

**PREVENTING AND COPING WITH HIV/AIDS IN POST-  
CONFLICT SOCIETIES: GENDER BASED LESSONS FROM  
SUB-SAHARAN AFRICA**

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**GENDER BASED EXPERIENCES IN PREVENTING AND COPING WITH  
HIV/AIDS IN POST-CONFLICT SUB-SAHARAN AFRICA**

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# **PREVENTING AND COPING WITH HIV/AIDS IN POST-CONFLICT SOCIETIES: GENDER BASED LESSONS FROM SUB-SAHARAN AFRICA**

## **Introduction**

Sub-Saharan Africa constitutes the part of the world that is most affected by the HIV/AIDS pandemic. In comparison to the rest of the world, Sub-Saharan Africa accounts for a cumulative total of 71% of the total number of people living with HIV/AIDS, 79% of aids deaths, and 92% of the world's AIDS orphans. Women and girls constitute the population groups that are disproportionately affected by the pandemic. Of the 25.3 million adults and children living with HIV/AIDS in the region, 55 % are women. Evidence from individual countries in Sub-Saharan Africa confirms the disproportionate infection rates between men and women. For example, Uganda's 2000 figures reveal a 55% prevalence rate for all women, a prevalence rate of 6.65 to 8.99 percent for women ages 15 to 24, and a range of 2.56 to 5.12 percent for men in the same age group. Zimbabwe's rates are 23.25 to 25.76 percent for women in ages 15 to 24, compared to a range of 9.77 to 12.85 percent for men in the same age group. For Senegal, the rates are 53% for women, 1.12 to 2.97 for women in ages 15 to 24, compared to a range of 0.39 to 1.02 percent for men in the same age group. And for Botswana, the rates are 54% for all women, 32.55 to 36.07 percent for women in ages 15 to 24, compared to a range of 13.68 to 18.00 percent for men in the same age group. Estimates by UNAIDS further highlight the evidence that average rates of infections among adolescent girls in many of the countries in the region is over five times higher than those among boys in the same age group. And among women in their early 20s, rates are three times higher for women than men.

The disproportionate impact of the disease on women and girls has been found to be linked to their weak social and economic status. The impact on women and girls is compounded by culturally prescribed standards of behavior for men and women. Additionally, the poor economic status of women and girls tends to force them to depend on forming sexual relationships with men, and sometimes engaging in prostitution in order to meet their survival needs. Women and girls further get exposed to HIV/AIDS through sexual violence crimes such as rape. The burden of caring for those affected by HIV/AIDS also falls disproportionately upon women, due to their role as caretakers in the family. On the other hand, men's vulnerability stems from their position of power and socially promoted image of masculinity. Young men's vulnerability stems from their tough, experimental and masculinity image that is supported by their societies. The extent to which the above factors influence the vulnerability and impact of the HIV/AIDS pandemic on women and men, however, has been found to be closely linked to various other social and economic related environmental factors that include poverty, unemployment, migration, and weak health infrastructures.

Countries that have been affected by war and conflict in Sub-Saharan Africa have a history of a high degree of sexual violence and prostitution activities that are associated with the presence of military troops, which consequently increased the exposure of

women and girls to HIV. In Rwanda for example, research indicates that 24,000 incidences of rape occurred during conflict, and 24% of those cases happened to women living in refugee camps. Furthermore, the wars have destroyed social support systems, infrastructure, and have also left many individuals, families and communities destabilized. The extent to which these factors are influencing the ability of individuals and communities to reduce their vulnerability to HIV/AIDS is still yet to be fully comprehended in terms of designing effective intervention programs to control and mitigate the impact of the HIV/AIDS crises in these countries.

This paper highlights factors contributing to the spread of HIV/AIDS in the post-conflict societies and the challenges of controlling the disease. The paper starts by discussing the challenges that are faced by women, men, and young people in post-conflict societies, in their ability to prevent and cope with the HIV/AIDS, given the multiple and complex dynamics that shape the HIV/AIDS pandemic in their society. In the second part, the paper briefly discusses the various ways in which men and women in their various communities have responded to the HIV/AIDS crises. The third section of the paper attempts to delineate the experiences of men, women and young people/adolescents from different social groups, and the barriers they face with preventing and coping with HIV/AIDS. This section of the paper also highlights gaps that still exist in our knowledge of barriers faced by certain groups, as well as ideas on how to effectively address some of the challenges of meeting the needs of the various groups. The last section of the paper summarizes issues that need to be addressed in designing and implementing effective HIV/AIDS intervention programs for post-conflict societies in Sub-Saharan Africa.

## **SPECIFIC CHALLENGES OF HIV/AIDS IN POST-CONFLICT SOCIETIES IN SUB-SAHARAN AFRICA**

Post-trauma counseling and rehabilitation programs have not evolved to the level of addressing many of the needs of the women that suffered from the wars and their aftermath.

In post-conflict societies in Sub-Saharan Africa, the vulnerabilities and challenges to coping with HIV/AIDS crises are compounded by the wide range of institutional breakdowns and the disastrous consequences that follow wars and their aftermath. Wars throughout the region have set women apart as easy objects for sexual crimes, such as rape, sexual slavery, enforced prostitution and forced pregnancy, all of which increased their risk of contracting HIV/AIDS. In all the countries where there were peace keeping forces, numerous horrendous stories have been reported about women suffering from sexual violence and humiliation from the hands of soldiers and members of the enemy groups [5, 13, 36, 49]. The mental and emotional trauma that followed the incidences of rapes and forced pregnancies has been accompanied by stigmatization of the women by their community members. First, for having been raped or having an enemy's child, and secondly, for being a potential source of HIV infection. Hence many women who might have gotten infected chose to suffer in silence. The wars also escalated the economic challenges for women, who found

Women are facing isolation, poverty, and increased responsibilities as a result of armed conflicts.

themselves either widowed, separated from their spouses, or had become displaced from their homes and productive resources. In order to survive, they often have to fend for themselves and their children most of the times through forming various types of sexual relationships with men in exchange for economic and social protection, or join the ranks of prostitution. If they were lucky they found some low paying jobs in the formal sector, or alternatively joined the informal sector. In many cases their families from their extended family network (including their in-laws) could no longer absorb them. In spite of the emotional and economic challenges that the women faced, they still assumed the burden of ensuring the well-being of their families including taking care of the sick, and the orphaned [4, 13, 36].

