

**WOMEN AND HIV/AIDS PREVENTION
REPORT**

of a

DAY OF DIALOGUE

co-sponsored by

Advocacy for Women's Health Group

Para55 Group

UK NGO AIDS Consortium

International AIDS Vaccine Initiative (IAVI)

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Introduction

The Programme of Action for the International Conference on Population and Development (1994), now known as the *Cairo Agenda*, includes as one of its objectives the prevention of “sexually transmitted diseases, including HIV/AIDS . . . with special attention to girls and women”.¹ The following year the Beijing Platform for Action, adopted at the Fourth World Conference on Women highlighted that women and particularly adolescent girls and young women “often do not have the power to insist on safe and responsible sex practices and have little access to information and services for the prevention [of HIV]”² and called on Governments to:

“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 ..”³

and

“provide financial and institutional support for research on ... methods to protect against HIV/AIDS and the other sexually transmitted diseases ...”⁴

It would be true to say however that even though HIV/AIDS was having a devastating impact on the health of women and adolescent girls, and that it was both a sexual and a reproductive health issue for women of all ages, it was not recognized as an immediate priority and was rarely integrated within the context of sexual and of reproductive health. However, the UN General Assembly twenty-first special session on the Implementation of the Programme of Action of the International Conference on Population and Development (ICPD+5) in 1999 placed far greater emphasis on the effects of HIV/AIDS on women and girls in the *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*.

Known as the *Cairo+5 Agenda* this document called for greater information and access to treatment and care.⁵ It also called on Governments to make a strong commitment to prevention of HIV/AIDS for women and girls and “... to ensure wide provision of and access to female and male condoms, including through social marketing”.⁶ In looking to the future it also called on

“The private and public sectors [to] increase investments in research on the development of microbicides and other female-controlled methods, simpler and less expensive diagnostic tests, single-dose treatments for sexually transmitted diseases and vaccines.”⁷

This was followed in June 000 by a further re-iteration in the *Further actions and initiatives to implement the Beijing Declaration and the Platform for Action* of the

twenty-third special session of the General Assembly entitled “Women 2000: gender equality, development and peace for the twenty-first century”. This stated:

“As a matter of priority, especially in those countries most affected, and in partnership with NGOs, wherever possible, intensify education, services and community-based mobilization strategies to protect women of all ages from HIV and other sexually transmitted infections, including through the development of safe, affordable, effective and easily accessible female-controlled methods, including methods such as microbicides and female condoms that protect against sexually transmitted infections and HIV/AIDS; voluntary and confidential HIV testing and counselling; the promotion of responsible sexual behaviour, including abstinence and condom use; and the development of vaccines, simple low-cost diagnosis and single dose treatments for sexually transmitted infections.”⁸

Today, 17 years after the identification of HIV as the cause of AIDS, we have to confront the fact that we are not succeeding, in spite of all our efforts, to control the epidemic spread of HIV, and that we are particularly failing to do so for women of all ages. Although we now possess a tremendous fund of information about how to do this, action to implement what we do know at community and national level has been slow to happen. It is therefore imperative that current methods of prevention are promoted and fully utilized and that greater commitment and resources are made available for ‘methods of the future’ such as microbicides and vaccines both of which will greatly assist in protecting women from infection in the future.

This Day of Dialogue, co-sponsored by *Advocacy for Women’s Health*; the *Para55 Group*; the UK NGO AIDS Consortium; the International AIDS Vaccine Initiative (IAVI); the BMA Foundation for AIDS; and the National AIDS Trust (NAT); in collaboration with the Commonwealth Secretariat; was held to provide representatives of concerned women’s organizations, HIV/AIDS organizations; reproductive health organizations and others with the opportunity to focus on Women and HIV/AIDS prevention. This report was prepared by the Commonwealth Medical Association (CMA) to allow the findings of the Day to be considered at the Expert Group Meeting on the *HIV/AIDS Pandemic and its Gender Implications*, which was held in Windhoek, Namibia from 13-17 November 2000; the 45th session of the Commission on the Status of Women, which will be held in New York from 6-16 March 2001; and the UN General Assembly Special Session to aim to intensify international action to combat HIV/AIDS and to secure a global political commitment and the resources needed, which will be held in New York from 25-27 June 2001.

Marianne Haslegrave⁹

I **Prevention of HIV/AIDS, Gender and the Cairo+5 Agenda¹⁰**

This paper is about gender issues in the prevention of HIV/AIDS and how they relate to the Cairo+5 Agenda on promoting women's reproductive and sexual health and rights at national level, issues that deserve a great deal more thought and analysis than they have received in the past.

First, it is important to explain what a gender perspective is. A gender perspective is required where issues in which being a man and being a woman have different consequences. The reason why a gender perspective is important is because there is a power imbalance between men and women. This does not mean women are powerless and men are powerful. Not at all. Hence, a gender perspective is not merely a picture of women as oppressed, powerless victims who, for example, are unable to insist on condom use or to protect themselves from HIV. Rather, it means that men hold the balance of power as a group over women as a group and can exercise that power individually on the basis of their social status as men. This happens in spite of women's own abilities and power, not because these are absent. The reason to develop a gender perspective is to find solutions to this power imbalance in such a way that efforts can be made to redress that imbalance in favour of women. Hence, a gender perspective is a women's rights perspective as well.

To develop a gender perspective on HIV/AIDS prevention is easier than knowing what to do to make HIV prevention work successfully. Women of all ages are still, 20 years into the HIV epidemic, being portrayed either as powerless victims or as carriers of disease. As each country in the world discovers that it too has an HIV problem, these stereotypes emerged again and again, making it impossible to move forward in finding ways to support women to protect themselves. . Hence, even in the three countries in the developing world where prevention efforts are succeeding to some extent, namely Thailand, Senegal and Uganda, it seems it is men more than women who are experiencing lower infection rates. Similarly, in developed countries, it is men in the gay community who have succeeded better than men and women in heterosexual relationships in reducing sexual transmission of HIV. Further, gender issues arise in relation to prevention of mother-to-child transmission (MTCT), injecting drug use and blood transfusion, which are the three main other ways in which HIV is transmitted apart from through sexual transmission. Injecting drug users therefore may find it easier to reduce infection rates in their communities through safer injection practices than through safer sex.

There are three main areas where gender and the prevention of HIV infection intersect. The first relates mainly to sex, the second to health, and the third to rights. One of the reasons why HIV prevention efforts have not yet succeeded for

women is that almost all of the issues that fall under the following three categories (which are essential areas for action) are controversial. They include:

- sex, sexuality, sexual education, sexual behaviour, sexual relationships and safer sex;
- women's health, women's reproductive and sexual health, men's health, men's reproductive and sexual health, public health, and health policies, programmes and services;
- universal human rights, women's rights, women's reproductive rights, women's and men's sexual health rights, and women's and men's sexual rights.

Some examples of the kinds of action required to slow down and stop the HIV epidemic among women in the coming decades follow.

Sex, sexuality, sexual education, sexual behaviour, sexual relationships and safer sex:

- Sexuality education is needed for children; for adolescents (in school and out of school); and for their parents, teachers, older carers and grand-parents who are increasingly responsible for their upbringing where parents have died from AIDS. Sexuality education, which must begin before young people start having sex, helps them to postpone unwanted sex and to protect themselves better when they do begin to have sex. The need for sexuality education does not stop at the time of leaving school. Most adults in most societies would benefit from it and would be interested in it, particularly those with children, who will feel a need to keep up with what their children are learning. Innovative use of the media, especially radio and television and theatre, is one way of delivering this.
- Social and juridical action is needed to combat gender-based violence – including sexual abuse and domestic violence. Studies show that adolescent girls are all too often pressured and even coerced into having sex by their boyfriends. Studies also show that women who were sexually abused as children are at greater risk for injecting drugs, which in turn puts them at risk of HIV. Sexuality education must recognize the role of violence in putting women of all ages at risk sexually.

