



**Gender
and HIV/AIDS**



**UNAIDS
Technical update**

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At a Glance

- Whereas sex is biological, gender is socially defined. Gender is what it means to be male or female in a certain society as opposed to the set of chromosomes one is born with. Gender shapes the opportunities one is offered in life, the roles one may play, and the kinds of relationships one may have—social norms that strongly influence the spread of HIV.
- For women, risk-taking and vulnerability to infection are increased by norms that make it inappropriate for women to be knowledgeable about sexuality or to suggest condom use; the common link between substance use and the exchange of sex for drugs or money; and the resort to sex work by migrant and refugee women and others with family disruption.
- For men, risk and vulnerability are heightened by norms that make it hard for men to acknowledge gaps in their knowledge about sexuality; the link between socializing and alcohol use; the frequency of drug use, including by injection; and predominantly male occupations (e.g. truck-driving, seafaring, and military) that entail mobility and family disruption.
- For young people, norms that discourage access to information and services for safer sex; prescribe the preservation of female virginity (which may encourage alternative practices such as anal sex); and that pressure young males to have early and repeated sexual "conquests" also increase the risk and vulnerability to infection.
- In cultures where HIV is seen as a sign of sexual promiscuity, gender norms shape the way men and women infected with HIV are perceived, in that HIV-positive women face greater stigmatization and rejection than men. Gender norms also influence the way in which family members experience and cope with HIV and with AIDS deaths. For example, the burden of care often falls on females, while orphaned girls are more likely to be withdrawn from school than their brothers.
- Hence, responses to the epidemic must build on an understanding of gender-related expectations and needs, and may need to challenge adverse norms.
- For example, people should be assisted in identifying unhelpful norms and sharing personal prevention strategies. Affordable female condoms and the development of microbicides can reduce women's vulnerability. Health care for sexually transmitted diseases (STDs), which magnify HIV transmission if untreated, should be geared to the specific needs of young and adult men and women. The reproductive rights of women with HIV should be protected, and men encouraged to care for those with AIDS.
- To reduce vulnerability through social transformation, partnerships should be created with those working outside the AIDS field to raise women's status, reduce coercive or violent sex, and support family integrity among migrants and mobile workers.

UNAIDS Best Practice materials

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is preparing materials on subjects of relevance to HIV infection and AIDS, the causes and consequences of the epidemic, and best practices in AIDS prevention, care and support. A *Best Practice* Collection on any one subject typically includes a short publication for journalists and community leaders (Point of View); a technical summary of the issues, challenges and solutions (Technical Update); case studies from around the world (*Best Practice Case Studies*); a set of presentation graphics; and a listing of key materials (reports, articles, books, audiovisuals, etc.) on the subject. These documents are updated as necessary.

Technical Updates and Points of View are being published in English, French, Russian and Spanish. Single copies of Best Practice materials are available free from UNAIDS Information Centres. To find the closest one, visit UNAIDS on the Internet (<http://www.unaids.org>), contact UNAIDS by email (unaids@unaids.org) or telephone (+41 22 791 4651), or write to the UNAIDS Information Centre, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

Gender and HIV/AIDS: UNAIDS Technical Update (UNAIDS Best Practice Collection: Technical Update). Geneva: UNAIDS, September 1998.

1. Acquired immunodeficiency syndrome—transmission
2. Women

WC 503.71



Background

Gender roles and relations have a significant influence on the course and impact of the HIV/AIDS epidemic in every region of the world. Understanding the influence of gender roles and relations on individuals' and communities' ability to protect themselves from HIV and effectively cope with the impact of AIDS is crucial for expanding the response to the epidemic.

UNAIDS uses a broad definition of gender (see below). Whereas sex is biological, gender is socially defined. Our understanding of what it means to be a girl or a boy, a woman or a man, develops over a life-time; we are not born knowing what is expected of our sex—we learn it in our families and communities. Thus, these meanings will vary by culture, by community, by family, and by relationship,

with each generation and over time.

Research shows that being a girl or boy and a woman or man, influences how a person experiences and responds to the HIV/AIDS epidemic. A gender-based approach to understanding HIV/AIDS examines the ways in which gender influences:

- individual risk and vulnerability to HIV;

- the experience of living with HIV/AIDS;
- the impact of an individual's HIV-related illness and death within a family or community; and
- responses to the epidemic at the individual, community, and national level.

An effective *response* to the epidemic must be built on understanding those influences.

