SECTION I

CHALLENGES OF THE HIV/AIDS EPIDEMIC: THE GENDER AND HUMAN RIGHTS CONTEXT

HIV: BASIC FACTS ABOUT THE DISEASE

i. HIV - Human Immune Deficiency Virus

- HIV is a retrovirus.[1]
- HIV attacks the immune system, which helps defend the body against infections. Over a period of time, the virus overwhelms the immune system. The body is then not able to successfully defend itself from opportunistic infections[2].
- The virus targets a cell known as the T4 lymphocyte.
- It can be isolated from blood, semen, and secretions that include cervical and vaginal, breast milk, saliva, tears and urine. But a certain viral load[3] is necessary for the infection to be successfully transmitted.

ii. AIDS – Acquired Immune Deficiency Syndrome

- It is a life threatening condition and is characterised by the destruction of certain cells mainly the T4 lymphocytes. This leads to opportunistic infections, which are severe and ultimately fatal.
- The length of time from when a person is infected with HIV to the development of AIDS varies from person to person. People can remain healthy for any time from a few years to more than ten years before developing any AIDS related symptoms.
- If a blood test shows that a person has HIV it does not necessarily mean that he/she has AIDS.

iii. Modes of Transmission

- Sexual Intercourse
- Pregnancy-related vertical transmission
- Blood transfusion
- Sharing of infected needles used to inject drugs intravenously.

iv. HIV Cannot be Transmitted by:

- Casual everyday contact e.g. shaking hands, hugging, kissing, coughing, sneezing
- Donating blood
- Using common swimming pools or public toilet seats

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[1] A virus containing genetic RNA material rather than DNA. For the virus to replicate itself within an infected cell its RNA must be converted to DNA. It does this by using an enzyme known as reverse transcriptase.

[2] Over the course of a lifetime, starting from infancy, we are all subjected to infections that are held in check by our own immune systems. When HIV suppresses a person's immune system, these infections can manifest themselves, e.g. tuberculosis while others may never cause disease unless the immune system is weakened, e.g. CMV retinitis. These infections move a patient from HIV status to AIDS, and are referred to as opportunistic infections.

[3] Viral load is the amount of HIV per milliliter of blood.

- Sharing bed linen, eating utensils, food
- Animals, mosquitoes, and other insects

v. Origin and History

- In the late 70's doctors began to recognise a new pattern of illnesses.
- In 1981 – AIDS was recognised as a syndrome (a group of symptoms emerging from a common cause) of illnesses.
- In 1983 – HIV was identified.
- In 1984 – HIV was isolated in France and the United States.[4]
- In 1985 – HIV semen antibody test for the diagnosis of HIV became available.

vi. Diagnosis

- HIV antibodies can be detected through the HIV antibody test about 3-6 months after infection.
- The period during which the antibodies are not yet detected is called the window period. Transmission of infection can take place during this period.
- Screening is done by a test know as the ELISA test – Enzyme Linked Immuno Sorbent Test Assay. If it is positive it is followed by a confirmatory test which is either Western Blot or Fluorescent Antibody Technique.
- Incubation period of AIDS is the time between infection and the onset of symptoms. It varies from person to person.

vii. Treatment of HIV

Since HIV is a retrovirus, medications are mainly anti-retroviral. Treatment is a three-drug combination therapy. The drugs are:

a) NRTIs: Nucleoside Reverse Transcriptase Inhibitors[5]

b) NNRTIs: Non-Nucleoside Reverse Transcriptase Inhibitors[6]

Reverse Transcriptase is an enzyme that changes the HIV in a way that enables it to become part of the nucleus of a target cell thereby allowing it to make copies of itself. NRTIs and NNRTIs inhibit (slow down) the action of this enzyme. If this enzyme does not do its job properly HIV cannot take over and start making new copies of itself.

