Economic Commission for Africa

# Gender and HIV/AIDS

CHGA
Commission on HIV/AIDS and Governance in Africa

## Discussion Outcomes

November 2004

Economic Commission for Africa

# CHGA

**Commission on HIV/AIDS and Governance in Africa**

## Gender and HIV/AIDS

**Discussion Outcomes**

For this and other publications, please visit the CHGA web site at the following address:

http://www.uneca.org/CHGA

Or contact

CHGA
Economic Commission for Africa
P.O.Box 3001
Addis Ababa, Ethiopia
Tel.:251-1-44 54 08
E-mail: chga@uneca.org

# Discussion outcomes
# Gender and HIV/AIDS

*'Current information suggests that between 12 and 13 African women are infected for every 10 African men. Of newly infected 15-19 year olds, more than two thirds are female. What are the implications of this for changing gender roles, social norms and values? What are the implications of this for our labour force so dependent on female labour? The resulting social decay and community breakdown may well threaten the socio-economic fabric of our continent.'*

**K.Y. Amoako, Executive Secretary, Economic Commission for Africa**

# Contents

# About CHGA

Under the Chairmanship of the Executive Secretary of the Economic Commission for Africa, **K. Y. Amoako**, the Commission on HIV/AIDS and Governance in Africa (CHGA) represents the first occasion on which the continent most affected by HIV/AIDS will lead an effort to examine the epidemic in all its aspects and likely future implications. The challenge for CHGA is to provide the data, and help consolidate the design and implementation of policies and programmes that can help contain the pandemic in order to support development and foster good governance.

## Patrons:

HE Kenneth Kaunda
HE Pascoal Mocumbi

## Commissioners:

Seyyid Abdulai
Abdoulai Bathily
Mary Chinery-Hesse
Awa Coll-Seck
Haile Debas
Richard G.A. Feachem
Marc Gentilini
Eveline Herfkens
Omar Kabbaj
Milly Katana
Madeleine Mukamabano
Benjamin Nzimbi
Joy Phumaphi
Peter Piot
Ismail Serageldin
Bassary Toure
Paulo Teixeira
Alan Whiteside

# About the Beijing +10 Interactive Meeting

The Seventh African Regional Conference on Women (Beijing+10) was held in parallel with the Fourth African Development Forum (ADF IV) on Governance, 6-15 October 2004 in Addis Ababa, Ethiopia. Beijing+10 fits within the global evaluation framework for assessing progress achieved after 10 years of implementing the 1995 Beijing Platform for Action on Women (BPFA). The Beijing +10 Interactive Meeting provided an open forum where all participants of the Beijing+10 were welcome to share their experiences and provide key recommendations for the work forward for HIV/AIDS and women.

**The meeting was organized by**: African Centre for Gender and Development (ACDG) at ECA and Commission on HIV/AIDS and Governance in Africa (CHGA)

**Facilitator:** Mr. Bunmi Makinwa, UNAIDS-Ethiopia

**Presenters:**

**Nana K. Poku, Research Director CHGA, "Gender and HIV/AIDS"**

**Hilda Tadria, Regional Advisor, ACGD, "The Gender Dimensions of HIV/AIDS in Africa"**

**Barbara Watson, Specialist Consultant on HIV/AIDS "Sexual violence and HIV/AIDS "**

**Participants:**

In addition to Ministers in charge of women and gender issues, other participants from key sectors also attended the conference including African women parliamentarians and representatives of various constituencies, women entrepreneurs, African institutions, inter-governmental organizations, international organizations, United Nations Specialized Agencies, and representatives of international donor and funding agencies.

# Gender and HIV/AIDS

## The feminisation of HIV/AIDS

Women comprise an increasing proportion of people living with HIV/AIDS and of new infections worldwide. Over the last few years prevalence among women has accelerated from consisting of 41% of infected adults in 1997 to 50% in 2002. However, in Sub-Saharan Africa women represent almost 6 in 10, (57%) living with HIV/AIDS.[1] Sub Saharan Africa is the only region where more women than men are infected with the virus, and the share of women with HIV/AIDS is increasing.