Adolescent girls also suffered the same fate as their mothers when it came to sexual violence and exposure to HIV/AIDS. In fact they were the most preferred by men because of their virginity, innocence and weakness. Heartbreaking stories about young girls being sexually violated by soldiers and many other men in their communities and refugee camps have also been cited in many of the countries in the region [4, 13, 36]. Young girls like their mothers were subjected to separation from their families, forced into prostitution and marriages, including also being subjected to incest. Many of them become unwilling mothers at an early age. The sexual violence and exploitation against women and young girls, including the limited economic options except prostitution, still continue even after the war, with many of the soldiers having settled back into communities through the demobilization and re-integration efforts [5, 19, 36, 54].

Adolescents are woefully overlooked and underserved in their various social and economic needs.

Adolescent girls who's lives entail adult responsibilities with their own children, have been one the most neglected group. Usually society almost forgets them by trying to push them into marriage for their own security, or expects them to grow up "faster" and find means to support their children [54]. When their families cannot afford to help them they often end up in a series of relationships with men, and thus increasing their exposure to HIV/AIDS. The fragile nature of their relationships tends to result in them fighting the disease by themselves with no husband or boyfriend, sorely being supported by family members usually female relatives if they are lucky.

Among women and girls who are internally displaced, or live in refugee camps, the situation of rape, sexual abuse and forced prostitution is an everyday occurrence. This is due to the harsh and poorly regulated and secured conditions under which they live. In a place where there is sometimes shortage of food, young girls and women are forced to exchange sex for food and other economic items that they need. The hard conditions under which they live, often force them to exchange sex for protection and survival. In the camps lack of access to contraceptives, including the social pressure to replace children who died, contribute to the exposure of women to HIV/AIDS [13].

As a generation that has lost its innocence and sense of purpose, they may resort to criminal activities and violence as a means of coping or creating a meaning in their lives.

Wars have subjected adolescent boys to a somewhat more difficult life than elderly men. Whilst in service, they were often sexually abused, brain washed with military values of fearlessness and were violence indoctrinated, with their educational needs neglected [36, 54]. When they were demobilized and re-integrated into their communities, they were ill prepared for a productive life. The harsh conditions in their communities often forced them to leave and go and seek jobs in towns which were already facing high levels of unemployment. In many cases these young men ended up having to become migrant laborers in nearby countries. The trauma of war often destroyed their ability to adjust and they ended up leading lives that are characterized by crime and sexual violence against women. Many of them are faced with adult obligations of having to earn a living or support a family before they are ready. The young men that have been destroyed by the experiences of war end up being those we often refer to as “street kids”, “thieves” and “beggars”. In the streets their lives are characterized by disillusionment and loss of confidence and hope for a positive future, which leave them with no incentive for positive behavior change. To them HIV/AIDS becomes one of many challenges they cannot overcome. The brunt of social rejection makes the long-term probability of dying from AIDS far less compelling than the immediate needs for food, social stability, companionship and acceptance [5, 36, 54].

Ex-members of the armed forces who have been demobilized and returned to communities through the various peace agreements are more likely to be infected, given the high rates of HIV/AIDS infections reported in the military forces in many of the countries. Many of these men are more likely to transmit the HIV/AIDS virus to the communities where they settled. Also men who might have contacted HIV during their military service will now be left to deal with the disease in communities that have inadequate health services, and limited economic resources to afford effective treatment [5, 39].

Women who served in the military also suffered from sexual violence from their male counterparts. Rape and sexual slavery stories have been told by the few women who were able to summon enough courage to do so, given the risk of inviting hostility, embarrassment and social rejection from the military establishment and the governments in their countries [36]. Furthermore, just like their male counterparts, their working conditions involved being exposed to high risk situations that increased their exposure to the HIV/AIDS virus. They too will need support for their health and emotional needs in their returned communities.

In the era of HIV/AIDS therefore, we are seeing a picture of post-conflict societies that are characterized by a lot of economic insecurity, social instability and high level of psychosocial stress in the lives of women, children and men. The family breakdowns

caused by the wars have left women with very little support and economic security, hence many of them earn a living through depending on different relationships with men, the informal sector, or prostitution. Marriage life has also been disrupted by wars and poverty that force men to migrate to cities and nearby countries. The wars themselves have destroyed the economy and support institutions, and has in turn created a culture of violence that has become the norm and a way to survive for those that are facing a circle of poverty, particularly the young unemployed men. Young girls who are generally less educated than boys are facing a life of poverty, and many depend on relationships with men or else prostitution. Women, because of their role as caretakers of the family, are caught up more in a vicious cycle of poverty as they try to look after children by themselves, many of whom have no fathers, due to death or abandonment. Women and girls who are internally displaced have limited control over the situation of being exposed to HIV/AIDS. Men themselves are caught in this cycle of social instability and poverty, given the impact of changes in the global market that always affect their economic security in their various countries [4, 5, 13, 36, 54]. All of these factors compound the vulnerability of post-conflict societies to HIV/AIDS. With the wars having destroyed much of the infrastructure in the various countries, many of the countries do not have appropriate health infrastructure and resources to deal with the HIV/AIDS crises.

Because peace does not automatically fall into place when peace agreements are signed, the aftermath of war in most post-conflict societies in Sub-Saharan Africa, is still characterized by divisions and mistrust between various groups. These divisions will in turn affect the ability of a nation to respond as a unified force towards a crises situation like HIV/AIDS, which tends to perpetuate a culture of blaming other groups for the disease, particularly outsiders.

