

**\*DRAFT\***

**Vulnerability and Resilience:  
Gender and HIV/AIDS in Latin America and the Caribbean<sup>1</sup>**

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## Introduction

The most striking characteristic of the HIV/AIDS epidemic in Latin America and the Caribbean (LAC) is its diverse nature. Epidemiological data indicate that the levels of infection and patterns of spread are more varied in the LAC region than in any other geographical region of the world (PAHO/WHO/UNAIDS 2001). As a result, the overall regional rate of infection tends to mask the complexity and diversity of the multiple HIV/AIDS epidemics in the region<sup>2</sup>.

Despite this diversity, sexual transmission of HIV is the most common mode of transmission across the region. Homosexual transmission of infection dominates in Mexico and Costa Rica, while heterosexual transmission is overwhelmingly responsible for the spread of infection in many other countries in the region. In Brazil, which has the largest number of people living with HIV in LAC, the vast majority of early infections occurred among men who have sex with men. That picture has changed dramatically in recent years; unprotected sex between women and men now accounts for more HIV infections than ever before (PAHO/WHO/UNAIDS 2001).

The increasing number of HIV infections due to unprotected heterosexual interactions has put women directly in the path of the virus. It was estimated that by the end of 1999, 25 and 37 percent of HIV positive adults were women in Latin America and the Caribbean, respectively (UNAIDS 2000). Just two years later, the proportion of HIV cases among women was estimated at 30 percent in Latin America and 50 percent in the Caribbean (UNAIDS/WHO 2001), underscoring women's vulnerability in the epidemic.

For more than a decade it has been recognized that gender plays a significant role in both the heterosexual and homosexual transmission of HIV. It is also known that gender greatly influences the differential experiences of women as compared to men who are infected with or affected by HIV/AIDS. Hence, HIV/AIDS prevention, treatment, care, and support programs and policies must take gender-based experiences and differences into consideration in order to be effective.

This paper examines the ways in which gender norms and ideals in the LAC region increase women's *and* men's vulnerability in the HIV/AIDS epidemic. The paper is divided into two sections. The first section focuses on the gender-related factors - sociocultural and economic - that contribute to women's and men's vulnerability to infection and their access to treatment, care, and support services. The second section reviews and recommends programmatic and policy interventions to reduce gender inequalities and modify the gender norms that fuel the spread of the epidemic in the region.

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<sup>2</sup> An epidemiological overview of the HIV/AIDS epidemic in each sub-region, with sex differentials in the prevalence, is provided in Annex 1.

## **Gender-Related Factors Contributing to Women's and Men's Vulnerability**

Gender is defined as the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics and roles. It is a social and cultural construct that defines women's and men's responsibilities and the way in which women and men interact with each other. Typically, gender norms ascribe greater access to productive resources and decision-making authority to men as compared to women, which results in an unequal balance in power in gender relations that favors men.

The inequality evident in gender relations that provides men with greater access to economic resources, is often replicated in heterosexual interactions. Male pleasure supercedes female pleasure and men have greater control over their sexuality than women do. Sexuality is the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is a multidimensional and dynamic construct. Explicit and implicit rules imposed by society, as defined by one's gender<sup>3</sup>, profoundly influence an individual's sexuality (Zeidenstein and Moore 1996; Dixon Mueller 1993; Parker and Aggleton 1999).

Power is fundamental to both sexuality and gender. The power underlying any sexual interaction, heterosexual or homosexual, determines whose pleasure is given priority and when, how, and with whom sex takes place. The balance of power in any sexual interaction determines its outcome (Rao Gupta 2000). An understanding of individual sexual behavior or sexual risk thus necessitates an understanding of gender and sexuality as constructed by a complex interplay of sociocultural and economic forces that determine the distribution of power.

### ***Sociocultural Factors***

Gender norms that create an unequal balance of power between women and men are deeply rooted in the sociocultural context of each society (Wingood and DiClemente 2000). By defining the societal ideals for feminine and masculine behavior and sexuality, sociocultural factors greatly affect women's and men's access to information and services, their sexual behavior and attitudes, and how they cope with illness once infected or affected. This section reviews how cultural prescriptions in the LAC region for masculinity and male sexuality (i.e. the dominant culture of *machismo*) and for femininity and female sexuality (i.e. the culture of *marianismo*) influence both men's and women's vulnerability in the HIV/AIDS epidemic by affecting what women and men know, their sexual communication and behavior within relationships, and their ability to access resources and services when infected or affected by HIV/AIDS.

*Marianismo* defines the role of the ideal woman as modeled after the Virgin Mary, with chastity, virginity, subordination, moral superiority, obedience, and spirituality as key

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<sup>3</sup> Other factors, such as age, economic status, and ethnicity influence sexuality. However, this paper focuses on the interrelationships between gender and sexuality.

virtues (Gil and Inoa-Vasquez, 1996 as cited in Ortiz-Torres et al. 2000; Stevens 1973). *Machismo*, in contrast, characterizes the male role in Latin society in terms of virility and sexual prowess, independence and physical strength, courage, aggression and domination, and invulnerability (Carrier 1995; Ramirez 1993 cited in Ortiz-Torres et al. 2000). Interestingly, a macho man is defined by what differentiates him from women and from homosexual men (Prieur 1998; Gutmann 1996). Thus, as Prieur (1998) explains, “masculine domination, feminine subordination, and the degradation of homosexuals, are related.”

A central characteristic of masculinity is heterosexuality. It is believed that a man’s body is made to penetrate. To be the passive partner in a sexual interaction is to be a woman. As a result, the active male partner in a homosexual interaction maintains his masculinity while the passive partner is demeaned for being female. Different studies verify that men use homosexual practices to reaffirm their heterosexuality (Izazola 1994; Parker 1991; Murray 1995) and as a result do not identify themselves as homosexual or bisexual. The ideology of *machismo* thus validates heterosexuality and tacitly supports homophobia and sexism (Kaufman 1987; Marques 1997; Kimmel 1997).

Although *machismo* and *marianismo* are the two dominant ideologies that define male and female roles in the region, it is important to remember that, in reality, there are many kinds of masculinity and femininity in each society that vary by social class, ethnicity, sexuality, and age. Increasingly, therefore, the vast body of literature on sexuality and gender identities refers to multiple forms of masculinity and femininity (UNAIDS 2001; Mane and Aggleton 2001). It is also now recognized that the multiple forms of masculinity and femininity are dynamic, subject to change, constructed through social interaction, sustained and enacted not only by individuals but also by groups and institutions (Rivers and Aggleton 2001; Gutmann 1996).

As Aggleton (2001) points out, this more nuanced understanding of masculinity and femininity is very useful in terms of HIV prevention. If masculinities are constructed and dynamic, for example, then modifications in gender identities may be possible over time. Additionally, the presence of multiple masculinities offers hope that there are other masculinities that exist that are more useful in promoting gender equitable relationships and safer sex than a more damaging dominant model that emphasizes aggression and dominance.

Despite the existence of multiple masculinities and femininities in the LAC region, the ideals of *machismo* and *marianismo* dominate, making men (both heterosexual and homosexual) and women more vulnerable in the HIV/AIDS epidemic. Some of the different ways in which these ideologies manifest and influence women’s and men’s vulnerabilities are described below.

Knowledge of Sex and HIV Risk: The ideology of *marianismo* dictates that “good” women should be ignorant about sex and passive in sexual interactions (Paiva 1993; Stevens 1973). In a study in Guatemala, for example, male and female respondents felt that women should be uninformed about sexual matters. They reported that an unmarried woman who knows about sex is viewed suspiciously (Bezmalinovic et al. 1994). Not

surprisingly, then, studies conducted in Brazil and Jamaica found that young women knew little about their bodies, pregnancy, contraception, and STDs (Vasconcelos et al. 1995; Wyatt et al. 1995). A more recent analysis of levels of knowledge about HIV/AIDS prevention in 23 developing countries, found that levels of knowledge are almost always higher among men than among women, with 75 percent of men, on average, having accurate knowledge about HIV/AIDS transmission and prevention as compared to roughly 65 percent of women (Gwatkin and Deveshwar-Bahl 2001). Within the LAC region the greatest differences between the levels of knowledge of men and women occur in Peru (12.7percent), Nicaragua (8.9percent) and the Dominican Republic (7.8percent). The smallest difference occurs in Brazil (1.9percent).

Ignorance about sex, reproductive anatomy, and HIV prevention increases women's vulnerability to HIV infection because it makes it difficult for women, particularly young women, to be informed about risk reduction. Some studies have shown that a lack of knowledge or incomplete knowledge also fosters the development of fears and myths about condom use. For example, in studies conducted in Brazil and Jamaica, some women reported not liking condoms because they feared that if the condom fell off inside the vagina it could get lost or travel to the throat, or that a woman's reproductive organs would come out when the condom was removed (Goldstein 1995; Wyatt et al. 1995). Even when a woman is informed or has accurate information about sex and HIV prevention, the societal expectation that a woman, particularly a young woman, should be uninformed makes it difficult for her to be proactive in negotiating safer sex. As Paiva (1993) found from her research on adolescents in Sao Paulo, Brazil, to be a woman is to be "naturally more fragile, less aggressive and more able to control the sexual drive." The norm for women to be naïve and never take the initiative in sexual interactions acts as a significant constraint to their ability to introduce the topic of safe sex, including condom use in sexual interactions.

Simultaneously, prevailing norms of masculinity expect men to be more knowledgeable about sex. In a study conducted in Guatemala, for example, respondents believed that men should be more knowledgeable and experienced in sexual matters and serve as women's teachers (Besmalinovic et al. 1994). Studies from other countries in the region revealed that among youth who had not undergone sex education, boys were more likely than adolescent girls to know how to use a condom properly, and to recognize the symptoms of STDs (Morris et al. 1987; Castellanos et al. 1989). Adhering to the gender-based expectation to know more, puts men, particularly young men, at risk of infection by preventing them from seeking information or admitting their lack of knowledge about sexual matters (Paiva 1993, World Bank 2001). It has been noted that many men as a result have erroneous information about sexual and reproductive health (Barker and Lowenstein 1997).

Fidelity versus Multiple Partnerships: The dominant ideal of femininity emphasizes uncompromising loyalty and fidelity in partnerships. It is this ideal that distinguishes a "good" woman from a "woman of the street" and defines sexual practices linked to reproduction as moral while those that are linked to pleasure as immoral. Overall, women

are expected to engage in sexual interactions to please their male partners and are not supposed to know enough about sex to enjoy it (Goldstein 1994).

In sharp contrast, it is believed that sexual release is essential for men and therefore, variety in sexual partners is essential to men's nature as men (Paiva 1993; Goldstein 1994; Weiss et al. 1996; Rao Gupta 2000). Results from sexual behavior studies from around the world indicate that heterosexual men, both married and single, as well as homosexual and bisexual men, have higher reported rates of partner change than women (Jenkins et al. 1995; Orubuloye et al. 1993; Sittitrai et al. 1991). This finding is supported by several studies conducted on Latino and Caribbean populations. For example, in a study on Haitian women in Florida, 95 percent of women reported currently being in a committed relationship with a single partner, but only 5 percent believed that their current partner was monogamous (Malow et al. 2000). Multiple partnerships and unofficial polygamy were described by this study and others as accepted behaviors for men within Haitian culture, as a way for men to prove their sexual prowess and virility (Foreman 1998; Malow et al. 2000). A World Bank (2000) report on HIV/AIDS in the Caribbean states that to prove their machismo, many men in Caribbean countries, as elsewhere in the region, engage in sex with multiple partners. In another study, focus group discussions with Jamaican working women revealed that they were very concerned about the infidelity of their male partners but felt that the trying to achieve male monogamy was "pie in the sky" (Wyatt et al. 1995).

Recognition and condoning of multiple sexual partnerships for men but not for women begins during adolescence. In a study of Brazilian teenagers, Paiva (1993) found that there is a strong belief among adolescent boys that not having sex for a long time is harmful and that infidelities among men are "natural." This double standard for sexual behavior – that men are sexual beings and women ought not to be – seriously challenges the effectiveness of HIV prevention efforts that expect women to negotiate the use of a condom or refuse unsafe sex, and expect men to be faithful and reduce the number of sexual partners (Rao Gupta 2000). It underscores the need for HIV/AIDS prevention efforts to attempt to change the gendered norms of sexuality, if they are to be effective.

