I. Introduction

HIV/AIDS is a significant—and worsening—health, economic, and social issue in SSA. Africa’s share of the global AIDS pandemic is very high (Figure 1).i Around 24.5 million adults and children in SSA (out of 34.3 million worldwide) are living with HIV/AIDS.

II. Why Gender and AIDS?

There are three critical factors—all interconnected—that place gender issues at the core of the HIV/AIDS problem in Africa. These are: (i) risk factors and vulnerability are substantially different for men and for women, as is most evident in the marked age- and sex-differentiated HIV prevalence rates—this has implications for strategies to reduce overall prevalence in SSA and for how and to whom AIDS prevention activities are directed; (ii) the impact of HIV/AIDS differs along gender lines—this has implications for care, treatment, and coping mechanisms, including addressing the needs of AIDS orphans; and (iii) tackling the AIDS pandemic is fundamentally about behavior change—this essentially means effecting a “transformation” of gender roles and relations in Africa.

III. Gender Issues and HIV/AIDS

A. Vulnerability and Risk Differ by Sex and Age

Many factors account for why vulnerability and risk differ for men and for women, and for men and women at different ages. Some are physiological, where women’s risk of infection is higher.ii Others are socio-cultural, reflecting different roles, norms, and

---

i HIV infections and AIDS deaths in men outnumber those in women on every continent except Africa. Globally, 41% of 33.4 million adults living with HIV/AIDS are women. Data indicate 8% adult prevalence in SSA of which 53% are women, compared with a 0.13% prevalence rate for N Africa of which 20% are women. Source: UNAIDS.
expectations, and economic, reflecting differences in command over assets (including productive resources, employment, and education). At the July 2000 Durban conference on AIDS, differences in power relations between men and women (largely grounded in economic inequality and vulnerability) were identified as one of the major factors contributing to the spread of AIDS (Box 1). Significantly, gender inequality contributes to the greater vulnerability to HIV/AIDS of both women and men.iii This is confirmed by research which points to complex inter-linkages between poverty, inequality and, in particular, gender inequality, and the AIDS epidemic.iv

**Box 1: Power is fundamental to both sexuality and gender**

The unequal power balance in gender relations that favors men, translates into an unequal power balance in heterosexual interactions, in which … men have greater control than women over when, where, and how sex takes place. An understanding of individual sexual behavior, male or female, thus, necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural, and economic forces that determine the distribution of power.

Source: Geeta Rao Gupta. (See Source iii).

Strategies to prevent the spread of HIV have focused on the promotion of condom use, reduction of the numbers of sexual partners, and treatment of STDs. Many of these responses have failed to address social, economic, and power relations between women and men, among men, and among women. These relationships, together with physiological differences, determine to a great extent women's and men's risk of infection, their ability to protect themselves effectively and their respective share of the burdens of the epidemic.v Gender analysis is essential in understanding these social and cultural underpinnings of the spread of HIV/AIDS, key elements of which are summarized in Table 1 below.

**Table 1: Attitudes and Behaviors Raise Risk and Vulnerability for both Men and Women**

<table>
<thead>
<tr>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual relations at an early age</strong></td>
<td></td>
</tr>
<tr>
<td>Stigma attached to HIV/AIDS discourages testing, knowledge sharing, and leads to ostracism</td>
<td></td>
</tr>
<tr>
<td><strong>Different perceptions of, and responses to, risk and vulnerability</strong></td>
<td></td>
</tr>
<tr>
<td>* Usually infected at later age (&gt;30)</td>
<td>* Usually infected 5-10 years earlier than men, especially aged 11-29.</td>
</tr>
<tr>
<td>* Frequency of drug abuse, including by injection</td>
<td>* Physiology: women four times more likely to contract HIV and other STDs than men.vi</td>
</tr>
<tr>
<td>* Link between socializing and alcohol use</td>
<td>* Transmission to unborn child (20% - 40% risk).</td>
</tr>
<tr>
<td>* Imbalance of sexual power (incl. violence)</td>
<td>* Link between substance abuse and exchange of sex for drugs or money.</td>
</tr>
<tr>
<td>* Lack of responsibility for own sexuality</td>
<td>* Vulnerable to coerced sex, including rape and other sexual abuse, practice of “dry” sex.</td>
</tr>
<tr>
<td>* Prevailing norms, including emphasis of sexual domination over women, and expectation of greater knowledge which prevents seeking information (difficulty in recognizing gaps in knowledge on sex and contraception).</td>
<td>* Prevailing norms, including culture of silence in sexual matters (inappropriate to be aware of sexuality or to suggest condom use), social value of motherhood, traditional value of virginity, female genital cutting, ritual cleansing, widow inheritance.</td>
</tr>
</tbody>
</table>
* Imbalance of economic power.
* Predominantly male occupations (e.g. truck-driving, seafaring, and military) that involve mobility and family disruption.

