GENDER POWER IMBALANCES IN HIV/AIDS TRANSMISSION:

OPPORTUNITIES FOR CREATING AN ENABLING ENVIRONMENT

BY

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DECLARATION

This library research project is my original work and has not been presented for a degree in any university.

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This library research project has been submitted for examination with my approval as a University of Nairobi supervisor.

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TABLE OF CONTENTS

CHAPTER THREE: FINDINGS AND DISCUSSIONS

ABBREVIATIONS

The following abbreviations were used in the research paper.

AIDS	-	Acquired Immune Deficiency Syndrome
CEDAW	-	Convention for the Elimination of All Forms of Discrimination against Women
CIDA	-	Canadian International Development Agency
FAWE	-	Foundation of African Women Educationists
FEMNET	-	African Women's Development and Communication Network
FHI	-	Family Health International
FIDA	-	Federation of Women Lawyers - Kenya
FSW	-	Female Sex Workers
HIV	-	Human Immunodeficiency Virus
ICRW	-	International Centre of Research on Women
KANCO	-	Kenya AIDS NGO's Consortium
KENWA	-	Kenya Network of Women with AIDS
NAPs	-	National Aids Programmes
NASCOP	-	National AIDS/STD Control Programme
NGO	-	Non Government Organisation
RTI	-	Reproductive Tract Infection
STD	-	Sexually Transmitted Disease
STI	-	Sexually Transmitted Infection
SWAA	-	Society for Women and AIDS in Africa
UNAIDS	-	United Nations Programmes on HIV/AIDS

UNDP	-	United Nations Development Programme
UNESCO	-	United Nations Educational, Scientific and Cultural Organization
UNICEF	-	United Nations Children's Fund
WHO	-	World Health Organization
WOFAK	-	Women Fighting AIDS in Kenya

ABSTRACT

Since the AIDS virus was discovered two decades ago, it has claimed over 18 million lives globally, over 50% (or 10 million) of these deaths have occurred in sub-Sahara Africa. Available data show that women are at a greater risk of HIV infection. This situation has been aggravated by the high poverty levels of the people that has led to lack of basic amenities like food, water, sanitation services and access to education and health services.

The problems faced by women clearly indicate a degree of power disparities between women and men. This imbalance is in favour of men. This study reveals that women face socio-cultural, economic, political and legal obstacles, in addition to heightened biological vulnerability. These obstacles lead to differential HIV infection rates. Consequently, over 50% of HIV infected individuals are women. In Kenya, where poverty and unemployment levels are high, many women resort to commercial sex work as an alternative to economic survival. Unfortunately, these women (and most of other women) do not have the power to decide whether to use protective devices thus rendering them extremely vulnerable to infection.

This study also explores in detail the non-biological factors that help to maintain the gender power imbalances. Various recommendations are made to help reduce these imbalances. Specifically, any programmes that address HIV/AIDS and gender differences in society should focus on a supportive and enabling environment, facilitating access to information and services, research, changing the way we think, sensitizing and mobilizing men, combating discrimination and developing gender-sensitive care and support.

CHAPTER ONE: INTRODUCTION

1.0 INTRODUCTION

Ever since the first HIV/AIDS case was diagnosed in Africa, there has been a rapid increase in the number of cases reported. Some parts of the continent are more affected than others but Sub-Sahara Africa is the worst hit by the disease (Anarfi, 1994). Further, there are differences between men and women that account for the high HIV prevalence rates among women in Sub-Sahara Africa (Musinguzi, 1993; Anarfi, 1994; UN, 1994). UNICEF (1995) has estimated that women account for 55% of all new cases of HIV cases in Africa.

Although currently differences in levels of seroprevalence among men and women in Africa are not significantly pronounced, the risk of infection is not equal. It is estimated that the risk level for women is almost twice as high as that of men (Chin, 1991; Berer,1993; Prado, 1994). In this paper, I explore reasons for differential infection among men and women.

HIV/AIDS is a fatal condition, which has caused untold suffering to its victims, claiming millions of lives and disrupting societies and economies. In the absence of a known cure, research has focused on behaviour change as a short-term measure as research into vaccine development continues to show little but encouraging results. Behaviour change implies change in risky sexual behaviour. This involves modification of those behaviours and practices, which predispose individuals to HIV infection and building on those aspects, which protect them. Currently emphasis is put on what may be termed as the 'ABC' approach. This approach lays emphasis on abstinence, being faithful to one partner and condom usage. The ultimate aim is to promote "safe sex" practices.

Behaviour change is deeply embedded in cultural practices, which specify expectations of different actors in society. Depending on one's classifications, these actors may be young or old and men or women. The different expectations also imply different emphasis on specific behaviours among the actors, in this instance the men and women. This is the focus of this paper.

1.1 STATEMENT OF THE PROBLEM

The first HIV/AIDS cases were reported in Kenya in the early 1980's. Since then the epidemic has gradually spread taking millions of people down with it. It is currently estimated that AIDS may be responsible for 700 deaths per day or over 250,000 per year. Women, unfortunately, are the main casualties. For example, in the year 2000, out of 2.5 million global deaths, 1.3 million were women. Upto the year 2000, 17.5 million adults had succumbed to the disease of whom 9 million were women (Commonwealth Medical Association, 2000).

Kenya alone had 2.2 million people infected by the year 2000, of whom 1.2 million are women and over 100,000 are children. Table 1 shows the steady increase in HIV infections and AIDS deaths over the last fifteen (15) years. If HIV prevalence continues at the same rate, then by 2005, there will be over 3 million infected people, therefore increasing the number of AIDS related deaths.

