UNAIDS reports that the number of women living with HIV/AIDS has risen from 35% in 1985 to 48% in 2004. In sub-Saharan Africa, 57% of adults living with the virus are women and 75% of 15-24 year olds infected with the virus are female. These data mark the failure of families, communities, religious organizations, governments and international agencies to reduce girls’ and women’s risks for HIV at the start of the epidemic. It took more than ten years for (mostly male) scientists and physicians to acknowledge that some AIDS-related opportunistic infections manifest themselves differently in women than in men. For example, it was not until 1993 that scientists finally expanded the clinical definition of AIDS to include female specific characteristics such as cervical cancer. Tired of waiting for leadership from the scientific and public health communities, women began to organize for themselves in the late 1980s, forming groups such as the International Working Group on Women and AIDS and the Society for Women and AIDS in Africa. Recognizing the increasing number of HIV-infected women, the World Health Organization’s Global Programme on AIDS (WHO/GPA) declared the 1990 World AIDS Day theme to be “Women and AIDS.”

Today in 2004, we have come full circle. A new Global Coalition on Women and AIDS made up of UN agencies, civil society groups including women living with HIV/AIDS, the public sector and academics was formed this year and the theme of the 2004 World AIDS Day will once again be women. Epidemiological data, new reports, press statements from the UN Secretary General and a heavy emphasis on women and girls in the 2004 UNAIDS report have renewed the focus on women’s biological, social, economic and political vulnerability to AIDS. Yet working groups and policy statements have been tried before. What might we learn from past strategies and policies to reduce women and girls’ risk for HIV infection and the impact of AIDS? The purpose of this paper is to review some of the leading

Kari A. Hartwig, DrPH, is an Assistant Clinical Professor in the Global Health Division of Yale’s School of Public Health and is a Research Scientist affiliated with Yale’s Center for Interdisciplinary Research on AIDS. She has more than 15 years of experience in global HIV/AIDS research and prevention programs.
women and AIDS policies and strategies put forward by the World Health Organization (WHO), UNAIDS and other international agencies from the 1980s to the present. From this review, what can we learn from our past actions and inactions in the global fight against HIV? Are our global policy initiatives moving us forward so that in another five years we will see reductions in the incidence of HIV globally, particularly in young women?

Setting the Women and AIDS Agenda

Even though the title of the 2004 UNAIDS, UNIFEM and UNFPA report, “Women and HIV/AIDS: Confronting the Crisis” suggests that we have waited for a crisis in order to motivate action, women and men have been meeting and advocating on the potential and real crisis of women and AIDS for two decades. In the 1980s, the issue of women and AIDS saw women divided by geography and class – although the class distinctions were often hidden behind epidemiological terms that cloaked the social and political divides. Geographically and epidemiologically, sub-Saharan Africa was already well entrenched in an epidemic largely transmitted through heterosexual sex and widely affecting African women. In 1988, a Sudanese academic formed the Society for Women and AIDS in Africa (SWAA) to organize women (mostly professionals and academics) across the continent to advocate for the support and protection of women and girls. Today, SWAA has chapters in more than 30 countries in Africa.

In the 1980s, the global divide present in scientific research limited most of the data on women and AIDS data to North America and Western Europe. Epidemiologically, two HIV trends in women were emerging that began to direct public health strategies. First, researchers were identifying higher rates of HIV in female sex workers; secondly, mother to child transmission of HIV began to be recognized as a priority. As Carovano describes, women became divided as “mothers or whores.” In both cases, a woman’s health status was subsumed under the priority to stop her potential as a “core transmitter” to her male partners and unborn children.

Not until 1989 did WHO/GPA formally address the issue of women and AIDS by hosting two conferences that highlighted epidemiological and social divide between men and women. The first conference focused on the health of women and children and perhaps foreshadowed some of the later framing of HIV/AIDS as more than merely an infectious disease but rather one specifically affecting reproductive health. The second conference or “consultation” was more groundbreaking, bringing together scientists and sex workers to talk about “HIV Epidemiology and Prostitution.” In 1990, WHO finally made its first formal statement on women and AIDS noting the importance of “empowering” women socially, economically and politically.