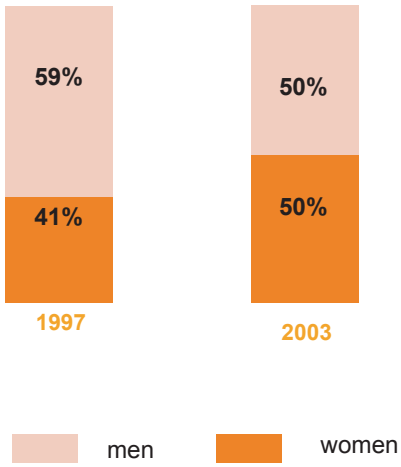
Among young people the gender gap is even larger than among adults. 75% of all young people living with HIV are female, with the worst samples ranging from 20 infected girls to every 10 boys in one country, and 45 girls to every 10 boys in another country.[2] More than one in five pregnant women are HIV infected in most countries in southern Africa, and in some countries, (in Gaborone, Botswana and Manzini, Swaziland) the prevalence among pregnant women is up to 40 per cent. Within South Africa, in five out of the nine provinces, at least 25 per cent of pregnant women are HIV positive. In Mozambique, the prevalence rate varies from 8 per cent among pregnant women in one region to 36 per cent in another region.[3]

### Context of Vulnerability

For reasons due to biology women have always been more susceptible for contracting the HIV virus than men. Biological factors include: the higher viral concentration in semen compared to vaginal fluids, larger exposed surface and longer viral contact among women. However, these grounds alone cannot explain the sudden acceleration or the geographical concentration of the feminisation of the

# A Growing Impact on Women and Girls

Women as % of adults living with HIV/AIDS worldwide



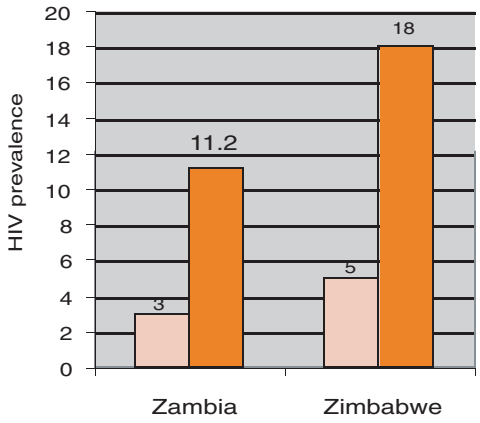

Women comprise increasing share of people living with HIV/AIDS and of new infections worldwide

In Sub-Saharan Africa, women represent almost 6 in 10 (58%) living with HIV/AIDS

In Sub-Saharan Africa about 75% infected 15-24 year old are women

Data Source: UNAIDS 2004

HIV prevalence among young men and women aged 15-24 years in national population based surveys, 2001




The gender gap is even greater among the younger population

Men
Women

Data source: WHO-AFRO 2003.

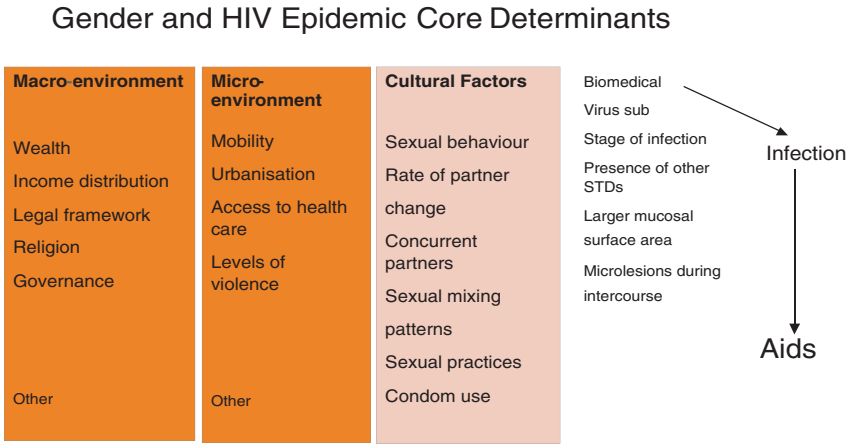
epidemic, which indicates that we must look beyond the immediate circumstance of biological vulnerability and to the broader socio-cultural context. The UNDP pre-Beijing Human Development report of 1995 states that according to the Gender Development Index (GDI) no country was found to treat its women as well as it treats its men. Existing evidence from the last ten years on the general situation of women in Africa shows that little has changed[4], and the data available on the HIV/AIDS pandemic highlight that nowhere else are these observations more pertinent than when applied to the situation of women and girls within the framework of HIV/AIDS in Africa.[5] This confirms that the feminisation of the pandemic is rooted in the complex dynamics between HIV/AIDS and gender inequality.