- Sexual behaviour, and behaviour in sexual relationships, is currently treated as a private or family matter in all societies. It is necessary to socialise this issue and to challenge these behaviours when they create risk, and to identify the differences in what men do and what women do to put themselves and each other at risk. Heterosexual behaviour in men has remained protected from criticism and critique at a public level and this must begin to be challenged openly. Women cannot be expected to take men on individually in isolation, any more than they can confront men individually in relation to domestic or sexual violence; it has been shown time and again at a population level that private solutions cannot succeed. Men must challenge men, first and foremost.
- It is important to develop and promote images of sexuality together with accompanying messages that help to create a safer sex ethos. Unsafe sex is the social norm in almost every society and social group. It is the majority behaviour. Current images of sex and sexuality in today's media also alternate between the unrealistically romantic, soft pornography and romanticised notions of sexual dominance, dressed up in the latest gender-blending fashion wear that appeals to youth. Together, these serve to make sexual violence appear more attractive and less destructive than it actually is, thereby promoting risk-taking rather than mutual respect and protection. What is needed instead are sex-positive images that do not trample on passion, but which still promote autonomy and equality in sexual relationships. Challenging the existing dominant images and messages is a major task.

Women's health, women's reproductive and sexual health, men's health, men's reproductive and sexual health, public health, and health policies, programmes and services

The determinants of health include economic and political development and democracy; eradication of poverty; education; housing; employment; health services which address prevention and treatment; and, finally, social support and social welfare services for those who need care and support. Women of all ages also need an independent income and financial independence in order to be able to access the determinants of health in their own right. In many societies, however, women still require the permission of their husbands or other family members just to go to the doctor or clinic, even if they are lying in their beds near death from complications of childbirth.

The determinants of women's sexual and reproductive health within this broader picture are of course related to fertility, pregnancy/birth and the post-partum period, birth control, infertility, reproductive tract infections (RTIs), which include sexually transmitted infections (STIs) and reproductive diseases such as cervical

cancer. These are clearly women's issues, which include women's HIV/AIDS issues.

The gender-related question is really whether and how these issues involve men as well, in ways that promote women's sexual and reproductive autonomy and well-being while at the same time helping to prevent women dying from causes related to sex and reproduction. The bottom line is: women have to change in order to take control of their lives. Men have to change too, and differently, for women's sake as well as for their own.

In the meantime, the intersection of HIV/AIDS with sexual and reproductive health concerns is a priority area for women's health, one that remains to be developed and acted upon in an integrated way. Examples of how and why this needs doing include:

- STIs not only increase HIV risk but also the risk of pelvic inflammatory disease (PID), infertility and perinatal morbidity and mortality.
- STIs and HIV do not require the same prevention strategies. They do not carry the same risk of transmission, nor do they pose the same threat to health and life; need the same treatment regimens or the same forms of care once contracted. (On the other hand it must be remembered that STI treatment programmes play an important part in reducing the risk of HIV infection.)

Unfortunately, those who work in sexual and reproductive health have a tendency neither to see nor to take account of these distinctions and often talk indiscriminately of STIs/HIV.

- Many, though certainly not all, women need 'dual protection' against STIs, HIV and unwanted pregnancy. Some women need one or the other but not both, eg women trying to get pregnant actively do not want contraceptive protection but may well need protection from infection as do older women past the age for child-bearing. The gender issue here is that men do not need 'dual protection'. Protection messages must make these distinctions and address women and men differently. Only seven abstracts from the Durban AIDS conference discuss 'dual protection' at all, and each of them has a different definition of what the term means, based either on biases against specific methods or whether or not abortion could be offered as a back-up to condoms, for example, as a legitimate form of 'dual protection'. Hence, the term requires a common definition.

- Access to and use of family planning methods and of safe, legal abortion remain problematic for many women in many countries. The safest and most effective method of 'dual protection' is condom use backed up by abortion. HIV positive as well as HIV negative women need access to safe abortion in cases of unwanted pregnancy and at the same time, must not be pressured to have an abortion they don't want in order to prevent mother to child transmission (MTCT). The legalisation of abortion and provision of safe abortion services is an urgent issue in both HIV/AIDS and sexual and reproductive health work.
- For many women condom use inside marriage is next to impossible, and not only because marriage partners do not want to admit having other partners, which is hard enough to address in itself. It is also because increasing numbers of women over the age of 30 and even the age of 25 are being sterilised; most of the rest are using non-barrier methods of contraception when they are not trying to get pregnant; and many are beyond the age for child-bearing. This means there is no valid reason for suggesting condoms except as protection from infection, and evidence shows that this is much more difficult for married and cohabiting women to suggest than suggesting condom use for pregnancy prevention.
- Rejection of condom use by those who need condom protection is a quintessential gender issue – fogged over by assertions that "women dislike condoms as much as men". This statement is rarely based on in-depth, gender-sensitive evidence. Many women, in line with the fact that they consider themselves to be "respectable", say that they won't use condoms because they are not "that kind of woman". So it is the symbolic value of condoms rather than the method itself that they reject. On the other hand, what woman would dare ask a man if he would use condoms during pregnancy to protect her from HIV?
- Everyone agrees that prevention of MTCT of HIV is an important priority. And everyone also agrees that primary prevention of HIV in women is essential for infants and children to benefit in the longer term. However, the fact is, that when it comes to action, antiretroviral therapy for pregnant and breastfeeding women is too expensive; the female condom is too expensive; subsidising infant formula does not automatically make it accessible for all women; antenatal and childbirth services are too expensive; mass STI treatment is too expensive; and most men will not use condoms. Although it has been shown that infants are more likely to die if their mothers are dead, and that we must therefore try to save women's lives in order to save infants' lives, it is still always too expensive.

- One issue that seems to have fallen off the agenda when it comes to saving women's lives is to do with blood safety. How much of the world's hospital-based blood supply is currently safe in relation to HIV? Given that complications of pregnancy, childbirth and abortion are still the most common reasons why women need blood transfusions and that the blood supply in most major hospitals with maternity units is used mostly for this purpose, current data on this question is important.
- Finally, under this heading, there is the subject of access to treatment, one that most HIV/AIDS activists raise in a gender-neutral way. It seems that once prevention of HIV in infants is seen to be covered, all that is considered left to do is to provide whatever treatment is available for men and women equally, no matter how scarce it is. This perception is gender-blind; the definition of treatment must be expanded to take account of women's specific needs. In addition to women's need for 'dual protection' methods, women also need breast-milk substitutes for infants, and cervical screening and treatment for cervical disease/cancer (an epidemic in itself and an AIDS-defining condition which is a frequent cause of death in women with AIDS.) Furthermore, women need post-exposure prophylaxis following rape as do pregnant health workers who get needle-stick injuries in the course of their work).

And these are only a few examples.

Universal human rights, women's rights, women's reproductive rights, women's and men's sexual health rights, and women's and men' sexual rights

The third and last main area to be considered is rights and again the suggested conceptual framework for this is not the usual one. Human rights are by definition universal and indivisible, and no one can be stripped of them. Women's rights apply to women universally, but not to men, and this is so because of gender differentials. It can be argued that women's reproductive rights are a subset of human rights, in this sense, yet they are also different in that they apply only to women for physiological reasons – ie only women can get pregnant. On the other hand, some would argue that because men are necessary for pregnancy and should be responsible for the children they engender, they also have certain reproductive rights. These are all matters that require further analysis.

Then, there are rights in relation to sexual health and there are sexual rights, and these are not the same, and there are gender differences in how these are defined and addressed.

