

The Female Face of HIV and AIDS

Annual Lecture

Trócaire and St. Patrick's College, Maynooth

March 2007

Michael J. Kelly, S.J.

Luwisha House

Lusaka

Zambia

mjkelly@jesuits.org.zm

The Female Face of HIV and AIDS

The Global AIDS Epidemic

Today's global agenda focuses heavily on the major issues of our time: war and terrorism, global warming and climate change, globalisation and prosperity, nuclear proliferation and the rights of nations, local and international politics. All are very compelling issues, indeed possibly so compelling that they deflect attention from one of the most disastrous health and development events of our time, the global HIV and AIDS epidemic. The scale of this epidemic is gigantic. It results in an average of more than five deaths each minute of every day, one of them being a child under the age of 15. It is maintained by some 500 new infections every hour. It leads to millions of children being left without parents. It leaves in its wake millions of men, women and children, experiencing a heartbreaking mixture of fear and anxiety, bodily pain and physical disability, isolation and rejection, loneliness and depression, anger and guilt.

In every severely affected country, the epidemic continues to reverse decades of health, economic and social progress; reduce life expectancy; slow economic growth; deepen poverty; contribute to and exacerbate food shortages; create a growing human capacity crisis; and augment gender inequalities by affecting women and girls more than men and boys. All this despite the fact that for more than 25 years global efforts have been directed at preventing HIV infection, treating the disease and minimising its negative impacts. Regrettably, although there has been some progress in terms of behaviour changes, national responses, and increasing access to prevention, care and treatment, the epidemic retains the upper hand. In parts of sub-Saharan Africa, "a mature epidemic continues to expand beyond limits that many experts believed impossible" (UNAIDS, 2006a: 3). Globally, the problem has doubled in just ten years, with the number of people living with HIV or AIDS rising from about 20 million in 1996 to almost 40 million in 2006.

Straightforward prevention and treatment measures exist, but inadequacy of leadership and a low sense of urgency have limited their application. The epidemic is also dogged by extensive stigma and discrimination and by silence and denial at national, community, and individual levels. To some extent these may signal a primordial and protective human response to situations that are excessively stressful. In the words of the poet, T. S. Eliot, "human kind cannot bear very much reality"¹. But consigning the epidemic to an underground of silence, secrecy, shame and self-recrimination will never lead to its mastery.

Progress towards the goal of rolling back the epidemic has also been constrained by the global strategy that up to very recently focused predominantly on short-term measures aimed principally at immediate results. But, in the context of the disease, global attention focused much less on the environment of poverty, malnutrition, the powerlessness in many societies of women and young girls, inadequate health support services, lack of job opportunities, and the absence of recreational outlets, all of which provide fertile ground for the transmission and development of the disease. There has also been insufficient attention to the physical, social, economic, recreational and psychological needs of youth, even though the AIDS epidemic will only be reversed when it is reversed among the youth — no sooner, no later.

¹ *Four Quartets. Burnt Norton*, 1

Fortunately, there are signs of a more constructive global approach. Thus, the Executive Director of UNAIDS has called for a justice response to the epidemic, stating that “an AIDS response that is not as embedded in advancing social justice as in advancing science is doomed to failure” (Piot, 2006a). He has further acknowledged that perhaps the greatest challenge facing the AIDS response lies in making real headway against the fundamental drivers of the epidemic, especially poverty, stigma and discrimination, and gender inequality (Piot, 2006b).

Gender Inequalities

The third Millennium Development Goal is to promote gender equality and empower women. The basis for this equality is the affirmation in the Universal Declaration of Human Rights that “all human beings are born free and equal in dignity and rights” (Article 1). Gender equality entails that the rights, responsibilities and opportunities for women and men, girls and boys, be independent of whether they are born female or male. The need for this particular goal arises from the universality of inequalities between women and men that are manifest in the responsibilities each are assigned, in the activities they undertake, in their access to and control over resources, and in decision-making opportunities (Hausmann, Tyson, and Zahidi, 2006: 3).

