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Gender, adolescents and the HIV/AIDS epidemic: the need for comprehensive sexual and reproductive health responses

Prepared by*

Maria De Bruyn

IPAS

(USA)

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This paper addresses the risks and needs of male and female adolescents in relation to the HIV/AIDS epidemic and the broader area of sexual and reproductive (SRH) health. It begins with a brief review of the risks to which adolescents are exposed and then proposes an SRH rights framework within which the risks and needs of both HIV-negative and HIV-positive teenagers can be examined. It then concludes with a few recommendations. (Note: adolescents and teenagers are used as synonyms in this paper.)

Adolescents and sexual/reproductive health risks

In recent years, increasing attention has been placed on the need to integrate a gender-based approach into efforts to deal with the HIV/AIDS epidemic. This trend has resulted from the recognition that the epidemic is affecting women and men in differential ways. For example, the generally lower status of women leads to their subordination and restricted opportunities to control the circumstances which may expose to them risks. Men, on the other hand, are often influenced by societal pressures that can make it difficult for them to adopt protective behaviours, both for themselves and their sexual partners [1].

These factors are compounded for adolescents who face additional restrictions due to age-based factors and biases. For example, young women often have less decision-making power regarding sexuality than adult women, especially because they tend to have older male partners who can dominate them both age- and gender-wise and/or because their parents more strictly control their possibilities of accessing services such as contraceptives and condoms. Young men, who like young women are in the phase of establishing their sexual and gender identities, face various pressures regarding the exercise of their sexuality not only from society at large (parents, religion, the media) but also from their peers.

> Richard Serunkuuma, a young man living with HIV in Uganda, described his treatment by friends when he was abstinent at age 17: "They felt that I didn’t

belong to them, started to tease me with a lot of embarrassing questions and statements like: 'You will suffer from backache because of not releasing the semen. Richard, you seem to be impotent – were you castrated?' To sum it up, they deserted me on those grounds." [2]

A study in Nicaragua noted that young men there may be ridiculed by their peers for not "being a real man" if they are not sexually active with multiple partners [3].

A frequent response to adolescents' vulnerability to HIV infection consists of attempts to "keep adolescents away from sex." Teenagers may be denied school-based sex education because adults fear provision of such knowledge will promote sexual experimentation and activity. For the same reason, their ability to access sexual and reproductive health (SRH) services may be curtailed. Nevertheless, such restrictions have neither stopped teenagers from engaging in sexual activity nor protected them from exposure to HIV/STI infection [4-6]:

- Each year more than one of every 20 adolescents worldwide contracts a curable STI, not including viral infections. At least 111 million new cases of curable (STIs) occur in young people under 25 years of age.
- More than half of all new HIV infections worldwide – over 7,000-8,500 each day – are among young people.
- According to conservative analyses cited by UNAIDS, in countries where 15% of adults are currently infected with HIV, approximately one-third of today's 15-year-olds will die of AIDS. Where adult prevalence rates exceed 15%, the lifetime risk of dying of AIDS is much greater.

In addition, both gender- and age-based factors contribute to other SRH risks that may be interrelated with HIV/STI infection [4-7]:

- Many victims of physical abuse and sexual violence are adolescents. Research in 19 countries has documented sexual abuse (ranging from harassment to rape and incest) among 7-34% of girls and 3-29% of boys. There is evidence that victims of abuse may be more prone toward risk-taking behaviours that can increase their chances of exposure to HIV/STIs (e.g., unprotected sex due to alcohol and substance use), while sexual violence may directly result in HIV/STI infections.
- Every year up to two million girls and young women risk undergoing female genital mutilation; if the procedure is practised on groups of girls without the use of sterilized instruments, HIV might potentially be transmitted from infected to uninfected girls.
- Many adolescents lack information about and access to contraceptive methods. Partly as a result of this, 10% of world births are to teenage mothers - in areas with high HIV prevalence the chances of these mothers having to deal with perinatal HIV transmission are increased. For example, the proportion of pregnant 15 to 19 year-olds infected with HIV rose from 6.5% in 1994 to 13% in 1996 in South Africa; in Botswana HIV prevalence was 28% for the same group in 1997.
- Deaths related to pregnancy and childbirth are two to five times higher among women under 18 than among those aged 20-29.
- Globally, one-third of women hospitalised for abortion-related complications are younger than 20. Some young women who are seropositive and end up with an unwanted pregnancy (because of unprotected sex, failed contraception or sexual violence) seek abortions. Where safe abortion is inaccessible, they may resort to dangerous self-induced methods or seek services from untrained persons who work in unhygienic and inadequate conditions, endangering their health even further.
- Every five minutes a young person somewhere in the world commits suicide, often because of emotional and social problems related to sexual and reproductive health. These include physical abuse, sexual violence, breakdowns of intimate relationships, alcohol and drug abuse, unwanted pregnancy and unsafe abortion, infection with HIV/STIs/HIV, and anxiety about being physically attracted to members of the same sex.

