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Community-level Interventions against HIV/AIDS
from a Gender Perspective

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In writing this paper I have deliberately avoided dwelling on the epidemiology of HIV/AIDS, its impact on women, families, communities and on development, as I believe these issues will be well highlighted in other papers and presentations at this meeting. I have chosen rather to focus on some salient issues pertaining to Community Level Health Interventions Against HIV/AIDS from a Gender Perspective, and from my own experience and personal perspectives.

I have also deliberately focused primarily on Community – level interventions within the African context for two reasons, one of which is objective and the other quite subjective.

On the subjective side, as an African and a HIV/AIDS prevention activist, I found it difficult to approach the subject with detachment. The subject of HIV/AIDS, women and the community and its overall impact in our sub - continent raises some of the most fundamental and deep-seated questions about human values which are not so easy to ignore. What is more, from my work, I am also naturally more familiar with community and women's realities in Africa.

On an objective note I have focused on the African experience for three reasons. The first is that Sub- Saharan Africa is the worst - hit region in the world accounting for 70% of global infections. According to the latest UNAIDS report on global HIV/AIDS epidemic (June 2000), in sub-Saharan Africa HIV is "now deadlier than war itself: In 1998, 200,000 Africans died in war but more than 2 million died of AIDS". In 16 countries of the sub-region, more than one-tenth of the population aged 15 – 49 is infected. Even Uganda, which is celebrated as having successfully reversed the progressive trend of HIV infection still has an estimated prevalence rate of 8%!

Secondly, the fact that health care systems are practically overwhelmed and that terminally ill people in this region are nursed at home and in the community implies that African women have an especially heavy burden as women, as poor people and as traditional caregivers. Thirdly, quite a few bold community-level initiatives have emerged in the region over the past decade in response to the devastating effects of the AIDS epidemic.

To cite a few examples of such community level initiatives: there is the CINDI project in Lusaka in Zambia, launched by catholic women in collaboration with other religious women's organisations and other community people, to provide care for orphans and for people living with HIV/AIDS. These women work to ensure that orphans have shelter, food, medicare, clothes and that they go to school, or learn skills; we have the WAMATA and the KIWAKKUKI projects in Tanzania which are also involved in care and support of people living with HIV, counseling and home-based care, as well as preventive education including promoting sexuality education for young persons and tackling socio-cultural issues pertaining to HIV/AIDS; there is the community-based counseling project of the Ugandan AIDS Control Programme which uses Voluntary Community Counseling Aides to provide HIV/AIDS education and counseling to families and communities and to engage them in dialogue on how to adopt healthier sexual behaviour; we have the ZINATHA programme in Zimbabwe which, in collaboration with the ministry of health, has mobilized traditional healers for preventive education, care and support, the adoption of safe medical practices and treatment of opportunistic infections; there is the INDENI HIV/AIDS workplace intervention in Zambia which provides preventive education, and support for treatment of opportunistic infections for workers. Under this programme, wives of workers were also organized around HIV/AIDS issues; the TASO project in Uganda launched by Noreen Kaleeba and her friends is very well known and has received wide acclaim for its dynamism in providing care and support for people living with HIV/AIDS. There is COMMUNITY LIFE PROJECT in Lagos, Nigeria which provides us a unique example of how synergistic partnerships between activists, community and religious organizations, local institutions, involving men, women, and children simultaneously, can help to effectively break the silence on sexuality issues, place sexuality education on the community's agenda, thereby creating a supportive environment for advancing women's reproductive and sexual health.

It is worthy to note that most of these interventions were either initiated by women or are being implemented by them. This implies that in discussing Community Level Health Interventions from a gender perspective and articulating policies for dealing with the gender dimensions of HIV/AIDS, we need to take into consideration women's own spontaneous and independent initiatives, and to build on those efforts.

Also worthy of note is the fact that these interventions all recognize and affirm the synergistic relationship between prevention and care; treat the family as a unit of intervention; recognise the vital role of the extended family and seek to strengthen those ties; they promote a sense of community rather than individual responsibility; they also demonstrate that a people's cultural heritage has a strong bearing on the ability to cope with crisis. Existing community level interventions thus provide a valued insight into what sort of policies are needed to deal with the gender implications of HIV/AIDS.