## **HOW HAVE COMMUNITIES IN POST-CONFLICT SOCIETIES IN SUB-SAHARAN AFRICA RESPONDED TO THE HIV/AIDS CRISES?**

Responses to the HIV/AIDS crises in post-conflict Sub-Saharan Africa have taken various forms of informal and formal group initiatives. They reflect both the diversity in the opportunities available in various communities to improve the capacity of families and communities to supporting those affected with the virus, and the multiple dimensions of the impact of the HIV/AIDS crises on their lives. Effective leadership in these groups emphasize the active involvement of women in structural transformations, institutional building, and a deep commitment to self reliance which rests on the indigenous cultures of all African societies. Many of the group initiatives draw upon the daily lives of women from different walks of life, and mobilize around common values and shared experiences to reject oppression by the system, and seek to change men and the system to act with a sense of responsibility, nurturance, openness and elimination of injustice. The central values upon which they mobilize are simply the basic human values that emphasize care for the sick, love for children, family and friendship, community, solidarity, support and respect for all people [46]. Women's involvement in the peace movements in their various countries have clearly

demonstrated the importance of these values in their commitment to end a crises situation that affects their families. In their struggle to fight the HIV/AIDS crises, these community groups are guided by the abiding principle that men and women in African countries can and should assume major responsibility in bringing about an end to the crises. Their working strategy rests upon drawing support and legitimacy from the grassroots elements in the society; working with other community organizations and civil groups; and drawing on international support to strengthen their voice and legitimacy in the eyes of their national political elite. Ultimately the common goal is to build a genuine civil society founded on plurality, tolerance and respect [13, 47, 48].

Among these multiple strategies therefore, we are seeing initiatives that are addressing issues of poverty, human rights, representation in decisions about the maintenance of peace and security, fighting the HIV/AIDS crises, supporting the sick, and raising orphaned children. For example, some communities have embarked on the reassertion of “traditional” values and forms of organization to try and improve family lives and the moral fiber in their society. The women use mainly the local traditional structures to address social issues such as laws relating to marriage, maintenance, and land rights [13,36, 47, 54]. Through various advocacy groups and NGOs, women are challenging traditional institutions that are found to be contributing to the vulnerability of women to HIV/AIDS by challenging customary and ritual practices such as female initiation ceremonies, forced marriages, and the inheritance of widows by brothers of their husbands. Programs for addressing HIV/AIDS and caring for the sick and orphaned children include various types of community based HIV/AIDS education and counseling projects, extended family care units; home care visits to orphans and HIV/AIDS patients; savings clubs and credit schemes for funeral benefits; voluntary based small projects organized by widows that combine care and income generation activities; etc. [31, 38, 43].

#### Major Challenges in the Various Projects:

1. Slow changes in behaviors.
2. Limited adoption and inconsistent use of condoms.
3. Difficulty mobilizing resources to deal with the gravity of the problems.
4. Difficulty in recruiting and retaining volunteers.
5. Difficulty enlisting support of local chiefs in some areas.

## **GENDER BASED EXPERIENCES IN PREVENTING AND COPING WITH HIV/AIDS IN POST-CONFLICT SOCIETIES**

The experiences of men and women in post-conflict societies should be viewed in a context where social transformations have occurred in family structures in both rural and urban households, due to wars that break up families, the rebuilding process, and the cumulative effects of urbanization. These changes have had greater implications in many of the societies that include the breakdown of gender stereotypes in many communities; a shift in gender relations, and increased variation in experiences of women, men and their families. The shifts have come about through massive household disintegration and large scale demographic shifts related to military conflicts and their aftermaths. These changes have forced women to join the labor force, including taking up jobs in domains that were previously reserved for man. Some industries even preferred women over men because they could pay them less salaries and benefits [4, 36, 54]. New forms of households including various types of single headed households emerged in both urban and rural areas.

Both women and men's understanding and reaction to HIV/AIDS and their coping capabilities are influenced by the social and economic institutions. Their experiences vary on the bases of factors such as race, class, education, age, ethnicity, residence, religions and culture.

The various of households in the region reflect different levels of poverty and security. This applies to households headed by women or by men. In some case, female headed households (particularly those of younger or more educated women), often ended up being more economically stable than male headed households, depending on the economic industriousness of the woman. Also in some cases women themselves have initiated forming their own household in pursuit of diminished social and sexual obligations to husbands, and to escape the patriarchal familial obligations to their in-laws [4, 36, 54]. These changes in family dynamics are still continuing in the lifestyles of many people particularly the younger generations in contemporary Sub-Saharan Africa. However, very few studies have attempted to interpret the changes in terms of their implications for gender relations and actual behavioral practices of men and women within a given society. The changes in family structures entail variations among different groups of women, men and types of households in relation to social and economic security, rights, responsibilities, obligations, duties, access to resources and freedoms. These changes have also occurred in the midst of breakdowns in traditional institutions, values and customs, which used to guide and support the daily lives of people. Therefore vulnerability issues and coping strategies related to HIV/AIDS in post-conflict societies can no longer be generalized across all groups of men, women and adolescents within the same country.

The analysis of gender experiences related to HIV/AIDS in post-conflict societies therefore will attempt to address the variation in the experiences of all affected individuals, paying attention to their lives as they have been shaped by different

historical events. Such an approach will also allow us to avoid the trap of basing our analysis on gender stereotypes which are also often perpetuated by both men and women for different reasons. It is important to note however, that our knowledge on gender experiences of many social groups particularly in the area of coping strategies is still limited, because research programs in HIV/AIDS interventions have been focusing on prevention, other than care, support and mitigation. Furthermore, the focus of research has tended to concentrate more on women than men, including also paying little attention to class differences. Notable knowledge gaps therefore exist concerning the experiences of men, adolescents and certain social groups among women [4, 40].

## **WHAT ARE THE GENDER EXPERIENCES?**

### **1. Capacity for Making Choices and Decisions on Sexuality Matters**

#### **What We Do Know:**

The ability to make decisions and choices concerning safe sex, childbearing, marriage, medical issues, etc. is one of the basic right that is key to protecting oneself and others from HIV/AIDS. In exercising this basic right, research studies from many of the countries in Sub-Saharan Africa have confirmed that women and girls face more barriers than men, due to economic and political inequalities, and cultural roles and identities [5, 17, 34, 40, 41]. In many countries in the Sub-Saharan region, the tradition of rewarding women respect, value, and acceptance on the bases of maternity is still very strong. Furthermore this right is very much still controlled by the husband, family, and even the communities where they live. The children often form the basis for accessing resources or inheriting property from their husbands. The very practice of the sex act itself is relegated to the control of their husbands or sex partners. Therefore, women are in a weaker position to avoid unprotected sex. Indeed research studies from many countries have showed that a large proportion of women are infected by their husbands [40]. Other studies also confirm that men in Sub-Saharan Africa still have their culturally based privilege of having more than one wife and also having sexual relationships outside the marriages.