An SRH rights framework

A first step towards effectively protecting adolescents from HIV/STI infection is to acknowledge that considerable numbers of young men and young women around the world are sexually active. In some countries, more of these adolescents are married than not, while in many other countries both wed and single adolescents engage in sexual encounters. Indeed, there are some studies showing that unmarried teenagers tend to have more partners than people in their mid-20s or older [8].

A second step is ensuring that these young women and men receive sex education so that they are well-informed about the reproductive process as well as the positive and negative consequences of sex. A 1997 review of 53 studies on sex education around the world revealed that only three reports found increases in sexual behaviour after teens participated in such programmes. On the other hand, 22 studies indicated that such courses helped delay the onset of sexual activity, led to a decrease in sex or reduced pregnancy/STI rates, while 27 reported no changes in sexual activity and pregnancy/STI rates among pupils [9].

Such education needs to be offered within a broad SRH framework because it is often the same risk behaviours and risk situations that place teens at risk of violence, HIV/STIs, unwanted pregnancies and, in the case of young women, unsafe abortions [10]. This education should be coupled with increased access to SRH services that are tailored to male and female adolescents' specific concerns and needs. It must also seek to highlight and eliminate gender biases as we have the most chance of success in changing harmful gender-based norms among adolescents - gender inequality is not as ingrained in their minds as something "normal" and "natural" as is often the case for adults.

Governments have acknowledged – through international treaties and agreements such as the Convention on the Rights of the Child and the Programme of Action from the International Conference on Population and Development held in Cairo in 1994 – that adolescents need access to such education as well as services that will protect their health. Government representatives in other forums have reiterated this. For example, in July 2000, the Fourth Conference of African Women Ministers and Parliamentarians, representing 44 countries, recommended in the Windhoek Declaration that: "Networks [of governmental, intergovernmental and civil society organizations] should ensure that the education and sensitization of adolescents in and out of school are carried out on their sexual and reproductive health rights and that adolescents are empowered to exercise these rights in a responsible manner.

It is therefore useful to situate a gender-based approach to examining adolescents' SRH problems and needs within a human rights framework. IPPF has issued a *Charter on Sexual and Reproductive Rights* that is based on the rights guaranteed through international conventions, treaties and conference consensus statements (such as the ICPD Programme of Action and the Beijing Platform for Action) [11]. The following two sections offer examples of how the rights in that Charter can be used in examining adolescents' needs.

Adolescents and prevention

The Right to be Free from Torture and Ill-treatment includes the right of all adolescents to protection from violence, sexual exploitation and abuse. This right is violated – more often for female teenagers – when their sexual partners refuse to inform them of their HIV status or to use condoms. Both young women and young men also need to learn that violence against women is unacceptable. For example, young Ugandan women blamed themselves for rape rather than the perpetrators of the crime [12], while 32% of 998 Australian men aged 14-26 in one study thought that men are sometimes justified in forcing women to have sex [13]. In addition, male and female adolescents who are tricked into the sex

trade are vulnerable to HIV/STI infection, while the young women are also at risk of unwanted pregnancies.

The Right to Information and Education relates to comprehensive information on the various factors that may affect sexual and reproductive health. This includes education on how hormonal changes can influence both boys' and girls' development and behaviour, as well as instruction on reproduction and condom/contraceptive use. The importance of male adolescents understanding the reproductive process must be stressed; for example, a study in Latin America and the Caribbean showed that fewer than 25% of young men aged 15-24 years could identify the female fertile period [14]. For young women information on emergency contraception (EC) is especially important; this must be tailored to their specific needs – for example, explaining the need to take hormonal EC within 72 hours of unprotected sex and the possibility of IUD insertion within 5-7 days if they are not suffering from an STI. For both young women and young men, a focus on shared male and female responsibility is important due to gender-based biases and influence.