One of the salient things to be said about community level interventions is that they should be the main ammunition in the fight against the gender dimensions of HIV/AIDS. Not only is the impact of HIV/AIDS felt more acutely at the community level in terms of human and social costs, it is also at this level that the virus is most vulnerable. A sustained programme of activities to systematically and effectively challenge the spread and impact of AIDS at this level would help to remove some of the socio-cultural obstacles to women's empowerment and help to curb HIV/AIDS. Considering that international and national policies and realities impact both directly and indirectly on realities at the community level, the success of Health Interventions at the grassroots can either be hindered or enhanced by the global or national situations and influence.

Logically, advocating for policies and effective interventions at the national and global level becomes an important part of the mission of community level health interventions from a gender perspective. The mission will include helping to create a conducive policy environment and socio-economic framework for the implementation of programmes to reduce women's vulnerability to HIV/AIDS and promote their empowerment at the grassroots.

Policy advocacy should therefore be one of the major roles of Community Level Health Interventions; the special needs of women as felt and articulated by women at the community level should help to shape policies at the national level.

The slogan "think globally and act locally" has been part of the rhetoric applied to women's health issues. While that may be positive, it is important to point out that for global thinking to succeed in bringing about anticipated changes at the local level, it has to be founded on "local" perspectives and realities. The active participation of "local" thinking and experience in decision-making process at the global level is vital to the effectiveness and relevance of global policies. In-short, global thinking should be a consensus of local thinking.

The gender dimensions of HIV infection and AIDS have become all too obvious today. It is a well known fact that women are particularly vulnerable to HIV infection because of an interplay of biological, cultural and socio-economic factors. Women's low socio-economic status – marked by low-income levels, poverty, low educational levels, subordination, especially in sexual decision-making – as well as their traditional roles within the family and community expose women to a greater risk of HIV infection. The situation is compounded by unhealthy traditional practices such as wife inheritance and wife cleansing to which some women even willingly subscribe. The denial of women's basic rights – the right and access to treatment, and the right to inherit property, the dispossession and stigmatisation of widows, further compound women's miseries.

A STRATEGIC PERSPECTIVE

A strategic perspective is required to reduce women's vulnerability to HIV/AIDS. Such a perspective would be one which addresses environmental and structural factors which render women vulnerable to HIV/AIDS. Policies and programmes to reduce women's vulnerability must boldly tackle the socio-cultural and socio-economic factors which militate against women's empowerment such as men's sexual behaviours and sexual power relationships between men and women; poverty, structural adjustment programmes, bad governance and unhealthy cultural practices.

A strategic response also requires a shift in paradigm. In the past, a gender perspective has often been interpreted to mean the feminisation of intervention programmes in which women are the primary or sole focus. Thus, women were provided information and services including access to micro-credit only to return in many cases to the same unjust and discriminatory structures that engender their subordination. The urgency of HIV/AIDS prevention and control challenges us to proactively address root causes.

Men – centred programmes

Due to the influence and power which men exert over women in relationships and because men's sexual behaviours impact directly on women's exposure to the risk of infection, it ought to be as clear as the day that men should be at the center stage of interventions against HIV/AIDS from a gender perspective. The rather timid approach in women's reproductive health initiatives which promotes 'male involvement' and "male responsibility for family planning" ought, in the light of HIV/AIDS, to make way for bolder initiatives which address, in a more wholistic and comprehensive manner, men's reproductive and sexual health and rights. The current emphasis on getting men to use condoms while maintaining the status quo, in terms of the dynamics of their sexual relationship with women, amounts to treating the symptoms and not the cause. It would only be stating the obvious, to say that it is not in the interest of interventions to resign themselves or adopt a somewhat fatalistic attitude to men's sexual behaviour.

There is need to have a clear understanding of factors which drive men to unhealthy sexual behaviours – multiple partner relationships, infidelity to steady partners, sexual abuse of girls and women etc, and to take steps to address these factors. Empowering men to adopt healthier sexual

behaviours (not simply to use the condom) will help to attenuate the vulnerability of women to HIV/AIDS and other Sexually Transmitted Infections (STIs) in particular and to sexual violence in general.

In very poor settings simply urging men to use the condom raises the issue of sustainability. With the formula of one-condom-per-act of intercourse, having an adequate supply of condoms could become a challenge, except of course one is looking at a scenario in which community level interventions will supply free condoms over a fairly long time-frame. Programmes at the community level must therefore promote with equal vigour, other healthy options which reduce the spread of HIV such as mutual fidelity, reduction in number of partners, respect for women's rights etc.

