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Gender, Youth and AIDS

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* The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations.

Summary

In this paper I discuss how prevention of the spread of the HIV/AIDS epidemic is central to the successful realization of the Beijing Platform for Action (Platform), as well as to the achievement of the Millennium Development Goals (MDGs). I also argue that this relationship is mutually reinforcing, as the war against AIDS will not succeed without addressing gender inequalities. Specific recommendations for a gender sensitive strategy are presented.

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Introduction

Tragically, 2005 began under the signal of destruction and desolation, when a shocking 170,000 people across multiple countries died within mere minutes as a result of the Tsunami in the Indian Ocean[2]. This unprecedented natural disaster forces us to confront accompanying ongoing socio-economic inequality, political instability and a generalized lack of human security. One of the challenges that have recently received media attention is the risk of trafficking of children who were orphaned or separated from their families, to be "exported for sale as sex slaves or sweatshop labor", in a business that involves an estimated $12 billion annually.[3] This phenomenon reflects just one dimension of the ongoing threats to global health, safety, and equity as addressed in the Beijing Platform for Action. Natural disasters such as the December Tsunamis or conflicts and wars further aggravate a reality already marked by all types of violations and inequality against women and girls.

The AIDS situation today, ten years after the Beijing Platform of Action

Today it is becoming increasingly clear that HIV and AIDS are fundamental threats to the broader realization of the goals of the Beijing Platform for Action but ten years ago the governments gathered in Beijing felt short in recognizing this. For example, in Chapter III "Critical Areas of Concern," there is no mention of either HIV/AIDS or sexual health. Although these topics are briefly addressed under the lengthy strategic objectives and actions, they are not established among the most significant barriers to female empowerment. It is important to mention, however, that the Platform was an important step in combating the HIV/AIDS epidemic, and helped to lay the increasingly solid foundation of awareness and action. However, having aged 10 years, the Platform is no longer an up-to-date, advanced strategy. The more recent MDGs provide a more contemporary strategy to address today's epidemic.

Ten years ago, when the Platform was issued, HIV and AIDS were viewed mainly as a health problem. Now, ten years later, the situation has shifted; HIV is now recognized as posing enormous threat, ranging from endangering individual health to hampering international

[1] Great help from Jane Galvão and Jessica Halverson is grateful acknowledged.
[2] Butcher, 2005
[3] *The New York Times*, Jan 13, 2005

development to destabilizing nations-states.[4] The numbers suggest the frightening dimension and breadth of the epidemic's impact: in 1995 the total number of people living with HIV and AIDS was around 19.5 million, 8 million of which were women[5]; by the end of 2004, 40 million people are living with HIV and AIDS, and 20 million of those are women.[6]

In many countries, HIV and AIDS are not only devastating the present, but also destroying the hope of a better future, especially in the least developed regions. According to the U.S. Census Bureau, "at the beginning of the 21st century, AIDS is the number four cause of death globally but the number one cause of death in Africa".[7] This phenomenon reveals the global impact, but also the ongoing regional disparities reflected in the epidemic. HIV and AIDS are ravaging countries and even entire regions of the world, with Sub-Saharan Africa as the most dramatically affected. In some places in Africa as well as other countries hit hard by HIV, such as Haiti, the synergy of the epidemic coupled with natural disasters, wars, civil conflicts and extreme poverty, increases the population's vulnerability to HIV infection.[8] For example, "life expectancies are projected to be 10-14 years lower in Honduras, the Bahamas, and Guyana than they would be without AIDS"[9]. In Trinidad & Tobago, "40 percent of under-5 deaths are likely to be due to AIDS".[10]

With this situation in mind, in June 2001 the United Nations promoted a General Assembly Special Session on HIV/AIDS (UNGASS), recognizing that the world was facing a global crisis and that the response to this crisis demanded global action.[11] Following the UNGASS, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was created in 2002 to address these three deadly threats to health and their devastating impact on developing countries (GFATM, n.d.). More recently, in 2003, the World Health Organization launched the "3 by 5" campaign. The aim of this initiative is to treat 3 million people in developing countries with antiretroviral therapy by the year 2005.[12]

The last decade has seen some achievements regarding HIV and AIDS, including advances in treatment and a better understanding of the importance of a multi-sectoral response. Nonetheless, existing measures remain insufficient and inadequate. Here are some examples of current unmet need:

- "Globally, fewer than one in five people at risk of infection [by HIV] have access to basic prevention services";[13]
- "Nine out of every ten people who need antiretroviral treatment are not receiving it";[14]

