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Women and HIV/AIDS*

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A. INTRODUCTION

In a December 2002 *New York Times* article headlined "In Africa, AIDS has a woman's face", the Secretary-General of the United Nations, Kofi Annan, noted that: "*…today, as AIDS is eroding the health of Africa's women, it is eroding the skills, experience and networks that keep their families and communities going. Even before falling ill, a woman will often have to care for a sick husband, thereby reducing the time she can devote to planting, harvesting and marketing crops. When her husband dies, she is often deprived of credit, distribution networks or land rights. When she dies, the household will risk collapsing completely, leaving children to fend for themselves. The older ones, especially girls, will be taken out of school to work in the home or the farm. These girls, deprived of education and opportunities, will be even less able to protect themselves against AIDS…If we want to save Africa from two catastrophe* (HIV/AIDS and famine)*s, we would do well to focus on saving Africa's women."*

It is estimated that almost 50 per cent of those living with HIV and AIDS are now women (UNAIDS, 2002). UNAIDS data shows that there is a similar pattern of HIV infection for women around the world. The prevalence of HIV infection is highest in women aged 15-25 years, while it peaks in men between five to ten years later. A new epidemic appears to be emerging in some countries amongst older people (over 50 years), and particularly amongst women, with numbers increasing 40 per cent in the last five years (ibid). Low overall prevalence rates of HIV infection in some countries can mask serious epidemics within certain geographic localities or in specific groups in the population. In Myanmar, for example, while there is a national prevalence of less than two per cent, the prevalence rate among sex workers is 40 per cent (BRIDGE, 2002).

In addition to increased representation among victims, women are also disproportionately affected by the pandemic in many areas because of their caring roles. Women are often left with the sole responsibility for providing for the sick and dying. The risk of mother-to-child transmission is also a particular feature of the HIV/AIDS epidemic. In 1990, the first antenatal survey conducted in South Africa showed that one per cent of pregnant women were living with HIV. Twelve years later the prevalence had increased to 24 per cent, with one province recording a prevalence rate of over 36 per cent (UNAIDS, 2000).

To adequately address HIV/AIDS and women and girls, it is important to focus on the gender perspectives – i.e. the differences and inequalities that exist between women and men – in relation to prevention, causes and consequences of HIV/AIDS infection and the potentials for developing adequate coping strategies. The vulnerability of women and girls to HIV/AIDS is directly related to the relations between women and men and to the attitudes and behaviour of men and boys, as well as to persistent stereotypes about masculinities and about what is appropriate and acceptable behaviour for women, particularly in relation to reproduction and sexuality. The inequalities which emanate from these relations, attitudes, behaviours and stereotypes are critical factors in the spread of HIV/AIDS. Baylies (2000) notes that the factors driving the epidemic are embedded in the power relations that define male and female roles and positions, both in intimate relations and in the wider society. Gender inequality is a driving factor in the spread of HIV/AIDS; and HIV/AIDS contributes to the entrenchment of gender inequality in societies (BRIDGE, 2002).

Issues of power, human rights and socio-cultural expectations are critical elements in addressing HIV/AIDS from a gender perspective. The report of the Expert Group Meeting on "The HIV/AIDS pandemic and its gender implications", organized by the United Nations Division for the Advancement of Women in Namibia in 2000, concluded that inequality and women's disempowerment at different levels – in families, in decision-making at community and other levels, in education, in employment and economic opportunities – can be linked to the rate of spread of infection and the severe impacts on families, communities and countries (UN Division for the Advancement of Women, 2000).

Women must, however, not be seen only as vulnerable. Women and girls are also actors and change agents. The active mobilization of women and support to their efforts can enhance the social, economic and political empowerment of women, and as a result support more effective preventative strategies and appropriate approaches to address the consequences of HIV/AIDS.

B. CAUSES AND IMPACTS OF HIV/AIDS ON WOMEN AND GIRLS

There are critical differences and inequalities between women and men to consider in relation to prevention of HIV/AIDS; the risks of infection, including factors identified as increasing vulnerability, such as health and nutritional status and poverty; the social impact and socio-economic consequences of infection on individuals at both household and community level and possible means of addressing these; as well as access to and quality of care.