Furthermore, there are human rights issues, which are commonly raised in relation to HIV/AIDS and in each case these are not gender neutral either. These include issues such as stigma, non-discrimination, the right to confidentiality,

access to, as well as the right to, refuse voluntary testing and counselling, informed consent in research, and, on the other hand, mandatory testing of sex workers, questions of disclosure and partner notification and how the need to protect the rights of all the partners concerned can be addressed. Each of these has gender aspects as well as ethical and legal and public health aspects, which deserve greater care and attention.

For example, the risk of violence against women in relation to HIV has been shown to increase, not necessarily overall, but most commonly in cases where a woman is tested for HIV first and by herself, so that when she tells her partner, he blames the infection on her regardless of whether he is HIV positive himself and how either of them came to be that way. To complicate this picture, most women are offered an HIV test for the first time in antenatal settings for the sake of their infants, not for themselves, at a point and in a place when the offer of having the test with their partners is least likely. Testing strategies need to address these gender-related practices and find women-centred ways to provide testing. Counselling and testing of couples before women get pregnant has been shown to support women in their relationships and their reproductive rights best and yet the two together remain an unusual practice almost everywhere.

Conclusion

Thus, there is a close link between the prevention of HIV / AIDS, gender issues and the Cairo+5 Agenda. This link pertains in relation to sex and sexuality, sexual and reproductive health, and women's rights, including their sexual and reproductive rights. In fact, underneath every seemingly gender-neutral label, there is a gender issue waiting to be identified and dealt with. Prevention works, but only if prevention activities are allowed and encouraged to take place. Recently an African leader declared that AIDS was a national disaster in his country, yet in the same breath he refused to promote condoms. Implementation is therefore missing and the epidemic continues to take its toll.

The most important gender issue in this regard is that women of all ages are still being sidelined in terms of access to prevention, treatment, care and resources. They are being denied the protection of condoms and other forms of safer sex, in spite of their crucial roles as mothers of infants and children, and as partners per se, and as valued human beings in their own right, as well as in their role as carers for sick husbands and family members, including those with HIV and AIDS-related illnesses or in bringing up grand-children where parents have died from AIDS. This reflects women's status, and women's status is preventing women getting priority in either HIV / AIDS work or in actually implementing – not only talking about implementing – the Cairo+5 agenda. This is the starting point for change and these are the prerequisites to any sort of change that has a chance of achieving its goal.

In conclusion, empowering women is not a means to an end, eg in order to lessen the HIV epidemic; it is an end in itself. Prevention efforts work – there is 20 years of evidence for that --but first they must be applied. Only when this is the case will the prevention of future epidemics, as well as this epidemic, and such fine goals as sexual and reproductive health and rights for women, be possible.

Box A

WHAT IS A GENDER PERSPECTIVE?

- Æ A gender perspective is required on issues for which being a man and being a woman have different consequences.
- It is important because there is a power imbalance between men and women.
 - This does not mean women are powerless and men are powerful.
 - It means that men as a group hold the balance of power over women as a group and can exercise that power individually on the basis of the social status which their power as men has given them.
 - This happens in spite of women's own abilities and power, not because they are absent.
 - From a feminist point of view, the reason to develop a gender perspective is to find solutions to this power imbalance in such a way that efforts can be made to redress the imbalance in favour of women.
 - Hence, a gender perspective is a women's rights perspective as well.

II

Current methods of prevention

Empowering women and promoting gender equity¹¹

If women are to be protected against sexual transmission of HIV infection it is important that they are in a position to negotiate safer sex effectively. Women of all ages, and young women in particular, are vulnerable to HIV infection for a number of reasons. The environment where women live and work as well as the prevailing macro-economic and micro-economic policies that affect them all impact on women in a variety of ways which increases their vulnerability. For example the feminization of poverty has resulted in women and especially young girls working as domestic servants or commercial sex workers, which exposes them to abuse and high-risk behaviour. Women's prescribed sexual roles may also predispose them to infection eg most women cannot say 'no' to a man. They enter marriage at risk of infection and cannot negotiate safer sex. They are often expected to produce more children and once they have finished producing children they are not in a position to insist that their partners use condoms for their protection. Women and particularly girls frequently do not have the bargaining power to make relevant decisions about their lives and especially about sexuality issues. Girls may be subjected to early and forced marriages or given or hired out to older men because of the widespread belief that sex with a virgin will cure HIV. In all societies gender norms, which are reinforced by social sanctions have resulted in creating acceptable behaviour for men that puts both women and men at risk. The social construction of sexuality and the meaning ascribed to women's bodies influences men and women's perceptions of risk behaviour and often results in women being blamed as carriers of infection. In other contexts the inadequate legislation and social tolerance of gender-based violence makes it difficult for women who are at risk to seek redress.

The key areas to promote the interests of women and girls and to strengthen their position to prevent infection can be identified as follows:

Æ Role of men

Men can make a difference because they play the dominant role in women's sexual lives. While men's health is important, it receives little attention and greater male equality is required in the provision of services. Men's behaviour not only puts them at risk of HIV but it also puts women at risk. Unprotected sex between men endangers both men and women. It is important to target men of all ages in order to increase contraceptive use and the proper treatment of STIs. It is most important that men give greater consideration to their social responsibilities in order to prevent the spread of HIV/AIDS.

Æ Gender-sensitive services

Women and girls of all ages must have access to appropriate health care and HIV/STI prevention services in places and at times that are convenient for them and that these services should be integrated in order to make them more accessible. Provider skills in communication should be improved and gender biases and attitudes addressed, as well as age sensitive approaches to dealing with issues of sexuality and power relations. Female condoms should be made available where women can obtain them without embarrassment and account must be taken of the special needs of young women and girls.

Æ Education

In the long-term girls and women should have improved access to formal and non-formal education. Sexuality education is often absent in schools and measures should be taken to ensure that it is included in the school curriculum and that women and girls are taught the necessary skills to enable them to say no to unwanted or unsafe sex. Older women should have access to education and information in a form that is culturally acceptable and age sensitive, and be encouraged to participate in educating and informing their young charges. Both boys and girls should be provided with information about their bodies, and the functions and the changes that they will experience during puberty. This would facilitate a greater understanding of emerging sexuality.

Æ Enabling laws

Existing legal instruments and laws should be re-examined with a gender-sensitive lens, including laws relating to the prevention and suppression of commercial sex work. NGOs and other interested groups should lobby to repeal laws that discriminate against women's access to productive assets including laws on inheritance, marriage and divorce. Abusive practices perpetrated against older women and widows also require special attention and action. Codes of conduct that relate to the ethical and professional obligations of service providers including non-discrimination, confidentiality, informed consent and respect for the patient/client should also be reviewed and implemented. In countries which have not already ratified, NGOs and others should work to promote ratification of the *Convention on the Elimination of All Forms of Discrimination against Women* (Women's Convention) and the Optional Protocol and also

work for their implementation. Effective legislation should be introduced and implemented against gender-based violence.

Æ Improving the social environment

Measures should be introduced to enable and support women's groups and community organizations to challenge adverse cultural norms and traditions including the condoning of child abuse, rape and sexual coercion, and to provide increased access to shelters for women in distress and centres for child care for women who have had to leave home because of abusive relationships. Women should be empowered so that they do not have to exchange sex for money. Training opportunities should be increased and strengthened to provide opportunities for women of all ages, eg credit programmes, saving schemes and women's cooperatives and these should be integrated with HIV prevention programmes. Socio-economic policy changes, including community health programmes, should be introduced and implemented. Programmes to build the self-esteem, skills and confidence of women and girls should be introduced in order to challenge discrimination and bias and to make choices. Men and boys should be encouraged to share responsibility for protecting themselves and their sexual partners from STIs including HIV and to acknowledge and accept that they have important responsibilities in the reproductive process.