Some facts speak to the extent of these inequalities:

- Of the world’s one billion poorest people, three-fifths are women and girls.
- Of the 960 million adults in the world who cannot read, two-thirds are women.
- Seventy percent of the 130 million children who are out of school are girls.
- Although women spend about 70 percent of their unpaid time caring for family members, that contribution to the global economy remains invisible².
- In developing countries, women have less access to information, education, employment and productive resources (land, property, credit, etc.).
- Globally, women are conspicuously absent from parliaments, making up, on average, only 16 percent of parliamentarians worldwide.
- Women everywhere typically earn less than men, both because they are concentrated in low-paying jobs and because they earn less for the same work. (UNDP, 2006a: 3).

No country in the world has succeeded in bridging every aspect of the gap between women and men in their access to resources and opportunities and in the full and equal exercise of their human rights. Most countries have reduced gender-based inequality along certain dimensions, but every country still has considerable ground to cover before it closes the gender gap entirely.

Ireland has been doing well in this regard, particularly in the field of education and in the opportunities for advancement among professional and technical workers. The *Global Gender Gap Report 2006* estimated that Ireland had closed 73 percent of its gender gap and ranked tenth out of 115 countries (with Sweden, having closed 81 percent of its gap, ranking first). Nevertheless, inequalities persist in Ireland:

- Women receive about 70% of what men receive for equal work.
- Women’s average income (€17,000) is just 40% of men’s (€41,200).

² It is estimated that the value of unpaid work can be equivalent to at least half of a country’s Gross Domestic Product (GDP) (UNDP, 2006a: 9)

- Women comprise only 29% of legislators, senior officials and managers.
- Only 13% of those in the Dáil and 21% of Government Ministers are women (Hausmann, Tyson, and Zahidi, 2006: 77).

Women and AIDS

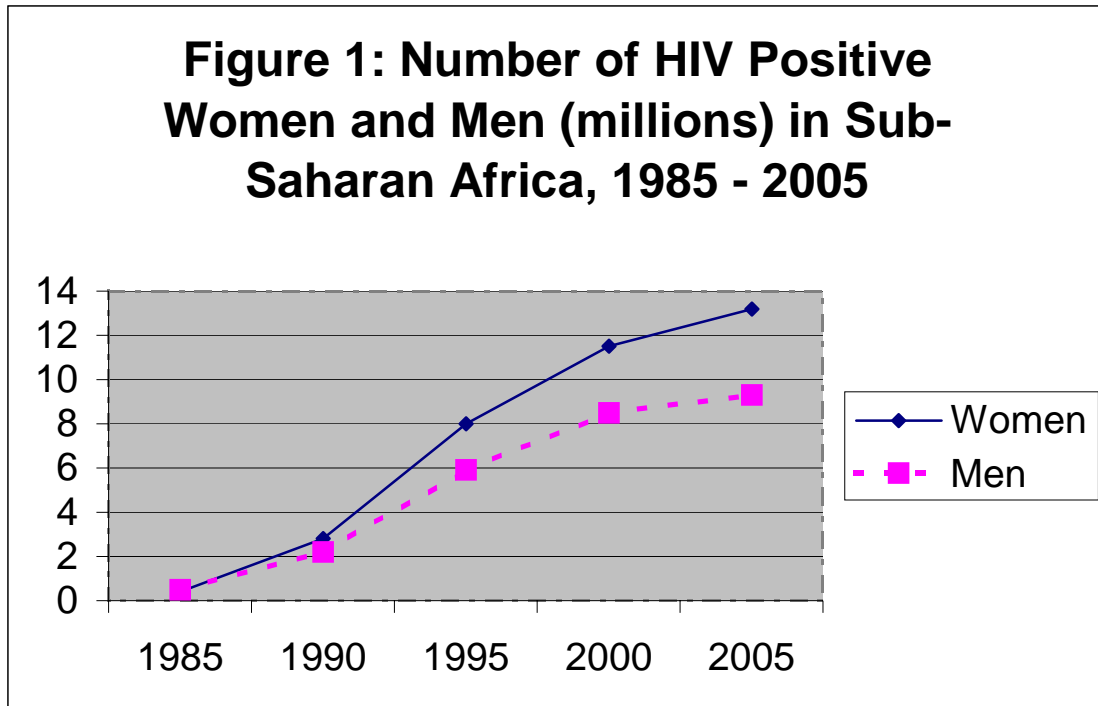
Reference is increasingly being made to the feminisation of AIDS or to the female face of HIV and AIDS. These terms refer to the ways in which the epidemic has an increasing and disproportionate impact on women and girls through

- a steady increase in the number and proportion of women and girls living with HIV or AIDS;
- the younger ages, compared with boys and men, at which girls and women become infected and die; and
- the more extensive way in which girls and women are affected by the presence of HIV or AIDS.