> Researchers who analysed the responses of 104 adolescents aged 17-18 years during focus groups in Uganda found that HIV infection and unplanned pregnancy were two of the major consequences of unprotected sex. While the young women clearly recognized concrete risks associated with early childbearing, the young men did not nor did they feel a need to take responsibility for this. On the contrary, "Having a child could, in fact, enhance a boy's status and prove his manhood: 'We are fond of impregnating the girls.' 'It is normal to have a child.'" [15]
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> Contributors to a website for youth explained: "It [contraception] is the man's responsibility. After all, the man controls the woman," says one 19-year-old male from Ghana; "Women are responsible because it is them who become pregnant and carry the baby for nine months," according to an 18-year-old male from Zambia [16].

Information on alcohol and drug abuse is important for all adolescents, both regarding its effects on protected sex (e.g., forgetting "intentions" to use condoms and a greater risk of incorrect use) as well as the potential for HIV infection through sharing unsterilized injecting equipment. This is especially relevant for young men, however, since UNAIDS reports that four-fifths of drug injectors are male [17]. Some research has shown that most men who inject drugs do not use condoms, thereby placing their sexual partners at increased risk of infection with HIV and hepatitis [18].

In addition, we must begin acknowledging – especially in countries with high HIV seroprevalence rates – that large numbers of the adolescent population to whom IEC messages are given are already infected with HIV. This requires a reorientation of education so that it does not only address issues of preventing HIV infection but also living with HIV infection (e.g., the importance of avoiding re-infection, the urgent need to have STIs treated, rights and responsibilities concerning sexual relationships, planning for a family, etc.).

The importance of gender curricula cannot be over-emphasized in this regard. As long as social norms continue defining "good women" as those who do not concern themselves openly with sexuality or "manhood" through "proof" of sexual experimentation, "conquests" and denigration of behaviour that does not conform to "macho" images, adolescents (both seropositive and seronegative) will find it difficult to challenge these stereotypes by adopting healthy behaviours. By the same token, as long as social norms continue making parenthood a – or "the" - key factor in determining whether a person has value as an adult, it will remain difficult for adolescents living with HIV (or teenagers with unknown or negative serostatus) to consider not having children, delaying childbearing or limiting the number of their children as a viable option. If we believe that adolescents have a right to decide how they live their lives, they must truly have options from which to choose. Changing gender norms so that young

women and men have equal opportunities to make choices is an important step toward achieving that goal.

The Right to Freedom of Thought includes freedom from religious texts that are used to restrict access to SRH care. This means that health providers who refuse to give adolescents access to contraceptives, condoms and other reproductive health services permitted by law are obliged to refer them to health providers who will do so. This can be especially relevant for young women, who are often characterized as being "immoral" when they seek to protect their sexual and reproductive health.

The Right to Equality and Freedom from all Forms of Discrimination in one's sexual and reproductive life includes the rights of adolescents to decide whether they will be sexually active or not and with whom (e.g., the right to express one's sexual orientation). The discrimination and marginalization suffered by homosexual young men and lesbian young women can make it much more difficult for them to practise healthy sexual behaviours since they feel compelled to hide their sexual preferences. And homophobia may also be present in the very organizations that seek to promote HIV/STI prevention and care. A male staff-member of a Kenyan HIV/AIDS NGO stated, for example: "Homosexuals are a menace to society. They should not only be jailed, but the key to the lock should be thrown away…I would disown him [his son if he found out he was homosexual] before I caused him grievous harm. I would rather sire a cow than a homosexual. With a cow you get milk, but what possible good or value would come out of a homosexual?" [19]

This right also includes adolescents' right to privacy and confidentiality when they seek access to SRH services, as well as the right of adolescent parents of both sexes to be treated equitably. For example, male teenagers are rarely expelled from school if they father a child, while pregnant young women routinely suffer this fate in numerous countries. The young mothers often do not complete their education and thus have fewer opportunities to earn a reasonable income, making them more vulnerable to various SRH risks (e.g., inaccessibility of antenatal and postnatal care, inability to properly care for newborn infants, in some cases trading sex for income with the attendant risks for HIV/STI infection, etc.)

Adolescents and care/services

The Right to Life means that no woman's life should be put at risk by reason of pregnancy and unsafe abortion. While many young women living with HIV do indeed wish to become mothers, others do not; where antiretroviral therapy is lacking to prevent perinatal transmission, this may especially be true.