Health-based approaches to HIV/AIDS initially failed to give adequate consideration to the critical social, cultural, and economic factors underlying the spread of HIV/AIDS and to understand its differential impacts. While there are important physiological reasons for women's susceptibility to infection, there are also major socio-cultural and economic factors which need to be identified and addressed. Today, there is recognition of the need to move beyond the epidemiological dimensions to also identify and address the wide range of driving factors in a holistic manner, which includes a human-rights approach. Increasing the effectiveness of existing strategies and approaches requires greater explicit attention to the situation of women and girls. Progress in responding effectively to HIV/AIDS is dependent on what is done for women and girls (UNAIDS, 2003).

The lack of control by women and girls over their own bodies and sexual lives, in the context of more general socio-economic and political inequality and subordination they face, is a critical factor in the vulnerable situation of women in many parts of the world in relation to HIV/AIDS. Women and girls as unequal partners in sexual relationships are not able to negotiate in order abstain from sex or demand condom use to protect themselves from STIs and HIV/AIDS. This was highlighted in an article in a 2001 *New York Times* article by the former Minister of Health in Mozambique, Mr. Mocumbi: *"In Mozambique the overall rate of HIV infection among girls and young women, 15 per cent, is twice that of boys their age, not because the girls are promiscuous, but because nearly three out of five are married by age 18, 40 per cent of them to much older, sexually experienced men who may expose their wives to HIV and*

sexually transmitted diseases […] Abstinence is not an option for these child brides. Those who try to negotiate condom use commonly face violence or rejection…"

The HIV/AIDS pandemic has opened up debates around issues of sexuality and sexual relationships in many contexts and has highlighted the importance of gender equality in all social relations but particularly in sexual relationships (BRIDGE, 2002). However persistent stereotypes, attitudes and beliefs about both women and men remain a serious obstacle to preventing the spread of HIV/AIDS. One example is the commonly held belief in some cultures that having a variety of sexual partners is acceptable for men and even considered an essential aspect of masculinity (ibid). A study of women from over ten countries revealed that *"Though many women expressed concern over the infidelities of their partners, they were resigned to their lack of control over the situation. Women from India, Jamaica, Papua New Guinea, Zimbabwe and Brazil report that raising the issue of their partners' infidelity can jeopardize their physical safety and family stability*" (Gupta and Weiss, 1993).

Male violence against women – based on existing inequalities and power disparities in societies – is one of the critical stumbling blocks in the development of effective prevention strategies for HIV/AIDS. In violent relationships, women and girls have little means of protecting themselves from infection. Women may have to put themselves in situations of risk of HIV infection rather than risk injury or death for themselves or their family members at the hands of a violent partner. As a result, many women and girls live in intolerable environments of fear – fear of the violence itself and fear of the consequences of not being able to say no, to make demands and to protect themselves.

The links between HIV/AIDS and poverty are complex but critical. Poverty is not only a cause but also a consequence of HIV/AIDS (UN Division for the Advancement of Women, 2000). While poor and non-poor alike are affected, the persistent poverty in many parts of the world facilitates the spread of HIV/AIDS. People living in poverty are more likely to become sick and can die more quickly due to malnutrition and lack of access to appropriate health care (Collins and Rau, 2000). Poverty can reduce access to treatments for opportunistic infections and the dietary supplements required to strengthen the immune system (UN Division for the Advancement of Women, 2000). The consequences of HIV/AIDS epidemics are most severe in regions where deep poverty and economic inequality exist, gender equality is pervasive and access to public services is limited (Collins and Rau, 2000).

The vast majority of the total number of people living with HIV are in the developing world, with 71 per cent of the men, women and children infected living in Sub-Saharan Africa (UNAIDS, 2002). The gender perspectives in terms of causes of poverty, impacts of poverty and potential for developing adequate coping strategies, need to be given more serious consideration in work on HIV/AIDS. Poverty may prevent women from accessing information on safe and responsible sexual relationships and the risks of HIV/AIDS, as well as on their rights and the support mechanisms available. Poverty may also prevent women from seeking treatment once infected. As a result of poverty, women can be forced to engage in what has been termed "survival sex", i.e. seeking economic opportunities in exchange for sex to solve short-term financial problems – a desperate solution which in reality can lead to illness, death and impoverishment for their families.

