



RE-EVALUATING UNAIDS FAST-TRACT STRATEGY FROM WOMEN'S PERSPECTIVES

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ABSTRACT

The world has made significant progress in halting and reversing the AIDS pandemic over the four decades. However, women and especially young girls and adolescents are still disproportionately affected by HIV. Today, women still constitute 52% of the total People Living With HIV/AIDS (PLWHA), which is more than half of the total population globally and AIDS is still one of the leading cause of early death amongst women. Therefore, it is high time to erase this long overdue issues of gender inequalities, gender-based violence and HIV infection by progressing towards a sustainable, women-centered development strategy. Keeping all these issues in mind, this paper attempts to critically examine the Fast Tract Strategy of 2014 adopted by the United Nation Political Declaration on Ending AIDS by 2030 with reference to women.

Keywords: *Women, HIV/AIDS, Vulnerability, UNAIDS Fast-Tract Strategy, Indian scenario.*

Introduction

The existence and rapid spread of HIV and AIDS poses a serious challenge to every nation across the globe. HIV and AIDS have the potential to undermine the massive improvements that have been made in the global health over the years (NACO, 2008). While the effects of HIV and AIDS are equally detrimental for all persons, certain sections of the population across the world like women, whether married, single, divorced, sex worker, seasonal migrants or

adolescent girls are most vulnerable towards the negative impacts of AIDS. Today, women and especially young girls and adolescent are still disproportionately affected by HIV and women still constitute 52% of the total population and AIDS is still one of the leading cause of early death amongst women (UNAIDS, 2019a). Despite of the various efforts given by the governments both at the global and national level, the alarming growth rate of HIV/AIDS is still seen in the picture. This

paper would therefore, attempt to critically examine one of the major steps taken by the Joint United Nations Programme on HIV and AIDS (UNAIDS), that is, The UNAIDS Fast Tract Strategy of 2014 with special reference to women. In this paper, the words HIV and AIDS would be used interchangeably.

Given the high stigma and confidentiality associated with HIV/AIDS, the study draws largely from secondary sources such as recent Reports and Fact Sheets of UNAIDS, Technical reports of National Aids Control Society (NACO), World Health Organisation (WHO), UNWOMEN etc. Primary data include telephonic interview with Outreach Worker of Gilead drop-in-centre, Mizoram. The target population of the study mainly includes HIV Positive victims of young girls and women from third-world countries such as sub-Saharan Africa, Bangladesh and India. The main objectives of the study include:

1. To study the global commitment towards Fast - Tract Strategy of Ending AIDS by 2030 in relation to women.
2. To address the determining factor of vulnerability of women towards HIV/AIDS.
3. To highlight India's Commitment towards the Fast- Tract Strategy.

The Fast-Tract Strategy

On World AIDS Day, that is, 1st December, 2014, The Joint United Nations Programme On HIV and AIDS (UNAIDS) sets the Fast Tract Strategy, that is '90-90-

90' targets for 2020 aimed at ending the epidemic by 2030. The targets include achieving '90% of people living with HIV knowing their HIV status', '90% of people who know their HIV-Positive status on treatment' and '90% of people on treatment with suppressed viral load' (UNAIDS, 2014). These goals and targets were reiterated in the UNAIDS 2016-2021 Strategy, which also aligns with the Sustainable Development Goals (SDG's). The SDG have put forward 17 goals in which the SDG Target 5 is mainly dedicated to achieving gender equality including:

- 'End all forms of discrimination against all women and girls everywhere'.
- 'Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision making in political, economic and public life'.
- 'Ensure universal access to sexual and reproductive health and reproductive rights'.
- 'Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels' (Avert, 2020).

As part of the UNAIDS Fast-Track Strategy, in the 2016 United Nations Political Declaration on Ending AIDS, countries made commitments for adolescent girls and young women such as 'To reduce the number of new HIV infections among adolescent girls and young women from 390,000 in 2015 to below 100,000 in 2020', 'To ensure that 90% of young people have

the skills, knowledge and capacity to protect themselves against HIV' and '90% of young people in need have access to sexual and reproductive health services and combination of HIV prevention options by 2020' (UNAIDS, 2019b). Eventually, to stay on track towards ending the AIDS epidemic by 2030, UNAIDS has set a global target of achieving less than 500,000 new infections by 2020. To close current gender-related HIV preventions gaps, UNAIDS recommends the following:

- 'Strengthen legislation, law enforcement and programmes to end intimate partner violence'.
- 'Increase girl's access to secondary school'.
- 'Use cash transfers to empower women economically, to keep them in school and to enable them to make healthy partner choice'.
- 'Remove third-party authorization requirements and other barriers to women and young people's access to HIV and sexual and reproductive health services' (UNAIDS, 2016b).

