

# Women and AIDS

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UNAIDS – 20 avenue Appia – 1211 Geneva 27 – Switzerland  
Telephone: (+41) 22 791 36 66 – Fax: (+41) 22 791 41 87  
E-mail: [unaids@unaids.org](mailto:unaids@unaids.org) – Internet: <http://www.unaids.org>

# WOMEN AND AIDS

## INTRODUCTION

The AIDS epidemic is affecting women and girls in increasing numbers. Globally, just under half of all people living with HIV are female. In most regions, an increasing proportion of people living with HIV are women and girls, and that proportion is continuing to grow, particularly in Eastern Europe, Asia and Latin America, as shown in Figure 2.

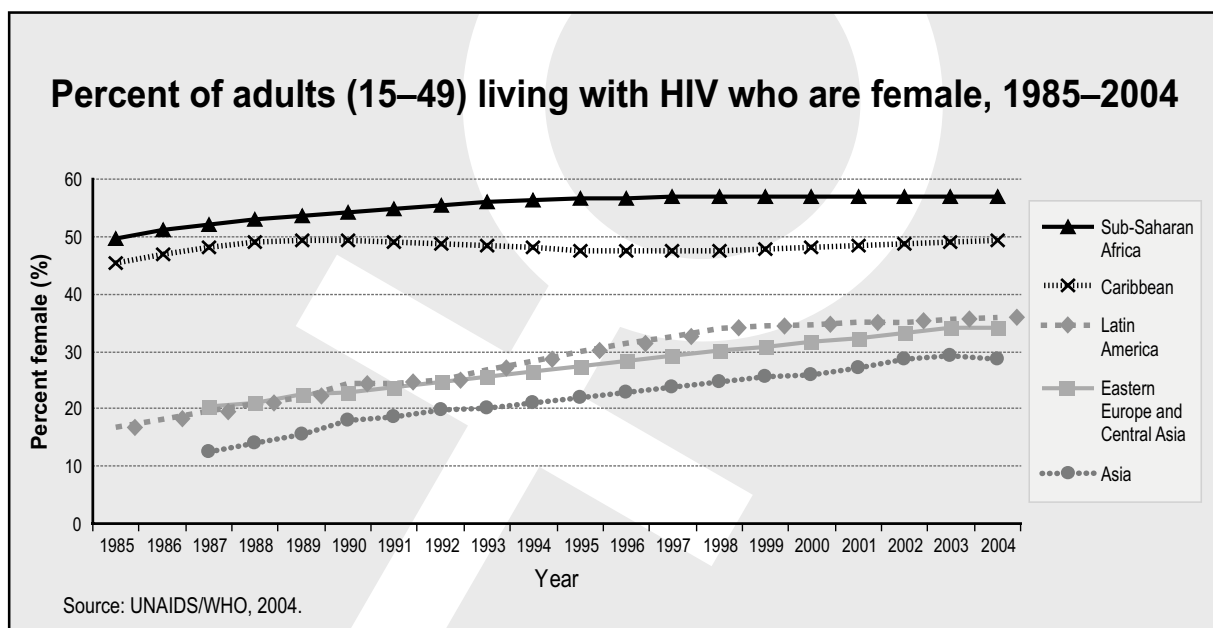


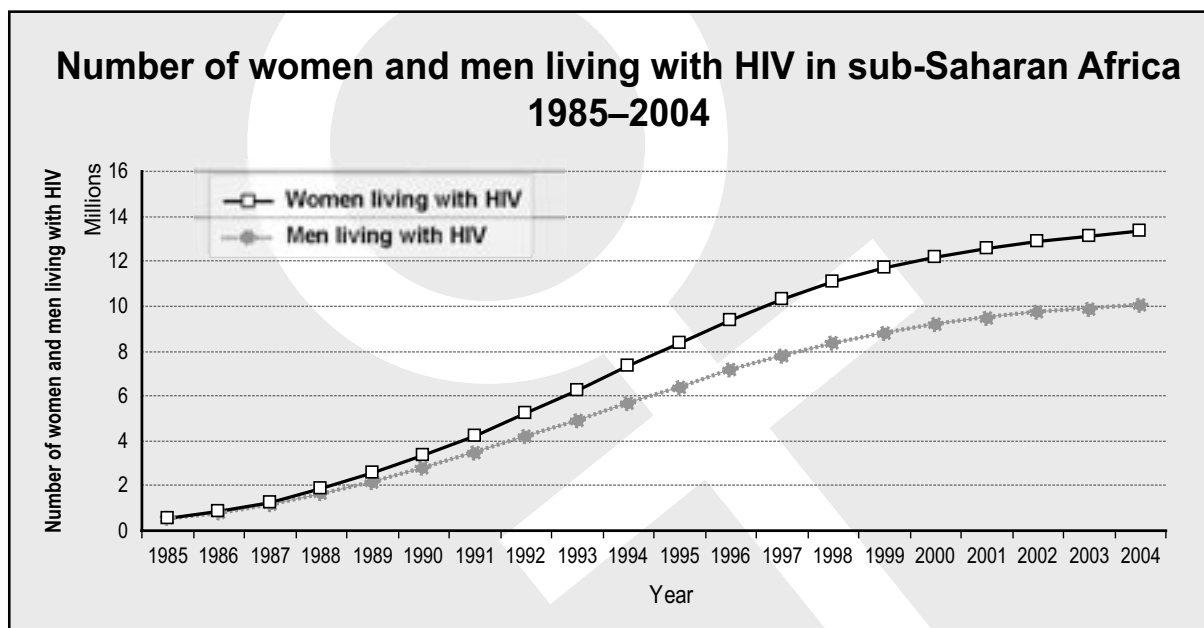
Figure 2

AIDS is affecting women most severely in places where heterosexual sex is a dominant mode of HIV transmission, as is the case in sub-Saharan Africa and the Caribbean. Women and girls make up almost 57% of adults living with HIV in sub-Saharan Africa (see pages 19-30). Overall, three quarters of all women with HIV worldwide live in that region. According to recent population-based household surveys, adult women in sub-Saharan Africa are up to 1.3 times more likely to be infected with HIV than their male counterparts

(UNAIDS, 2004). This unevenness is greatest among young women aged 15–24 years, who are about three times more likely to be infected than young men of the same age.

