HIV/AIDS

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HIV/AIDS is the fourth most common cause of death worldwide. It is a direct threat to stability in many parts of the world. Governance may be threatened, as serious crimes and sexual violence increase. For example, UN Security Council Resolution 1308 states that "HIV/AIDS is exacerbated by conditions of violence that increase the risks of exposure to the disease through large movements of people, widespread uncertainty over conditions and reduced access to medical care. If unchecked, HIV/AIDS may pose a risk to stability and security."[1]

The death of men and women may result in significant reduction in productivity and labour. In 1999 in sub-Saharan Africa, 860,000 teachers died of AIDS, thus affecting the education of countless children.[2] In the South Pacific, in **Bougainville**, HIV/AIDS is affecting the sexually active, highly educated and economically productive members of communities, resulting in the loss of skilled labour and productivity, and increasing the socio-economic impact.[3] The social burdens on the state also increase as children are orphaned. It is estimated that there are 14 million AIDS orphans in the world today and this figure is growing.[4]

The fundamental rights of infected persons are often violated based on their known or suspected HIV status.[5] At the individual level, in addition to the physiological effects of the virus, fear, stigma, discrimination, shame and ignorance keep people from practicing prevention and seeking treatment, care and support. Women, due to gender inequality, poverty and other factors, make up the majority of newly infected persons.[6] They face double stigma and discrimination if they or their partner contract HIV/AIDS. Many are blamed for the disease and can be treated badly as a result.

1. WHAT IS HIV/AIDS?

HIV is the **human immunodeficiency virus**.[7] HIV attacks the immune system by replicating itself and overwhelming the human body over time, thus opening a way for **opportunistic infections (OIs)** such as tuberculosis (TB) and pneumonia. The **Acquired Immune Deficiency Syndrome** is the life-threatening condition known as **AIDS**, which is described "as a combination of symptoms that attack the human body following progressive damage to the immune system by the HIV virus. AIDS is not a disease but a syndrome."[8] The length of time between when a person becomes infected with HIV to when they develop AIDS varies from person to person. Individuals with HIV can remain healthy for any length of time between a few years to more than ten years before developing AIDS. Being infected with HIV does not necessarily mean that an individual has AIDS, as some people can be **carriers** and **transmitters** of the HIV virus without developing full-blown AIDS.[9]

Once the disease has progressed to a moderately advanced state, an HIV positive person (HIV+) needs a three-drug combination of anti-retroviral (ARV) drug therapy to prevent the virus from destroying their immune system. This treatment is expensive, but is effective in prolonging a person's life. There is currently no known cure for HIV/AIDS.

The HIV virus can be transmitted through:

- **Sexual intercourse**: The vast majority of HIV/AIDS infections are sexually transmitted, typically between men and women or men and men and in at least one case, between women.[10]

- **Pregnancy-related vertical transmission (mother to child transmission, or MTCT)**: Women can transmit HIV to their babies during pregnancy or childbirth. Transmission during pregnancy is possible, but very rare. Approximately one-quarter to one-third of all untreated pregnant women infected with HIV will pass the infection to their babies when they give birth. HIV can also be spread to babies through the breast milk of mothers infected with the virus.[11]
- **Blood transfusions** with unscreened or infected blood: Between 5 and 10 percent of HIV/AIDS infections worldwide are estimated to be transmitted through infected blood transfusions.
- **Sharing of infected needles and syringes** between drug users of either sex who inject drugs intravenously: Small quantities of infected blood may remain in needles or syringes and may contribute to the spread of the disease.
- **Tattoos and body piercing** may introduce tainted fluids into the bloodstream, resulting in the transmission of the hepatitis B virus as well as HIV.
- **Disfigurement**: Some traditional practices such as circumcision, female genital mutilation and ritualised scarring may also contribute to the spread of the hepatitis B and HIV viruses.[12]

MYTHS, TABOOS AND BELIEFS ABOUT HIV/AIDS

Many people do not understand what HIV/AIDS is or how it is spread, treated or prevented. This lack of understanding gives rise to incorrect beliefs about the virus, often derived from, and strengthened by, cultural and religious practices and traditions. Research conducted among 400 college students in **India** demonstrated that 55 percent of males and 68 percent of females knew that the disease was communicable and was spread by a virus, but only 9 percent knew exactly how it was transmitted.[13] Innumerable myths exist about condoms carrying the virus. Many people still believe the myth that sex with a virgin or young girl can cure men of HIV/AIDS. In **Botswana**, where nearly 40 percent of the adult population has the virus, this myth is particularly widespread, and some men may deliberately seek out young girls for intercourse as a way of avoiding HIV infection.[14] Another lesser-known myth is that sex with older women can cleanse men of HIV/AIDS. This belief is said to result from the perception that when women stop menstruating, they become clean again. Other incorrect beliefs include that HIV can be transmitted through:

- everyday contact such as shaking hands, hugging, coughing or sneezing;
- using public toilets or swimming pools;
- sharing bed linen, eating utensils or food; and
- contact with animals, mosquitoes or other insects.

GENDER DIFFERENCES AND HIV

Gender relationships and sexuality are significant factors in the sexual transmission of HIV/AIDS. They also influence the treatment, care and support of those infected and affected by the disease. Gender is a culture-specific construct that results in differences in women's and men's roles and authority, including access to information relevant to decision-making about health. Women's sexual autonomy is affected by the power imbalances between men and women, thus increasing their vulnerability to HIV/AIDS within male-female relationships, including marriage.