The poor economic status of women forces them to depend on men, and thus have very limited choices to leave a relationship that puts them at risk, to leave abusive husbands, or refuse having sex with their husbands or partners. Research has also shown that families still play a big role in decisions concerning the childbearing practices for women. As a result they present barriers to women who are HIV positive in avoiding having other children.

Young girls are also experiencing a large number of barriers in protecting themselves from unsafe sex or undesired sexual relations. Like their mothers they are also subjected to the pressure of proving themselves by having children. They also face problems challenging their partners authority on sex matters. Challenging their partners often lead them to being abused or rejected by their partners [5, 15, 50, 54]. Young

girls also experience poverty which often drive them to become easy targets to older men who sexually exploit them in so called “sugar daddy” relationships. Sometimes they find themselves having to earn a living through prostitution. Furthermore the mystic power associated with virginity, including their physical weakness makes them easy targets for rape and incest. Some girls are often subjected to forced marriage, due to poverty in their families. In another dimension, cultural expectations in many of the countries, still expect young girls to maintain an image of innocence, and never show any knowledge or interest about sex matters. Reports from various countries have confirmed that parents are still challenging programs that are seeking to provide information and services such as providing condoms to adolescents who need them. Many programs cite generational based problems as obstacles to extend services to adolescent girls who are sexually active.

There is also a growing number of reports that indicate that young boys who are experiencing conditions of increasing levels of poverty and unemployment are also facing challenges in their decisions to avoid getting into relationships that expose them to the risks of contracting HIV. Reports of young boys being involved in sexual relationships with older and married women (referred to as sugar mummies) are now common in many countries. Those that earn a living in the streets are often exposed to sexual abuse by men [8, 25].

Women and girls who live in the camps face double barriers in protecting themselves against HIV/AIDS compared to other groups of women. Their lives in the camps live them at the mercy of the situation that is characterized by destitution, violence and high levels of psychosocial stress [13].

### **What We Do not Know:**

Our knowledge about grassroots initiatives that are effectively addressing the experiences and needs of men and women from various social groups is still limited. Many Sub-Saharan African countries are characterized by variation in the experiences of men and women that are based on ethnicity, religious affiliations, social class, race, and geographical residence. In many cases, these differences represent sub-cultures in sexuality practices that present special challenges and unique opportunities to address the problems of sexuality practices and HIV/AIDS.

“It is no longer a required norm to be virgin”.

“Women are no longer embarrassed to initiate sexual activity”.

Also, our knowledge of programs that are effectively addressing the generational based differences in providing services to young people is also still limited. This is particularly important because a few studies that have investigated changes in attitudes and practices related to the sexual culture of contemporary young people have indicated that young women and men no longer uphold many of the old traditional values regarding sexuality, including marriage [21, 25, 37]. This raises challenges for dealing with many of the issues regarding acknowledgement and acceptability of

“Sex has become a part of life, believed to build your love”.

“I don’t support female circumcision because it kills their sexual feelings”.

the cultural evolution and emergent sexuality practices by older leaders in the various countries. How to best bridge this gap between older leaders and young people remains to be learned from many of the programs that are successfully reaching young people [26]. While research studies have reported success stories from countries such as Uganda, Senegal, and Tanzania, knowledge on how communities mobilize around common values and shared experiences to put together expanded responses for preventing HIV/AIDS through behavior change and safe sex practices using local structures are still evolving [44, 45].

“Some women love children too, and they decide to become single parents”.

“Some women are bearing the appellation of a Ms, to which many have come to attach different meanings ...man are scarce”.

“Time ticks for men too, but they just cover up with their machoness”.

“ I never think about marriage because it is too difficult”.

Our knowledge is also limited concerning programs that are effectively addressing the barriers and needs of women from different experiences. The high rates of seroprevalence among single professional women in many Sub-Saharan African countries suggest that we still do not know about the full range of barriers that are faced by women in protecting themselves from contracting HIV/AIDS. To suggest that these professional woman still have no control over their lives regarding sexuality would be too naïve [4, 9]. First, in many countries particularly in the urban areas, there are various households that involve women who are taking care of themselves and their children through their own means. Secondly, much of Sub-Saharan Africa, particularly in the urban areas, is characterized by various types of legitimate and illegitimate short term and stable relationships that do not qualify as “prostitution “ or “even casual sex” in the eyes of the local people [3, 22]. Anecdotal data from various countries strongly suggest that marriage no longer means the same thing to every one. Both men and women are actively involved in shaping these new meanings and relationships. Therefore given the various changes in gender relations, our analysis of contemporary men and women’s sexual behavior and responsibility issues, still needs to be improved. Sharing approaches on this issue is still very critical for many countries that are characterized by many variations in marriage patterns and lifestyles.

## **2. Biological**

### **What We Do Know:**

It is a well established fact that women and girls bear the brunt of HIV/AIDS, due to their biological vulnerability, which also subjects them to specific barriers that men do not experience. Research has established the fact that young girls are particularly more susceptible to getting infected with HIV/AIDS and sexually transmitted infections (STIs) because of the immaturity of their genital tract. Studies from various countries in Sub-Saharan Africa have further confirmed the existence of high rates of STIs among adolescents, and hence their high risk of getting infected with HIV, since many of them tend not to get proper treatment due to lack of income. Some studies have also reported that young girls tend to face problems accessing treatment for STIs due to culturally based restrictions that stem from the expectations that they are supposed to be virgins until they are married. As a result they are often treated unkindly by adults in health facilities. Girls living in rural areas also face the problems of poor access to services [ 35, 38, 41].

Women and girls further carry more of the burden of HIV/AIDS due to their child bearing role. They suffer disproportionately the trauma of carrying a child that they know might be born infected by HIV, and that the child might soon die from AIDS. A study reported on women who are participating in the Mother To Child Transmission (MTCT) program in Botswana and Zambia has confirmed that women and the family members are experiencing mixed feelings about saving the child while allowing the mother to die. Economic barriers were also cited as a major concern. The study also revealed that women face emotional and mental barriers in terms of avoiding to breastfeed their infants in communities that do not know much about HIV/AIDS and the various medical interventions. This challenge is also due to the fact that breast feeding and maternity are still culturally sanctioned by communities and strong symbols of being a proper mother. The low economic status of women further raise some concerns in accessing the MTCT intervention. Rural women further cited concerns related to sanitation and availability of plentiful water for mixing feeding formula [12, 53].