Virginity and Motherhood: The strong norm of virginity for unmarried girls and of motherhood for married women that exists in many LAC countries constrains women's ability to protect themselves in the epidemic and exposes them to risk. Adolescents in Recife, Brazil, reported that there are many negative repercussions of losing one's virginity, including hurtful gossip, pressure from boys to have sex, and being socially ostracized (Vasconcelos et al. 1995). In addition, the erotic imagery that surrounds the passivity and innocence of virginity also puts young women at risk of sexual coercion and rape.

Although delayed sexual debut is a legitimate core element of many HIV prevention efforts for adolescents, it is important to note that the severe negative sanctions associated with the loss of virginity, paradoxically, increase young women's risk of HIV infection in many ways. For example, the strong sanctions associated with virginity restrict young unmarried women's ability to ask for information about sex or reproductive health services out of fear that they will be thought to be sexually active. Adolescent girls in

Brazil noted that they are afraid to access gynecological services. As one of the girls in this study said, *“Imagine if I ask my mother to take me to a gynecologist! She will say I am no longer a virgin”* (Vasconcelos et al. 1995).

Research also shows that when virginity is highly valued, some women will practice alternative sexual behaviors to preserve their virginity, even though these behaviors may put them at increased risk of HIV infection. Reports from Brazil and Guatemala suggest that anal sex is practiced among unmarried couples to prevent pregnancy and safeguard the woman’s virginity (Vasconcelos et al. 1995; Goldstein 1994; Bezmalinovic et al. 1994). In a paper that highlights the risk posed by anal sex among heterosexuals in Brazil, Halperin (1998) points out that anal sex is much more common among heterosexual couples than previously known. He cites the results of a household survey done in Brazil that found that over 40 percent of rural dwellers and 50 percent in the urban area of Rio de Janeiro considered anal sex a normal part of sexuality. Both Halperin and Goldstein (1994) found that in addition to serving contraceptive purposes and the preserving of virginity, anal sex is preferred by men because it is the “conquering of a second virginity.” The prevalence of anal sex as a sexual practice is of concern given that the efficiency of HIV transmission is significantly greater for unprotected anal than vaginal or oral sex (Padian et al. 1997; Voeller 1991).

More recent research on the norm of virginity in Latin America notes a shift in young people’s attitudes toward premarital sex. Studies from Chile and Costa Rica on the attitudes and behaviors of adolescents found that there is a “rupture in the salience of virginity” as a normative ideal for adolescent girls (Dowsett et al 1998). The authors attribute this change to an increasing sexual assertiveness by young women and the acceptance by some young men of more equitable gender roles for women (for example, defending women’s right to be employed). It is notable, though, that these changes have not created a dent in other attitudes about gender roles, such as women’s ‘natural’ inclination to get married and have children, and men’s ‘natural’ need to be sexually assertive.

Data also indicate that despite the norm of virginity, young women and men are having sex early in their teens. A study in Venezuela showed that one quarter of young people had sex for the first time between the ages of 10 and 14 and another two thirds had sex for the first time while still in their teens while a similar study in Mexico showed that by the age of 18 half of the men and one-fifth of the women said they had already had sex (PAHO/WHO/UNAIDS 2001). Similar results have been reported from Peru, Colombia, and El Salvador (Soto 1998; Fajardo et al. 1998; PAHO/WHO/UNAIDS 2001). Young people in the Caribbean appear to initiate sex at a particularly young age. Studies conducted between 1990 and 1999 in Barbados, Jamaica, Trinidad and Tobago showed that the median age at first sex ranged between 13 and 15 years, with the median age for males being lower than that for females (Walrond et al. 1992; Ministry of Health, Jamaica 1994; National AIDS Program, Trinidad and Tobago 1995; Allen et al. 2000).

In many cultures in the region, motherhood, like virginity, is considered to be a feminine ideal (Paiva 1993; Carovano 1991). Children provide a social identity for many women (UNAIDS 1999). In addition, data from many countries in the region point to the

economic realities that reinforce the value of motherhood for women (Malow et al. 2000; Le Franc et al. 1996; Fitzgerald et al. 2000). In Jamaica, for example, women have children to guarantee economic support from the father (Le Franc et al. 1996; Handwerker 1992) and for Haitian women, children serve as economic security in old age (Malow et al. 2000). These social and economic realities pose significant hurdles for women in HIV risk reduction because the use of condoms or the adoption of other safer sex options prevents conception.

Sexual Experience: Just as the societal pressure to be virgins and mothers influences women's vulnerability to HIV, social norms that expect men to be sexually experienced before marriage put men at increased risk of infection. Such norms pressure men into experimenting with sex in unsafe ways, and at a young age, to prove their manhood (Rao Gupta 2000). In a study on university students in Colombia, for example, the majority reported between one and four lifetime partners but only one quarter reported frequent condom use (Fajardo et al. 1998). In addition, 45 percent of the young men in this sample said that they had sex with a prostitute at least once.

In creating a case for the need to understand the role of men's vulnerabilities in fueling the HIV/AIDS epidemic, Mane and Aggleton (2001) point out that "cultural and societal expectations and norms create an environment where risk is acceptable, even encouraged for 'real' men." As a result, men are less likely to seek health care than women and are much more likely to engage in risk behaviors such as engaging in unsafe sex, drinking, using illegal substances, or driving recklessly (Luck et al. 2000). In addition, many men are socialized to be self-reliant, not to show their emotions, and not to seek assistance in times of need or stress (WHO 1999). This expectation of invulnerability associated with being a man runs counter to the expectation that men should protect themselves from potential infection and encourages the denial of risk.

Sexual Domination, Homophobia, Stigma, and Violence Against Women: As mentioned earlier, the ideals of *machismo* emphasize sexual and physical domination over women as a defining characteristic of manhood. Thus, to be the passive partner in a sexual interaction is to be a woman. As a result, in a homosexual interaction the passive partner is stigmatized as being homosexual while the active partner is viewed as being a man. As Parker and Aggleton (1999), in their analysis of Brazilian sexual culture point out, this seriously limits the effectiveness of HIV/AIDS prevention efforts that seek to target homosexual men because such efforts fail to reach those men who play an active role in homosexual interactions but have a heterosexual identity. Such a sexual culture contributes to homophobia, and by stigmatizing homosexuality, encourages the denial of risk among men who have sex with men.

Another disturbing outcome of the emphasis of sexual and physical domination of women as central to masculinity is violence against women. In population-based studies conducted worldwide, anywhere from 10 to 50 percent of women report physical assault by an intimate partner, and one-third to one-half of physically abused women also report sexual abuse (Heise et al. 1999). For example, in Monterrey, Mexico, 52 percent of physically abused women had also been sexually abused and in Leon, Nicaragua, among 188 women who were physically abused, only five were not also abused sexually,

psychologically, or both (Ellsberg et al. 1999; Granados 1996). Moreover, most women who reported experiencing physical violence had been abused more than once (Heise et al. 1999).

The pervasiveness of violence has significant implications for HIV prevention. Research conducted in countries as diverse as Jamaica, India, Guatemala, Papua New Guinea and Haiti found that fear of violence acts as a significant barrier to women negotiating condom use or fidelity with their partners (Le Franc et al. 1996; George and Jaswal 1995; Bezmalinovic et al. 1994; Jenkins et al 1995; Malow et al. 2000). The threat of violence constrains women's ability to leave relationships that they perceive to be risky (Rao Gupta and Weiss 1993). Fear of violence can also limit women's use of HIV/AIDS counseling and testing services (Temmerman et al. 1995) and inhibit women's disclosure of their serostatus. In a study conducted in Tanzania among women who sought HIV testing and counseling services, more than half of the women who did not disclose their status to their partner reported fear of a violent reaction as the reason why they did not do so (Maman et al. 2000). These findings suggest that domestic violence should be considered when formulating partner notification policies and HIV counseling protocols.

In studies in Africa, the stigma associated with HIV/AIDS and the fear of violence that results have also been found to be barriers to the success of efforts that seek to reduce the perinatal transmission of HIV. Fear of stigma and domestic violence are important reasons that pregnant women refuse HIV testing or do not return for test results (Maman et al. 2001). Similar concerns have been voiced by HIV-positive women who have been advised to bottle-feed their babies to avoid the risk of HIV transmission (Brown 1998). Because breast-feeding is the norm in many African societies, women feared that using a bottle would brand them as being HIV-infected and expose them to the stigma and violence that often results. A study in Botswana showed fear of violence and stigma were the foremost reasons women declined to participate in voluntary counseling and testing or programs to prevent mother-to-child transmission (Nyblade and Lyn Field 2000). Such factors may also constrain women's use of VCT in LAC.

Traditional notions of male and female roles appear to foster violence against women. In the LAC region several authors cite *machista* values as an underlying cause of violence against women (Barker and Lowenstein 1997; Kaufman 1989; Montoya 1998). For example, a study household survey administered to a sample of 749 Brazilian men between 15-60 years of age found that men who believed in traditional gender roles for women and men and strongly agreed with statements such as "women's most important role is to take care of the family" and "men should have the final word in household decision making," were significantly more likely to report physical abuse of partners and lack of condom use (Pulerwitz et al. 2002). Similarly, a national survey of adolescent males aged 15 to 19 in the U.S. found that young men who adhered to more traditional views of manhood were more likely to report violence (Courtenay 1998).

The nexus between violence, risky behavior, and reproductive health has been documented by a number of researchers. In a review of the literature on sexual and physical violence, Heise et al. (1999) found evidence that individuals who have been

sexually abused as children are more likely to engage in unprotected sex, have multiple partners, and trade sex for money or drugs. This relationship is also apparent from the results of a study conducted in India in which men who had experienced extramarital sex were 6.2 times more likely to report wife abuse than those who had not. In addition, men who reported symptoms of sexually transmitted diseases were 2.4 times more likely to abuse their wives than those who did not (Martin et al. 1999).

The experience of gender-based violence has also been found to be a strong predictor of HIV. In a study conducted in Tanzania among women who sought services at a voluntary HIV counseling and testing center, younger HIV-positive women (aged 18-29 years) were almost 10 times more likely to report partner violence than similarly aged HIV-negative women (Maman et al. 2000).

The close relationship between women's subordinate status in society, their experience of violence, and HIV/AIDS is most vividly described through the findings of a small qualitative study on 13 sex workers in San Jose, Costa Rica (Downe 1997). Despite the fact that sex work is legal in Costa Rica, sex workers are marginalized and stigmatized for being the vectors of HIV infection, and experience violence as a daily threat in their lives. Because of the link between their role as vectors of HIV disease and their experience of violence, the sex workers who were interviewed did not distinguish between violence and HIV/AIDS. For them the two were related cognitive concepts. They described violence to be a disease, "contagious, caused by a germ, passed from one man to another, and closely related to other diseases including HIV/AIDS." By describing the spread of HIV infection as intricately linked to their own lack of power in society and their daily experiences of violence, these sex workers intuitively understood the gender-based roots of the epidemic which only recently became accepted in public health discourse.

### ***Economic Factors***

Strong evidence establishes the direct links between women's low economic status and HIV exposure. Methodologically, the most rigorous research establishing these links comes from the United States. One notable study conducted on a random probability sample of 580 women showed that women with lower incomes were less likely to use condoms than those with higher incomes (Peterson et al. 1992). A similar study established that women who had less than a high school education were less likely to use condoms (Anderson et al. 1996). Research in the U.S. has also conclusively established the link between unemployment or underemployment and HIV risk. For example, a study that compared women who were employed to those who were on welfare, found that the latter were three and a half times more likely to never use condoms (Wingood and DiClemente 1998). These studies highlight the importance of reviewing women's economic status in order to accurately assess vulnerability to HIV in any region.

The U.S. research is strongly supported by smaller, mostly qualitative studies conducted in Latin America and the Caribbean that have identified several ways by which the economic vulnerability that women face, and their dependency on their male partners for economic survival, create fertile ground for vulnerability to HIV infection.

Women's economic status in the LAC region, overall, has shown some improvement in the past decade with the closing of the gender gap in primary and secondary education and economic growth. Today there is increased participation of women in the labor market and the number of women earning an income has increased dramatically. Yet, 30 to 70 percent of women in the region are in insecure jobs in the informal sector and even those that are employed in the formal sector earn less than men. Occupational segregation also persists, with women employed in much larger numbers as teachers, office assistants, and domestic help than men (UNIFEM 2000; Deutsch et al. 2001). Within countries there are also sharp differences among women based on ethnicity, race, and socioeconomic status. Labor market challenges, such as unemployment, wage gaps, and occupational segregation, are greater for poor and indigenous women, as well as those of African descent (IDB 1998).

Sex as a Marketable Commodity: Poor women in the region, as in most other regions, are much more likely to sell or exchange sex as a way to earn money or gain economic stability. Poverty and a lack of economic alternatives have repeatedly been identified as the reasons that many adult women and children become sex workers (Burgos 1999; ILO 1998).

