandonment. Despite this, many HIV/AIDS prevention and family planning programmes have expected women to assume responsibility for the prevention of both pregnancy and sexually transmitted diseases (STDs), including HIV infection, in a context in which they have limited control over when, with whom, and how they engage in sexual activity.

10. Male resistance to condom use and women's inability to negotiate safer sex puts women (as well as men) at greater risk of HIV infection. For men, the rationale for resisting the use of condoms includes concern about reduced sensitivity, ignorance about how to use the condom properly, and fear that using it will permanently interfere with fertility. In addition, within marriage or other long-term relationships, the very suggestion of condom use carries with it an indication of "infidelity" or other behaviour that could threaten the security of the relationship, making it difficult for both men and women to introduce condoms into an existing relationship.

11. Some countries have statutory or *de facto* restrictions based on age or gender regarding access to information about sexuality, contraception, disease prevention, condoms and lubricants, and health care. In many communities, schools and other institutions that work with adolescents are wary of providing sex education or otherwise discussing issues related to sexuality, due to social and cultural concerns about "protecting" young women from sexual experience. As a result, young women and men lack adequate information and skills to protect themselves if they are sexually active. In addition, children and adolescents, in some countries, must have a parent's permission to obtain health care services. This is a particular problem for young people who have left home or are homeless.

12. Women are also vulnerable to coerced sex, including rape and other sexual abuse, in and outside of the family, and forced sex work. Any non-consensual penetrative sex can carry an increased risk of transmission of HIV and other STDs, particularly as men who rape are not likely to use condoms. Moreover, even when sex is non-consensual, women are often stigmatized and blamed, causing them to be ostracized from family and support networks. The problems associated with rape and other forms of violence against women are often intensified in war situations, in which occupying or invading armies, systematically rape women as part of a strategy to intimidate the local population.

13. In all countries there are customs related to women's sexual activity. Some have become deadly in the AIDS era, such as ritual intercourse with a male relative in the event of death of the husband. Traditional practices such as female genital mutilation, ritual scarification, tattooing and blood letting can also, if performed with unsterile equipment, result in infection.

Economic Subordination Leads to HIV Vulnerability

14. In virtually every society, women face discrimination in education, employment, and social status, resulting in economic vulnerability to HIV/AIDS. This includes, for example:

- discrimination that girls face in both educational institutions and the family; for example, girls who are encouraged to take different subjects from those taken by boys have less access to financial and other family resources, and are often withdrawn from school to assume domestic responsibilities;
- occupational segregation of women into low-paying clerical and service jobs, unequal pay and fewer promotions (*vis-à-vis* men), fewer workplace benefits and concentration of women in the informal sector;

- lack of access to technical assistance, training and credit; for example, in agricultural sector development, policies have traditionally provided funds and technical training to men involved in cash crop farming and not to women, who have been more likely to be engaged in subsistence farming.

15. Households headed by women are much more likely to be financially poor than those in which there is a working resident male. Women's economic dependence on male partners in order to avoid poverty for themselves and their children makes it difficult for women to negotiate safer sex practices to protect themselves from infection.

16. Some national laws reinforce women's economic dependence on men. Laws that restrict property ownership and inheritance to men, and in some cases limit women's ability to enter into independent contracts or obtain credit under their own names, impede women's ability to control income and property, and reinforce their economic dependence on male relatives. This dependence makes it difficult for them to refuse sexual practices that put them at risk of STDs and HIV infection. Laws regarding marriage, divorce, and child custody can impede women's ability to leave relationships in which they or their children are physically or sexually abused, or exposed to the risk of HIV infection.

17. Worldwide, many women rely on prostitution, or sex work, for economic survival. The proportion and the number of women who do so, in both developed and developing countries, is often directly related to the economy and the level of unemployment. In many parts of the world, prostitution is illegal and underground, which means that prostitutes may have to work without adequate control over the conditions of the sex work transaction.

A woman in Asia put in a nutshell the dilemma faced by so many women like herself across the world: "AIDS might make me sick one day," she said. "But if I don't work my family would not eat and we would all be sick anyway".

18. Migration as a result of war, famine, political oppression or poverty, can increase a woman's vulnerability to HIV infection if she is isolated from community structures, and does not speak or read the local language. Furthermore, women who are migrant workers, refugees or returnees are often more vulnerable than other women to some kind of sexual barter, (e.g., to obtain entry or residence permits, in exchange for transport, or to obtain or hold onto jobs), receiving financial support from men with whom they have sex, or engaging in formal prostitution. Similarly, when men migrate to urban centres, leaving wives and girlfriends at home, they may have other partners in cities.