Globally, and in every region of the world, more adult women than ever before are living with HIV infection — in 2006, 17.7 million women were living with the virus compared with 16.5 million in 2004. In these two years, Eastern Europe and Central Asia experienced an increase of more than 24 percent in the number of infected women, while there was an increase of more than 16 percent in North America, of more than 31 percent in East Asia, and of almost five percent in sub-Saharan Africa. In 1997, 41 percent of the HIV-infected adults in the world were women; by 2006 this had increased to 48 percent (UNAIDS 2006b: 4).

From the beginning of the AIDS crisis in sub-Saharan Africa, the epicentre of the epidemic, the number of infected women has been growing more rapidly than that of infected men. The widening gap between the numbers of infected women and men, especially in recent years, provides a dramatic illustration of the increasingly female face of the epidemic (Figure 1). By the end of 2006, an estimated 59 percent of the infected adults in the region were women. For every ten infected adult men, there were more than 14 infected adult women. This gender differential has arisen partly because HIV transmission in sub-Saharan Africa occurs mainly as a result of heterosexual activity, and partly because of the extensive gender inequality experienced in the region. In other regions of the world, where transmission occurs mainly through homosexual activity, injecting drug use or commercial sex work, men are still more likely than women to be infected with HIV.

In addition to their greater probability of contracting HIV infection, women are becoming infected with HIV at an earlier age than men. At the end of 2003, an estimated ten million young people worldwide between the ages of 15 and 24 were living with the virus. Of these, 6.2 million were young women and 3.8 million were young men — for every two young men, more than three young women were infected. Moreover, although prevalence rates among men increase quite rapidly from age 25 onwards, they remain below those of women until, from about age 35 onwards, the deaths of women begin to bring down the female prevalence rates.



This has major implications. First, the proportion of women with the disease will continue to increase, especially the proportion of young women in child-bearing and child-caring ages. This in turn will lead to increases in both the number of infants who may be born with HIV and the number of orphaned children.

Second, women experience AIDS-related illness and possible death at younger ages than men. Thus, an investigation in Zambia found that, in a significantly large group studied over three years, 61 percent of all deaths occurred among women, and that women on average died at younger ages than men (Chapoto and Jayne, 2006: 40, 41). This is already changing demographic structures and life expectancies, with major implications for the care of the upcoming generation. In southern Africa, as in most parts of the world, women tend to live longer than men, but because of AIDS this situation is now changing. In 1998, the average life expectancy for women in southern Africa was 61 years compared with 54 for men; by 2004 this had declined to 48 for women and 46 for men and by 2010 is projected to stand at 42 for women and 44 for men (see UNDP, 2006b: 265-267). One outcome of this development is that an increasing burden of orphan care will fall on grandparents, but because of AIDS this pool will itself decline, the reduction being severest in terms of grandmothers.

The Vulnerability of Women to HIV Infection

Women experience these disproportionate impacts because they are at higher risk of infection on physiological and health grounds, whilst social and economic factors make them more vulnerable to HIV infection.

Vulnerability on Biological Grounds

The physiology of the female genital tract puts women at greater risk of becoming HIV infected, with the risks being greatest in young girls and menopausal women (UNICEF, 2002: 8). The extensive and fragile tissues in the sexual areas of the female body, their greater exposure during sexual intercourse to large volumes of potentially

high-risk body fluids, and the retention of such fluids for relatively lengthy periods, make women more vulnerable than men to HIV infection. These factors result in HIV transmission from male to female being seven times more likely than transmission from female to male (Abdool Karim, 2005: 249).

Moreover, a woman may also have more difficulty than a man in detecting that she has a sexually transmitted infection, the presence of which can bring a tenfold increase in the risk of HIV infection. The vulnerability of a teenage girl is further aggravated by the ease with which her immature genital tract can be lacerated and become infected. Women are also in greater danger because the risk of HIV infection doubles during and immediately after pregnancy (NWHRC, 2006: 2). Being under-nourished or in a run-down health condition, as frequently is the case in conditions of poverty or where a woman has experienced several pregnancies, heightens the risk of HIV infection, since in such situations the woman's immune system is already at a low level.