* Economic insecurity: less access to and control over economic assets, and fewer options for income/asset creation (= vulnerability).
* Lack of legal recourse and discrimination in legal rights and protections.
* Resort to sex work by migrant or refugee women when families are disrupted.

Sources: Adapted from Geeta Rao Gupta (Source iii), and other materials. See Annex I. vii

Women’s economic dependency increases their vulnerability to HIV. Research has shown that the economic vulnerability of women makes it more likely that they will exchange sex for money or favors, less likely that they will succeed in negotiating protection, and less likely that they will leave a relationship that they perceive to be risky. Geeta Rao Gupta (Source iii)

HIV Prevalence Rates Differ by Sex and Age

Of Africa’s 24.5 million people living with HIV/AIDS, 12.9 million (or 53%) are women, constituting 82% of the world’s women with HIV/AIDS. Africa is the only continent where HIV prevalence is higher for women than for men. The aggregates mask key age/sex differences in HIV prevalence. For every 15-19-year-old boy that is infected, there are five to six girls infected in the same age group. viii The trend of marked gender differences in prevalence rates among 15-24 year-olds can be observed systematically for countries where statistical information is available (Figure 2). Women under 25 years of age represent the fastest-growing group with HIV/AIDS in SSA, accounting for nearly 30 percent of all female HIV/AIDS cases in the Region.

For men, the reverse is true. The data indicate that there is a higher prevalence rate among men over 30 years of age (Figure 3).
B. Impact of HIV/AIDS and Coping Mechanisms

The impact and consequences of HIV/AIDS also differ markedly for men and for women, and reflect their different roles and responsibilities and their access to and control of resources. In most African agricultural economies, women are more active in agriculture than men, providing over 70% of total agricultural labor and up to 90% in food production. The loss of this economically productive potential (both male and female) is a significant development challenge for Africa, and especially in high-prevalence countries, where the development gains of the last few decades are being eroded. The different structural roles of men and women in African agriculture are coupled with their equally different—and unbalanced—roles in the household economy. Analysis of men’s and women’s time allocation captures the interdependence between the market and the household economies and the marked imbalance in total labor effort. Compared with men, women operate under severe time constraints, which limit their options and flexibility to respond to changing economic opportunities. While the African farmer is busy farming, she is also fetching fuelwood and water, grinding grains, preparing meals, doing housework, and looking after the sick and elderly (this last is especially significant in the context of the HIV/AIDS pandemic). She is working 12-15 hours/day, where men work 8-10 hours/day. Moreover, the poorer the household, the larger is the share of total output generated from the unrecognized labor of women. The health of children is often the responsibility of women, and the impact of AIDS on young people therefore affects women more than men. Women also carry by far the most substantial burden of caring

---

Figure 3: Malawi: AIDS Cases by Age and Sex, 1998

---

2 For further discussion of men’s and women’s role in African agriculture, and of the gender dimensions of poverty in SSA, see Blackden and Bhanu 1999.
for the sick and dying, and often become principal breadwinners in the absence of male household heads.