Table 1: Projected HIV Prevalence

Year	Projected people infected with HIV	Annual no. of AIDS deaths
1985	100,000	40,000
1990	600,00	70,000
1995	1,500,000	120,000
2000	2,200,000	210,000

(Adopted from NASCOP, 1999)

In Nairobi, there were 70,300 reported AIDS cases between 1986 and 1998 (NASCOP, 1999). It is clear that slightly more than 50% of those infected are women

(Table 2). However, there are differences within different age groups; more women appear to be infected between ages 15-30 years. The reasons for these differences are explored in detail in Chapter two.

Table 2: Age and Sex Distribution of Reported AIDS Cases in Nairobi (1986–1998)[1]

Age Group (Years)	Male	Female
0-4	3,300	2,700
5-9	200	400
10-14	100	500
15-19	600	2,300
20-24	3,100	7,700
25-29	7,100	8,100
30-34	8,300	6,600
35-39	5,700	3,700
40-44	4,300	2,000
45-49	2,300	1,400
CUMM. TOTAL	**35,000**	**35,300**

(Adopted from NASCOP, 1999)

Further, Table 2 reveals several interesting facts:

- More than 75 percent of AIDS cases and therefore the resulting AIDS deaths occur to adults between the ages of 20 and 45 years.
- The peak ages of AIDS cases are 25-29 for females and 30-34 for males.
- Young women in the age groups 15-19 and 20-24 are more than twice as likely to have AIDS as males in the same age group.
- About 10 percent of reported AIDS cases occur in children under five years of age, most of them due to vertical or mother-to-child transmission.

These figures clearly show that women are more vulnerable to HIV infection than men. For a long time now, women have been portrayed as powerless victims or carriers of the disease. HIV/AIDS is not just a problem of powerlessness anymore; it is a societal problem that needs urgent redress. The purpose of this study therefore is to investigate factors that differentially impact more on women than men.

1.2 RESEARCH OBJECTIVES

1.2.1 GENERAL OBJECTIVE

To establish and understand how gender power imbalance influences HIV transmission.

1.2.2 SPECIFIC OBJECTIVES

1) To investigate how socio-cultural and economic differences between women and men influence women's vulnerability to HIV infection.

2) To understand how balancing gender power can help reduce women's vulnerability to HIV infection.

3) To examine the strategies that can be implemented to help curb the rate of HIV infection among women.

1.3 RATIONALE OF THE STUDY

The integration of gender perspectives into the fight against HIV/AIDS is a relatively new concept. This concept is spearheaded by Professor Peter Piot, Executive Director of the United Nations Programme of HIV/AIDS (UNAIDS) when he emphasizes that:

> *Gender inequality is a fundamental driving force of the AIDS epidemic and therefore must be addressed centrally in responding to the epidemic. Slowing down the spread of HIV means important changes are needed in relationships between women and men. Men have a crucial role to play in bringing about this radical change* (UNAIDS Press Release: Gender is Crucial Issue in Fight Against Aids, www.thebody.com/unaids.gender/html)

There is need to change the power imbalance between women and men to help curb the rapid spread of HIV/AIDS, especially in Sub-Saharan Africa. Gender awareness must focus on the needs of both women and men and integrate them into the fight against HIV/AIDS. This is the focus of my research.

1.4 METHODOLOGY, SCOPE AND LIMITATIONS

This paper is based on library research only. I have accessed over 100 sources of information on HIV/AIDS from different libraries and resource centres in Nairobi as well as from internet sources, notably from UNAIDS and ICRW. In this paper, however, I limit myself to literature I consider most pertinent to the topic under review. This being a library based research, I was limited to using already published work. The data relied on comes from figures already published as at the year 2000. However, I know that the actual numbers are higher, especially because many cases go unrecorded.

Due to a lot of published books, articles, internet postings and journals on women and AIDS, my scope of the research was very wide but it had to be narrowed down to Kenya and specifically to women in Nairobi. This was a major challenge as getting broken down data on infected men, women and children in Nairobi proved to be problematic.

1.5 OPERATIONAL DEFINITIONS

Gender refers to the roles and responsibilities given to women and men by society. These roles are influenced by perceptions and expectations arising from cultural, political, environmental, economic, social and religious factors as well as custom, law, class, ethnicity and individual or institutional bias. Gender attitudes and behaviours are learned and can be changed.

Gender power differences refers to the power imbalance between men and women in social, political, economic and legal issues.

CHAPTER TWO: LITERATURE REVIEW

2.0 INTRODUCTION

There is an enormous amount of research that has been done on areas pertaining to HIV/AIDS and its effects on women and children in particular. In fact, special organizations that deal with women and HIV/AIDS have been formed and are active in this field. These organizations include UNAIDS, KANCO, WOFAK, KENWA, WHO, UNDP, The Population Council. These organizations recognize women's vulnerability to HIV infection. For example, UNAIDS (2000) focuses on factors that promote women's vulnerability towards HIV/AIDS. It is estimated that 55% of all adults living with HIV/AIDS are women. Not only have women been reported as having a heightened physiological susceptibility to HIV infection (ICRW 1999), they also have an increased social vulnerability. Women have unequal access to education and economic resources. They wield less power than men in social and sexual relations (Mane, Gupta and Weiss, 1994). Entrenched stereotypes and differences in role expectations from the sexes also mean that women often have less to say in decisions about when and how sexual intercourse takes place, including whether or not a condom will be used. What is more, women more than men are likely to experience rape and sexual coercion, and sometimes forced to sell or exchange sex for their economic survival. In addition to their own increased risk of HIV infection, women also carry the lion's share of the social burden of the epidemic in terms of providing care for relatives with AIDS. Women with HIV infection also often experience more social blame and stigma than men in the same position.