Vulnerability on Social Grounds

Gender inequity and inequality in the areas of sexual expectations and behaviour compound this biological vulnerability of women. Socially constructed images of masculinity, promoted in many cultures, portray a picture of the controlling male. The man is seen as the main initiator of sexual activity and the dominant partner in most sexual interactions. "Widespread stereotypes of masculinity, 'machismo' and what it means to be a 'real man', encourage male dominance over women, risk-taking and promiscuous sex" (Jackson, 2002: 88). Integral to this stereotype are the widespread beliefs that a man "needs" sexual activity in order to establish his identity and that to exert sexual and physical domination over women defines what it means to be a man.

On the other hand, stereotyped femininity portrays women as submissive, docile, and compliant. In line with this "feminismo" image, the interest of girls and women in sexual activity is seen as being motivated by three factors, operating singly or in combination: images of love and friendship that carry with them the imperative of maintaining a satisfactory relationship; the prospect of childbearing; and acquiring social status, money and material resources (Kempadoo and Dunn, 2002: 170).

These concepts of masculinity and femininity lead to imbalances in decision-making power, with women almost invariably being in a subordinate role and submissive to men. In practice this means that women are weakly placed to determine the circumstances of their sexual lives. They cannot control when, with whom, and under what conditions they have sex, and may often be forced to have unwanted sex.

The stereotyped concepts of masculinity and femininity also lead to double standards governing the sexual behaviour of women and men in both traditional and modern societies. Men are expected to be knowledgeable and experienced in sexual matters, whereas women are expected to be somewhat naïve — if they show knowledge or interest in sexual areas they may be regarded as immoral or "cheap" (Marston and King, 2006: 5). Promiscuity among men is more readily condoned than among women. As a result, boys and men tend to have more sexual partners than do girls and women.

All of these practices, and the attitudes that validate them, increase the vulnerability to HIV infection of both men and women, but because of their subordinate status the risk for women is greater.

The vulnerability of women is further accentuated by harmful societal practices, some quite widespread, others occurring in more restricted settings. Widespread practices include age-mixing, where younger women partner with older and more sexually experienced men, and multiple sexual relationships in which an individual maintains a number of sexual partnerships, either successively or at the same time. Age-mixing increases in a number of ways the risk that the girl will become HIV infected. There is a possibility that the older male partner will already be sexually experienced and hence may already have contracted HIV. If the girl is young, her vagina may still be immature and easily torn. The girl has almost no power within the relationship to insist on safer sexual behaviour, while there is always potential for violence, especially if the girl attempts to end the affair. It seems likely that this form of relationship is responsible for much of the HIV transmission in the 15 to 24 age group. The girl becomes infected through her older and more experienced sexual partner. But she also maintains relationships with her male age-mates and hence can pass infection on to them.

Globally, multiple partnerships are reported more commonly in developed than in developing countries (Wellings and others, 2006), but concurrent sexual relationships in which the individual maintains a number of sexual partnerships at the same time appear to be more common in some regions where HIV prevalence is high. Such partnerships allow more rapid spread of sexually transmitted infections than do the corresponding number of new sequential partnerships. Multiple concurrent partnerships have been identified as key drivers of the AIDS epidemic (Halperin, 2006). The situation arises frequently in the transport industry, where truckers and railways workers engaged in long haul operations may maintain second and third homes along their route, in addition to their official home at the point of origin. Recent research has shown that being away from home is associated in both developing and developed countries with concurrency of partnerships (Wellings and others, 2006). In addition, many societies condone the practice of an older married man having a “girlfriend” on the side and understand the meaning underlying references to a “small house” or a “second office”. This well-established practice has the twofold outcome of demeaning women and enhancing their risk of HIV infection.

Women’s vulnerability to HIV infection may also be increased in societies that have preserved long-standing traditional practices. These include early marriages for girls, before they have reached physiological maturity and when they should still be attending school; ritual cleansing which requires that a widow have intercourse with a member of her late husband’s family; dry sex where herbs are used to dry out and tighten the vagina (in order to increase male pleasure, but at the risk of vaginal abrasions that facilitate the entry of HIV and other viruses); and female genital mutilation (the partial or total removal of the external female genitalia) which causes chronic genital injury, easy tearing and possible ulceration, thereby heightening HIV risk³.