The imbalance in gender roles, which is problematic even in the absence of HIV/AIDS, is greatly aggravated by the pandemic, which puts substantial additional pressure on labor availability and allocation at the household level. Because the household and market economies co-exist and are interdependent, trade-offs and linkages among household and market tasks may be very significant for asset- and labor-constrained (i.e., by any definition “poor”) individuals and households. These trade-offs are exacerbated by the burdens of the HIV/AIDS pandemic. In households where women have major responsibility for farming (as is the case in SSA generally, this leads to:

* reduction of productive time on farms;
* threat to food security of the family;
* withdrawal of girl children from school to bridge demand for additional unpaid labor in the household;
* increase in households headed by women, including at times by girl children, with little access to productive resources, often driving them into sex work.

Africa has a disproportionately high number of AIDS orphans. Approximately 7.8 million AIDS orphans, 95% of the global total, live in SSA. African communities had always taken in orphans, but as the numbers rise as a result of HIV/AIDS and civil wars, and as many able-bodied men and women die, communities are not able to cope with having to look after orphans. Care of orphans, predominantly women’s responsibility, is overwhelming African communities and households. This is occurring in a climate in which AIDS is changing the structure and composition of households, where one finds many households headed by girl children or girl children are heading a combination of two or three households that may have come together for security. But often, they are heads without assets or economic opportunity, which increases their vulnerability to HIV/AIDS, as they fall prey to older men.

IV. The Way Forward: Putting Gender into the MAP

Transforming Gender Roles and Relations

Empowering women is not equal to disempowering men. The key is to transform gender roles and relations. Customs and practices associated with male and female roles and sexuality in many societies today are compromising the rights and freedoms of individuals and promoting a cycle of illness and death. There can be no more powerful reason for change: gender roles that disempower women and give men a false sense of power are killing our young and our women and men in their most productive years.

Geeta Rao Gupta

The challenge of HIV/AIDS prevention and mitigation in Africa is enormous. Government AIDS strategies, supported by MAP operations, need to support profound and deep-rooted behavior change—a transformation of gender roles and relations in Africa. This goes far beyond expanding the use of condoms. Projects at all levels
supported by the MAP need to work from this starting point. Key questions for country strategies and the MAP to ask are how is one to overcome these seemingly insurmountable barriers of gender and sexual inequality? How can the cultural norms that create these damaging, indeed fatal, gender disparities and roles be changed?

An important first step is to recognize, understand, and publicly discuss the ways in which the power imbalance in gender and sexuality fuels the epidemic. A study of female youth in South Africa showed that 71 percent of the girls had experienced sex against their will. xii

The composition of teams (in-country and Bank PCD/PAD) should include the necessary expertise to address, from the outset, the gender dimensions of HIV/AIDS identified here. Key tasks involve:

* developing and applying systematically tools and methods for gender-differentiated analysis of risk and vulnerability, and of impact (see Annex 3);
* gender-appropriate targeting of interventions;
* systematic age- and sex- disaggregation of data and indicators;
* gender inclusion in participatory processes at all levels, and in setting and implementing priorities.

Key gender-inclusive responses for government AIDS strategies and MAP operations are indicated in Table 2 below.

<table>
<thead>
<tr>
<th>Gender Dimension of HIV/AIDS</th>
<th>Key Gender-Responsive Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Risk and Vulnerability</td>
<td>* Integrate gender-differentiated analysis of risk and vulnerability, and of perceptions.</td>
</tr>
<tr>
<td>* Prevalence Rates</td>
<td>* Systematic (age and) sex-disaggregation of prevalence and other data</td>
</tr>
<tr>
<td>* Unequal power balance</td>
<td>* Address economic empowerment of (young) women as a key element of the multi-sectoral response: raise their access to productive assets, resources, and decision-making.</td>
</tr>
<tr>
<td></td>
<td>* Review and reform laws and regulations relating to property rights and access to and control of economically productive assets, as well as those concerning the prevention and suppression of commercial sex work, homosexuality.</td>
</tr>
<tr>
<td></td>
<td>* Review and reform policies regulating sex education in schools.</td>
</tr>
<tr>
<td></td>
<td>* Review and reform rules relating to ethical and professional orientation of service providers.</td>
</tr>
<tr>
<td>* Impact and Consequences</td>
<td>* Specify the different impacts on men and on women (impact much greater for women).</td>
</tr>
<tr>
<td></td>
<td>* Measures to strengthen male responsibility for sexuality and family life.</td>
</tr>
<tr>
<td></td>
<td>* Advocate women’s right to accurate information regarding HIV status during pregnancy (75% do not transmit the virus to fetus) to avoid coerced abortions and further trauma.</td>
</tr>
<tr>
<td></td>
<td>* Access to health services for adolescents.</td>
</tr>
<tr>
<td>* Care and coping.</td>
<td>* Address gender-differentiated burden of care for the sick, and for AIDS orphans.</td>
</tr>
</tbody>
</table>
Focus on needs of child- (and girl-) headed households.