It has been reported, for example, that 30-40% of HIV-positive women in Northern Thailand have abortions, often in unsafe conditions [20]. A large percentage of abortions in the country occur among adolescents; undoubtedly some of them are HIV-positive. Women living with HIV (including three aged 15-25 years) interviewed in Zimbabwe for the Voices and Choices project - being carried out by the International Community of Women Living with HIV/AIDS - stated that most HIV-positive women do not want children when they know their serostatus; this was especially the case for those who already had children [21]. Indeed, several of the women had attempted to secure an abortion without success:

> "Three of the women said they would have liked to have had a termination but in one case the nuns at the health centre where she went for HIV care were opposed to abortion. Another said she would have terminated the pregnancy if she had had the opportunity and if pregnant now, she would seek an abortion using traditional herbs or from private doctors. One woman who did not disclose to her partner (a long-term boyfriend) already had one child from a previous relationship. She would have tried to get a termination but because she wanted to keep her status secret it was impossible to get one. One woman who has known her status since 1989, and has been widowed since 1992 took traditional herbs to abort the pregnancy. One other woman with two other children was in a new relationship

> and had not wanted a termination. All these women said they would not want any more children."
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> Another woman had complications after a self-induced abortion: "One day my husband came and forced me to have sex with him. He raped me and I became pregnant. When I found that I was pregnant I tried to terminate it but it was not easy. The doctors refused to terminate my pregnancy even though I told them about my HIV status. Another doctor told me to give her Zim$3000, which I could not have at that time. I tried to look for it to no avail…. Seeing that I had failed to have an abortion from the specialist I looked for traditional medicine. I used it and I had an incomplete abortion. I was very sick and taken to Harare Hospital."

It may be surmised that adolescent women living with HIV, in Zimbabwe and elsewhere, also seek abortions for such reasons as fear and shame or because they feel unable to care for a baby or are unable to continue their schooling. Adolescents are more likely than older women to have abortions at a late stage, when clinical risks are higher, and to have unsafe abortions.

The Right to Liberty and Security of the Person implies that that no person should be subject to female genital cutting, forced pregnancy, forced sterilization or forced abortion. Because of their age and consequently lower status and lack of decision-making power, teenage (and younger) girls are even more vulnerable to coercive sex and forced pregnancy than adult women. Adolescents living in situations of ethnic violence such as the wars in Rwanda and Kosovo are especially vulnerable to violations of this right. In the earlier days of the HIV epidemic, there were reports of forced abortions and sterilization among women living with HIV (e.g., in Thailand [22]); the extent to which this still happens is unkown, but adolescents may be especially susceptible to coercion in such matters by health providers who use their authority and status to influence teen clients' decision-making.

The Right to Choose Whether or Not to Marry and to Found and Plan a Family and the *Right to Decide Whether or When to Have Children* have different implications for adolescent women and men. Both of course have the right to marry (although it might be argued that delaying marriage and childbearing would be preferable for adolescents in many cases); however, their access to information about their partner's serostatus may be very different. Reports of young women being married to men who knew they were HIV-positive but did not inform them of this are unfortunately not uncommon. Adolescents seldom have the power to insist that their potential spouses be tested for HIV prior to marriage and protected sex is out of the question if the couple wishes to start a family.

In the case of sero-discordant couples, some young women may have options for becoming pregnant without infecting their partners (artificial insemination), yet young men living with HIV cannot sire a child in the knowledge that they can completely avoid infecting their partners. Some experimentation has taken place with "sperm washing" yet insufficient evidence is available on the success of this procedure [23, 24]. Moreover, even when it does become a feasible option, it will most likely not be available to the vast majority of men living with HIV. Sex and family life education for adolescents living with HIV must therefore help them consider carefully the benefits and risks of planning and raising a family.

The Right to Health Care and Health Protection and the *Right to the Benefits of Scientific Progress* are closely linked in the field of HIV/AIDS. To prevent HIV/STI infection as well as unwanted pregnancies, adolescents must have access to a wide range of contraceptive options, including emergency contraception. For teenagers seeking to avoid pregnancy, an ideal would be dual protection – a contraceptive and condom use – yet the availability and feasibility of this option can be questioned. In many places, adolescents are not welcomed or are prohibited from seeking contraceptives; in other areas, female teens may be able to visit family planning centres yet there are few measures there to accommodate young men and their needs. The costs of dual methods may also be prohibitive for low-income adolescents and only a small percentage of parents worldwide are willing to take on this expenditure for their children.