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[4]ICG, 2001
[5] UNIFEM, n.d.
[6] UNAIDS/WHO, 2004, p. 2
[7] U.S. Census Bureau, 2004, p. 3
[8] IACS, 2003, n.d.; UNAIDS, 2005
[9] U.S. Census Bureau, 2004, p. 21
[10] U.S. Census Bureau, 2004, p. 27
[11] United Nations, 2001
[12] WHO/UNAIDS, 2003; WHO/UNAIDS, 2004
[13] Global HIV Prevention Working Group, 2003, p. 2
[14] UNAIDS/WHO, 2004, p. 5

- UNFPA "estimated in 2000 that over 7 billion additional condoms were needed in developing countries to achieve a significant reduction in HIV infection" (Human Rights Watch, 2004: 3);
- In 2003, "more than 20 years into the HIV/AIDS epidemic, fewer than half (42 percent) of all people at risk of sexual exposure to HIV are able to obtain a condom".[15]
- "Only 8 percent of pregnant women are offered services for preventing transmission to their infants (UN Millennium Project, Working Group on HIV/AIDS, 2005: 1).

At the Millennium Summit in 2000, history's largest gathering of world leaders adopted the UN Millennium Declaration, thereby committing their nations to reach eight major goals. One of these goals is to halt and begin to reverse the spread of HIV/AIDS by 2015. There has since been a growing recognition of the importance of HIV and AIDS, but what is still lacking is the recognition that achievement of the other seven MDGs, and by extension the Platform, will not succeed without addressing gender and HIV/AIDS as cross-cutting issues. These are perhaps some of the biggest gaps in the international response: the insufficient recognition that today HIV and AIDS present a comprehensive threat that is linked with almost all aspects of human life — especially for people living in those parts of the world where the epidemic is advanced and extensive —, as well as lack of attention to the link between gender inequality and the HIV/AIDS epidemic.

Gender and HIV/AIDS

Today, half of all PLWHA across the globe are female. In Latin America, women now represent 36% of adults living with HIV.[16] The 'genderization' of the epidemic is even more pronounced in parts of Africa. In Sub-Saharan Africa, the prevalence rate among 15-49 year olds is 8.6 for women and 6.4 for men. As UNAIDS reports, "in South Africa, Zambia and Zimbabwe, young women (aged 15-24 years) are three to six times more likely to be infected than young men".[17]

The world's youth population and the potential health risk it faces today are astounding. The Economist notes that "the largest generation of teenagers in history — 1.3 billion 10-19 years-olds is now making its sexual debut."[18] In many parts of the world, being young and female puts an individual in dangerous situations with limited choices, if any, exposing her to violence, risk and exploitation.[19] For example, according to the Center for Health and Gender Equity, "infection rates among women in Sub-Saharan Africa peak at around 25 years of age, indicating that the majority of women and girls contracted HIV *within marriage.*"[20] Only with an improvement in the status and power of women will these figures begin to be reduced. As mentioned in a recent article about progress of the MDGs, "virtually all countries are failing (…) in the goals for gender equality and maternal mortality".[21]

[15] Global HIV Prevention Working Group, 2003, p. 6;
[16] UNAIDS/WHO, 2004, p. 8
[17] UNAIDS/WHO, 2004, p. 7
[18] Economist, 2004
[19] Bankole, Singh, Woog, Wulf, 2004
[20] Center for Health and Gender Equity, 2004, p. 29
[21] Sachs & McArthur, 2005, p. 348

The recent report of the Millennium Project presented in January of this year (2005) to UN Secretary-General Kofi Annan acknowledges that *reducing gender inequality is essential for reducing hunger, containing HIV/AIDS, promoting environmental sustainability, upgrading slums, and reducing child and infant mortality* (Millennium Project, 2005: 31).

In the 2005 Millennium Project Report, the HIV/AIDS Working Group elaborates how past attempts to change sexual behaviors have met limited success due to inadequate consideration of the multiple contextual factors fueling the epidemic. The following paragraphs draw largely on their report. Poverty and disparate power relations place constraints on the choices one can make. Gender inequality is the most important factor to vulnerability to HIV in many settings. Women and girls bear a disproportionate and increasing share of the suffering caused by the epidemic. Migration, intergenerational sex between young females and older men, coerced sexual relations including rape, lack of economic opportunities, low education levels, and cultural attitudes all contribute to the spread of HIV/AIDS among women and girls. The vulnerability of females is further heightened due to biological factors as well.

In addition to high risk for infection, women also receive a disproportionate burden of caregiving for HIV-infected family members, greater cultural blame for their own infection as well as the introduction of the virus into the family circle, and yet have limited rights to inheritance and property ownership.

Young women are at the highest risk. In sub-Saharan Africa, rates of HIV infection are more than three times as high among women ages 15-24 than among boys of the same age. Sex between girls and older men, often rooted in disparities in economic opportunity, is an important driver of the epidemic.