2.1 WOMEN'S VUNERABILITY TO HIV/AIDS

The Kenya AIDS NGOs Consortium (KANCO) has done extensive research focusing on the factors that make women more vulnerable to HIV/AIDS infection. Vulnerability emanates from two sources: biological and socio-economic (KANCO 1997).

In biological vulnerability, the risk of becoming infected with HIV during unprotected sex is 2-4 times higher for women than for men. This is because women have a bigger surface area of mucosa exposed during sex to their partner's sexual secretions. Furthermore, in young girls and women, the uterine muscles are weak and underdeveloped and therefore lacerate easily during sexual intercourse. Similarly, semen infected with HIV typically contains a higher concentration of virus than a woman's sexual secretions; therefore the duration of exposure to the virus is higher for women (as they are depositories) than for men. This makes male-to-female transmission higher than female-to-male.

Women are also more vulnerable to other sexually transmitted infections (STIs) which often go untreated. Between one-half to four-fifths of STI cases in women go unrecognized because the sore or other signs are absent or hard to see and because women, if they are monogamous, do not suspect they are at risk. When the infections go untreated in either partner, the risk of HIV transmission multiplies by 300-400% (KANCO 1997). Women are brought up to accept ill health and thus have little or no access to appropriate health services. Similarly, women are often stigmatized by society and as a result, they are reluctant to visit STI clinics for fear of being recognized and discriminated against.

Most women have little control over how and when they have sex and this emanates from lack of social and economic independence. Socio-economic vulnerability is greater for younger women. The lack of economic independence together with perceived "safety" has caused a sexual behavioural shift of men towards them. This contributes to the high infection rate of women aged between 15-29 years. In some communities, men believe that having sex with young girls, preferably virgins will cleanse them of any sexual disease including HIV/AIDS. These men are normally older and referred to as "sugar daddies". They offer the young girls money, clothes, jewelry in return for sexual favours therefore giving them economic power. Girls in the same age group tend to have multiple sexual partners thus putting them at a high infection risk.

Similarly, millions of young girls are brought up with little understanding of their reproductive system or the mechanisms of HIV/STD transmission and prevention. They lack education on human sexuality because when it is taught in schools, girls are disadvantaged, especially in developing countries as they are taken out of school earlier than boys so as to be married off. In many African societies, parents prefer marrying their daughters at an early age to providing them with continued education. Unfortunately, this practice introduces a new dimension in the spread of HIV/AIDS. Girls who are taken out of school early to be married to older men, first, become economically independent on their husbands, and secondly, are likely to be widowed at a younger age. This exposes them to economic hardships and the temptation to seek sexual liaisons with other men, married or single, to ease economic hardships cannot be overlooked. Under these circumstances the likely unprotected sex enhances the transmission of HIV if one of the partners is already infected. This, in turn, has a multiplier effect (Nyamongo 2000).

Culture also dictates that initiative and decision-making in sex is a male domain, where male needs and demands are expected to dominate over the females. Male predominance often comes with a tolerance of predatory, violent sexual behaviour. For example, in some African communities, dry sex is preferred as it gives the men more sexual pleasure. The women are then subjected to inserting particular dried herbs into their vaginas prior to sexual intercourse, so as to achieve dryness. Unfortunately, this causes lacerations and wounds thus exposing the women to possible HIV infection, especially if the partner is already infected. This is done irrespective of the woman's discomfort and compliance.

Failure to respect the human rights of girls and women in terms of equal access to schooling, training and employment opportunities reinforces their economic dependency on men. This reliance may force them to sell themselves in exchange for opportunities like jobs, passing grades, getting trade licenses or even permission to cross a national border. Similarly, a woman in a stable relationship but economically dependent on her partner cannot afford to jeopardize his emotional and financial support even when she suspects he has HIV. If she refuses him sex or asks him to use condoms, it is construed as an admission on her part of being unfaithful. While some men agree to use condoms, others mete out violence on their partners.

Poverty has forced many women into prostitution (commercial sex work). Commercial sex work constitutes another setting in which women have little power to protect themselves from HIV. Girls forced or sold into sex work are generally unaware of the AIDS risk and unable to run away or take protective action. The sexual exploitation of girls is one of the most pernicious forms of child abuse. However, not all prostitution is

forced, some women turn to it as an alternative to dire poverty therefore increasing the risk of contracting the virus.

Olenja (1998) focuses on the socio-cultural, economic and demographic risk *factors involved in HIV/AIDS transmission. The rapid rural-urban migration, imported cultural models, social dislocations and multiple economic pressures*, including poverty through recession and structural adjustment programmes have taken their toll on women. With low education, women are disadvantaged in the labour market and as economic conditions, particularly in Kenya decline, the limited opportunity in the labour market forces many women to engage in sex work. The need for income precludes any other considerations including safer sex even when the awareness has been created. Therefore, economic circumstances become a motivation for female sex work and at the same time, a risk factor for HIV/AIDS transmission. Economic dependence on men makes it difficult for women to insist on mutual fidelity or condom use (WHO, 1993).

Several cultural practices have been identified to be detrimental to women's reproductive health as these practices facilitate the rapid spread of HIV/AIDS. They include:-

- Rites of passages such as female genital mutilation where unsterilized instruments are used on many initiates;
- Early marriages (sometimes forced or arranged) and consequently early sexual debuts of young girls;
- Societal tolerance of multiple sexual partners for males;
- Polygyny (where the sexual relations of at least one person extends beyond the polygynous unit) and levirate (widow inheritance) relations;

- Frequent or prolonged separation of spouses due to labour migration; where the men patronize prostitutes or have casual sex in the growing urban centres;
- Availability of significant populations of female sex workers, seeking sexual contacts in exchange for money.