### **What We Do Not Know:**

Knowledge about the coping strategies for women and girls who do not have access to the mother to child transmission program is very limited. However reports of young girls abandoning aborted children have been made through the media. How to intervene effectively with human rights policies and mother to child transmission treatment remains to be resolved.

### **3. Sexual Violence**

#### **What We Do Know:**

HIV/AIDS is a disease that is characterized by a lot of violence and abuse. Studies have confirmed that women and girls are often exposed to domestic violence and sexual abuse from men in their communities . Reports citing incidences of women and young girls being beaten by their husband for refusing them sex or suggesting the use of condoms are quite common in many of the Sub-Saharan African countries. Young girls are reported as having been subjected to rape and sexual abuse by family members. In some cases young girls and women have been reported as having been targets of organized gangs of men who go on a mission to terrorize and rape women and girls [5, 36, 54]. Various reports have also confirmed that in refugee camps women and girls have been subjected to rape, sex slavery, and abuse. The violence that women and girls endure stems from their social and political subordination. In various societies, the stigma of being raped and the trauma they experience from the violence often force women to keep these incidences a secret. Those who manage to come forward to report the cases tend to face challenges from the legal system.

The reporting of domestic violence cases however is also constrained by cultural norms that view domestic violence as an issue to be resolved by the family, since tradition gives man the right to discipline their wives.

There are also reports that mention young boys in refugee camps and in the streets often being subjected to rape and sexual abuse by older men [54].

Counseling centers to help women and girls cope with their psychosocial stress related to violence are not accessible in many of the countries, particularly in the rural areas. Among the population of displaced communities, the situation is projected to be worse.

#### **What We do Not Know**

The implementation of policy measures to address issues of rape and sexual violence against women still remains a major challenge in many of the countries.

Community Initiatives for supporting victims of violence in coping with the psychological stress of living with their painful experiences are still evolving in many of the countries, and the major strategies and activities that are effective in the African setting, still remain to be identified and shared. This is more important because modern counseling centers are at a relatively early stage of development in many of the countries in the region.

## **4. Risk Behavior**

### **What We Do Know:**

The practice of risk behavior is one of the major factors that is contributing to the HIV/AIDS crises in Sub-Saharan Africa. Studies and media reports have confirmed that in many countries in the region, men are the major group that is transmitting HIV through engaging in risk behavior. Men tend to have more multiple sexual partners than women, and they also have more extramarital relations than women. Their risk taking behavior is linked to both cultural and social factors. 1) The cultural image of masculinity: In many of the societies in Sub-Saharan Africa being a man is associated with virility and the belief of men having an innate need for multiple sex partners. A man is also given traditional authority to control a woman's sexuality. 2) Many men also face cultural barriers with the use of condoms in the sense that it violates the cultural notions of sexual pleasure, as well as notions of trust. 3) The migratory nature of the working conditions of many of the men encourages them to have multiple sex partners. 4) Economic and political power enhance the masculine image of man as a provider, a breadwinner, and a protector for women and families. Men in certain professions are influenced more by these gender roles and relations: These include the miners, transport workers, security personnel, teachers, agricultural workers, construction, tourism, and the military [5, 11, 27, 32, 38, 40].

Among adolescents however, studies suggest lack of knowledge and poor access to services as major contributing factors to risk behavior practices [25, 37, 40]. Studies reveal that young boys are growing up with no guidance on matters of sexuality. This is partly due to the fact that their parents do not educate them about sex matters. At the same time the institutions which used to prepare them for adulthood (initiation ceremonies), are no longer existing in many places. Young boys who are unemployed however have been reported to engage in prostitution due to their poverty situation, which limits their ability to protect themselves. In camps also, the factors influencing risk behavior among men are complicated by the harsh conditions under which they live. Poverty in the camps can produce a situation where the fear of dying from HIV/AIDS appears more remote than from dying from hunger [14, 40].

### **What We Do not know**

Our knowledge of designing, implementing and monitoring programs that are successful in reaching men is still limited. This includes knowledge about workplace based programs, particularly those designed to reach men in high risk sectors that involve migration.

Furthermore, our knowledge is also limited on how changes in social institutions have affected men's roles, responsibilities, obligations, rights and freedoms in family relations and marriage. As a result information is limited on the experiences of men from different social classes.

## 5. Voluntary Testing and Counseling

### What We Know:

“ I can’t tell them I’ve got HIV because I’m the eldest and the best educated in the family, and it would be like admitting that I can’t do anything for them. They would feel betrayed”.

“People will be saying that is what you get for bitching around”.

“There is no life apart from death, and because HIV/AIDS has no cure, you know that death is around the corner”.

“The spouse that goes for an HIV test first is guilty”.

“ The person would loose respect, access to loans, and votes (if she held an elected office)”.

“People think you have been careless and promiscuous”.

Testing and Counseling constitutes one of the interventions that is designed to help individuals develop the capacity to deal and cope with HIV/AIDS.

Studies reveal that both man and women face socio-cultural and economic barriers that are affecting them differently in their ability to utilize voluntary testing and counseling services. The biggest barrier to both men and women to being tested is the social stigma attached to HIV/AIDS which still exists at a high level in most of the countries in Sub-Saharan Africa [6, 12, 31, 33, 41]. Women however suffer the consequences of stigma more than men, due to their culturally prescribed moral standard as women and mothers, as well as their weak social and political position. The stigma attached to HIV/AIDS consists of fear, and a complex blend of powerful social and religious symbols that go with a set of prejudice towards certain groups of people and behavior. The association of HIV/AIDS with prostitution and infidelity sets women apart as easy targets for discrimination. Prostitution in most of Sub-Saharan Africa is used to describe the moral standards of women. Indeed they are often viewed as being the ones that are responsible for infecting their husbands. As mothers they also bear the brunt of stigmatization when their adult children get sick from HIV/AIDS. HIV infected women also tend to suffer more rejection by their partners, families of their husbands and the community.