Reaching men with reproductive and sexual health programmes such as health information, education, counseling and services should include sharing with them the gender dimensions of HIV/AIDS, and the implications of their sexual behaviours for women, families and communities. It should also include information and services for the early detection and treatment of Sexually Transmitted Infections. Men can be reached through a combination of formal and informal channels – social clubs, community organizations and workplaces.

Addressing Poverty as a Human Rights issue

It is common knowledge that poverty is one of the major driving forces of the HIV/AIDS epidemic. Poverty is not only a cause but also a consequence of HIV/AIDS. The epidemic deepens the poverty level of infected families and communities who have to channel their often meager resources into the treatment of opportunistic infections, into providing terminal care and funerals, added to the loss of income due to the unproductivity of the sick.

Women are among the poorest of the poor and this contributes significantly to their vulnerability. The ability of families to care for their infected loved ones and help their terminally ill die with dignity depends to a large extent on their level of income.

This has meant that poor women are having to nurse millions of their sick loved ones and struggling to keep millions of their orphans alive under conditions of unimaginable deprivations.

HIV/AIDS has thus demonstrated clearly that poverty is both a women's rights issue and a human rights issue. We have witnessed how the lop-sided distribution of resources both globally and within countries has resulted in a situation in which HIV infected people in rich settings enjoy the best quality health care, including anti-retroviral therapies, while the poor, mostly women have had to fall back on their own resources and receive inadequate (if any) medical care. It has also brought about the marginalisation of the hardest-hit region from the centers of HIV/AIDS bio-medical research, power and influence. The difference between the rich and the poor is also evident in the area of mother-

to-child transmission and in the debates around breastfeeding and bottle-feeding of babies born to infected mothers.

Redistribution of Resources

The goal of establishing a more equitable relationship between countries and within countries for a more equitable redistribution of resources needs to be pursued with greater vigour. There is perhaps not a more opportune time to keep the debates on a more just economic order alive. Mechanisms should be established within the framework of the United Nations to ensure that a more equitable economic order and redistribution of resources become a reality.

Reviewing Structural Adjustment Programmes

Community-level interventions from a gender perspective requires that Structural Adjustment Programmes (SAPs) be reconceived and restructured to be more people-oriented. In the last few decades, SAPs have contributed in no small measure to reversing some of the gains made in maternal and child health in several developing countries. They have contributed to bringing about the systematic impoverishment of populations in the middle and low income brackets, as well as the **feminisation of poverty**. By promoting a reduction in government spending on social services and welfare, especially in education and health care, SAPs worsen disease conditions, increase illiteracy and ignorance, social unrest, consequently increasing the vulnerability of young girls and women to HIV/AIDS and violence.

It is most ironic that financial institutions located in major centers of a rich country where the citizens enjoy social security benefits, including benefits for the unemployed and single mothers, should recommend policies to deprive citizens of poor countries any such benefits!

SAPs should shift their focus from promoting "economic growth" to ensuring the improved quality of life especially for the most vulnerable populations, of which women are a significant part. If "economic growth" is not about guaranteeing the well being of the population, what do we need it for? If SAPs are allowed to continue their unfriendly policies towards women and the poor, they will continue to undermine the effectiveness of Community Level Health Interventions.

Political and Social mobilization

Integrating Health and Human Rights Agenda into Existing Grassroots Programmes

Community Level Interventions should help underscore the relationship between health and human rights. Increased participation of civil society – particularly

women and people at the grassroots in political affairs and governance is necessary for ensuring more genuine representativeness of political office and greater political responsiveness to women's health issues. Democracy and governance issues from a non-partisan perspective should be integrated into programmes at the community level. Communities need to be educated on basic human rights, civic rights and responsibilities and on the implication of political participation and good governance for access to more equitable and better – prioritised resource allocation.

Promoting increased participation in the political process at the grassroots level is a long-term strategy for bringing about more democratic and stable societies. It will be possible to achieve widespread political education of grassroots people if it is integrated in existing community level efforts. United Nations agencies, development agencies, the donor community and non-governmental organisations with programmes at the community level should explore the possibilities and be encouraged to integrate democracy and governance issues, particularly human rights issues into their existing programmes.