Physiologically, women have a greater vulnerability to HIV as the soft tissue in the female reproductive tract tears easily during intercourse, especially during incidences of forced penetration. Women are also more likely to have other untreated sexually transmitted infections (STIs), which may not have noticeable symptoms. Additionally, women's differential access to medical care, counselling and information means that they are less likely than men to receive accurate diagnosis, care and treatment once they have contracted HIV/AIDS.

Additionally, in many societies, a culture of silence surrounds sex. Women are often ignorant about, and passive in, sexual interactions. This makes it difficult for women to be informed about risk reduction or, even when informed, to be proactive in negotiating safe sex.[20] Moreover, unmarried girls are often expected to remain virgins. The taboo of premarital sex restricts women's access to information, and this increases

Global Trends in HIV/AIDS[15]

Over 20 million people have died of AIDS since 1981. An estimated 4.8 million people became newly infected with HIV and 2.9 million died of AIDS in 2003. Some 37.8 million people are currently living with HIV.[16]

Asia: In Asia, about 7.4 million people are living with HIV. Around 500,000 are believed to have died of AIDS, and about 1 million are estimated to have been newly infected with HIV in 2003. The United Nations Population Fund (UNFPA) estimates that within the next decade, China and India, the two most populated nations in Asia, will be the most widely affected.[17]

The Australian Subcontinent: Over a five-year period, annual new HIV diagnoses have increased from around 650 cases in 1998 to about 800 in 2002.

Sub-Saharan Africa: Sub-Saharan Africa, with just over 10 percent of the world's population, has close to two-thirds of all people living with HIV—some 25 million. In 2003 there were an estimated 3 million people newly infected, while 2.2 million died of AIDS.[18]

North Africa and the Middle East: Available information, based only on case reporting, suggests that about 480,000 people are living with HIV in the region. Some 75,000 people are believed to have become newly infected in 2003.

Eastern Europe and Central Asia: At the end of 2003, about 1.3 million people were living with HIV, compared with about 160,000 in 1995. During 2003, about 360,000 people in the region became newly infected, while 49,000 died of AIDS. The Russian Federation, Ukraine, Estonia, Latvia and Lithuania are the worst affected countries. Women in these regions account for 33 percent of those infected.[19]

Latin America: About 1.6 million people are living with HIV in Latin America. In 2003, almost 84,000 people died of AIDS, and 200,000 were newly infected.

The Caribbean: Around 430,000 people are living with HIV in the Caribbean. In 2003, around 35,000 people died of AIDS, and 52,000 were newly infected.

the risks of infection and pregnancy. In places where it is believed that sex with a virgin "cleanses" or "cures" men of HIV/AIDS, young girls are at particular risk of rape and sexual coercion. Attempting to access treatment for STIs can be stigmatising and may be dangerous for adolescents, young women and young men.[21]

A woman's economic dependence on a man may result in her giving priority to his decisions on matters of sexual relations, the use of condoms or other protective measures. Men may also dictate the amount of financial resources to be spent on accessing health care. Women migrants, those employed in the informal economy, as market sellers for example, and women who work at home are less likely to have access to testing and counselling, care or prescription drugs. As a result of their disadvantaged status, women may engage in commercial sex thus increasing their vulnerability to the virus. There is a direct correlation between women's low status, the violation of their human rights, and HIV transmission.[22]

Violence against women is the most disturbing form of male power. It contributes both directly and indirectly to women's vulnerability to HIV. The threat of violence, actual physical violence and the fear of abandonment, act as significant barriers for women who have to negotiate the use of a condom, discuss fidelity with their partners or leave risky relationships.[23]

MEN'S VULNERABILITY

Among other factors, the risk of men contracting HIV can increase as a result of cultural attitudes to

masculinity, fatherhood and the stigma of homosexuality. In some cultures, men are expected to be more knowledgeable and experienced about sex than women. Prevailing norms of masculinity that idealise men who have multiple partners can put men, particularly young men, at risk of infection, while shame, fear or stigmatisation can prevent them from seeking information or admitting their lack of knowledge about sex or protection. It can also encourage them to experiment with sex in unsafe ways to prove their manhood at a young age.[24] There is also the practice of late-age marriage in some societies, where men do not marry until they have built up economic resources. Meanwhile they may have no legitimate access to sex with women and so may engage in sex with other men, often younger men, thereby increasing their vulnerability.

HIV/AIDS, STIGMATISATION AND DISCRIMINATION

HIV/AIDS is strongly associated with stigmatisation, scapegoating, blame and discrimination. Stigma and discrimination affect everyone especially from children to AIDS widows, who are particularly vulnerable to violations of their inheritance and property rights. Orphans are frequently denied their right to schooling, and adoptive parents sometimes take away their inheritance unlawfully. Efforts to prevent HIV have at times unintentionally reinforced prejudice and stigma, resulting in an increased burden on those most badly affected. Research undertaken by the global consortium Agency for Cooperation and Research in Development (ACORD) in northern **Uganda** and **Burundi** indicate that stigmatising attitudes and discriminatory behaviour pervade all spheres of life, i.e. the home, family, workplace, school, health settings and the community at large.[25]

HIV positive persons suffer neglect and lack of care and are frequently excluded from community gatherings. Children of **people living with HIV/AIDS (PLWHA)** may be cruelly teased at school and excluded from games and social interaction with their peers. In addition to their social exclusion, the basic human rights of PLWHA to health, housing, education and employment protection are affected. The ACORD research identified employees who were dismissed or denied access to training and employment opportunities once their HIV status had been discovered. Such stigmatising and discriminatory attitudes negatively affect PLWHA and can seriously affect their emotional and physical health. Stigma and discrimination, and fear of being labelled, may also prevent people from being tested or from using condoms. In many cases, fear prevents people from attending clinics where they can seek and receive treatment, including ARVs.