The World is Off -Tract Towards It's Commitment

Globally, despite all the above Political Commitments and Targets, the scale-up interventions specific to gender inequality and HIV has not been fast enough. Indeed, translating these commitments into effective policies and programmes remains a challenge (Avert, 2020). The main arguments may be expressed as follows:

- 'In 2014, a survey of 104 countries found that only 57% has HIV strategy that included a specific budget for women' (UNAIDS, 2015).
- Of all 37.9 million people globally living with HIV (end of 2018), 79% knew their status, 62% were accessing treatment and 53% were virally suppressed in 2018 and about 8.1 million people did not know that they were living with AIDS (hiv.gov, 2019b).
- Evidence suggests that women and girl's participation in national HIV planning process is declining globally. In 2012, UNAIDS reported that 61% of women living with HIV participated in formal planning and review mechanism down from 66% in 2010. A research conducted by the Association for Women's Rights in Development (AWID) found that, while women and girls are recognized as key agents in development, a large majority of women's organization are underfunded.
- A major gap remains between global and regional policies and the actual implementation of comprehensive sexuality education on the ground. Gender-responsive and life-skill based HIV and sexuality education is only covered in the national curriculum by 15% of the 78 countries analysed in UNESCO's 2016 Global Education Monitoring Reports (UNAIDS, 2016a).
- An alarming seven in 10 young women in Sub-Saharan Africa still do

not have comprehensive knowledge about HIV (UNAIDS, 2019a).

- In Sub-Saharan Africa, more than 50% of rural young women (15-24 years of age) have been pregnant before their 18th birthday (UNAIDS, 2019a).
- Forty five countries have laws that impose the need for parental consent for the adolescent and young people below 18 years to access HIV testing (UNAIDS, 2019a).
- Seventy-eight countries require parental consent for adolescent to access sexual and reproductive health-services (UNAIDS, 2019a).

The UNAIDS (2019) Fact Sheets perhaps best explains the unsatisfactory global scenario of HIV and women as follows:

- ‘Every week, around 6000 young women aged 15-24 years become infected with HIV. In the Sub-Saharan Africa, young women aged 15-24 years are twice as likely to be living with HIV than men’.
- ‘More than one-third (35%) of women around the world have experienced physical and sexual violence and women who have experienced such are 1.5 times more likely to acquire HIV than women who have not experienced such violence’.
- Only 68% with uncertainty bounds of 52-82% of female adults aged between 15 years and above had access treatment.
- Only 82% with uncertainty bounds of 62-95% pregnant women living with HIV had access to anti retroviral

medicines to prevent transmission of Mother to Child.

- The risk of acquiring HIV is still 21 times higher for female sex worker (UNAIDS, 2019b).

Addressing women’s vulnerability

Since 2010, the global AIDS -related deaths and the rate of new infection have been declining by an estimated figure of 33% and 16% respectively as per the UNAIDS, 2019. This is quite an achievement as compared the previous year’s records. However, some disturbing scenes that highlights the vulnerability of women is still seen in the picture. The former Secretary General, Ban Ki-Moon had rightly said that ‘the world must do more to improve maternal health care, not enough attention was paid to the fact that HIV is one of the leading causes of death among women of reproductive age worldwide’ (United News Centre, 2010). The main disturbing scenes of vulnerability of women may be highlighted as follows:

Biological Vulnerability

Women being biologically different from men affects men and women differently. Chance of contracting HIV is two to four times more higher among women than men during sexual intercourse (Medline Plus, 2019). Women living with HIV/AIDS have some different problems than men such as repeated vaginal yeast infection, severe pelvic inflammatory disease (PID) and a higher risk of cervical cancer (Medline Plus, 2019). Besides gynaecological problems, women may experience a severe side-effects of Anti

Retroviral Treatment. These include early aging and menopause or osteoporosis. They also face the same health problems that many other older women do, such as heart disease, diabetes, high blood pressure, arthritis and some cancer (hiv.gov, 2019a).

