

---

# The UNGASS, Gender and Women's Vulnerability to HIV/AIDS in Latin America and the Caribbean



**Women, Health and Development Program  
Pan-American Health Organization**

---



**The UNGASS, Gender and Women's  
Vulnerability to HIV/AIDS in  
Latin America and the Caribbean**

Prepared by Karen Marcovici

for

**The Program on Women, Health and Development**  
Division of Health and Human Development  
with the Program on AIDS and Sexually Transmitted Infections

**Pan-American Health Organization**  
Regional Office of the World Health Organization

December 2002  
Washington DC

## Contents

I. Introduction.....	1
II. Gender, Sex and Sexuality.....	3
a) The Social Construction of Gender.....	4
Femininity and Female Sexuality.....	4
Masculinity and Male Sexuality.....	4
III. Gendered Vulnerabilities to HIV/AIDS.....	4
a) Biological Factors.....	4
b) Social Factors - Gender, Sexuality, Vulnerability and Risk.....	5
Women, Sexuality and Vulnerability.....	5
Men, Sexuality and Risk.....	6
c) Economic Factors.....	7
IV. HIV/AIDS and Women's Gender Roles.....	8
a) Gender-Based Violence.....	8
b) Commercial Sex-Work and Sex Tourism.....	9
c) Trafficking for Sexual Exploitation.....	10
d) Migration and Displacement.....	10
Voluntary Migration.....	10
Crisis, Forced Migration and Internal Displacement.....	11
Inter and Intra-State Conflict.....	12
V. Infected and Affected - Women, Men and the Epidemic.....	13
a) Infected.....	13
b) Affected.....	14
VI. Responding to Women's Needs.....	15
a) Vertical or Mother-to-Child Transmission.....	15
b) "Female-Controlled" Methods.....	16
The Female Condom.....	17
Microbicides.....	17
VII. Program Responses.....	17
VIII. Conclusion.....	20
IX. Bibliography.....	22

*For there to be any hope of success in the fight against HIV/AIDS, the world must join together in a great global alliance.<sup>1</sup>*

*Kofi Annan*

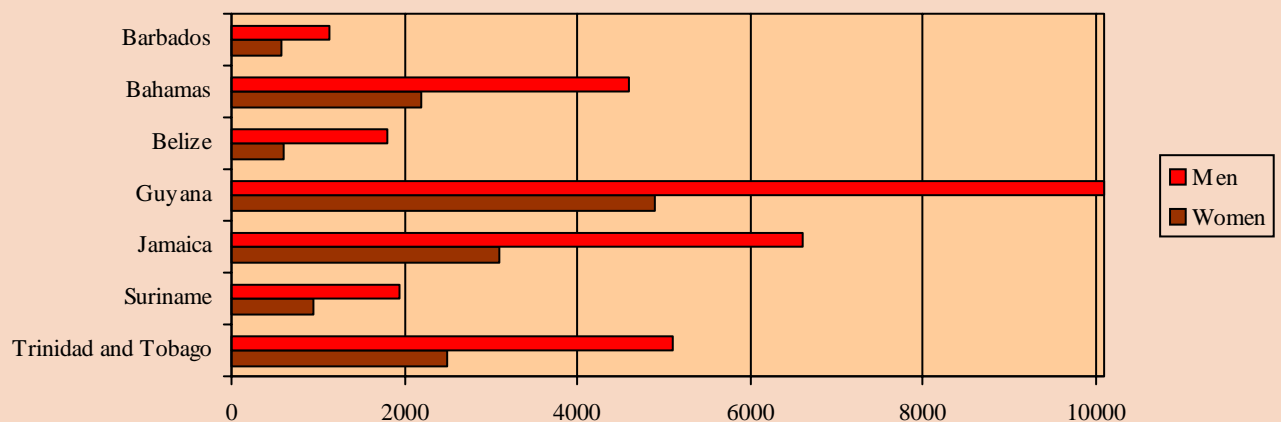
## I. INTRODUCTION

Worldwide, the HIV/AIDS pandemic has reached devastating proportions and continues to escalate. On a global scale, 40 million women, men and children are living with HIV/AIDS. The Caribbean has the second highest HIV/AIDS infection rate) in the world (after Sub-Saharan Africa. At the end of 1999, women made up 25% of HIV positive adults in Latin America, and 30% in the Caribbean. Today, those percentages have increased to 30% in Latin America and 50% in the Caribbean.<sup>2</sup> While globally more men than women are living with HIV/AIDS, an examination of the transmission trends and prevalence statistics reveals that the gap between the number of women and men infected with HIV/AIDS is narrowing. In some of the worst affected countries in the region, the number of newly-infected women in certain age groups now outnumbers men. For example, in Trinidad and Tobago HIV/AIDS rates are five times higher for girls than for boys aged 15-19.<sup>3</sup>

Gender has a significant impact on (1) the transmission of HIV/AIDS in both heterosexual and homosexual relationships, and (2) the differential experiences of infected and affected women and men.<sup>4</sup> Social and cultural definitions of gender shape female and male behaviour, particularly in the realm of sexuality. Throughout the world, the unequal social status of women places them at higher risk for contracting HIV/AIDS. Women are at a disadvantage with respect to access to information about HIV/AIDS prevention, the ability to negotiate safe sexual encounters and access to treatment for HIV/AIDS once infected.

As the world addresses the HIV/AIDS pandemic, the inequitable sexual interaction between men and women will continue to have grave consequences, highlighting the importance of addressing gender-related expectations and attitudes.

**Table 1 - Estimated Number of Men and Women Living With HIV/AIDS, 1999 (selected countries) <sup>5</sup>**



<sup>1</sup> Declaration of Commitment on HIV/AIDS: United Nations General Assembly Special Session on HIV/AIDS. Geneva and New York: United Nations, 2001. Foreword

<sup>2</sup> *AIDS Epidemic Update*. Geneva: UNAIDS/WHO, 2001.

<sup>3</sup> *HIV and AIDS in the Americas, an Epidemic with Many Faces*. Washington DC: PAHO/WHO/UNAIDS, 2001.

<sup>4</sup> Rao Gupta, G. *Vulnerability and Resilience: Gender and HIV/AIDS in Latin America and the Caribbean*. Washington DC: International Centre for Research on Women, 2002. (Unpublished paper).

<sup>5</sup> Compiled using data from *Epidemiological Fact Sheets*. Geneva: UNAIDS/WHO, 2002

Despite this reality, policies and programs have been slow to incorporate a gender perspective into the HIV/AIDS agenda.<sup>6</sup>

While data about the prevalence of HIV/AIDS measures the current pandemic, information about women and men's knowledge, attitudes and behaviours allows us to shape its future<sup>7</sup>. Gender norms and roles have a profound effect on the sexual activity and risk behaviours<sup>8</sup> of both men and women. Gender inequities, such as the unequal distribution of power and economic and social resources further exacerbate this situation. The difference between risk and vulnerability to HIV has been highlighted by previous authors,<sup>9</sup> and it is a central point of this paper. Whereas men have historically been at an increased risk of HIV infection, women are more vulnerable to infection. For example, women often cannot control with whom or under what circumstances they have sex, whereas men often feel pressured to have sex with many different partners. Both are victims of the social construction of gender, but men's risk of HIV infection is primarily determined by their own proactive behaviour, whereas women's vulnerability to HIV infection is largely beyond their control.

The recent United Nations General Assembly Special Session on HIV/AIDS (UNGASS, June 25-27th, 2001) declared HIV/AIDS to be a worldwide emergency requiring immediate and effective action. All the countries present at the UNGASS endorsed a number of key resolutions and commitments that addressed women's increased vulnerability to HIV, and proposed solutions for combating it.

*Article 37. By 2003, ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS that... confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets... fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; address risk, vulnerability, prevention, care, treatment, and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity;<sup>10</sup>*

**Rates of HIV Infection among Women (15-49) in Selected Countries**

Country	Infected Adults	Infected Women	%
Argentina	130,000	30,000	23.0%
Bahamas	6,100	2,700	44.3%
Barbados	2,000	N/A	N/A
Belize	2,200	1,000	45.5%
Bolivia	4,500	1,200	26.8%
Brazil	600,000	220,000	36.7%
Canada	55,000	14,000	25.5%
Chile	20,000	4,300	21.5%
Colombia	140,000	20,000	14.3%
Costa Rica	11,000	2,800	25.5%
Cuba	3,200	830	26.0%
Dom. Rep.	120,000	61,000	50.8%
Ecuador	19,000	5,100	26.8%
El Salvador	23,000	6,300	27.4%
Guatemala	63,000	27,000	42.9%
Guyana	17,000	8,500	50.0%
Haiti	240,000	120,000	50.0%
Honduras	54,000	27,000	50.0%
Jamaica	18,000	7,200	40.0%
Mexico	150,000	32,000	21.3%
Nicaragua	5,600	1,500	26.8%
Panama	25,000	8,700	34.8%
Paraguay	51,000	13,000	25.5%
Peru	N/A	N/A	N/A
Suriname	3,600	1,800	50.0%
Trin & Tob	17,000	5,600	33.0%
USA	890,000	180,000	20.2%
Uruguay	6,200	1,400	22.6%
Venezuela	62,000	N/A	N/A

This paper will discuss the effect of female and male gender roles, power relations and sexual behaviour on the spread of HIV/AIDS in the Latin American and Caribbean Region (LAC), specifically exploring women's vulnerability to the epidemic. The issues of violence, commercial sex-work and sex tourism, human trafficking, population displacement and crisis will also be addressed in relation to women and men's susceptibilities to HIV/AIDS. The discussion will be situated within the framework of the commitments made at the 2001 UNGASS, and their critical implications for the national, regional and international response to the epidemic. Relevant resolutions from the UNGASS Declaration of Commitment on HIV/AIDS will be cited

<sup>6</sup> "Facing the Challenge of HIV/AIDS/STDs: A Gender-Based Response". Geneva: UNAIDS, 2001a

<sup>7</sup> PAHO/WHO/UNAIDS, 2001

<sup>8</sup> It is important to highlight the difference between modes of transmission and risk behaviours. Though HIV can be transmitted in several ways: through unprotected sex, intra-venous drug use, mother-to-child transmission and tainted blood transfusions - women's and men's specific vulnerabilities to HIV/AIDS are influenced by gendered "risk behaviours", primarily unprotected sex (heterosexual and homosexual sexual activity).