Key factors contributing to the incidence and perpetuation of stigma and discrimination include ignorance and fear, cultural values, religious teachings, the absence of legal sanctions, lack of rights awareness, the design of government and NGO programmes and inaccurate and/or irresponsible media coverage.

HIV/AIDS AND SECURITY

HIV/AIDS is increasingly regarded as a security issue that can negatively affect social and economic progress. In its 2001 publication, the International Crisis Group (ICG) identified HIV/AIDS a threat on five levels:

1. personal security: as adult illness and fatality increases, there may be a decline in health and longevity and an increase in infant mortality. Families and communities can fall apart, and young people particularly "cease to have a viable future;"[26]

2. economic security: increases in adult infection and fatality can reduce national growth and income;

3. communal security: HIV/AIDS "directly affects police capability and community stability. It breaks down national institutions that govern society. Furthermore, it affects those most educated and mobile—civil servants, teachers and health care professionals;"[27]

4. national security: this is most evident in Africa, where military forces have higher infection rates than civilian populations. Severely weakened military and security structures can make states vulnerable to internal and external threats; and

5. international security: weakened military forces may mean that states cannot participate effectively in international peacekeeping operations.

2. WHAT IS THE IMPACT OF HIV/AIDS AND CONFLICT ON WOMEN?

The breakdown of societal structures resulting from conflict often means that women of all ages can become caretakers of family members and relatives, including orphans affected by and infected with HIV/AIDS.[28] This can prevent girls from going to school and women from contributing to the workforce or engaging in political activities, which in turn weakens the economic and social participation of the population at a crucial time of national crisis.

In such insecure situations, when life is threatened on a daily basis and poverty is on the rise, people—particularly women and girls—may sell sex to local populations as well as to peacekeepers, humanitarian, and other foreign workers as a means of economic survival. This increases their exposure to HIV/AIDS. Moreover, where security is a concern and men are seen as protectors, it is unlikely that women will be able to negotiate safe sex or to leave a relationship, even if it is perceived to be risky. The following also increase women's vulnerability to HIV/AIDS:

GENDER-BASED VIOLENCE

During armed conflict, women and girls are at greater risk of domestic violence, sexual exploitation, trafficking, humiliation, and other types of violence. Gender-based violence and sexual exploitation may include the use of small arms and light weapons (see chapter on small arms, light weapons and landmines). This type of violence increases women's vulnerability by lowering their self-esteem and limiting their mental and physical freedom. The use of sexual violence such as rape and systematic rape as a strategic, tactical weapon of war contributes to the spread of STIs, including HIV/AIDS. Recent examples from **Bosnia and Herzegovina** and **East Timor** reveal systematic use of rape and sexual violence as tools of war.[29] Rape victims in the **Rwandan** genocide report that HIV infection was deliberately used as a weapon of war against women. Such reports are further corroborated by the fact that the HIV infection rate among women surviving these rapes is high, with two-thirds of a recent sample of Rwandan genocide widows testing HIV positive. Human Rights Watch also estimated that over 5,000 children were born to raped and infected Rwandan women. Little data is available, however, reflecting the number of these children with HIV/AIDS.[30] In **Sierra Leone** it is estimated that 70 to 90 percent of rape survivors have contracted STIs, including HIV/AIDS. Abducted girls were also particularly at risk, due to the many episodes of sexual violence they faced.[31]

DISARMAMENT, DEMOBILISATION AND REINTEGRATION (DDR)

As peace processes are negotiated and agreements made, DDR processes become very important (see related chapters). However, there is often a failure to consider women's forced or voluntary participation in conflicts as combatants, camp followers, sex slaves, spies, cooks, porters and wives. As a result, DDR programmes are rarely designed in a gender-sensitive manner that takes into consideration women's physical, vocational, psychosocial and reproductive health care needs.

During the demobilisation period, women are vulnerable to abandonment by their combatant partners. Women and girls, particularly those with children born of rape or other relations with armed actors, often find it difficult to reintegrate into their communities. Few programmes combine training or education with childcare provisions to enable their participation. If women or their children suffer from HIV/AIDS, the stigma and discrimination against them can be severe.[32] In **Mozambique** in the early 1990s, little attention was given to HIV/AIDS or any form of STIs among dependents of armed actors.[33] While awareness and concern has risen over the last decade, the challenges are still immense, as demobilisation itself can trigger the spread of the disease into previously uninfected communities as ex-combatants return to their families, or to new relationships.[34] For example before 2003 in Angola, demobilised soldiers and returning refugees were said to be carriers of the virus, resulting in an increase in infections across the country.[35]

PEACEKEEPING PERSONNEL, WOMEN AND VULNERABILITY TO HIV/AIDS

The presence of peacekeepers can help maintain the peace in societies emerging from violent conflict (see chapter on peacekeeping). The international community is becoming increasingly dependent on peacekeepers drawn from military and police forces of both developed and developing countries to staff such operations. Most of these soldiers are of a sexually active age, are geographically mobile and

are away from home for long periods. To relieve the stress of combat, they often engage in risky and sometimes violent behaviour as they have greater opportunities for casual sexual relations. Such behaviour increases the risk of HIV infection for them and their sexual partners.