The Human Rights community is yet another avenue for promoting community participation in governance and political decision-making and in mobilizing political will at the national level. For now, most human rights organizations and activists tend to confine their activities to curbing the excesses of governments and exposing human rights violations in the political arena. Steps should urgently be taken to place the issue of women's vulnerability to HIV/AIDS on the agenda of human rights organizations especially in the countries most affected by the AIDS epidemic. By their vocal nature and access to the mass media, human rights groups should form a solid constituency for both advocating and monitoring the establishment of non-discriminatory HIV/AIDS policies and programmes and in defending the rights of women (and everyone) infected and affected by HIV/AIDS.

Building partnerships at the community level

One of the key lessons we glimpse from existing Community Level Interventions is that building partnerships at the community level is very important in meeting the special needs of women, girls and children infected or affected by AIDS. Creative ways of harnessing existing resources and support mechanisms – such as traditional healers, opinion leaders, the extended family and religious communities are important.

Religious communities, traditional healers, traditional birth attendants, community leaders are necessary allies in challenging stigmatization, discriminatory and harmful cultural beliefs and practices, in preventive education in providing care and support to infected and affected women and children and in promoting healthier sexual behaviours.

The strategy should be to work within the existing ideological frameworks of religious organizations to expand the frontiers of women's reproductive and sexual health and rights as well as their basic human rights rather than seeking to convert churches to a secular ideology. Marginalising religious organisations in HIV/AIDS prevention and control programmes on grounds that they do not promote condoms and the tendency to engage churches in ideological battles is a luxury that women at the community level can ill afford. It is tantamount to throwing away the baby with the bath water. Most churches promote mutual fidelity and pre-marital abstinence, which do not in any way increase the spread of AIDS.

Energies and resources should therefore be more constructively channeled towards the mobilisation and education of religious communities, traditional healers, birth attendants and other local organizations, on HIV/AIDS issues, on factors which predispose women to HIV infection, on the implications of HIV infection in women for the stability of the family and the community.

These community groups can be engaged in reducing stigmatization, discouraging wife inheritance and wife cleansing, strengthening home and community based care, providing preventive information and counseling, assisting orphans and widows etc. If religious groups are empowered to provide knowledge and skills necessary to delay the onset of intercourse in young girls they will help to decreasing the vulnerability of teenage girls whose biological immaturity places them at special risk. Traditional healers should also be empowered to treat opportunistic infections.

Culture-Sensitive Programmes

It is imperative that women and communities participate in designing programmes and the content of preventive education. This is crucial for ensuring the receptability of information. Because sex and sexuality are conceptualised differently in different cultures, and because different cultures uphold different values relating to sexuality, the outside, expert-led approach to HIV/AIDS interventions at the global level, must give way to a more participatory and culture sensitive approach at the community level. Local people everywhere must be seen as the experts in their own realities and as the protagonists of sustainable change.

In view of the foregoing I wish to propose the following specific recommendations towards policy formulation and actions:

RECOMMENDATIONS

There are immediate, short-term and long-term interventions to be considered.

A. IMMEDIATE INTERVENTION

A1. EMERGENCY RELIEF FOR SERIOUSLY AFFECTED WOMEN, FAMILIES AND COMMUNITIES

To relieve the burden on women who are caring for infected and affected people in seriously affected communities, direct relief, both material and financial, needs to be provided. Women, families and communities in resource poor settings who are caring with great difficulties for people living with HIV/AIDS and for orphans should be urgently assisted with relief materials such as:

- o food
- o clothing
- o schooling materials
- o scholarships for orphans
- o income-boosting resources
- o technical assistance.

A2. FOSTER CARE FOR DESTITUTE ORPHANS

As much as possible, the placement of orphans with extended family members and distant blood relatives should be encouraged. But orphans without extended family care should be placed in foster care. Families fostering orphans should be assisted with relief materials. In addition, a long-range programme of social security should be urgently initiated.

A3. EMERGENCY RELIEF FUND/OTHER FUNDING SOURCES

An emergency relief fund should be created within the framework of the United Nations, to be controlled by a people friendly mechanism, to facilitate the provision and distribution of the relief measures suggested above such as food, clothing, shelter, scholarships for orphans etc.