19. There is often a lack of social and financial support to help women with HIV infection plan for the care of their surviving, and often healthy, children. This lack of support increases the emotional and psychological stress among women who understand that they are going to die while their children are still young. In some countries, as the number of children orphaned as a result of the epidemic has increased, some women have assumed responsibility for these children, taking them into their homes, often without any financial or other support, and often with inadequate space, food, or other supplies.

Female Biological Vulnerability to HIV

20. AIDS is essentially a sexually transmitted disease (STD), which like some other such diseases can also be spread through blood and blood products, and from an infected woman to her unborn or newborn child. Women are biologically more vulnerable than men to HIV infection and other STDs. Studies in many countries have found that male-to-female transmission of HIV appears to be 2-4 times as efficient as female-to-male transmission. Postulated as the major factors responsible for differential transmission are the larger mucosal surface area exposed to virus in women and the greater viral inoculum present in semen compared with vaginal secretions. Male-to-female transmission of some STDs is at least 15% more efficient than female-to-male transmission. Young girls are particularly vulnerable. Their immature cervix and relatively low vaginal mucus production presents less of a barrier to HIV, making them biologically more vulnerable to infection than older premenopausal women.

21. Other data suggest that STDs — especially those, such as chancroid and syphilis, which cause ulcerative lesions — greatly facilitate both the acquisition and transmission of HIV. However, women with STDs often are asymptomatic and fail to recognize any infections. As a result, women are more vulnerable to HIV infection because they are more likely to have untreated STDs. Often their vulnerability to STDs is the result of their partners' behaviour rather than their own. This increases the likelihood that they will not recognize low-grade infections. At the same time, women tend to avoid STD clinics for fear of being recognized and stigmatized. Women who do seek medical services often choose to go to primary health, family planning, and maternal and child health clinics for their care. Unfortunately, such facilities are often less well equipped to diagnose and treat STDs or may be unsympathetic or judgmental towards women with STDs.

22. Finally, women are disproportionately the recipients of blood transfusions and other blood products (e.g., for anaemia or childbirth complications). In the absence of adequate blood screening, women's vulnerability to blood-borne HIV transmission increases.

Impact of HIV/AIDS on Women

23. Because women are sexually, economically and biologically vulnerable to HIV/AIDS, they are often stigmatized and blamed for "causing" HIV/AIDS and other STDs. Women are frequently identified as "reservoirs of infection" or as "vectors for transmission" to their male partners and their offspring. This inaccurate view is actually harmful in a number of ways: it fails to focus on men's equal responsibility to prevent HIV/AIDS; it prevents programmes from developing services which meet the needs of women; and it underlies some research and intervention strategies which have been designed more to protect men from women than to enable women to protect themselves.

"All the gender issues we had never tackled came up at once", says Theresa Kadjage, a founding member of the Tanzanian AIDS Service Organization called WAMATA. "Initially we ignored them or thought they were irrelevant. We thought it was Eurocentric to tackle them in Africa. We thought our African culture was different and dealt with things in a different way. All the agendas that we had ignored - legal, educational and health problems, inequitable gender relations - suddenly we are dealing with these multiple issues, which people have not learned to analyze in a way that promotes equal sharing of both resources and power at all levels. In order to deal with AIDS, we have had to confront these."

24. Many people assume that if a woman has HIV infection, she has had multiple partners or engaged in prostitution and that such behaviour marks her as a "bad woman". As a result of this social stigma associated with HIV infection, women known or thought to be infected have been dismissed from their jobs or not hired, evicted from their homes, abandoned by their husbands or other long-term partners, and denied the custody of their children. In addition, women perceived to be at risk of HIV infection have been denied health insurance, and health care personnel have refused to treat women they thought were or might be infected.

25. Some countries have implemented mandatory testing schemes targeting women. Women who test positive or who are suspected of being infected suffer from increased discrimination, random and institutional violence, arrest, incarceration, and deportation. Most often such testing is without the woman's informed consent, and without appropriate pretest and post-test counselling.