Widespread violence against women and girls has direct and indirect effects in shaping the vulnerability to AIDS. It restricts the freedom of women and girls to enter and leave relationships, to choose when to have sex, to use safer practices and to benefit from treatment

Gender roles put men at risk as well, by sanctioning multiple partners and encouraging risk taking. Attitudes towards sexuality and gender shape the sexual behavior that facilitates the transmission of HIV. Prevention programs should stimulate societal reconsideration of gender roles.

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Addressing the gender and HIV link entails more than offering gender-sensitive services. The promotion of microbicide development, increased access to female condoms, and delivery of MTCT (mother-to-child-transmission) services are merely the beginning attempts to reduce female powerlessness. Interventions must address the underlying basis of the epidemic's 'genderization', including female low education levels, limited economic and political opportunity, limited rights including ownership of property and inheritance, and voice against all forms of violence.

The UNAIDS' 2004 Global Coalition on Women and AIDS identified the following seven priorities:

- "Prevent HIV infection among girls and young women.
- Reduce violence against women (promote 'zero tolerance').
- Protect the property and inheritance rights of women and girls.
- Ensure equal access by women and girls to care and treatment.
- Support improved community-based care, with a special focus on women and girls.
- Promote access to new prevention options for women, including microbicides.
- Support on-going efforts toward universal education for girls".[22]

Two major conclusions can be reached from the above discussion:

1. **1.** The relationship between HIV prevention and gender equity is reciprocal; gender inequality increases women's vulnerability to infection and the spread of HIV deepens women's unequal burden in the family and in society as whole. Therefore, addressing gender inequality requires effective prevention, and vice versa. Failure in either front threatens progress on both fronts;

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2. **2.** Young women are the most vulnerable. Without age specific and gender specific strategies, prevention will fail. In this regard, the Working Group on HIV/AIDS/Millennium Project has proposed to "reduce prevalence among young people to 5 percent in the most affected countries and by 50 percent elsewhere by 2015", as one of the two targets for 2015.[23]

Comprehensive sexuality education, abstinence and condoms

Without effective prevention of the spread of HIV and treatment of those already infected, poverty reduction and the Platform will not be achieved, nor will the other MDGs.

The Millennium Project's Working Group on HIV/AIDS notes that overwhelming evidence supports the effectiveness of condoms as a powerful means of prevention. One example is the great success achieved in Cambodia and Thailand, where the promotion of condoms among sex workers and gay men achieved significant results. Social marketing of condoms, via media efforts and large-scale access, has also met success.

Nonetheless, prevention efforts have swung towards an emphasis on abstinence and fidelity. The touted 'ABC approach' (standing for 'Abstain, Be faithful, and use Condoms when Necessary') has been held up as the ideal response, particularly by the US government. In Uganda, the HIV prevalence rate was remarkably reduced, and the US has repeatedly highlighted this unique situation to support their continued promotion of abstinence-only programs. This oversimplifies a multifaceted prevention strategy by ignoring other elements of Uganda' strategy such as greater condom use, expansion of voluntary counseling and testing, treatment of sexually transmitted infections and campaigns to combat stigma. Also the ABC program does not prove

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[22] UN Millennium Project, Working Group on HIV/AIDS, 2005, pp. 53-59
[23] UN Millennium Project, Working Group on HIV/AIDS, 2005, p. 3. The other target is "ensure equitable and sustainable access to antiretroviral therapy to at least 75 percent of those in need by 2015".

effective when applied to other situations and contexts. For example, in the US, research on abstinence-only education finds that while such efforts may produce an initial delay in sexual debut, participants end up engaging in unsafe sexual behaviors later on. Furthermore, abstinence until marriage has not reduced HIV risk in East Africa.

While abstinence and fidelity messages have their place, they must also include a comprehensive sexual education component, promoting condoms. Concentrated epidemics, in particular, necessitate strong condom promotion efforts.[24]

Undoubtedly, schools can play an important role in providing sexual education that can help young people to "practice safe behaviors".[25] Studies have demonstrated the efficacy of comprehensive SRH programs. In the US for example, evaluations find that young participants of comprehensive sex education had delayed sexual debut, and lower rates of abortion and child-birth. Other programs across the globe have met similar success. Evaluations demonstrate that comprehensive sex education improve youth knowledge about STI/HIV prevention, and also improve confidence and skill in safer sexual practices, including the use of condoms and refusal to engage in sex. The effects of such programs are usually most beneficial for girls and younger age groups

At same time, the promotion of abstinence until marriage as a form of sexual education does not protect married women, whose vulnerability has been largely ignored. In Kenya and Zambia, for instance, young married women are more likely to be HIV positive than their unmarried peers because they have sex more often, use condoms less often, are unable to refuse sex, and have partners who are more likely to be HIV positive.[26]

This evidence raises a broader concern regarding national aid policies and consequential impact on achievement of the Platform and several MDGs (such as the arenas of HIV and AIDS and reproductive health services). Rigid policies –based on ideological notions of limited morality – ignore scientific information and preclude adequate health interventions. For example, the assumption that abstinence and fidelity offer better protection than condoms fails to address the real protection needs of vast numbers of men and women across the globe.[27] Such narrow policies thereby neglect the basic health, well-being, and rights of millions of individuals.