The fear dimension of the stigma attached to HIV/AIDS for most people in Sub-Saharan Africa is linked to the fear of dying prematurely for those infected, and the fear of contracting the disease for those who are not infected. Indeed, studies report that there is still a lot of misinformation or incomplete knowledge about HIV/AIDS among many communities. Dying prematurely itself triggers a lot of other fears related to losing a job, leaving children to suffer, and bringing shame to the family. Hence many HIV/AIDS affected people choose to avoid testing early because it often leads to having other people know about your status. Lack of confidentiality in testing for HIV/AIDS is still cited as a major problem. Anecdotal data and a few studies from some of the countries further reveal that those who are infected or see the danger of being infected will also respond

Who is blamed?

Prostitutes, Youth,  
Foreigners,  
Uneducated people,  
Rich people, girls  
without regular  
income, Americans,  
Rape victims,  
Gay people  
Women working in  
bars, High class  
people, Educated  
people, University  
students, Drunkards  
Footballers,  
polygamists.

to the fear of dying by being in denial. Denial in the context of HIV/AIDS in Sub-Saharan Africa is indeed a coping strategy to a situation that is beyond anybody's comprehension, both in terms of its nature and its impact on the viability of families and society. The disease has produced a sense of "shock" to most people who now have to view "normal" and "innocent" sexual relations as very risky or representing death [3, 5, 22]. Hence the general response among many people is to cope by blaming the disease on others. Many people are reported as finding themselves being overpowered by the situation. Furthermore, in the midst of the many challenges of every day life where there is constant flow of tragedies (wars, droughts, infectious outbreaks, hunger, etc) people are forced to deal with HIV/AIDS in the wider context of other everyday survival challenges. In spite of the fear of rejection, however, communities and families are showing a tremendous amount of support to those affected (families taking care of their sick & supporting families during funerals).

Recent reports have further confirmed that treatment is viewed as one of the key elements that can encourage people to test, as well as help encourage behavior change. A participant in a study expressed it in the following term: "Many people feel that knowing about their positive status when they cannot do anything about it will even shorten their life because they would " worry themselves to death" [12, 31].

How have people coped? Various studies have confirmed that women, due to their social role as caretakers in the families and in the community tend to mobilize support for those suffering from HIV/AIDS. As a result they have assumed leadership in supporting those affected by HIV/AIDS through advocacy and providing counseling to those infected. Men because of their masculine image have tended to "suffer in silence" by trying to live up to the male image of being strong and resilient [27]. At the grassroots level however, churches have become the backbone of support for the spiritual lives of people infected by HIV/AIDS and their families.

The barriers to using voluntary testing and counseling in some parts of Sub-Saharan Africa also stem from the cultural orientation and philosophical view of illness, health, and death. For most people testing when you are not showing signs of illness is not common practice [12, 24]. Therefore full utilization of testing and counseling services is going to take more than information and technical knowledge to bring about a transformation in the beliefs and the actions of most people. Furthermore, men in most of the countries are difficult to reach because of the long establish social bias of viewing health centers as a place for women and children, particularly for preventive health services. Indeed many of them still utilize traditional healers for many of their

health problems. Having to talk to female health workers about their health problems is also a problem for many men.

### **What We Do Not Know**

We still have limited knowledge of the range of initiatives at the work places and grassroots level that are helping people utilize testing and counseling services.

We have limited knowledge of support programs for helping men cope with the stigma of HIV/AIDS.

We have limited knowledge of initiatives that are helping adolescents cope with stigma of HIV/AIDS. Reports have been made about increasing numbers of suicide among young people who are HIV infected.

We also have limited knowledge on programs that are helping people cope with stigma among the displaced communities.

## **6. Access to Treatment**

### **What We Do Know:**

The ability to access treatment for a disease such as HIV/AIDS is a major concern for everyone affected by the disease. Research shows that women face proportionately more barriers in seeking and accessing treatment and special support services for HIV/AIDS and its other symptomatic diseases, due to their lower economic status [20, 40, 41, 47]. The majority of women in most of the countries in Sub-Saharan Africa are employed mostly in the poorly paid jobs in the formal sector where they have no sick pay or health insurance, and no “safety” net [11]. Many of them also earn their living from the urban informal sector or subsistence farming, and thus have little economic security – with few savings to draw on during a period of sickness, and little income to spend on medicine. With limited income, they resort to public services which costs less, but often have poorly trained staff and lack of adequate medicines. Women in the rural areas are often isolated from health centers, and tend to rely on the traditional health system. Poor men and adolescent also face economic barriers, and suffer similar consequences. Eventually all of those suffering end up going home to be looked after by relatives until they die.

### **What We Do Not Know**

How best to help mitigate the suffering of those who cannot access improved treatments for HIV/AIDS still remains to be resolved.

## **7. Care for People Living With Aids**

### **What We Do Know:**

The growing numbers of HIV infected people that acquire full blown AIDS earlier than in developed countries, have resulted into a situation where the sick have to be kept at home. Research shows that women, due to their care taking role (which has remained unchanged by any of the new developments), carry the burden of caring for the sick. They have to do this with very meager resources and inadequate skill to handle some of the complications of the AIDS disease. With household production falling due to woman having no time to work the farm, and with economic resources getting depleted, poverty levels tend to escalate. Individuals begin to suffer from food shortages and malnutrition. With having to ensure adequate food supply, and continuously taking in more sick and abandoned children, women inevitably end up neglecting their own health. Young girls also share the burden as they are often taken out of school to help take care of the sick and infected. Anecdotal data also reveal that women with economic resources hire other women to take care of the sick in their homes.

Research also shows that women suffering from HIV/AIDS are less likely to be looked after by their spouses. Some women are even chased away from their homes by their spouses and have to seek care in their mother's homes or with other relatives. Some also loose rights to land and other assets with the death of a husband. The loss of rights to property and land however, when a woman's husband dies however, has been attributed to "corrupted new customary laws" that have been invented and perpetuated by women as well as men [4, 12, 16, 53].

The challenges faced by people living in displaced communities and camps, in coping with the task of taking care of the sick is viewed as being double that of the rest of the population outside this situation, due to the lack of resources and poverty.