<sup>9</sup> Villela, W. "On Women's Vulnerability to HIV" in A.Gomez and D. Meacham (eds.) *Women, Vulnerability and HIV/AIDS: A Human Rights Perspective*. Chile: Latin American and Caribbean Women's Health Network, 1998.

<sup>10</sup> UNGASS *Declaration of Commitment on HIV/AIDS*, 2001.

where appropriate.

The paper will conclude with a review of program responses that have taken into account women and men’s gender-based vulnerability to HIV/AIDS in project design and implementation with selected populations. It will end with a series of recommendations based on the resolutions adopted during the 2001 UNGASS.

## II GENDER, SEX AND SEXUALITY

An understanding of gender, sex and sexuality is essential to addressing these issues, yet the three terms are often confused and interchanged.

*Sex refers to the sum of biological characteristics that define the spectrum of humans as females and males.*<sup>11</sup>

*Gender is the sum of cultural values, attitudes, roles, practices and characteristics based on sex.*<sup>12</sup>

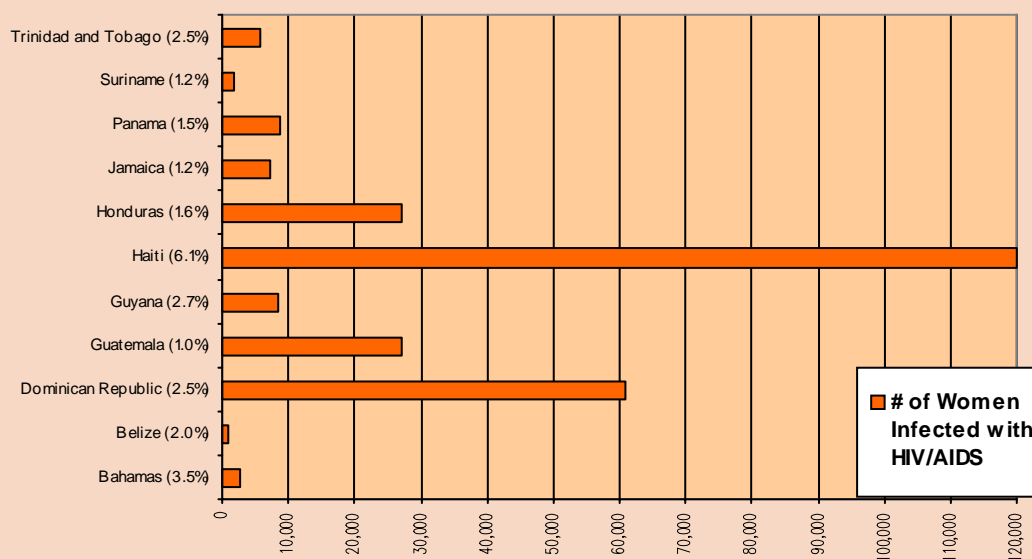
Unlike “sex”, which refers to biological/physical differences alone, gender is a series of expectations, norms and behaviours which are differentially based on sex. Women become “feminine” and men become “masculine” through processes of social, cultural and political socialization.

*Sexuality refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love, and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles, and relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors.*<sup>13</sup>

Gender is instrumental in defining human sexuality for both women and men.

Gender relations are an essential component of the socio-cultural fabric of a society. From the earliest age boys and girls are socialized to adopt specific ideals of masculinity and femininity. These *socio-cultural norms* have a significant impact on women and men’s sexual behaviour,

**Table 3 - HIV/AIDS among Women in the Worst Affected Countries in LAC (2001)<sup>14</sup>**



<sup>11</sup> Promotion of Sexual Health: Recommendations for Action. Washington DC: PAHO, 2000.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> Compiled using data from UNAIDS Global HIV/AIDS and STD Surveillance Fact Sheets, 2002.

*Article 47. By 2003...intensify efforts to....challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;*

*Article 4. Noting with grave concern that all people, rich and poor, without distinction as to age, gender, or race, are affected by the HIV/AIDS epidemic, further noting that people in developing countries are the most affected and the at women, young adults and children, in particular girls, are the most vulnerable;*

*Article 14. Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS;*

on their respective sexual responsibilities, on their sexual education and on their ability to access information about sex and resources, including sexual health care<sup>15</sup>.

#### a) The Social Construction of Gender

The culture of *Machismo* (masculinity) and *Marianismo* (femininity)<sup>16</sup> in the LAC region influences women and men's exposure and vulnerability to HIV/AIDS.

##### *Femininity and Female Sexuality*

The term *Marianismo* originates from the Virgin Mary or "Maria" and portrays the ideal woman as being modest, pure, dependant, weak, acquiescent, vulnerable and abstinent until marriage, at which point the woman becomes subordinate to and obedient of her spouse<sup>17</sup>. These assigned characteristics are accompanied by a series of cultural norms and expectations. In terms of defining female sexuality, "femininity" implies that a woman must be innocent and self-sacrificing, placing the needs and desires of her male partner before her own. She is expected to remain silent and acquiescent regarding her desires and her pain.<sup>18</sup>

##### *Masculinity and Male Sexuality*

*Machismo*, the male counterpart to *Marianismo*, applies to the typical construction of "masculinity" in the LAC region, depicting the male as the provider, independent, strong, willing to face danger, and dominant<sup>19</sup>. This social construction of masculinity defines male sexuality as heterosexual, virile and even promiscuous, knowledgeable, aggressive and

in control of his environment, including the women around him<sup>20</sup>.

### III. GENDERED VULNERABILITY TO HIV/AIDS

#### a) Biological Factors

Specific biological factors place women at a greater risk of contracting HIV than men. The soft tissue in the female reproductive tract tears easily, producing a transmission route for the virus. Additionally, vaginal tissue absorbs fluids more easily, including sperm, which has a higher concentration of the HIV virus than female vaginal secretions and may remain in the vagina for hours following intercourse.<sup>21</sup>

Women's increased biological vulnerability is compounded by their subordinate social status. A woman is more likely to have sexual contact even though she does not want to, whether she is raped or because she lacks the power to refuse her partner's demands (forced sex). When the vagina is not lubricated, the tissue tears more easily, increasing women's risk of exposure to HIV. When comparing the risk of transmission from male to female and vice versa, it has been estimated that women's risk of exposure is up to 2 to 5 times higher than men's.<sup>22</sup> In both women and men, tears in sensitive anal tissue increase the risk of transmission during anal sex.

Another risk factor for HIV infection is the presence of other sexually transmitted infections (STIs). Women are more likely than men to have other untreated STIs, primarily because

<sup>15</sup> Rao Gupta 2002

<sup>16</sup> Mane, P and P. Aggleton. "Gender and HIV/AIDS: What do men have to do with it?" *Current Sociology* 49: 2001.

<sup>17</sup> Stevens, E. "Marianismo: The Other Face of Machismo in Latin America." In A Pescatello (Ed.). *Female and Male in Latin America*. Pittsburgh: University of Pittsburgh Press, 1973.

<sup>18</sup> Enos, R., and S. Southern. *Correctional Case Management* Anderson Publishing, 1996.

<sup>19</sup> *Masculinity and Gender Violence: Gender Issues Fact Sheet #5*. New York: UNIFEM, 2001.

<sup>20</sup> Barker, G. *The Misunderstood Gender: Male Involvement in the Family and in Sexual and Reproductive Health in Latin America and the Caribbean*. MacArthur Foundation, 1996

<sup>21</sup> *Gender and HIV/AIDS: A Technical Update*. Geneva: UNAIDS, 1998a.

<sup>22</sup> European Study Group on Heterosexual Transmission of HIV. As cited in Aggleton, P. *Men's Role in HIV Prevention and Care*. London: University of London, 2001 (Unpublished paper).

STIs in women are more often asymptomatic, but also because the shame or fear of visiting a doctor may prevent women from seeking screening and treatment.<sup>23</sup>

The risk of infection among young girls is significantly higher because their reproductive tracts contain fewer layers of epithelial cells, which offer a less effective barrier against viral infection, than the multiple layers of modified epithelial (squamous) cells found in the vaginas of adult women.<sup>24</sup> This is of particular concern in the Caribbean, where age-mixing places young girls at an increased risk of HIV/AIDS and STI exposure and throughout LAC, where vulnerable street children may be raped or forced to exchange sex for survival needs.

*Article 59. By 2005, bearing in mind the context and character of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;*

## **b) Social Factors - Gender, Sexuality and Risk Behaviour**

### *Women, Sexuality and Vulnerability*

The social construction of femininity in the LAC region endangers women's health and acts as an obstacle for women who are trying to attain knowledge about their reproductive and sexual health - their bodies, pregnancy, childbirth, contraception, reproductive complications and sexually transmitted diseases including HIV.<sup>25</sup>

The expectation that women will be virgins and the stigma that is attached to female sexuality often prevent sexually active women from accessing health services and information. In depth interviews with women in Nicaragua show that unmarried women fear that even

seeking information about reproductive and sexual health will imply that they are sexually active, thus jeopardizing their reputations.<sup>26</sup>

This lack of empowering information is devastating to both women and men's health, especially considering data which shows that women and men in the region initiate sex in their early teens.<sup>27</sup> In a study conducted in Brazil, 36% of women reported having had intercourse by the age of 13.<sup>28</sup> Adolescence is a crucial time during which information about sex and sexuality can be most useful to both girls and boys. Cultural taboos which prevent discussion of sex in schools, churches, clinics and other fora endanger women and men's health.

Cultures that support the femininity/masculinity dichotomy inhibit adult women's ability to discuss issues such as extramarital partners, use of barrier methods/protection, timing and safety of sexual contact, access to necessary health services and their own sexual pleasure with their male partners<sup>29</sup>. The belief that women have sex solely for reproductive purposes while men need sexual release also creates obstacles for HIV/AIDS prevention programs that promote female negotiation with their partners.<sup>30</sup> The outcomes of decisions in heterosexual relationships frequently leave the female partner with less power and more vulnerability to contracting sexually transmitted infections (STIs) including HIV/AIDS.<sup>31</sup> Social constructions of masculinity and femininity can also be contributory risk factors for HIV.