[4] France – Luc Montaguier et al, 1983. US – Robert Gallo, et al, 1984.
[5] NRTI's : Retrovir (AZT/Zidovudine), Videx (ddi/Didanosine), Zerit (d4T/Stavudine), Hivid (ddC/Aziciabine), Epivir (3TC/Lamivudine)
[6] NNRTI's: Delavirdine (Rescriptor), Nevirapine (Viramune)

c) PI: Protease Inhibitors[7]

These slow down the enzyme protease, which works on the HIV virus after it comes out of the nucleus of the cell. Protease acts like a pair of chemical scissors by cutting up the long chains of HIV proteins into smaller pieces so that it can make active new copies of itself. Protease Inhibitors gum up (block) the protease scissors.

d) Prophylactic Medications

These help prevent opportunistic infections when the immune system becomes weak e.g. Foscarnet and Ganciclavin to treat Cytomegalovirus Eye infections, Fluconozole to treat yeast and other fungal infections, TMP/SMX or Pentamidine to treat Pneumocystis Carinii Pneumonia.

[7] Protease Inhibitors: Indinavir (Crixivan), Nelfinavir (Viracept), Ritonavir (Norvir), Saquinavir (Invirase/Fortovase)

GLOBAL SUMMARY OF THE HIV/AIDS EPIDEMIC[8]

People newly infected with HIV in 2000	**Total** Adults Men *Women* Children <15 years	**5.3 million** 4.7 million 2.5 million *2.2 million* 600,000
Number of people living with HIV/AIDS	**Total** Adults Men *Women* Children <15 years	**36.1 million** 34.7 million 18.3 million *16.4 million* 1.2 million
AIDS deaths in 2000	**Total** Adults Men *Women* Children < 15 years	**million** 2.5 million 1.2 million *1.3 million* 500,000
Total number of AIDS deaths since the Beginning of the epidemic	**Total** Adults Men *Women* Children <15 years	**21.8 million** 17.5 million 8.5 million *9 million* 4.3 million

[8] AIDS Epidemic Update: December 2000.

REGIONAL OVERVIEW OF THE EPIDEMIC

Region	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate[9]	Percent of HIV-positive adults who are women	Main mode(s) of transmission[10] for adults living with HIV/AIDS
Sub-Saharan Africa	Late '70s - Early '80s	25.3 million	3.8 million	8.8%	55%	Hetero
North Africa & Middle East	Late '80s	400 000	80 000	0.2%	40%	IDU, Hetero
South & South-East Asia	Late '80s	5.8 million	780 000	0.59%	35%	Hetero, IDU
East Asia & Pacific	Late '80s	640 000	130 000	0.07%	13%	IDU, Hetero, MSM
Latin America	Late '70s - Early '80s	1.4 million	150 000	0.5%	25%	MSM, IDU, Hetero
Caribbean	Late '70s - Early '80s	390 000	60 000	2.3%	35%	Hetero, MSM
Eastern Europe & Central Asia	Early '90s	700 000	250 000	0.35%	25%	IDU, MSM
Western Europe	Late '70s - Early '80s	540 000	30 000	0.24%	25%	MSM, IDU
North America	Late '70s - Early '80s	920 000	45 000	0.6%	20%	MSM, IDU, Hetero
Australia & New Zealand	Late '70s - Early '80s	15 000	500	0.13%	10%	MSM, IDU
TOTAL		**36.1 million**	**5.3 million**	**1.1%**	**47%**	

[9] The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2000, using 2000 population numbers.

[10] MSM (sexual transmission among men who have sex with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

HIV: A RAPIDLY EXPANDING EPIDEMIC[11]

- In 1999, there were nearly 33.6 million people living with HIV. By the end of 2000, this figure rose to approximately 36.1 million.
- The percentage of women infected by HIV in 1997 was 41%, in 2000 this figure had risen to 47%.
- Since 1994 in almost every country of Asia there has been a 100 percent increase in the prevalence rate.
- In the last three years the prevalence rate in 27 countries has doubled. In Botswana and Zimbabwe the prevalence rate among adults is 25 percent.
- HIV infections in the former Soviet Union have doubled in just two years.
- The Caribbean is the region hardest hit by HIV/AIDS in the world outside sub-Saharan Africa.
- HIV is considered to be among the top ten killers in the world.
- In 1998, there were 2.6 million deaths from HIV/AIDS, as many as from malaria.
- Thirty percent of the AIDS deaths have resulted from tuberculosis (TB).
- Around half of all the people who acquire HIV become infected before they turn 25 and typically die of the life threatening illnesses called AIDS before their 35th birthday.
- In 1998, Africa witnessed 5,500 funerals per day due to HIV/AIDS related deaths.
- At the end of 1999, there were 11.2 million AIDS orphans around the world.

