



Gender and HIV/AIDS in Sub-Saharan Africa: Putting Gender on the MAP

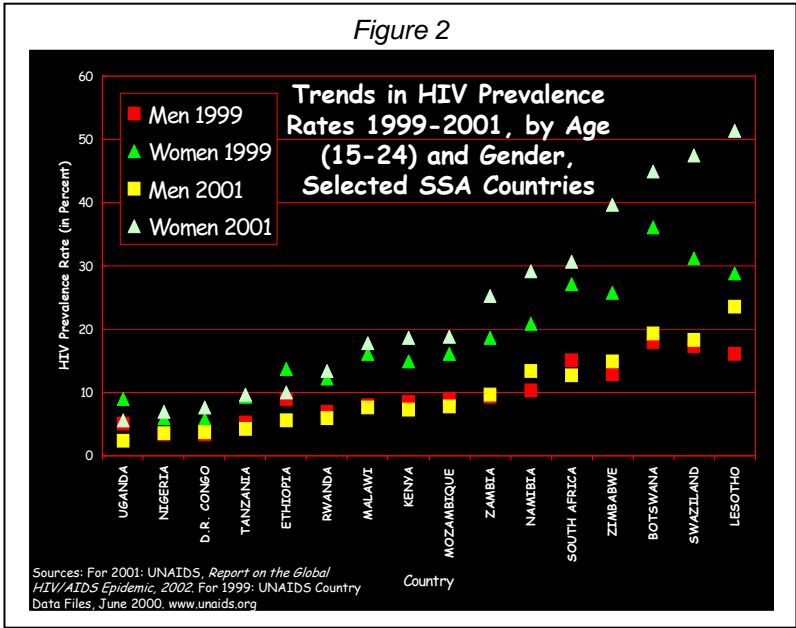
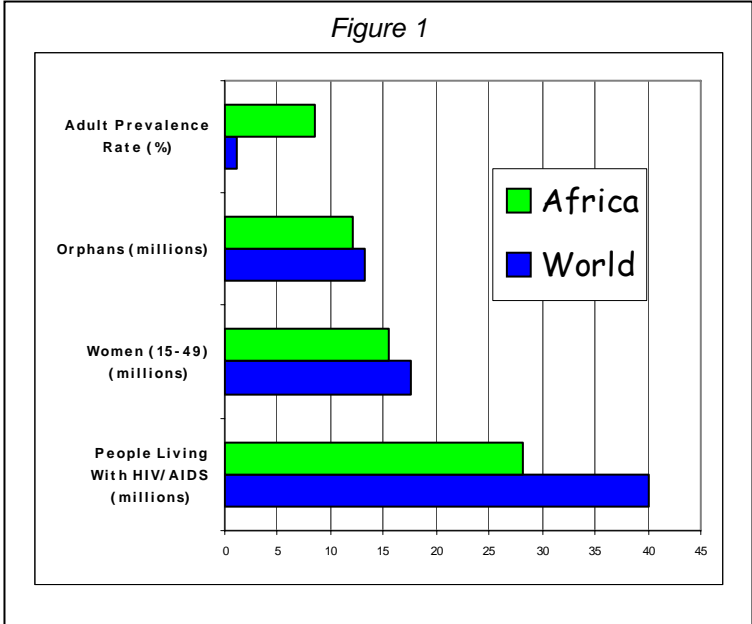
I. The “Gender Dynamics” of HIV/AIDS in Africa

HIV/AIDS is a significant—and worsening—health, economic, and social issue in Sub-Saharan Africa (SSA). Africa’s share of the global pandemic is very high (Figure 1). Of Africa’s 23.0 million adults living with HIV/AIDS, 13.2 million are women, constituting 77% of the world’s women with HIV/AIDS (data for end-2003). Africa is the only continent where HIV prevalence is **higher** for women than for men—women account for the **majority of adults (57%)** living with HIV/AIDS. The aggregates mask key age/sex differences in HIV prevalence. For every 15-19-year-old boy who is infected, there are five to six girls infected in the same age group. The trends in age/sex differentiated prevalence rates for people aged 15-24, as revealed in the end-2001 UNAIDS data, suggest that the situation for young women has worsened considerably in most countries over this period, while the situation for young men is more mixed (Figure 2). On this evidence, Africa is losing the fight to protect its youngest—and most vulnerable—women from the scourge of HIV/AIDS.