In general, other funding mechanisms are needed to meet the challenge of implementing global policies. Rich countries, governments, philanthropists and the organized private sector are potential funding sources.

At the national level the debt for HIV/AIDS prevention activities could be a good funding source for concerned countries.

B. SHORT-TERM MEASURES

The short-term strategy would be to balance prevention, with treatment, care and support, and to view treatment, care and support as prevention measures. Short-term measures will include:

B1. BLOOD SAFETY

Strengthening the blood safety mechanisms in different countries, especially in countries where serious measures are yet to be taken to ensure blood safety.

B2. DIAGNOSIS

Strengthening the diagnostic capacities of countries

B3. COMMUNITY OUTREACH/FREE TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS

In view of the widespread prevalence of STIs, a community outreach programme for the Prevention and Treatment of STIs should be launched. STI treatment could be approached as a Community Health Campaign, much like UNICEF's Immunisation Campaigns.

Under a "Free Medical Check-Up and Treatment Scheme", involving health workers, NGOs, and Volunteers, community people should be screened and treated free for STI.

Implementing a free STI treatment policy will encourage more men to come forward for treatment and to complete treatment regimes. Pharmaceutical companies are important allies in implementing this policy.

B4. UNIVERSAL VOLUNTARY TESTING

A free universal voluntary testing policy will enable more and more people to come forward for voluntary testing instead of the present situation where many people are screened mostly on medical grounds.

Early detection will help to ensure early treatment and the continued productivity of infected people, which in-turn will guarantee more livelihoods, and food security for many households.

B5. UNIVERSAL ANTI-RETROVIRAL THERAPY

Access to anti-retroviral therapy should be treated as a human right. That being the case, no one should be excluded from benefiting on the basis of their socio-economic status. Thus, free universal anti-retroviral treatment should be guaranteed for everyone especially in resource-poor countries. Pharmaceutical should be persuaded to give generic rights to developing countries who should be technically and financially assisted to produce anti-retroviral drugs.

Special attention should be paid to the prevention of mother-to-child transmission and all pregnant women worldwide should be guaranteed access to therapies for the prevention of mother-to-child transmission

B6. DECENTRALISATION OF HEALTH SERVICE DELIVERY FOR HIV/AIDS PREVENTION AND CONTROL

All the outlined screening and treatment activities should be decentralized as much as possible and located or administered from the Primary Health Care or secondary Health care levels as the case may be. Fully functional HIV/AIDS units at the Primary Health Care level should provide HIV/AIDS screening, treatment of opportunistic infections, diagnosis and treatment of Sexually Transmitted Infections and tuberculosis.

The decentralization of these services will facilitate access to them by women at the community level. It will also facilitate the early detection and treatment of STIs in men and women.

Note: There may be a lot of concern as to where to derive the resources for these diagnostic, treatment and care policies; however, a Social Cost Benefit Analysis need to be applied here. These are short-term measures with long-term benefits as these measures will impact drastically on levels of infection.

B7. GLOBAL HIV/AIDS WORKPLACE INTERVENTION PROGRAMME

Another short-term measure is to implement a global workplace intervention programme. Partnerships should be entered into by labour ministries, employers of labour. Chambers of Commerce and trade or labour unions for compulsory workplace HIV/AIDS intervention scheme. The scheme should involve:

- HIV/AIDS, education on modes of transmission, prevention, factors driving the epidemic, the gender dimensions of HIV/AIDS, the implications of male sexual behaviour, promotion of STI treatment, the benefits of Voluntary Testing etc
- Integration of HIV/AIDS prevention and control into companies' health policies and the articulation of workplace policies which are non-discriminatory.

This workplace intervention is strategic for several reasons:

- It is a viable medium for reaching millions of men worldwide.
- It provides a unique opportunity to sensitise men to the gender dimensions of HIV/AIDS.
- It will help to reduce stigmatization and discrimination of infected workers thereby helping to protect the rights of infected people.
- It will enable employers of labour ensure a healthier workforce and increase productivity by reducing the loss of their productive workforce to HIV/AIDS
- It is highly cost effective as it will be reaching staff where they are.

The major resource required for implementing such a programme would be technical assistance which should come from within the country or the community in which the company or business is sited, so that the education can be culture appropriate.