The picture is particularly disturbing when viewed close-up. In **South Africa, Zambia and Zimbabwe**, for example, young women (aged 15–24 years) are three to six times more likely to be infected than young men (Zambia Central Statistical Office, 2003; Zimbabwe Young Adult Survey 2001-2002). More than three quarters

Figure 3



of all young people living with HIV in those countries are women (WHO Regional Office for Africa, 2003; Reproductive Health Research Unit and Medical Research Council, 2004). Women constitute nearly half of the 420 000 [260 000–740 000] adults living with HIV in the Caribbean, where young women 15–24 years of age are almost twice as likely to be infected than are young men (UNAIDS, UNIFEM, UNFPA, 2004) (see pages 31–35).

In other parts of the world, most HIV infections occur through injecting drugs with contaminated equipment, unprotected sex between men and unsafe commercial sex. The notion that those epidemics are confined to specific populations is fanciful, however. Most injecting drug users are young and many are sexually active, risking double exposure to the virus. In some countries, particularly in Asia and Eastern Europe, a significant share of sex workers also inject drugs. Most male clients of sex workers have other sexual partners, including wives and steady girlfriends. In every region, a sizeable proportion of men who have sex with men, also have sex with women. No aspect of the AIDS pandemic is an island unto itself. As AIDS epidemics become more firmly established, more and more women are becoming infected.

Women now represent 36% of the 1.7 million [1.3 million–2.2 million] adults living with HIV in Latin America, where the epidemic has been centred largely among men who have sex with men and injecting drug users (see pages 57–61). As

more women in Eastern Europe and Central Asia acquire the virus through the use of contaminated equipment when injecting drugs and from male partners who are either injecting drug users and/or clients of sex workers, the overall proportion of women living with HIV in the region is also inching higher (see pages 47–56). There, women account for 34% of people with HIV, compared with 33% two years ago. In **Russia**, which has the biggest epidemic in this region, the proportion of women among people diagnosed with HIV increased to 38% in 2003, compared with 24% in 2001 (Russian Federal AIDS Center, 2004).

As in Eastern Europe, parts of Asia are experiencing AIDS epidemics that are spreading within and between particular population groups—such as sex workers or injecting drug users—and then into the general population, with women and girls increasingly affected. In East Asia women comprise 22% of all adults living with HIV, and 28% of young people (aged 15–24 years) living with HIV. In South and South-East Asia, 30% of adults (up from 28% two years ago) and 40% of young people living with HIV are women and girls. Women now account for more than one quarter of new HIV infections in India, according to estimates, and 90% of those who test positive at antenatal clinics say they are in single, long-term relationships (Cohen, 2004). HIV transmission between spouses has become a more prominent cause of new infections in countries such as **Cambodia, Myanmar and Thailand**—countries which, like parts of India, are already

## Widespread ignorance about HIV and sex

Social norms impose a dangerous ignorance on girls and young women, who often are expected to know little about sex and sexuality. That lack of knowledge magnifies their risk of HIV infection. In many countries, most young women do not know how to protect themselves against HIV infection, as Figure 4 illustrates. In countries such as **Cameroon, Lesotho, Mali, Senegal** and **Viet Nam**, two thirds or more of young women (aged 15 to 24 years) did not know three HIV prevention methods when surveyed. In **Moldova, Ukraine** and **Uzbekistan** more than 80% of young women lacked that knowledge. Knowledge about sex in general is also surprisingly low in many places. A recent study among rural married women in Uttar Pradesh, **India**, for example, found that 71% of the women (all of whom had married before puberty) knew nothing about how sex occurs when they began cohabiting with their husbands, and 83% did not know how a woman could become pregnant (Khan et al., 2004).

contending with serious epidemics. Twelve years ago, approximately 90% of HIV transmission in Thailand was occurring between sex workers and their clients. Projections show that by 2002, an estimated 50% of new infections were between spouses, as current or former male clients of sex workers transmitted the virus to their wives (Thai Working Group on HIV/AIDS Projections, 2001).

Around the world, the epidemic's escalating impact on women is occurring in the context of profound gender, class and other inequalities. This is also evident in industrialized countries in Western Europe and North America, where about one quarter of people living with HIV are women and where HIV has become increasingly lodged among women who belong to marginalized sections of populations, including minorities, immigrants and refugees (see pages 69-73). African American and Hispanic women, for example, represent less than one quarter of all women in the **United States of America**, but accounted for 80% of AIDS cases reported among women at the turn of this century (US Centers for Disease Control and Prevention, 2002).

## INEQUALITY, GENDER AND HIV

In many places, HIV-prevention efforts do not take into account the gender and other inequalities that shape people's behaviours and limit their choices. Many HIV strategies assume an idealized world in which everyone is equal and