Resources needed

UNAIDS and the WHO, while recognizing that "global funding has increased from roughly US$ 2.1 billion to an estimated US$ 6.1 billion in 2004…," warn nonetheless that:

> "…*business as usual spells disaster... Without invigorated HIV prevention strategies that deal boldly with the epidemic and that also address the wider imperatives of social justice and equality, the world is unlikely to gain the upper-hand over AIDS in the long run*".[28]

[24] UN Millennium Project, Working Group on HIV/AIDS, 2005, pp. 64-65
[25] UN Millennium Project, Task Force on Gender Equality, 2005, p. 64
[26] Bruce and Clark, 2003, cited in UN Millennium Project, report of Task Force Gender Equality, page p. 59
[27] Human Rights Watch, 2004
[28] UNAIDS/WHO, 2004, p. 6

Following the recommendations from UNAIDS, the UN Millennium Project Working Group on HIV/AIDS affirmed that an estimated:

> *"$11.6 billion will be required in 2005 and $19.9 billion in 2007. Of the 2007 total, prevention accounts for 50 percent, treatment and care for 34 percent, and support for orphans and vulnerable children for 11 percent. About 43 percent of these resources would be needed in Sub-Saharan Africa, 28 percent in Asia, 17 percent in Latin America and the Caribbean, 9 percent in Eastern Europe, and 1 percent in North Africa and the Middle East*" (UN Millennium Project, Working Group on HIV/AIDS, 2005: 129-130)

We know that gaps are ubiquitous. Just as the HIV epidemic has far from sufficient resources, the SRH arena also remains under-resourced.[29] As mentioned in an article published by the Economist last year, the "ICPD estimated the cost of implementing its recommended programmes at $18.5 billion by 2005 – or $23.7 billion in today's dollars. The goal was to mobilise one-third of that money from rich donors, and the rest from developing countries themselves. But current spending is well below the mark (…). In 2003, they [the donors] spent an estimated $3.1 billion on reproductive health."[30]

Such funding is falling short of protecting millions of women and girls. A joint report by the Alan Guttmacher Institute and UNFPA states that "the cost of providing contraceptive services to the 201 million women in developing countries with unmet need (…) would be $3.9 billion per year".[31]

Rapid scaling up of both prevention and treatment could reduce costs in later years[32] The Force on Gender Equality of the Millennium Project mentions in its report that "an early study in Mexico found that for every peso the Mexican social security system spent on family planning during 1972-84, it saved nine pesos for treating complications of unsafe abortion and providing maternal and infant care. Every $1 invested in Thailand's family planning program saved the government more than $16. An analysis in Egypt found that every $1 invested in family planning save the government $31".[33] Yet in addition to cost effectiveness, SRH services provide other benefits, including social, economic, and health benefits, such as disease prevention, enhanced social status of women, and greater economic and development investments.

Taking these scenarios into consideration, the following recommendations are suggested:

1. Substantial resources should be devoted to prevention, especially targeting youth and young adults.

[29] Vlassoff, Singh, Darroch, Carbone, Bernstein, 2004
[30] Economist, 2004
[31] Singh, Darroch, Vlassoff & Nadeau, 2003
[32] UN Millennium Project, Task Force on Gender Equality, 2005, p. 131
[33] UN Millennium Project, Task Force on Gender Equality, 2005, p. 60

2. Integration between HIV and SRH services must be accelerated to maximize use of available resources.[34] This strategy is especially indicated because SRH services usually serve women, and also offer available, established entry points.
3. Use of male and female condoms should be widely disseminated and ideological restrictions to their use and distribution should be resisted.
4. Investment in the development of effective microbicides must also be increased.[35] Potential benefits could be enormous. Researchers at the London School of Hygiene and Tropical Medicine have estimated that if microbicides were used by 20 percent of the women in low income countries reachable through existing services, 2.5 million new HIV infections in women, men and children could be avoided over a period of three years.[36]
5. Women's access to HIV and AIDS treatment must be expanded. "Internationally, men tend to have better access to AIDS care and treatment in places where AIDS treatment is provided (…)."[37]
6. Equal gender power relationships should be addressed through educational, social, legal and economic programs designed to empower women, and especially young women.[38]

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[34] UNAIDS, 2004
[35] UNAIDS/WHO, 2004: p. 14
[36] UN Millennium Project, Task Force on Gender Equality, 2005: p. 62
[37] UNAIDS/WHO, 2004: p. 14
[38] Grown, Gupta & Pande, 2005

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