Barrier methods of prevention

Male condom

The only two available barrier methods for prevention of sexual transmission of HIV infection at the present time are the male and female condom. As has been discussed above, condom use inside marriage is universally perceived as next to impossible, because married partners do not want to admit having other partners. Increasingly women as young as 30 or even 25 are seeking sterilization or relying on non-barrier methods of contraception in order to avoid pregnancy and women are frequently sexually active once they have completed child-bearing. Pregnant women are not in a position to ask men to use a condom to protect them. Although the condom offers the safest and most effective method of 'dual protection' when backed up by access to emergency contraception or abortion, it is rarely promoted as an effective method of contraception and is perceived instead as means of prevention of infection from HIV and STIs. In some cultures, moreover, men will not consider using condoms under any circumstances and it has been seen time and again that they will even pay more for unprotected sex with a sex worker, rather than use a condom when indulging in such high risk behaviour.

Female condom¹²

The female condom, which is manufactured by the Female Health Company (FHC) was originally launched in Switzerland in 1992 and is produced under a number of trade names¹³. As stated in the WHO/UNAIDS Information Pack, 1997:

“The public health rationale for introducing a method that provides protection against pregnancy and STI/HIV is clear. Globally, health and human rights advocates have been demanding that scientists develop fertility regulation methods that are safe and reversible, under the control of the user, not systemic in action, which protect the user against STIs and HIV, and do not need to be provided by a health service. The female condom comes closer to these requirements than any other family planning methods.”

The twenty-first Special Session of the United Nations General Assembly for the Review and Appraisal of the Implementation of the Programme for Action of the International Conference on Population and Development recognized that services should include “access to preventive methods such as the female . . . condom”.¹⁴ The following year the twenty-third special session of the General Assembly entitled “Women 2000: gender equality, development and peace for the twenty-first century” , called for the “development of safe, affordable, effective and easily accessible female-controlled methods including methods such as microbicides and female condoms . . .”¹⁵ as a matter of priority.

Experience to date has shown, however, that donor commitment to the female condom has been very limited and that while there have been numerous ‘pilot’ projects, there have been very few programmes of scale. There has been considerable interest in the female condom at policy making, programming and user levels, but it has not always been clear as to how to turn this interest towards protected sex. Expanded access to and use of the female condom requires targeted advocacy and strategic planning and programming. Since the UNAIDS/FHC Partnership began in 1996, the female condom has been promoted in 60 countries in Africa, Asia, Eastern Europe and Latin America. Initial sales tend to be for pilot projects, which can evolve into substantial, annual programmes provided that strategic planning and advocacy take place ie Brazil, Ghana, Namibia, South Africa and Zimbabwe.

In 1996 a Global Public Sector price of £0.38 per condom was established which allowed donors to make the female condom available more widely with an increase in sales from 866,000 in 1996/97 to an estimated 5,297,000 in 1999/00. The launch of a joint initiative in 1999 – the UNAIDS/FHC Partnership – has encouraged:

- stimulation of programmes in various countries;
- quick response to requests for information and supplies;

- support in developing introductory strategies;
- catalysing of new ideas and expansion of good practices;
- advocacy for effective integration of male and female condoms into national HIV / AIDS strategies and programmes;

UNAIDS, FHC and WHO have recently produced *The Female Condom: A guide for planning and programming* — a step-by-step guide to help design, implement and monitor programmes incorporating the female condom.

The 'lessons learned' to date have shown that there is a significant demand for the female condom, although some of it may be 'novelty demand'. It is important to assess the actual use over time and to prioritise the target audience (or audiences), especially if supplies are limited, to ensure that actual users have the opportunity for an on-going and consistent supply. There is, moreover, a need to provide samples and good education on its correct use, even though it is not complicated. It is also crucial to involve men in the introduction strategy. Service providers who have a bias against barrier methods including the female condom should be desensitised and encouraged not to allow their biases influence potential users negatively.

While the female condom is more expensive than the male condom, it can be a cost-effective intervention as it increases protected sexual activity. It may require the use of peer-support groups to encourage wide adoption and it can be culturally inappropriate in some contexts. At present the use of a female condom more than once is not promoted, although it may be considered in the future in certain situations, eg for married couples as opposed to female sex workers, provided that proper instruction is given on washing etc. It may not be the 'perfect product' but it has an important role to play, as it is the only female controlled method available at this time that provides protection against HIV, other STIs, and pregnancy.

Many of the lessons learned from female condom introduction are not specific to the product; rather, they are fundamental issues that must be addressed when introducing any new technology. These include:

- obstacles in changing people's behaviours;
- overcoming deeply rooted biases (especially among providers);
- breaking down gender disparities;
- addressing existing dynamics between sexual partners and between providers and patients;
- addressing the stigma of sexuality; and
- allocating resources between different technologies.

As more products become available – beyond male and female condoms, microbicides, anti-retroviral therapies, vaccines, etc – there will be greater challenges for resource allocation.

It is also important to note the experiences with the female condom in moving it from research to the marketplace. In fact, proving efficacy and gaining regulatory approval have been far easier than developing strategic and effective approaches to introducing, pricing, distributing, promoting and motivating use of the product. While the scientific and regulatory issues for other preventive technologies under development (eg microbicides and vaccines) are different from female condoms, many of the policy and programmatic issues are similar, and it is crucial that experiences, lessons learned and resources are shared.

Other prevention strategies

As compared with male and female condoms, other prevention strategies are predominantly behavioural or medical. It has been proved that adolescent girls are particularly susceptible to HIV infection and other STIs, as tissue damage associated with sexual intercourse at such a relatively early age together with the immature cervix and vaginal secretions makes infection far more likely, and at a time when they are vulnerable to sexual abuse. Adolescent girls are especially vulnerable as their natural mucosal defence mechanisms may not be developed, the lining of the immature cervix provides a poor barrier against infection and the lining of the vagina and its secretions are inadequate to provide a protective layer of acidity. Consequently delaying sexual activity is important in reducing HIV infection in this age group, and this can be promoted through providing sexuality education as indicated above.

Limiting the number of sexual partners is also an effective strategy in decreasing the spread of HIV infection. Publicizing this important fact has been successful in countries such as Uganda, although, as already stated, the rates of infection in men have so far decreased more than in women. The treatment of existing STIs is also important in preventing HIV, as studies have shown that women suffering from STIs are more susceptible to HIV infection than those who are not infected with STIs. Men with untreated STIs are also more likely to infect their partners.

Development of new barrier methods

Research is being undertaken for the development and evaluation of new mechanical barrier methods as means of prevention of HIV transmission. These include diaphragms, cervical caps and sponges such as FemCap, Oves Silicone Cap, the Vaginal Barrier Device and Today Sponge. Withdrawal is also being evaluated as an effective means of avoiding transmission.

Ethical issues surrounding current methods of prevention

There are ethical issues involved in dealing with gender-based violence, particularly in the case of under-age girls. Where the victim is under-age the health professional has to decide whether she is mature enough to understand the implications and possible consequences of what has happened to her, and of what the health professional decides should be done about it. If the health professional considers she is sufficiently mature to understand, an attempt should be made to persuade her to involve her parents or guardian unless, of course, they are the cause of the violence. If she refuses to consent to their involvement the health professional must respect her ethical right to confidentiality and, subject to specific legal requirements, should not inform anyone else without her consent.

If the health professional forms the opinion that the girl is unable to understand the implications of what has happened to her and what should be done about it the health professional must take whatever steps are in the best interests of her health even though she may withhold her consent to them and should inform the parents or guardian unless of course they are the cause of the problem. Notifying the police or other relevant authorities immediately may not, of course, be the best way of protecting the interests of her health. Generally speaking health professionals are not irrevocably bound to observe ethical principles, but they can expect to be required to justify their actions if they do not observe them.

In cases where a health professional has conscientious objection to providing condoms, he or she still has an ethical obligation to ensure that the patient concerned is able to obtain them elsewhere, particularly where no other health professional is available locally.