## **8. Taking Care of Orphans**

### **What We Do Know:**

In all the countries in Sub-Saharan Africa, the number of orphans has increased with the HIV/AIDS epidemic. Women, through their care taking role are doing the best they can to help raise the orphaned children. Some are using extended family networks where aunties and grand mothers take care of the orphaned. Widows are also coming together to form groups that combine promoting survival skills together with meeting the needs of the sick. Various types of foster care family structures are also being used [23, 30, 31, 43].

People living in displaced communities are facing more challenges, due to their lack of resources and poverty.

## **What We Do Not know**

How to transform the grassroots initiatives to viable projects is still a big challenge.

How to promote the development of responses in which men and women share the burden of the epidemic more equitably still remains a challenge.

## **Unique Challenges to Controlling the Spread and Mitigating the Impact of HIV/AIDS, on Specific Groups of Men, Women and Children in Post-Conflict Societies.**

The data presented above is lacking in specificity of capturing the unique experiences of various groups of men, women and adolescents. The absence of data is evident of particularly those that are extremely poor, or still live under refugee status or as internally displaced people. The challenges in helping these groups prevent and cope with the HIV/AIDS epidemic will be more severe and prolonged than in groups less affected by the war. These conditions are due to the following factors:

The sudden breakdown of cultural norms and values, and the loss of support and protection exacerbate the situation of poverty and sense of disillusionment. The HIV/AIDS challenge, in the midst of the multiple other challenges in their lives, makes risk taking options less threatening. With loss of communal rights to productive resources, ownership of property, and access to information and freedom to take charge of their own livelihoods, the impact of HIV/AIDS on the poor groups particularly women will be more severe. One contributing factor is that women take over the responsibilities of taking care of family members and children abandoned as a result of war related experiences and also the HIV/AIDS pandemic.

Higher levels of domestic violence, sexual abuse and exploitation tend to characterize the lives of those living under extreme poverty. In addition, loss of dignity, low self-esteem, limited education and economic options and opportunities further curtail the efforts of these groups. At the same time, the social support systems for the weaker members of society continue to collapse, still further exposing women and adolescents to HIV/AIDS infection. Unless more aggressive steps are taken to protect them, the grave situation will continue.

The high mobility that characterizes the lives of many of the people in the post-conflict societies in Sub-Saharan Africa, with people migrating for employment reasons, or seeking safety from continuing conflicts and harsh living conditions, will add to pre-exposing various groups of men and women to HIV infections.

Overall, women and men in post conflict-societies will face multiple and compounded barriers in preventing and coping with HIV/AIDS. The various barriers they face are related to family disruptions, accelerated levels of breakdown and changes in norms and values, and institutional incapacities, all of which have been exacerbated by war and conflicts.

## **SUMMARY AND CONCLUSION**

### **Women are Disproportionately Affected by HIV/AIDS.**

The above discussion has clearly demonstrated that although HIV/AIDS affecting the lives of both men and women in Sub-Saharan Africa, women are disproportionately bearing the brunt of the disease due to their lower economic, social, and political status, as well as their sexual subordination that is still a reality in all the countries in the region. These factors do not only put limitations on women's ability to protect themselves from HIV/AIDS, but also result in the neglect of the magnitude of the problems they face in meeting their various needs in relation to their social roles, including the neglect of their right to protection against violence. At the same time, the devastating impact of wars and HIV/AIDS on the viability of family structures, economic and social institutions, have left women with the burden of taking care of those that are suffering from HIV/AIDS, including the orphans, rebuilding of communities, and restoring the social fabric in their countries. Women's coping capacity has been stretched beyond limits by the HIV/AIDS crises in Sub-Saharan Africa. Women from different social experiences however, are impacted upon differently by HIV/AIDS, due the differences that exist among them in terms of access to resources, family structures, cultural orientation, locality, education, etc. These variations among women result in differences in the way that they react to the disease, including also the barriers they face in preventing and coping with the HIV/AIDS disease. Amongst those women bearing the brunt of the disease are widowed women, grandmothers, rural women, poor women, adolescent girls, and women who are in internally displaced communities.

The challenges of dealing with HIV/AIDS are also experienced differently by men from different social groups. However, data on their specific experiences is scanty. The available data confirms however that adolescent boys, and poor young men face more barriers than men who are economically secure, in preventing and coping with HIV/AIDS.

In order to mitigate the impact of HIV/AIDS on women, local governments and their international partners must intervene with effective policies and resources to address the root causes that increase the vulnerability and impact of HIV/AIDS on women and other disadvantaged groups. As outlined throughout the paper, the root causes identified are social norms and values, poverty, access to resources, and decision making power at various levels of society. To bring about a reduction of the impact of HIV/AIDS on any group, changes should occur in all of these areas. Men, women and local governments can address these challenges. Because women are disproportionately impacted by HIV/AIDS, their role in bringing about changes in the social and political environment is key to addressing the HIV/AIDS crises. Women's leadership in addressing issues of social injustice, social change, and promoting the viability of communities to fight HIV/AIDS, can be promoted through many of the already existing social structures in post-conflict societies that have been set up to promote peace, rebuild communities, and mobilize for change and fight injustice.

Effective control of the HIV/AIDS crises also demands that men be supported in playing their respective roles both in the domestic, personal and political spheres. A true gender partnership between men and women will result from developmental interventions that seek to maximize the provision of care and support for all affected and minimize the blame that serves to fuel the HIV/AIDS disease.

The task at hand for each country, is to develop and implement effective, culturally appropriate and gender sensitive programs that are targeted at all the change agents in the country. These include policy makers, development sectors, community leaders, religious leaders, traditional healers, educators, medical practitioners, parents, women, men and youth.