It is therefore stressed that the dynamics of gender power relations are a major focus of research, particularly in relation to women's reproductive health in the fight against the spread of HIV/AIDS.

2.2 CONSTRAINTS TO SAFE SEX

The literature presented in this chapter points to one key aspect of HIV/AIDS and women; that, by far, the most important component of the transmission is not their biological vulnerability. Rather, the socially triggered components are of greater significance. In some cases, in fact, they accentuate women's biological vulnerability. Consequently, any approach that socially empowers women to take control of sexual relations will enhance the strategies against HIV/AIDS.

Gallois, Statham and Smith (1992) have argued that women do not constitute a 'risk group' for HIV infection in the usual sense of the term because women do not usually infect each other but instead acquire HIV mainly through their relations with men. Women's attitudes towards sex and sexual behaviour differ considerably from those of men, preferring sexual relations based on mutual fidelity, intimacy and open communication. They have fewer partners than men. When women do express a desire for safer sex, men are often obstructive. Perhaps not surprisingly, therefore, the major HIV risk for women is their regular sexual partner or husband. Dominant ideologies of masculinity on the other hand promote the display of sexual prowess and encourage men to have multiple partners.

Many existing HIV prevention strategies fail to take adequate account of the social vulnerability of women or the unequal power relations that make it difficult for women to influence decision-making in their sexual relationships. The key elements of many programmes – partner reduction, condom usage and STD treatment – are not necessarily appropriate for women who do not have multiple partners, cannot influence the decision to use condoms and may be asympotomatic to STD's (Goodridge and Lamptey, 1999). HIV prevention strategies need to take into account the social disadvantaged position of women and empower them adequately so as to be effective.

Reid (1990) has stressed that women need empowerment in order to protect themselves and their children from HIV/AIDS. She notes that in developing countries, the three main prevention strategies are reduction of number of sexual partners, condom usage and faithfulness in relationships. These strategies have their merits for men but the same cannot be said of women. For example, preliminary data from African studies show that 60 – 80% of all infected women have one sexual partner. Therefore is of little relevance to the women's lives nor to the lives of those women who are forced to sell or exchange sexual intercourse due to economic hardships. Condom usage empowers men but not women. Negotiating for condom usage is a rare skill among women as most women do not use them nor do they have the ability or leverage to protect themselves in this way. For most women, spousal faithfulness in the relationship is not within the women's power to negotiate therefore leaving them unprotected against possible infection. The key question that emerges from all this is; ***is there hope for women***? This is my focus in Chapter three.

CHAPTER THREE: FINDINGS AND DISCUSSIONS

3.0 INTRODUCTION

In this chapter, I synthesize the findings from the literature reviewed in Chapter two. What emerges from the literature is the clear imbalance of power in favour of men. This imbalance at once raises important issues in dealing with the spread of HIV/AIDS. In the following sections, these issues are delved into deeper. In the first section, I deal with gender, sexuality and HIV/AIDS. In the section following, a gender-based response is discussed. Longer-term strategies to deal with the problem are highlighted and, in order to put the strategies in place, a supportive and enabling environment is crucial. This is the focus of section three. As well, there is need to develop a mechanism to facilitate access to information and services, conduct research relevant to gender-power imbalance, change the way we think and act towards HIV, sensitize and mobilize men, combat discrimination as well as to develop gender-sensitive care and support.

3.1 GENDER, SEXUALITY AND HIV/AIDS

Gender is a culture-specific construct – there are differences in what men and women can or cannot do. These change from one culture to another. But what is common across cultures is that there is a distinct difference between women's and men's roles, access to resources and decision-making authority. Men are usually responsible for the productive activities outside the home while women are responsible for the reproductive and productive activities within the home. Women, however, have less access to and control over productive resources like land, credit and education. While the extent of this difference varies considerably from one culture to the next, it almost always exists.

Sexuality is distinct from gender yet intimately linked to it. It is the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behaviour; it is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, influence an individual's sexuality (Zeidenstein and Moore 1996).

A gender perspective is needed where issues in which being a woman and being a man have different consequences owing to the power imbalance between them. This does not mean that women are powerless and oppressed while men are powerful. On the contrary, it means that, men as a group hold the balance of power over women as a group and can exercise that power individually on the basis of their social status. This happens inspite of women's own abilities and power (Commonwealth Medical Association, 2000).

The reason to develop a gender perspective is to find solutions to this power imbalance and to redress that imbalance of power in favour of women. Therefore, a gender perspective is a women's rights perspective too. There are three main areas where gender and prevention of HIV infection intersect, that is sex, health and rights. I deal with these three areas in turn.

3.1.1 Sex, sexuality, sexual education and behaviour, sexual relationships and safer sex.

Sex education is needed for children, for adolescents (in and out of school) and for their teachers, parents, older caretakers and grandparents (who are increasingly responsible for the upbringing of AIDS orphaned children). It is imperative to note that this education must begin before young people start having sex as it helps them postpone unwanted sex

and protect themselves better when the time comes. Similarly, parents would benefit from this education as they need to keep up with the trend of their children.

Sexual behaviour is currently shrouded in a culture of silence and treated as a very private matter. It is necessary to socialise this issue and talk about sexual behaviour, especially those that create a risk, openly and identify the differences in what women and men do to put themselves and each other at risk. Women cannot be expected to take men on individually in isolation about their risky sexual behaviour as this often precipitates violence. Therefore a collective approach is needed, where men challenge men first and foremost and then women can challenge men collectively.