**Gender
a broad definition**

"What it means to be male or female, and how that defines a person's opportunities, roles, responsibilities, and relationships."

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The Challenges

The gender dimensions of risk and vulnerability

Physiological differences in the genital tract directly contribute to women running a higher risk of acquiring HIV infection and STDs than men. Additionally, the presence of an untreated sexually transmitted infection in both men and women greatly enhances the risk of transmitting and contracting HIV through unprotected intercourse (See UNAIDS's Technical Update *The public health approach to STD Control*). In women, many STDs are asymptomatic, so that many women are unaware that they need to seek care.

Beyond these purely physiological factors, women who believe they may have been exposed to or are infected with an STD face many gender-related barriers to getting appropriate treatment. Distance to health services is one, since in many instances, women are restricted by household responsibilities and their lack of mobility. Service costs and the medicines the service provider prescribes can also restrict women's access to appropriate treatment since women often lack independent funds to pay for them. In addition, women-oriented health services generally do not include STD-related services. At the same time, services that only focus on STD treatment carry a greater stigma than integrated services, which creates yet another barrier to access for women (and men as well).

Existing STD clinics are generally not designed to suit the needs of users—both men and women.

Although STD symptoms are easier to recognize in men, they too often delay or receive inappropriate treatment. Both HIV-positive men and women with an untreated STD are more infectious and place their partners at higher risk of contracting HIV through unprotected intercourse.

Gender norms often determine what women and men are supposed to know about sex and sexuality, and hence, limit their ability to accurately determine their level of risk and to acquire accurate information and means to protect themselves from HIV. In many societies, it is inappropriate for women to seek out or have extensive knowledge about sexuality or reproductive health. Men, in contrast, are expected to be well informed about matters related to sex, although many are not. Masculinity norms can make it especially difficult for men to admit this lack of knowledge. In both cases, norms may be based on incorrect information or myths. For example, many truck drivers in India believe that their safety as drivers depends on regularly having sex in order to release heat that builds up in their bodies during driving.

Gender roles also contribute to behaviours that foster HIV risk or inhibit preventive action. In many societies, the feminine ideal is characterized by women's passivity, ignorance, and expectations that they will defer to men's sexual needs, while sexual prowess, multiple partnerships, and control over sexual interactions define masculinity. These factors

contribute to risk of infection in both men and women.

In many parts of the world, male control and dominance is expressed as sexual coercion and violence. Many women around the world express powerlessness at being able to exercise control over when sex takes place and under what circumstances. Under situations of violence or the threat of violence, women are severely constrained in their ability to take measures to protect themselves from infection or insist that their male partners take precautions.

Alcohol and drug use increase men's and women's vulnerability to acquiring HIV. Socializing for men often involves alcohol. Excessive levels of consumption can contribute to unsafe as well as violent sexual behaviour. Other controlled substances, including injecting drugs, are also used predominantly by men, increasing their risk of acquiring HIV, and contributing to the risk of those women who are their sexual partners. Among women, alcohol and drug use is often linked to the exchange of sex for drugs or money, further elevating their risks of acquiring HIV.

Broader societal realities further contribute to gender-related vulnerability to HIV infection. Macroeconomic and political situations encourage or compel many men and women to leave their homes and families in search of work or safety. Many migrant and refugee women, and some men, girls, and boys turn to sex work to support themselves or their families.

The Challenges

Others are made vulnerable to HIV by virtue of the disruption mobility causes to their families and social support networks. The military and many mobile occupations (e.g. truck driving and seafaring) are predominantly taken up by men and also contribute to circumstances that elevate their risk. (See UNAIDS *Refugees and AIDS*—Technical Update and *AIDS and the military*—Point of View)

Male condoms are the primary prevention technology available to protect against HIV transmission during sexual intercourse. While they are effective when used consistently and correctly, there are many gender-related barriers that limit their use. In cultures where condoms are associated with illicit sex and STDs, women who attempt to introduce them into a relationship encounter problems such as being perceived as unfaithful or “over-prepared”. Condom use may conflict with their own or their partner’s desire to conceive. Among both women and men, barriers to condoms also include perceptions that they reduce pleasure and intimacy, and the fear that suggesting them would insult their partners.