Gender-based Violence

Gender-based violence is another serious issue that needs to be highly addressed. The fear of intimate partner violence has been shown to be an important barrier to the uptake of HIV testing and counseling, to the disclosure of HIV-positive status and to treatment uptake and adherence, including pregnant women who are receiving Antiretroviral Treatment (ART) as part of services to prevent Mother-to-Child transmission (UNAIDS, 2016a). Rape, sexual assault, submission due to fear of violence, assault by family members or friends, violence in the course of trafficking or at workplace all add up to the higher chances of contracting of HIV among women (WHO, 2020). Violence Against Women (VAW) and the disclosure of HIV/AIDS status to their male partner are closely linked and as such, HIV positive women usually hide their status. One such striking incidence is that in 2000, Susan Teffo from Kenya discovered that she was HIV positive. When she told her husband of her status, he grabbed her and burnt her face over a primus stove. Her four year old son was also burnt when he tried to stop his father from hurting Susan. Susan laid charge of attempted murder against her husband, but he did not plan to leave him. If she divorced him, she would lose access to her husband's medical aid, which provided life-

prolonging anti-retroviral drugs (WHO, 2004).

Power-Imbalance

The power imbalance between men and women has affected the women's ability to make their own decisions when it comes to the practice of safe-sex and use of condom. This power imbalance between genders also means that many young women are not able to make decisions about their own lives. For example, in 29 countries of Sub Saharan Africa, women required the consent of a spouse/ partner to access sexual and reproductive health (SRH) (UNAIDS, 2017a). In Uganda, research indicates that women were afraid to ask for money or permission from their husbands to attend HIV/AIDS facilities or seek information and in some cases explicitly forbidden from taking HIV tests (WHO, 2004). A 31 year old Ugandan woman clearly narrated the sad reality of power imbalance between man and woman when it comes to safe sex negotiation as:

“My husband hated condom. He never allowed it. He would beat me often. He used to beat me when I refused to sleep with him. He wouldn't use a condom. He said we are married, how can we use a condom? It's a wife's duty to have sex with her husband because that is the main reason you come together. But there should be love. When I know about his girlfriends, I feared that I would get infected with HIV. But he didn't listen to me. I tried to insist on using condom but he refused. So I gave in because I really feared him” (Human Rights Watch, 2003).

Illiteracy

Research has shown that uneducated girls are twice as likely to acquire HIV as those who have attended school (UNAIDS, 2019a). Illiteracy often leads to ignorance about the preventive mode of HIV transmission which is also closely related to higher chance of contracting the disease. Young girls who did not even get access to secondary school are thus very vulnerable to HIV as they are not even aware of what HIV is. Surprisingly, in Sub-Saharan Africa, survey data from 35 countries show that only 36% of young men and 30% of young women could correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. Nearly, all women had heard about HIV and AIDS, however 24% did not know that HIV was the cause of AIDS and 48% did not know that HIV could be transmitted by sexual intercourse without a condom with an HIV infected person (UNAIDS, 2017a).

Poverty

In a poverty-stricken country, women and young girls become very prone to HIV. Hunger or insufficient food may lead to early prostitution, human trafficking and early exposure to sexual relationship. Unemployment is often the push factor that makes both men and women undertake unsafe practices, making them vulnerable to HIV infection (Pascoe *et al.*, 2015). Women especially the young Female Sex Worker (FSW), the marginalized women and the injecting women (IDU)'s are very helpless in this case as they have to earn their livelihood in whatever possible means.

Moreover, Female Sex Worker are ten times more likely to acquire HIV than the general male population (UNAIDS, 2017a). For instance, a handful number of the Female Sex Workers in Mizoram, being the sole bread-winner had little choice but to pursue towards prostitution and are not in the position to bargain for use of condoms for practice of safer sex (Interview with HIV/AIDS Counsellor). A study of age-disparate sex and HIV risk for young women conducted in South Africa between 2002 to 2012 revealed that when a young woman is in a relationship with a man who is older than herself, she is more at risk of acquiring HIV if the age gap is 10 years or more. In many instances, these relationships are transactional and non-commercial in nature by the implicit assumption that sex will be exchanged for food and some other material support (Avert, 2019). Apart from being the sole care-taker at home, financial constraints coupled with unavailability of nearby medical facilities has often led women to miss the timely treatment of opportunistic infection and Anti Retroviral Therapy (ART) as compared to man even in Mizoram (Interview with Lalchhandama, an Outreach Worker).