³ The World Health Organisation estimates that between 100 and 140 million women and girls have undergone female genital mutilation and that about two million more are added to that number each year.

Vulnerability on Economic and Legal Grounds

Economic factors further accentuate women's vulnerability to HIV infection. They remain dependent on men because society accords them limited access to capital, credit, understandings or opportunities. Some societies do not allow women to own land. Because they receive inadequate financial support from their spouses or partners, many women must apply their own ingenuity and resources to maintaining their household. All too frequently the sale of sex becomes the only way for many of them to do so.

Women also experience various legal disabilities. Although the law may offer them nominal protection, widows in many parts of the world experience considerable violations of their property and inheritance rights. Relatives may "grab" the property of their late husbands, evict them from their homes, strip them of their possessions, or force them to engage in risky sexual practices if they are to keep their property.

Note must also be taken of the many impediments that girls face in accessing education, staying in school, and performing well while there. These range from the insufficiency of school places and low levels of educational quality, through the costs that prohibit poor families from ensuring the school education of girls, to the ease with which girls are taken from school in order to provide household labour. There is now strong evidence that school education can reduce girls' vulnerability to HIV in a variety of ways, principally by helping them to build their self-esteem and capacity to act on HIV prevention messages, influencing the level of power within sexual relations, and leading to better economic prospects, which in turn lead to lifestyle changes that can influence HIV vulnerability (Hargreaves and Boler, 2006: 4). But persisting gender inequalities in education continue to exclude a disproportionate number of girls from these benefits⁴ and thereby heighten their vulnerability to potential HIV infection.

The Feminisation of AIDS Care

In countries where AIDS is very extensive, the principal option available to those at advanced stages of HIV infection is home-based care, with hospital care, where available and affordable, being provided only at critical junctures. The burden of this home-based care falls squarely on the shoulders of women and girls. When a male member of the household falls sick, women and girls provide care and take on additional duties to support the family. When women fall sick, other women from the household or community provide the care, even to the detriment of needs in their own families. The care burden of women is also greatly increased by additional responsibilities in caring for orphans from their own or their husbands' extended families.

Although strongly supported by communities, non-governmental organisations, and governments, the policy of voluntary home-based care has been allowed to slip into place without due attention to the enormous human and financial costs it is imposing on households, particularly on women. The policy has, in fact, been castigated as "an absurd misnomer for what amounts to additional forced labour for women" (Lewis, 2003). It is doubtful whether a patriarchal society, or its patriarchal state and church

⁴ Globally, 91 million girls and 39 million boys do not receive any form of school education.

organs, really appreciates the implications for a veritable army of women volunteers of providing home-based AIDS care, almost as a matter of course, but also at enormous personal cost.

A feature that aggravates the problem of home-based care in subsistence agricultural systems is that women tend to be the major producers of food. Their additional AIDS caring responsibilities greatly constrain their food producing activities but do not free them from massive pressures to provide the household with at least one meal a day. They may have to go to great lengths to ensure the availability of food for this purpose, even to the length of engaging in transactional sex, selling themselves in exchange for food or the cash to buy food. The circumstances of these sexual encounters are such that they frequently entail high risk of HIV infection.

The burdens of AIDS and care fall even more heavily on a woman who is pregnant or caring for young children. If she is pregnant and is HIV positive herself, she would very likely die rather than admit it — even though she got the virus from her husband, and even though her silence may literally lead to her own death and the eventual death of her infant. If there are other children, she will slave and sell herself so that they can eat — and her husband may acquiesce in what she does because she is bringing food into the family. Where the environment is one of poverty, AIDS brings out in stark relief the continuity in women's self-renunciation for their children. They nourish the unborn infant in the womb. They feed the child at the breast. And should the need arise, they sell their body and risk HIV infection so that the child may not go hungry.

In terms of care for themselves, many women feel disempowered by attitudes that give priority to the health needs of men. Even if personally HIV infected, or ailing from some other illness, women must continue to manage their households, provide care for the sick and the young, produce food and generate income. A nurse at a health centre in Zambia reported that she had often seen women bringing their husbands to the clinic on wheelbarrows, bicycles and even on their backs, like babies; but she had yet to see a man even offering the support of his arm and bringing his wife for treatment (IRIN, 2004). The access of many HIV infected women to life-preserving antiretroviral drugs may also cause problems because they cannot take time away from their household, care and income-generating activities for the necessary regular visits to health centres. Further, the bureaucracy surrounding the delivery of antiretroviral therapy may be daunting to some women. There are official documents to sign and because many women are illiterate⁵, they feel intimidated.