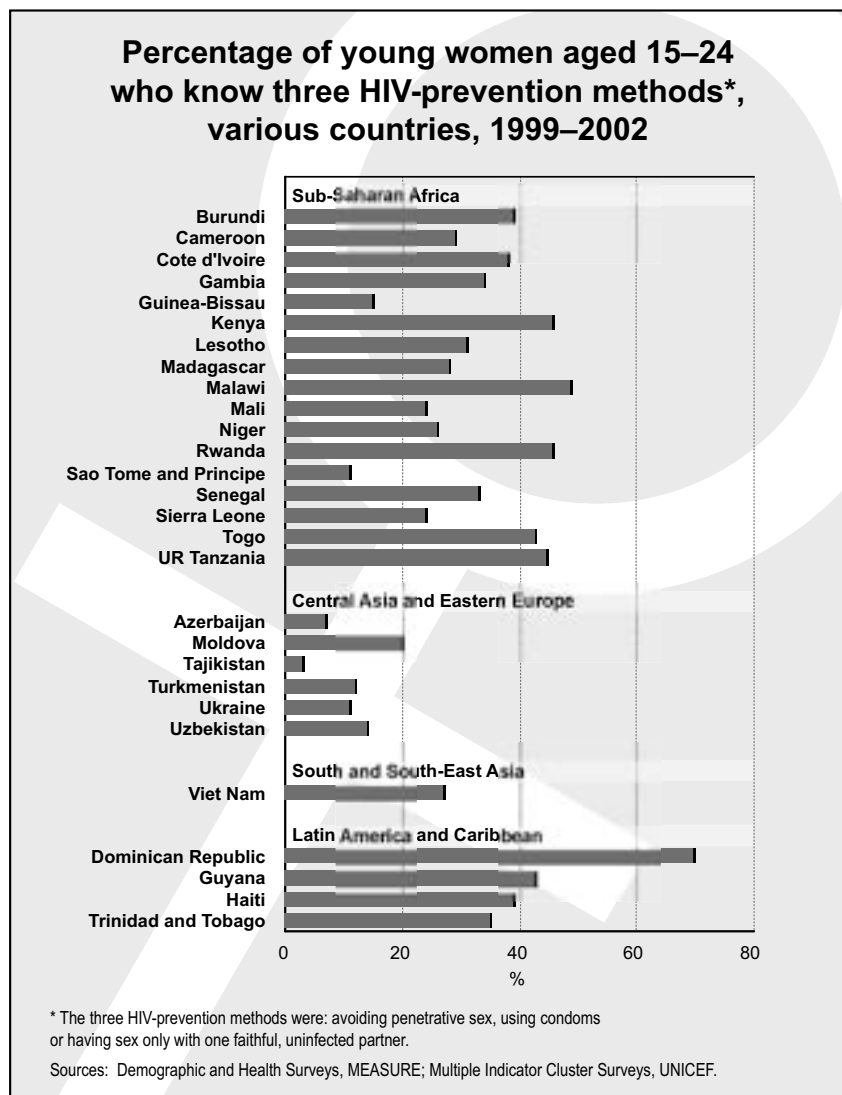


Figure 4

free to make empowered choices, and can opt to abstain from sex, stay faithful to one's partner or use condoms consistently. In reality, women and girls face a range of HIV-related risk factors and vulnerabilities that men and boys do not—many of which are embedded in the social relations and economic realities of their societies. These factors are not easily dislodged or altered, but until they are, efforts to contain and reverse the AIDS epidemic are unlikely to achieve sustained success.

Multiple partner relationships, underscored by “gifts”, can be a key survival strategy for many poor women. Driven by poverty and the desire for a better life, many women and girls find themselves using sex as a commodity in exchange for goods, services, money, accommodation, or other basic necessities—often with older men (Halperin and Epstein, 2004). Such “transactional sex” involves non-marital sexual relationships, often with multiple and older male partners, that reflect men's superior economic position and access to resources, women's difficulties in meeting basic needs, and the cultural value placed on men having multiple sexual partners (Jewkes and Wood, 2001).

One of the defining features in southern Africa, the worst-hit part of the world, is its social and economic inequality, not just between rich and poor but also among the poor. The relationship between HIV prevalence and socioeconomic indicators is highly complex. Nevertheless, social inequalities, layered atop widespread impoverishment and the social distortions wrought by migrant labour systems, and coupled with a burgeoning culture of consumerism, provide fertile ground for exploitative transactional, “survival” and intergenerational sex in southern Africa (UN Secretary-General's taskforce on women, girls and AIDS in southern Africa, 2004). Migrant labour systems have aggravated women's economic dependence on their male partners to a much greater extent than in other parts of the continent where women are more prominent in market trading and other forms of commercial activity. Across this subregion, income-earning opportunities for women with low educational attainment are particularly poor, and industrial sectors in which female workers predominate (such as garment manufacturing) have been hard-hit by job losses related to changes in tariffs and

### Until death do us part

Focusing programmes on persuading girls to abstain from sex until marriage is of little help to many young women. In some places, the main HIV risk factor for a woman is the fact that she is faithful to a husband with previous or current other sex partners. Among sexually active girls aged 15–19 years in the cities of Kisumu (**Kenya**) and Ndola (**Zambia**), a multicentre study reported that HIV-infection levels were 10% higher for married than for sexually active unmarried girls (Glynn et al., 2001). In rural **Uganda**, among HIV-infected women aged 15–19 years, 88% of the girls were married (Kelly et al., 2003). This is because young women, particularly teenagers, often marry men significantly older than they are, and these men are more likely to have had other partners and therefore are more likely to have been exposed to HIV.

The fact that the balance of power in many relationships is tilted in favour of men can have life-or-death implications. Women and girls often lack the power to abstain from sex or to insist on condom use—even when they suspect that the man has had other sexual partners and might be infected with HIV. In a study in Zambia, for example, only 11% of women believed that they had the right to ask their husbands to use a condom—even if he had proven himself to be unfaithful and was HIV-positive. In Mumbai, **India**, many women felt that the economic consequences of leaving a long-term relationship they saw as risky far outweighed the health hazards of staying in the relationship (Gupta, 2002). A recent study among women attending antenatal-care clinics in Soweto, **South Africa**, found that women were more likely to be HIV-positive in relationships where men wield considerably more power and control than they do (Dunkle et al., 2004). Special attention must be paid to preventing HIV infection within marriages. Women the world over need greater power and skills to help decide the terms of sexual relationships, and, at the same time, the HIV risk of their male partners must be reduced (Stephenson and Obasi, 2004).

subsidies. This has further weakened women's economic status, aggravating gender inequalities and possibly heightening women's vulnerability to HIV (Hunter, 2002).