Human rights issues surrounding current methods of prevention

Instances where the patient/client cannot access services because of the times at which or the places where they are available constitute discrimination. Provider skills, moreover, may have to be improved to ensure that the patient/client's rights to health are not being compromised and in the case of young women and girls it is important to see that education and information are provided in a creative and easily understandable way. Older women may be difficult to reach because of cultural barriers in dealing with issues of sexuality. Not providing the female condom for women is a violation of their rights to the benefits of scientific progress.

III

Microbicides¹⁶

Women need a method for HIV prevention that they are able to control. Currently there is no such method available. Therefore microbicide development is extremely important.

What is a microbicide?

A microbicide is any substance that can substantially reduce the transmission of STIs when applied in the vagina or rectum. It can potentially be produced in many forms eg gel, cream, film, suppository, or sponge. Important characteristics to consider are whether it can be used potentially without the partner's knowledge and whether or not it can be used as a contraceptive eg whether it can enable women to get pregnant while at the same time being protected against infection, a benefit, which could be extremely important in many cultures. Microbicides should be able to provide protection against a range of STIs. They should protect men as well as women and be effective for anal, oral and vaginal sex. Ideally they should be available over the counter at low cost.

Microbicide product specification

- Contraceptive activity
- Contraceptive inactivity
- Interaction with existing contraceptive use
- Capacity to be used undetected
- Method of application (eg jelly, film etc)
- Postcoital effectiveness
- Onset and duration of action
- Activity against a range of microbes

It is also necessary to take into account:

- Its disposability
- affordability
- smell/taste
- 'messiness'
- shelf life
- stability at room temperature
- ease of insertion
- appropriateness for anal, oral and vaginal sex .

A microbicide should be able to be used as an adjunct or back up to condoms. It should be useful for individuals or couples unable to use condoms consistently

and as a mouth rinse for protection after oral sex. It might also be possible to develop a microbicide that can be used vaginally for reducing peri-natal transmission prior to delivery or post-coitally to reduce infection in cases of forced sex or condom failure.

Prevention equation

The level of protection (ie number of cases averted) depends on three factors:

- efficacy of method
- consistency of use
- extent of use ('coverage')

Widespread and regular use of a lower-efficacy microbicide would prevent more HIV infections than lower coverage with a higher-efficacy method. Even a partially effective microbicide, provided it is used regularly, could have a significant individual and public health benefit. In other words it's not a question of waiting for the perfect solution.

Current approaches to microbicide development

Various approaches are being used in the development of a microbicide. These include testing existing spermicides for microbicidal potential eg Nonoxynol-9, Octoxynol-9, benzalkonium chloride and exploring new compounds that:

- kill or immobilize HIV/STIs
- create a barrier between the pathogen and the vaginal or rectal tissue
- prevent infection or replication
- boost the vagina's natural defences

A number of steps are necessary in order to get a product to the users

- discovery of product lead
- pre-clinical testing (in vitro and animal models)
- clinical testing/trials ie
 - phase I: safety (10-50 women at little or no risk)
 - phase II: expanded safety (+/- 200 women x 6-12 months)
 - phase III: effectiveness (+/- 3000 women x 1-3 years)
- manufacturing and distribution
- education
- access and use

Currently the only products that have been tested in phase III HIV/STD effectiveness trials are products containing Nonoxynol-9 (the Today Sponge, VCF, Advantage-S gel, and Conceptrol gel). Nonoxynol-9 products have been marketed as spermicides for over 50 years. However, the results of the HIV/STI

effectiveness trials that have been conducted to date have been disappointing and difficult to interpret. For example, all trials were conducted in sex worker populations, who used the products much more frequently than would be expected with women in the general population (an average of four times per day in the Advantage-S trial). Nevertheless, concern about the safety of Nonoxynol-9 and similar detergent-like products has shifted attention to newly developed products that are not detergents.

Five of these newly developed products have reached phase II safety testing and 18 are in phase I. An additional 26 products are thought to be promising based on animal and in-vitro test results. All newly developed microbicides to date have been shown to be much safer than Nonoxynol-9 products, and phase III effectiveness trials for three promising products (Carraguard, BufferGel and Pro-2000) are currently being planned.

It is difficult to anticipate how microbicides will fit into the mix of HIV/STIs/pregnancy. It is unlikely that they will be more effective than condoms although they will undoubtedly be more acceptable. They are being developed both by the private sector and by NGOs, which will ultimately have an impact on their affordability. The Population Council, for example, is working on the development of *Carraguard*TM/*PC-515*, for which the main ingredient is recovered from seaweed.

Conclusion

After more than 10 years the development of microbicides is now gaining momentum as was shown by the recent *Microbicides 2000* conference in Washington DC which was attended by 600 participants in March this year. *Microbicides 2002* will be held in Antwerp. They are now increasingly being recognized as an important approach to HIV prevention. With some 60 products in clinical development, of which five are in the advanced stages, it is likely that microbicides will be available in the foreseeable future. In order for this to become a reality, however, it is important that adequate financial resources are available and that there is increased collaboration between the key players.

“An AIDS vaccine for low income countries is an international public good which is not likely to happen without innovative international public action.”

James Wolfenson, President, The World Bank

Preventive vaccines are one of the most powerful and cost-effective health interventions available today and exist for a variety of diseases including measles, chicken pox, influenza, mumps, poliomyelitis, pertussis, and hepatitis A and B. Each year vaccines save millions of lives and many more people are prevented from falling ill. At present, however, there is no preventive vaccine against AIDS.

The development and widespread use of a preventive AIDS vaccine would provide an important addition to the current range of HIV prevention strategies. A preventive vaccine would provide women with another technology from which to choose and one with a different set of characteristics from condoms or microbicides. A fully effective AIDS vaccine would not need to be taken prior to each sexual act and would provide protection against forced sexual intercourse. It would also have no affect on a woman's ability to become pregnant and it might be particularly helpful in allowing girls and adolescents to avoid HIV.

It should be noted, however, that a preventive vaccine is not a replacement for other preventive measures. The first generation of vaccines is unlikely to be 100% effective and will not protect people from other STIs or pregnancy and hence should be used only at the same time as other effective methods.

The challenge today is to accelerate vaccine development as rapidly as possible whilst not detracting from the existing measures of prevention. On no account should political and community leaders delay the introduction or strengthening of prevention programmes in the hope of the early arrival of a preventive vaccine.

The early development and availability of a vaccine will depend on accelerated and targeted research and development that is focused on:

- inducing broad and durable immune responses;
- identifying the characteristics of a vaccine can be used widely throughout the world (see Box B);
- identifying the subtypes of HIV found in developing countries

Box B

The Ideal Vaccine

The ideal preventive vaccine would:

be safe

be easy to administer

provide long duration of protection

protect against any route of HIV infection

protect against all subtypes of HIV

be effective regardless of nutritional or health status

be easy to transport

be stable under field conditions

be inexpensive to manufacture

How likely is it that a preventive vaccine will be developed?

There is a growing consensus that scientific progress over the last decade has now made a vaccine against HIV an achievable goal. Non-human primates have been protected by experimental vaccines, and a number of candidate vaccines have been shown to be safe in Phase I trials and to trigger important immune responses.

What is the current situation?

In the 17 years since HIV was identified as the cause of AIDS more than 30 vaccine candidates have been tested in early (Phase I) clinical trials. Of these, only one candidate vaccine has entered Phase III clinical trials, which is the definitive test of a vaccine's efficacy before it can be licensed for use. Two Phase III trials with this candidate are currently on-going. The interim results from the first trial are expected at the end of 2001 and the final results at the end of 2002. Unlike microbicides, however, there are no candidates waiting to move into Phase III trials today.

To date only one candidate vaccine aimed specifically at one of the main subtypes of HIV found in sub-Saharan Africa has entered Phase I clinical trials. This vaccine entered Phase I trials in Oxford in August 2000 and hopefully will enter Phase I trials in Nairobi by the end of 2000.