<sup>23</sup>Gender and Health: A Technical Paper WHO, 1998.

<sup>24</sup>Report on the Global HIV/AIDS Epidemic. Geneva: UNAIDS, 2000c.

<sup>25</sup>Rao Gupta 2002

<sup>26</sup>Zelaya, E et al. "Gender and Social Differences in Adolescent Sexuality and Reproduction in Nicaragua." *Journal of Adolescent Health* 21, 1997.

<sup>27</sup>PAHO/ WHO/ UNAIDS, 2001

<sup>28</sup>Weiss, E. D. Whelan and G. Rao Gupta. *Vulnerability and Opportunity: Adolescents and HIV/AIDS in the Developing World*. International Centre for Research on Women: Washington DC, 1996

<sup>29</sup>Progress of the World's Women: UNIFEM Bilateral Report. New York: UNIFEM, 2000.

<sup>30</sup>Goldstein, D. "AIDS and Women in Brazil: The Emerging Problem." *Social Science and Medicine* 39, 1994 and Rao Gupta, G. and E. Weiss. "Women's Lives and Sex: Implications for AIDS Prevention." *Culture, Medicine and Psychiatry* 17, 1993.

<sup>31</sup> Rao Gupta and Weiss, 1993

For example, in Brazil the pressure for women to remain virgins until marriage leads some of them to engage in risky sexual practices, including anal sex, in order to preserve their virginity<sup>32</sup>.

The heterosexual ideology of Marianismo also fosters stigmatization of lesbians and bisexual women. There is a dearth of data on patterns of homosexual and bisexual behaviour among women, as well as rates of HIV/AIDS transmission and prevalence among these groups. It seems reasonable to suppose however that the marginalization of their behaviour makes it challenging for women who have sex with women in developing countries to access information, services, and appropriate barrier methods, such as the dental dam.<sup>33</sup>

### *Men, Sexuality and Risk Behaviour*

Gender-based norms also increase men's risk of HIV infection. From a young age, boys are socialized to associate prolific sexual activity with masculinity and they are encouraged to be sexually active and knowledgeable regarding sexual issues.<sup>34</sup> A study in Nicaragua reported that adolescent boys are pressured by older men to have sex as early as possible. In fact, there have been numerous documentations of fathers arranging for their sons to initiate sexual activity with a sex worker.<sup>35</sup> Boys that do not comply with this expectation of sexual prowess often face ridicule and questioning of their masculinity.<sup>36</sup> As a result, boys and men are more likely to engage in risky behaviour, and less likely to

seek information about their sexual health because it involves admitting their lack of knowledge, an indication of their sexual inexperience.<sup>37</sup> When compared to any group, young men have the greatest number of sexual partners and feel least at risk from HIV/AIDS.<sup>38</sup>

Men engage in risk behaviours, including having unprotected sex, sometimes with multiple partners or under the influence of alcohol and illegal substances. Men are more likely than women to partake in substance use which is associated with more prolific sexual activity and sexual violence, both risk factors for HIV infection. In Latin America, young men reported that alcohol provides them with the courage to initiate sexual activity.<sup>39</sup> A study in Guatemala City revealed that men frequently demand sex after drinking alcohol, creating additional obstacles for female partners to initiate or negotiate condom use.<sup>40</sup> Men are also more likely to be intra-venous drug users, placing them at risk for infection from contaminated needles and syringes.<sup>41</sup>

*Age mixing* - older men having sex with young women - is another manifestation of unequal gender relations, especially prevalent in the Caribbean. Age-mixing is guided by two central factors: (1) the belief among men that younger women are more passive, more fertile, and less likely to be infected with HIV, and (2) the belief among young women that an older man will be a better and more stable economic provider for herself and her children. Though the practice of age-mixing pre-dates HIV/AIDS, it has significant

<sup>32</sup> Goldstein, 1994

<sup>33</sup> Rivers, K. and P. Aggleton. *Adolescent Sexuality and Gender and the HIV Epidemic*. New York: United Nations Development Programme, 1998

<sup>34</sup> Barker, G. and Lowenstein. "Where the Boys Are: Attitudes Related to Masculinity, Fatherhood and Violence Toward Women Among Low-income Adolescents and Young Adult Males in Rio de Janeiro, Brazil." *Youth and Society* 29, 1997.

<sup>35,36</sup> Zelaya et al., 1997.

<sup>37</sup> Paiva, V. "Sexuality, Condom Use and Gender Norms among Brazilian Teenagers." *Reproductive Health Matters* 1, 1993.

<sup>38</sup> *Young Men and HIV: Culture, Poverty and Sexual Risk*. London: PANOS, 2001.

<sup>39</sup> Barker and Lowenstein, 1997.

<sup>40</sup> Lundgren, R. As cited in Rao Gupta and Weiss, 1993.

<sup>41</sup> *Men Make a Difference*. Geneva: UNAIDS, 2000b

consequences for the spread of the pandemic, placing young women at an increased risk of infection. In one Jamaican surveillance center for pregnant women, young women in their late teens had almost twice the HIV/AIDS prevalence rate of older women<sup>42</sup> Although most men are initially infected before the age of 25, older men have generally been sexually active longer and are therefore more likely to be already infected than younger males<sup>43</sup>.

It has been well documented that men are less likely to seek health care than women, since they are socialized to believe that men do not get sick. This remains true for men who are infected with HIV/AIDS, even though the virus is easier to detect in men than in women.<sup>44</sup> Men who do not use health services regularly, yet continue to engage in high-risk behaviour such as unprotected sex with multiple partners, place themselves and all of their partners at risk. Although in Latin America, there are more health services directed toward young men than in any other region, HIV/AIDS and STI services still tend to be offered within a broader reproductive health context, which targets women rather than men for health interventions, missing the needs of this most important population.<sup>45</sup>

#### a) Economic Factors

Research indicates that economically vulnerable women are less likely to terminate a potentially dangerous relationship, less likely to have access to information regarding HIV/

AIDS, less likely to use condoms and more likely to resort to high-risk behaviours for a source of income.<sup>46,47</sup> In economically desperate circumstances, women may exchange sex for money, food or other favours.<sup>48</sup>

Although the feminization of poverty in the LAC region persists, there has been some improvement in women's economic status, largely a result of higher levels of education among more girls.<sup>49</sup> While the percentage of salaried women working in LAC has significantly increased, the majority of women are still employed in the volatile, informal and maquila sectors of the economy, the latter of which are especially common in Mexico and Central America. Women who work in the formal sector still earn less than men on average.<sup>50</sup> Finally, millions of women are neither formally nor informally employed, but work taking care of their families and managing households. This domestic or "reproductive" labour is usually unpaid.

These unstable employment circumstances increase women's vulnerability to HIV in two ways. First, the fact that fewer women are employed, have less job security and are paid less leads to women's economic dependence on men. This creates a relationship in which the man's decisions are given priority on matters which include sexual relations, use of protection, household spending on health and access to health care,<sup>51</sup> all of which are central factors in the prevention and care of HIV

<sup>42</sup> UNAIDS, 2000a

<sup>43,44</sup> *AIDS and Young People: A Generation at Risk*. London: PANOS, 1996.

<sup>45</sup> PANOS, 2001

<sup>46</sup> Weiss, E. and G. Rao Gupta. *Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention*. Washington DC: International Centre for Research on Women, 1998.

<sup>47</sup> Blanc, A. *The Effect of Power in Sexual Relationships on Reproductive and Sexual Health: An Examination of the Evidence*. Prepared for the Population Council Meeting on Power in Sexual Relationships, 2001.

<sup>48</sup> LeFranc, E. et al. "Working Women's Sexual Risk-Taking in Jamaica." *Social Science and Medicine* 42 (11), 1996.

<sup>49</sup> Rao Gupta 2002 and UNIFEM 2000

<sup>50</sup> WHO, 1998.

<sup>51</sup> Rao Gupta, 2002

**Violence against Women**

"Any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."

*UN Declaration on the Elimination of Violence against Women*

*Article 61. By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;*

Second, women employed in the informal and maquila economies, and women who are not employed but work at home are less likely to have access to health or social security to cover the costs of testing, counseling and prescription drugs.<sup>52</sup>

Women are often reluctant to raise discussion regarding sexual desires and protection, particularly when they have invested in a relationship. In some countries in the region, where motherhood ensures access to financial resources from the father,<sup>53</sup> the promotion of contraception and other types of negotiation is risky for women who are financially dependent on their male partners. As demonstrated by one Jamaican study, many women will tolerate a husband with multiple sexual partners, or they themselves will have multiple sexual partners in order to guarantee financial stability for themselves and their children.<sup>54</sup> Research<sup>55</sup> shows that multiple-partnership is a demonstration of masculinity for men in the Caribbean.

#### IV. HIV/AIDS AND WOMEN'S GENDER ROLES

##### a) Gender-Based Violence

Gender-based violence is an extremely damaging form of female disempowerment. It leads to women's increased susceptibility to HIV infection by limiting their physical and mental freedom.<sup>56</sup> The relationship between physical violence and HIV is often indirect.

Women have less control than their male partners over decision-making on the use of protection, distribution of resources and access to health and social services, making it more difficult and dangerous for them to refuse unsafe sex.<sup>57</sup> In the case of sexual violence and HIV however, the relationship is a direct one.

Studies on violence in the LAC region indicate that the power and control implicit to the social construction of masculinity place women at risk of HIV infection.<sup>58</sup> Violence is manifested in a variety of forms including physical, sexual and psychological abuse. These forms of violence are more frequently manifested concurrently rather than independently. It is the interplay of these forms of violence and *fear* that act to suppress women's power and enhance their risk of contracting HIV.

Violence is inflicted at the family, the community and the state level.<sup>59</sup> According to studies conducted in a number of countries, approximately a third of married women say they have been beaten or physically assaulted in some manner by their partner.<sup>60</sup> According to an international report on the status of women, in Chile approximately 60% of women living with partners experience some form of violence, more than 10% of which is severe physical abuse.<sup>61</sup> A 1997 survey of 378 women aged 15-49 in Managua revealed that 69% were physically assaulted at somepoint in their relationship, while 33% were physically assaulted in the past year.<sup>62</sup>

<sup>52</sup> Gomez, 2001

<sup>53</sup> Mallow, R.M. et al. "Relationship of Psychosocial Factors to HIV Infection among Haitian Women." *Education and Prevention* 12 (1), 2000. and *HIV/AIDS and the World of Work*. Geneva: ILO Fact Sheet, 2002

<sup>54</sup> LeFranc 1996.