Role of media/social marketing

- Improve public understanding of the epidemic, particularly the socio-economic causes and consequences.
- Build alliances between activists, civil service, academia, and health service.

Transformation

- Focus on actions that contribute to transformation of gender relations, i.e., focus the needed behavior change on men (especially men over 30).
- Lowering incidence of violence against women by:
  - Creating shelters for women in distress and more centers for child care for abused women;
  - Increase group housing areas for women living with HIV/AIDS.
- Factors that enable women in particular to be able to negotiate “safe” sex.
- Support to hospices run by NGOs to assist women living in nuclear families without any support for care and nursing of the sick.
- Support to programs ensuring women remain visible as workers in the labor market.
- Avoid damaging stereotypes (male and female).

Specific actions to integrate gender into MAP operations are as follows:

Build on existing country knowledge and capacity on the gender dimensions of HIV/AIDS, and on local examples of good practice in addressing the cultural sensitivities surrounding gender issues, which are often considerable (Box 2).


The draft framework, prepared by the Government of Uganda, is striking for its awareness of the gender dimensions of HIV/AIDS in the diagnostic. The framework brings out gender when it refers to girl orphans; the greater vulnerability of girls and young women in the 14-24 age group, and the higher prevalence of HIV/AIDS among men over thirty; the greater burden of caring for the sick that falls to women, with very limited resources; and the higher levels of trauma women go through when loved ones die, with the attendant impact on households, communities and their ability to cope. The framework portrays the greater risks women face compared with men with respect to HIV/AIDS.

Undertake systematic age- and sex-disaggregation of data on HIV/AIDS, in all its dimensions, to provide a basis for gender analysis of these data, and for gender-responsive design and monitoring of MAP-supported interventions (An indicative example is in Table 3 below).

---

3 Proposal from: Madhu Bala Nath, UNAIDS/UNIFEM, Gender and HIV Adviser.
Table 3: Uganda: Summary HIV/AIDS Data

<table>
<thead>
<tr>
<th>Variable</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>People Living with HIV/AIDS end 1999 (Adults and Children)</td>
<td>820,000</td>
<td></td>
</tr>
<tr>
<td>Adults Living with HIV/AIDS (Age 15-49)</td>
<td>420,000</td>
<td>350,000</td>
</tr>
<tr>
<td>Adult Prevalence Rate (%)</td>
<td>8.30</td>
<td></td>
</tr>
<tr>
<td>Orphans (Cumulative)</td>
<td>1,700,000</td>
<td>110,000</td>
</tr>
<tr>
<td>Estimated AIDS Deaths, end 1999 (Cumulative)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Prevalence Rate in Young People (15-24), High Estimate (%)</td>
<td>8.99</td>
<td>5.12</td>
</tr>
<tr>
<td>Female Sex Workers/Male STD Patients (Major Urban Areas) (%)</td>
<td>n.a.</td>
<td>29.4</td>
</tr>
</tbody>
</table>

*Source: UNAIDS Table of Country-Specific HIV/AIDS estimates and data, June 2000. n.a. = data not available.*

ตัด List of Transforming Gender Roles and Relations: Some Examples and Possibilities