Some of the armed forces from which these troops are drawn exhibit high levels of HIV infection. The risks of sexual transmission to local populations as well as among peacekeepers must therefore be considered. For example, the National AIDS Co-ordinating Agency of **Botswana** estimates that HIV infection in the armed forces is between 35 and 40 percent. Similarly recent studies have found that in **Tanzania**, **Uganda**, **Zambia** and **Zimbabwe**, 75 percent of soldiers were dying of AIDS within one year of discharge.[36] In response to the problem of troops being both victims and transmitters of the virus, the **United Nations Security Council** (**UNSC**) has adopted Resolution 1308, which calls for national strategies to address the spread of AIDS among uniformed services, including through awareness-raising and training among their ranks.[37]

The UN itself is involving peacekeepers in activities to raise awareness and slow the spread of HIV. In **Sierra Leone**, 15,000 peacekeepers are being trained in HIV/AIDS prevention, gender awareness and women's rights. The UN peacekeeping mission in **Eritrea** and **Ethiopia** (**UNMEE**) has taken the lead in providing training on HIV/AIDS.[38] Other such training initiatives are taking place in **Botswana** and other affected countries. The United Nations Population Fund (UNFPA) is also partnering with other UN agencies, national health ministries, and military and police forces to provide HIV prevention training.[39]

Trafficking and Prostitution: Trafficking in persons, particularly women and children, is among the most serious crimes of international concern in the Rome Statute of the International Criminal Court (ICC).[40] Women who are trafficked for sexual exploitation are vulnerable and at risk of HIV. Trafficked women are often unable to access health services or information because they may be unable to communicate due to language difficulties, are unfamiliar with the local environment, are being held captive or are afraid of their captors. Additionally, fear of deportation or continued threats of violence towards them may ensure that they remain silent.

In conflict-affected situations, including **Mozambique**, **Cambodia**, **Sierra Leone**, the **Democratic Republic of the Congo** (**DRC**), **Bosnia** and **Kosovo**, peacekeepers and others with responsibility for providing protection and security to local populations have been implicated in trafficking and prostitution. Since the deployment of an international peacekeeping force to Kosovo in 1995, the International Organization for Migration (IOM) has identified Kosovo as a major destination, changing its status from a route, for women trafficked into forced prostitution.[41] Additionally, in 1999, peacekeeping troops and personnel of private security firms based in Kosovo were reported to be clients of brothels that practiced forced prostitution.

REFUGEES, INTERNALLY DISPLACED PERSONS (IDPs), FORCED MOBILITY, AND THE SPREAD OF HIV/AIDS[42]

Refugee and displaced populations (see chapter on refugees and IDPs) are particularly at risk, as the camps in which they are housed may be the settings where women and children are most vulnerable to exploitation, violence and abuse.[43]

Poverty, economic disparity and the effects of conflict often lead to migration, forcing both men and women as well as girls and boys into commercial sex work and survival prostitution. Forced population movements such as refugees or IDPs as a result of armed conflict affect the spread of HIV/AIDS. Changed personal circumstances of forced migrants—including separation from family and sexual partners, the stresses and vulnerabilities associated with the displacement process, broken community relations, and loss of social support networks—may lead to personal risks such as multiple partners and engagement in sexual activity with local providers of sexual services.[44]

Refugee women's marginalised status or cultural and linguistic barriers may prevent them from accessing health and social services, and may increase their vulnerability to HIV. In **Angola**, for example, after nearly three decades of war, refugees are returning, but they are bringing HIV/AIDS home with them.[45] In most

cases, **Angolan** refugees were based in neighbouring countries such as **South Africa**, **Namibia** and **Zambia**, countries that are devastated by the disease. In the **DRC**, massive displacement and systematic rape during the last violence in 1998–99 have had a severe impact on HIV/AIDS infection rates in the country, and it is estimated that the disease has increased dramatically.[46] A high incidence of rape was also reported among **Somali** refugees in Kenya in 1993.

Often refugee communities can become centres of sex work. Sexual harassment and exploitation of mobile populations by soldiers and other armed groups is commonplace, and refugees and other forced migrants have little or no recourse to legal or social protection. UNAIDS, the Joint United Nations programme on HIV/AIDS concludes that war or violent conflict and forced migration promote increased sexual intimidation of women and states that "as physical, financial and social security erode in the refugee setting, women are often forced into high-risk sexual behaviour, by trading or selling unprotected sex for goods, services and cash, in order to continue their travel."[47] Furthermore, when refugees and IDPs return to their place of origin, women may find that the self-reliance and skills they acquired during displacement are viewed negatively. Younger women in particular may experience strong social pressures to conform to their pre-conflict roles, including early marriage and childbearing—often with men who continue to have multiple partners—thus putting them at risk of contracting HIV/AIDS.[48]

ARMED NON-STATE ACTORS AND THEIR IMPACT ON WOMEN'S VULNERABILITY TO HIV/AIDS

Armed groups such as paramilitaries and guerrillas may target women and girls during violent conflict. Research by Human Rights Watch into sexual violence against women in the **Eastern DRC** has highlighted that rape and sexual crimes are not just committed by armed factions but also increasingly by police and others in positions of authority and power.[49] These include opportunistic criminals and bandits, who take advantage of impunity and the culture of violence against women and girls forced to ally themselves with such groups, offering sex in exchange for protection or for economic remuneration.[50] In such situations, vulnerability to HIV may increase. Additionally, many rape survivors infected with the HIV virus have no recourse to justice and are unable to demand reparations and accountability from those who commit sexual crimes against them.