Gender-Based Violence

Violence against women is a major human rights problem that has special significance for HIV and AIDS. Violence in sexual encounters greatly increases the possibility of HIV transmission, both at the time of the assault and in subsequent life. This is the situation with numerous women and several children. Fear of subsequent violence also inhibits women from seeking HIV treatment and thereby leads to a worsening of the AIDS situation. Because of its wide-ranging extent and implications, gender-based violence is one of the reasons why women are more vulnerable to HIV infection than men.

⁵ Two-thirds of the 960 million adults in the world who cannot read are women.

Violence against women is the most pervasive of all human rights violations. Up to half of all adult women are reported to have experienced violence at the hands of their intimate partners. Systematic sexual violence against women has characterized almost all recent armed conflicts and is used as a tool of terror and ‘ethnic cleansing’. Moreover, apart from the direct role of coerced sex inside and outside marriage and in conflict situations, fear of possible violence reinforces the domination and control that underpins women’s subordination (UNDP, 2005: 42).

The statistics make bleak reading:

- Some 30 percent of women are forced into their first sexual experience.
- One in three women worldwide will experience violence in her lifetime.
- One in five women worldwide will survive rape or attempted rape.
- A high proportion of young people (up to 60 percent in some areas) believe that forcing sex with someone known to you is not sexual violence.
- Women who have experienced violence may be up to three times more likely to acquire HIV than those who have not.
- Twenty percent of girls and ten percent of boys experience sexual abuse during childhood.
- Almost half of all sexual assaults in the world are against girls aged 15 or younger.
- Violence against children takes place in the home, school, and community — perpetrators are frequently individuals that children know and trust.
- Sexual abuse in childhood may have long-term HIV infection consequences as lower self-esteem leads many victims of abuse to take greater sexual risks (Global AIDS Alliance, 2006: 6,7).

It also happens that justice systems may not be victim-friendly, resulting in women and girls being blamed for rather than protected from gender-based violence. Regrettably, the attitude of the legal and law enforcement agencies frequently reflects the way of thinking of a male-dominated society. “The courts often do not take (the) case seriously and, in the case of an older girl with a complaint of sexual abuse, the case may hinge on whether or not the judge believes she ‘asked for it’” (Human Rights Watch, 2003: 60). The poor protection offered by the courts increases the reluctance of families to seek justice for crimes of sexual abuse against women and children. The light sentences that courts frequently hand down also proclaim the very degrading message that these are not regarded as serious offences and that officially the state takes them quite lightly.

Finding a Way Forward

It cannot be doubted that HIV and AIDS bring unspeakable additional sufferings and problems to women and girls, for no other reason than that they are women and girls. In this way the AIDS epidemic brings out in stark relief that prejudice against women is a universal reality. Like a very powerful spotlight, the epidemic reveals this weakness in almost all societies where a legacy of systematic discrimination against women is embedded in economic, social, political, religious and linguistic structures. This points to a situation that is all too easily overlooked. The central HIV issue is not technological, biological, behavioural or sexual. It is the inferior status or role of women.

Hence, no response to the AIDS epidemic will succeed until robust, sustained and specific action is taken to reduce and ultimately eliminate the prejudice, discrimination and unjust treatment that women experience. Without a frontal attack on the injustice of gender inequality, the dominance of the epidemic will continue.

In his message for the 2007 World Day of Peace, Pope Benedict XVI drew attention to the persistent inequalities between men and women in the exercise of their basic human rights. Among the injustices present in today's world, he noted:

- The persistent inequalities between men and women in the exercise of their basic human rights.
- The exploitation of women who are treated as objects.
- The mindset persisting in some cultures, where women are still firmly subordinated to the arbitrary decisions of men.
- The many ways that a lack of respect is shown for the dignity of women and girls (Benedict XVI, §7).

Each of these creates and favours women's vulnerability to HIV and AIDS.