Although commercial sex work is the most common way for women to exchange sex for money, there are a range of other types of "transactional" sexual partnerships, that are not identified as sex work, that women use as a rational means to make ends meet. For example, in Jamaica, it is fairly common for women to take on several sexual partners in what are called "visiting unions," as a survival strategy. The children born from these unions are more likely to be economically stable because of the presence of multiple fathers, each of whom is then responsible for the woman and her children (LeFranc et al. 1996).

Multiple fathers as an economic strategy were also reported in a study conducted with women in Haiti's rural Artibonite Valley, where HIV/AIDS is rapidly spreading among the poor (Fitzgerald et al. 2000). Faced with trying to balance the multiple demands of family and economic survival, single mothers in this rural context often enter into a series of sexual relationships, call *plasaj*, in order to obtain food and housing for themselves and their children. Data from this study showed that of the 476 women included in the sample, one third reported entering a sexual relationship out of economic necessity, and of these, 95 percent had children by multiple fathers. The study also confirmed that women who entered a sexual relationship out of economic necessity had increased odds of having syphilis and HIV infection.

In the LAC female headed households are common, ranging from 17 percent of total households in Mexico to 39 percent in Haiti (PRB 2002). These households are significantly disadvantaged in access to key productive resources and economic assets and, thus, are more vulnerable to HIV infection and less able to deal with the consequences of infection, illness, and death (Deutsch et al 2001). Therefore, addressing

the particular vulnerabilities faced by single mothers and other women heads of household is critical to containing the epidemic in this region.

Another notable trend is the number of young women who have sex with older men for security at times of economic upheaval (Zelaya et al. 1997) or, as is more common in the Caribbean, for material goods and gifts. In Trinidad, for example, according to a 1995 survey of men and women aged 15 to 24, 28.5 percent of girls said they had sex with older men in exchange for gifts such as clothes and cosmetics (National AIDS Programme, Trinidad and Tobago 1995). A similar pattern was detected in Tobago where young women revealed that they are attracted to older men who drive cars and have the money to buy them fast food and clothes (National AIDS Programme, Trinidad and Tobago 1995). This is a troubling trend because unprotected sex with older men is riskier than sex with same age partners. Older men are likely to have had more previous sex partners and, therefore, are more likely to have been exposed to HIV and other sexually transmitted infections.

Lack of Economic Leverage: Women who are economically vulnerable are less able to negotiate the use of a condom or fidelity with a non-monogamous male partner or less likely to leave relationships that they perceive to be risky because they lack the bargaining power and fear abandonment and destitution. Studies conducted in Mexico and on Haitian women migrants in Florida found that women in long-term relationships perceive the negative consequences of leaving high-risk relationships to be far more serious than the health risks of staying in the relationship (Morris et al. 1987; Malow et al. 2000). Similarly, a study on women who work as small-scale traders and garment factory workers in Jamaica found that women cannot “afford” to consider the possibility of terminating high-risk relationships or negotiating condom use because they fear it will result in losing their primary source of income – their male partners (Le Franc et al. 1996). Interestingly, these women subscribe to prevailing gender norms by viewing their own incomes as supplementary to that of their male partners. The researchers found that since these unions typically are fragile and susceptible to dissolution, the women find themselves in a cycle of serial relationships that are high risk and motivated by the need to supplement their incomes.

Young women bear a double disadvantage in accessing economic resources and negotiating the use of a condom – they are young and they are women. Studies conducted in Peru and Dominican Republic show that adolescent girls reported using condoms far less often than adolescent boys. In Peru, 50 percent of sexually active boys compared to 70 percent of sexually active girls had never used a condom (Soto 1998). The gender difference was even greater in the Dominican Republic where among sexually active 13 to 24 year olds, close to half of the men said they had used a condom the last time they had sex while just 17 percent of women said the same (PAHO/WHO/UNAIDS 2001).

Lack of Access to Information: Women and men who are economically disadvantaged are less likely to have information about HIV/AIDS than those from higher income levels, and are therefore likely to be more vulnerable to infection. A recent analysis conducted by Gwatkin and Deveshwar-Bahl (2001) shows that knowledge of HIV/AIDS

prevention is distinctly higher among the better-off than among the disadvantaged in almost every country with available data. Moreover, regional comparisons revealed that in the lowest socioeconomic groups, knowledge was found to be higher in sub-Saharan Africa (62percent) than in Latin America and the Caribbean (52percent).

As mentioned earlier, this analysis also found that levels of knowledge about HIV/AIDS are almost always higher among men than among women. A closer examination also reveals that gender differences are approximately the same at all socioeconomic levels (about 8 percentage points), except in the lowest quintile where the difference between men and women's knowledge increases to 11 percentage points. This holds equally true for Latin America and the Caribbean as it does for Sub-Saharan Africa (Gwatkin and Deveshwar-Bahl 2001).

The Impact of Migration: Poverty and the lack of economic opportunity make it more likely that both women and men will migrate in search of income and employment, which can destabilize and disrupt stable social and familial relationships and expose both men and women to increased risk of infection. Moreover, in most settings, migrant populations are more likely to be socially marginalized, with restricted access to economic assets and information and services.

Research from Africa has shown that rural-to-urban migration of men leads them to form new sexual networks in areas where an unequal ratio of men to women and a higher seroprevalence rate is likely to make men more vulnerable to infection (Bassett and Mhyloyi 1991; Sanders and Sambo 1991). Men from Mexico and countries in Central America who migrate in large numbers to the United States, as farm labor or factory workers, face similar risks. Further, because most men who are engaged in seasonal migration often return home to their country or community of origin, the vulnerability of their female partners who are left behind is significant. The possibility that HIV/AIDS will be transmitted to these women, even when they themselves are monogamous, is very high. As a study in rural Mexico demonstrates, the situation is further exacerbated by the fact that wives and other long-term sexual partners of migratory workers find it extremely difficult to insist on the use of condoms when their men have been away for so long working hard to send money home (Salgado de Snyder et al. 1996 as cited in Haour-Knipe et al. 1999).

The demand in the United States and other industrialized countries for women workers from the LAC region for factory work, seasonal agricultural labor, and domestic help, puts women in a similar situation of vulnerability. Being far away from home makes it likely that they will establish new sexual networks or engage in multiple partnerships for economic gain or security. Young women workers are also more likely to initiate sex early and engage in risky sexual interactions than if they had been close to home. For example, one of the significant risk factors for Haitian women who migrate in the harvesting season to work in the *bateyes* (sugar plantations) in rural Dominican Republic was that they migrated without their partners (Brewer et al. 1998). The root of their risk, as single mothers, often is to exchange sex for money or goods.

The Impact of Ethnicity and Race: Gender intersects with ethnicity and race to create multiple vulnerabilities for those who belong to marginalized ethnic and racial minorities. In the LAC region, there are large gaps in terms of schooling and employment opportunities between those who belong to racial and ethnic minorities and those who do not (Florez et al. 2001). Ethnic and racial minorities are also disproportionately represented among the poor in the region. With less economic opportunity and hope, individuals from minority groups are more likely to resort to risky behavior such as injecting drug use or exchanging sex for a means to survive (PAHO/WHO/UNAIDS 2001). Socially and economically marginalized populations typically also have less access to health information and services, increasing their vulnerability of contracting illness and reducing the chances that illness will get adequately treated (e.g. Gomez and VanOss Marin 1996; Brewer et al. 1998).

HIV prevalence rates among ethnic or racial minorities is usually politically sensitive and as a result very few countries in the LAC region have data on the extent of the concentration of infection in such populations or the reasons for it. A recent report from PAHO, WHO and UNAIDS (2001) underscores the paucity of data but also suggests that there is a rapid rise of HIV/AIDS cases among ethnic minorities.

Coping with the Socioeconomic Impacts of the Epidemic: Gender also affects the way in which women and men are affected by the economic impacts of the epidemic and the extent to which they are able to access services for care, support, and treatment. Much of the gender-related research on these issues has been conducted in sub-Saharan Africa where the prevalence rates are staggeringly high and the economic impacts of the epidemic are more visible than in countries in the LAC region. Much of that research shows that women are disproportionately affected by the epidemic. For example, girl children are much more likely than boys to be pulled out of school to help with the care of an HIV-infected household member or to fill the gap in food production or income (World Bank 1997). In such circumstances, girls may be particularly vulnerable to being forced to barter sex for cash or other resources, substantially increasing their risk of infection.

Since traditional gender norms often cast women as the primary caretakers of children, the elderly and sick, the burden of caring for household members who are infected with HIV or for orphaned children often falls on women. From high prevalence settings it is known that the combined physical and emotional burdens of caring for sick family members and ensuring food security under harsh economic conditions, often takes a toll on women's own health and well being (Danziger 1994).

The economic vulnerability of women also exposes them to graver consequences when faced with the stigma and discrimination typically associated with being infected or affected by HIV/AIDS (e.g. Le Franc et al. 1996). When faced with the social ostracism and abandonment that often result, such women often face tragic consequences because they lack the necessary economic resources to cope.

Access to and Use of Services and Treatments: Economic factors also affect women's access to and use of services. Research has shown that due to economic constraints such as the lack of money to pay for services or transportation, or the high opportunity costs of lost time, women face significantly greater barriers than men in accessing health services and treatments in general (Moses et al. 1992; Leslie and Rao Gupta 1989). As a result, the formidable cost of HIV/AIDS treatments in most developing countries, even for women in higher income groups, are more likely to constrain women's access than that of men.

Most of the research in the LAC region on gender differentials in the use of HIV/AIDS testing and treatment services has been conducted in Brazil, a country that is the only middle-income country to provide free and universal access to antiretroviral (ARV) therapy for the treatment of HIV/AIDS. Evidence indicates that Brazil has made significant progress in creating and sustaining access to ARVs and other AIDS treatments, as well as innovative care and support services to respond to the multiple needs of people living with HIV/AIDS (Bastos et al. 2001).

One of the challenges that remains is the large numbers of individuals, particularly women, who are not being diagnosed until the late stages of HIV infection. Despite the presence of a large and comprehensive network of anonymous voluntary counseling and testing units throughout the country, poor women and injecting drug users have lower rates of early diagnosis and hence of initial and continued access to ARV therapy (Bastos et al. 2001; Luppi et al. 2001). One of the explanations offered for women's late diagnosis is that testing is most typically offered to women in prenatal clinics. Yet, many women in Brazil, particularly poor women, do not receive prenatal care till late in their pregnancy (Bastos et al. 2001). Another possible reason is that women do not perceive themselves to be at risk of HIV and therefore do not seek testing. In a study of HIV-positive women at a clinic in Sao Paulo, more than half (53 percent) of the 148 HIV positive women interviewed did not perceive themselves to be at risk before learning of their HIV status and 29 percent of those did so only after their partners became ill (Ventura-Filipe 2000). It is also interesting to note that the majority of women reported that they did not receive pre-test counseling and of those who received post-test counseling, 14 percent claimed to have been mistreated by a physician or health professional. They reported being discriminated against, being treated as if they were prostitutes or injecting drug users, and informed about their AIDS status without any explanation.

Other research conducted in Brazil highlights the way in which gender biases in health care settings undermine the health of women. An examination of clinical practices of the management of sexually transmitted diseases (STDs) in gynecological and antenatal programs in Rio de Janeiro showed that doctors found it difficult to disclose to married women that they had a STD and to discuss how they may have contracted the infection (Giffen and Lowndes 1999). The doctors justified their behavior by stating that they did not want to cause problems for the couple and that the discussion of sexuality was not within the realm of their professional responsibilities. These results were supported by another quantitative study carried out in Rio de Janeiro and Sao Paulo. The results

showed that men clients were much more likely than women clients to be given condoms or information about condom use and they were much more likely to be given information that would help them inform and treat their partners (Vuylsteke et al. 1997). These findings suggest a replication of societal gender norms within health care settings that severely compromises the health of women.

The barriers that men face in using services are more often related to sociocultural factors than economic ones. Many services deliver HIV/AIDS information and services in settings that primarily meet women's health care needs (such as maternal and child health clinics or prenatal clinic sites), making men less likely to receive and benefit from those services (Mane and Aggleton 2001; UNAIDS 2001).

In summary, gender-related factors increase women's economic vulnerability and dependency, which in turn increases their vulnerability to being infected, restricts their access to much-needed information and services, and exposes them to severe consequences when infected or affected by HIV/AIDS. For men, gender-related norms and economic need force them to migrate without their families in search of work, creating situations that foster multiple sexual relationships that may lead to HIV infection. Overall, poverty greatly exacerbates both women and men's vulnerability by restricting access to information and services and making it more difficult to cope with the impact of the epidemic.