It is important to recognize that sex plays other social functions, too, and is entangled in people's need to seek and express trust, in their search for status and self-esteem, and in their efforts to escape loneliness and relieve boredom. Research in **South Africa**, for example, indicates that in the context of widespread impoverishment and high unemployment (as well as the absence of affordable recreation), sexual relationships often serve as opportunities for enhancing self-esteem and peer status, and relieving boredom (Jewkes, Vundule and Maforah, 2001). What makes these

## MIND THE GAP

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Sex between young women and considerably older men is common in many countries, including in Asia, the Caribbean and sub-Saharan Africa. Whereas in Asia, for example, this often occurs within (arranged) marriages, in many African countries the phenomenon can be more diffuse and is often tied to the prestige of families that bond for mutual benefit, or to economies of need. Intergenerational and transactional sex are frequently intertwined. Research in parts of Africa, for example, has found that older men often help girls' families meet essential needs such as school fees, transport costs and groceries (Buve, Bishikwabo-Nzarhaza and Mutangadura, 2002;

*Reducing infection rates in women and girls is essential if AIDS is to be brought under control. Current prevention programmes are not achieving this.*

quests dangerous for so many women is that they are played out not only in areas where HIV has firm footholds but in circumstances marked by glaring gender inequality—where men tend to hold the upper hand, and where social norms and legal frameworks often brace that hand.

Information and awareness is not enough. If prevention efforts are to succeed in the long-run, they need to address the interplay between gender and socioeconomic inequality and vulnerability to HIV. Prevention activities need to take into account the unequal terms on which most women have to conduct their lives. Strategies need to address the fact that, for millions of people, sex can be one of the few valorized forms of capital at their disposal (Stephenson and Obasi, 2004; Cates, 2004). Much sexual risk-taking by girls and young women is marked by unequal gender relations, and unequal access to resources, assets, income opportunities and social power. Far more must be done to ensure sustainable livelihoods for women and girls, particularly those living in female-headed households, if they are to be able to protect themselves against HIV infection and deal with its impact. Boosting women's economic opportunities and social power should be seen as part and parcel of potentially successful and sustainable AIDS strategies.

Gregson et al., 2002; Hallman, 2004; Luke and Kurz, 2002). Nevertheless, the hidden costs can be high. Men in their late twenties and thirties are more likely to be HIV-infected, while the dependencies built into these relationships limit women's abilities to protect themselves from HIV infection, especially when the perception of younger women as "pure" encourages men to avoid using condoms (Gregson et al., 2002; Preston-Whyte et al., 2000). In addition, the risk of becoming infected during unprotected vaginal intercourse is greater for women than men, and the risk for young girls is greatest because the lining of the neck of the womb is not fully developed.

In southern Africa, for example, women and girls often get infected with HIV almost as soon as they start having sex. In a study in **Zambia**, 18% of women who said they had been virgins a year before being tested for HIV were found to be HIV-positive, while in **South Africa**, 21% of sexually active girls 16–18 years of age tested HIV-positive. There is evidence that the age gap between partners affects the chances that young women will become infected (Kelly et al., 2003). HIV prevalence was approximately 16% among teenage girls (15–19 years) in rural **Zimbabwe** whose last partner was less than five years older

than themselves, but among girls with partners 10 or more years older, HIV prevalence was twice as high (Gregson et al., 2002). In Kisumu, **Kenya**, among women three years or less the junior of

intimate partners. When surveyed, between one third and one half of women in **Namibia**, **Peru** and **Thailand**, for example, said they had been physically and/or sexually assaulted by their

*Relationships with older men are more likely to be premised on unequal power relations, leaving girls vulnerable to abuse and exploitation.*

their husbands, none was found to be infected with HIV, but half the women with husbands 10 years or more their senior were HIV-positive.

For many girls, violence or coercion marks their first experience of sex. According to surveys, in rural **Peru** 24% of young women said their first sex had been forced, while in **Jamaica** a significant percentage of girls (12% in a 2001 study) who had sex before they were 20 years of age had been raped. In **South Africa**, 10% of sexually experienced young women said they had been forced to have sex, according to a recent national survey (Reproductive Health Research Unit and Medical Research Council, 2003). One in six teenage girls in a **Zambian** study said that they had been forced to have sex with a man at some stage (Measure DHS, Central Statistical Office, Central Board of Health Zambia, 2002).

## **HIV AND VIOLENCE AGAINST WOMEN**

Violence against women is a worldwide scourge, and a massive human rights and public health challenge.\* It also increases women's vulnerability to HIV infection. Research has confirmed a strong correlation between sexual and other forms of abuse against women and women's chances of being HIV-infected (Garcia-Moreno and Watts, 2000; Maman et al., 2000). In addition, the fear of violence—not just from partners but from the wider community—prevents many women from accessing HIV information, from getting tested and seeking treatment, even when they strongly suspect they have been infected.

The most common form of violence perpetrated against women is violence at the hands of their

partners (WHO, forthcoming 2005). Women often have no legal recourse in countries where laws to prevent domestic abuse are absent or poorly enforced.

Research has uncovered strong links between intimate partner violence and increased likelihood of HIV infection (Heise, Ellsberg, Gottemoeller, 1999). A study in Kigali, **Rwanda**, among women in stable relationships showed that HIV-positive women were more likely to have experienced a history of physical and sexual violence at the hand of male partners than were women without HIV (Van der Straten et al., 1998). Among women younger than 30 years in a **Tanzanian** city, HIV-positive women were more likely to have experienced physical or sexual violence at the hands of their current partner than were HIV-negative women (although, in women older than 30 years HIV status was not associated with violence) (Maman, et al., 2002). At antenatal clinics in Soweto, **South Africa**, HIV infection was found to be more common in women who had been physically abused by their partners than in those who were not (Dunkle et al., 2004).