The gender dimensions of relevance to HIV/AIDS penetrate numerous aspects of society, including the economic, legal, cultural, religious, political and sexual status of women. Riding on the back of existing gender inequalities, HIV/AIDS aggravates the situation of women, translating existing differences in male and female statuses into even harsher conditions on the ground. The dynamics of gender and HIV/AIDS does this by creating multiple mechanisms that exacerbate the vulnerability of women both for contracting the virus, coping with the disease and caring for others affected by the pandemic. Many of these links do not only manifest themselves as mechanisms of vulnerability, but also become factors that fuel the spread of the epidemic.

## Prevention of HIV: women have less control of their own sexuality

In terms of vulnerability to contracting HIV, the control of women's own sexuality is considered key to prevention. But advocating behaviour modification and chastity often fails to take into account women's lack of control. This includes the intricate manipulation of sexual relations that are necessary for women to engage in to socially and economically manage in deprived circumstances. The lack of control is particularly emphasized by the fact that marriage and monogamous relations by women do not protect them against HIV. In some African countries it has been found that "adolescent, married 15-19 year old females have higher HIV infection than non-married sexually active females of the same age".[6] Another aspect is the social tolerance of gendered violence and forced sexual encounters, with as many as 1/3 of girls having reported forced sexual initiations in certain cases. While there are vast regional differences, the patriarchal dominance in all African countries embedded in legal frameworks as well as cultural practices, tends to determine a woman's social and cultural status based on her

ability to marry and bear children. These expectations override the HIV status of men and women involved in a relationship and further increase women and girls' vulnerability to the virus. [7]




## Coping with the disease: women face more stigma, discrimination and abuse

With regards to coping with HIV and AIDS, women face more harms from stigma and discrimination than men, exacerbating the already unequal and poor access to testing, treatment and care. Because the struggles for gender equality begin in the family, it is also the primary site for greater stigmatisation, discrimination and violence against women. Research confirms that it is "not just the sero-status that is key to altering women's lives, but equally (and at times, more) important their spouse/partner's response to the new crisis in the family".[8] As a result many women hesitate to test for HIV and to disclose their HIV positive status even to their husbands. Discrimination takes place in other areas as well, including in the work place and in communities, making it more difficult for women to demand equal treatment and care. The ABC message, which upholds faithfulness and is promoted in many HIV/AIDS campaigns, is in certain cases found to intensify stigma as married women with HIV are unfoundedly accused of engaging in extramarital affairs. A particularly vulnerable group is orphan girls. These children face increased risk of violence and exploitation.[9] Invisible, uncounted and unaccounted for, the girl orphan continues to be marginalized, sexually abused and exploited.[10]

## Caring for others: Women are doubly affected by the epidemic

Women's culturally determined role in the care economy means that disease and death significantly fall within their domain. The impact of HIV/AIDS on the household level is therefore very much a woman's issue, particularly as the epidemic becomes ever more severe, and women's unpaid care workload increases dramatically. "In Sub-Saharan Africa, an estimated 90% of AIDS care occurs in the home, placing extraordinary strains on women."[11] Particularly young girls and older women carry the heaviest burden. In addition to looking after children and the sick, women must also produce supplementary income or food crops when other productive members of the family fall ill. On the micro-level, women also play an important role in extended family networks. The viability of the social safety nets that the extended family provides is threatened by the impact of HIV/AIDS. However, it is still the case that households headed by women are more likely to take in orphans than households headed by men, adding to their burden of care.

## Women's vulnerability to HIV/AIDS fuel the epidemic

People living in limited resource settings are likely to enter into an irreversible downward spiral of increasing expenses and loss of income and property when affected by HIV/AIDS. The process is thus insidious, as poverty is considered one of the main factors fuelling the epidemic. The feminisation of poverty is well established, which implies that women are disproportionably affected by the HIV/AIDS and poverty dynamics. Their increased vulnerability caused by lack of resources, unfavourable status and greater threats of discrimination, does not only mean that they are at higher risk of contracting the virus, but that once infected they are often unable to protect others. This includes their own children as well as their sexual partners. The gendered dynamics of HIV/AIDS therefore necessitates a gendered response if HIV/AIDS programmes are to be effective.