<sup>55</sup> McEnvoy, P. Heightening Awareness of HIV/AIDS in the Caribbean Region: Bridging the Gap from Denial to Acceptance to Prevention." Geneva: UNAIDS, 2000 (Speech).

<sup>56</sup> Blanc, 2001. and UNAIDS, 2000a

<sup>57</sup> UNAIDS, 2000c

<sup>58</sup> Barker, 1997

<sup>59</sup> United Nations Declaration on the Elimination of Violence against Women, 1993.

<sup>60</sup> UNAIDS, 2000c

<sup>61</sup> Neft and Levine. *Where Women Stand: An International Report on the Status of Women in 140 Countries*. New York: Random House, 1997. As cited in *Gender-Based Violence: An Impediment to Sexual and Reproductive Health* United Kingdom: International Planned Parenthood Federation, 1998.

<sup>62</sup> Heise, L., M. Ellsberg and M. Gottemoeller. "Ending Violence against Women" *Population Reports* 27 (4). Baltimore: Johns Hopkins University Centre for Communications Programs, 1999.

A World Bank report estimates that in developing countries 5% of healthy years of life lost to women of reproductive age result from rape and domestic violence.<sup>63</sup>

Physical, sexual and psychological violence increases women's risk of HIV infection in two other ways. First, sexual violence towards girls/women and boys/men increases their risk of HIV infection at the time of sexual abuse. Second, studies show that girls and boys who are victims of physical and/or sexual abuse during childhood are more likely to exhibit high-risk sexual behaviour later in life, lowered self-esteem, and decreased ability to negotiate safer sex.<sup>64</sup> A survey conducted by UNFPA in the Caribbean depicts the magnitude of the problem in that region, 21% of boys and 18% of girls were sexually abused before the age of sixteen.<sup>65</sup>

The absence of regulation of the sex industry, and an unwillingness to legitimize sex-work as a form of "labour", has resulted in a lack of response from the health sector, police and social services to sex-workers' concerns. Thus, health insurance, information and services are often out of reach of this crucial population.

While some women and fewer men are forced into sex-work or turn to the industry as a last resort in desperate circumstances, others choose to be sex-workers.<sup>69</sup> Though they represent less than 5% of all sex workers and their autonomy should not be overstated, this group of sex-workers often has more freedom and thus is more likely to engage in safer behaviours. They have more control over condom use, who they have sex with and how often they have sex.

The perceived exoticism of Caribbean people and the inherent anonymity of sex tourism attract men and women from all over the world. Depictions of the Caribbean as a place to fulfill fantasies and evade negative repercussions draw tourists to the region. The interaction between the well-to-do tourist, seen as a financial resource, and the local people is frequently founded on economic dependence and necessity. Typically, the desires of the tourist are prioritized which results in limited negotiating power for sex-workers, particularly, women and girls. At the same time Caribbean countries, which all rely heavily on the tourist industry fear that initiating HIV/AIDS public information campaigns or prevention efforts will deter tourism to the region.<sup>70</sup>

*Article 62. By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including...all types of sexual exploitation of women, girls and boys, including for commercial reasons. Such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement;*

## **b) Commercial Sex-Work and Sex Tourism**

Exploring the impact of commercial sex-work on HIV/AIDS reveals a gendered distribution of power that favours men and fuels the spread of the epidemic, particularly in tourist centers. Poverty, economic disparity and urban migration are forcing women and men into commercial sex work, often with tourists.<sup>66</sup> Since sex between men is highly stigmatized in the LAC region, some men turn to sex work as a way to find male partner.<sup>67</sup>

Stigmatization and the illegal nature of sex-work prevent sex-workers, particularly women, from seeking protection from abusive clients or bar and brothel owners.<sup>68</sup>

<sup>63</sup> Heise, L., J Pitanguy and A Germain. *Violence against Women: The Hidden Health Burden*. Washington DC: World Bank Discussion Paper 255, 1994

<sup>64</sup> Heise et al., 1999.

<sup>65</sup> "Caribbean Strategic Action Plan" Washington DC: World Bank, 2000 (Draft).

<sup>66</sup> *Trafficking of Women from the Dominican Republic for Sexual Exploitation*. Washington DC: International Organization for Migration, 1996. and AMFAR, 2001

<sup>67</sup> PANOS, 2001

<sup>68</sup> Torres, A. "Puerto Rico: AIDS Prevention with Sex Workers in the Streets." in Gomez and Meacham, 1998

<sup>69</sup> Blanc, 2001

<sup>70</sup> AMFAR, 2001

In Continental Latin America, particularly Central America, studies indicate high rates of child sex tourism. Children who lack support networks; food, shelter and money may resort to or be forced into sex-work. While both boys and girls are vulnerable to rape by adults, girls are far more likely than boys to be targeted, coerced or enticed into sex by someone older, stronger or richer.<sup>71</sup> The power adults have over children, especially girls, is compounded by their greater physical strength, the social pressure on children to obey their elders or children's own need for financial and emotional security. Girls moreover are usually unaware of their increased biological vulnerability to HIV/AIDS and STIs, have less access to knowledge regarding safe sex and have less power to negotiate contraceptive use.<sup>72</sup>

### c) **Trafficking for Sexual Exploitation**

Trafficking in women and girls for purposes of sexual exploitation is an increasing factor in the spread of HIV/AIDS. Globally, Colombia is the third most popular origin country for trafficked women. Approximately 35 000 women a year leave Colombia through Ecuador, escaping the violence in their own country, and from there are recruited to work as prostitutes in Asia and Europe.<sup>73</sup> Current estimates indicate that more than 50,000 women from the Dominican Republic are working abroad in the sex-trade, mainly in Europe but also in other parts of Latin America and the Caribbean.<sup>74</sup>

Trafficking is a difficult issue because it is seldom clear whether women and children have been trafficked with or without their consent, and what type of work they expected to be doing upon arrival. There are three basic categories of women trafficked

for sexual exploitation - those who are trafficked with their full consent, and with knowledge that they will be working as commercial sex-workers, those who are trafficked with their consent, but with the belief that they will engaged in domestic or manufacturing work, and finally those who are kidnapped, that is trafficked without their consent. Although these are three different groups, all of these women are at an increased risk of HIV infection and transmission.

Trafficked women present many of the same vulnerabilities and risks for HIV as commercial sex workers. However, their situation is complicated by the fact that they are often unable to access health information and services because they are being held captive, are unfamiliar with their local environment, are afraid of being deported, do not speak the local language, or have been threatened with violence or deportation by their traffickers, pimps, or brothel owners.

### d) **Migration and Displacement**

#### *Voluntary Migration*

The marginalized status of migrants increases their vulnerability to HIV.<sup>75</sup> Poverty, language barriers and lack of social support and insurance mean that many migrants do not have access to health information or services.

Poverty and economic, political and social instability have resulted in the increased migration of men, women and children both within and between countries, as migrant labourers leave their homes to seek other sources of income and employment. In the Caribbean there has been a shift in migration patterns such that women are increasingly dominating migration routes to, within and away from the region (*see sections on sex*

<sup>71</sup> UNAIDS, 2000c

<sup>72</sup> Ibid.

<sup>73</sup> Ward, J. *If Not Now, When? Addressing Gender-Based Violence in Refugee, Internally Displaced and Post-Conflict Settings*. Washington DC: Reproductive Health for Refugees Consortium, 2002.

<sup>74</sup> IOM, 1996

<sup>75</sup> Gomez, A. "Women and HIV/AIDS: A Gender Perspective", in Gomez and Meacham, 1998.

*tourism and trafficking*)<sup>76</sup>

Male and female migrants are isolated from family and community relations and social support networks, and may engage in sexual activity with sex-workers and/or multiple partners, exposing themselves and by association their partners at home to HIV infection.<sup>77</sup> A study of rural Mexican women whose partners have migrated illustrates the complexity of this situation, in which women do not always possess the power to protect themselves. Upon the return of male migrant workers, women are hesitant to demand condom use because their partners have been working away from home in order to send money back to their families.<sup>78</sup>

The mobile and socially isolated life style of truck drivers and miners causes them to seek casual sex partners, increasing their vulnerability to HIV/AIDS, and perpetuating the epidemic. A recent study of Honduran truck drivers revealed that some men had engaged in sex with both their regular partners *and* sex or domestic workers within the last six months. Moreover, 40 percent of the survey respondents reported never using a condom with sex workers and two thirds never used a condom with a domestic worker.<sup>79</sup>

In recent years, marginalized indigenous populations are increasingly migrating in search of income. Cultural and linguistic barriers often prevent indigenous men and women from accessing health and social services. Indigenous women in particular are faced with the double burden of gender and ethnicity,

and their severely limited power places them at an even greater risk of contracting HIV/AIDS. While there is a dearth of information on indigenous populations throughout the Americas, fewer opportunities for education, employment or access to services have lead experts to predict a rapidly rising rate of infection<sup>80</sup>

### *Crisis, Forced Migration and Internal Displacement*

The differential social status and vulnerability of men and women before, during and after a *crisis*<sup>81</sup> significantly impact their susceptibility to being infected and affected by HIV/AIDS.<sup>82</sup> The risk of HIV transmission, barriers to care and women's burden of work are all increased during crisis and post-crisis periods. Debilitated community or national infrastructure and over-burdened health services during and after a crisis increase women and men's vulnerability to HIV/AIDS. The "tyranny of the urgent"<sup>83</sup> which prevails following a crisis, means that reproductive and sexual health services tend to be overlooked in favour of more pressing concerns (such as access to safe drinking water and adequate shelter).