ADDRESSING AND COMBATING HIV/AIDS: TREATMENT, CARE AND SUPPORT

HIV/AIDS often spreads where there is a lack of security resulting from violence and conflict. An effective response demands an integrated multi-sectoral strategy focused on education, information and communication, training, care and protection. HIV/AIDS prevention requires a strategic focus on empowerment and redressing gender imbalances, reducing vulnerability of individuals, providing treatment and care including voluntary counselling in pre- and post-testing phases, monitoring and evaluating trends and progress, and building knowledge through education and information.

Partnerships and alliances of different types need to be developed as HIV/AIDS affects many different sectors. A key measure is to ensure that women have access to affordable reproductive health care including free condoms.[51]

The research and development of vaccines is also critical. For the last 15 years, international organisations, the pharmaceutical industry and others have been involved in such work. In addition there is ongoing research into the development of **microbicides**—substances applied in the form of creams or gels that could reduce the transmission of STIs, including HIV.[52]

Voluntary counselling and testing (VCT) and access to affordable and long-term treatment can be effective in preventing HIV transmission. It can also be an important entry point for treatment of related illnesses such as TB. The **World Health Organization (WHO)** recommends that VCT be introduced to serve people's overall sexual and reproductive health needs. In fact, results from two pilot projects in **Côte d'Ivoire** and **India** indicate that integrating VCT into sexual and reproductive health services can reduce the stigma associated with HIV/AIDS, strengthen healthy sexual behaviour and increase access to and use of services.[53]

3. WHO DESIGNS POLICIES AND PROGRAMMES TO ADDRESS AND COMBAT HIV/AIDS?

There are currently many organisations, governmental bodies and others involved in this field. The list below provides an overview of key entities, including UN agencies, regional institutions, international non-governmental organisations (NGOs) and bilateral development cooperation agencies.

THE UN FAMILY

UNAIDS is a joint response to HIV/AIDS. Established in 1994 by a resolution of the UN Economic and Social Council (ECOSOC) and launched in January 1996, UNAIDS is the main advocate for global action on the epidemic, leading responses aimed at preventing transmission of HIV, improving care and support, reducing vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic. UNAIDS guides global responses to AIDS through leadership and advocacy for effective action; provides strategic information to guide efforts against AIDS worldwide; tracks, monitors and evaluates the epidemic and responses to it; and promotes civil society engagement, partnership development, and mobilisation of resources.

The nine UNAIDS co-sponsors each have their own programmes and priority focus. They are United Nations Children's Fund,[54] World Food Programme,[55] United Nations Population Fund,[56] United Nations Office of Drug Control,[57] International Labour Organization,[58] United Nations Economic, Social and Cultural Organisation,[59] World Health Organization,[60] the World Bank,[61] and United Nations Development Programme.[62] In addition, United Nations Fund for Women (UNIFEM) has set up a web portal with information on a range of conflict-related issues, including HIV/AIDS.[63]

GOVERNMENTS AND DEVELOPMENT COOPERATION AGENCIES

The United States (US) government has several initiatives including ones led by the Global AIDS Co-ordinator and the Director of the Office of National AIDS Policy. It has provided an annual AIDS budget of US $2.4 billion that will be spent globally, primarily by the US Agency for International Development (USAID). Among the United Kingdom (UK) government initiatives to combat and address HIV/AIDS globally is the programme by the Department for International Development (DfID).[64] Canada also provides funding for HIV/AIDS globally; information can be accessed from the website of the Canadian International Development Agency (CIDA).[65] Information on Swedish support can be accessed from the website of the Swedish International Development Cooperation Agency (SIDA).[66] Information on the European Union (EU) initiatives can be accessed from their website.[67]

4. WHAT POLICIES EXIST TO ADDRESS HIV/AIDS?

The majority of key human rights or health-related declarations to emerge from the international community in the past two decades highlight the spread of HIV/AIDS and the need for integrated and concerted preventive measures. Those particularly related to women are noted below and can be used to strengthen advocacy strategies and hold governments accountable.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). While there is no mention of HIV/AIDS, as the disease was discovered after CEDAW was drafted, Article 12 addresses the area of health. CEDAW remains the most widely recognised convention on women's rights internationally. In 1990, the CEDAW Committee issued **General Recommendation on the Avoidance of Discrimination Against Women in National Strategies for the Prevention of AIDS**, which recommends that states that are parties to CEDAW make information more widely available to increase public awareness of the risks and effects of HIV infection and AIDS, especially to women and children.