If HIV-prevention activities are to succeed, they need to occur alongside other efforts that address and reduce violence against women and girls. Violence against women and girls is not a private matter, but a violation of basic human rights with significant economic and social consequences for families, communities and nations. Laws against such violence must be formulated and adopted, and law enforcement structures need to be adapted and officials trained to ensure such laws are implemented.

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\* Violence against women refers to a range of behaviours, including sexual violence (rape and forced sex), physical assault, emotional abuse (for example, prohibiting a woman from seeing family and friends), ongoing belittlement, humiliation or intimidation, and economic restrictions (such as preventing a woman from working, or confiscating her earnings).



## STUNTED EDUCATION AND HEALTH CARE

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The imbalances of power women experience within relationships mirror wider, societal inequalities that limit women's autonomy and opportunities. Most African and Asian countries made strong strides in expanding education opportunities—especially for girls—after colonialism ended. Despite such progress, there remains a wide gap in school attendance between boys and girls in many regions, particularly Asia. Alongside other factors, including deepening poverty and unaffordable schooling expenses, AIDS is threatening those gains in the hardest-hit countries.

Disturbing in their own right, downward trends in education also hold implications for the epidemic's growth. Education is a key defence against the spread of HIV. Studies in **Zambia**, for example, have found lower levels of HIV infection among better educated people (UNICEF, 2003b), while in **Kenya** research has linked higher education levels with increased AIDS awareness and knowledge, higher rates of condom use, and greater communication on HIV prevention among partners.

**Nigeria's** latest round of HIV surveillance has found infection levels to be highest among pregnant women with only primary education (5.6%) and lowest among those with tertiary education and no formal education (4% and 3.8%, respectively) (Federal Ministry of Health Nigeria, 2003). The link between no formal education and lower HIV levels may be related to geographical and other factors. However, it is clear that completing secondary school can boost women's social power, employment opportunities, economic autonomy, and reduce their risks of HIV infection.

While secondary education can be a protective factor for girls, it is also a sad fact that in too many places, going to school may also place girls at risk. A **Zimbabwean** study has found that girls face sexual harassment and violence both from male students and teachers. Other studies, including in **Botswana, South Africa, Swaziland** and **Zambia**, have reported similar findings (Human Rights Watch, 2001).

Access to education—for girls and boys equally—must be expanded. Abolition of school fees would eliminate at least one barrier to universal education. Schemes to enable girls to complete secondary school are particularly vital. Evidence

*Choosing to abstain or have safer sex  
is not an option for the millions of women around the world  
who endure rape and sexual violence.*

The relationship between education and HIV is complex, though. In **Burkina Faso**, HIV levels among pregnant women were highest among women who only attended primary school or who failed to complete secondary school (at 2.9% and 2.6%, respectively). Prevalence was lowest among women who completed secondary school (1.6%) or who never attended school (1.9%) (Ministère de la Santé, Burkina Faso, 2003). In **Ghana**, HIV prevalence among pregnant women with only primary school education was almost two times higher (2.8%) than among those with no formal schooling (1.5%) and one third higher (2.1%) than among those who finished secondary school (Ghana Statistical Service et al., 2003). Meanwhile,

shows that secondary education can significantly reduce girls' vulnerability to HIV, since those years of schooling boost the skills and opportunities they need to achieve greater economic independence. Experience in many countries confirms that school subsidies increase girls' access to education and offer other benefits for girls and their families. They are also easier to monitor than other forms of direct subsidies. Steps must also be taken to ensure that schools provide a safe environment for girls. Concerted efforts are needed to expand mainstream life skills, as well as sexual and reproductive health education in primary and secondary school curricula, and to upgrade teacher training so that these topics can be taught effectively.

## NOT ENOUGH ACCESS TO PREVENTION AND TREATMENT OPTIONS

Women are much more likely than men to contract HIV from a single act of unprotected sex with an HIV-infected partner. But whether women have sex and whether that sex is protected often depend on the decisions and behaviour of their male partners. Unfortunately, a female-controlled prevention method is not yet widely available. Female condoms offer protection to increasing numbers of women, but they still require some degree of negotiation and male cooperation. They are also significantly more expensive than male condoms and, despite indications of increased uptake, they remain neither widely available nor socially accepted. Microbicides, which have anti-HIV activity and can come in the form of gels, creams, suppositories and rings, hold out much promise for female-controlled prevention. Several countries are now involved in trials of candidate microbicides. Microbicides (see box) can allow women to take control of their reproductive health (while efforts should continue to address underlying inequalities).

The overwhelming majority of children with HIV contract the infection from their mothers, during pregnancy, delivery, or through breastfeeding. In sub-Saharan Africa, about 1.9 million [1.7 million–2.3 million] children (younger than 15 years) were living with HIV at the end of 2004—almost 8% of the total number of people living with HIV in the region (UNAIDS, 2004). Many of these infections can be avoided if women do not become infected in the first place and if those

who do become infected can access HIV testing accompanied by antiretroviral drug prophylaxis for them and their newborns. In too many places, though, voluntary counselling and testing services to learn HIV serostatus outside of pregnancy are still absent; and currently a mere 1% of pregnant women in heavily-affected countries are offered services aimed at preventing mother-to-child HIV transmission. Such programmes are being expanded in most of the heavily-affected countries, particularly in sub-Saharan Africa, but few also include provision of antiretroviral treatment to the mothers in need of ongoing treatment.