26. Perinatal transmission can occur during pregnancy, during the delivery, or as a result of breast feeding. About 30% of children born to women with HIV acquire HIV infection; consequently women infected with HIV are sometimes pressured not to become pregnant or to be sterilized, or if they are already pregnant, to terminate their pregnancies. Women infected with HIV who wish to prevent conception or terminate a pregnancy may have little access to contraceptive measures or to safe abortion, increasing the likelihood that they will either bear an unwanted child or risk their lives in unsafe, illegal abortions.

27. Most societies rely on women to be voluntary caregivers for their families, as well as occupational caregivers for the community. Older women may be expected to assume a major caregiving responsibility at the same time that adolescent daughters may be kept out of school to care for younger children or other family members who are ill. The expectation that women will provide most of the care for people with HIV infection and AIDS results in high stress, especially if such care must be provided in addition to other work, including paid work outside of the home and family-centred work, such as subsistence farming. Such stress is compounded when the women become ill themselves, often with no one to care for them.

III. RESPONDING TO REALITY: AGENDA FOR ACTION

28. If the vulnerability of women to HIV infection is to be reduced, both men and women must work to counter gender discrimination and the subordination of women. Policy makers, community leaders and other people in positions of power must recognize the connection between women's economic and social status and their vulnerability to HIV infection. Men and women need to reassess the way they see themselves and each other, the way they relate as husband and wife, partners, lovers, brothers and sisters, parent and child, colleagues and friends.

"To enable women to protect themselves there are three issues at stake: improving the social and economic status of women; providing a method over which they have sufficient control; or getting more men to adopt safer sex. This is not an academic exercise in setting priorities, but a question of life and death for many women."
Dr Eka Esu Williams, Nigeria.

29. The inequality between men and women fuels the spread of HIV/AIDS. Unless the interaction between HIV infection, cultural values and the rights and needs of women is recognized, the fundamental change required to stem this pandemic is unattainable. While women require urgent consideration in the response to the epidemic, interventions must mobilize all sectors of society, including, and in particular, men.

30. It is important, therefore, to develop complementary and interlinked strategies for action, incorporating a gender analysis of the socioeconomic and cultural causes and effects of the pandemic. Specific activities are listed below.

Reducing the Vulnerability of Women to HIV/AIDS

Preventing HIV Infection among Women

31. Support the development of HIV/AIDS prevention interventions that provide the necessary messages, skills, and support services to men and women, including marginalized or hard-to-reach groups, such as migrants, the wives and non-marital partners of migrating men, women and men in prison, and adolescent girls and boys both in and out of school:

- increase girls' access to education, including access to scholarships and other financial assistance;
- support programmes that target both men and women with informed messages about the importance of using condoms to protect both partners from HIV and other STD, and about their mutual responsibility to engage in safer sex practices;
- support sex and HIV/AIDS education for young people (male and female) in school and out of school to increase their understanding and skills in human sexuality;
- support the development of sound HIV/AIDS workplace policies and effective workplace education programmes;
- remove obstacles to women's ability to earn money and engage in productive labour by supporting child care services, equal pay for equal work, employment training programmes, as well as small business and agricultural development programmes;
- ensure a safe blood supply through blood donations from low risk, voluntary, non-remunerated blood donors and test all blood for HIV.
- reduce unnecessary blood transfusions by improving women's nutrition, preventing anaemia, treating infections, preventing the loss of blood due to complications in pregnancy, and using blood substitutes wherever possible;

32. Reduce the incidence and prevalence of STDs among women by increasing their access to and utilization of appropriate STD services:

- develop appropriate educational programmes that target both men and women concerning the increased risk of acquiring HIV infection in the presence of an STD;
- fund activities that educate women how to prevent and recognize signs and symptoms of STDs and to seek appropriate health care services;
- provide high quality condoms through effective social marketing programmes and promote the use and distribution of lubricants and other agents that reduce the likelihood of microscopic vaginal lesions associated with sexual intercourse;
- improve the provision of STD diagnostic and treatment services for women, regardless of age or marital status;
- support research to better understand women's biological vulnerability to HIV, and the impact of contraceptives and other means of fertility regulation, and of pregnancy, on HIV infection and disease progression;
- advocate that biomedical scientists and private industry give top priority to developing a vaginal virucide or microbicide active against HIV and other STDs.

Reducing the Impact of HIV/AIDS on Women

33. Reduce the stigmatization and discrimination of women regarding HIV infection:

- encourage countries where mandatory testing or routine HIV screening programmes exist to replace them with voluntary, confidential testing supported by counselling services;
- support programmes that work with families and communities of women with HIV/AIDS in order to reduce the likelihood that women will be ostracized due to their HIV status;
- plan and implement HIV/AIDS prevention interventions with sex workers, and support self-help and advocacy organizations for sex workers;
- review the impact of laws and regulations relating to prostitution on working conditions as well as on the ability of HIV/AIDS and STD prevention activities to operate effectively.