### **Reducing Gender-Related Vulnerabilities: Recommendations for Program and Policy Interventions**

Gender norms that pressure women and men to adhere to dominant ideals of femininity and masculinity and restrict women's access to productive resources fuel the spread of HIV/AIDS and negatively affect individuals' experience when infected or affected by the disease. By curtailing women's sexual rights and autonomy, encouraging irresponsible and risky sexual behavior among men, restricting women's access to and use of economic resources, and fostering homophobia, gender norms in the LAC region, as in most other regions of the world, have contributed to a culture of silence and shame that surrounds sexuality and an unequal balance of power between women and men. This inequality and culture of silence pose significant challenges for policies and programs that seek to contain the spread of the epidemic in the region.

An individual's power in any society is greatly enhanced by increased access to five key resources: information and education, services and technologies, economic resources and assets, supportive social networks and norms, and political capital. Thus, in order to equalize the balance of power between women and men that currently favors men, efforts must be made to ensure that women have increased access to each of these resources. Such efforts must be accompanied by policies and programs that foster open communication and information on sex and sexuality, as well as a redefinition of the traditional prescriptions for male and female sexual roles.

The recommendations listed below are designed to achieve each of these goals: to increase women's access to key resources, reverse the culture of silence and shame that

surrounds sexuality, and create new, less damaging definitions of male and female sexuality. Programs from the LAC regions are used as examples to illustrate ways to implement these recommendations. Compared to other regions, Latin America and the Caribbean has led the way in implementing innovative programmatic interventions to meet these goals. The best and most creative examples of programs to empower adolescents and women, provide sex education, and foster a redefinition of traditional norms of masculinity have emerged from this region.

***Increase young people's, particularly girls', knowledge about sex, gender roles, and HIV prevention, support, and care***

As established above, the lack of knowledge about sex and HIV/AIDS greatly constrains young people's ability to protect themselves from infection. The gender gap in access to such information underscores the need to ensure that girls, in particular, have access to accurate information in a frank and open way. Although it is true that knowledge about prevention is not enough to bring about behavior change, it is also true that there are many individuals, particularly young women, who are seriously disadvantaged in this epidemic because of a lack of knowledge.

At the June 2001 United Nations General Assembly Special Session on HIV/AIDS, member states committed to “ensure that by 2005 at least 90 percent of young men and women aged 15-24 have access to the information and education necessary to develop the life skills required to reduce their vulnerability to HIV” (United Nations 2001). For the many LAC countries that have a relatively high rate of secondary school enrollment for both girls and boys<sup>4</sup>, the first and most direct way to achieve this goal is to utilize the formal education system to provide students with the necessary information on sex and HIV prevention, support and care. Unfortunately, in some countries in the region, the existence of a predominantly conservative social culture has made it politically difficult to introduce sex and life skills education for young adolescents within schools. In spite of such obstacles, some schools have successfully introduced curriculum on sex education, although data on the impact of these curricula are not always available.

An exception is a school-based AIDS education program in Brazil which found that students who participated in the program reported having fewer sex partners than students in schools without the AIDS program (Das Gracias Rua and Abramovay 2001). Another HIV education program was successfully introduced into schools in Toluca, Mexico (IMIFAP 2002). In a quasi-experimental longitudinal study, three rounds of questionnaires were administered to 2,064 students from four public high schools over a fifteen-month period. The results indicated that the intervention was effective in improving HIV/AIDS knowledge, attitudes toward people living with HIV/AIDS, and confidence to use condoms among adolescent females as well as males. However, the intervention did not have an effect on actual condom use, which is not surprising given that there was no effort to improve condom distribution among students. It is interesting

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<sup>4</sup> Examples of countries that have a higher than 80percent net enrollment ratio for secondary education are Argentina, Chile, Colombia, Dominican Republic, Jamaica, Panama, Peru, and Uruguay (World Bank 2001).

to note that there was no significant change after the intervention in the attitudes of girls and boys to the statement “I think that a woman should stay a virgin until she is married”.

To be effective in changing gender-based attitudes and creating changes in behavior, school-based sex and HIV/AIDS prevention programs must be participatory and address peer pressure and norms that encourage risky behavior and must provide open, non-judgmental, and honest information about sex, gender roles and relationships, and the methods of avoiding infection (Kiragu 2001; Weiss et al. 1996; UNAIDS 1999). In addition, experience has shown that to be effective such curricula must be age appropriate and provide opportunities for the modeling and practice of communication, negotiation and refusal skills (Kiragu 2001; Kirby et al. 1994). For example, programs that target younger adolescents must focus on delaying the onset of sexual activity, whereas those for older adolescents must include a discussion of condoms and other contraceptives.

Because many young people who are most at risk are not in school, it is important that school-based sex education programs be complemented by community-based interventions to provide information and skills. An example of such a program is an AIDS prevention intervention offered to 14-20 year old youths in a poor section of the city of Sao Paulo in Brazil (Paiva 1993). Most of the targeted adolescents worked during the day and half of them were migrants or children of migrants. The intervention was developed based on research and consisted of educational workshops with males and females in separate groups, with one session that brought them together. Using a mix of creative, group participatory methods, over the course of four three-hour sessions, issues including sexual anatomy and reproductive health, gender roles and expectations, the risks of pregnancy and HIV infection, and the safer sex, were discussed. A qualitative evaluation undertaken six months later revealed several positive changes. Perceptions of risk and communication about sex and safer sex had increased and participants revealed empathy towards those living with HIV/AIDS.

Another popular strategy to reach youth, both in and outside of school, is peer education. The principle underlying peer education is that because the educators are the same age as the audience they reach, they are more likely to be viewed as credible and as setting feasible goals for behavior. The goal of peer education is to set standards for acceptable behavior and to help young people acquire the skills to negotiate protection and be assertive. While there are many examples of peer education programs in the LAC region, there is a paucity of evidence from evaluations of such programs in the region or elsewhere, particularly related to youth. The available evidence does suggest that peer education programs for adults in combination with other essential program elements, like condom distribution and STI diagnosis and treatment, have reduced the incidence of sexually transmitted infections, including HIV, changed risky behavior, and improved health (Horizons 2000; Kerrigan 1999). However, additional research is needed to understand the effects of peer education on risky behaviors of youth.

Another popular method to reach young people with information about sex and HIV/AIDS prevention is through the mass media. Data show that both girls and boys have access to mass media and many of the programs viewed by adolescents have the

effect of promoting unsafe attitudes and reinforcing traditional gender-stereotypes (Kiragu 2001). Several studies have shown that mass media campaigns effectively improve individuals' HIV/AIDS related knowledge and attitudes (e.g. Ross et al. 1990; Wolitski et al. 1996). However, the evidence for mass media's ability to effect positive *behavior* change is less consistent. Some studies have demonstrated that when used appropriately television and radio do effect positive behavior change. For example, in Uganda, self reported condom use among sexually active young men rose from 33 percent to 70 percent and among young women from 58 percent to 73 percent following The Safer Sex or AIDS Campaign (Lewicky et al. 1998). Other studies, largely in industrialized countries, have shown little or no positive behavior change associated with mass media campaigns (Jha et al. 2001).

In summary, while it is true that adolescence is a particularly vulnerable time, it is equally true that it provides a window of opportunity to bring about changes in levels of knowledge, attitudes, and behaviors before they are fully formed. In order for HIV/AIDS interventions to use this window of opportunity to reduce young people's vulnerability to HIV and address their needs within the epidemic, it is critical to first provide them with accurate information and the skills they need to protect themselves in the epidemic. There are many proven ways to provide young women and men with such information. The challenge now lies in taking these proven interventions to scale by expanding them into national or regional programs. It is also important for such interventions to ensure that the information they provide is not restricted to HIV/AIDS prevention but also meets the gender-specific needs of both boys and girls and addresses specific gender-related issues that make negotiating protection in relationships difficult.

### ***Invest in the development and increased accessibility of female controlled technologies for HIV prevention***

As described above, negotiating the use of the male condom poses significant challenges for women. Therefore, it is essential that the international community (bilateral and multilateral agencies and private foundations) invest in the development and increased accessibility of female controlled technologies, such as the female condom and microbicides.

Although the female condom has been available for over two decades now, it remains a "boutique" method, expensive and accessible to only a few in some countries. Reactions of program managers and policy makers to the usefulness of this method of prevention have been mixed. While some have been positive about the prospect of a device that women can control, others have been worried that it yet again absolves men of responsibility and reinforces traditional gender relations (Aggleton et al. 1999). Acceptability studies have also had mixed results. While studies conducted in Europe and North America (Ford and Mathie 1993; Hoffman 1991) resulted in a wide range of views, studies conducted in the developing world report more favorable reactions. A review of over 40 studies acceptability studies conducted worldwide concluded that overall the female condom is an acceptable method, favorably viewed by many

(UNDP/UNFPA/WHO/World Bank Special Programme of Research on Human Reproduction 1997).

Currently, in the LAC region, the female condom is available through the public sector in Costa Rica and Brazil and is also available through social marketing programs in Bolivia, Guatemala, Haiti, and Venezuela (Female Health Company 2002). In UNAIDS-sponsored studies conducted in four countries, including Costa Rica and Mexico, researchers sought to determine the extent to which the female condom would help empower women to communicate and negotiate in sexual interactions (Aggleton et al. 1999). In both Costa Rica and Mexico the study was conducted on small groups of sex workers and non-sex workers. The results showed that the female condom was received favorably by the majority of participants in both sites, although most participants expressed concern when they were first shown the product. Most of these concerns were allayed through the experience of using the condom. The women reported feeling more in control and having “more power” because of the female condom. Sex workers in both sites reacted more positively to the female condom than non-sex workers, and reported that their clients preferred the female condom to the male condom. The researchers concluded that the female condom is most effective in enhancing sexual communication and women’s empowerment when used by sex workers who have some experience in negotiating safer sex with their clients or in contexts where the male condom is unpopular, making the female condom the preferred option (Aggleton et al. 1999).

Microbicides, substances that women can apply vaginally to protect against HIV infection and other sexually transmitted diseases, are another potential female controlled prevention option that are not yet available. Although there are eleven compounds with potential microbicidal properties in the pipeline, none have yet been proved to be effective in clinical trials in humans. A recent analysis, supported by the Rockefeller Foundation, found that if a 60 percent efficacious microbicide were available in 73 low-income countries, it could avert over 2.5 million infections over three years (Rockefeller Foundation Microbicide Initiative 2002). The development of microbicides has been seriously crippled by a lack of political and financial support for the research required to move products through the research pipeline. Today there is increased interest in the potential that this technology offers and a substantially greater amount of support from the governments of industrialized countries. For this momentum to continue, however, global advocacy for increased resources and commitment to the development of microbicides must continue.

Increased accessibility of the female condom and the availability of safe, effective, and accessible microbicides will greatly increase women’s ability to protect themselves from infection and thereby provide women with greater control of the outcome of sexual interactions. While these products offer women an option today in a context in which gender inequities persist, there is no doubt that the impact of these technologies will be greatly enhanced with improvements in women’s social and economic status. Thus, efforts to make female controlled technologies more accessible to women must go hand in hand with investments to improve women’s economic and social status.

### *Improve women's economic options and livelihood opportunities for adolescents*

As stated earlier, the inequities that women and girls experience in accessing income, employment, credit, and land ownership makes it more likely that they will exchange sex for money, gifts or favors, less likely that they will succeed in negotiating safer sex or fidelity, and less likely that they will leave relationships that they perceive to be risky. As a result, an additional way to help protect women and girls from HIV infection is to implement policies and programs that improve women's access to economic resources and adolescent girls' livelihood opportunities.

The LAC region has an advantage over other regions because of the small gender gap in primary and secondary school enrollment rates. Despite this advantage, however, there are noticeable gaps in women's access to economic opportunities and security. Thus, it is important to implement policies and programs that improve women's economic status by:

- ◆ Providing women and girls who are engaged in micro and small enterprises with microfinance and business development services to expand their businesses;
- ◆ Supporting the organization of home-based workers for collective action;
- ◆ Promoting the provision of safety nets for poor households, particularly those headed by women;
- ◆ Ensuring that women who are employed in the informal and formal sector are protected by labor standards
- ◆ Ensuring that women have property and inheritance rights.