Internationally, men tend to have better access to AIDS care and treatment in places where AIDS treatment is provided mainly within the private sector, and through drug trials. Again, this is a marker of the many other advantages that men enjoy. In sub-Saharan Africa, overall access to treatment for both men and women remains distressingly low at about 150 000 as of June 2004 (WHO, 2004). Access to voluntary counselling and testing still poses a significant challenge for girls and women who do not seek reproductive-health services, as well as for men, who generally are less likely to use public health facilities than women. As treatment programmes are expanded globally, there is a justifiable concern that many women may miss out on opportunities to learn their serostatus and receive treatment because they fear that if they discover they are HIV-positive their partners will become aware of their HIV status.

The obstacles barring women's access to treatment and care must be identified and overcome. Part

### Develop and provide microbicides to women

Microbicides hold the promise of a prevention tool women can control. Modelling indicates that even a 60%-efficacious microbicide could have substantial impact. If such a product were used by only 20% of women in 73 low-income countries, 2.5 million new infections could be averted over three years among women, men and children.

A first-generation microbicide could be ready for distribution in five to seven years. But for that to happen, investment in microbicide research and development needs to expand rapidly and dramatically so that highly potent, cheap microbicides with novel mechanisms of action can be tested in experienced, high incidence sites. Currently, the incentive structure of the private market is not funnelling sufficient investment towards microbicides, despite the fact that estimates point to a potential US\$ 1.8 billion market for a successful product by 2020 (Access Working Group, 2002). Substantially increased resources are required to ensure that testing of the most promising candidate microbicides proceeds without delay and that the groundwork is laid now for efficient distribution of successful products.

of the answer lies in strengthening sexual and reproductive health services, and improving the entry points for women's access to treatment and care services through improved referral systems. By integrating sexually transmitted infection treatment services with family planning activities, women's fear of social censure could be reduced and their uptake of services increased. Wider efforts to reduce HIV-related stigma are vital, too. Also needed are steps to ensure that girls

many areas are combining with AIDS to turn the care burden for women into a crisis that has far-reaching social, health and economic consequences.

Women pay a price beyond the immediate toil and distress. As their time and energy are increasingly absorbed by care duties, their opportunities to advance their education, achieve some financial independence through income-generation,

*As the epidemic's toll grows, more grandmothers are now caring for orphans than they did a decade ago*

younger than 18 are not barred from voluntary counselling, testing and treatment because they lack guardians' consent or proper identification. Stronger participation of women in clinical trials of new drug treatments is also needed.

### **A GROWING BURDEN OF CARE**

AIDS underscores and exacerbates the unequal divisions of labour and responsibility within households. Already, southern Africa has the highest average proportion of female-headed households on the continent—approximately 34% of households with children in that subregion are female-headed, compared with 18% in West and Central Africa, and 21% in East Africa (UNICEF and UNAIDS, 2003). With most AIDS care occurring within households (in sub-Saharan Africa, an estimated 90% of AIDS care happens at home), women bear a disproportionate burden of those responsibilities (Ogden and Esim, 2003).

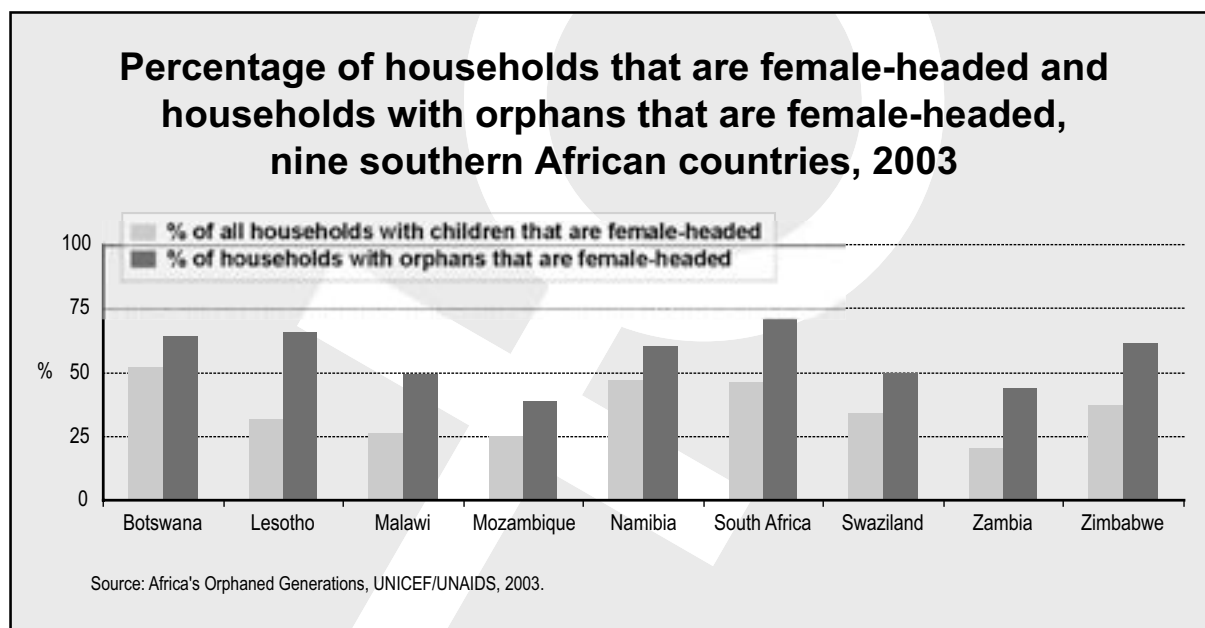
Generally, women and girls provide the bulk of home-based care (in **Viet Nam**, for example, women make up 75% of all caregivers for persons living with HIV), and are more likely to take in orphans, cultivate crops and seek other forms of income to sustain households (Ogden and Esim, 2003). In **South Africa**, a three-province survey found that almost three quarters of AIDS-affected households were female-headed, a significant proportion of whom were also battling AIDS-related illnesses themselves (Steinberg et al., 2002). Poverty and faltering public services in

or build skills fade. In South Africa, more than 40% of affected households reported that the main caregiver had taken time off work or school to care for an AIDS patient. Entire families are affected when women are diverted from other productive tasks. Most of the surveyed households in South Africa were already poor—some extremely poor—before AIDS appeared. The epidemic has compounded their predicament. They reported an average two thirds loss in household income as a result of having to cope with AIDS-related illness (Steinberg et al., 2002). Research in **Tanzania** has shown that women spend up to 50% less time doing farm work when their husbands are seriously ill (Rugalema, 1999). Meanwhile, access to productive resources such as land, credit, knowledge and skills, training and technology is very often decided along gender lines, with women typically discriminated against.