Discriminatory Social and Cultural Norms

In every society, there exists a dominant cultural and social norms about masculinity, femininity and sexuality which has adverse effects on the fight against HIV/AIDS. In a patriarchal society, the specific roles and norms for women are well-defined. They are strictly confined to homes to look after the whole family member. Education is meant mainly for

men. In some society, women are not allowed even to walk out of the door and have to ask for prior permission even if they do so. Women are meant to be submissive and unquestioning. Men, on the other hand, are regarded as the bread-winner and extra-marital affairs on the side of men are more or less socially accepted norms (NACO, 2008). For Instance, it is estimated that about 30 million men in India buy sex on a regular basis while the social and culture limits placed on women's sexuality imply that a majority of women abstain from sex before marriage and post marriage remain monogamous (NACO, 2008). Thus, an innocent women are at a great risk of acquiring the disease through their husbands. Besides, a 'culture of silence' towards the issue of sex and sexuality are the main domain in many countries. Any discussions about safer sex and condom is regarded as a social taboo. This 'culture of silence' surrounds sex and the implicit assumptions is that good women should be ignorant about sex and passive in sexual interactions. This makes it difficult for imparting awareness about risk reduction or to be cautious in negotiating safer sex. Practices such as *Purdah* or the seclusion of women from public observation among several groups in India also restrict the mobility of women and their ability to access resources, including information and counseling, testing and treatment services (NACO, 2008).

Stigma and Discrimination

HIV/AIDS is such a topic which is widely studied in terms of stigma and discrimination and it is also highly

associated with socio-psychological problems among the victims as well. A suicidal tendency, a feeling of being unwanted and outcasted have closely marked this pandemic. The International Center for Research on Women (ICRW) reported that in Bangladesh, more than half of women living with HIV have experienced stigma from a friend or neighbour and one in five feels suicidal (The Well Project, 2020). Moreover, HIV positive women are highly stigmatised by the society, and even by their own family members and by the medical workers in some places as well. In India, 90% of women who were widows as a result of their husband dying of AIDS have stopped living in her marital home (NACO, 2008). Therefore, women did not usually disclose their status due to fear of being stigmatised and discriminated and has acted as the main factor for inability to access medical help, inability of adherence to ART and also poses a threat to prevention of mother to child transmission of HIV.

Migration

AIDS and migration are two of the crucial issues facing today's changing world. By the end of 2019, the number of international migrants worldwide reached 272 millions. Female migrants constituted 48% of this international migrant stock (Global Migration Data Portal, 2020). All migrants are vulnerable to abuse and exploitation but female migrants are particularly at risk. They face additional vulnerabilities when they are displaced due to conflict or natural disaster. Lack of shelter, overcrowding in camps and poorly lit public toilets all increase the gender-

based violence, including sexual violence (UNFPA News, 2018). All these have increased the chance of contracting HIV among the female migrant. Attitude of the host communities towards the migrants poses another serious threat which may put migrants at a heightened risk of contracting HIV. They are seen as outsiders who take away their job and also labelled as people who make their city dirty (NACO IV, 2011). A study conducted by UNDP in Papua New Guinea has also highlighted the high risk sexual behavior that coincides with high level of migration in urban areas. Young men worker who are engaged in mining, construction and plantations due to long periods of being away from home are attuning to commercial sex (UNFPA, 2018). This has also heightened a high vulnerability of contracting HIV for their monogamous wives who stayed back home.

Indian Scenario

India, as a signatory of the Sustainability Development Goals (SDG's) aims to achieve 'End of AIDS by 2030 as a Public Threat' and as such committed to achieve this goal through it's National AIDS Control Programme (NACP) in collaboration with National Health Policy (NHP, 2017) and National Strategic Plan for HIV and STI (2017-2020) by following the medium term targets for 2020. The target are (NACO, 2017):

1. To attain reduction in new HIV infections by 75% from the baseline value of 2010.
2. To attain treatment target of 90-90-90.
3. To eliminate Mother-to-Child transmission of HIV by 2020.

4. To eliminate HIV/AIDS related stigma and discrimination by 2020.

The aforesaid India's goal, however, is still something very difficult to achieve in comparison with the actual facts that is prevalent in India. The biennial sentinel surveillance on HIV/AIDS carried out by National AIDS Control Organisation (NACO) in collaboration with the Indian Council Of Medical Research (ICMR) represents a mere aspirational picture rather than achievable goal at this stage. The 14th round of surveillance carried out in 2017, being the latest and the most reliable data narrates a different story as compared to India's target of 'End of Aids By 2030' The Executive Summary' of the surveillance shows that:

- India has the third largest HIV epidemic in the world. By the end of 2017, there were an estimated 21.40 lakhs with uncertainty bounds of (15.90-23.39 lakhs) people living with HIV in India where females accounting to 8.79 lakhs.
- 79% of the people living with HIV know their status where only 22% of young women (aged 15-24) know how to prevent from HIV.
- 71% of the people living with HIV are on treatment out of the total 128,5880 HIV positives. Only 60% of pregnant women are on treatment.
- Out of 88,000 new infections, 34000 new infections among women and around 3700 among children (aged 0-14) were found.
- One in five women in relationship likely to experience violence from

their male partners which is a constant level that has remained unchanged for the past decades.