At the individual level, HIV-infected persons have to deal with the emotional, social and economic consequences of infection. The level of impact is conditioned by other factors, such as age, race/ethnicity, social class, income levels, and sexual orientation. Gender also plays a critical role, but to date, not enough research has focused on the differences and inequalities in impacts on women and men.

The human rights aspects of HIV/AIDS are complex and include the lack of equal access to prevention methods, information and treatment and care. People living with HIV/AIDS may find it difficult to live a life of dignity and freedom. Stigmatization can lead to violation of human rights in relation to continued education or employment, as well as at the level of privacy, confidentiality and freedom of movement. Stigmatization can be more extreme for women and girls because of existing stereotypes, inequalities and patterns of discrimination in society, and HIV-infected women can find their human rights at greater risk. In the context of reproductive health, women face new risks. Control over reproductive health choices for HIV-infected women may be exerted by healthcare workers, without the full involvement of the women themselves (Seidel and Tallis, 1999). Women can also face judgemental and hostile attitudes from service providers or even be denied access to services (Manchester and Mthembu, 2002).

Stigma and discrimination on the basis of HIV status stifles open discussion on causes of HIV/AIDS and appropriate responses (Aggleton and Parker, 2002). It can lead young women to neglect their reproductive health needs, to fail to access necessary information, and to postpone seeking treatment and care. Women who are HIV-infected, or suspected to be infected, can be subjected to discriminatory treatment such as abuse and rejection by their families and communities or dismissal from employment (Tallis, 1998). Women may also lose their rights to property or even their children (UNAIDS, 2003). Where women's value is linked to their children, women may risk infection to become pregnant rather than face the stigma of childlessness. To reduce risk of stigmatization, women may choose to continue to breastfeed their babies rather than disclose their infection status (BRIDGE, 2002). Gender-based violence can also increase where women are blamed for the spread of the virus and stigmatized as promiscuous. Factors such as age, disability, socio-economic position, membership of a particular ethnic, racial or religious group can lead to increased forms of discrimination for women and girls, particularly in relation to HIV/AIDS. Failure to address the differences between groups of women can obscure serious issues of double discrimination for some groups of women.

It is important to understand and highlight the direct impact of the roles of women and men and the relationships between them on the responsibilities imposed by infection of women or men themselves or of family members. Women bear a huge responsibility of care in relation to HIV/AIDS, in both the formal and informal sectors. Inability of healthcare systems to cope with the demands of caring has pushed responsibility into the domain of the family and community. While community and family-based care can be a very effective and humane support strategy, it often relies to a very large extent on the inputs of women. Caring for sick family members, in addition to the other reproductive and productive responsibilities women have, can have severe physical, emotional, social and economic consequences, including leading women to neglect their own health and wellbeing.

Coping with the medical costs of HIV infection and providing for families economically following the death of males in the family also places a large burden on women, Women and girls do not have the same access to economic resources, including land, and this can make survival precarious in many rural areas. Inadequate access to labour, income and food supplies also hinder women's efforts to provide for their families. This results in children, particularly girls, being withdrawn from school to provide different forms of support. In urban areas, women may lack the support of extended families or other social support systems. In areas with high death rates of women and men in productive years, older women face enormous responsibilities without financial and other resources to ensure the survival of their grandchildren and other relatives.

There are gender differences and inequalities in access to health information and health care, including access to more expensive drugs and treatments. Factors such as economy, time, mobility and attitudes of healthcare workers can negatively impact women's access to adequate and appropriate treatment and care. In developing countries, men working in the formal sector may also have greater access than women to workplace clinics and medical benefits (Tallis, 2001). Gender disparities in access to education in many areas – which can be exacerbated in areas with high infection rates as girls are taken out of school to provide care – can reduce the effectiveness of information programmes through schools. In some cases gender stereotypes, particularly related to cultural images of aggressive, dominant masculinity and stereotypes of women as hopeless victims, have been utilized to get HIV/AIDS advocacy messages across, which can entrench existing stigma, stereotypes and discrimination. This can include, for example, advocacy materials which focus negatively on sex workers as the source of infection (Gupta, 2000).