It is also important to develop and promote images of sexuality together with accompanying messages that help create 'safe sex' ethos. Unsafe sex is the social norm in almost every society and social group and the current media programmes normally propagate this by expounding on a romanticised notion of sexual dominance where sex is spontaneous, rather than being premeditated. This serves to make the practice of unsafe sex appear attractive and less destructive thus promoting risk-taking rather than mutual respect and protection. What are really needed are programmes that portray passion together with autonomy, equality, mutual respect and protection in sexual relationships. Challenging the existing dominant images and messages in the media is a major task.

3.1.2 Women's and men's health, reproductive and sexual health.

Health determinants include economic and political development and democracy; poverty eradication; education; housing; employment; health services; social welfare services and support for those who need care and support. Women of all ages also need an independent income so as to access good health. However, in many African societies,

since women are financially dependent on their husbands, they require permission from their husbands or male relatives, to go to hospital or even to attend clinics. On the other hand, men, since they have the upper hand in the power equation, they have easy access to the health determinants and therefore their health is not really at any risk.

The determinants of women's sexual and reproductive health are related to fertility, pregnancy/birth and the post-partum period, birth control, infertility, reproductive tract infections (RTIs) which include sexually transmitted infections (STIs) and reproductive diseases such as cervical cancer. These are clearly women's issues, which include women's HIV/AIDS issues (Commonwealth Medical Associations, 2000). The gender-related question is really whether and how these issues involve men in ways that promote and enhance women's sexual and reproductive health and well-being while at the same time helping to prevent women dying from diseases related to sex and reproduction. It is simple and clear: women have to change in order to take control of their lives. They have to be willing to be empowered socially, economically and politically so as to balance the scales of power. Men too, have to change, and differently, for women's sake as well as for their own.

3.1.3 Universal human rights, women's rights (reproductive and sexual)

Combating discrimination and stigmatization is an important aspect of ensuring that women's human rights are not violated. Human rights are by definition universal and indivisible, and no on can be stripped of them. Women's reproductive rights apply to them exclusively, as they are the only ones who can get pregnant. However, they are regarded as a subset of human rights. Why? Because they apply to women only.

There are several human rights issues, which are commonly raised in relation to HIV/AIDS, and they are not gender neutral. These include issues such as stigma, discrimination and the right to confidentiality. Cases have been reported of women who are stoned to death, fired from their jobs, kicked out of their marital homes just because they have AIDS (in most cases, these women get the virus from their male partners who have already passed away). Such discriminate action against the infected women is a violation of human rights.

Voluntary counselling and testing, informed consent in research, disclosure and partner notification are other issues that need serious consideration. Most women are offered an HIV test for the first time in antenatal settings for the sake of their infants, not for themselves, at a point and in a place when the offer of having the test with their partners is least likely. Similarly, the risk of spousal violence against HIV positive women has been shown to occur where a woman is tested for HIV first and by herself. When she informs her partner, he blames the infection on her, regardless of whether he is positive or not. Testing strategies thus need to address these gender-related practices and find ways to provide testing for both women and their partners at the same time. Counselling and testing of couples before pregnancy has been shown to best support women in the their relationships and reproductive rights and yet the two together remain an unusual practice almost everywhere. So, the only hope for women lies in a gender sensitive response towards the disease.

3.2 WHAT DOES A GENDER – BASED RESPONSE INVOLVE?

Governments and NGO's are now beginning to integrate a gender perspective into their HIV/AIDS/STD's programmes. Women living with HIV/AIDS are playing an increasingly important role in the process of educating and informing the public about HIV/AIDS. But what does a gender-based response entail?

The goal of a gender-based response to HIV/AIDS is to decrease vulnerability to infection, reduce stigmatization and discrimination and curb the epidemics socio-economic impact. This will best be achieved through gender-based approaches promoting shared responsibility for prevention and care between women and men (WHO, 2000). Gender sensitive strategies must address both short and longer term needs and goals. Short-term strategies focus on people's immediate needs in specific communities, including obtaining basic information about HIV/AIDS and STD's, gaining access to sexual health education, acquiring condoms, providing women with female condoms and obtaining back-up support for home based care. Longer-term strategies are aimed at underlying cultural and social structures. They aim to promote mutual respect between men and women and equal access to all types of resources and facilities. The goals of longer-term strategies include but are not limited to:-

- Changing societal norms, structures and ideas that keep women in an inferior social position.
- Achieving shared decision-making power between men and women at all levels in relationships, community, political and economic affairs.
- Creating structural changes to give women equal access to education, training and income-earning opportunities.
- Reallocating work responsibilities so that women and men share them fairly.

- Encouraging legalization of traditional marriages or unions so as to strengthen the rights of women to property inheritance and children.

3.3 A SUPPORTIVE AND ENABLING ENVIRONMENT

The social environment must enable people to achieve effective prevention of HIV/AIDS and care incase of illness. Policy, legal and human rights, economic, social, cultural and educational structures are needed to benefit women to the same extent as men. If such structures were developed, then women will have a much better chance to change the social norms, values and traditions oppressing them in their daily lives. Although structural changes take time to achieve, strategies must be developed to address them at the same time as grass-root initiatives improve women's daily life situation.