Gender, youth, and vulnerability

In most societies, adults act as gatekeepers to young people’s access to information about sex and health. Yet many adults are uninformed about HIV/AIDS, and many others hold the misperception that young people’s access to information about sex will lead to early

sexual initiation (see UNAIDS Technical Update *Learning and teaching about AIDS at school*.) The protection of virginity is a key message in young girls’ sexual socialization in many cultures. Where virginity among girls is highly valued, young women are inhibited from seeking out sexual and reproductive health information and services. If they do so, they risk being perceived as sexually active, with severe consequences, including expulsion from the home. The adoption of alternative and unsafe sexual practices, including unprotected anal sex, sometimes results from the desire to protect virginity. In many places, unmarried women do not have access to family planning or STD services.

Many young people, especially girls, are also vulnerable to HIV as a result of their desirability to adults who perceive them as “clean” and therefore free from disease. Coupled with this perception are circumstances which compel young people (especially girls) to trade sex for money or goods. In many countries where economic conditions make it more difficult for girls to afford school fees, they may seek out the favours of a “sugar daddy” (an older man who offers compensation in cash or kind in exchange for sexual favours), engage in transactional sex (i.e., exchange sex for money or goods on an occasional basis) or enter the sex trade in order to pay for school or support their families.

While research shows that many boys are taught to demand virginity in a potential spouse,

they are also often encouraged by adults and peers to demonstrate their masculinity through early sexual initiation and multiple sexual “conquests,” including visiting sex workers as a first sexual encounter. HIV prevention messages that promote abstinence or the delay of sexual initiation among boys without addressing broader gender expectations of masculinity may often simply create conflict and confusion.

Influence of gender on the experience of living with HIV/AIDS

In all societies, the experience of living with HIV/AIDS is one frequently defined by discrimination, often leading to loss of employment or housing, or the denial of treatment and care. Fear of ostracism prevents many women and men living with HIV from confiding in others or seeking the care or support they need. Many suffer unnecessary isolation.

An important biological difference between men and women that leads to additional social and cultural consequences with regard to HIV/AIDS is that women with HIV can transmit the virus to their babies before or during birth or through breastfeeding. This reality raises many complex issues surrounding pregnant women’s right to freely choose whether to be tested for HIV, and the right of those who know they are infected to make independent, informed choices about childbearing and breastfeeding (see UNAIDS Technical Update *Mother-to-child transmission of HIV*). It also



The Challenges

means that women with HIV who have children are often de facto denied the right to keep their infection status confidential.

In places where HIV is associated with sex between men or with drug use, family and friends often deny the nature of the illness, or simply abandon those infected for fear of being associated with the disease.

Where HIV is seen as a sign of “sexual promiscuity”, the stigma is much more burdensome for women than men. Throughout the world there are reports of women living with HIV who have been thrown out of their homes, often by husbands who were most likely the source of their infection.

For people living with HIV/AIDS, as well as other chronic illnesses, access to care and support also frequently varies by sex. Data from Africa indicate that men are more likely than women to be admitted to the hospital, and family resources are likely to be used—and potentially depleted—for medications and care for male rather than female members of a household.

The gender-related impact of HIV/AIDS

Because of the very different roles and responsibilities assumed by men and women, an HIV-related illness in the family affects men and women differently, and its impact also varies depending on whether the person who falls ill is female or male. In many instances, when a man falls ill, there is likely to be a drop in disposable household income. However, in

many cultures where women are the primary source of food for the household, if a woman becomes ill there is more likely to be a problem with food security.

When a man becomes debilitated or dies from HIV/AIDS, his wife or partner is likely to lose her main source of economic and social support, as are other dependent members of his extended family. In societies where women are not allowed to own property, the death of a spouse often means that a woman will lose her home and land. Practices such as levirate (widow inheritance) and women's limited access to productive resources and work opportunities may compel widows to exchange sex for money, food or shelter.

The burden of caring for her sick spouse generally falls to the wife and other female members of the household. In some situations, this results in the withdrawal of young girls from school. In situations where the woman caretaker herself is living with HIV/AIDS, these additional burdens can worsen her own deteriorating health. When a man's wife or partner becomes ill, established nurturing, care-taking, and productive roles are affected. Most men must continue to work outside the home, and many have never learned to cook or care for children or the sick. In addition to their lacking skills, these tasks are often considered socially unacceptable for men. While female members of the extended family or community may help in the short-term,

many men feel forced to remarry once their wives pass away in order to keep their family together. Because these men are likely to be infected with HIV themselves, this cycle places other women at risk.

Children who lose a parent to AIDS often suffer discrimination, isolation, and impoverishment. When both parents die, extended family or community members, primarily women, often take in these orphaned children. Even when cared for by others, studies reveal that girls and boys who are orphaned are more likely to be withdrawn from school and are more vulnerable to sexual exploitation. How the experiences of girls differ from those of boys is something that requires better understanding.