Framing the “Women’s Issue”

Karen Booth’s case study of WHO/GPA’s internal debates on how to frame the Women and AIDS agenda within GPA presents
IN FOCUS: WOMEN’S HEALTH

a fascinating portrait of the politics inherent in a multilateral institution subject to oversight by multiple nation-states. Despite sharing a common commitment to reduce all women’s vulnerability to HIV/AIDS, the six women and two men on the Women and AIDS Strategy team were divided on how to achieve women’s empowerment. Booth suggests that the dividing line was a less ideological and more institutional split between “internationalists,” represented by long-term WHO or UN professionals, and “globalists,” consultants brought in from outside the international institutionalized structures and perceived as activists on a short-term assignment. Debates arose around how prescriptive they should be about emphasizing reducing social and political inequities in some countries. Would this be threatening or imposing on national sovereignty or other cultures? In turn, a human rights lawyer in the ‘globalist’ group suggested that “internationalism could no longer suffice as an excuse for tolerating human rights abuses and that GPA had to intervene directly.”

Though the internationalists suggested strengthening national policies and programs that improve women’s access to treatment for sexually transmitted diseases (STD), by increasing access to and de-stigmatizing condoms as well as providing counseling to HIV positive women, they generally avoided dealing with laws that affected class and gender relations.

Though the final agenda that emerged combined both ‘internationalist’ and ‘globalist’ preferences, it emphasized health policy and systems changes over social and political reform to reduce gender inequalities. The 1992 Global AIDS Strategy put forward by GPA included as one of its six major strategies to reduce women’s and children’s vulnerability to HIV infection “through an improvement of women’s health, education, legal status and economic prospects.”

Although many activists and public health practitioners viewed the inclusion of women on the agenda as a great achievement, the Global AIDS Strategy was criticized for providing few specific recommendations for achieving gender equity. Despite the criticisms, many national AIDS programs built upon the WHO/GPA recommendation and integrated objectives to address women’s vulnerability to HIV into their national strategies.

Women and AIDS policy strategies: the second decade

By the end of the first decade of HIV/AIDS, women had been added to the clinical definition of AIDS and had made it onto the global agenda. Now in 2004, with renewed attention to the growing epidemic in women, it is interesting to reflect on which strategies have remained the same, what has been dropped and added, and how problems are now being framed. In Table 1, we can see a comparison of the primary strategic objectives highlighted in WHO’s 1994 “Women and AIDS: Agenda for Action” and UNAIDS, UNIFEM and UNFPA’s 2004 “Women and HIV/AIDS: Confronting a Crisis.” What is most striking in this comparison is that although the language used to frame some issue has changed, the majority of action points and strategies remain the same. Commonalities include a focus on girls’ education and on educating both girls and boys about life
Table 1. A Comparison of UN Women and AIDS policy strategies: 1994 to 2004