Adolescent girls and boys, too, need better livelihood opportunities to reduce their susceptibility to transactional sexual interactions. Most adolescents contribute to the economic security of their households by earning an income or providing their labor to family enterprises. Yet, adolescents often are not viewed as being economic agents and do not get the support they need to develop and expand their economic opportunities. Livelihood programs for adolescents include components that help them find employment and other opportunities, provide credit and other financial help for initiating micro or small businesses, provide job training and business development skills, and link them to larger alliances and networks that focus on improving the economic skills of youth. While a wide range of adolescent livelihood programs exist, most of them are small and typically they help young people pay school fees or buy food or get loans (Population Council and ICRW 2000). Only recently have adolescent livelihood programs begun to link their activities with reproductive health and HIV/AIDS prevention and support programs in an effort to have a more synergistic effect on the determinants of risky sexual behavior (Esim et al. 2001).

Providing women and adolescents with economic security also helps to mitigate the impact of the epidemic on affected families and households. A recent study in Zimbabwe compared the experience of women who were clients of a microfinance program and belonged to households that were affected by chronic illness and death to those who were not clients of such a program but were also similarly affected (Barnes et al. 2001). The findings revealed that those women who were clients of the program had more sources of income, practiced better financial management, and were more likely to have kept their

6-16 year old sons in school despite the burden of illness and death in the household. This suggests that the households of clients of microfinance programs may be in better position to cope with the impact of HIV/AIDS than those of non-clients.

These results as well as the centrality of economic need to the spread of the epidemic, have led several program experts to call for interventions that link HIV/AIDS services with economic or financial services. A recent review of programs for adolescents that link reproductive health services with economic services found that the most compelling reason for arguing for the continuation of such programs is that they developed in response to demand from the communities they serve (Esim et al. 2001). However, most of the linked programs reviewed were only marginally effective in meeting both the reproductive health and livelihood needs of adolescents. Thus, the added value of having a linked program versus two separate programs serving the same community of adolescents was not apparent. More research is needed to determine how each component in a linked program can be implemented well enough to have added value.

***Develop programs that foster the development of gender equitable norms of masculinity and femininity***

The last few years have seen a burgeoning of efforts that seek to transform traditional gender roles and create more gender-equitable relationships worldwide. Most of these efforts have focused on men and examining the costs of the dominant ideology of masculinity for the health of women and men. As discussed above, it is often men's risky behavior that makes their female partners vulnerable to infection. It is equally true that sociocultural norms create an environment for men where risk is acceptable, even encouraged for "real" men (Mane and Aggleton 2001). Thus, dominant forms of masculinity, which are created and reinforced by both women and men, oppress both women and men and increase their vulnerability in the epidemic.

In response to this new understanding, there have been several program interventions that have sought to change the sociocultural definitions of masculinity. Some of these interventions have targeted men at particular risk, such as the efforts to reach truck drivers in Central America with messages to reduce the number of sexual partners and more consistently practice safer sex (Rivers and Aggleton 2001). Others have gone beyond by providing men with the opportunity to reflect on the dominant forms of masculinity and their costs to their own health and well-being as well as that of their families (e.g. Barker 2000; Montoya 1998).

The impetus for the latter type of programming arose out of a belief that the dominant form of masculinity could be changed and replaced with more gender equitable models of masculinity. Research conducted by Gary Barker (2000) in Brazil and by others in Peru and Argentina (Yon et al. 1998; Necchi and Schufer 1998) were influential in establishing that alternative, more equitable masculinities do exist. Each of these studies identified young men who showed some degree to gender equity in their intimate and sexual interactions with young women.

Barker (2000) went a step further and analyzed how the socialization of these more gender equitable young men was different. By studying in-depth the experience of young boys in a *favela* in Brazil who did not conform to traditional expectations of masculinity, Barker identified a number of factors associated with gender equitable attitudes. These factors include acknowledgment of the costs of traditional masculinities to their own health and well-being, access to adults who do not conform to traditional gender roles, family intervention or rejection of domestic violence, and the presence of a gender equitable male peer group.

These insights have been used to develop programs that seek to foster constructive roles for men in sexual and reproductive health. These programs typically use a workshop format and curricula that incorporate a wide range of activities (games, role plays, and group discussions) to facilitate an examination of gender and sexuality and its impact on male and female sexual health and relationships, as well as violence against women. Examples of such programs in the LAC region include the work of Salud y Genero, a small NGO based in Mexico that reaches young men, men in prisons and a wide range of professional and working class men; Project Papai in Recife, Brazil, that targets young men on themes related to fatherhood; and workshops conducted for men who have sex with men by Amigos Siempre Amigos in the Dominican Republic and Lambda in Colombia, that aim to destigmatize homosexual activity, reduce homophobia, and support men who have sex with men to recognize their risk (Barker 1998; UNAIDS 2001).

Unfortunately, workshop formats used by these programs have the disadvantage of being able to reach only a small numbers of participants. Although it is important to scale-up these efforts to reach more people there is no substitute for the face-to-face communication and group dynamics offered by working with small groups through a workshop format. Therefore, multiplying the number of workshops conducted may be a more effective way to reach more people rather than trying to expand the scope of any single workshop. Another challenge is to find ways to rigorously evaluate the impact of such interventions on attitudes and behavior since such data do not currently exist.

Other programs that seek to transform gender relations include efforts to work with couples as the unit of intervention, rather than with individual women or men. Couple counseling in HIV testing clinics to help couples deal with the results of their tests and in family planning programs that promote dual-protection against both unwanted pregnancy and infection are recent examples of efforts that seek to reduce the negative impacts of the gender power balance by including both partners in the intervention. The challenge facing these programs is in being able to recruit couples who are willing to participate. Although many couples who do participate describe couple counseling as a positive experience, so far the numbers who participate have remained low (Becker 1996). Further research is needed to identify ways to overcome barriers to couple counseling and to test the effectiveness of this method in creating more gender-equitable relationships.

***Address gender-based factors that restrict women's access to services because of stigma and discrimination related to living with HIV/AIDS***

Evidence presented above indicates that gender-related factors and poverty combine to make it more difficult for poor, marginalized women to seek HIV/AIDS related services and treatments. As a result poor women are found to be HIV positive later than others and as a result their long-term survival is greatly compromised. Research also suggests that HIV positive women, particularly poor, minority women, face prejudice and discrimination within health care settings.

Addressing these barriers to accessing care and support services requires a two-pronged approach: first, an investment of resources to try to reach and attract low-income, minority women to services through greater service delivery, outreach, and education to the communities in which they live, and second, intensive training programs for health care providers in settings that offer VCT, treatment, and care services.

Helping people living with HIV/AIDS (PLHA) organize and become more visible is also a useful strategy to reduce stigma and discrimination. An analysis of four NGOs in Ecuador that involved PLHA to varying degrees, showed that the benefits of doing so accrued to the PLHA themselves, as well as to other prevention and education efforts that were implemented by the NGOs. Most importantly, the involvement of PLHA decreased the sense of isolation and stigma experienced by them and their families and there was a greater overall acceptance of HIV positive people as active and productive individuals who need to be integrated into society (Horizons 2000). This and several other efforts around the world suggest that providing resources and support for PLHAs to organize, support each other and share solutions, and become spokespersons and educators in prevention programs, is a very effective way to reduce the stigma and discrimination associated with the epidemic. The Horizons study reported that HIV-positive women faced distinct barriers to involvement compared to HIV-positive men, such as the responsibility for childcare. Programs that recognize the value of PLHA visibility and involvement must therefore reduce gender-related constraints of HIV-positive women to facilitate their full participation in service-delivery.

## **Conclusion**

The recommendations listed above are only a few of the many actions required to contain the spread of HIV/AIDS in the LAC region. From the perspective of reducing the gender-related vulnerabilities of women and men in the epidemic, the recommendations presented above are of high priority. The diversity of the epidemic in the region, however, calls for different emphasis to be given to each recommendation in different country settings, depending upon the nature of the epidemic in that particular context. In each case, nevertheless, particular attention must be paid to the gender-related needs of marginalized minorities, such as the poor, ethnic and racial minority groups, sex workers, and men who have sex with men, because each of these groups face multiple disadvantages that greatly increase their vulnerability in this epidemic.

Addressing gender inequities and changing societal definitions of masculinity and femininity are no small challenge. They require significant and sustained social change.

Yet, it is now well accepted that the socio-cultural and economic factors that subordinate women and trap men in damaging patterns of sexual behavior are compromising the rights and freedoms of individuals and, through the HIV/AIDS epidemic, promoting a cycle of illness and death. The fact that gender inequities and many traditional societal norms are now fatal can provide no stronger argument for them to change.

## **Annex 1: An Epidemiological Overview by Sub-Region<sup>5</sup>**

### ***The Caribbean***

Only sub-Saharan Africa surpasses the HIV prevalence rate found in the Caribbean region, where it is estimated that close to 4 percent of the adult population is currently infected (UNAIDS/WHO 2001). The vast majority of people in the Caribbean are infected through heterosexual contact; a pattern that is visible through the high rate of HIV prevalence observed for both pregnant women and female sex workers.

At 13 and 7.1 percent, respectively, Haiti and Guyana report the highest rates of HIV prevalence among pregnant women. In both these countries the similarity of rates of infection between sex workers and pregnant women suggests the presence of a generalized epidemic in which a very high proportion of the population is exposed to the risk of HIV infection. In other parts of the Caribbean, rates of infection among pregnant women, ranging from 1 to 3.5 percent, are noticeably lower than that for sex workers, yet sufficiently high to suggest the beginnings of a generalized epidemic. Another notable feature in the epidemiological data from this sub-region is the dramatic increase in infection over the past seven years in all countries in the Caribbean, for the population as a whole, as well as among pregnant women and sex workers (Figure 1). In the Dominican Republic, for example, the national average of HIV prevalence among pregnant women in 1997 was 1.7 percent, five times higher than the rate recorded in 1991.

### ***Mexico***

In Mexico, the primary mode of HIV transmission continues to be unprotected sex between men. Some studies have found that as many as 14.2 percent of men who have sex with men (MSM) are HIV-positive. In comparison, HIV prevalence rates among heterosexuals, including sex workers, are low – 1 percent or lower (Figure 2-7). It is not surprising then that HIV infection rates in pregnant women are even lower. In a voluntary testing and counseling program offered to pregnant women between 1996 and 1998, the HIV prevalence rate was found to be just 0.09 percent. PAHO (2001) estimates that currently one in every 1,000 women of childbearing age is infected with HIV compared to one in every seven men who have sex with men. Overall, prevalence rates for adults remain low at 0.28 percent, but the impact of the epidemic is significant. Currently, for the 25 to 44 years age group, HIV is the third most common cause of death in men and the sixth for women (PAHO 2001).

### ***Central America***

Among the countries in continental Latin America, the northern countries of Central America (Honduras, Guatemala, Belize, and Costa Rica) are the hardest hit by the epidemic. While the HIV/AIDS epidemic in Honduras, Guatemala, and Belize is heterosexually driven, MSM account for the greatest number of infections in Costa Rica and Panama (PAHO 2000).

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<sup>5</sup> Unless otherwise stated, data for the appendix were drawn from the U.S. Census Bureau's country profiles, available on-line at <http://www.census.gov/ipc/www/hivctry.html> and last accessed on July 5, 2002.

The best HIV/AIDS surveillance data for Central America is from Honduras, where four out of five infections occur due to unprotected heterosexual interactions. In Honduras, seroprevalence rates among antenatal clients in urban areas vary between 2 and 5 percent. Of concern is that HIV prevalence among pregnant 15 to 19 year old women was found to be 1.5 percent, suggesting the potential for an acceleration in HIV infections in the future. Seroprevalence for female sex workers is high in urban areas, especially in San Pedro Sula, a major commercial center and the HIV epicenter in Honduras, where as many as 1 in 5 female sex workers were found to be seropositive in 1995 (Figure 5). With regard to men, data from a study on night watchmen undertaken in two cities in Honduras in 1999 found an HIV prevalence rate of 0.5 percent. Interestingly, 11 percent of the respondents reported that they had had anal sex with other men but also engaged in heterosexual sex, a pattern of bisexual behavior that is common in other parts of the LAC region as well.

In recent years, Belize has begun to challenge Honduras for being one of the worst hit countries in the region. HIV prevalence rates for pregnant women rose from 1 percent in 1994 to 2.5 percent in 1995. In contrast, HIV prevalence among pregnant women is low in Panama and Costa Rica, where HIV is spread primarily through unprotected homosexual interactions. In 1993, recorded HIV prevalence rates among men who have sex with men in Costa Rica was between 10 to 16 percent.