The Responses

Promote gender awareness in prevention activities

HIV prevention programmes for young people and adults that focus exclusively on modes of transmission and safer sexual practices will not be sufficiently effective. Rather, they should include discussions of gender roles, sexuality, and relationships (see Box 1). They should also focus on developing skills to identify and change gender-related norms that act as barriers to HIV prevention. Creating school- and community-based opportunities for women and men, and girls and boys, to discuss and share experiences and personal prevention strategies is critical. While mixed-sex groups may be appropriate in some settings, separate groups are best for allowing men and women to identify gender-related norms that support behavioural change and challenge those that inhibit such change. (See Technical Updates *Learning and teaching about AIDS at school* and *Community mobilization and AIDS*.)

Promote HIV prevention technologies

As long as male condoms remain the primary HIV prevention technology, efforts must continue to ensure that they are made easily available to women, men, and most importantly, young people. Different marketing strategies and distribution channels may be needed to ensure that male and female, young and old, have easy access to condoms. Yet since it is men who use condoms, more condom promotion activities should target men and boys.

Box 1. *Stepping Stones*: A curriculum to address gender roles and relations

Stepping Stones is a training package for community-wide participatory discussion groups among adult and young men and women on HIV/AIDS, gender, community, and relationship skills, designed largely for use in sub-Saharan Africa but adaptable for use anywhere.

Of particular interest is the range of topics covered before a discussion about HIV/AIDS even begins, including sexual health, use and over-use of alcohol, the role of money in decision-making around sex, the hopes and fears of young men and women. The final sessions focus on assertiveness training, encouraging each peer group to consider and to apply ways in which they can change their behaviour and prepare for the future, even in the face of death. Thus the whole workshop enables individuals, peer groups, and communities to explore their own social, sexual, and psychological needs, to analyse the communication blocks they face and to practice different ways of addressing their relationships.

To date, the curriculum has been used in many sites in Uganda, and efforts are underway to bring it to Ghana and Zambia. Initial evaluation of the programme has measured qualitative changes among both adult and young men and women.

Care must be taken to ensure that marketing messages do not reinforce negative gender norms (such as aggressive or predatory

male sexuality), but instead promote responsible attitudes toward sexuality and family. Condom promotion should be coupled with gender-specific programmes to teach "negotiation skills" with a partner and condom use skills.

Introducing and distributing female condoms at affordable prices to both adult and young women and men should also be done with sensitivity to the gender implications of this new technology. Care must be taken to ensure that women are given the skills to negotiate its use and employ it correctly, and that men are well informed of its benefits to them and their partners. (See UNAIDS Point of View *The Female Condom and AIDS*.)

Develop new technologies

In order to enhance women's capacity to protect themselves from HIV and STDs, research on microbicides must be expanded and up-to-date findings on their efficacy and safety must be widely and regularly disseminated. Both advocacy and information dissemination in this area can be facilitated by working closely with family planning organizations, women's networks, those working with sex workers, and the media. (See Technical Update *Microbicides for HIV prevention*.)

Currently, many countries cannot afford costly laboratory tests for testing the presence of an STD. Therefore, one of the priorities in STD research is to develop a simple tool for detecting a sexually transmitted infection.

Finally, a vaccine will make the greatest difference for those

The Responses

populations that have the least control over their risk and vulnerability, and this is particularly true of adolescents and poor women. Among the social challenges of any vaccine that may be developed will be to ensure availability to those who need it most, reducing gender-related barriers to access (e.g. distance, cost, and stigma) that prevent women, men, and youth from receiving health services in developing countries, and ensuring that the vaccine is affordable to those with limited economic resources.

Expand and integrate HIV and STD services

It is imperative that there be greater awareness of and information about the signs and symptoms of STDs and HIV/AIDS within communities. Since many of the STDs are asymptomatic, especially in women, self-risk assessment should be taught to both men and women, and the importance of partner notification and referral should be emphasized. STD and HIV/AIDS services must be made more accessible and appropriate to meet the needs of adult women and men and, even more importantly, adolescent girls and boys. Integrating such services into existing primary health care facilities, family planning clinics, maternal-child health care centres and private clinics makes them available and accessible to far more people than are currently being served, especially sexually active unmarried women and adolescent girls (see Box 2). In order to better meet the needs of youth, STD and HIV services can be integrated

into school health services and into social and cultural centres for youth. In all cases, the staff should be trained to approach the patients in culturally and gender-sensitive ways.