What is being done to accelerate vaccine development?

A number of different national and international organizations as well as pharmaceutical companies are now actively engaged in AIDS vaccine development. At the international level the key players in vaccine development include the International AIDS Vaccine Initiative (IAVI), WHO-UNAIDS, and the European Commission. These organizations are working to accelerate vaccine development; to facilitate clinical trials; and to ensure that when a vaccine is

developed it will be accessible to those who need it and want it as rapidly as possible.

Why do we need to be thinking about access issues today?

The adverse experiences with other vaccines cannot afford to be repeated with HIV. Nearly 20 years after Hepatitis B was licensed only 30% of the world's cohort of infants is vaccinated against Hepatitis B. By taking proactive steps today we can work to reduce the delay between an effective AIDS vaccine being licensed and its uptake. A number of things could be started now, including the establishment of a credible financing system to purchase an AIDS vaccine and the development of delivery systems for reaching those groups that will be targeted initially ie adolescents, sexually active adults, and other at risk groups.

What does vaccine development entail?

Vaccine development is a lengthy process involving testing of ideas and products. It is also a complex process involving a number of scientific challenges. For example, there are no ideal animal models; the correlates of immunity are not fully understood; and vaccine developers have to grapple with the genetic diversity of HIV.

Vaccine development is a sequential process where products move from pre-clinical research through clinical studies and then, provided they are effective and safe, are licensed for use. Box C describes the three phases of clinical trials in humans a vaccine must go through before it can be licensed.

Box C

Clinical Trials

Phase I:

- designed to assess the safety of the vaccine and to provide some basic information on immunogenicity
- conducted in a small number (usually 60 or less) of low-risk HIV negative volunteers
- usually last between 12 and 18 months

Phase II:

- designed to identify side-effects and risk associated with the vaccine and to collect preliminary indicators of its potential efficacy
- conducted in a few hundred HIV-negative individuals at risk of infection
- usually lasts about two years

Phase III:

- designed to assess the efficacy of the vaccine and collect more information on potential side-effects
- conducted in several thousand HIV negative volunteers from the population where the vaccine would be used (the actual numbers depend on the incidence of infection in the study population)
- usually lasts three to four years

Those responsible for a clinical trial must ensure that no-one is worse off as a result of participating in a trial than they would have been if they had not taken part, regardless of whether or not they receive the vaccine under study. Individual informed consent and voluntary participation are fundamental to clinical trials and must not be compromised at any time. Trial participants must also understand fully what participation in the trial means and have access to the best standards of HIV prevention currently available. UNAIDS has published ethical guidelines that set out a number of issues related to the conduct of AIDS vaccine clinical trials. These include ensuring that there is an active community voice and that women are not excluded from vaccine trials.

Ethical obligations and the development of microbicides and vaccines

The *Declaration of Helsinki* clearly sets out the ethical obligations in the development of microbicides and vaccines, particularly with regard to participation in trials. These are further expanded in the UNAIDS *Ethical Guidelines*, which stipulate that control subjects must be given the current best standards of HIV prevention. They also state that, in setting up any Phase II or

Phase III trials, a number of issues must be taken into account including potential side effects and the need for consultation with the community.

Human rights obligations and the development of microbicides and vaccines

As women have higher rates of illiteracy than men, their right to information must be protected by providing them with information about trials and that the use of microbicides and vaccines is made easily understandable.

It also should be a fundamental right that once approved, microbicides and vaccines (as well as male and female condoms) should be available as widely as possible. In addition to funding product development donors must ensure that resources are sufficient to ensure broad accessibility of all products once they have been approved.

V

Recommendations

1 Issues relating to specific prevention technologies

1.1 Recommendations to Governments

Governments should address the specific needs of women of all ages to obtain appropriate diagnosis and treatment for sexually transmitted infections (STIs) and reproductive tract infections (RTIs), and increase the promotion and use of male and female condoms, as a means of preventing the spread of HIV/AIDS infection, by means of:

strategies to integrate HIV prevention with Health and Education services, including sexual and reproductive health services and family planning.

political advocacy

development and delivery of effective treatment and prevention services based upon the principles of access, affordability and availability

collaboration and the development of partnerships with women's groups, NGOs, community-based organizations and other community groups

developing promotional campaigns that also address the different power dynamics between men and women throughout the life cycle.

1.2 Recommendation to Development Agencies and Governments

Recognizing that the testing of women in antenatal services without the involvement of their male partners frequently gives rise to gender-based violence against women if they are identified as HIV positive, and that it fails to protect those identified as HIV negative from infection by HIV positive partners during pregnancy, it is recommended that the voluntary counselling and testing component of mother to child transmission (MTCT) prevention programmes should be extended to include women's male partners and referred to as 'parent to child transmission' (PTCT).

1.3 Recommendation on vaccines and microbicides

Women need accelerated development of microbicides and preventive AIDS vaccines as part of a long-term strategy to enable them to protect themselves against HIV/AIDS. To ensure that these

products become available at the earliest possible date it is recommended that:

Microbicides

The international public health community needs urgently to identify mechanisms for speeding up microbicide research and development, ensuring that a greater number of candidates reach clinical trials sooner. These should include products with contraceptive properties as well as those without them.

Emphasis should be placed on products appropriate to developing countries and which meet the needs of women in those settings

Governments and development agencies should substantially increase investment in microbicides development through funding public/private sector partnerships; by working with local communities to ensure that they are well informed and participating pro-actively in the preparations for the trials; and providing support to expand the number of clinical trials. .

Vaccines

Understanding should be increased among governmental and non-governmental organisations of the role of vaccines in controlling the HIV/AIDS pandemic and of the measures needed to ensure their rapid and universal availability.

Governments, development agencies, communities and the private sector should work together to ensure sustained and increased investment in vaccines; to overcome the barriers to their development and to establish the infrastructures necessary to ensure they are accessible to all who need them.

Education about HIV/AIDS vaccines at community level should be seen as a continuing process to ensure the success of clinical trials and to achieve the optimum use of vaccines in protecting against HIV once they are available.

In the development of both microbicides and vaccines:

women must be actively involved in all phases, from research to product development and delivery;

measures must be taken to ensure they are accessible and affordable to women and girls, and must be planned for NOW.

lessons learned from female condom introduction over the past five years should be documented and used as appropriate

in the development of strategies for the introduction of future technologies

2 Implications of choice

2.1 In the context of HIV prevention, and based on evidence that increased choice leads to increased use of condoms and other preventive behaviour, governments should take action to promote access to choice of new and existing/developing sexual and reproductive health technologies and strategies.

2.2 To enable women to exercise choice, governments should provide resources and support for:

information on available technologies; on the effectiveness of technologies and on the right of individuals to choose them

education of individuals of all ages and on families

both qualitative and quantitative research

integrated services, including sexual and reproductive health services

commodities including male and female condoms and hormonal contraceptives

2.3 For more effective HIV prevention, governments should work towards further integration and linking of sexual and reproductive health services (eg Genito-Urinary Medicine (GUM), family planning, maternal and child health) in order to address the full range of women's needs and available prevention choices and technologies. This will enable women of all ages to make the choices they currently face and will do so increasingly in relation to contraception, reproduction and preventing infection.

Governments should support initiatives/projects that provide an enabling environment to promote equity and equality that will allow women of all ages to exercise choice in protecting themselves from HIV infection.

3 Women's rights, women's health HIV/AIDS: dialogue and advocacy

3.1 Recognizing that women and girls are more vulnerable to HIV infection through sexual transmission than men, effective HIV prevention must redress the power differentials between men and women and between men and girls, in order to enable women to protect their health better.

It is therefore recommended that all States that have not ratified the Convention on the Elimination of All Forms of Discrimination against Women and its Optional Protocol be urged to do so and those and those States that have done so be urged to accelerate implementation.