The International Conference on Population and Development (ICPD). Section C, 7:30–33 of the Programme of Action (PoA) deals with sexually transmitted infections including HIV/AIDS. Section D calls on governments to mobilise all segments of society to control the AIDS epidemic. At the review session of the ICPD in 1999 (ICPD+5), the UN General Assembly (UNGA) agreed a new set of targets, including that by 2005 at least 90 percent of young women and men aged 15–24 should have

access to preventive methods to reduce vulnerability to HIV/AIDS infection, e.g. male and female condoms, voluntary testing, counselling and follow-up.

Fourth World Conference on Women: Beijing Platform for Action (BPFA): Strategic Objective C.3 under Health recommends that governments involve HIV positive and HIV affected **women living with HIV/AIDS (WLWHA)** in decision-making on development, implementation, monitoring and evaluation of policies and programmes on HIV/AIDS and other STIs. Governments should also review and amend laws and combat practices that may contribute to women's susceptibility to HIV infection and other STIs. At the Beijing +5 Review, the UNGA organised a special session entitled *Women 2000: Gender Equality, Development and Peace for the 21st century*. At this meeting, governments adopted *Further Actions and Initiatives to implement the Beijing Declaration and PFA*, including agreement to adopt measures to promote respect and privacy for, and non-discrimination against, those living with HIV/AIDS and STIs.

United Nations General Assembly Special Session on HIV/AIDS (UNGASS): In 2001, member states unanimously agreed to a *Declaration of Commitment on HIV/AIDS* to reduce infection rates by 25 percent by 2005, to end discrimination by challenging "gender stereotypes and attitudes" and to provide AIDS education to 90 percent of young people by 2005. Specific timelines and targets include the development and implementation of multi-sectoral national strategies and finance plans for combating AIDS by 2003. These should involve partnerships with civil society and the business sector and should include the full participation of PLWHA, including those in vulnerable groups and people most at risk, i.e. women and young people.

Other notable policies include the **Millennium Development Goals (MDGs)** in the *Millennium Declaration* agreed on at the Millennium Summit in 2000. Goal 6 deals with combating HIV/AIDS, malaria, and other communicable diseases and seeks to halt and reverse the spread of HIV/AIDS by 2015. **UN Security Council Resolution 1308, 1308 S/Res/1308** (2000), calls for national strategies addressing the spread of AIDS among uniformed services to be in place by 2003 and employment of uniformed personnel to conduct AIDS awareness and prevention training among their ranks. In response, an HIV/AIDS Awareness Card was produced for peacekeepers containing facts about HIV/AIDS, a Code of Conduct for Uniformed Services, prevention instructions and a sleeve to carry a condom.

Additionally, **Security Council Resolution 1325 (October 2000) on Women, Peace, and Security** requests the UN Secretary General to provide member states with training guidelines and materials on the protection, rights and particular needs of women. It also invites member states to incorporate these elements, as well as HIV/AIDS awareness training, into their national training programmes for military and civilian police personnel in preparation for participation in peace support operations. It also recommends special measures to protect women and girls from all forms of violence in situations of armed conflict, particularly rape, other forms of sexual abuse and gender-based violence.

At the regional level, notable policies developed include the *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases: Africa Summit on HIV/AIDS (2001)* and the *Communication from the Commission to the Council and the European Parliament. Programme for Action: Accelerated Action on HIV/AIDS, Malaria and Tuberculosis in the context of poverty reduction.*[68]

There are also a number of other initiatives, including **UNHCR 2002-2004 Strategic Plan on HIV/AIDS and Refugees**, which is based on a human rights framework and the US-led **ABC** approach: **A**bstain, **B**e faithful, and use **C**ondoms. For this approach to be effective in reducing HIV/AIDS, it needs to be supported by addressing issues of gender inequality, women's empowerment, and improved and increased access to affordable reproductive health, rights and services.[69]

The **World Health Organization's (WHO) 3x5 Initiative** is a joint WHO UNAIDS effort to provide anti-retroviral therapy to 3 million people with HIV/AIDS in developing countries by the end of 2005. It is based on the core principles of "urgency, equity, and sustainability."[70] Additionally, People Living with HIV/AIDS launched the Greater Involvement of PLWHA Initiative (GIPA) in 1983 to

protest their exclusion from the planning process. Since then the acronym GIPA has been agreed on and a set of five principles developed to support PLWHA. The GIPA principles are endorsed by the UN Declaration of Commitment (2001).[71]

5. WHAT HAS BEEN DONE AT THE LOCAL, NATIONAL, REGIONAL AND INTERNATIONAL LEVELS TO ADDRESS HIV/AIDS?

Some initiatives that address women's concerns regarding HIV/AIDS in both post conflict and peace are listed below.

GLOBAL

The **International AIDS Candlelight Memorial** is a global movement, involving over 1 million people in more than 3,000 communities, who each May celebrate those living with AIDS and those who have died as a result of the disease. Increasingly, the community organisers and principal subjects of the Candlelight Memorial are young women."[72]

UNAIDS Global Coalition on Women and HIV/AIDS was created by UN AIDS in February 2004. It is a movement of people, networks and organisations launched in London. It has four key goals: to raise the visibility of issues related to women, girls and AIDS; to catalyse action to address those issues; to facilitate collaboration at all levels; and to scale up action that will lead to concrete, measurable improvements in the lives of women and girls. The Coalition seeks to build global and national advocacy to highlight the effects of HIV and AIDS on women and girls and stimulate concrete, effective action.