Reduce women and men's vulnerability to HIV

Dealing with gender-related factors that increase men's and women's vulnerability to HIV is central to an expanded response. Both short- and longer-term efforts will be needed, though most are similar in their aim to promote some level of social transformation. All require the creation of partnerships between organizations working locally, nationally and, in some instances, internationally.

Programmes aimed at improving women's access to education and to economic resources, such as training, legal reform, and credit schemes, have been shown to have positive results in reducing fertility and contributing to women's overall decision-making power within households. Such efforts can lead to more equal decision-making power in sexual relationships between men and women. Policy reform to mitigate the negative health consequences of migration by reducing male, female, and young people's vulnerability to HIV/AIDS must be supported and expanded.

An expanded response to HIV/AIDS must also address the issue of coercive or violent sex,

Box 2. Service Integration

In response to the rapid expansion of the AIDS epidemic among Brazilian women during the early 1990s, Sociedade Civil Bem-estar Familiar do Brasil (BEMFAM) began integrating HIV/STD prevention and STD diagnosis into their family planning services by training their personnel and providing these services to their clients. A central theme in the training and services provided, is that integration can improve the overall quality of and sensitivity to women's and men's health. A BEMFAM physician is quoted as saying "Someone can be a good professional, knowing how to insert an IUD correctly and knowing exactly which medication should be given for gonorrhoea, but their approach needs to involve viewing a person as a whole, tending to a client from a holistic perspective of overall health and well-being."

In Brazil, more than 3000 women have participated in group discussions run by BEMFAM that allowed them to share concerns with other women about sexual issues, such as STD history, risk, and condom use, and to "practice" conversation with their partners.

BEMFAM staff say that these sessions have had positive results and that the integration of HIV/STD prevention and STD diagnosis and treatment within reproductive health and family planning services can improve the quality of services and can meet a broader range of clients' sexual and reproductive health needs. Similar discussion sessions were held in Honduras and a focus group of community members in Jamaica has recommended that assistance be provided to build communication skills between the sexes.



The Responses

which often carries with it a high risk of infection. In situations where sexual violence is prevalent—such as some refugee situations, for example—programmes to prevent sexual violence should be given the highest priority. Given that these circumstances are most often not about sexual pleasure but rather are about issues of power and control, counselling programmes—such as those to meet the needs of men who themselves have been sexually violated—are critical to slowing the cycle of coercion, vulnerability, and HIV risk. Emergency interventions that can reduce the risk of HIV infection for women victims of sexual violence also need to be explored.

The repeal of laws and policies that place obstacles in the way of effective HIV/AIDS prevention should be a priority in the agenda for action. Furthermore, HIV/AIDS programmes can and should collaborate with local and national human rights groups to actively promote human rights as a means of reducing vulnerability.

Equally, HIV/AIDS-related stigmatization and discrimination magnify broader levels of discrimination based on gender, age, and economic and social status. HIV/AIDS programmes should continue to make a concerted effort to ensure that those most vulnerable to discrimination are protected in the areas of access to care and treatment, security in education, housing, and employment, and that the reproductive and sexual rights of women living with HIV/AIDS are not violated with respect to having and/or raising children.

Reduce gender's impact on living with HIV/AIDS

The best way to guarantee that policy, prevention, and care programmes for men and women living with HIV/AIDS are gender-sensitive and appropriate to their needs is to ensure their full participation in planning and implementation. To strengthen their capacity to participate and help alleviate the isolation experienced by many, support groups should be encouraged and facilitated. While mixed-sex groups may be appropriate in some settings, separate groups will allow men and women to identify and address gender-related experiences and concerns. Providing legal services for women and men living with HIV/AIDS will also be important to alleviate the impact of gender and HIV-related discrimination. Finally, an enhanced clinical understanding of HIV disease in women is necessary to ensure that women are given the highest level of care available.

Special efforts will be needed to guarantee the protection and enhancement of the reproductive and sexual rights of women living with HIV/AIDS. This should include ensuring that both women and their partners are given accurate information about HIV and pregnancy and pregnancy termination, where legal. They should also be informed about the risks and benefits of breastfeeding so they can make informed decisions. Efforts will also be needed to ensure that women and girls living with HIV/AIDS have equal access to available care, treatment, and support. This may require efforts to influence national, community,

and household-level resource allocations decisions.