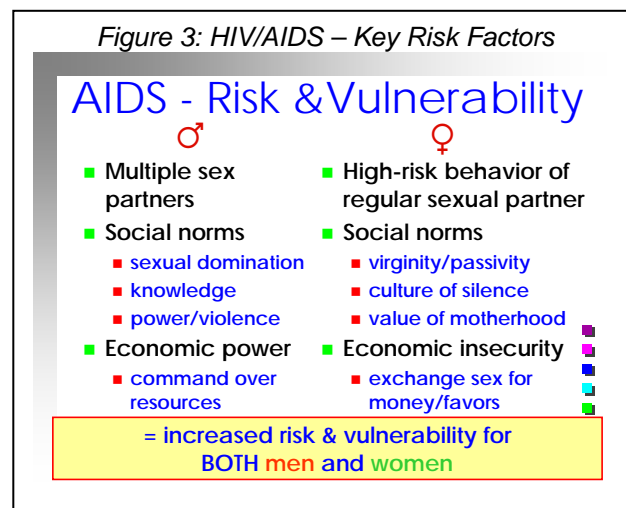
Between 2001 and 2003, the number of adult women (15-49) living with AIDS rose by 5.3 percent to 13.2 million, while the number of men rose by 5.0 percent to 9.8 million. The ratio of women to men has risen from 12:10 in 2001 to 13:10 in 2003. Young people aged 15-24 comprise almost one-half of new infections worldwide, and in this age group gender disparities are the most marked, ranging from 24:10 females/males in South Africa to 45:10 in Kenya and Mali. The feminization of AIDS continues unabated.

There are three critical factors—all interconnected—that place gender issues at the core of the HIV/AIDS pandemic in Africa, and which must be addressed systematically if the Multi-Country AIDS Program (MAP) operations are to achieve their objectives. The first factor is that **risk and vulnerability to HIV/AIDS**

are substantially different for men and for women, as is most evident in the marked age- and sex-differentiated **HIV prevalence rates**—this has implications for strategies to reduce overall prevalence in SSA and how and for whom AIDS **prevention** activities are undertaken. The second is that the **impact** of HIV/AIDS differs markedly along gender lines, reflecting men’s and women’s different roles and responsibilities in household and market activities, and critical gender differences in access to and control of resources—this has implications for **care, support, and treatment** programs, and especially for addressing the needs of the **12 million AIDS orphans** in SSA. The third is that tackling the AIDS pandemic is fundamentally about a radical change in gender relations in SSA, through behavior change that empowers both men and women to “**transform**” gender relations. This combination of factors can be termed the “gender dynamics” of HIV/AIDS. (1) Understanding and explicitly acting on these gender dynamics is essential if Africa is to halt, or reverse, the AIDS pandemic and address its long-term impact.



Many factors account for why vulnerability and risk differ for men and for women, and for men and women at different ages (Figure 3). Some are **physiological**, where women's risk of infection is higher. Others are **socio-cultural**, reflecting different norms, roles and expectations, and **economic**, reflecting differences in command over assets (including productive resources, employment, and education). Differences in **power relations** between men and women (largely grounded in culture, economic inequality, and vulnerability) have been identified as one of the major factors contributing to the spread of AIDS. Significantly, gender inequality contributes to the greater vulnerability to HIV/AIDS of **both** women and men, with age being a major factor. As a result, young women represent the most vulnerable group. (1) This is confirmed by research which points to complex inter-linkages between poverty, inequality and, in particular, gender inequality, and the AIDS epidemic.(2) In a cultural environment in which multiple sexual partners is considered normal for men, the vulnerability and powerlessness of married women deserves particular attention, especially as studies in Africa show that HIV infection levels are around 10 percent higher for married women than for sexually active unmarried girls. (3) As many country studies point out, the single most important factor of vulnerability to HIV for women is being married, which in turn has an impact on the effectiveness of the traditional "ABC" approach to HIV prevention (see Box 1).