Stepping Stones is an international initiative first developed in 1995 in **Uganda**. Since then it has been used by over 2000 organisations in 104 countries worldwide. The initiative targets young men and women to redefine gender norms and encourage healthy sexuality. Local groups have translated and adapted it for their own use in many different countries, including **Sri Lanka** (Sinhala), **Cambodia** (Khmer), **Russia**, **South Africa**, **Tanzania** (Ki-Swahili), **Argentina** (Spanish), and **Mozambique** (Portuguese). Stepping Stones is based on three principles: that the best solutions are those developed by people themselves, that men and women each need private time and space with their peers to explore their own needs and concerns about relationships and sexual health, and that behaviour change is much more likely to be effective and sustained if the whole community is involved. Stepping Stones works through individual groups of women or men of similar ages: older women, older men, younger women, and younger men.[73]

The **International Community of Women Living with HIV/AIDS (ICW)** is the only international network, representing 19 million women living with HIV/AIDS (WLWHA) in the world. The ICW was formed in 1992 by 52 WLWHA. Thirteen of the founding members are still alive. The network focuses on research, advocacy, capacity building and networking. Members include mothers, professionals, academicians, researchers, sex workers, injecting drug users, religious leaders, wives, partners, sisters, daughters, poor and rich women. ICW has 4000 members in over 90 countries.[74]

In April 2004, the United States and 15 other wealthy nations signed up to an international agreement to streamline HIV/AIDS programmes in developing countries so that funds can be more efficiently used. Donor nations and developing countries have developed three principles called the **Three Ones** to help streamline the international community's response to AIDS. These principles are: 1. One HIV/AIDS Action Framework to coordinate all involved parties, 2. One National AIDS Authority with a mandate that cuts across all sections of society, and 3. One Country-Level System that monitors and evaluates programmes. The US, Britain, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Japan, Luxembourg, the Netherlands, Norway, and Sweden have all signed this agreement.[75]

Increasingly there is a widespread effort to clarify incorrect beliefs about HIV/AIDS. One powerful way of doing this is by showing PLWHA as they really are—human beings from every walk of life who are learning to live with their diagnosis as well as their hopes and dreams. For example, **Photo-Voice**, a London-based NGO, worked with women in the **DRC** living with HIV/AIDS, teaching them how to take photographs of each other as a form of healing, a source of sustainable income and a coping mechanism for positive self-representation. These photographs were exhibited in London. Participants in this initiative are using their

skill to earn an income by taking photographs and recording the lives and memories of PLWHA.

There are countless national-level initiatives launched by governments and NGOs, often in partnership. For example, in **Guatemala APAES-Solidaridad**, an NGO founded in 1990, has trained several thousand teachers to provide information on HIV/AIDS to students. Solidaridad has also held seminars for both men and women in Guatemala's prisons and provides nutritional and medicinal programmes for patients and their families.[76] In **Cambodia, the Reproductive Health Association (RHAC)** runs voluntary counselling and testing programmes, raising awareness of the consequences of risky behaviour and contributing to the reduction of infection rates.[77]

In **Northern Tanzania**, after an influx of refugees and the accompanying health and social problems, a one-stop medical project was launched by the African Medical Research Foundation (AMREF), local civil society and government organisations. The project targeted primarily women but actively sought the involvement of male partners where possible. AMREF and its partners provided a variety of integrated services, including HIV testing, counselling, family planning, life education skills, and training culturally acceptable counsellors for the community outreach support of women and families that suffered from violence and abuse.[78]

In Freetown, **Sierra Leone**, the **Women in Crises** project has two drop-in centres where women and girls can learn how to protect themselves against HIV/AIDS.[79] In **Rwanda**, the Polyclinic of Hope established in 1995 addresses the medical, psychological and economic needs of women victims of rape and related crimes. The Centre provides HIV awareness programmes, testing, special care and support to victims of HIV.[80] Commercial sex workers who were the victims of the **Ethiopia-Eritrea** war benefited from an integrated programme of counselling, care and income generation.[81] And, as noted in the table below, there are also a number of private sector initiatives across Africa.

Private Sector Actor	Initiative
Eskom—a South African utility company	Implements a programme to upgrade the skills of medical practitioners in rural areas. Complements ESKOM's own in-house response to prevention, care and support activities.
Coca-Cola	Provides voluntary counselling, HIV testing and anti-retroviral therapy to all eligible employees.
Private Investors for Africa—a group of multinational companies, including **Barclays**, **Diageo**, **UNILEVER**, and others	Has created a Working Group on HIV/AIDS to better understand how joint action and shared experiences of the private sector and broader community can improve efficiency in addressing AIDS.
The Global Business Coalition on HIV/AIDS—an organisation of large multinational companies	Members of the Coalition must adopt a set of company principles and practices for dealing with HIV/AIDS including non-discrimination, prevention and awareness, VCT and care, support and treatment.
Merck and Company, the Bill and Melinda Gates Foundation, and the Government of Botswana	Have developed the African Comprehensive HIV/AIDS Partnership to scale up the country's national programme to provide ARV treatment.[82]

6. TAKING STRATEGIC ACTION: WHAT CAN WOMEN PEACEBUILDERS DO?

1. Women can lobby and advocate for the implementation of local, national, regional and global policies developed and adopted to address HIV/AIDS.