For their part, the United Nations, UNAIDS and various UN organisations are equally concerned about the issues raised by the Pope – and the promotion of gender equality, with a specific focus on preventing and responding to gender-based violence, is a guiding principle for Ireland's official aid programme, Irish Aid. Clearly, there is unanimity on the need to move towards the broader goal of gender equality. This is necessary in order to combat HIV and AIDS. Even more fundamentally, it is necessary in its own right. AIDS or no AIDS, women and men are essentially equal. Making that equality a lived reality is a major challenge for every individual, community, institution and country.

The promotion of good quality education for girls is one way of hastening the day when equality between women and men will become a universal and lived reality. The power of school education of acceptable quality to prepare young people, especially girls, for an improved social and economic life and to help ease them out of poverty is universally recognised. It is also being increasingly acknowledged that school education contributes powerfully to equipping young people with the knowledge, skills, attitudes and values that enable them to live responsibly and safely in a world with AIDS (see Hargreaves and Boler, 2006). This was recognised in June 2006, when the United Nations Secretary General proposed to the General Assembly that to reverse the AIDS epidemic high priority should be given, among other things, to girls' education (United Nations, 2006: §59).

Ireland's long-standing success in achieving gender equality in education is integral to its world-class performance in narrowing the gender gap and in promoting social and economic well-being. This is surely a success that is worth sharing with other less advantaged parts of the world. Using Irish human and financial resources, and building on the experience of what it took to bring about gender equality in education, Ireland has the potential to bring significant improvements into the lives of millions of people. This would be enormously valuable in promoting integral human development. It would also contribute greatly to getting ahead of the AIDS epidemic.

The Challenge to the Church

The female face of HIV and AIDS refers to two issues, the more extensive and severe impact the epidemic has on women and girls than on men and boys, and the role of women and girls at the forefront of household and community responses. Both constitute a significant challenge to the Church.

In the situation of HIV and AIDS the Church has played a significant service role, being responsible for about one-third of global AIDS care and for a wide range of dynamic responses to orphan needs. It has also played a significant role in HIV prevention through its unfaltering commitment to abstinence before marriage and fidelity within marriage. What is needed now is that it should maintain these responses, but also go beyond them.

The female face of the epidemic is a real challenge to it to do so. In the context of AIDS, the Church as a multi-sectoral, ministering and healing community must manifest a clearer feminine profile and more distinctly feminine features (Orobator, 2007: 124). Because our Mother the Church herself has AIDS, because our sisters are carrying the brunt of the epidemic and at the same time providing the most significant response, HIV and AIDS challenge the entire Church to move more boldly towards affirming the participation and contribution of women. The feminisation of AIDS calls for the feminisation of ecclesial identity, with an equal role for women in the exercise of ministry, authority and decision-making. Having voiced his concern about “the mindset persistent in some cultures, where women are firmly subordinated to the arbitrary decisions of men”, Pope Benedict called for this form of discrimination to be overcome. Clearly this has to occur as much in the Church as in secular cultures.

The moment of AIDS is undoubtedly a moment of monumental human suffering and anguish. But it is more. It is a moment of special grace, a unique *kairos* moment when God calls us to move from our set ways and be converted personally and structurally. The epidemic impels us to a new *kenosis*, a new emptying away of gender stereotypes and discriminations so that, inspired by what HIV and AIDS are doing to women and what women in their turn are doing to the epidemic, we work collectively towards a Church that

- Actively values the contributions of women in every situation, especially those of HIV and AIDS.
- Gives women more freedom in representing to the rest of society the reality of the Church as Mother.
- Strives to dismantle the structures of gender-based discrimination in both Church and society.
- Works to promote the active empowerment of women in Church and society, as the full equals of men.

In this way the feminisation of AIDS may help bring the Church closer to the vision of Saint Paul, neither male nor female, but all one in Christ (Gal., 3:28).

Trócaire’s Lenten Campaign stresses the importance of making the essential equality between women and men a lived reality. The vicious assault of HIV and AIDS on women is a further compelling reason for concern and action. It is not enough that we take note of the persistent inequalities that Pope Benedict laments. We should also do something about them. Hence, each one should constantly ask:

- What have I done in order to overcome the persistent inequalities between women and men?
- What am I doing about this right now?
- What more can I do in the future?

Anything one can do in this sphere will hasten the day when the full equality between women and men will be recognised not just in principle but also in practice. It will also hasten the day when the stranglehold of HIV and AIDS will be loosened so that men, women and their children can experience a life of dignity and fulfilment.