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention</strong></td>
<td><strong>Prevention</strong></td>
</tr>
</tbody>
</table>
| • Increase girls’ access to education, including access to scholarships & other financial assistance | • Promote girls’ primary & secondary education & women’s literacy  
  → eliminate school fees to keep girls in school  
  → promote zero tolerance of violence against women & girls in schools  |
| • Support sex and HIV/AIDS education for young people (male and female) both in school and out of school to increase their understanding and skills in human sexuality | |  
  → Provide life-skills education both in and out of school that fosters mutual respect and equality between boys and girls  |
| • Support programs that target both men and women with informed messages about the importance of using condoms to protect both partners from HIV and other STD, and about their mutual responsibility to engage in safer sex practices | • ’Ensure that adolescent girls and women have the knowledge and means to prevent HIV infection  
  → Institute population-wide gender-sensitive communication and advocacy campaigns  
  → ’Increase access for women to both male and female condoms and skills to negotiate their use  |
| • Remove obstacles to women’s ability to earn money and engage in productive labor by supporting child care services, equal pay for equal work, employment training programs, as well as small business and agricultural programs. | • Empower women and girls economically by providing them with access to credit and business and leadership skills to break the cycle of poverty, gender inequality and vulnerability to HIV transmission  
  → ’Promote zero tolerance of all forms of violence against women and girls |
| • Support the development of sound HIV/AIDS workplace policies and effective workplace education programs | |  
  → Support programs that target both men and women in order to reduce the likelihood that women will be ostracized due to their HIV status  |
| • Ensure a safe blood supply | • Review the impact of laws and regulations relating to prostitution on working conditions as well as on the ability of HIV/AIDS and STD prevention activities to operate effectively |
| • Reduce unnecessary blood transfusions by improving women’s nutrition, preventing anemia, etc. | |  
  → Reduce the incidence and prevalence of STDs among women  |
| • Encourage countries where mandatory testing or routine HIV screening programs exist to replace them with voluntary, confidential testing supported by counseling services | • Encourage countries where mandatory testing or routine HIV screening programs exist to replace them with voluntary, confidential testing supported by counseling services  |
| • Support programs that work with families and communities of women with HIV/AIDS in order to reduce the likelihood that women will be ostracized due to their HIV status | |  
  → Ensure universal access to voluntary counseling and testing that addresses stigma, discrimination and gender-based violence and encourages partner testing, couples, counseling and confidentiality  |
| • Review the impact of laws and regulations relating to prostitution on working conditions as well as on the ability of HIV/AIDS and STD prevention activities to operate effectively | • Support positive women and their organizations and networks  |
| • Plan and implement HIV/AIDS prevention interventions with sex workers, and support self-help and advocacy organizations for sex workers | • Promote and protect the human rights of women and girls  
  → Codify and revise laws and practices to protect and promote the rights of women and girls  
  → ’Protect and promote women’s property and inheritance rights  
  → Support free or affordable legal services to protect the rights of women and girls  |
| **Reducing the Impact of HIV/AIDS on Women** | **Reducing the Impact of HIV/AIDS on Women** |
| • Encourage programs that work with families and communities of women with HIV/AIDS in order to reduce the likelihood that women will be ostracized due to their HIV status | • Make AIDS money work for women  
  → Ensure fully resourced programs that respond to women’s needs and circumstances  
  → Ensure that new and existing funding is channeled rapidly in this direction  |
| • Plan and implement HIV/AIDS prevention interventions with sex workers, and support self-help and advocacy organizations for sex workers | • Undertake gender analysis at every stage of policy design, implementation and evaluation  |
| **Caring for Women with HIV/AIDS** | **Caring for Women with HIV/AIDS** |
| • Increase the availability of support services for HIV-positive women who want help with reproductive decision-making and for women with children who need help with planning for their care  
  → Support programs to assist women with HIV/AIDS in family planning decisions and planning for their surviving families  
  → Ensure that HIV-positive women are not pressured or forced to be sterilized and that pregnant women with HIV infection are not pressured or forced to terminate pregnancies | • Strengthen and expand traditional and reproductive health services and training for health care providers to provide HIV/AIDS treatment and prevention  
  → ’Ensure equal and universal access to treatment  |
| • Ensure that women do not carry the burden of care for people with HIV/AIDS | |  
  → ’Provide social protection mechanisms for caregivers to help relieve women’s heavy burden of caring for sick and dying family members and for orphans  |
| • Support community-based institutions that can provide professional alternatives to home care and respite care for primary caregivers  
  → Encourage men and women to share in the care giving role, and support interventions that provide training for women and men in basic health care procedures  
  → Encourage families to keep their daughters in school and discourage them from relying on adolescent girls for care giving responsibilities | • Strengthen public health and caring facilities and services to relieve the workload entailed in providing community and home-based care  
  → Provide training, counseling, and psychosocial support to home-based caregivers and volunteers  |

† Italics indicate unique strategies that are not replicated in the other action plan

† These items correspond with the seven action areas of the Global Coalition on Women and AIDS
skills (i.e. reproductive health, sexual communication). Other common prevention strategies include empowering women economically, assuring that girls have adequate knowledge about HIV prevention, and ensuring access to reproductive health clinics that provide contraceptive counseling, STD clinical care, and safe and confidential HIV testing and counseling. With regard to issues of care, both strategies emphasized supporting HIV-positive women and reducing their stigma as well as reducing the burden on women in caring for orphans and ailing family members.

The most striking difference between the two action strategies is the framing of the 2004 action points from a human rights perspective. The inhibitions that had halted stronger language in the 1991-1992 internal GPA debates are no longer visible as strong recommendations were put forward, such as codifying and revising laws that protect and promote the rights of women and girls. Further attention has also been given to gender-based violence such as war, rape or beatings from a male partner that heighten women’s and girls’ vulnerabilities. Further structural and policy changes focus on funding women’s initiatives as well as conducting systematic gender analyses of HIV/AIDS programs and policies. The one new item that is perhaps unsurprising given treatment changes in the past decade is the addition of a point that specifically mandates that women have full and equal access to anti-retroviral treatment.