Households often dissolve when an adult female dies—as happened in the case of two-thirds of households surveyed in Manicaland (**Zimbabwe**) (Mutangadura, 2000). Much of the burden generated by the death of an adult woman then tends to shift onto other, usually older, women who step in to foster the children, as several studies have found (Steinberg et al., 2002; UNICEF and UNAIDS, 2003).

In many countries, female-headed households—including those run by elderly women—are much more likely to take in orphans and to take in a greater number of orphans than male headed households, as Figure 5 shows. As the epidemic's toll grows, more grandmothers are now caring for

Figure 5



orphans than they did a decade ago. It is estimated that grandmothers in **Botswana**, for example, care for roughly half the children who have lost a mother or father (UNICEF and Ministry of Local Government Botswana, 2003).

Social welfare systems in most of the hardest-hit countries are too flimsy to relieve these burdens. As a result poor households—and particularly the women and girls in them—have very little possibility of accessing external support that could shield them against the brunt of the epidemic's impact. Families, communities and governments cannot rely on women's fortitude and resilience alone to provide sustainable safety nets. Whether tending the sick, tilling fields, earning income or volunteering help, women's work is an essential part of household and national economies. The burdens added by AIDS entail costs not just to women and their households but to economies at large—and those burdens have to be relieved. AIDS home care programmes need to be extended beyond medical and nursing care to include counselling, food assistance, welfare support, schooling subsidies and income opportunities that benefit households. Needed, too, are social protection and economic support for older people and

those caring for orphans—as well, as smoother administrative procedures for accessing pensions and child support grants, which often sustain entire families (HelpAge International, 2004).

## DENIAL OF WOMEN'S INHERITANCE AND PROPERTY RIGHTS

Women's vulnerability to HIV is further exacerbated by unequal property and inheritance rights. The status of those rights varies greatly around the world. Among developing regions, most of Latin America has relatively egalitarian gender inheritance norms, though some land reform and post-war resettlement initiatives have neglected gender concerns. Striking gender inequalities in control over property and other assets persist in South Asia, despite efforts to extend women's rights. In much of sub-Saharan Africa, property is usually owned by men, with women occasionally acquiring rights mainly by virtue of marriage. Multiple legal regimes overlap in many African countries, incorporating old colonial laws, more recent constitutional law, and ongoing customary law (and, in some places, Shariat). Shifts in customary law during colonial rule in southern Africa, for example,

have meant that the law is often interpreted to the detriment of women. Colonial administrations superimposed concepts of private property and a rigidly patriarchal system on traditional property dispensations. This helped transform the principle that men administer and inherit property to the benefit of the clan into claims of individual property ownership without corresponding obligations (Women and Law in Southern Africa Research Trust, 1998).

The payment of bride-price upon marriage tightens men's control over women and property; in some countries women remain legal minors even after marriage (Human Rights Watch, 2003a). The outcome is a status quo that often fails to recognize or uphold women's property rights, that reduces women's economic security and can lead to women having to endure abusive relationships or resort to sex for economic survival. In some countries, women whose male partners die of AIDS are subjected to property stripping by their spouses' relatives, which casts them into deeper economic insecurity (Human Rights Watch, 2003a; Drimie, 2002).

Lacking the enforceable right to own or inherit land and property, women and girls risk possible destitution after the death of their partners or parents, while poverty and economic dependence leave them exposed to increased sexual exploitation and violence (Strickland, 2004). One FAO study in **Namibia** found that 44% of widows lost cattle, 28% lost small livestock, and 41% lost farm equipment in disputes with in-laws after the death of a husband (Kaori, 2004). Even though legal protections exist in some countries, the reality is that most women are left without recourse. Recalcitrant or disinterested officials, women's own lack of awareness of their rights, and fear of violence, along with the social stigma attached to pursuing a claim mean that many relent to dispossession (Human Rights Watch, 2003a and 2003b).

Legal systems must be adapted to establish and uphold women's property and inheritance rights, and legal precedents need to be established through test cases. This could help cushion the economic impact of AIDS in households. In addition, boosting

women's economic independence can reduce their vulnerability to intimate partner violence, intergenerational and transactional sex—and other HIV-related risk factors. But legislation alone is not enough. Public awareness of these issues must be raised. Women's land and housing rights and tenure security should be documented, particularly in high HIV prevalence areas. It is vitally important that traditional authorities and leaders become partners in these efforts, not least because they hold the powers to interpret and adapt customary laws in ways that favour women's rights.

## DEALING WITH THE BIG PICTURE

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Strategies are needed to address the structural dynamics of the AIDS epidemic—particularly the wide-ranging gender inequalities that help power the spread of HIV. One of the first steps required is to understand the problem better. National programmes should ensure that data on the epidemic are disaggregated by sex. This will enable a clearer analysis of how gender relations feature in the epidemic, and will highlight the varied demands that AIDS places on women and girls, and men and boys—knowledge that is vital for more effective AIDS programming.

It is equally important that women are more closely involved in designing and guiding programmes that are meant to serve them. This applies particularly to women living with HIV, who can contribute in unique ways to strengthening responses to the epidemic. In addition, the nurturing of strong civil society organizations, particularly women's and youth groups, can improve the reach, accountability and effectiveness of AIDS programmes.