- Encouraging young men and women to form groups where sex and HIV/AIDS could be discussed openly, with a view to instilling responsibility by both girls and boys, especially the latter, to themselves, their partners and families. Groups such as Positive Living in Zambia suggest that this could be done. Such groups could be channels for medical literature and facilitating economic and social empowerment for young women.
- Actions that directly empower young women economically, including sex workers, by enabling them access to assets and information on HIV/AIDS to lessen their vulnerability.
- Linking girls to women’s groups to offer guidance proactively or support in case they are infected.
- Providing support, for example through grants to serve as seed capital, to girl household heads for income-generation activities, thereby reducing their economic vulnerability.
- Encouraging reviews of national policies and laws to put in place policy and legal measures to strengthen women’s rights and legal protections.
- Pay attention to men’s roles and responsibilities, as with the UNAIDS current focus on men as key actors in HIV/AIDS prevention.

Explicit focus on gender-inclusion in priority setting and participatory processes at all levels, and especially at the community level (so that the different needs/priorities of men and women can be identified and acted on)—this is also relevant in constituting the various policy, oversight, coordination, and technical committees (institutional arrangements) established at different levels to address HIV/AIDS in the country. Involve a wide range of stakeholders, including national women’s machineries and NGOs in these processes. Monitor this (pro-activity) in the MAP, at all key levels.
Integrate full attention to the gender dimensions of HIV/AIDS in the IEC, sensitization, and awareness-building programs supported by MAP projects—this could be done through design and development of gender-focused modules and informational messages on HIV/AIDS, using local gender expertise and capacities, which are tailored to the specific socio-cultural and economic circumstances of the country.

Ensure pro-active gender inclusion in all training and capacity-building activities—and do so in ways which take account of men’s and women’s different workload, availability, education/literacy levels, and other constraints to participation.

Focus actions on the care of AIDS orphans in ways that specifically address gender-differentiated roles and responsibilities for orphan care, and the different risks and vulnerabilities of male and female orphans—for example, constraints to school attendance or to access to social and other services.

Integrate child-, and especially girl-, headed-households into the monitoring of households targeted for, or receiving assistance from, government or NGO agencies.

Behavioral changes do not come just because individuals are better informed or condoms are more readily available. Actions are needed: (i) to change the social conditions facilitating the spread of HIV/AIDS; and (ii) to create social stimuli to induce behavioral changes. Sustained and responsible sexual behavior change is not possible without:

* Gender awareness, especially advocating (among men and community leaders) women’s right to discuss sexual matters with their partners such as multiple partners and extra-marital relations and their right to protect themselves from infection.
* Changes in gender roles in the community, especially to enhance women’s socio-economic status in the community and their formal representation in decision-making.
* Changes in sharing responsibility between men and women, especially with regard to caring for the sick and dying, and for orphans.
* Changes in power imbalances that exist in the community and the society at large.
* Mobilizing resources to improve women’s access to quality sexual and reproductive health care and to meet their needs for information and services.

Annex 1: Schematic Presentation of the Emerging Approach to Promote Behavioral Change to Control the Spread of HIV/AIDS

**Society**
- Political support / Media support
- Poverty reduction and development
- Expanded health services
- Mainstreaming HIV/AIDS into sector planning
- Supporting an expanded response
- Employment opportunities for youth
- Income generation for women and other groups
  - **Addressing gender inequality**
  - Decentralization / health reforms

**Facilitation Support at the District level**
- Political support / media support
- Basic health services: STD/STI and TB; continuity of care; referral options; voluntary counseling and testing; safe blood transfusions
- Mainstreaming HIV/AIDS into district planning
- Facilitating local response development
- Employment opportunities for youth
- Income generation for women and other groups
  - **Addressing gender inequality**
  - Decentralization / devolution

**Community**
- **Gender sensitive community actions** for a supportive environment for behavioral change
- Creating economic opportunities
- Priority for vulnerable groups
- Priority for high transmission areas
- Community actions to strengthen care and support