Box 1: Beyond the ABCs

The interface between violence and HIV/AIDS, mediated through women's economic dependency and cultural subordination, suggests that the "conventional" model of attacking AIDS, A(abstain) B (be faithful) C (use condoms) has little or no applicability in many SSA countries. In the words of the Task Force on Women, Girls and HIV/AIDS in Southern Africa:

"Abstinence is unrealistic in an environment in which boys are encouraged to be sexually aggressive and girls are kept in ignorance about their own sexuality. And calls for abstinence are, of course, meaningless when sexual activity is coerced, or when women and girls feel they must resort to sex as a matter of survival.

Being faithful only works if both partners play by the same rules. Yet prevailing norms encourage men to have multiple partners. ... Fidelity will do nothing to protect a girl or woman against HIV/AIDS if her partner is unfaithful; nor will fidelity to an older male who is more likely to be infected.

Condom use is almost invariably a male decision, and many men remain deeply reluctant to use them. Alternative forms of contraception ... which might give greater power to women and girls, are hard to come by." (4)

II. Strategic Priorities for Addressing the "Gender Dynamics" of AIDS in SSA

- ◆ Focus on women's **legal rights and protection**. Expand access to legal and judicial services, legal literacy and education, and gender-responsive reform of laws. In country dialogue, the focus should be on passage and effective enforcement of family laws (such as the Domestic Relations Bill and Sexual Offences Bill in Uganda), which criminalize [marital] rape and which provide women stronger legal rights relating to marriage, divorce, inheritance, and division of property.
- ◆ Address gender-based obstacles to women's **economic empowerment and agency**, and increase women's effective access to productive resources (including land), and to entrepreneurship skills. Support in-country initiatives aimed at "transforming" gender relations, especially in relation to sexual behavior and reproductive health.
- ◆ Identify and disseminate in MAP operations **good practice** in: (i) gender-differentiated analysis of risk/vulnerability, and impact; (ii) gender-appropriate targeting of prevention, care, treatment, and support programs; (iii) systematic age- and sex-disaggregation of data/indicators; (iv) gender-inclusion in participatory processes at national and community levels.
- ◆ Focus interventions on **care tasks**, with particular attention to the needs of AIDS orphans, in ways that specifically address gender-differentiated roles and responsibilities for care, and that reduce the substantial additional time burdens on women and girls. This requires targeted investment in household energy, water, and labor-saving technology accessible to women.
- ◆ Integrate child- , and especially **girl-headed households** into the monitoring of households targeted for assistance by government or NGO actors.

Principal Data Sources and Resources on Gender and HIV/AIDS. (1) Geeta Rao Gupta, *Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How*, Plenary Address, XIIIth International AIDS Conference, Durban, South Africa, July 12, 2000. (2) *Confronting AIDS: Public Priorities in a Global Epidemic*, A World Bank Policy Research Report, Washington, D.C. 1997. (3) *Women and AIDS, An Extract from the AIDS Epidemic Update December 2004*, UNAIDS, Global Coalition on Women and AIDS, www.unaids.org. (4) *Facing the Future Together: Report of the Secretary General's Task Force on Women, Girls, and HIV/AIDS in Southern Africa*. UNAIDS/Global Coalition on Women and AIDS, July 2004. (5) World Bank (2001). *Engendering Development: Through Gender Equality in Rights, Resources, and Voice*. A World Bank Policy Research Report, Washington, D.C. (6) Blackden, C. Mark and Chitra Bhanu (1999), *Gender, Growth, and Poverty Reduction*, Special Program of Assistance for Africa 1998 Status Report on Poverty, World Bank Technical Paper No. 428, Washington D.C.