In the tragic circumstances wherein adolescents are victims of rape, antiretroviral therapy in the form of post-exposure prophylaxis (PEP) can now help protect them from HIV infection. A clinic in São Paulo, Brazil, offers comprehensive services to female rape victims – including large numbers of adolescents - that include emergency contraception and PEP when the case is reported within 72 hours, STI diagnosis and treatment and abortion for unwanted pregnancies. A study conducted since PEP has been offered showed that none of 182 women treated with PEP seroconverted, while four of 145 (2.7%) in a control group without PEP did acquire HIV infection [25]. Calls for such treatment were frequent during the Durban AIDS Conference and WHO is assessing the evidence for post-rape PEP effectiveness. It should not be forgotten, however, that male adolescents also suffer from rape, albeit in smaller numbers than female teenagers – they, too, should have access to this ultimately life-saving measure.

Whereas in the early days of the epidemic, children and adolescents living with HIV only had a few years' life expectancy, the advent of antiretroviral therapy has changed this picture. Yet the benefits of this scientific progress are beyond the reach of the vast majority of adolescents living with HIV in our world today. So far efforts to increase the accessibility of such treatments have focused on preventing perinatal transmission but extending the life expectancy of young people living with the virus merits equal consideration.

Adolescents and advocacy

The Right to Freedom of Assembly and Political Participation may be broadly interpreted to include the right of young people to advocate that communities and governments prioritize their SRH rights. Young men and women do indeed wish to exercise this right; for example, the Youth Coalition on ICPD+5 united 37 NGOs and youth organizations from 26 countries worldwide to participate in the review process of implementation of the Cairo Programme of Action [26]. The International Planned Parenthood Federation is being advised by 12 young people from the six regions where it works through a Youth Working Group. They will shortly launch and manage the *Youth Shakers* website, which will promote the IPPF Youth Manifesto with details on what young people precisely want concerning SRH rights and services [27]. Greater efforts are needed to enable young people to participate in designing, implementing and evaluating SRH services so that they become truly youth-oriented and youth-friendly.

Recommendations

Adolescents' risks and concerns regarding HIV/AIDS cannot be addressed in a "vacuum" if we are to achieve effective responses. Adolescents must be enabled both to recognize and act on gender biases that affect their health and development negatively as well as to receive comprehensive services that address all their SRH needs. The following measures can contribute to developing a gender-based SRH rights approach to protecting adolescents from HIV/STIs and other SRH risks:

- Programmes must recognize the heterogeneity of the adolescent population. Though many teenagers share concerns and needs, these will also differ according to whether they are male or female, HIV-negative or HIV-positive, single or married, rural or urban, in early or later adolescence, working or studying, heading households or living on the streets, etc.
- Special attention must be given to the needs of adolescents living with HIV, both in prevention and care programmes. We must stop talking about the adolescent population as if it comprises only young people who must be protected against HIV – in many countries, large numbers of teenagers are already living with the virus.
- Full use must be made of legislation to promote the protection of adolescents. This includes passing and enforcing relevant legislation and regulations (e.g., regarding comprehensive sex education in schools, adolescents' access to SRH services, decriminalization of homosexuality and penalties for sexual abuse and sex trafficking of minors).
- Policy-makers must ensure that adolescents' freedom of choice regarding sexual and reproductive health matters is respected. This includes making contraceptive services available

and affordable (including emergency contraception), prohibiting coerced measures such as forced sterilization or abortion, and ensuring that their access to post-abortion care for treatment of incomplete abortions and safe abortion where permitted by law is feasible.

- Education on HIV/STIs should be integrated into broader SRH education with a strong gender focus. Ipas and WHO are currently developing such a curriculum, *Gender, Adolescents and Reproductive Health,* while Healthlink Worldwide is collaborating with the Commonwealth Youth Programme to prepare a resource kit on gender, adolescents and sexual health. Financial and other support is needed to make such resources – as well as those produced regionally and locally (such as ARROW's excellent gender materials in Malaysia) – widely available. Such resources and curricula do not detract from the need for topic-specific training modules (e.g., on HIV/STIs or violence, such as the *Healthy Relationships* anti-violence curriculum developed by Men for Change in Canada and the *Stepping Stones* curricula) but provide a basic framework in which the specific topics can be better discussed and explored with teenagers.
- Adults who work with adolescents – as well as community leaders, parents, and other influential adults – must receive gender training that not only focuses on "gender knowledge" but that aims to help them re-examine their values and how gender biases are reflected in their actions, especially regarding adolescents.
- Sexual and reproductive health services must not only be made "youth-friendly" but also "male and female-friendly" and "youth participatory" so that both young men and young women gain access to the information and services they need and want.

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