[11] AIDS Epidemic Update: December 1999; AIDS Epidemic Update: December 2000; and the Speech to the House Committee on International Relations on 16 September 1998 by Peter Piot M.D., Ph.D. Executive Director Joint United Nations Program on HIV/AIDS.

HARD WON VICTORIES[12]

There is sound evidence that HIV infection rates are stabilising or decreasing in places where focused and sustained prevention programs have resulted in significantly safer behaviour. This is not just the case in the developed countries in Europe and the Americas. It is true around the world. Widespread access to highly effective antiretroviral therapy has significantly prolonged life and improved the quality of life for people living with HIV in the western world and has resulted in a dramatic decline in AIDS deaths in these countries.

- In Uganda delayed first sexual intercourse, increased condom use, and fewer sexual partners have been responsible for a 40 percent drop in HIV prevalence among pregnant women.

- In Thailand there is comprehensive evidence that prevention campaigns work. Annual representative surveys in young men showed both substantial reductions in risk behaviour and decreases in HIV infection levels. Between 1991 and 1995, visits to sex workers reported by these men were cut by almost a half; and those who reported using a condom on the last visit increased from nearly 60 percent in 1991 to slightly under 95 percent in 1995. HIV prevalence among this group has gone down as a result from 8 percent in 1992 to less than 3 percent in 1997.

- In Senegal, prevention efforts appear to have reduced rates of sexually transmitted diseases and stabilised HIV rates at low levels of less than 2 percent among sexually active adults.

- In northern Tanzania the first sign of an HIV turnaround has also been seen among young people. In areas with active prevention programs, prevalence in young women fell by 60 percent over a period of six years.

- New research findings from Thailand demonstrate that even a short course of AZT for HIV-infected pregnant women could reduce by half the risk of HIV transmission to their new-born.

- It has been confirmed that the usefulness of tuberculosis prophylaxis will now allow more effective action against this important co-epidemic.

- Brazil and other South American countries have started widening access to treatment, including access to antiretroviral therapy.

- Significant progress in expanding global capacity to monitor the epidemic has also been made. There are now country-specific estimates and data for almost every country in the world.

[12] Speech to the House Committee on International Relations on 16 September 1998 by Peter Piot M.D., Ph.D. Executive Director Joint United Nations Program on HIV/AIDS.

UNDERSTANDING GENDER

Gender

The word "gender" differentiates the sociologically attributed aspects of an individual's identity from the physiological characteristics of men and women. Gender has to do with how we think, how we feel and what we believe we can and cannot do because of socially defined concepts of masculinity and femininity. Gender relates to the position of women and men in relation to each other. These relationships are based on power.

Difference Between Sex and Gender

The word gender is used to describe socially determined characteristics; sex describes those, which are biologically determined. Sex is something one is born with, whereas gender is imbibed through a process of socialisation. Sex does not change and is constant, whereas gender and consequent gender roles change and vary within and between cultures.

Implications for HIV/AIDS[13]

- Where sex is biological, gender is socially defined. Gender is what it means to be male or female in a certain society as opposed to the set of chromosomes one is born with. Gender shapes the opportunities one is offered in life, the roles one may play, and the kinds of relationships one may have – social norms that strongly influence the spread of HIV.
- For women, risk-taking and vulnerability to infection are increased by norms that make it inappropriate for women to be knowledgeable about sexuality or to suggest condom use; the common link between substance abuse and the exchange of sex for drugs or money; and by resorting to sex work by migrant and refugee women and others with family disruption.
- For men, risk and vulnerability are heightened by norms that make it hard for men to acknowledge gaps in their knowledge about sexuality; by the link between socialising and alcohol use; by the frequency of drug abuse, including by injection; and predominantly male occupations (e.g. truck-driving, seafaring, and military) that entail mobility and family disruption.
- In cultures where HIV is seen as a sign of sexual promiscuity, gender norms shape the way men and women infected with HIV are perceived, in that HIV-positive women face greater stigmatisation and rejection than men. Gender norms also influence the way in which family members experience and cope with HIV and with AIDS deaths. For example, the burden of care often falls on females, while orphaned girls are more likely to be withdrawn from school than their brothers.
- Hence, responses to the epidemic must build on an understanding of gender-related expectations and needs, and may need to challenge adverse norms.