   • Develop alliances with men's groups in order to form a more powerful advocacy platform, e.g. examine the UN Declaration of Commitment (2001), identify which articles most respond to the needs of your community, and advocate for them, targeting local and national authorities.

   • Organise a policy dialogue between women's organisations and policy-makers in your country.

   • Set up a village or community AIDS Council that could have the following functions:

   - organising AIDS prevention efforts;

   - increasing access to health services; and

   - creating projects to re-educate the community in order to lessen stigma and discrimination.

2. Conduct assessment analyses to identify the sectors of the community most at risk and plan appropriate interventions. For example, if there are sex workers in the area, training and awareness-raising programs could be targeted at them.

3. Identify and include local men into the network of activists—and encourage men to initiate awareness-raising or training programmes among men in the community.

4. Link up with PLWHA groups to provide counselling services tailored to men, women, youth, children and older people. Develop an alliance and perhaps engage in a campaign for the inclusion of these groups in decision-making to address or combat HIV/AIDS.

   • Launch initiatives to unite orphans with other family members and relatives.

5. Reach out and work with refugee and IDP communities. Draw on Article 75 of the **Declaration of Commitment** (that focuses on emergency situations) to inform groups of their rights.

   • Make contact with your local, national or regional UNHCR office and other relevant policy-makers to generate support.

   • Provide basic services to AIDS victims. In **Uganda**, for example, PLWHA groups provide services to infected refugees and IDPs.

6. Focus on national policies and monitor the government's implementation of its international commitments and the time frames and targets they have set themselves.

   • Build the capacities and knowledge of members of your organisation to monitor commitments, lobby the government and launch public awareness-raising campaigns.

7. Develop an alliance with targeted businesses to secure funding for multi-sectoral initiatives on community information, education and communication.

8. Where peacekeeping operations are present, work with the Gender Units and HIV/AIDS Officers to educate, inform and raise awareness of HIV/AIDS issues among the peacekeeping personnel (both military and civilians) of these missions.

   • Reach out also to humanitarian workers and offer training workshops on addressing HIV/AIDS in a culturally appropriate manner.

9. Traditional healers, religious and even military leaders, and other such actors can play a role in changing perceptions, correcting false beliefs and addressing stigma and discrimination. Develop a project to build the capacity of such actors to become peer educators and champions to address and combat HIV/AIDS in your community.

10. Training is also an important issue. UNFPA is training health care providers and their families in the knowledge and skills needed to prevent the disease. You can engage in training local men and boys as well as security forces and the police in your country. Launch a programme to train and

educate demobilised soldiers—either on their own or if possible with their families—and include both men and women. Try to link up with local UNFPA offices and other agencies that fund and support such projects. Wherever possible, involve men as partners for change.

11. Counselling services: Integrate the prevention of HIV/AIDS infection with reproductive health, including family planning services.

    - Set up counselling services that are tailored to women and also to husband-and-wife teams to educate both women and men on HIV/AIDS.
    - Create polyclinics where counselling services and medical help are combined with economic support programmes to assist victims of rape and the HIV infected.

12. Condom provision: Launch a campaign to educate local women and adolescents as well as sex workers about the benefits of using female condoms if male condoms usage is low.

    - Launch promotional campaigns for condom distribution at parties, group discussions, local plays, etc.
    - Contact UNAIDS or any one of the individual UN partners for help in how to engage effectively.
    - Make condoms available to refugees and IDPs in food and non-food distribution centres.

13. Target and support refugee communities, providing basic health care as well as education, information and counselling about HIV/AIDS, free condoms, confidential testing and, if possible, medication.

14. Target commercial sex workers, combining income-generating projects with integrated counselling and information on HIV/AIDS prevention.

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ACRONYMS

ABC	**A**bstain, **B**e faithful, and Use **C**ondoms
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-Retroviral Drugs
BPFA	Beijing Platform for Action
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIDA	Canadian International Development Agency
DDR	Disarmament, Demobilisation and Reintegration
DFID	UK Department for International Development
DRC	Democratic Republic of the Congo
ECOSOC	Economic and Social Council
FGM	Female Genital Mutilation
GIPA	Greater Involvement of People Living With AIDS
HIV	Human Immunodeficiency Virus
HIV+	HIV-Positive Person
ICC	International Criminal Court
ICG	International Crisis Group
ICPD	International Conference on Population and Development
ICW	International Community of Women Living with HIV/AIDS
IDP	Internally Displaced Person
ILO	International Labour Organization
IOM	International Organization for Migration
IPAA	International Partnership on AIDS in Africa
MDGs	Millennium Development Goals
MSM	Men Who Have Sex With Men
MTCT	Mother-to-Child Transmission
NGO	Non-Governmental Organisation
OIs	Opportunistic Infections
PFA	Beijing Platform for Action
PLWHA	People Living with HIV/AIDS
POA	Programme of Action
PTCT	Parent-to-Child Transmission
RHAC	Reproductive Health Association, Cambodia
RHRC Consortium	Reproductive Health Response in Conflict Consortium
SIDA	Swedish International Development Cooperation Agency
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Economic, Social and Cultural Organisation
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commission on Human Rights
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
UNODC	United Nations Office of Drug Control
US	United States
UNSC	United Nations Security Council
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WBG	World Bank Group
WFP	World Food Programme
WHO	World Health Organization
WLWHA	Women Living With HIV/AIDS

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