In all these efforts, men and boys must play a greater role. Men currently shape much of the world in which women live; as such, they must be partners in social change. Programmes targeting women must also learn to embrace men as partners in order to help nurture social structures that are more supportive to women. Men's participation in home-based care and other support programmes would be one way of heeding their responsibilities for the health and welfare of their communities and societies. Men and boys are best-placed

to challenge and recast harmful stereotypes of masculinity, to confront the scourge of violence against women, and to assume their share of responsibility for HIV prevention and protection, especially within intimate relationships.

All this marks a huge challenge. Interim, crisis-driven efforts alone might achieve temporary relief

but they will prove inadequate in the long run if the conditions that enable HIV to spread are left untouched. This does not mean that the epidemic can only be vanquished once gender equality is achieved. But progress on that front almost certainly will help reduce the scale, severity and duration of the global AIDS epidemic.

## **The Global Coalition on Women and AIDS**

The Global Coalition on Women and AIDS was launched by UNAIDS in early 2004 to highlight the effects of AIDS on women and girls and to stimulate effective action to reduce that impact. The Global Coalition on Women and AIDS is not a new organization but a movement of people, networks and organizations supported by activists, leaders, government representatives, community workers and celebrities. Its work is focused on seven areas:

- preventing HIV infection among adolescent girls;
- reducing violence against women;
- protecting the property and inheritance rights of women and girls;
- ensuring equal access by women and girls to care and treatment;
- supporting improved community-based care, with a special focus on women and girls;
- promoting access to new prevention options, including female condoms and microbicides; and
- supporting on-going efforts towards universal education for girls.

For more information, contact UNAIDS or visit <http://womenandaids.unaids.org>

# GLOBAL SUMMARY OF THE AIDS EPIDEMIC

## DECEMBER 2004

<b>Number of people living with HIV in 2004</b>	<b>Total</b>	<b>39.4 million (35.9–44.3 million)</b>
	Adults	37.2 million (33.8–41.7 million)
	Women	17.6 million (16.3–19.5 million)
	Children under 15 years	2.2 million (2.0–2.6 million)
<b>People newly infected with HIV in 2004</b>	<b>Total</b>	<b>4.9 million (4.3–6.4 million)</b>
	Adults	4.3 million (3.7–5.7 million)
	Children under 15 years	640 000 (570 000–750 000)
<b>AIDS deaths in 2004</b>	<b>Total</b>	<b>3.1 million (2.8–3.5 million)</b>
	Adults	2.6 million (2.3–2.9 million)
	Children under 15 years	510 000 (460 000–600 000)

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information.

### Regional HIV statistics and features for women, end 2002 and 2004

		Number of women (15–49) living with HIV	Percent of adults (15–49) living with HIV who are women (%)
<b>Sub-Saharan Africa</b>	2004	13.3 million [12.4–14.9 million]	57
	2002	12.8 million [11.9–14.3 million]	57
<b>North Africa and Middle East</b>	2004	250 000 [80 000–770 000]	48
	2002	200 000 [62 000–620 000]	48
<b>South and South-East Asia</b>	2004	2.1 million [1.3–3.1 million]	30
	2002	1.8 million [1.1–2.7 million]	28
<b>East Asia</b>	2004	250 000 [120 000–400 000]	22
	2002	160 000 [79 000–250 000]	21
<b>Oceania</b>	2004	7 100 [4 100–11 000]	21
	2002	5 000 [3 000–7 500]	18
<b>Latin America</b>	2004	610 000 [470 000–790 000]	36
	2002	520 000 [390 000–690 000]	35
<b>Caribbean</b>	2004	210 000 [120 000–380 000]	49
	2002	190 000 [110 000–360 000]	49
<b>Eastern Europe and Central Asia</b>	2004	490 000 [310 000–710 000]	34
	2002	330 000 [220 000–480 000]	33
<b>Western and Central Europe</b>	2004	160 000 [120 000–200 000]	25
	2002	150 000 [110 000–190 000]	25
<b>North America</b>	2004	260 000 [140 000–410 000]	25
	2002	240 000 [120 000–390 000]	25
<b>TOTAL</b>	2004	17.6 million [16.3–19.5 million]	47
	2002	16.4 million [15.2–18.2 million]	48

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## **Explanatory note about UNAIDS/WHO estimates**

The UNAIDS/WHO estimates in this document are based on the most recent available data on the spread of HIV in countries around the world. They are provisional. UNAIDS and WHO, together with experts from national AIDS programmes and research institutions, regularly review and update the estimates as improved knowledge about the epidemic becomes available, while also drawing on advances made in the methods for deriving estimates. Because of these and future advances, the current estimates cannot be compared directly with estimates published in previous years, nor with those that may be published subsequently.

The estimates and data provided in the graphs and tables are given in rounded numbers. However, unrounded numbers were used in the calculation of rates and regional totals, so there may be small discrepancies between the global totals and the sum of the regional figures.

UNAIDS and WHO will continue to work with countries, partner organizations and experts to improve data collection. These efforts will ensure that the best possible estimates are available to assist governments, nongovernmental organizations and others in gauging the status of the epidemic and monitoring the effectiveness of their considerable prevention and care efforts.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

This extract from the annual **AIDS epidemic update** focuses on women and AIDS. With maps and regional summaries, the 2004 edition of the *AIDS epidemic update* provides the most recent estimates of the epidemic's scope and human toll. The original document is available at <http://www.unaids.org>.

<http://womenandaids.unaids.org>

UNAIDS – 20 avenue Appia – 1211 Geneva 27 – Switzerland  
Telephone: (+41) 22 791 36 66 – Fax: (+41) 22 791 41 87  
E-mail: [unaids@unaids.org](mailto:unaids@unaids.org) – Internet: <http://www.unaids.org>