In times of instability there are often shifts in power and status within the family, the community, the region and the state, as a result of unemployment, migration, stress and re-adjustment. Unemployment usually rises immediately following a crisis, which disproportionately affects women because they are concentrated in the agricultural, informal and manufacturing economies, the hardest hit by

*Article 75. by 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies, and natural disasters, including refugees, internally displaced persons and in particular women and children, are at increased risk of exposure to HIV infection; and, where appropriate, factor HIV/AIDS components into international assistance programmes;*

<sup>76</sup> World Bank, 2000

<sup>77</sup> PANOS, 2001 and ILO, 2002

<sup>78</sup> Brewer et al., 19981

<sup>79</sup> PAHO/WHO/UNAIDS, 2001

<sup>80</sup> Ibid.

<sup>81</sup> A crisis here is defined as the occurrence of inter or intra-state conflict and natural disasters.

<sup>82</sup> Moraga, E. *Género y Desastres - Introducción Conceptual y Criterios Operativos: La Crisis del Huracán Mitch en Centroamérica* Costa Rica: Fundación Género y Sociedad, 1999.

<sup>83</sup> Enarson, E. *Gender and Natural Disasters*. Geneva: International Labour Organization Working Paper, 2000.

crises.<sup>84</sup> Following Hurricane Mitch in 1998, women are now estimated to make up 88 percent of the poor in Nicaragua.<sup>85</sup> However it is men who most often migrate in search of employment in the aftermath of a crisis. Women are usually left at home or in shelters and refugee camps to cope with the increased domestic burden brought on by the collapse of regular and emergency health services and water treatment, sewage, heating and electrical infrastructure.

The risk factors for HIV which are present in voluntary migration (unprotected sexual contact with other partners) continue to apply in periods of forced migration, or internal displacement, but they are compounded by the psychological trauma and stress which is associated with a crisis situation, be it conflict or natural disaster. Victims of crisis continue to be sexually active and may even engage in more sexual activity as a means to relieve stress or feel intimacy.<sup>86</sup> HIV/AIDS, STI and gender-based violence prevention and care are not high priorities during a crisis situation, and are not systematically integrated into relief efforts.<sup>87</sup> The trauma and tension occasioned by a crisis, together with persistent gender-based inequalities act to increase the incidence of physical and sexual violence against women and children, a notable risk factor for HIV/AIDS.

Because internally displaced populations (IDPs) and refugees tend to move in large numbers, and they are often regarded with hostility by the communities near or in which they settle. This hostility can prevent IDPs and refugees from accessing health services, education, information and other social support networks, which can increase their

vulnerability to HIV/AIDS. In the case of intra-state conflict, these services may not even be available to IDPs or refugees because the government has collapsed.

An increase in female-headed households is another common effect of crisis, as a result of male mortality and migration. Female-headed households are usually more susceptible to economic deprivation. Women continue to fulfill typical care giving responsibilities and become increasingly overburdened with other responsibilities.<sup>88</sup> Their decreased access to material resources and time diminishes their chances of regaining stability through rebuilding businesses or planting fields.<sup>89</sup> As a result, women are more likely to turn to sex-work, or grant sexual favours in exchange for food, money or other commodities. Female heads of households are also more likely to be victims of sexual violence. Both of these realities significantly increase women's vulnerability to HIV.

#### *Inter and Intra-State Conflict*

Gender-based violence as a means of attaining power is most clearly illustrated in times of conflict. Rape has always been used as weapon of war to degrade and debilitate communities, though this reality has only recently been addressed by the international community.

This egregious act of violence is practiced by both military personnel and civilians to humiliate, intimidate and control the "enemy". In Colombia, the UN Special Rapporteur on Violence against Women noted that "...84 percent of human rights violations against women are committed by paramilitaries, 12

*Article 77. By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence forces, and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/AIDS awareness and prevention activities, including participation in emergency, humanitarian, disaster relief and rehabilitation exercises.*

<sup>84</sup> Ward, 2002

<sup>85</sup> Ibid.

<sup>86</sup> Enarson, 2000.

<sup>87</sup> PAHO/WHO/UNAIDS, 2001

<sup>88</sup> Moraga, 1999

<sup>89</sup> Enarson, 2000.

percent by guerillas, and 3 percent by state actors.” Many of these violations included sexual violence.<sup>90</sup> During the lengthy conflict in Guatemala, women were routinely kidnapped and raped by military personnel in an attempt to humiliate indigenous (Maya) communities.<sup>91</sup> Armed forces personnel of all types have a rate of HIV infection between 2 to 5 times higher than the general population,<sup>92,93</sup> so women’s risk of HIV infection in war time is increased. Recently, higher than average rates of HIV infection have also been found in communities which are close to military bases or installations.<sup>94</sup>

In most societies, the male is socialized to act as the protector and the head of the family. In cultures where a woman is viewed as the property of the male head of the household, the act of rape is a direct violation on the husband’s “territory”, and illustrates his inability to protect his family, seen as the ultimate form of humiliation. In some situations, families are forced to watch as women and children are violated.

During times of conflict, women and girls may, or may be forced, to ally themselves with paramilitaries, offering sex in exchange for money or protection. Anecdotal evidence from Colombia indicates a higher than average rate of prostitution among internally displaced women, as they turn to sex-work in an effort to support their families.<sup>95</sup>

## V. INFECTED AND AFFECTED - WOMEN, MEN AND THE EPIDEMIC

### a) Infected

Gender influences the effects of HIV/AIDS prognosis and treatment medically and socially, in both women and men.<sup>96</sup> Women face a number of barriers to HIV prevention, testing and counseling, including embarrassment, fear of rejection and stigma, partner’s objection to testing, and lack of access to financial resources, reliable, accessible information, time and transportation. These obstacles deter women from taking preventive measures, accurately assessing their own risks and from seeking early diagnosis and treatment of HIV.<sup>97</sup> Additionally, stereotypes associated with high-risk groups, in particular sex-workers, contribute to blaming women for the spread of HIV.<sup>98</sup>

Research has only recently begun to address the critical biological differences in the progression of HIV/AIDS between men and women.<sup>99</sup> Until recently, women have been excluded from most clinical trials of antiretroviral therapy (ARV) and other drugs and significantly more funds have been provided for research on men.<sup>100</sup> Thus health workers themselves are often ill-informed about the best course of treatment for women infected with HIV/AIDS.

*Article 60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework;*

<sup>90</sup> Ward, 2002

<sup>91</sup> Ibid.

<sup>92</sup> PANOS, 2001

<sup>93</sup> *Combat AIDS: HIV and the World's Armed Forces*. London: PANOS, 2002.

<sup>94</sup> PANOS, 2002.

<sup>95</sup> Ward, 2002

<sup>96</sup> WHO, 1998.

<sup>97</sup> “Facing the Challenge of HIV/AIDS/STDs: A Gender-Based Response.” *From Why Gender and HIV/AIDS/STDs?* Geneva: UNAIDS, 2001a.

<sup>98</sup> Ibid.

<sup>99</sup> Anderson, K. “Women, AIDS and Poverty in Urban Shantytowns in Chile” in Gomez and Meacham, 1998.

<sup>100</sup> Korvick, J. et al. *Women's Participation in AIDS Clinical Trials (ACTG): Enough or Still too Few?* Bethesda: NIAID and NICHD, 1993.

Women's differential access to medical care, counseling, and information means that they are less likely than men to receive accurate prognosis and treatment of HIV. Consequently, women who have HIV/AIDS have a shorter life expectancy than men under the same circumstances.<sup>101</sup> A study in Mexico revealed that the gendered division of labour created obstacles to women's access to government provided anti-HIV drugs, because they were only distributed to those employed in the formal sector, predominantly men.<sup>102</sup>

As discussed earlier, men are less likely than women to seek health care and their reluctance to be tested or seek treatment for HIV or other STIs has obvious negative repercussions for their sexual partners, be they male or female. Those men who do seek sexual health services may encounter obstacles, because these services are usually incorporated into reproductive health services which target women, including prenatal and family planning clinics. Like women, men's sexual health needs have also been overlooked, which increases the transmission of HIV among men and women alike.<sup>103</sup> Partner notification programs can be useful when a man is willing to be tested, and they have the potential to reach non-infected, or infected and asymptomatic individuals.<sup>104</sup> However they assume that men are informed enough to ask to be tested, and that health services are accessible and appropriate.

#### **b) Affected**

Aside from the obvious challenges posed by HIV infection *among* women, HIV creates a

different set of challenges for both infected and non-infected women. As the principal care-givers in the vast majority of homes, women carry the greatest psychosocial and physical burden of care for HIV/AIDS-infected individuals.<sup>105</sup> Women are responsible for an inestimable amount of unpaid health work, taking care of family, friends and community members. Current trends in health sector reform shift more responsibility for health care from hospitals and other institutions to the home, and this shift is not gender neutral.<sup>106</sup> HIV/AIDS is a disease which attacks over the long-term, and infected individuals may require many years of care. Care-giving is a 24-hour-a-day job for many women, leaving them with little or no time to pursue their own interests, continue paid labour or care for their own physical and psychological health.

Women may have to quit formal employment or other income-generating activities in order to care for their partner or another family member. Gender norms dictate that young girls abandon their studies in order to care for infected family members, or to seek employment to supplement the household's lost income.<sup>107</sup> Studies indicate that many women turn to prostitution as a source of income in order to pay medical bills or provide an income for their families once the infected person is no longer able to.

A separate set of problems arises when women are infected with HIV/AIDS however. Since women are primarily responsible for the family's overall health and nutrition, when they are no longer able to carry out their domestic responsibilities, there is often a notable decline

*Article 68. By 2003, evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; review the social and economic impact of HIV/AIDS at all levels of society, especially on women and the elderly, particularly in their role as caregivers, ...;*

<sup>101</sup> WHO, 1998

<sup>102</sup> UNIFEM, 2000

<sup>103</sup> UNAIDS 2001b

<sup>104</sup> Collumbien, M. and S. Hawkes. "Missing Men's Messages: Does the Reproductive Approach Respond to Men's Sexual Health Needs?" Culture, Health and Sexuality 2 (2000)

<sup>105</sup> ILO, 2002

<sup>106</sup> Gomez, 2001.

<sup>107</sup> Donelan, K. M. Falik and C. Desroches. "Caregiving: Challenges and Implications for Women's Health" Women's Health Issues 11), 2001.