Infection rates in Guatemala vary widely by location, with higher rates found among women in the coastal city of Puerto Barrios than in the highland cities. Data from Nicaragua and El Salvador are scarce which makes it difficult to characterize the nature of the epidemic.

### ***Andean Area***

There is relatively little HIV/AIDS trend data for the Andean Area of South America. The best data have been collected for Colombia and Peru. Relatively less is known about Bolivia, Ecuador and Venezuela. What is available suggests that while these countries still do not appear to be heavily affected by the disease, several are ripe for an epidemic. While HIV seroprevalence trends for pregnant women are not widely documented for Colombia, a study done in 1994 for several cities found a HIV prevalence rate of 1 percent or less (U.S. Census Bureau 2000). While the epidemic has traditionally been characterized by men, more recent data has found the male to female ratio has decreased from 37:1 in 1987 to 5:1 in 1998 (PAHO 2000). The pattern of infection in Colombia varies by region, with MSM making up the majority of the cases in the highlands and unprotected sex between men and women the primary mode of transmission on the coast. Peru has a more concentrated HIV epidemic, with males 4 to 5 times more likely to be infected (through unprotected sex with men) than women. Seroprevalence rates among pregnant women were similar to those found in Colombia, with less than 1 percent testing positive.

### ***Brazil***

Brazil, the most populous country in Latin America, accounts for 75 percent of all AIDS cases reported in the region (UNAIDS 1996). 60 percent of those currently living with

HIV are concentrated in the urban centers of Sao Paulo and Rio de Janeiro. An increased number of HIV infections due to unprotected heterosexual sex is rapidly putting women at the forefront of the epidemic. The impact of HIV/AIDS on women is most apparent in urban centers, such as Sao Paulo, where AIDS is now the leading cause of death for women of reproductive age (UNAIDS 1996). As seen in Figure 11, women appear to be infected early with the virus; in 1997 0.5 percent of 13-19 year olds attending an antenatal clinic and over 1 percent of 20-29 year olds were HIV-positive. Other data from 1997 also indicate an epidemic that varies according to geographical area, with pregnant women in the South and North more likely to be HIV-positive (Figure 12). Female sex workers show a high rate of seropositivity, with 10 percent or more of prostitutes in Rio de Janeiro found to be infected between 1988-1993 (Figure 13). Again, sex workers in Sao Paulo had the highest seroprevalence rate (Figure 14) than any other city considered. AIDS deaths in Brazil are decreasing due to an expanded program for the provision of antiretroviral therapy (Figure 15). The MOH began to supply such treatment in 1991 and a subsequent law was passed in 1996 that all HIV-related drugs should be provided free of charge by federal, state, and city authorities (UNAIDS 1998). Incident cases, however, continue to rise.

### ***Southern Cone***

MSM and injecting drug users (IDU) continue to be the primary groups affected by HIV/AIDS in the Southern Cone region. HIV transmission due to IDU in countries such as Chile, Argentina and Uruguay has been responsible for the shift of the disease towards the younger age groups (from 30-49 to 20-34) as well as for the increased cases in women who accounted for 20 percent of HIV cases in 1996 (PAHO 2000). Argentina, with its HIV epidemic concentrated among injecting drug users, has some of the best data in the region. As shown in Figure 8, HIV prevalence among pregnant women in major urban areas of Argentina has declined, dropping from just over 3 percent in 1994 to less than 1 percent by 1998. Trend data of HIV among women who use injecting drugs, however, appears to be extremely high. In one study, conducted with IDU in Granadero Baigorria in 1995, 29 percent of males and 17 percent of females were HIV positive (U.S. Census Bureau 2000).

Other countries in the region, such as Chile still appear to be relatively little affected by HIV/AIDS. Less than 3 percent of sex workers and 1 percent of pregnant women were seropositive in 1999 (U.S. Census Bureau 2000). Figure 9 demonstrates the differences in epidemic states, showing Argentina with a much higher rate of reported AIDS cases than Chile. This graph also shows the apparent success of a 1995 law passed in Argentina requiring unions to cover 100 percent of HIV treatment-- an effort that was matched in Brazil during the same year (UNAIDS 1998). As a result of this law, the number of AIDS deaths in Argentina dropped from 1996 to 1999.

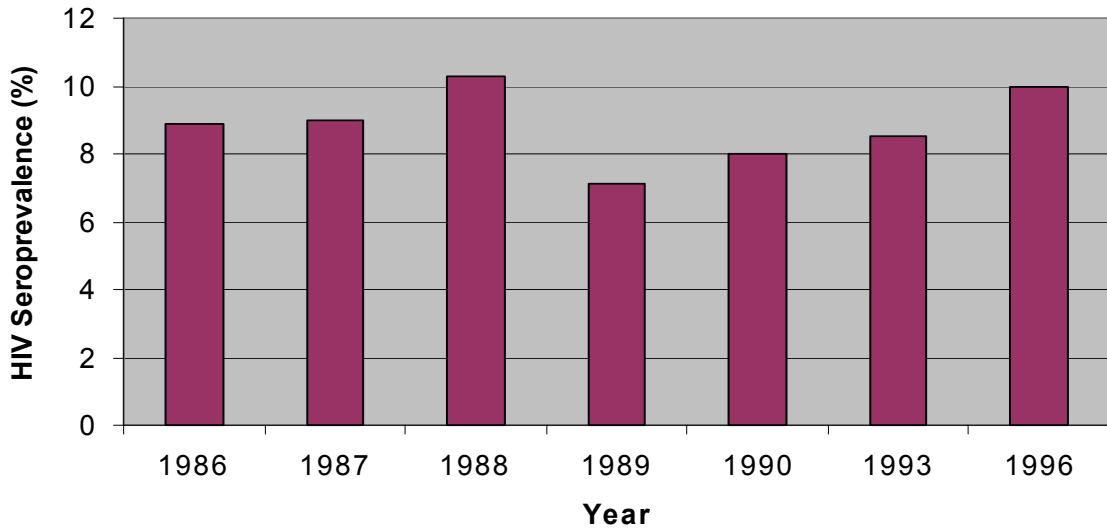
## Annex 2: Figures<sup>6</sup>

- Figure 1. HIV Prevalence in Pregnant Women in Urban Areas, Haiti 1986-1996.
- Figure 2. HIV Seroprevalence for Pregnant Women in Various Cities in Haiti: 1993-1996.
- Figure 3. HIV Seroprevalence Among Sex Workers and Pregnant Women in Santo Domingo, Dominican Republic: 1991-1998.
- Figure 4. HIV Prevalence Among Pregnant Women and Female Sex Workers in Major Urban Areas Honduras: 1989-1998.
- Figure 5. HIV Seroprevalence Among Pregnant Women and Female Sex Workers, San Pedro Sula, Honduras: 1989 - 1998.
- Figure 6. Reported AIDS Cases: Honduras, El Salvador and Nicaragua: 1990-1999.
- Figure 7. HIV Seroprevalence Among Female Sex Workers in 18 States Mexico: 1990-1997.
- Figure 8. HIV Seroprevalence Among Pregnant Women in Major Urban Areas Argentina: 1994-1996, 1998.
- Figure 9. Reported AIDS Cases: Argentina and Chile, 1990-1999.
- Figure 10: Reported AIDS Cases in Colombia and Peru: 1990-1999.
- Figure 11. HIV Seroprevalence for Pregnant Women by Age Group in Brazil: 1997.
- Figure 12. HIV Seroprevalence for Pregnant Women in Five Areas of Brazil: 1997.
- Figure 13. HIV Seroprevalence Among Sex Workers in Rio de Janeiro, Brazil: 1987-1993.
- Figure 14. HIV Seroprevalence for Sex Workers in Various Cities in Brazil: 1992-1998.
- Figure 15. Reported AIDS Cases in Brazil, 1990-1998.
- Figure 16. HIV/AIDS prevalence in Latin America and the Caribbean by country at the end of 1999.

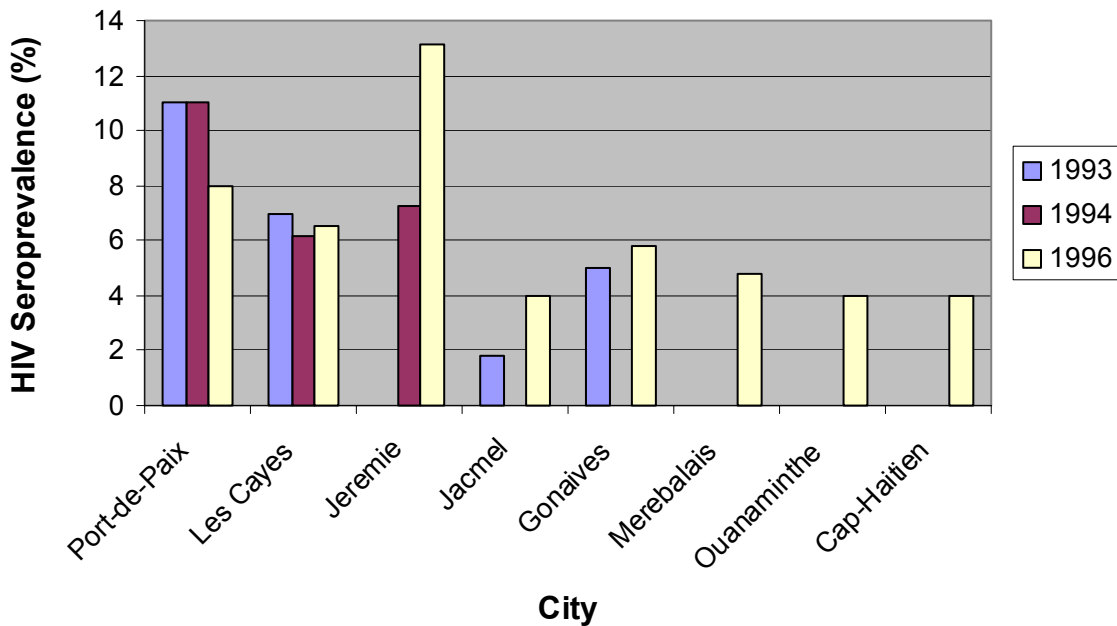
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<sup>6</sup> Data for figures 1-15 were drawn from the U.S. Census Bureau's HIV/AIDS Surveillance Database, available on-line at <http://www.census.gov/ipc/www/hivaidsd.html> and last accessed on July 5, 2002.

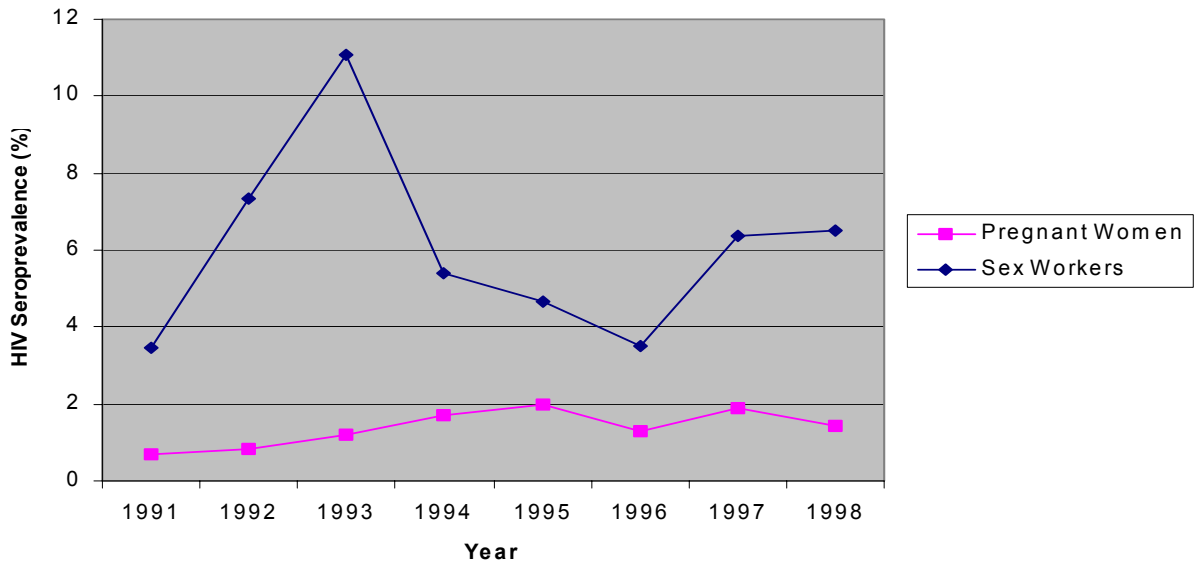
**Figure 1: HIV Prevalence in Pregnant Women in Urban Areas, Haiti 1986-1996**