# Discussion Outcomes

During the interactive session, a number of experiences, reflections and suggestions emerged. These have been structured and clustered into five groups. The first section is concerned with the underpinnings of the epidemic, investigating socio-cultural factors in African societies that facilitate the spread of the HIV virus among women. The second section looks at the impact of the epidemic, specifically focusing on gender dimensions. The third section revolves around issues of access, or lack of it, to various resources. Lastly, the session provided messages for the Commission's advocacy, which are listed in the fourth and final section.

## Socio-cultural factors underpinning the epidemic

"There is no country that treats its women as well as its men. I think this is especially true when we talk about the HIV/AIDS epidemic."

"Much of the gender dynamics that further the spread of HIV can be changed because they are culturally constructed, and therefore they can be culturally deconstructed."

"While women are marginalized, among us, we have even more marginalized groups, such as institutionalised women, disabled, prisoners as well as sex workers."

### Subversion of women creates vulnerability to infection

The subordination that African women experience creates vulnerability to infection through a number of paths. Women are economically dependent on the men in their family, be it their father or husband, and therefore also depend on

their goodwill for their upkeep and livelihood. Legally, women have less access to productive assets such as land. Women's rights are generally not respected, and women enjoy little protection against abuse and exploitation. Social constructions of masculinity and femininity render women powerless to resist their husband's demands for unprotected sex. These and other gender dynamics underpin the spread of HIV in Africa, and lead to the present feminisation of the epidemic.

"No matter how much a woman feels empowered, we operate under patriarchal systems under which HIV is affecting women directly. Components of the patriarchal ideology that has to be addressed is the legitimisation of male dominance that leads to the subordination of women. As mothers, we women perpetuate this in how we teach our children. We enforce the gender role structure in our systems and in our societies. One of the aspects of this is the predominance of women in the care economy." (Hilda Tadria)

"In our societies, men have a 'cultural license' to demand sex, unprotected, at any time, and the woman can not say no, even if she knows he's infected. This has to change."

"All these years we have failed to protect the rights of women, this is why we are now seeing the feminisation of HIV/AIDS."

## Acceptance of men's multiple sexual partners

The message that is advocated in a number of HIV prevention programmes is ABC: Abstain from sex until marriage, Be faithful to one partner, and if you can't, use a Condom. However, evidence shows that marriage and monogamous relationships do not protect women against AIDS. Adolescent married girls (15-19) have higher HIV prevalence than non-married sexually active girls in the same age group. The ABC message is fine in itself, but the unfolding reality is that if on of the partners – in practice, the main - is not faithful, the other is less protected than they would have been outside marriage. In Uganda, infected women interviewed say that they are tired of the ABC message, because when they contract HIV, they are attacked as not having been faithful, although they have been.

"It should frighten you when marriage becomes a death certificate."

"If you stay monogamous AIDS still meets you in the bedroom."

"In our polygamous societies, it is accepted that men have multiple partners, while women have to be faithful to one"

"A woman who has been paid a bride-price for is even more vulnerable to HIV."

## Men are not involved

Gender issues are still generally seen as women's issues. Although addressing the gender dynamics that further the spread of HIV requires the participation of both genders, men are only involved to a very limited extent. This may be a result of a lack of interest and unwillingness to relinquish status and privileges that men have under the present system. However, women may also have excluded men in discussions and actions on this. Greater partnership between women and men is therefore required.

"How do we activate the role of men and their role as protector of the family, in the fight against HIV/AIDS?"

## Intergenerational sex: older men with younger women

A number of studies show that young girls have sex with older men for money, gifts or status – their partners are 'sugar daddies'. However, this phenomenon may not be new, and changing it requires a deeper understanding of the cultural underpinnings of these sexual relations. For those girls who engage in transactional sex because of poverty, providing the resources they need – be it money for school materials or food – will help to curb this practice.

"In this continent it has always been a practice for older men to marry younger women. "Sugar daddy" is too simplistic an explanation, we need to look at the cultural root causes of this phenomenon." Barbara Watson

## Sexual violence

In some countries, up to 30 per cent of African girls report that their first sexual encounter was forced. Rape and sexual violence increases the risk of HIV transmission, and seem to be on the increase. Some sexual violence may even be spurred by HIV, as in some cases infected men believe that sex with a virgin will 'cleanse' them of the virus.