*Article 54. By 2005, reduce the proportion of infants infected with HIV by 20 percent, and by 50 percent by 2010, by ensuring that 80 percent of pregnant women accessing antenatal care have information, counseling and other HIV-prevention services available to them, increasing the availability of and providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as through effective interventions for HIV-infected women, including voluntary and confidential counseling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care;*

in overall family health, particularly nutrition.<sup>108</sup>

## VI. RESPONDING TO WOMEN'S NEEDS

### a) Vertical or Mother-to-Child Transmission

Women's lack of access to health care and information, leads to an increase in the number of infected women and children. HIV infection in women increases the risk of infection in infants because the virus can be vertically transmitted through the mother during pregnancy, childbirth (delivery) and breast feeding. Approximately 3000 children are born to HIV positive mothers each year in the Caribbean.<sup>109</sup>

As the number of HIV infected women in the Caribbean and Central America increases, the number of HIV infected children also increases. Up to 70 percent of mother-to-child-transmission (MTCT) occurs during childbirth, the remainder during gestation or lactation. In the absence of treatment, 23%-30% of children born to HIV infected mothers will be infected themselves. In Honduras it is estimated that each year approximately 400 children will be born to HIV positive mothers. Without intervention an estimated 120 of these children will be infected with HIV.

Prevention of MTCT involves a complex series intervention, including prevention of HIV infection among women, offering voluntary counseling and testing through ante-natal care services, different regimens of anti-retroviral (ARV) therapy, delivery through cesarean section and counseling on breast feeding. Some studies have shown that a course of ARV therapy during the last month

of pregnancy reduces the transmission rate to 1 in 10 children.<sup>110</sup>

Breast feeding also significantly increases the risk of HIV transmission by 14%-20%.<sup>111</sup> A number of substitutes for breast milk have been developed, and if used correctly are 100 percent successful in preventing the transmission of HIV. Counseling about the risks of breastfeeding, and available alternatives should be a regular part of HIV counseling through ante-natal care. It is important to stress that if a woman decides to breastfeed her children, breastfeeding should be exclusive because the risk of transmission through mixed breastfeeding is higher than for exclusive breastfeeding. Many women will insist on breastfeeding for two reasons. First, women are concerned that substitutes are not as nutritious as breast milk, and will not provide children with the same immunities and resistance to illness. Second, in more traditional communities, women may be afraid not to breastfeed because it will single them out as being HIV positive, stigmatizing them and their children for life.

Since women are the key promoters of child health, providing them with accurate and timely information is a means of improving the health of the entire family. Yet access to knowledge is ineffective unless accompanied by the power to make and implement informed decisions. Programs that target vertical transmission work through antenatal health services to test pregnant women for HIV infection, offering pre- and post-test counseling and ARV to those women who test positive. These services are on a voluntary basis however. Many women, especially in the Caribbean will refuse to be counseled or

<sup>108</sup> UNAIDS, 1998a.

<sup>109</sup> Bilali, C. "Eighteen Years of the HIV/AIDS Epidemic in the Caribbean: A Summary" CAREC Presentation <http://www.carec.org/publications/presentations.htm>

<sup>110</sup> Rutenberg, N. et al. *Community Involvement in the Prevention of Mother-to-Child Transmission of HIV: Insights and Recommendations*. Washington DC: Population Council, 2001.

<sup>111</sup> *Atención Integral de la Salud Sexual y Reproductiva de la Mujer Infectada por el VIH y Prevención de la Transmisión Vertical*. Washington DC: PAHO, 2001. Draft.

*Article 55. By 2003,... in an urgent manner make every effort to provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled anti-retroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance;...*

*Article 23. Recognizing that effective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, inter alia, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs, including anti-retroviral therapy, diagnostics and related technologies, as well as increased research and development;*

tested for HIV, whether due to lack of knowledge or fear of stigmatization. A recent study however, indicates increasing acceptance rates for HIV testing (following counseling) among pregnant women in the region.<sup>112</sup> The main purpose of HIV counseling in antenatal care is to assist mothers in making their own decisions with regard to understanding their test results, continuing pregnancy and mode of feeding.<sup>113</sup>

Countries in the LAC region that have implemented and monitored MTCT programs have documented positive results.<sup>114</sup> The success of MTCT programs however largely depends upon the accessibility coverage of antenatal services and the perceptions of HIV testing among pregnant women. HIV detection and treatment through ante and post-natal care programs tends to focus on the delivery of an HIV-negative child, however these programs should take both the mother's as well as the child's health into account. It is essential to give mothers continued access to ARV therapy once they have given birth; otherwise their bodies can build up resistance to ARV drugs, making treatment at a later stage much more challenging.

#### **a) “Female-Controlled” Methods**

The distribution of power between men and women, their ability to negotiate and their respect for one another's freedom will influence the utilization of any contraceptive/protective technology.<sup>115</sup> The male latex condom is currently the only widely-available

form of contraception which also protects against HIV and other STIs. However, both men and women present challenges to the use of the male condom. Studies from Brazil, Guatemala and Jamaica<sup>116</sup> show that both sexes associate intimacy and trust with unprotected sex, and may perceive the use of condoms as an accusation of infidelity.

Insisting on the use of the condom may be interpreted as a challenge of male power and integrity, suggesting that he is not trusted or loved. Moreover, both men and women have stated that the condom interferes with their physical enjoyment of sex as well as their emotional rapport.<sup>117</sup> In a Puerto Rican study, women opted to have unprotected sex in order to maintain a feeling of closeness with their partners.<sup>118</sup>

Prevention efforts which rely solely on use of the male condom are only partially effective, because women are not always free to negotiate condom use with their male partners.<sup>119</sup> In Brazil, the United States, and Argentina<sup>120</sup> women indicated the existence of barriers to applying their knowledge about HIV/AIDS prevention, and to demanding the use of the condom. A study in Brazil revealed that some women chose sterilization over other contraceptives in order to avoid a discussion of contraceptives with their male partners.<sup>121</sup> These studies illustrate the necessity for programs to incorporate negotiating skills and address the gendered imbalance of power between men and women.

<sup>112</sup> PAHO/WHO/UNAIDS, 2001.

<sup>113</sup> PAHO, 2001

<sup>114</sup> Rutenberg et al., 2001

<sup>115</sup> *Micribicides for HIV Prevention: A Technical Update*. Geneva: UNAIDS, 1998b.

<sup>116</sup> Rao Gupta and Weiss, 1993

<sup>117</sup> Giffin, K. and C.Lowndes. “Gender, Sexuality and the Prevention of Sexually Transmissible Diseases: A Brazilian Study of Clinical Practice.” *Social Science and Medicine* 48 (1999).

<sup>118</sup> Serrano, I. N. Torres and N.Galarza. *Las relaciones de poder y la prevención de VIH/SIDA entre mujeres Puertorriqueñas*. Puerto Rico: University of Puerto Rico, 1996

<sup>119</sup> *Ibid.*

<sup>120</sup> *Ibid.*

<sup>121</sup> Goldstein, D. “AIDS and Women in Brazil: The Emerging Problem.” *Social Science and Medicine* 39(7), 1994

### *The Female Condom*

One development which has been hailed as a new “female controlled method” is the female condom. Though as effective in preventing transmission of HIV as the male condom, the female condom carries with it the same obstacles as the male condom.<sup>122</sup> It is visible, cannot be used without the consent of both partners, it can imply the same lack of trust and intimacy and it can still interfere with the physical enjoyment of sex. In fact, the female condom has been reported to be even more obtrusive than the male condom, it is uncomfortable, noisy, and it slips. Women who fear violence or experience insecurity in a relationship cannot depend on the female condom any more than the male condom.

The advantage of the female condom is that it can be inserted hours before sexual contact, so that if a male partner does not have a condom available or forgets, a woman can still be protected. The female condom is also made of polyurethane instead of latex, so it has become a viable option for the many people who are allergic to latex.<sup>123</sup>

### *Microbicides*

Another option, though not yet available, is the microbicide, a compound in the form of a gel, cream, suppository, film, sponge or vaginal ring that targets and eliminates or reduces the presence of HIV.<sup>124</sup> Some microbicides can kill, neutralize or block only HIV, whereas others can also eliminate other STIs, and even act as a contraceptive. Microbicides could potentially prevent HIV and STIs in both men and women when applied vaginally and rectally.<sup>125</sup>

Scientists are currently in the trial stage phase of testing 11 microbicides. They are striving to develop a technology that is odorless, colorless, tasteless, non-inflammatory, active throughout time of sexual activity and not affected by temperature changes. At the heart of the campaign for microbicides is accessibility. It should be inexpensive and available without prescription so that it can be used by women and men from all regions.

An additional advantage presented by microbicides is that, like an IUD or a contraceptive vaginal ring, in certain forms they would be undetectable during sex. Thus they would not interfere with physical enjoyment of sex, and if necessary could even be used without the other partner’s knowledge<sup>126</sup>

## **IV. PROGRAM RESPONSES**

The enabling factors that increase women and men’s vulnerability to HIV infection must be addressed in order to effectively reduce HIV transmission. Program responses must address and even challenge gender norms and stereotypes, particularly the unequal distribution of power and resources between men and women:

*Article 52. By 2005, ensure: that a wide range of prevention programmes ... is available in all countries...including information, education and communication...aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counseling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;*

*Article 53. by 2005, ensure that at least 90 percent, and by 2010 at least 95 percent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers;*

<sup>122</sup> *The Female Condom and AIDS*. Geneva: UNAIDS, 1997.

<sup>123</sup> *Ibid.*

<sup>124</sup> *Mobilization for Microbicides: The Decisive Decade*. New York: Rockefeller Foundation Microbicide Initiative, 2001

<sup>125</sup> UNAIDS, 1998b.

<sup>126</sup> UNAIDS, 1998b and Rockefeller, 2001

*Article 63. By 2003, develop and/or strengthen strategies, policies and programmes which recognize the importance of...ensuring access to secondary education, including HIV/AIDS in curricula for adolescents, ensuring safe and secure environments, especially for young girls; expanding good-quality, youth-friendly information and sexual health education and counseling services; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes,...*

*Article 94. Conduct national periodic reviews with the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, of progress achieved in realizing these commitments, identify problems and obstacles, to achieving progress, and ensure wide dissemination of the results of these reviews;*

### **Recommendation 1**

Empower couples to communicate and negotiate openly about sexual needs, desires and perceived risks, challenging gender norms which privilege men's decisions and pleasure in sexual relations (see box 2).