3.3.1 Structural measures

Decreasing women's economic dependence on men is an important step towards enabling them to reduce infection risks for themselves and their families. For example, CIDA has established a credit scheme which provides financial supports to FSW's in Nairobi who request for and seek alternative livelihood sources to reduce their dependence on sex work incomes. This programme has enhanced women's autonomy and self-confidence and led to a change in sexual behaviour, for example, number of sexual partners has reduced, condom usage increased and the STD prevalence has dropped. In addition to income generating, other structural measures are necessary. These include guaranteeing women:-

- Better access to schooling, vocational training and higher education.
- Equal access to employment opportunities and equal pay for equal work.
- Equitable access to social and health services.
- Legal and human rights protection equal to that of men.

- Better representation in political, legislative and economic bodies.
- Freedom from restrictive cultural expectations and practices.

3.3.2 Political and Community Support

Broad political and bureaucratic support is necessary if the Kenyan government is to implement the measures outlined above. The stigmatization and discrimination associated with HIV can be reduced significantly if politicians, high-powered people and the population in general came out and talked openly about HIV/AIDS. Asking people to abstain from sex for two years is not an effective strategy to prevent HIV/AIDS transmission! The culture of silence that Kenya has developed needs to be broken and support mobilized for a gender-based response to the epidemic. This can be done by formulating policies that provide various ministries and NGO's with a framework for action.

Similarly, National AIDS Programmes (NAPs) should be made intersectoral, involving all ministries, women organizations, associations created by people living with HIV/AIDS, NGOs and churches. Analysis of gender disparities and women's disadvantaged socio-economic status should be incorporated in the NAPs policies. By determining how gender disparities affect women through out their lifetime, in public and private spheres of life, interventions can be facilitated at community, school and workplace levels to ensure that girls do not grow into adults with increased vulnerability to HIV/STD infection. Interventions also need to take account of women's responsibility for providing family and community care. Programmes developed by social welfare agencies, NGO's and employers should make provision for these responsibilities. Similarly, education and communication programmes should encourage the sharing of domestic responsibilities and tasks between women and men. Only when Kenya

addresses gender disparities squarely in it's economic, political and social development strategies and incorporate women's concerns into HIV/AIDS programmes, will there be a sustainable impact on prevention of HIV/AIDS.

The media can also serve as a channel for information. It can mobilize public support for gender sensitive programmes by highlighting the effects of the epidemic on women and children. It can also produce programmes dealing with women's concerns and issues therefore providing women with a forum to air their views. Personalising the epidemic also works well; when people tell their stories, they provide concrete examples rather than distant images of 'AIDS victims' or 'HIV carriers'. Most importantly, media workers must be enlisted to help create a climate tolerant towards those affected by or responding to HIV/AIDS. This is clearly captured by the testimony of a Caribbean woman living with HIV:

> *"The most critical decision of my life was to reveal to representative of the Caribbean media that I had tested positive for the AIDS virus. Coming face-to-face with a battery of journalists was a nerve-racking experience. I decided to impose this agony on myself in an effort to dispel some of the myths surrounding HIV positive people ... During my presentation, information that would usually be regarded by journalists as a "juicy story" was instead treated as a moving commentary. On the admission of some of the journalists, my presence and commentary were edifying and represented their first opportunity to understand the plight of HIV infected people". A woman living with HIV,* (KIT, SAfAIDS, WHO, 2000)

3.3.3 Policy making and agenda setting

To ensure broad-based support, all agencies, NGOs and government ministries must add HIV/AIDS and STDs to their action agendas. In this way, alliances for policy-related advocacy as well as initiatives will arise at the national and community levels. For example, the Society for Women and AIDS in Africa (SWAA) raises political awareness

concerning gender in relation to HIV/AIDS and STD's and provides a voice for women in many parts of the continent.

In addition, issues of access to women controlled preventive measures should be given prominence. For example, the female condom should be promoted as a method that women can effectively use to protect themselves. Unfortunately, in sub-Saharan Africa, the female condom is expensive and cannot be afforded and accessed easily by majority of the women who live below poverty level. Governments should institute policies and structural measures that ensure affordability and accessibility of the female condom.

3.4 FACILITATING ACCESS TO INFORMATION AND SERVICES

Printed materials can be improved by involving women and men in creating more appropriate messages and materials that address their specific needs. Including HIV/STD information in a variety of health programmes such as ante and postnatal clinics, mother and child health and family planning clinics reaches more people. Community counsellors, women and men associations, church-based groups, sports and recreational clubs provide entry levels for individual and group educational sessions. Similarly, training peer educators has proved particularly effective among women.

NAPs and NGOs are reorienting services to better meet the needs of women and men. They are providing information and condoms to women and men at sites they visit regularly, for example, nightclubs, supermarkets, clinics, and hair salons. Clinics are being relocated nearer to where people live. For example, there are STD clinics located in slum areas like Dandora and Majengo where female sex workers get treatment without feeling stigmatized. However, accessibility and acceptability of STD clinic services must

be increased; stigmatization by and negative attitudes of hospital or clinic staff must be reduced so as to reduce women's vulnerability to HIV/AIDS.

3.5 RESEARCH

Biomedical studies on opportunistic infections in women and ways to reduce vertical transmission are increasing in scope but need expansion. More support is required for research on female controlled methods to prevent HIV/STD infection, especially on the female condom. This way women would be empowered to protect themselves against HIV/STD infection and thus gain more leverage in controlling how sex takes place. Currently, researchers have given priority to the development of microbicides, which appear to have a great potential for acceptance. A microbicide is any substance that can substantially reduce the transmission of STI's when applied in the vagina or rectum. Other important points to note for a gender sensitive research agenda include:-

- Barriers to female control over HIV/STD risks and ways to overcome them.
- How young women and men define personal risk in relation to different types of relationships.
- How women and men currently protect themselves from infection.
- Barriers to female and male STD treatment and how to improve access.
- The appropriateness of counselling messages and methods in meeting women's and men's specific concerns.
- Partner notification, confidentiality and information sharing.
- Division of labour concerning reproductive and productive tasks at the household and community levels and how these contribute to maintaining women in their current lower status and increasing their burdens related to care.