References

- Abdool Karim, Q. (2005), "Heterosexual transmission of HIV – the importance of a gendered perspective in HIV prevention", in S. S. Abdool Karim and Q. Abdool Karim (eds) *HIV/AIDS in South Africa*, Cape Town: Cambridge University Press
- Chapoto, A. and Jayne, T. S. (2006), "Socioeconomic characteristics of individuals afflicted by AIDS-related prime-age mortality in Zambia", in S. Gillespie (ed.) *AIDS, Poverty and Hunger: Challenges and Responses*, Washington: International Food Policy Research Institute
- Global AIDS Alliance (2006), *Zero Tolerance: Stop the Violence against Women and Children, Stop HIV/AIDS*, Washington, D.C.: Global AIDS Alliance
- Halperin, D. (2006), "Why is HIV prevalence so severe in (Southern) Africa", presentation to Expert Think-Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa, Maseru, Lesotho, 10-12 May 2006, Gaborone: SADC Secretariat
- Hargreaves, J. and Boler, T. (2006). *Girl power: the impact of girls' education on HIV and sexual behaviour*, London: ActionAid International
- Hausmann, R., Tyson, L. D., and Zahidi, S. (2006), *The Global Gender Gap Report 2006*, Geneva: World Economic Forum
- Human Rights Watch (2003), *Policy Paralysis: A Call for Action on HIV/AIDS-related Human Rights Abuses against Women and Girls in Africa*, New York: Human Rights Watch
- IRIN (Integrated Regional Information Network) (2004), "Zambia, the ultimate sacrifice", IRIN PlusNews, 5 March
- Jackson, H. (2002), *AIDS Africa: Continent in Crisis*, Harare: SAfAIDS
- Kempadoo, K. and Dunn, L. L. (2002), "Factors that shape the initiation of early sexual activity among adolescent boys and girls", in *Meeting Adolescent Development and Participation Rights: The Findings of Five Research Studies on Adolescents in Jamaica*, Kingston: UNICEF and UNFPA
- Lewis, S. (2003), "Gender and HIV in Southern Africa: a discussion with Stephen Lewis, UN Special Envoy on HIV/AIDS", Southern African Regional Poverty (SARPN) Network Brief, February 2003, Pretoria: Human Sciences Research Council (HSRC)
- Marston, C. and King, E. (2006), "Factors that shape young people's sexual behaviour: a systematic review", *The Lancet* 2006; 368:1581-1586
- NWHRC (National Women's Health Resource Center) (2006), *Women & HIV, National Women's Health Report*, vol. 28, no.2

- Orobator, A. E. (2007), "When AIDS comes to Church", in B. Bujo and M. Czerny (eds) *AIDS in Africa. Theological Reflections*, Nairobi: Paulines Publications Africa
- Piot (2006a), "AIDS: The next 25 years". Address to XVI International AIDS Conference, Toronto, 13 August 2006.
- Piot (2006b), Speech to the 19th Meeting of the UNAIDS Programme Coordinating Board, Lusaka, 6 December 2006
- Pope Benedict XVI (2006), *Message for the celebration of World Day of Peace 2007*, Vatican City, 8 December
- UNAIDS (2006a), *2006 Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition*, Geneva: UNAIDS
- UNAIDS (2006b), *AIDS Epidemic Update, December 2006*, Geneva: UNAIDS
- UNDP (2005), *En Route to Equality. A Gender Review of National MDG Reports*, New York: UNDP
- UNDP (2006a), *Taking Gender Equality Seriously. Making Progress, Meeting New Challenges*, New York: UNDP
- UNDP (2006b), *Beyond Scarcity: Power, Poverty and the Global Water Crisis: Human Development Report 2006*, New York: UNDP
- UNICEF (2002), *HIV/AIDS Education: A Gender Perspective. Tips and Tools*, New York: UNICEF
- United Nations (2006), "Declaration of commitment on HIV/AIDS: five years later", Report of the Secretary-General to the Sixtieth Session of the United Nations, UN document A/60/736, 24 March
- Wellings, K, Collumbien, M., Slaymaker, E., Singh, S., Hodges, Z., Patel, D. and Bajos, N. (2006), "Sexual behaviour in context: a global perspective" *The Lancet 2006*: 368, 1706–1728