### **Recommendation 2**

Empower girls and boys, women and men by increasing their access to education, literacy and information about sexual and reproductive health. Comprehensive and appropriate sexual education should explore gender relations, masculinity, femininity and their effect on sexual behaviour and health (see box 2).

### **Box 3 - ReproSalud**

ReproSalud in Peru targets the poorest women (15-49), living in the Andean highlands and the Amazon basin. It emphasizes factors that fuel women's vulnerability: limited power to negotiate within sexual relationships, social isolation, violence, lack of access to financial resources, and low self-esteem.

This project led participants to prioritize reproductive health matters and design and implement appropriate strategies. The involvement of men, initiated on the demands of women, allowed communication between partners about risk behaviours more often associated with men, yet which affect both women and men: alcoholism, violence and forced sex.

### **Box 2 - Women's Life Collective**

WLC, an NGO in Brazil, works to develop a new relationship between women and men, by targeting young women's self-esteem and sexual identity, which are crucial to understanding women's vulnerability to HIV.

The main focus of the program is violence-prevention. Emphasis is placed on reaching young women who work in the sex trade, or are at risk of joining. Additionally, the program encompasses an educational component which gives young women the opportunity to take foreign language, theatre or professional classes, including computer repair.

Results have been positive. Participants have shown improved school performance and self-esteem. A key factor in the success of this program has been its holistic nature - it addresses the multiple complex needs of young women that involve family relations, work, school, drugs, and sexuality.

### **Recommendation 3**

Work with men to explore the effects of masculinity, violence, power and control on relationships and sexual health (see box 3). Though men are the driving force behind the HIV/AIDS epidemic, the responsibility and capacity that is an essential component of masculinity could be used to fight the epidemic as well.

### **Recommendation 4**

Improve sexual and reproductive health services for all, their coverage, accessibility and gender sensitivity. Create more male-friendly sexual and reproductive health services (see box 3). Women and men should be encouraged to access health services and monitor their own risk factors and behaviour.

### **Recommendation 5**

Empower women to participate in community and national decision-making about HIV/AIDS issues

### **Recommendation 6**

Incorporate a gender perspective and sexual and reproductive health services into crisis response plans, in order to ensure that a crisis does not worsen the spread of HIV.

**Recommendation 7**

Increase the advocacy for microbicides because the technology is needed sooner rather than later. Develop more female-controlled prevention methods which can be used regardless of a woman's relationship with her partner, and which will be accessible to even the poorest women.

**Recommendation 8**

Address the impact of gender norms and stereotypes on women living with HIV/AIDS and the barriers to services which they face. Improve health workers understanding of HIV positive women's distinct physical and psychological needs. (see box 4)

**Box 4 - International Planned Parenthood Federation**

Program affiliates of IPPF in **Brazil** (BEMFAM), **Honduras** (ASHONPLAFA) and **Jamaica** (FAMPLAN) have applied a gender perspective to their counseling programs.

The new approach compliments technical training on HIV/AIDS with awareness of sexual health and gender issues that influence vulnerability to STIs, such as the power to negotiate with partners. The experience of the planners led them to conclude that, in order to be an effective HIV/AIDS counselor, it is crucial to address individual risks and circumstances of clients' sexual lives in a non-judgmental manner. The programs reaped the benefits of including sexuality in counselor training as the unique needs of each client became more readily and rapidly apparent.

**Box 5 - Casa de la Mujer**

Casa de la Mujer in Bolivia applies a holistic perspective to women's reproductive health, taking relationships, politics, economics and culture into account. As a result, Casa de la Mujer offers not only reproductive health services, but legal services (for domestic violence and child support cases), psychological care, education (literacy training and educating women about rights and citizenship), access to water, nutrition, primary and preventive health, the environment, and labour training.

**Box 6 - 100 Percent Condom Program**

In the Dominican Republic, the Horizons 100 Percent Condom Program works with commercial sex-workers and sex establishment owners to promote the mandatory use of condoms in every commercial sex act. Condoms were made available and posters were put up in every room of the establishment.

The same program was implemented in Thailand in 1991, with impressive results. Participating sex establishments reported a 76 percent increase in condom use, and a 79 percent decrease in STIs among male clients.

Source – *Horizons Report*, May 2002 (Population Council)

**Recommendation 9**

Acknowledge that women are the primary caregivers within the family and community, and that this work is unpaid. The financial, physical and psychological burden placed on women by the HIV/AIDS epidemic has a significant impact not only on her health, but on the well-being of her family and the national economy.

**Recommendation 10**

Approach women's health from a holistic perspective. Women's vulnerability to HIV/AIDS is not merely physiological, but situational, it is directly related to her gendered social status (see box 5).

**Recommendation 11**

Work with key population groups which are at a high risk for HIV transmission. This includes sex-workers, intravenous drug users, men who have sex with men and adolescents (see box 6).

## VII. CONCLUSION

*Article 6. Recalling and reaffirming our previous commitments on HIV/AIDS made through:...*

*o The political declaration and further action and initiatives to implement the **Beijing Declaration and Platform for Action** of June 10, 2000;*

*o Key actions for the further implementation of the **Programme of Action of the International Conference on Population and Development**, of July 2, 1999,....;*

Due to the prevalence and urgency of the HIV/AIDS pandemic, the public health sector is gradually being forced to discuss issues of sexuality and power in sexual relationships. Prior to the HIV/AIDS pandemic, the prevailing stance was that sexual relationships were private matters to be discussed between sexual partners, however HIV itself has gone a long way towards putting women's sexual and reproductive health and rights on to international and national agendas. The International Conference on Population and Development (Cairo) and the Fourth World Conference on Women (Beijing) called due attention to the impact of gender on sexual relations, reproductive health decision-making and the transmission of HIV/AIDS.

While these links are recognized, they have yet to be fully operationalized in health policies and programs. Changes of this magnitude usually take decades, but the sheer virulence of the HIV/AIDS pandemic has robbed the international community of the luxury of time. Changes in gendered power relations, couple communication and access to health information and services must be made now in order to impact the pandemic before it claims millions more lives, women's and men's.

### **Programme of Action: International Conference on Population and Development**

#### **Article VII. Paragraph C.**

#### **Sexually transmitted diseases and prevention of human immunodeficiency virus (HIV)**

**Basis for action - 7.27.** The world-wide incidence of sexually transmitted diseases is high and increasing. The situation has worsened considerably with the emergence of the HIV epidemic. Although the incidence of some sexually transmitted diseases has stabilized in parts of the world, there have been increasing cases in many regions.

7.28. The social and economic disadvantages that women face make them especially vulnerable to sexually transmitted infections, including HIV, as illustrated, for example, by their exposure to the high-risk sexual behaviour of their partners. For women, the symptoms of infections from sexually transmitted diseases are often hidden, making them more difficult to diagnose than in men, and the health consequences are often greater, including increased risk of infertility and ectopic pregnancy. The risk of transmission from infected men to women is also greater than from infected women to men, and many women are powerless to take steps to protect themselves.

**Objective - 7.29.** The objective is to prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women.

**Actions - 7.30.** Reproductive health programmes should increase their efforts to prevent, detect and treat sexually transmitted diseases and other reproductive tract infections, especially at the primary health-care level. Special outreach efforts should be made to those who do not have access to reproductive health-care programmes.

7.31. All health-care providers, including all family-planning providers, should be given specialized training in the prevention and detection of, and counselling on, sexually transmitted diseases, especially infections in women and youth, including HIV/AIDS.

7.32. Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.

7.33. Promotion and the reliable supply and distribution of high-quality condoms should become integral components of all reproductive health-care services. All relevant international organizations, especially the World Health Organization, should significantly increase their procurement. Governments and the international community should provide all means to reduce the spread and the rate of transmission of HIV/AIDS infection.

## Declaration and Platform for Action - Fourth World Conference on Women

### Strategic Objective C.3.

#### Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues

##### Actions to be taken

108. By Governments, international bodies including relevant United Nations organizations, bilateral and multilateral donors and non-governmental organizations:

- a. Ensure the involvement of women, especially those infected with HIV/AIDS or other sexually transmitted diseases or affected by the HIV/AIDS pandemic, in all decision-making relating to the development, implementation, monitoring and evaluation of policies and programmes on HIV/AIDS and other sexually transmitted diseases;
- b. Review and amend laws and combat practices, as appropriate, that may contribute to women's susceptibility to HIV infection and other sexually transmitted diseases, including enacting legislation against those socio-cultural practices that contribute to it, and implement legislation, policies and practices to protect women, adolescents and young girls from discrimination related to HIV/AIDS;
- c. Encourage all sectors of society, including the public sector, as well as international organizations, to develop compassionate and supportive, non-discriminatory HIV/AIDS-related policies and practices that protect the rights of infected individuals;
- d. Recognize the extent of the HIV/AIDS pandemic in their countries, taking particularly into account its impact on women, with a view to ensuring that infected women do not suffer stigmatization and discrimination, including during travel;
- e. Develop gender-sensitive multi-sectoral programmes and strategies to end social subordination of women and girls and to ensure their social and economic empowerment and equality; facilitate promotion of programmes to educate and enable men to assume their responsibilities to prevent HIV/AIDS and other sexually transmitted diseases;
- f. Facilitate the development of community strategies that will protect women of all ages from HIV and other sexually transmitted diseases; provide care and support to infected girls, women and their families and mobilize all parts of the community in response to the HIV/AIDS pandemic to exert pressure on all responsible authorities to respond in a timely, effective, sustainable and gender-sensitive manner;
- g. Support and strengthen national capacity to create and improve gender-sensitive policies and programmes on HIV/AIDS and other sexually transmitted diseases, including the provision of resources and facilities to women who find themselves the principal caregivers or economic support for those infected with HIV/AIDS or affected by the pandemic, and the survivors, particularly children and older persons;
- h. Provide workshops and specialized education and training to parents, decision makers and opinion leaders at all levels of the community, including religious and traditional authorities, on prevention of HIV/AIDS and other sexually transmitted diseases and on their repercussions on both women and men of all ages;
- i. Give all women and health workers all relevant information and education about sexually transmitted diseases including HIV/AIDS and pregnancy and the implications for the baby, including breast-feeding;
- j. Assist women and their formal and informal organizations to establish and expand effective peer education and outreach programmes and to participate in the design, implementation and monitoring of these programmes;
- k. Give full attention to the promotion of mutually respectful and equitable gender relations and, in particular, to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality;
- l. Design specific programmes for men of all ages and male adolescents, recognizing the parental roles referred to in paragraph 107 (e) above, aimed at providing complete and accurate information on safe and responsible sexual and reproductive behaviour, including voluntary, appropriate and effective male methods for the prevention of HIV/AIDS and other sexually transmitted diseases through, inter alia, abstinence and condom use;
- m. Ensure the provision, through the primary health-care system, of universal access of couples and individuals to appropriate and affordable preventive services with respect to sexually transmitted diseases, including HIV/AIDS, and expand the provision of counselling and voluntary and confidential diagnostic and treatment services for women; ensure that high-quality condoms as well as drugs for the treatment of sexually transmitted diseases are, where possible, supplied and distributed to health services;
- n. Support programmes which acknowledge that the higher risk among women of contracting HIV is linked to high-risk behaviour, including intravenous substance use and substance-influenced unprotected and irresponsible sexual behaviour, and take appropriate preventive measures;
- o. Support and expedite action-oriented research on affordable methods, controlled by women, to prevent HIV and other sexually transmitted diseases, on strategies empowering women to protect themselves from sexually transmitted diseases, including HIV/AIDS, and on methods of care, support and treatment of women, ensuring their involvement in all aspects of such research;
- p. Support and initiate research which addresses women's needs and situations, including research on HIV infection and other sexually transmitted diseases in women, on women-controlled methods of protection, such as non-spermicidal microbicides, and on male and female risk-taking attitudes and practices.