3.6 CHANGING THE WAY WE THINK AND ACT

Programmes can facilitate community exploration of how gender is related to prevention and care by addressing the following issues:

Beliefs: People should be assisted to re-examine ideas related to HIV/AIDS/STD's and sexuality, which hinder prevention. For example, belief that men need to release semen to be healthy, men need to have sex with virgins to cleanse themselves of any infections.

Relationships: Definition of relationships, kind of sexual contact involved in casual or regular relationships, decision-maker in relationships, circumstances that increase or decrease HIV/STD infection are issues that need to be explored and answered.

Power between women and men: How can power relations between the two be changed? How can women gain greater control over their lives and situations contributing to their risk of HIV/STD infection?

Care and support: Who provides what types of care and support to family members and needy people in the community? Why is care taking divided between women and men in a particular way? What can be done to ensure that women and men both participate actively in providing care and support?

These can be done through participatory groups, which increase awareness and motivate adults and youth to devise solutions to the gender-based problems identified. Skills building is also important so that women and men can learn how to talk openly about sex, resist pressure from peers and partners to engage in unwanted practices and stand up for their rights.

Changes in attitudes need to begin in childhood. Although parents are expected to play the primary role, it is normally difficult for them to talk to their children. NGO's and

schools need to offer courses and activities for school going children and out-of-school youth that explore gender relations, values, sexuality and related issues. As few teachers and youth workers have been trained to deal with such subjects, organisations like UNICEF, WHO, UNESCO as well as NGO's are assisting governments to develop appropriate materials and training programmes for them. Training of youth peer educators has also shown promising results.

3.7 SENSITIZING AND MOBILIZING MEN

Men must be sensitized and mobilized to a greater extent for an effective response to HIV/AIDS and STD's. Since men occupy most positions of influence, their participation in advocating gender-sensitive policies and programmes is essential. The training and collaboration of influential men like chiefs, pastors, businessmen, village headmen in educational interventions and home and community based care is most important. They act as role models for the community and can set the example for acceptance of 'new' ideas concerning men's and women's responsibilities in preventing HIV transmission and coping with AIDS.

Men can be approached through their work or socialisation places. A good example is that of the Heterosexual Men's Project in New South Wales, Australia which conducted focus-group discussions with building workers to determine what was important to them in preventing HIV prevention. Two issues were highlighted by the workers; role of alcohol in promoting unsafe behaviour and difficulties in communicating about sex with women.

Based on the men's suggestions, a campaign was designed using messages on beer coasters and toilet stickers in pub and clubs (see for examples Figure 1 and Figure 2). The beer coasters used 'themes' to demystify safe sex and challenge some male sexuality myths. The toilet stickers aimed to facilitate discussion of condom use between men and women by providing humorous icebreakers. Evaluations showed that 50% of the men familiar with the campaign saw it personally relevant: 19% of those who read the beer coasters and stickers said they were helpful in providing conversation starters on safe sex with their partners, 27% said it led them to discuss this with their colleagues. Generally, the campaign messages were best recalled by men 18 to 24 years old, single men and condom users.

Figure 1: **Messages on beer coasters based on the Heterosexual Men's Project in New South Wales, Australia.**

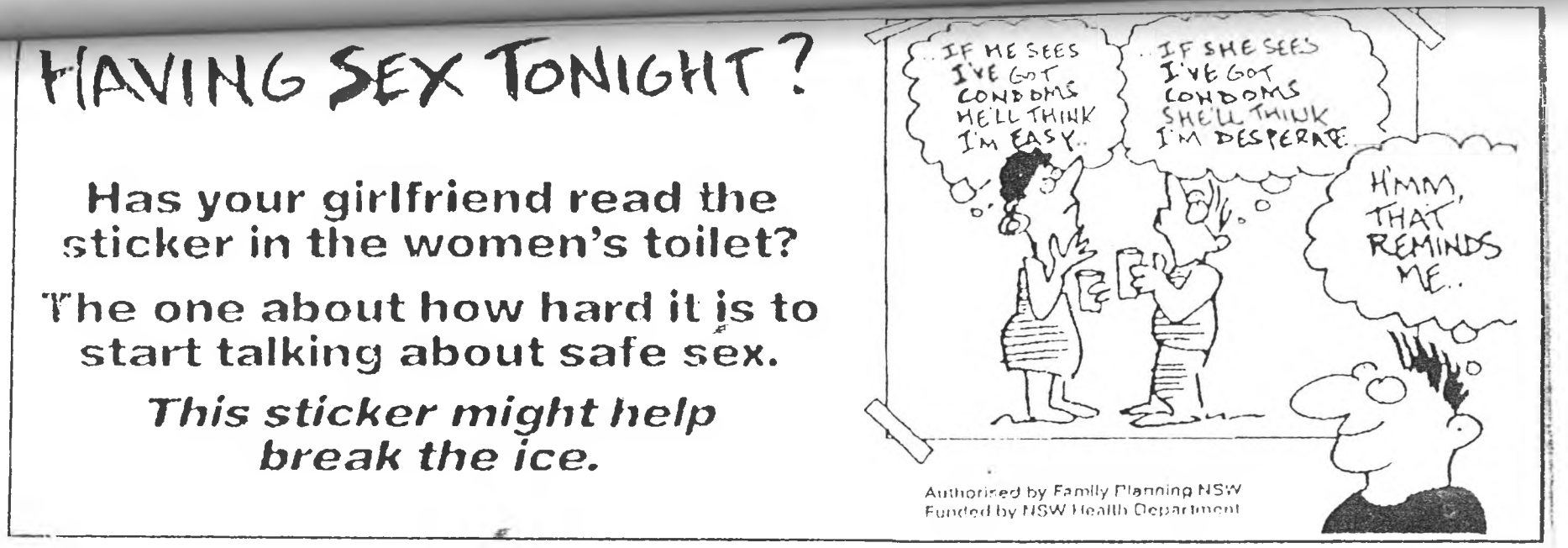

Figure 2: **Wall sticker from the Australian Heterosexual Men's Project in New South Wales.**