Caring for Women with HIV/AIDS

34. Increase the availability of support services for HIV-positive women who want help with reproductive decision-making and for women with children who need help with planning for their care:

- ensure that women have access to voluntary, safe and affordable contraceptive measures;
- support programmes to assist women with HIV/AIDS in family planning decisions and planning for their surviving families;
- ensure that HIV-positive women are not pressured or forced to be sterilized, and that pregnant women with HIV infection are not pressured or forced to terminate pregnancies.

35. Ensure that women do not carry the entire burden of care for people with HIV/AIDS:

- encourage men and women to share in the caregiving role, and support interventions that provide training for women and men in basic health care procedures;
- support community-based institutions that can provide professional alternatives to home care and respite care for primary caregivers;
- encourage families to keep their daughters in school, and discourage them from relying on adolescent girls for caregiving responsibilities;
- support programmes and interventions to assist women and men who provide foster care to children orphaned as a result of HIV/AIDS and other diseases.

IV. CONCLUSION

36. The sexual and economic subordination of women continues to fuel the HIV/AIDS pandemic. Women are increasingly becoming infected with HIV and at a significantly younger age than men. At the same time, proportionately more girls and young women are becoming infected in their teens and early twenties than women in any other age group. Today, the stakes are higher than ever. The ways in which we respond to the pandemic now will influence the ways in which women participate and contribute in the twenty-first century.

ANNEX

Global HIV/AIDS Situation

Every day, over 6000 additional persons --- nearly half of them women --- are newly infected with HIV. Although Africa remains the most heavily infected area, the pandemic continues to spread throughout the world, particularly in Asia. Almost all countries are now reporting a growing number of infections. There is no doubt that the HIV/AIDS pandemic is now truly global, that no country will be spared, and that no country or population is immune.

Africa: As of mid-1994, WHO estimates that over 10 million adult HIV infections have occurred in Africa. Throughout all of Africa, heterosexual sexual intercourse is the predominant mode of transmission. More than one half of newly infected adults are women, and more than 5 million women of childbearing age have been infected. Perinatal transmission (mother to child) is also a widespread and increasing problem. As of mid-1994, WHO estimates that a total of approximately 900 000 children have been infected with HIV in Africa. As many as one in three pregnant women attending antenatal clinics in some major African urban centres are infected. HIV prevalences of more than 50% are found among some groups of female sex workers, with rates of 15-20% among people attending STD clinics.

Asia: As of early 1994, almost half of all adults newly infected with HIV in Asia are women. This compares with less than 25% just six years ago. Although the extensive spread of HIV in Asia began only in the mid-1980s or even later, the progression of the pandemic in this region has been particularly rapid. As of mid-1994, WHO estimates that over 2.5 million HIV infections have occurred in adults. While India and Thailand account for the majority of infections, rapid HIV spread into specific populations has been seen elsewhere in the region. This expansion of the pandemic is largely due to heterosexual transmission.

Middle East: The few studies which are available regarding this region suggest that the extensive spread of HIV began in some parts of the Middle East in the late 1980s. As of mid-1994, WHO estimates that close to 100 000 cumulative adult HIV infections have occurred in the Middle East and North Africa. HIV prevalence rates as high as 40% have been found among female sex workers in some countries.

Latin America: Since the mid-1980s, there has been increasing heterosexual transmission, principally among bisexual men and their female sex partners, and among female sex workers and their clients. HIV prevalence rates as high as 15% have been observed in some STD clinic attenders. As of mid-1994, WHO estimates that 2 million cumulative adult HIV infections have occurred in Latin America and the Caribbean, with one-quarter of all infections being among women.

North America and Europe: HIV began to spread extensively in these regions in the late 1970s to early 1980s. The people predominantly affected thus far have been homosexual or bisexual men and injecting drug users, together with their sex partners. However, the transmission of HIV through heterosexual intercourse increased during the latter half of the 1980s and the early 1990s, with especially noticeable increases in urban populations with high rates of injecting drug use or STDs. As of mid-1994, over 1.5 million cumulative infections in adults are estimated to have occurred in these regions.