Although women were diagnosed with HIV/AIDS in the early 1980s, there has been little investigation of the differences between women and men in disease progression, opportunistic infections and disease management strategies. By the end of 1999, women accounted for only 12 per cent of trial participants (BRIDGE, 2002). Some research has shown that there are differences between women and men in length of survival, levels of viral load and drug toxicity. Differences in disease progression for women and men cannot be ignored in treatment. Antiretroviral treatment and opportunistic infection management has to be tailored specifically for women and men (ibid).

As well as addressing the socio-cultural, economic and political factors operating at local and national levels – including urbanization, violence and lack of security, discrimination of specific groups, religious beliefs and practices – it is equally critical to identify the impact of global and regional factors such as the increased trafficking of women, and situations of armed conflict, on the spread of HIV/AIDS and the particularly vulnerable position of women and girls in these situations. In armed conflict and its aftermath, women and girls can be subjected to rape and other forms of sexual exploitation, including trafficking, which are linked to political instability and lawlessness, lack of adequate protection of women's human rights and impoverishment.

C. IMPACTS OF FEMALE MORBIDITY AND MORTALITY

AIDS is now the leading cause of death in Sub-Saharan Africa and the fourth cause of death globally (UNAIDS, 2002). The latest figures indicate an increasing impact of the HIV/AIDS epidemic on women and girls (UNAIDS, 2003). Apart from the impacts at individual level, there are serious social, economic, political and demographic consequences which need to be addressed in a gender-sensitive manner.

Female morbidity and mortality can have dramatic effects in many parts of the world because of the critical contributions women make to family survival and community development. In many areas women have strongly defined care-giving roles, providing the major or sole care for children, the elderly, the sick and the disabled. Loss of a mother can have severe consequences for child survival. Many families face an uncertain and impoverished future that further increases their vulnerability to HIV/AIDS. Orphaned children are more likely to be malnourished, poorly educated, emotionally traumatized and alienated from society (UN Division for the Advancement of Women, 2000). There can also be negative impacts on the education and development of girls as they are forced to take over many of the responsibilities of their mothers. These negative consequences for individual girls can have more long-term impact on development at family and community levels. Older women – grandmothers and other relatives – may have to take over the raising of children and to provide for young orphaned relatives.

In developing countries, particularly in Africa, women play a crucial role in agricultural production. HIV-infected women may find they are unable to maintain normal levels of production, with health and nutrition implications for themselves and their families. In female-headed households, the lowered production levels through HIV infection or death of the head of household has serious developmental impacts for families and communities.

Since the work of women in the home, the community and in informal sectors is not taken adequately into account in research and data collection, the full economic impact of the morbidity and mortality of women through HIV/AIDS is not known. Gender perspectives need to be taken into account in all types of impact studies –assessing the impacts of HIV/AIDS on overall economic development or in specific sectors such as agriculture, industry; identifying the impact of HIV/AIDS on development of the labour market, food security, or on education; or in highlighting changes in family patterns or age structures as a result of HIV/AIDS. Such studies should integrate gender perspectives to a greater extent than at present, and should highlight the impacts at different levels of female morbidity and mortality as a result of HIV/AIDS.

D. GENDER PERSPECTIVES ON DEMOGRAPHY IMPACTS OF HIV/AIDS

Gender, or the social attributes, relationships and opportunities associated with being male and female, is a central organizing principle in society. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as in decision-making opportunities.

Integrating gender perspectives into demographic models would enable demographers "…*not only to better understand how gender systems affect fertility, mortality and migration under certain conditions, but also to gain a better grasp of how certain patterns of demographic behaviour (e.g. age at marriage and at first birth) affect gender inequality and control over resources.*" (Presser, 1997:321).

It is recognized that incorporating gender perspectives in demography requires more than disaggregation of data on key population characteristics or activities by sex. Increased attention is given to gender as a variable in models of demographic processes. Gender analysis in demography goes beyond describing differences between women and men to examining the processes through which these differences arise and what they mean for demographic behaviour (Riley, 1999).

HIV/AIDS impacts on major demographic processes, such as mortality and fertility. It is critical to give more attention to gender perspectives in demographic studies on HIV/AIDS because of the developmental impacts of morbidity and mortality of women as well as men, in particular the erosion of development gains, as outlined earlier. One very basic requirement is that all statistics related to HIV/AIDS – on infection rates, mortality rates, access to care, care provision, etc. – should be sex-disaggregated. However sex-disaggregation of existing data does not go far enough. It is important to ensure that the information required to address the critical gender perspectives identified is collected and used in analysis and policy making and planning processes. Ensuring that gender perspectives are an integral part of all research requires that terms of reference for studies take up gender perspectives specifically; that researchers are briefed adequately on requirements for incorporating gender perspectives, including consultation with both women and men; and that wherever possible, gender specialists should be included on research teams.