3.8 COMBATING DISCRIMINATION

People living with HIV/AIDS still face stigmatization and discrimination. Combating this is an important public health strategy. Educational messages can emphasize the need for solidarity with those who are discriminated against. A first step is to explain how HIV is and is not transmitted, exposing false myths and associated fears. These messages can be communicated through print and electronic media.

NGO's also play a useful 'watchdog role' regarding human rights violations. Lobbying for changes in discriminatory laws and the passage or endorsement of protective ones (for example, CEDAW) is another important action area. A lot of work must be dome to change customary and written laws so women have legal recourse in cases of abuse, loss of maintenance and discrimination over inheritance. Many women are unaware of their rights and do not know that they are legally protected against certain abuses. This knowledge gap is slowly being filled by lawyer groups and NGO's through 'legal literacy' programmes and civic education making the law accessible to women and promoting their capacity to understand and assert their rights. For example, in Kenya, the Federation of Women Lawyers (FIDA) holds "Legal Aid" clinics every month in rural areas to help women be more aware of their legal rights.

3.9 DEVELOPING GENDER-SENSITIVE CARE AND SUPPORT

A first step towards making care and support systems more sensitive to the specific needs of women and men is to re-evaluate policies and assess whether they are gender sensitive. Training programmes for care-providers and counsellors need adaptation so that they, for example, respect women's wishes and needs regarding pregnancy, breast-feeding, abortion, sterilization and deal with the negative consequences of testing women but not their partners for HIV.

Follow up counselling and support for women and men living with HIV/AIDS required expansion. Social and legal assistance must be available even when people cannot pay. Women's lack of money worsens their burden when they care for family members and yet lack care for themselves, especially if the husband dies first. Seropositive women need ways to generate income despite suffering periodic bouts of illness.

Because much of the care and support for people affected by HIV/AIDS now falls on women's shoulders, a major task is to find ways of lessening women's extra workload. One such way is to provide help with home care nursing. Analysis of successful programmes is needed to determine what it is that motivates people, especially men, to volunteer their time, energy and resources to community and home-based care and support. Insights then need to be shared widely so that new initiatives can benefit from them and volunteer support can be maintained.

3.10 CONCLUSION

This study set out three objectives; namely to understand the vulnerability of women to HIV/AIDS due to the cultural and socio-economic differences between women and men; how to reduce this vulnerability by balancing gender power between them; and to identify and examine gender sensitive strategies that can be implemented to curb the high infection among women.

It is clear from the foregoing that there is a close link between HIV/AIDS and gender issues. Although women account for more than 55% of the adult population in the world, they are marginalised in relation to access to education, training, health services, productive resources and employment opportunities. One in every three women lives in abject poverty lacking basic amenities. These poor conditions deprive them of economic, social and legal power thus making them vulnerable to various preventable diseases like malaria, typhoid, dysentery and cholera. This link also exists in relation to sex and sexuality, sexual and reproductive health, human and women's rights especially sexual and reproductive rights. The most important gender issue is that women of all ages are still being sidelined in terms of access to prevention, treatment, care and resources. They are being denied access to protection of condoms and other forms of safe sex, as they cannot afford these preventive devices. Women's poor status prevents them from getting first priority in HIV/AIDS related care (in either treatment or vaccination) or in actually implementing any prevention programmes.

In order to help reduce women's vulnerability, they need to be socially, politically and legally empowered. Empowerment is an issue within the broader context of gender and development and it can only be done through education. Women need equal access to educational facilities so as to empower themselves, their families and their

communities. However, power relations between men and women also need to be shifted so as to give women more authority and power in the family and community. This shift can only occur when men, as the other constituent of gender, are educated in areas that are viewed as the natural preserve of women, for example, reproductive health and family planning. As men tend to have greater authority in the family, they would have the potential of influencing areas pertaining to family life and health and this would be a major step towards empowerment of both women and men. A positive effect could follow from a collaborative nature of the relationship that would result as the balances of power begin to subtly shift within the family. Women would find themselves interceding from a relatively weak position for themselves and their children if the men remain isolated. The challenge therefore is, firstly, to educate women so as to empower them in both private and public spheres of life and secondly, to bring men into the fold so as to begin recognising their responsibilities towards the health of the family and the community.

Lastly, any strategy that is used to fight HIV/AIDS needs to examine and address the power imbalance between men and women. The strategies outlined in this paper have laid emphasis on empowering both men and women and involving them in the fight against the spread of HIV/AIDS. Only when social and legal power imbalances are addressed, and women given preventive measures that address their needs and concerns, will the fight against HIV/AIDS be effectively dealt with. In the words of Peter Piot:

It is simplistic to think in terms of evil transmitters and innocent victims. In the AIDS game, there are not winners or losers, just losers. Women and men must be helped to understand that by protecting themselves, they are protecting others and the future generations (Piot, 2000).

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