Ensure equity in care-giving responsibilities

In response to the impact of the epidemic overall, families and communities are being forced to take up new roles and responsibilities. As this response evolves, care must be taken to ensure that hospital and home care strategies that rely on the labour of family members are sensitive to the demands they place on women and girls and are designed to protect them from undue burdens. Special attention should be paid to ensuring that boys and especially young girls in affected households are not withdrawn from school. As part of this, efforts must be initiated and supported to strengthen the involvement of young men and male adults in providing care and support for those living with HIV/AIDS. Strategies need to be identified and supported to facilitate the expansion of their roles and responsibilities in this area, including changing norms to consider these roles appropriate for men.

Both women and men are involved in developing effective community-level responses to the epidemic. While there is evidence that their involvement often differs on the basis of sex, how or why this is so has not been explored. Documenting the varied roles and responsibilities taken up by women and men in local community-based initiatives will help identify how we can best support each other in responding to the challenges of the HIV/AIDS epidemic.

Selected Key Materials

Ankrah M, Schwartz M, Miller J. Care and Support Systems. In: Long L, Ankrah M, eds. *Women's Experiences with HIV/AIDS: An International Perspective*. Columbia University Press, 1996. Drawing from the experiences of women in developed and developing countries, this article offers recommendations for a woman-centred approach to HIV/AIDS care and support systems.

Carovano K. *HIV and the Challenges Facing Men*, New York, HIV and Development Programme, United Nations Development Programme, 1995 (UNDP Issues Paper, No.15). Presents discussion based on contributions received from men from developed and developing countries on the issues of HIV-related behaviour change, illness and care, and death and loss as they relate to men.

Effective Approaches for the Prevention of HIV/AIDS in Women, Geneva, Global Programme on AIDS, World Health Organization, 1995. Summarizes 13 approaches to prevention, highlighting lessons learned from each and general findings. Central conclusion that programmes serving women vulnerable to HIV/AIDS should support social, economic, and legal measures that improve the status of women.

Facing the Challenges of HIV, AIDS, STDs: A Gender-Based Response, The Netherlands, Royal Tropical Institute, Southern Africa AIDS Information Dissemination Service, and the World Health Organization, 1995. Resource pack that aims to help policy-makers, implementers and service providers develop a

gender-based approach to their work on HIV/AIDS and STDs.

Rao Gupta G, Weiss E. *Women and AIDS: Developing a New Health Strategy*, Washington, D.C., International Center for Research on Women, 1993. Presents how economic and social conditions promote heterosexual HIV transmission, and suggests which immediate and longer-term strategies for ameliorating the relevant conditions may be most promising.

Reid E. *Some Thoughts on Women and HIV*, New York, HIV and Development Programme, United Nations Development Programme, undated (UNDP HIV and Development Programme Working Papers, No.1). A compendium of three previously published documents that provide clear, concise overviews of the urgency of male/female partnership in transforming social norms that drive the epidemic; adolescent girls' vulnerability to HIV infection; and, the inter-connection between lack of attention paid to women as agents and beneficiaries of development policies and programmes and the HIV epidemic.

Simmons J, Farmer P, Schoepf. A Global Perspective. In: Farmer P, Conners M, Simmons J, eds. *Women, Poverty and AIDS: Sex, Drugs and Structural Violence*, Common Courage Press, 1996: 39-90. Re-examines the global pandemic and the dynamics of the spread of HIV to poor women around the world. Provides data and illustrative examples for each region and five succinct conclusions about the state of the epidemic as it relates to women.

Weiss E, Whelan D, Rao Gupta G. *Vulnerability and Opportunity: Adolescents and HIV/AIDS in the Developing World*, Washington D.C., International Center for Research on Women, 1996. Presents findings from 17 studies highlighting sexual beliefs, attitudes, behaviour, sexual and AIDS communication patterns, sexual and reproductive decision-making, sexual coercion and violence among adolescents in the developing world. Presents policy and programme recommendations.

Welbourn, A. *Stepping Stones*. London: ACTIONAID, 1995. 240-page training manual and 70-minute workshop video on HIV/AIDS, gender issues, communication and relationship skills. Designed for use in sub-Saharan Africa.

Women and AIDS: Agenda for Action, Geneva, Global Programme on AIDS, World Health Organization, 1994. Examines factors which contribute to women's risk of infection with HIV, and suggests an agenda for action to prevent this, concluding that the sexual and economic subordination of women fuels the HIV/AIDS pandemic and that this subordination should be improved upon.