## Religious leaders' reluctance to address the gendered aspects of the pandemic

Religious leaders play an important part in creating and sustaining the moral and spiritual fabric of African societies and communities. Religious institutions have been important in providing care and support to people living with HIV. How-

ever, religious leaders have shown great reluctance to address the gender dynamics that underpin the spread of the epidemic, in some cases using their power to stop HIV prevention programmes.

## Female genital mutilation

In a range of African countries, female genital mutilation (FGM) is still widely practiced. Exacerbating the subordination of women and representation a grave violation of the human rights of women and girls, the practice itself also furthers the spread of HIV. In FGM ceremonies, many girls may be cut using the same blade, therefore increasing the risk of infection. Women who have undergone FGM are also more vulnerable to getting cuts and bruises during sex, further increasing the risk of HIV transmission into the bloodstream if their partner is infected.

## Abuse of orphans and the girl child

The HIV/AIDS pandemic is creating large numbers of orphans. African traditional coping systems, such as care for orphans in foster families, are being overburdened. The children who are in foster families are extremely vulnerable to abuse and neglect. Families that take care of orphans are often poor themselves, and therefore providing food to such families can provide an incentive for families to take orphans in. However, the experience in a number of countries is that the food is diverted to other family members, and the orphan does not benefit from it. There may therefore be a need for 'behaviour change' within the foster families, to ensure that orphans get necessary food and care. Orphan girls are particularly vulnerable to sexual abuse by members of the foster family, and increasingly, it seems that orphan girls to a large extent do experience sexual abuse. We need to ask ourselves whether the extended family is stretched too much that it is no longer viable.

"To what extent is the extended family still a viable way of taking care of orphans when abuse of orphan girls take place?"

"The escalation of orphans must be understood in relation to gender."

"There are an increasing number of households that are headed by orphans."

### Domestic workers

Domestic workers are often young girls. These are particularly vulnerable to sexual abuse and exploitation by male members of the household they are working in, particularly if they also live there. In most cases, domestic workers are aware of their rights, or have no means to exercise them, and find themselves with no supportive networks.

### Trafficking of girls and women

African girls are trafficked in large numbers. Studies have found that a large proportion of the trafficked women and girls are HIV positive. Many of the trafficked girls are orphans. However, a large number do have parents, but who are poor and who, according to traditions and customs, have sent their children to wealthier relatives for fostering, and these relatives in turn give the children up for trafficking and situations where sexual abuse occurs, exposing these girls to the risk of contracting HIV.

## Gendered impact of the epidemic

### Gendered stigma further marginalizes women

HIV is still commonly seen as an immoral disease, linked to sex, blood and death. As issues of women's sexuality are still culturally taboo, HIV-infected women experience higher rates of stigmatisation than HIV-infected men. HIV-infected women also experience higher rates of rejection. The implication of this is further marginalisation of HIV-positive women, but also that women will be more reluctant to come forward for testing, as well as being more reluctant to come forward for HIV-related treatment and support, for fear of exposing their status.

### Gendered loss of agricultural intergenerational knowledge

By the time one person dies, 2 years of productive time have already been lost. The illness and early death of an adult translates into significant losses of agricultural knowledge, as parents die too quickly to transfer knowledge to their children. Knowledge is gender-specific, and types of knowledge lost therefore

depends on the gender of the deceased parent. The lack of knowledge has lead to loss of biodiversity, and certain crops are no longer cultivated, there is a switch from labour intensive to less lab intensive crops, which in some cases have less nutritional value. Also, we see a loss of agricultural extension service staff. Taken together this exacerbates poverty, which in turn increases vulnerability to HIV infection.

"Female farmers and male farmer have their own knowledge. This gendered knowledge is lost because of AIDS." *Participant*

## Issues of access

### Availability of testing

Knowing your status is the entry point to further action, but HIV testing is only available to a very limited extent. Women have access to testing in connection with prenatal check-ups. *Participant*

"How does a woman deep in the rural areas get access to information and testing?" *Participant*

"More and more women are asking for tests to know if they have HIV, but test facilities are lagging behind." *Participant*

"There are girls who think they might have HIV, but are too frightened to come forward for testing." *Participant*

### Information on partner's HIV status

Voluntary counselling and testing (VCT), the testing model which is most used, generally tests patients individually, informs the testee individually of the result, and great emphasis is placed on confidentiality. However, women experience that their partner does not inform them of his HIV status, and when positive, women are unable to initiate negotiations of sexual practices that would reduce the risk of transmission.