**Organizational**
- Workplace support
- Workplace actions
- Mainstreaming HIV/AIDS
- Involve existing rural programs

**Interpersonal**
- Positive peer pressures for behavioral change
  - **Changing gender inequality**
  - Priority for the most vulnerable groups

**Individual Behavioral change**

*Source: Strategic Framework for District and Community Action in HIV/AIDS*
Annex 2: Resources for Gender and HIV/AIDS

Technical and Substantive Resources

UNAIDS’ Best Practice Collection on Human rights, Gender and HIV/AIDS  
(http://unaids.org/bestpractice/collection/subject/human/index.html#gender)
UNIFEM’s Gender, HIV and Humans Rights Training Manual  
(http://www.unifem.undp.org/public/hivtraining/)
World Bank’s Tools for Gender-Sensitive Monitoring and Evaluation for Rural Development Projects (draft), quite useful for M&E activities for Projects that are already being implemented, also includes a framework for Engendering the Logframe.  
PRSP Sourcebook: Gender Chapter
“The Process of Gender Analysis: Ten Steps” http://afr/aft2/gender/tensteps.htm (focus on agriculture, but can be useful in general terms)
Improving Women’s Health: Issues and Interventions, Anne Tinker et al, June 2000, World Bank, HNP

Useful Websites

http://www.worldbank.org/afr/findings/english/find84.htm/
http://www.ratn.org/ (Regional AIDS Training Network)
http://www.undp.org/hiv/
http://hivinsite.ucsf.edu/ (University of California San Francisco’s Youths, Adolescents and HIV/AIDS activities)
http://www.icrw.org/pubs.htm (International Center for Research on Women)
http://hri.ca/partners/alp/index2.shtml: (AIDS Law Project)
http://www.ids.ac.uk/bridge/ (BRIDGE, Institute of Development Studies, UK supports gender mainstreaming efforts)

(An Annotated listing of the contents is being developed)
Some technical experts for possible consultancies, training, support, missions, etc. (v. partial, selective, and incomplete)

<table>
<thead>
<tr>
<th>Name &amp; Country</th>
<th>Area of Expertise</th>
<th>Contact Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marthe Mahonde (Harare)</td>
<td>Gender-HIV/AIDS general</td>
<td><a href="mailto:Martha.mahonde@undp.org">Martha.mahonde@undp.org</a></td>
</tr>
<tr>
<td>Joshua Emannuel (Nigeria)</td>
<td>Gender-HIV/AIDS general</td>
<td><a href="mailto:Joshua.emmanuel@undp.org">Joshua.emmanuel@undp.org</a></td>
</tr>
<tr>
<td>Madhu Bala Nath (India)</td>
<td>Training Manual on gender and HIV/AIDS</td>
<td><a href="mailto:Madhubalanath@hotmail.com">Madhubalanath@hotmail.com</a></td>
</tr>
<tr>
<td>Suneeta Dhar (India)</td>
<td>Gender-HIV/AIDS general (NPO at UNDP country office)</td>
<td><a href="mailto:Suneeta.dhar@undp.org">Suneeta.dhar@undp.org</a></td>
</tr>
<tr>
<td>Geeta Rao Gupta (US)</td>
<td>Gender – ICRW</td>
<td><a href="mailto:Geeta@icrw.org">Geeta@icrw.org</a></td>
</tr>
</tbody>
</table>

Suggestions welcome

Financial Resources (Bank Trust Funds, TG resources, etc.)

Policy and Human Resources Development (PHRD) Fund
Japanese Social Development Fund (JSDF)
The various Gender and Development Thematic Groups Innovation Fund (e.g. Gender and Transport TG is currently accepting proposals for gender and transport projects).
Annex 3: Gender-Aware Tools

Tools such as situation analysis and action development have to be gender-sensitive and assess how HIV/AIDS affects men, women and youth in a given context.