## **POINTS FOR DISCUSSION**

### **1. Programs for Behavior Change.**

- HIV/AIDS is a disease that exists in social contexts that are characterized by values and beliefs, fears and suspicions, interests and needs, attitudes and actions, relationships and networks. All of these elements present special challenges and opportunities for bringing about changes that are conducive to controlling the HIV/AIDS pandemic in specific localities.
- Grassroots organizations which consist of leadership from communities and government, custodians of culture (which consist of both men and women from different social experiences), and religious leaders, will remain the best situated groups to promote changes in attitudes and behaviors necessary to control HIV/AIDS.
- Because of the differences that exist in different societies, the use of different strategies for achieving the same goal must be acknowledged and accepted by donors and stakeholders. Furthermore, there must be acknowledgement of the fact that people already know a lot about finding the solutions to their problems.
- The abilities and leadership of women in bringing about changes in attitudes and behaviors and social norms and values should not be underestimated because their power to do so evolves from the different roles they play in society as mothers, sisters, wives, caretakers and nurturers, and country leaders. Indeed it is precisely their subordination and roles as “carers” and nurturers that gives women the determinations to fight for social change [13, 47]. Through participatory approaches women and men and young people can resolve many of the differences among them.
- To be able to carry out their tasks, grassroots groups will need both resources and specific training in equipping each generation or group of people with knowledge, techniques and social skills for leading productive lives that reduces their vulnerability to lifestyles that HIV/AIDS.

### **2. Protection of Women Against Violence.**

- Governments and NGOs, with assistance from the international community, need to strengthen the implementation of laws and specific programs that address issues and actual acts of violence against women.
- These programs should target violence crimes such as rape, sexual slavery, forced prostitution, sexual harassment, domestic violence, and HIV/AIDS discrimination. Efforts should be made to ensure that women have the means to access and implement their rights for protection and redress.

- New and improved systems are required for reporting sexual abuse, rape, and domestic violence, as well as improved security for women and girls in refugee camps.
- International human rights documents should be adapted to local contexts, and grassroots people must be aware of their roles and basic rights for participation. This is particularly important in the Sub-Saharan countries where the security of people is still tied to families, and local traditions still represent a viable support system for many of the people. Indeed in the end it is communities and families that help implement policies.

### **3. Empowerment of women.**

- Priority must be given to improve women's economic conditions through a variety of approaches.
- The focus must be on developing new and strengthening existing programs for poverty alleviation for women, including improving their employment opportunities. Also important are programs of income generation and self and family development.
- The differences among women must be acknowledged, and their varying institutional and individual capacities for political participation in HIV/AIDS programs must be encouraged and supported.
- Women who are subjected to prostitution must be protected, and should have a right to participate in programs and plans affecting their livelihood and protection from HIV/AIDS. The opportunities and resources should be made available to those women to change income generation methods.
- Refugees and internally displaced women must be protected and should also participate in programs and plans related to HIV/AIDS prevention and treatment. Their right to self determination must be acknowledged.

### **4. Recognition of Specific needs of girls.**

- Empowering girls through protecting their rights to education and improving their social skills to help them take an active role in protecting themselves from HIV/AIDS and other diseases remains critical.
- The growing numbers of adolescent girls that are struggling with adult responsibilities of taking care of children, entering marriages early, and facing challenges of poverty deserve special attention.

## **5. Recognition of Specific needs of adolescent boys.**

- Empowerment of adolescent boys through programs that help them assume an active role in protecting themselves from HIV/AIDS, improve their economic status and acquiring appropriate social skills as productive citizens should be encouraged.
- This requires that education and training skill programs be expanded, improved and sustained.
- The growing numbers of adolescents who are heads of households, struggling with marriage, and caring for themselves and their siblings require adequate support.

## **6. Men's Involvement is Imperative.**

- There should be a major movement to work with men's formal, informal and traditional men's groups to take responsibility for their risk taking behaviors.
- Support programs for men suffering from HIV/AIDS should be expanded, improved and in some cases redesigned to meet their cultural sensitivities.
- More understanding of how men's behavior is affected by changes in social institutions and gender relations should be pursued. This can provide opportunity to work with men's formal, informal and traditional groups to tackle gender inequalities and stereotyping of women.

## **7. Strengthen the Institutionalization of Gender in All Sectors.**

- The task of institutionalizing gender considerations in all sectors which has already started with the peace movement should be strengthened.
- There is need to ensure that women have adequate skills and resources that will enable them to effect changes and introduce much-needed policies, including having an impact on resource allocations from national and local budgets. This requirement is important particularly for economically disadvantaged women whose needs often end up being neglected even by women in power positions.

## **8. Programs for High Rates of HIV/AIDS in the Military.**

- Introduce and strengthen HIV/AIDS prevention and treatment programs for military personnel and their families.
- Avoiding singling out the army as the only group that is facing the problem of extremely high rates of HIV/AIDS infections is important. In this case a Military HIV/AIDS program can be introduced as a model for peer education and support

system for workers in high risk sectors, which could be adopted by other sectors such as mining, transportation, security, and construction.

- The military can also play a role in strengthening medical services in their communities. This approach can help women and men share the responsibility of taking care of people suffering from HIV/AIDS.

## **9. Health Sector Development.**

- Commitment to improve and strengthen the infrastructure and personnel of the primary health care system as a priority for the treatment of STIs as well as other health problems affecting the majority of the population. This should be one of the key strategies for helping many of the people cope with the HIV/AIDS crises. This would improve the capacity of clinics in both rural and urban centers in providing comprehensive care for those suffering from HIV/AIDS.
- The poor economic status of the majority of people, particularly women and adolescents in post-conflict Sub-Saharan Africa will require increasing acceptance and access to free voluntary counseling and testing services. The distribution of condoms also need to be expanded.
- A gendered approach to addressing the impact of HIV/AIDS, should also include addressing the practical needs of women who are now caring for aids patients in their homes.

## **10. Meet the Needs of Orphans**

- Greater efforts and resources should be targeted towards strengthening the capacity of families, communities and governments to provide care services that go beyond food and shelter for the orphans.
- Empowering the orphans themselves through various education and training programs should remain a top priority.

## **10. Strengthen a Multi-Sectoral Approaches to HIV/AIDS.**

- Wars and civil violence have contributed to increased susceptibility of women and men to HIV/AIDS in Sub-Saharan Africa. The military must be included in supporting programs and interventions for reducing the spread of HIV/AIDS.
- Policies from the various developmental sectors have also contributed towards increasing the devastating impact of HIV/AIDS on individuals, families, communities and societies in Sub-Saharan Africa. All sectors must play their developmental roles in funding and supporting solutions to the HIV/AIDS crises.

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