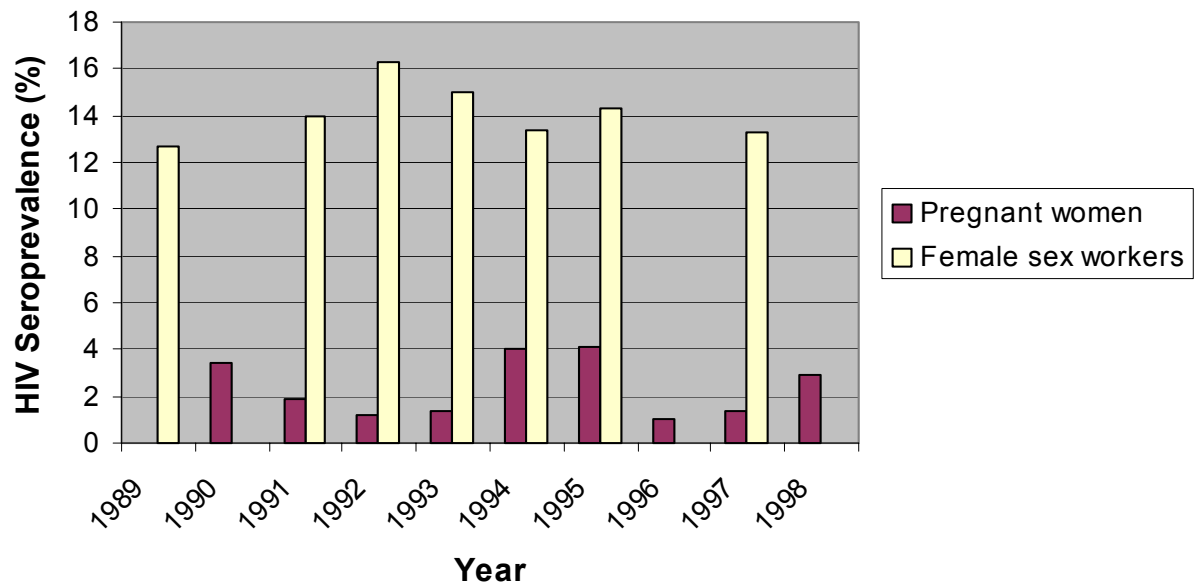
**Figure 2: HIV Seroprevalence for Pregnant Women in Various Cities in Haiti: 1993-1996**



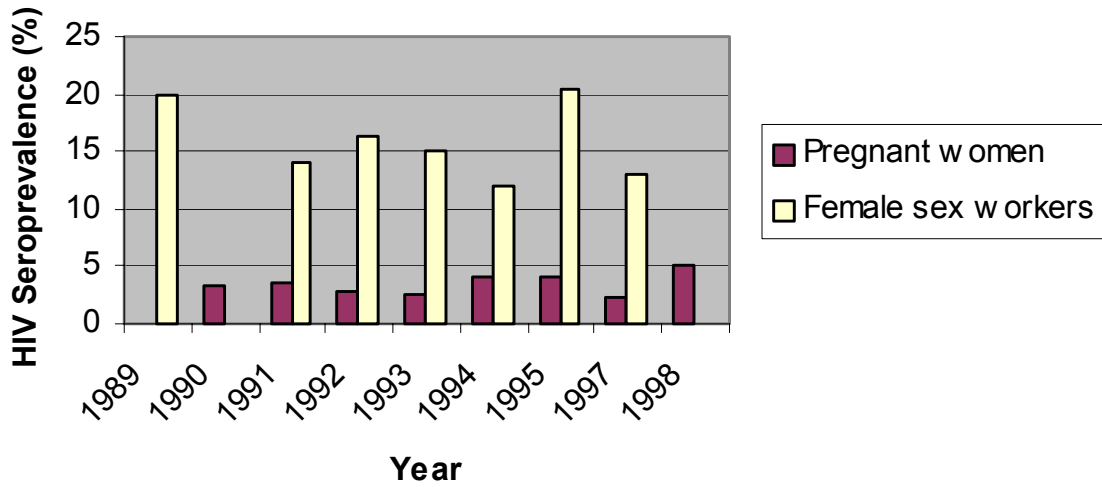
**Figure 3: HIV Seroprevalence Among Sex Workers and Pregnant Women in Santo Domingo, Dominican Republic: 1991-1998**



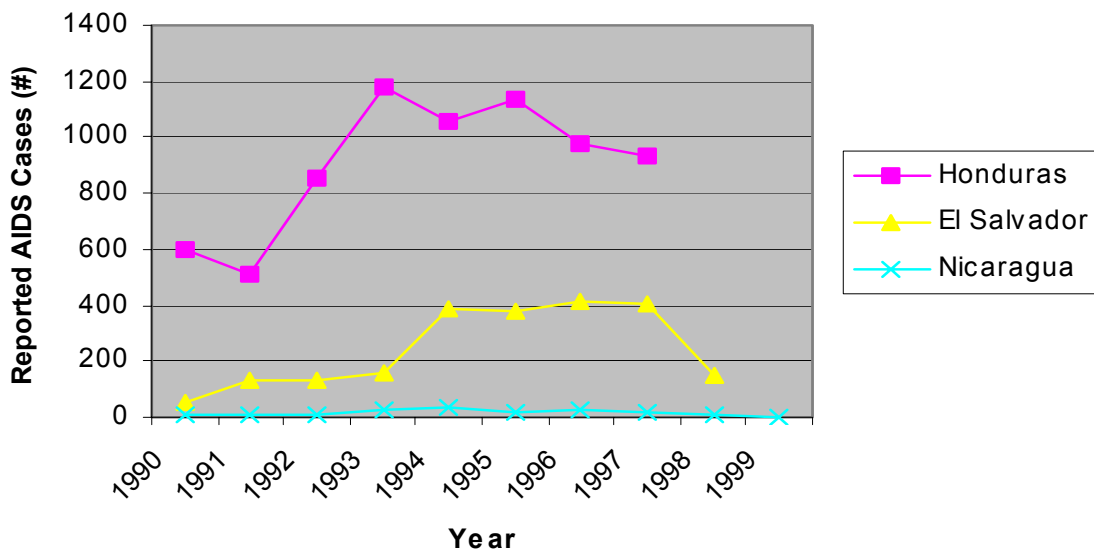
**Figure 4: HIV Prevalence Among Pregnant Women and Female Sex Workers in Major Urban Areas Honduras: 1989-1998**



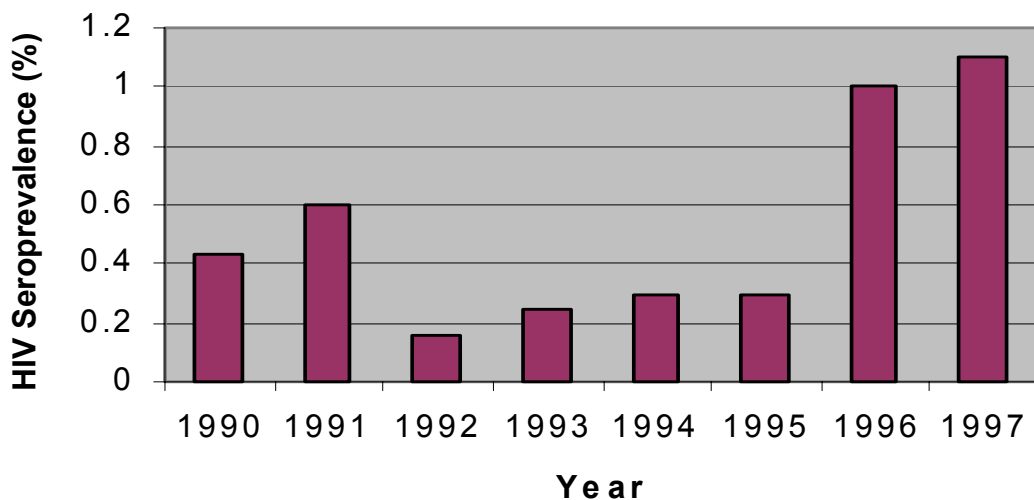
**Figure 5: HIV Seroprevalence Among Pregnant Women and Female Sex Workers  
San Pedro Sula, Honduras: 1989-1998**



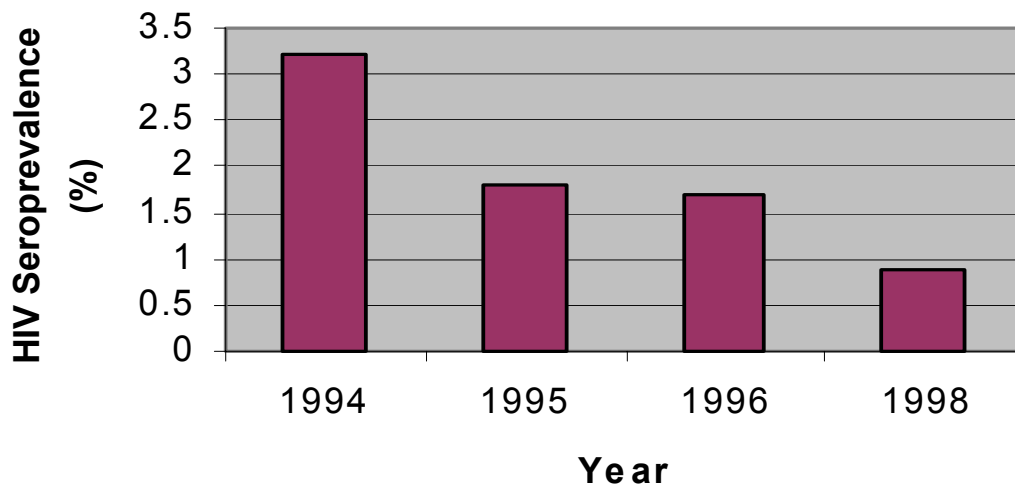
**Figure 6: Reported AIDS Cases: Honduras, El Salvador and Nicaragua: 1990-1999**



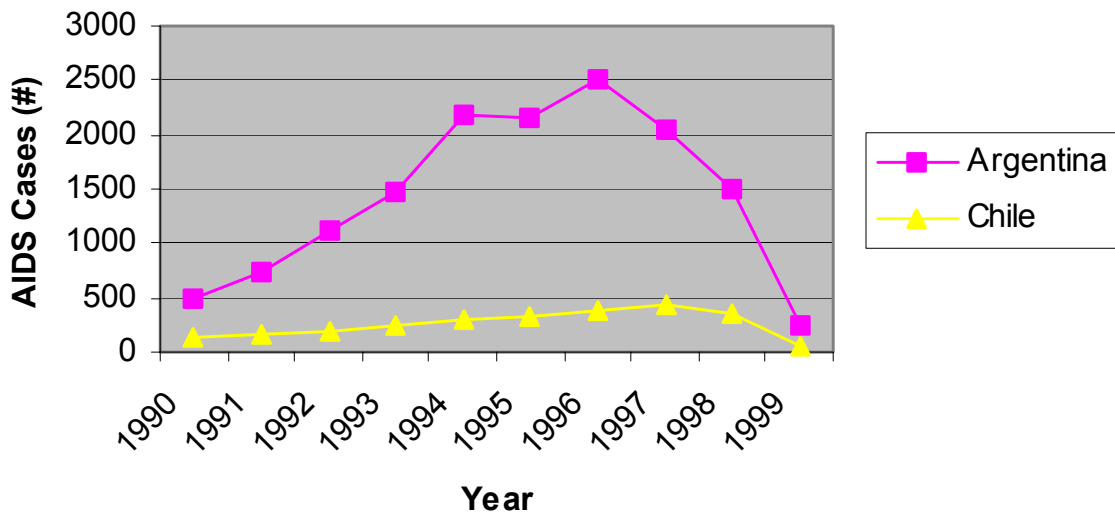
**Figure 7: HIV Seroprevalence Among Female Sex Workers in 18 States Mexico: 1990-1997**