Conclusions: Globally, the major route of HIV transmission to women is overwhelmingly through heterosexual intercourse. Women are increasingly becoming infected with HIV. From being almost absent from the AIDS epidemic in the 1980s, women infected with HIV now number more than six million -- with another one million women becoming infected this year. By the year 2000, over 13 million women will have been infected and 4 million of them will have died.

Figure 1
Estimated distribution of total adult HIV infections
from late 1970s/early 1980s until mid-1994

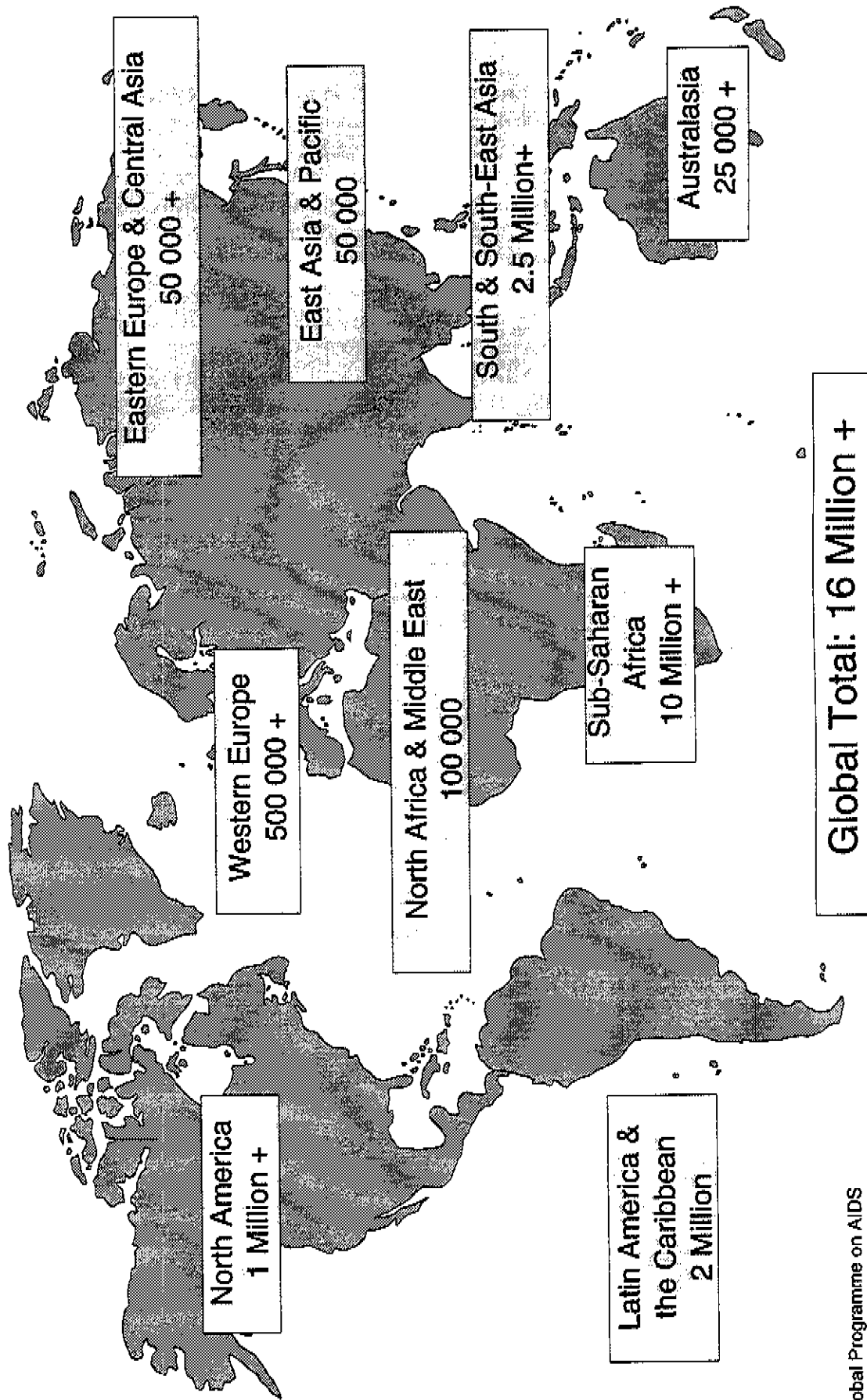


Figure 2
Projected distribution of HIV-infected women
(excluding AIDS cases) in 1995