[13] UNAIDS, Gender and HIV/AIDS: Technical Update, September 1998.

HIV: A GENDER ISSUE

HIV is a gender issue because:

i) Although HIV/AIDS affects both men and women, women are more vulnerable because of biological, epidemiological and social reasons.

- 41 percent of 33.4 million adults living with HIV/AIDS are women.
- 55 percent the 16,000 new infections occurring daily are women.
- 43 percent of pregnant women tested positive in Francistown, Botswana.
- Following a trend observed in some countries the male to female ratio among HIV infected persons has begun to equalise. In fact in some of the worst affected countries, women outnumber men.

"I have AIDS…Today it is me, tomorrow it's someone else. If I am not kind, if I do not sympathise and get involved with my neighbours, what will happen to me when my turn comes?"[14]

ii) The epidemic is fuelled by situations where macro policies have led to an increase in gender disparities.

- In Sub-Saharan Africa, policies leading to internal and external conflicts have resulted in mass population displacements. This has created unequal sex ratios among refugees, internally displaced and those remaining in the areas of conflict exacerbating gender disparities. As a result six women for every five men in conflict situations are HIV positive.
- UNDP estimates over 85 percent of the cases of paediatric infection in Africa have resulted from perinatal transmission. The infant mortality rate in this region is expected to increase by up to 30 percent.
- In the Asia-Pacific region, the exclusion of women from the emerging market economies led to an increase in existing gender disparities. Out of the 2.7 million estimated new HIV cases in the world in 1996, 1 million were in South and Southeast Asia.
- In Latin America and the Caribbean, policies promoting high urbanisation have pushed women into a low productivity informal sector, where they have to cluster for survival. In Sao Paolo, HIV/AIDS was the leading cause of death amongst women in the age group of 20-34 years.

"To be alone and dying, yet to care for one's own HIV infected child is tragedy, the dimension of which few of us can truly comprehend."

"Like every other epidemic, AIDS develops in the cracks and crevices of society's inequalities…."

[14] All the quotes in italics are voices of women living with HIV/AIDS.

iii) The rapidity of the spread of HIV/AIDS among women can be slowed only if concrete changes are brought about in the sexual behaviour of men.

- A study of female youth in South Africa showed that 71 percent of the girls had experienced sex against their will.
- A behaviour survey financed by USAID in Tamil Nadu in India shows that 82 percent of the male STD patients had sexual intercourse with multiple partners within the last 12 months and only 12 percent had used a condom.

" The women tell us they see their husbands with the wives of men who have died of AIDS. And they ask what can we do? If we say no, they'll say: pack and go. If we do, where do we go to?"

iv) The feminisation of poverty is a key characteristic of the socio-economic impact of HIV/AIDS

The burden of care of the infected and sick invariably falls on women in the family. In households where women are responsible for subsistence farming this leads to:

- Reduction of productive time on farms.
- Threat to the food security of the family.
- Withdrawal of the girl child from school to bridge the demand for additional unpaid labour in the household.
- Increase in households headed by women, at times by girl children with little access to productive resources, often driving them into sex work for survival.

"The children are lonely and sad without any family…I do not know how to comfort them. I tell them they cannot even rely on me, as I fear I am infected. I know I am asking them to grow up before their time, but I see no other alternative, if they are to survive."

"It is as if we are beginning a new life. Our past is so sad. We are not understood by society…we are not protected against anything. Widows are without families, without houses, without money. We become crazy. We aggravate people with our problems. We are the living dead."

v) Existing legal and policy frameworks need to be reviewed with a gender sensitive lens to ensure positive and sustainable changes.

The laws that need to be reviewed include:

- The laws relating to the prevention and suppression of commercial sex work.
- The laws relating to homosexuality. (Homosexuality is an act categorised under sodomy, which is punishable by law.)
- The laws both federal and personal that reduce women's access to productive assets like laws on inheritance, marriage, divorce, and cultural sexual practices.
- Policies regulating sex education in schools.
- Rules relating to ethical and professional orientation of service providers.

"*Sometimes sex work is a form of self-defence: We are going to sell what they want to take by force or by chance."*

"Through my and others personal experience I have learnt that many women suffer in silence…Now HIV has changed many aspects of our lives and humanity is facing a plague which requires that we reassess and reform some of our cultural and traditional values."