"When men go for testing and test positive they will often plead: "Please do not tell my wife". Three months later she might be pregnant." *Participant*

## Inequity in treatment and PEP

Life-prolonging medication for HIV/AIDS exists, but is not available to the vast majority of PLWHA in Africa. In the context of sexual violence and women's difficulty in negotiating safer sex, the short course treatment Post-Exposure Prophylaxis (PEP) would support women's struggle to stay HIV negative. As only treatment is still only available to a limited number of people, equity in treatment provision is an important issue, in that generally, men have had greater access to services than women.

"Many times, PEP is not offered even when we know the benefits." *Participant*

## PMTCT and continuing treatment of mother

The risk of transmission of HIV from an infected mother to her baby can be lowered significantly through appropriate interventions, including provision of ARV. This is only available to a limited extent on the African continent. In order to increase the survival chances of the baby, as well as improve the viability of the family and household, mothers can also continue to receive treatment after the birth. This is referred to as Prevention of Mother to Child Transmission Plus (PMTCT+), which also may include treatment of the father as a cost-effective way of sustaining the family.

"Treatment of women reduce the number of orphans, but this is not discussed." *Participant*

## Female condoms

Condoms are to a large extent available in Africa, but close to all of these are condoms for men. Female condoms exist, but are generally not promoted, not available, or too expensive, and the uptake of this female-controlled protection is therefore low.

"Who says that women do not want female condoms? They give sexual control back to women when being faithful is not enough to protect yourself. *Participant*"

### Unequal access to education

The key to lifting people out of poverty and increasing their options is education. Education increases the uptake and understanding of information, increases girls status and ability to negotiate either no sex or safer sex, increases age at marriage, as well supports a host of other factors favourable to preventing HIV infection. However, access to education is gendered – girls have lower enrolment rates than boys. HIV exacerbates this trend, as in households hit by HIV, girls are withdrawn from school before boys are, in order to help out in the household.

"The more education you have, the less likely it is that you are affected by HIV" while at the same time, "the educational system is exposing our children." *Participant*

"How do we ensure that girls stay in school, particularly with the increased care burden?" *Participant*

## Messages

"The pandemic is within us, we must not be so scared that we cannot see the way forward." *Participant*

### Leadership is needed at all levels

African leaders are waking up to the realities of the HIV/AIDS pandemic, but efforts need to be increased and strengthened significantly in order to curb the speed with which the pandemic is spreading. Leaders particularly need to organise an integrated response that addresses the subordination of women at all levels in African societies to mitigate the impact of HIV/AIDS.

"It is imperative with leadership and political will, and we need to foster an enabling political environment".*Participant*

"The epidemic is moving fast, but our governments are slow to respond" *Participant*

"Policy makers are reluctant to make the link between HIV and gender, and to address the gendered aspects of the epidemic." Hilda Tadria

"Those who manage HIV/AIDS programs are often the wealthiest people, we must end corruption and ensure proper implementation."

"We must insist that a national policy on HIV/AIDS is created." *Participant*

"With a growing number of organizations, we need to ensure that there is a 'marriage' between youth-led organizations and their 'adult' counterparts." *Participant*

## Protect women's rights and revise legal frameworks

Protection of women's rights is a powerful tool in enhancing the status of women and containing HIV. African countries have ratified a number of international conventions on human as well as specific women's rights, including sexual and reproductive rights, but implementation is lagging. Patchy and old legal frameworks are often inadequate for addressing new issues related to HIV/AIDS, and represent obstacles to an effective response in a range of countries. Governments need to revise legislation to provide an efficient legal framework for to the challenges posed by HIV. This includes enacting laws protecting the rights of women, such as access to land, heritance, credit and other productive assets as well as implementing Convention on All Forms of Discrimination Against Women (CEDAW), ensuring a ban on early marriages and on female genital mutilation. In order to facilitate access to medication, laws concerning drug procurement and management, including laws facilitating use of generic medication, need to be enacted. Securing access to free treatment, particularly PEP and medication for PMTCT+, should also be included in a country's legal framework.