- 3.2 Recognizing the effectiveness of the male and female condoms in the prevention of sexual transmission of HIV, and that they are also effective as a method of contraception when used consistently and correctly, it is recommended that:

Family planning and reproductive health organisations provide, promote and support condoms as a first line method of contraception and protection; and

HIV / AIDS organisations join with the women's rights movements to promote the availability of emergency contraception and safe abortion where it is not against the law¹⁸ to ensure that in cases of condom breakage or failure, women shall have the means to control their fertility.

- 3.3 Recognizing that men have a role to play in both the transmission and prevention of transmission of HIV to women and girls and in protecting themselves (which ultimately will also protect women), it is recommended that effective messages and education about prevention technologies, including condoms and service delivery, should be directed to, and include, men as well as women and girls.
- 3.4 Recognizing that implementation of a human rights framework has the potential to enable women to protect themselves more effectively from infection with HIV, organisations are urged to work together to identify the human rights dimensions of prevention activities, and governments and professional organisations are urged to develop policy frameworks which promote, fulfil and respect human rights
- 3.5 Services should be delivered in such a way as to take into account the needs of the particular client group for whom they are directed rather than the needs of health service providers.

4 Prevention of HIV/AIDS, Gender and the Cairo+5 Agenda

4.1 Sexuality education

Governments should provide sexuality education – for children and adolescents – both in school and out of school – and for their parents, grand-parents, other carers and teachers as well, at an age before young people start having sex in order to help them postpone unwanted sex and protect themselves against pregnancy, HIV / AIDS and STIs.

4.2 Combating gender-based violence

Social and juridical action should be taken at the national level to combat gender-based violence, including sexual abuse and domestic

violence, in order to protect women and girls, from the adverse consequences including the risk of HIV infection.

4.3 Sexual behaviour and behaviour in sexual relations

Governments and NGOs should promote programmes and other activities that

socialise sexual behaviour and behaviour in sexual relationships, which is currently treated as a private or family matter in all societies;

challenge these behaviours when they create risk; and

identify the differences in what men do and what women do to put themselves and each other at risk.

4.4 Portrayal of images of sex and sexuality in the media

Governments and NGOs should work with the media to develop and promote images of sexuality and accompanying messages that help to create a safer sex ethos, in preference to creating the current images of sex and sexuality, which alternate between the unrealistically romantic, soft porn and romanticised notions of sexual dominance, that are dressed in the latest gender-blending fashion wear to appeal to youth and which promote risk taking rather than mutual respect and protection. .

4.5 **Blood safety**

Greater emphasis should be placed on blood safety, which is critically important in saving women's lives, because complications of pregnancy, childbirth and abortion are still the most common reasons why women need transfusions.

Day of Dialogue Programme

0900 hours	Welcome by Chairperson Introductions Objectives for Day
0930 hours	Overview HIV/AIDS prevention: a gender perspective Marge Berer, Reproductive Health Matters
1015 hours	Panel presentations Current methods of prevention: Naana Otoo-Oyortey, International Planned Parenthood Federation Mitchell Warren, Female Health Foundation, presented by Susan F Crane, International Family Health Microbicides: Janneke van de Wijgert, Population Council Susan Crane, International Family Health Vaccines: Julian Meldrum, National AIDS Trust Jane Rowley, International AIDS Vaccine Initiative Commentators <i>Human Rights Issues:</i> Karen Newman, International Planned Parenthood Federation <i>Ethical Issues:</i> John Havard, Commonwealth Medical Association
1400 hours	Key issues arising from morning discussions
1500 hours	Framing of recommendations in working groups: Gender issues relating to specific technologies

	Implications of increasing choice
	Women's rights, women's health, HIV/AIDS – dialogue and advocacy
1600 hours	Report back
	Discussion of recommendations
1645 hours	Summing up and closure of Day of Dialogue

Key human rights issues¹⁹

HIV has brought into sharp relief two of the most insidious forms of human oppression – gender and sexuality – in a way that has exacerbated human rights violations, and made the epidemic more difficult to address effectively.

In particular, the basic human right to be free from all forms of discrimination is relevant for people living with HIV/AIDS, and for all professionals involved in its prevention and treatment, in as much as discrimination, as UNAIDS Executive Director Peter Piot has said, not only compounds human misery caused by HIV/AIDS but also fuels its spread to others. Gender issues are especially important to address, because women have, in many cases, and for several reasons, been stigmatised as “vectors of disease”. For example:

Women perceived to be HIV positive often face violence and discrimination, irrespective of the validity of the perception, or the relevance of the ‘threat’ they represent;

- Sex workers are often forced to undergo mandatory testing which is often carried out in the absence of services to provide health care or aimed at the prevention of HIV/AIDS and without being able to require their clients to use condoms,
- Pregnant women are often the focus of programmes; however, the prime aim of these programmes is the prevention of transmission of HIV to the fetus; rather than the health status of the women themselves;
- Mandatory pre and post-natal testing may co-exist with pressure put on women who are found to be HIV positive to agree to an abortion or sterilization..
- Access to treatment may be denied to women.
- Discrimination often makes it difficult for women living with HIV/AIDS to provide for themselves and contribute to their communities

‘Marginalized groups’ are often identified as having special needs with regard to the prevention of HIV/AIDS; women within those groups are often much more vulnerable, and less likely to be able to access available services than men. This would include women within ethnic or other minority population groups, indigenous peoples, homosexual women, sex workers, drug users, female prisoners and displaced women.

Discrimination is not the only human rights issue brought into sharp relief by HIV/AIDS; in the context of economic rights, poverty has been recognized as an effective human rights violation. Effectively addressing women’s human rights in the field of property, employment, divorce and access to economic resources can

maximize the space of freedom for women exercise control over their lives, for example, improve their capacity to leave abusive relationships which render them vulnerable to HIV infection. Of course, economic rights cannot be entirely separated from issues related to discrimination; women perceived to be living with HIV can face discrimination that strips them not only of their dignity, but also of their rights to employment, education, privacy, housing, social support, health care, an adequate standard of living and, in some case, their liberty. In such cases, women can find themselves facing a stark choice between destitution or prostitution.

Women's right to information, education and health are also an important part of the human rights landscape with respect to HIV/AIDS. Access to information and education about HIV and to the means of protection obviously correlates directly with vulnerability to infection.

Other relevant rights include those related to sexual health rights, and the right to safe sexuality, which are not the same thing, but which are often perceived to be the same, if addressed at all. As WHO has noted, "By and large most men, however poor can choose when, with whom and with what protection if any, to have sex. Most women cannot." Women, particularly but not exclusively women living in poverty, often face the following problems, each of which have an independently negative effect on HIV/AIDS:

- Lack of control over their own sexuality and sexual relationships
- Poor sexual and reproductive health
- Neglect of health needs
- Coerced sex
- Harmful cultural practices including Female Genital Mutilation, and 'dry' sex

Another critical group at the intersection of HIV/AIDS and gender issues are adolescent girls, whose basic right of access to education, condoms and services before and after they are sexually active is often violated. Sexual abuse – an underestimated mode of transmission of HIV infection in children – is an increasing phenomenon, as adult men seek ever younger female partners in efforts to avoid HIV infection, or, if already infected, in some cases in the erroneous belief that they will be 'cured'.

Other issues relevant to HIV/AIDS that have important human rights dimensions include those related to disclosure of HIV status, partner notification, and confidentiality. The area of mother to child transmission is another field where public health imperatives may look different if viewed through a human rights lens. Issues related to informed consent are legion within the HIV/AIDS field, whether in respect of HIV testing, and to any decision that may ensue, especially for pregnant women deciding whether to terminate, or continue with the pregnancy.

Adequate pre-test counselling is often not present, and is a prerequisite for informed choice with regard to testing for HIV/AIDS.