Equally of interest, are the action agenda items from 1994 that were not included in the 2004 plan. For example, the emphasis on timely and adequate treatment for STDs present in the 1994 study has disappeared, and in the 2004 study STDs are hidden behind the language of “sexual and reproductive health” that has been widely adopted following the 1994 International Conference on Population and Development. Consequently, the 2004 study lacks a specific action plan for measuring the incidence or prevalence of STDs and other reproductive tract infections. Especially because U.S. government funding of global family planning services has been slashed dramatically with the implementation of the “global gag rule,” forcing hundreds of clinics in the developing world to close their doors, issues of access to reproductive health services are probably in a worse state today than ten years ago. The 1994 agenda focusing on protecting the rights of sex workers bears no specific mention in the 2004 study. One wonders if they were invited to the table in 2003 to construct the agenda or if the more generic, neutral language is meant to be all-inclusive, no longer separating the sex workers from the mothers (who were sometimes both).

There was also a concern in 1994 for protecting the rights of HIV positive women to prevent coerced abortions and provide counseling so that the women could choose to have children if they desired. The absence of such specific guidance today suggests that there has either been a positive trend in providing HIV positive women with more choices, or that the increased availability of the drug nevirapine to pregnant women, which significantly reduces mother to child transmission, is presumed to be widely available, making the past objective obsolete. Two other highlights from the past include monitoring workplace policies and protecting the blood supply, neither of which appear in recent
proposals. Finally, the other conspicuous
difference between the two plans is the
more common inclusion of men and boys
in the 1994 action agenda, despite the fact
that both plans indicate the importance
of working with both sexes in coming up
with meaningful strategies.

In reviewing these action agendas to-
gether, the repetition of so many strategies
suggests that we as a global community
have done little to meet the 1994 Agenda
for Action objectives. Further, the lack of
reference to the 1994 document in the
2004 plan suggests that the 1994 Agenda,
lacking guidelines to track its progress, was
largely forgotten and sidelined after it was
written. Other than annual epidemiologi-
cal updates, there has been little attempt
globally to monitor changes in policies and
commitments that influence the HIV risk
environment at the local or national lev-
els. However, the UNAIDS’ 2003 report,
“Progress Report on the Global Response
to the HIV/AIDS Epidemic,” did reflect
progress on the commitments made at
the UN General Assembly Special Session
on HIV/AIDS held in 2001.13 The good
news is that of 54 countries that completed
a survey on national policy responses, 69%
indicated that they had policies ensuring
women’s equal access to HIV prevention
and AIDS care. Nevertheless, detailed in-
dicators were largely missing. The 2004
UNAIDS report noted:

[T]he Progress Report asked coun-
tries for gender breakdowns for a
number of key indicators. These
included: accurate diagnosis of sexu-
ally transmitted infections, anti-
retroviral coverage; young people’s
prevention knowledge; condom use;
and the percentage of HIV-infected
young people. Less than one in five
countries provided these gender-re-
lated data – an indication that gen-
der concerns are a minimal pre-oc-
cupation in many countries’ AIDS
responses. (p. 152)

The limited implementation of gender
sensitive policies at the national and lo-
cal level perhaps explains why the 1994
and 2004 women and AIDS plans bear so
much resemblance to one another and the
growing HIV epidemic in women.

Women and AIDS
policy: Moving from the
periphery to the center?

From this historical review of actions taken
to move women and AIDS onto the global
health agenda, can we feel confident that
we are moving forward? The best answer
is perhaps a qualified “maybe.” The inte-
gration and emphasis in UNAIDS main-
stream reports on women and girls’ risks for
HIV and the heavy care burden they carry
suggest that global leaders recognize its
importance. Many of the issues and strate-
gies indicated in “Confronting the Crisis”
also appear in the 2004 UNAIDS report
on the epidemic. Even though women and
AIDS have moved from the periphery to
the center of the AIDS movement, moving
this message and agenda from the “center”
of Geneva to the “periphery” of more than
150 national country programs remains
a challenge. Further, the gender analysis
and integration of programs and policies
that recognize women’s and girls’ differing
social, political and economic opportuni-
ties suggested in the 2004 report remain at the margins of most institutions working in HIV/AIDS care and prevention. This reality was evident once again at the 2004 International AIDS Conference in Bangkok when the same women – and a few men – appeared at sessions focused on women and AIDS, while few of the hundreds of other sessions and panels discussed or even acknowledged gender differences in their research, programs and policies. The question for all of us then is where will the world be 2014 on addressing women and girl’s risks for HIV? Will “Confronting the Crisis” be another document buried in a bureaucracy? We have the knowledge, we have the tools, and we have some of the political will. The challenge is taking the global to the local, motivating citizen action and bringing public health policy and practice to our local cities, states, provinces, and countries.

References