B8. BUILDING ON LOCAL COMMUNITY-BASED INITIATIVES

Community level programmes should build on existing local initiatives and involve women and communities in the design and implementation of HIV/AIDS prevention and control activities to ensure sustainability.

They should:

- Address the special needs of women and children
- Strengthen all support systems for women
- Treat the family as a unit
- Strengthen extended family ties
- Involve women and community people in policy formulation
- Promote a sense of community (rather than individual) responsibility for care and support
 - Partnerships should be built at the community level involving Religious groups, Traditional healers, Traditional birth attendants, NGOs, Community Organisations, to deal with the gender dimensions and socio-cultural issues of HIV/AIDS
 - Community level interventions should collaborate with local health institutions and coordinate their activities with those of local health agencies
 - Multi-sectoral collaboration should take place at the lowest tier of government which is usually closest to the grassroots and to communities.
 - To reduce the burden on women who are involved in caregiving, volunteers should be encouraged from community and religious organizations to assist women in care and support activities.

B9. USING MULTIPLES CHANNELS OF COMMUNICATION TO REACH PEOPLE AT THE COMMUNITY

Informal channels of communications such as local meetings, social clubs, associations etc should be exploited for reaching men, women and children with vital information and services.

B10. RURAL-BASED HIV/AIDS PREVENTION AND CONTROL ACTIVITIES

Another short-term measure will be to support more rural-based HIV/AIDS prevention activities. In view of the fact that the african family has traditionally been the mechanism for ensuring comprehensive care, many terminally ill AIDS cases end up in rural communities. Rural communities thus become effective intervention points not only for preventing infection but also for responding to the cultural norms which worsen the plight of women.

B11.ENGAGING HUMAN RIGHTS GROUPS ON HIV/AIDS ISSUES

Urgent steps should be taken to involve human rights groups all over the world in HIV/AIDS prevention and control issues, especially in the ethical and rights issues. This could be done through workshops, seminars or other training activities, including meetings at country levels to educate human rights groups on HIV/AIDS issues, on the gender implications of HIV/AIDS and on the ethical and human rights issues involved in the prevention and control of HIV/AIDS.

Such activities involving human rights groups should also include the articulation of concrete actions to be taken by them to ensure the protection of the rights of people infected and affected by HIV/AIDS and especially to eliminate discrimination against girls and women infected and affected by HIV/AIDS.

C. LONG – TERM MEASURES

Long-term interventions should involve measures to eradicate poverty:

- Promoting infrastructural development and business investments in rural areas in developing countries so as to reduce poverty and migration (another driving force for HIV/AIDS), which increase women's vulnerability.
- Encouraging greater government spending on social services.
- Creating an international mechanism for ensuring more equitable distribution of resources both globally and within countries
- Reviewing Structural Adjustment Programmes (Economic Recovery Programmes) to make them more people-centred
- Policies to improve the quality of life in rural areas and to control the rural-urban drift constitute a key strategic response with far-reaching implications both for food security and social security in general and will impact directly also on women's health status. Rural development will keep families together and provide women with support and security.
- Implementing non-partisan human rights education (including governance and democracy issues) at the grassroots level in developing countries.
- Establishing mechanisms for the control of pornography and violence in the mass media
- Implementing programmes aimed at ending prostitution and providing alternative livelihood for women wishing to quit prostitution.

I will conclude with the remark that whatever policies and programmes are eventually designed to help reduce the vulnerability of women and girls to HIV/AIDS will not make much difference in their lives if not backed by adequate resources. Pressures must be put on governments of every country not only to design gender sensitive programmes and policies but also to make resources available for implementing them.

There is need for a shift in priorities both at the national and at the global levels in terms of resource allocation. HIV/AIDS is a global catastrophe of a far bigger magnitude than any natural disaster or holocaust that we have seen in this generation and it demands new, speedy and radical responses. A shift in funding priorities for instance, demands that we spend less on the military and invest a percentage of money spent on the military for HIV/AIDS prevention. There are other areas where the priorities could be reorganised to make funds available for HIV/AIDS prevention and control.

One must commend the various United Nations programmes and commissions that have demonstrated dogged commitment over the years in fighting HIV/AIDS, especially for the special focus which is being given to the gender implications of the epidemic.

We only pray that the political will to INVEST adequately and speedily in reducing the impact of the epidemic on women, girls, children and communities will emerge on every front.