Breastfeeding is another gender issue often ignored; protection of confidentiality is especially important in communities where not breastfeeding amounts to public disclosure of HIV status. Another important element in the equation is the availability of alternative infant feeding or breastmilk substitutes.

Women's access to anti-retroviral drugs is another gender-related issue; this can be seen from the different status sometimes accorded to women with temporary 'animated incubator' status, when the fact that they are carrying a fetus means that, for that period of time, they may be eligible for drugs that are otherwise not available to them, and which may not continue to be available to them once they revert to being women without this special status.

What are some of the implications of the human rights dimensions of issues related to HIV/AIDS? In part, increased emphasis is needed to improve 'Human Rights literacy'; an increased understanding of human rights mechanisms – not only how the various treaty bodies work, but also, the remedies available to individual women and men at the national level. The concept of human rights has the capacity to engage a wide spectrum of civil society actors to work together to change policies and practices in ways that promote, protect, respect and fulfil human rights. Effective human rights work is aimed at empowerment for action that leads to social change. By identifying and strengthening accountability mechanisms that relate to the actions of governments, health care providers and others with an element of control over the social and economic lives of people, human rights activism can make a real difference to addressing effectively some of the gender issues which disadvantage women and men living with HIV/AIDS.

IPPF Charter and Issues Relating to HIV/AIDS

There are a number of basic human rights enumerated in the Charter, which may be useful to family planning associations (FPAs), NGOs and other actors in civil society in dealing with issues relating to HIV/AIDS.

Right to Health Care and Health Protection

- This right, like all other basic human rights, is one which applies equally to all persons. This means that FPAs are obliged to offer all services, to the best of their ability, equally to persons with HIV/AIDS.
- Comprehensive health care services include provision of contraceptive methods which prevent the spread of HIV/AIDS, as well as diagnosis and treatment for HIV/AIDS.
- Pregnant women should be given information about the risk of transmitting HIV/AIDS to their children, and offered testing and treatment upon their consent.
- All of these services should be accessible, both financially and geographically, private and confidential, and respectful of the dignity and comfort of the client.

Right to Liberty and Security of the Person

- No person should be subject to medical intervention related to their sexual and reproductive health without their free and informed consent, which means that:
 - no one, including pregnant women, should be tested for HIV/AIDS without their consent;
 - no one should be forced to undergo any procedure or treatment without their consent on the grounds they are HIV+.
- No one should be put at risk of being infected with HIV/AIDS by reason of lack of access to information about the transmission of the disease or lack of access to the means to prevent infection.

Right to Privacy

- This right requires that all sexual and reproductive health care services, including information and counselling services, be private, and that all personal information remain confidential. This applies equally to clients with HIV/AIDS, so that:
 - testing should be done on a confidential basis;

information regarding test results should only be released where required by law for reasons of public safety, or where authorized by the client;

treatment and other services must be rendered in a confidential manner, with due respect for the client's privacy.

Right to Equality and to be Free from all Forms of Discrimination

- The Charter recognizes that all human beings are born free and equal in dignity and rights, so that no person should be discriminated against in their sexual and reproductive lives in the access to health care and/or services on the grounds of race, colour, sex or sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status." "Other status" may include HIV status, which means that:-

persons with HIV/AIDS must not be discriminated in their access to sexual and reproductive information and services;

pregnant women with HIV/AIDS have the same right to pre- and post-natal care and services as pregnant women who are HIV negative;

all rights outlined in the Charter apply equally to persons with HIV/AIDS.

Right to Freedom of Thought

- While the right to freedom of thought includes the right of health care professionals to conscientious objection in performing certain services, this does not apply for persons living with HIV/AIDS, and cannot be invoked to excuse health care professionals from their duty of care towards such individuals.
- Religious texts, beliefs, philosophies and customs should not be given such a restrictive interpretation as to deny all persons the information and treatment relating to HIV/AIDS to which they are entitled.

Right to Information and Education

- All persons, including adolescents, are entitled to information and advice on sexual and reproductive health and rights, which should include information on:-

nature of HIV/AIDS;

prevention of HIV/AIDS;

HIV/AIDS testing;

HIV/AIDS treatment;

risk of passing HIV/AIDS to an unborn child;

risk of passing HIV/AIDS to a child through breastfeeding.

(Refer to the Standards section of the Charter, paragraphs 7.38 and 7.47, for extracts from the ICPD on the need for national policies and programs for adolescents on HIV infection and AIDS protection.)

Right to Choose Whether or Not to Marry and to Found and Plan a Family

- All persons should have access to the services necessary to found and plan a family, including treatment for HIV/AIDS and treatment for infertility arising there from.
- Persons with HIV/AIDS have equal right to found and plan a family.

Right to Decide Whether or When to Have Children

- All persons, including persons with HIV/AIDS, should have access to safe, effective and affordable methods of fertility regulation.
- Persons with HIV/AIDS should be free to determine, given information on the risks involved, whether or not they wish to have children. This means that:

pregnant women with HIV/AIDS should be given information about the special risks involved in their pregnancy;

under no circumstances should anyone undergo forced sterilization or forced abortion by reason of their HIV status.

(Refer to the Standards section of the Charter, paragraph 7.6, for an extract from the ICPD which calls for referral to family-planning services and further diagnosis and treatment for complications of, among other conditions, HIV/AIDS.)

Right to the Benefits of Scientific Progress

- All persons should be afforded access to all available technology for the prevention, diagnosis and treatment of HIV/AIDS.

(Refer to the Standards section of the Charter, paragraphs 12.12 and 12.14, for extracts from the ICPD which call for increased attention to barrier methods for fertility control and the prevention of sexually transmitted diseases, including HIV/AIDS, and the need for

governments to give special priority to research on sexually transmitted diseases, including HIV/AIDS.)

Right to be Free from Torture and Ill Treatment

- No one, including persons with HIV/AIDS, should be subject to medical trials or experimentation without their full, free and informed consent.

These will be placed AFTER corrections

¹ Programme of Action of the International Conference on Population and Development, Cairo, 5-13 September 1994, para 7.29

² Beijing Platform for Action, para 98

³ *ibid*, para 108(o)

⁴ *ibid*, para 110(h)

⁵ *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*, para 67

⁶ *ibid*, para 68

⁷ *ibid*, para 71

⁸ Report of the Ad Hoc Committee of the Whole of the twenty-third special session of the General Assembly, *Further actions and initiatives to implement the Beijing Declaration and the Platform for Action*, A/S-23/10/Rev.1, para 103(b)

⁹ CMA and Convenor of the *Advocacy for Women's Health and Para55* Group

¹⁰ Keynote presentation by Marge Berer, Editor *Reproductive Health Matters*

¹¹ Based on presentation by Naana Otoo-Oyortey, International Planned Parenthood Federation

¹² Based on presentation prepared by Mitchell Warren and presented by Susan Crane

¹³ Reality, femidom, femy, Preservativo, Feminino, El Condon Femenino, the Female Condom, care, Dominique and MyFemy.

¹⁴ *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development (Key Actions)*, para 71

¹⁵ Report of the Ad Hoc Committee of the Whole of the twenty-third special session of the General Assembly, *Further actions and initiatives to implement the Beijing Declaration and the Platform for Action*, para 103(b)

¹⁶ Based on presentations by Susan F Crane, International Family Health and Janneke van de Wijgert, Population Council

¹⁷ based on presentations of Jane Rowley, IAVI and Julian Meldrum, National AIDS Trust

¹⁸ Almost all countries that have restrictions concerning legal abortion do permit therapeutic abortion under their existing penal codes to save/protect the life of the woman and many also permit abortion to save/protect the health of the woman. This reference to abortion is in line with the ICPD Programme of Action, para 8.25, which states In circumstances where abortion is not against the law, such abortion should be safe.

¹⁹ Based on comments made by Karen Newman, IPPF