It is important to disaggregate statistics on life expectancy and to take gender perspectives into consideration in analysis. Fertility studies need to look at the relationships between women and men, particularly in relation to decision-making on reproduction and sexuality. Kabeer (1996) suggests that gender perspectives on fertility outcomes could consider how patterns of gender relations influence the interests of women and men in particular outcomes, as well as the relative capacity of women and men to take actions on the basis of these interests. One study identified three dimensions of the impact of HIV/AIDS on fertility: fewer births will result if women die before reaching the end of the child-bearing period; lowered fertility levels are found in women living with HIV/AIDS; and increased use of prevention methods such as male and female condoms could also reduce fertility (Whiteside and Sunter, 2000). There are also gender perspectives on the changes in composition and structure of households, not least the fact that the number of female-headed households increases with an increase in male deaths from HIV/AIDS. It is important to disaggregate data and collect and analyse relevant information on mortality of women as a result of HIV/AIDS, both because of the reversal of life-expectancy gains and the crisis of development that the HIV/AIDS pandemic entails.

It is also important to better understand the gender dimensions of mobility behaviour in order to prevent the spread of HIV and improve the care of those affected (O'Brien, 1995).

Increased poverty, lack of access to waged employment, instability and insecurity, unfavourable political and economic changes, and human rights abuses, as well as some positive pull-factors such as economic opportunity through higher wages, have led to an increase in the number of women migrants over the past decades. While migration in and of itself is not necessarily a risk factor for HIV infection, for many women separation from family, lack of social networks and vulnerability in new situations (low-status and low-paid work, isolation, economic dependency on employers) can lead to increased personal risks and vulnerability to HIV/AIDS (BRIDGE, 2002). Forced movement, for example in conflict situations or in trafficking, can lead to exposure to high risk for HIV infection. High male migration in some regions, where it is accepted that men will have multiple sexual partners, can also increase vulnerability to HIV infection (ibid).

E. CONCLUSIONS

Most approaches to prevent and address the HIV/AIDS pandemic have failed to adequately take gender perspectives into account. Organizations working with HIV/AIDS – Governments, international organizations and NGOs – need to reassess their goals, strategies, actions and resource allocations from a gender perspective and determine where in data collection, analysis, policy development and planning and implementation of activities it is important to pay attention to gender perspectives. Organizations need to develop specific strategies and action plans with clear goals, targets, timeframes and accountability mechanisms. Some form of institutional development – through the appointment of gender specialists or establishment of capacity-building activities – is usually needed.

Activities such as education for HIV/AIDS prevention must take into account the realities of women, men, boys and girls, be adapted to their needs and be accessible to all. Policy development and planning in the provision of care must consider the roles and responsibilities of women and men, particularly in terms of the care provided in the home, and the impact of the burden of care on the survival of the rest of the family. Gender perspectives need to be identified in relation to access to different types of medical treatment and services. Development interventions to support households and communities suffering negative socio-economic impacts of the epidemic must consider the roles, responsibilities and needs of women as well as men, particularly in relation to extension services, credits and other resources.

Ensuring appropriate and effective strategies and approaches to prevent the spread of HIV/AIDS is dependent on the adequate involvement of women as well as men. Women should be consulted and involved in the establishment of priorities, the development of overall policies and strategies, and the design, implementation and monitoring of programmes and projects. Women's groups and networks should be given a stronger voice in decision-making at all levels.

In conclusion, there are some positive developments which can contribute to ensuring that future work on HIV/AIDS is informed by an understanding of the realities, contributions, needs and priorities of both women and men and lead to more effective strategies. The gender perspectives of HIV/AIDS and the particularly vulnerable situation of women and girls, have been highlighted in major United Nations events over the past few years and clear goals and

targets have been defined. The Millennium Summit in 2000 established the target to have halted and begun to reverse the spread of HIV/AIDS by 2015, and to provide special assistance to children orphaned by HIV/AIDS. The Millennium Development Goals also provide an opportunity for giving greater attention to the situation of women. The sixth Millennium Development Goal focuses on combating HIV/AIDS, malaria and other diseases. While promotion of gender equality is a separate Millennium Development Goal, Goal 3, it is critical to incorporate gender perspectives into all other goals. In this respect it is necessary to closely link Goal 3 on promoting gender equality with Goal 6 on combating HIV/AIDS, malaria and other diseases and to identify and address gender perspectives in the implementation of Goal 6.