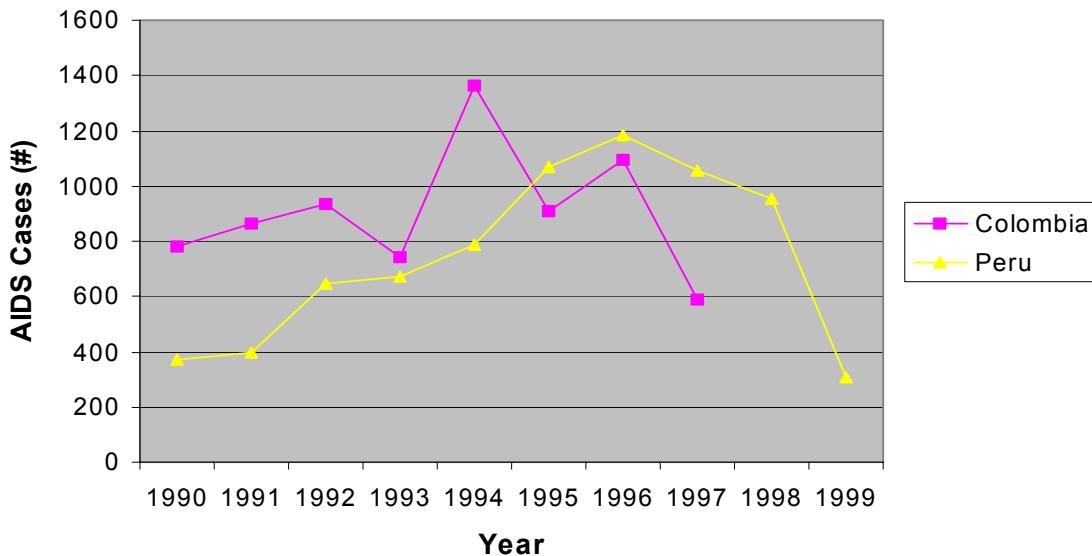
**Figure 8: HIV Seroprevalence Among Pregnant Women in Major Urban Areas Argentina: 1994-1996, 1998**



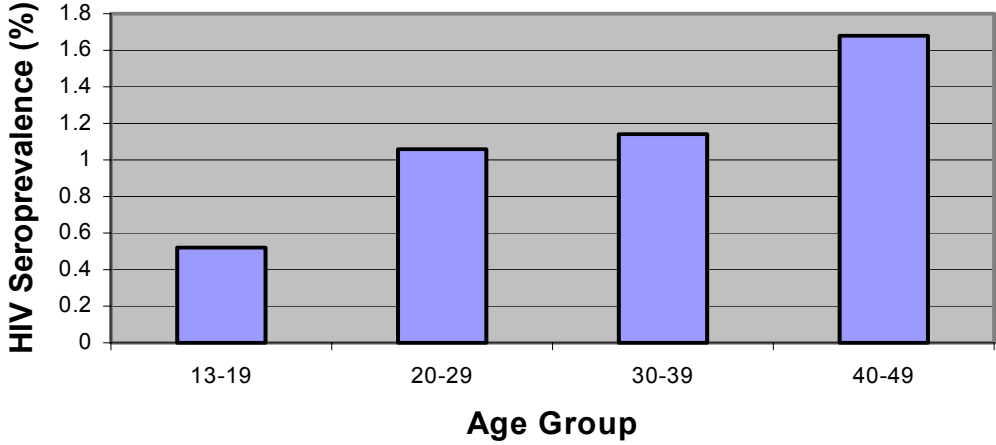
**Figure 9: Reported AIDS Cases  
Argentina and Chile: 1990-1999**



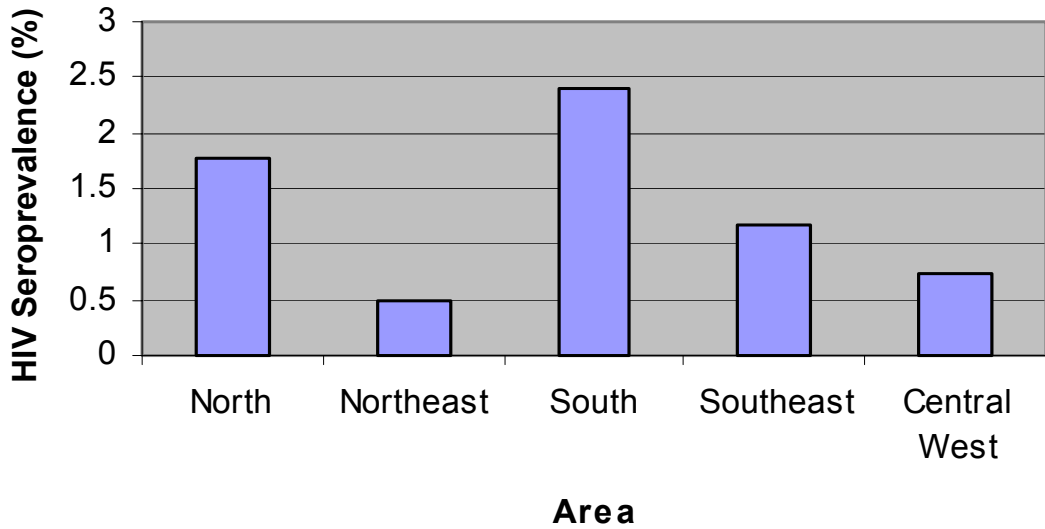
**Figure 10: Reported AIDS Cases  
Colombia and Peru: 1990-1999**



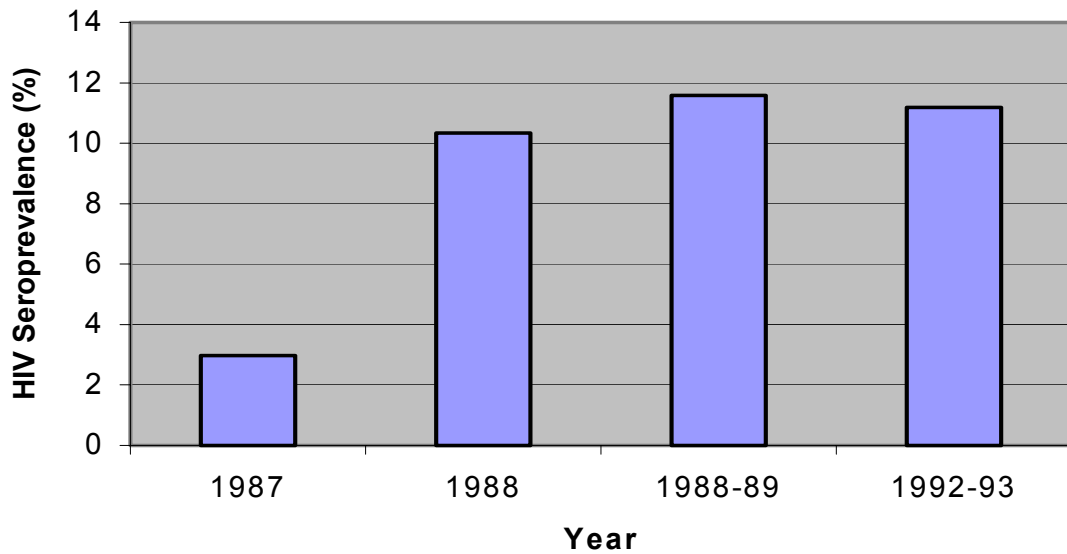
**Figure 11: HIV Seroprevalence for Pregnant Women By Age Group  
Brazil: 1997**



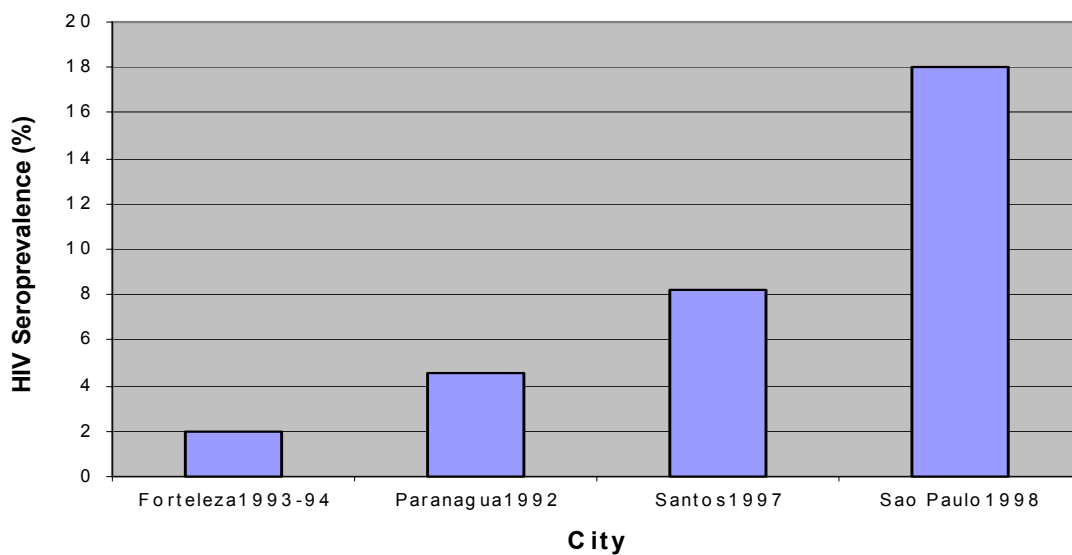
**Figure 12: HIV Seroprevalence for Pregnant Women in Five Areas of Brazil: 1997**



**Figure 13: HIV Seroprevalence Among Sex Workers in Rio de Janeiro, Brazil: 1987-1993**



**Figure 14: HIV Seroprevalence for Sex Workers in Various Cities in Brazil: 1992-1998**



**Figure 15: Reported AIDS Cases : Brazil, 1990-1998**

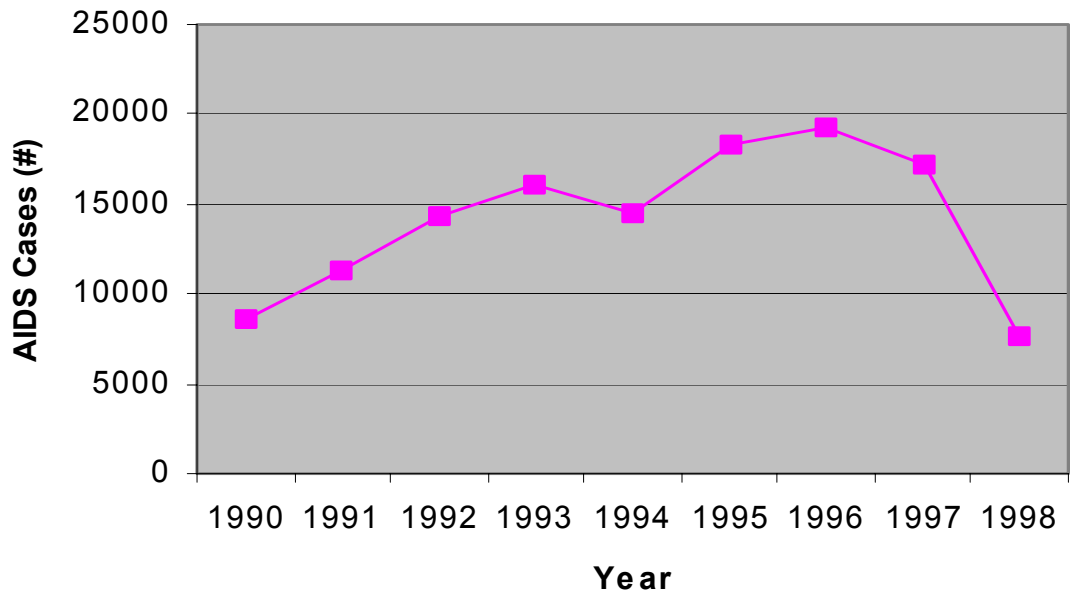


Figure 16. HIV/AIDS prevalence in Latin American and Caribbean countries at the end of 1999 (UNAIDS 2000).

	Percent of Adults (15-49) with HIV/AIDS	Percent of Adults (15-49) with HIV/AIDS that are Women
<b>Caribbean</b>	<b>2.11</b>	<b>37.14</b>
Bahamas	4.13	32.35
Barbados	1.17	33.53
Cuba	0.03	23.08
Dominican Republic	2.80	45.38
Haiti	5.17	33.50
Jamaica	0.71	31.96
Trinidad and Tobago	1.05	32.89
<b>Latin America</b>	<b>0.49</b>	<b>25.00</b>
Argentina	0.69	22.50
Belize	2.01	24.58
Bolivia	0.10	16.59
Brazil	0.57	24.53
Chile	0.19	17.33
Colombia	0.31	14.29
Costa Rica	0.54	25.45
Ecuador	0.29	14.21
El Salvador	0.60	25.26
Guatemala	1.38	39.44
Guyana	3.01	32.67
Honduras	1.92	50.00
Mexico	0.29	14.67
Nicaragua	0.20	25.00
Panama	1.54	40.87
Paraguay	0.11	17.93
Peru	0.35	25.53
Suriname	1.26	32.76
Uruguay	0.33	25.42
Venezuela	0.49	15.08

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