(A) Gender-Aware Risk Mapping

Mapping of risk places in the community is a good tool to visualize where risk behaviors take place in the community. It indicates places where people socialize, where they look for new sex partners and shows that not all sexual acts are voluntary. Once people have identified the risk areas in the community they will analyze factors of vulnerability by asking themselves why it is so difficult to avoid risk behavior, despite knowing the basic facts about HIV/AIDS. Based on the vulnerability analysis, the community makes decisions on actions to reduce vulnerability to HIV/STI infection. To show differences in vulnerability for men and women, it is recommended that the mapping be done by groups of women and men separately. Other vulnerable groups like youth should also follow this process separately. It is key that the different groups present their maps and analysis to each other along with their proposed actions, to stimulate discussion between the different groups. Box 1 presents an example of actions taken by the Kisesa community in Magu District, Tanzania.

Box 1: Example of actions to create a more supportive environment for behavioral change

1. Change in closing hours of bars and local beer shops
2. Imposing restrictions for youth to enter drinking establishments
3. Official meetings in the community should always address HIV/AIDS issues
4. Traditional dances close before darkness falls
5. Women only collect water/firewood after dark when men accompany them
6. Ensure condom availability at places where people meet new sex partners like bars, guesthouses, market places, etc.
7. Community drama groups present results of the mapping process and actions to the wider community, and stimulate discussion between men and women, boys and girls
8. Community asked for improved STI services, especially drug availability
9. Community asked for improved and more youth-friendly sexual and reproductive health (S and RH) services

(B) Gender-Inclusive Participatory Rural Appraisal (PRA)

Gender issues are an essential element in planning interventions for HIV/AIDS transmission. A gender perspective is necessary to understand sexual behavior, underlying social and economic factors, and to develop specific interventions. Participatory Rural Appraisal (PRA) methods can help address the needs of women, men, young people (boys, girls) as distinct stakeholders with specific needs. Action plans...
produced by each community should be prepared and implemented by the various groups of stakeholders to make sure that they reflect their respective needs and priorities (Box 2).

**Box 2: Example of Gender-based Situation Analysis in Tanzania**

Separate groups of men and women did a risk and vulnerability mapping exercise. This led to:

* Different maps by women and men; men mapped bars and guesthouses, women mapped the water well, firewood collection sites, the milling machine, the market and many other places.
* Men and women formulated different action plans.

Based on the analysis, discussions were held between men and women about the need for behavioral change and shared responsibilities for family matters and for care and support. Over the past 3 years, many villages produced “village laws” that have contributed to improved gender relations.

Source: *Strategic Framework for District and Community Action in HIV/AIDS.*

**Sources and References**

2. Cite some of the literature supporting this conclusion, including the “Why All the Talk About Women and AIDS?” factsheet of the AFR Region, July 1996.
5. This summary is drawn from the Royal Tropical Institute (KIT), the Netherlands, at www.kit.nl/IBD/extern/res_pack_why_gender.asp.
6. For women, there is greater biological vulnerability due to a larger mucosal surface exposed during intercourse, higher concentration of HIV virus in semen than in vaginal fluid, and other risk factors such as intercourse at a younger age when the mucosal surface is still tender or when it is damaged from rituals and practices such as FGM, rape, etc. There is also epidemiological vulnerability because of sex/marriage with older men who may have had more sexual partners (thus are more likely to be infected), and due to more frequent incidence of blood transfusions during childbirth and abortions, as well as anemia while pregnant.
7. Time and other labor constraints are addressed in GGPR.
8. Get this (World Bank, 1999) and other references.
9. Reference Zambia study (90% care provided by women) and other sources ....?
10. Time and other labor constraints are addressed in GGPR.
11. This section draws heavily from Geeta Rao Gupta, *op. cit.*
12. Source: to be specified ....
13. This note is an initial and incomplete draft. It was prepared by Shimwaayi Muntamba (smuntemba@worldbank.org) and Mark Blackden (mblackden@worldbank.org), Gender Team, Africa Region, in December 2000. Valuable contributions were made by Homira Nassery (HDNHE), Waafas Ofosu-Amaah (PRMGE), Marguerite Monnet (WBIHD), Arlette Campbell-White (WBIHD), and Jean Delion (AFTR2). Comments and suggestions to improve this document are welcome, and should be addressed to the e-mail addresses indicated here.