"HIV gives rise to a need to revise ancient legal frameworks that are inadequate to respond to the epidemic." *Participant*

"Women should not be forced to marry the brothers of their deceased husbands." *Participant*

## Advocating behavioural change is not enough

The mainstay of the response to HIV has been to prevent its further spread through efforts to change behaviour. Two decades into the epidemic, it seems that behaviour change communication and other efforts have not worked. The HIV virus spreads far faster than the norms underpinning behaviour are changing to facilitate behaviour that would stop the spread of the virus. This may have many reasons, for example that behaviour change messages have not been targeted enough to have an impact on different groups, or because the efforts have been to weak and not reached very far into communities. There seems to, however, be a need to evaluate and change accordingly the present behaviour change modification strategies.

"There is adequate knowledge, but behaviour is not changing." *Participant*

## Women must be economically empowered

Poverty makes women particularly vulnerable to HIV/AIDS. Poor women are more likely to contract the virus because they have fewer resources to protect themselves. Poverty also makes the extra burden of caring for the sick a trigger that pushes women deeper into poverty, creating a downward cycle that goes beyond the point of economic recovery.

"If young girls are economically empowered to say no to sex, we will make headway against AIDS." *Participant*

## Provide treatment and care free of charge

Women have less access to care and treatment than men, and equity in treatment must be on the top of the agenda. While many countries now offer shared costs of ARV treatment, most women cannot even afford subsidized drugs.

"Treatment must be offered free of charge." *Participant*

"Treatment of the mother must go on after the child is born." *Participant*

"Women must be informed and given access to PEP." *Participant*

## Protect orphans and vulnerable girls

More efforts need to be made to provide support and networks for orphans, and we need to reduce the risk of abuse to vulnerable girls. Girls need to be protected legally by abolishing female genital mutilation and by setting a minimum legal age of marriage.

"The issue is not to institutionalise or not, but to monitor care in institutions as well as foster homes of orphans." *Participant*

"We need to develop tools of psycho-social support for these children." *Participant*

## Mainstream HIV in agricultural policy

Women's role as knowledgeable farmers needs to be protected. We need to create information centres and training to address the loss of knowledge. We also need to provide access to information, counselling, testing and treatment in rural areas.

## "Shared confidentiality" need to be explored

HIV has received special treatment in the health care and other sectors. This may have exacerbated the stigma attached to HIV, by setting it apart as a special disease, surrounded by more confidentiality than other diagnosis. HIV in Africa is mainly a sexually transmitted disease, and should be treated as such along with other STIs.

While confidentiality of services and results is a key factor in encouraging people to come forward for testing, models of 'shared confidentiality', to support the infected person in their disclosure to their partner, where example through testing couples together, need to be explored further.

"Is confidentiality more important than the lives of women? The answer must clearly be no!" *Participant*

"We have to develop a concept of shared confidentiality, those who need to know need to know." *Participant*

## Partnership between women and men is crucial

Men need to be involved because they are currently in a position where their influence can make more of a difference than women. Men need to understand that the feminisation of the epidemic regards them. If the "other half" is dying they will be affected and must take action.

## Endnotes

[1] UNAIDS 2004 report on the global AIDA epidemic

[2] UNAIDS 2004 report on the global AIDA epidemic

[3] Hilda Tadria, Regional Advisor, ACGD, "The Gender Dimensions of HIV/AIDS in Africa"

[4] Gender in Africa: the issues, the facts, an ECA pocket reference publication in collaboration with the World Bank

[5] Hilda Tadria, Regional Advisor, ACGD, "The Gender Dimensions of HIV/AIDS in Africa"

[6] UNAIDS 2004 report on the global AIDA epidemic

[7] Hilda Tadria, Regional Advisor, ACGD, "The Gender Dimensions of HIV/AIDS in Africa"

[8] Study commissioned in March 2004, by the Commission on HIV/AIDS and Governance in Africa on "Gender Work and HIV /AIDS in Uganda

[9] UNAIDS 2004 report on the global AIDA epidemic.

[10] Hilda Tadria, Regional Advisor, ACGD, "The Gender Dimensions of HIV/AIDS in Africa"

[11] UNAIDS: 2004 report on the global AIDS epidemic.