The United Nations General Assembly Special Session on HIV/AIDS in June 2001 highlighted the centrality of gender inequality and discrimination to the pandemic (UN, 2001). It acknowledged that inequality and discrimination, based on power imbalances between women and men in societies, both increase women's vulnerability to infection and place a disproportionate burden on them in coping with HIV/AIDS in families and communities. In the Declaration adopted at the Special Session, Member States made commitments to a series of progressive, measurable targets related to the ability of women and girls to protect themselves from infection, obtain access to care and treatment and mitigate the impact of the epidemic on their daily lives (UNAIDS, 2003). While there is still need for more research in some areas, there is a generally good understanding of what the main issues are and what needs to be done.

The Convention on the Elimination of All Forms of Discrimination against Women provides an excellent human rights framework for approaching the gender perspectives of HIV/AIDS and focusing on the situation of women and girls. The Convention requires the elimination of all forms of discrimination against women. States parties are obligated to identify and eliminate discrimination in different areas of women's lives, by legislative change, policy development as well as specific programmes and projects. The Convention addresses the need for women and girls to receive information on reproductive health. The general recommendations on HIV/AIDS, women and health and violence against women prepared by the Committee on Elimination against Women provide further guidance to States parties, emphasizing the need for increased public awareness of the risk of HIV infection and AIDS, especially among women and children. The Committee has repeatedly raised the issue of HIV/AIDS in considering reports of States parties and made specific recommendations, particularly related to increased information, education and services.

UNAIDS recently established a Global Coalition on Women and AIDS, involving both the United Nations and NGOs, which aims at increasing the visibility, effectiveness and synergy of efforts related to women and AIDS and creating a global movement to mitigate the impact of AIDS on women's daily lives. The Coalition recognizes that sustained changes in the vulnerability of women and girls to HIV/AIDS will require fundamental shifts in the relationships between men and women and in the way societies view women and value their work and contributions. It highlights the factors making women and girls vulnerable as being largely related to the behaviour of others, to their limited autonomy and to social and economic inequities beyond their control. Zero tolerance on violence against women, protection of the property and inheritance rights of women and girls and attention to men and boys are emphasized by the Coalition (UNAIDS, 2003).

Finally, the increased attention to the role of men and boys is a positive development. Ideologies of masculinity and 'manliness' which encourage men to display sexual prowess by having multiple partners, by stressing aggressiveness and dominance and lack of responsibility in sexual relationships can be as dangerous as the stereotypes about female passivity and the need to keep women and girls ignorant. Men's attitudes and behaviour put themselves, as well as their partners, at risk (UN Division for the Advancement of Women, 2000). In many parts of the world, for example in Brazil and South Africa, men's groups and networks are challenging many existing stereotypes and addressing men's roles and responsibilities in sexual relationships as well as in the promotion of gender equality (BRIDGE, 2002). Equitable and responsible behaviour of men and boys will only increase if they can access appropriate information and support. Boys may have limited access to accurate information on HIV/AIDS because of the assumption that they are already knowledgeable or will learn from their peers (UN Division for the Advancement of Women, 2000). In areas where access to information on HIV/AIDS is focused in pre-natal and family planning clinics with largely female clientele, men may also have difficulties accessing relevant information (ibid).

In its session in March 2004, the Commission on the Status of Women will address the theme: the role of men and boys in achieving gender equality. In preparation for this session, the Division for the Advancement of Women is organizing an expert group meeting in October 2004 on the role of men and boys, which will have as part of its focus the role of men and boys in relation to HIV/AIDS. Greater attention to the roles and responsibilities of men and boys in achieving gender equality, and on the gains for men as well as women from gender equality, is an important step towards reducing the vulnerability of women and girls and ensuring more effective and sustainable strategies to halt and reverse the spread of HIV/AIDS.

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