Gender inequality is a key variable in the incidence of HIV/AIDS. As gender disparities increase, the epidemic is affecting more and more women who bear the negative consequences of the gender imbalances. And as the epidemic is maturing, it is drawing in women who have had only one sex partner. A decade ago women seemed to be on the periphery of the epidemic. Today they are at the centre of concern.

HIV/AIDS: MEN MAKE A DIFFERENCE[15]

All over the world, women find themselves at special risk of HIV infection because of their lack of power to determine where, when and how sex takes place. What is less recognised, however, is that the cultural beliefs and expectations that make this the case also heighten men's own vulnerability. HIV infections and AIDS deaths in men outnumber those in women on every continent except sub-Saharan Africa. Young men are more at risk than older ones: about one in four people with HIV are young men under the age of 25.

There are sound reasons why men should be more fully involved in the fight against AIDS. All over the world, men tend to have more sex partners than women, including more extramarital partners, thereby increasing their own and their primary partners' risk of contracting HIV, a risk compounded by the secrecy, stigma and shame surrounding HIV. This stigma may keep men and women from acknowledging that they have become infected.

Men need to be encouraged to adopt positive behaviours, and, for example to play a much greater part in caring for their partners and families. Numerous studies world-wide show that men generally participate less than women in caring for their children. This has a direct bearing on the AIDS epidemic, which has now left over 11 million children orphaned and in need of adult help to grow up clothed, housed and educated.

[15] Excerpts have been taken from a press release (6 March 2000) from UNAIDS about the UNAIDS Campaign 2000 to target men.

HIV: A HUMAN RIGHTS ISSUE

The WHO Constitution has defined health as "a state of complete physical, mental and social well being, not merely the absence of disease and infirmity." This state of human well being has been guaranteed as a human right through a number of international human rights treaties. Although health was first articulated as a human right in the Universal Declaration of Human Rights, a more detailed articulation of this right was set forth in Article 12 of the Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination Against Women reaffirmed these rights further.

The rapid spread of the HIV/AIDS epidemic has led to an infringement of the human rights of men, women and children affected by the epidemic in various ways. According to the World Development Report of 1993, half of the world's burden of disease is attributable to communicable diseases, to maternal and perinatal causes and to nutritional disorders. However women, particularly women in low-income nations, bear a large proportion of this disease burden. The overall morbidity and mortality for women from sexually transmitted diseases excluding HIV/AIDS is over 4.5 times that of men. The onset of the HIV/AIDS epidemic has exacerbated this situation in no small way. It has opened up a whole new area of human rights violations as the epidemic depicts a congruence of two most insidious forms of human oppression – gender and sexuality.

In response to this state of affairs the Second International Consultation on HIV/AIDS and Human Rights concluded that: the protection of human rights is essential to safeguard human dignity in the context of HIV/AIDS and to ensure an effective rights based response to the epidemic. This conclusion was based on the recognition that when human rights are protected, less people become infected and those living with HIV/AIDS and their families can better cope with the disease.

Prevention and care for women are often undermined by pervasive misconceptions about HIV transmission and epidemiology. There is a tendency to stigmatise women as "vectors of disease," irrespective of the source of infection. As a consequence, women who are or are perceived to be HIV-positive face violence and discrimination in public and in private life. Sex workers often face violence and discrimination in public and in private life. Sex workers often face mandatory testing with no support for prevention activities to encourage or require their clients to wear condoms and with no access to health-care service. Many HIV/AIDS programs targeting women are focused on pregnant women but these programmes often emphasise coercive measures directed towards the risk of transmitting HIV to the foetus, such as mandatory pre- and post-natal testing followed by coerced abortion or sterilisation.

The protection of the sexual and reproductive rights of women and girls is, therefore, critical. This includes the rights of women to have control over and to decide freely and responsibly on matters related to their sexuality. States should thus ensure women's rights are upheld in matters relating to property, employment, divorce, access to economic resources so that women can leave abusive relationships which threaten them with HIV infection. This will

also enable them to cope with the burden of caring for people living with HIV/AIDS in their households. An engendered human rights approach to the epidemic is therefore imperative.