## IX. BIBLIOGRAPHY

*AIDS Epidemic Update*. Geneva: UNAIDS/WHO, 2001.

*Atencion Integral de la Salud Sexual y Reproductiva de la Mujer Infectada Por el VIH y Prevencion de la Transmision Vertical*. Washington DC: PAHO/WHO, 2001(Draft).

Barker, G. *The Misunderstood Gender: Male Involvement in the Family and in Sexual and Reproductive Health in Latin America and the Caribbean*. MacArthur Foundation, 1996.

Barker, G. and Lowenstein. 1997. "Where the Boys are: Attitudes Related to Masculinity, Fatherhood, and Violence toward Women among Low-Income Adolescent and Young Adult Males in Rio de Janeiro, Brazil." *Youth and Society* 29, 1997.

Bilali, C. "Eighteen Years of the HIV/AIDS Epidemic in the Caribbean: A Summary" CAREC Presentation, 2001.

Blanc, A. *The Effect of Power in Sexual Relationships on Reproductive and Sexual Health: An Examination of the Evidence*. Washington DC: Population Council (Meeting on Power in Sexual Relationships), 2001.

Brewer, T. et al. "Migration, Ethnicity and Environment: HIV risk Factors for Women on the Sugar Cane Plantation of the Dominican Republic" *AIDS* (14), 1998.

*Caribbean Strategic Action Plan*. Washington DC: World Bank, 2000(Draft).

Collumbien, M and Hawkes, S. "Missing Men's Messages: Does the Reproductive Health Approach Respond to Men's Sexual Health Needs?" *Culture, Health and Sexuality* 2(2), 2000.

*Combat AIDS: HIV and the World's Armed Forces*. London: PANOS, 2002.

Enarson, E. *Gender and Natural Disasters*. Geneva: ILO, 2000.

Enos, R.. and S. Southern. *Correctional Case Management*. Anderson Publishing, 1996.

*Epidemiological Fact Sheets*. Geneva: UNAIDS/WHO, 2002.

"Facing the Challenges of HIV/AIDS/STDs: A Gender-based Response." *Why Gender and HIV/AIDS/STDs?* Geneva. UNAIDS, 2001a.

*Gender and Health: A Technical Paper*. Geneva: WHO, 1998.

Gender and HIV/AIDS: A Technical Update. Geneva: UNAIDS, 1998a.

Giffin, K. and C.Lowndes. "Gender, Sexuality and the Prevention of Sexually Transmissible Diseases: A Brazilian Study of Clinical Practice." *Social Science and Medicine* 48, 1999.

Goldstein, D.M. "AIDS and Women in Brazil: The Emerging Problem." *Social Science and Medicine* 39, 1994.

Gomez, Elsa. "Equity, Gender and Health Policy Reform in Latin America and the Caribbean." Peru: Economic Commission for Latin America and the Caribbean, 2000.

Heise, L., M. Ellsberg, M. Gottemoeller. "Ending Violence Against Women." *Population Reports* 27(4). Baltimore: Johns Hopkins University, 1999.

*HIV/AIDS and the World of Work*. Geneva: ILO Fact Sheet, 2002.

*HIV and AIDS in the Americas: An Epidemic with Many Faces*. Washington, DC: PAHO, WHO, UNAIDS, 2001.

*Infant Feeding Policy and Practice in Pregnant Women*. Washington DC: PAHO, 2001.

- Korvick, J. et al. *Women's Participation in AIDS Clinical Trials (ACTG): Enough or Still too Few?* Bethesda: NIAID and NICHD, 1993.
- LeFranc, E. et al. "Working Women's Sexual Risk Taking in Jamaica." *Social Science and Medicine* 42(10), 1996.
- Mallow, R.M. et al. "Relationship of Psychosocial Factors to HIV Risk Among Haitian Women." *AIDS Education and Prevention* 12(1), 2000.
- Mane P. and P. Aggleton. "Gender and HIV/AIDS: What do men have to do with it?" *Current Sociology* 49 (6), 2001.
- Masculinity and Gender Violence: Gender Issues Fact Sheet #5*. New York: UNIFEM, 2001.
- McEnvoy, P. *Heightening Awareness of HIV/AIDS in the Caribbean Region: Bridging the Gap from Denial to Acceptance to Prevention-Preparing for the Next Millennium*. Geneva: UNAIDS, 2000 (Speech).
- Men and AIDS-A Gendered Approach*. Geneva: UNAIDS, 2000a.
- Men Make a Difference*. Geneva: UNAIDS, 2000b
- Microbicides for HIV Prevention: UNAIDS Technical Update*. Geneva: UNAIDS, 1998b.
- Mobilization for Microbicides: The Decisive Decade* New York: Rockefeller Foundation Microbicide Initiative, 2001.
- Moraga, E. *Género y Desastres - Introducción Conceptual y Criterios Operativos: La Crisis Del Huracán Mitch en Centroamérica*. Costa Rica: Fundación Género y Sociedad, 1999.
- Nunez, C.A., S. Aguilar and V.H. Fernandez. "Exclusion Social y VIH-SIDA en Guatemala." *Cuaderno de Desarrollo Humano*. Guatemala: Proyecto Accion SIDA de Centro América, 2001.
- Paiva, V. "Sexuality, Condom Use and Gender Norms among Brazilian Teenagers." *Reproductive Health Matters* 1, 1993.
- Progress of the World's Women: UNIFEM Bilateral Report*. New York: UNIFEM, 2000.
- Promotion of Sexual Health: Recommendations for Action*. Washington DC: PAHO, 2000.
- Rao Gupta, G. *Vulnerability and Resilience: Gender and HIV/AIDS in Latin America and the Caribbean*. Washington DC: International Center for Research on Women, 2002 (Unpublished paper).
- Rao Gupta, G. and E. Weiss. "Women's Lives and Sex: Implications for AIDS Prevention." *Culture, Medicine and Psychiatry* 17, 1993.
- Report on the Global HIV/AIDS Epidemic*. Geneva: UNAIDS, 2000c.
- Rivers, K. and P. Aggleton. *Adolescent Sexuality and Gender and the HIV Epidemic*. New York: United Nations Development Programme, 1998.
- Rutenberg, N. et al. *Community Involvement in the Prevention of Mother-to-Child Transmission of HIV: Insights and Recommendations*. Washington DC: Population Council, 2001.
- Serrano-García, L, N. Torres-Burgos, and M. Galarza. *Las relaciones de poder y la prevención de VIH/SIDA entre mujeres Puertorriqueñas*. Puerto Rico: Universidad de Puerto Rico, 1996.
- Special Report: AIDS in the Caribbean and Latin America*. Iowa: American Foundation for AIDS Research. 2001.
- Stevens, E.P. "Marianismo: The Other Face of Machismo in Latin America." In A. Pescatello (ed.) *Female and Male in Latin America*. Pittsburgh: University of Pittsburgh, 1973.

*The Female Condom and AIDS*. Geneva: UNAIDS, 1997.

*Trafficking of Women from the Dominican Republic for Sexual Exploitation*. Washington DC: International Organization for Migration, 1996.

*United Nations Declaration on the Elimination of Violence against Women*, 1993.

Ward, J. *If Not Now, When? Addressing Gender-Based Violence in Refugee, Internally Displaced and Post-Conflict Settings*. Washington DC: Reproductive Health for Refugees Consortium, 2002.

Weiss, E. D. Whelan, and G. Rao Gupta. *Vulnerability and Opportunity: Adolescents and HIV/AIDS in the Developing World*. Washington, DC: International Center for Research on Women, 1996.

Weiss, E and G. Rao Gupta. *Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention*. Washington, DC. International Center for Research on Women, 1998.

*Women, Vulnerability and HIV/AIDS: A Human Rights Perspective*. A. Gomez and D. Meacham (eds.) Chile: Latin American and Caribbean Women's Health Network, 1998.

*Working with Men for HIV Prevention and Care*. Geneva: UNAIDS, 2001b.

Wulf, D. J. Frost and J.E. Darroch. *Microbicides: A New Defense Against Sexually Transmitted Diseases*. Washington, DC: The Alan Guttmacher Institute, 1999.

*Young Men and HIV - Culture, Poverty and Sexual Risk*. London: PANOS, 2001.

Zelaya, E. et al. "Gender and Social Differences in Adolescent Sexuality and Reproduction in Nicaragua." *Journal of Adolescent Health* 21, 1997.