- India is a home to one of the largest number of children orphaned by AIDS. It has 7 million children with at least one parent living with HIV and 1.5 million children orphaned due to HIV and these children endure high stigma and discrimination.
- ‘There was an adult (15-49 years) HIV prevalence of 0.22%. Slightly more than two-fifths (42%) of the total estimated People living with HIV/AIDS (PLWHA) were females’.
- ‘India is estimated to have around 22,677 (10,927-40,605) HIV positive women who gave birth in 2017 and needed prophylaxis for prevention of mother-to-child transmission of HIV’.
- ‘State-wise, the PMTCT need was highest in Maharashtra followed by the Uttar Pradesh, Bihar, Andhra Pradesh, Karnataka, Telangana, West Bengal, Gujarat, Tamil Nadu and Rajasthan. Together, these 10 states contribute almost three fourths of the total PMTCT need in the country.

Suggestions

1. A Gender-responsive and life-skill-based HIV and sex-education needs to be covered more exclusively in the curriculum both at the national and international level.
2. Greater efforts is needed towards gender mainstreaming and including HIV positive women in the decision making process and in the

implementation of HIV prevention programme.

3. A gender-friendly health care facilities like mobile Antiretroviral Therapy (ART) centre and Prevention of Mother to Child Transmission Centre (PMTCT) need to be established.
4. Special provisions and facilities to meet the needs of the female migrants refugees and crisis-affected populations are highly required to put a halt towards HIV infection rates.
5. Meaningful involvement of men in the HIV implementation programme and a move towards a continuum of femininity and masculinity would no doubt reduce gender-based violence associated with HIV.

Conclusion

The Sustainable Development Goal is a bold and ambitious step and still has miles to go in order to completely erase AIDS in the picture by the end of 2030. While efforts are being made to curb the spread of the epidemic, there however remains a number of challenges to be addressed and streamlining the policies to the actual trends on the ground is critical. However, despite all these challenges, there have been success and promising signs. Globally, the number of people newly infected with HIV and people on treatment in poor countries has been dramatically increasing in the past decade and a huge progress has been made in preventing mother to child transmission on HIV and keeping mother’s alive. For instance, as of 2019, 85% of pregnant women with HIV received ART (UNAIDS,

2019a). Out of the total women including young girls worldwide:

- 79% knew their HIV status.
- 86% of all people receiving Anti-Retroviral Treatment (ART) has viral suppression including both married women and young girls.
- 92% of pregnant women with HIV received ART to prevent transmitting HIV to their babies as compared to 49% in 2010.
- AIDS-related deaths have been reduced by more than 55% since the peak in 2004. In 2018, around 770,000 people died from AIDS-related illness world-wide compared to 1.2 million in 2010 and 1.7 million in 2004 (hiv.gov, 2019b).
- Increase in condom use has also been reported which has led to a decline in HIV infections in countries like Botswana (94%, 2013), Zimbabwe (85%, 2015), Namibia (80%, 2013) and Malawi (76%, 2015) (UNAIDS, 2017b).
- Global progress was seen in improving knowledge of HIV awareness from 66% (48-80%) in 2015 to 70% (51-84%) in 2016 (UNAIDS, 2017b). By 2017, in eastern and southern Africa, nearly twice as many adults aged 15 to 49 years were aware of the mode of transmission (UNAIDS, 2017b).
- There has been an increasing recognition for the need to address gender-based violence and the need to engage men for successful implementation of programme in order to do away with harmful practice of masculinity and discriminatory gender

roles which has been carried out under SASA, Community Mobilization in Uganda Yaari Dosti in India etc. This has tremendously reduced the risk behavior in regards to gender-based violence (UNAIDS, 2019b).

- Introduction of school based sex-education and Cash Transfer to Girl Child had remarkably improved the status of women, towards prevention of contracting HIV at an early age, enabling girls to stay in school, decreasing level of unintended pregnancy and reduced risk of partner violence (UNAIDS, 2017b).

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