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The spread of the HIV/AIDS epidemic to women and girls in Europe

Report
Committee on Equal Opportunities for Women and Men
Rapporteur: Mrs Catherine FAUTRIER, Monaco, Group of the European People's Party

Summary

The Parliamentary Assembly is concerned that, more than 25 years after it first made its appearance, the HIV/AIDS pandemic is continuing to spread, including in Europe. In particular, the HIV/AIDS epidemic has increasingly started to spread to women and girls – in Europe as well as globally.

Physiologically, women are more prone to the virus than men. Coupled with social and economic dependence, sexist attitudes, and domestic violence, a deadly cocktail can develop: for women who are – in one way or another – dependent on the men with whom they have sexual relations, refusing sexual relations or insisting on condom use may not be an option.

The empowerment of girls and women in Europe is thus a key factor in the fight against HIV/AIDS. Girls and women in Europe must both be properly informed of the risks associated with certain behaviours, and must be put into a position where they have the power to act on this information.

The Assembly thus recommends that the Committee of Ministers ensure that a gender perspective is taken in all work on HIV/AIDS within the Council of Europe and its member states, and that they focus their efforts on halting the spread of the HIV/AIDS epidemic to women and girls in Europe.

The Assembly furthermore recommends that the Council of Europe run a European awareness-raising campaign to combat AIDS in the near future, similar to the one being run this year to combat domestic violence.

A. Draft recommendation

1. The Parliamentary Assembly is concerned that, more than 25 years after it first made its appearance, the HIV/AIDS pandemic is continuing to spread, including in Europe. The apparent lack of ability of European governments to control the spread of the disease is particularly worrying, since they do appear to know how HIV is transmitted and which behaviours are associated with transmission.

2. In particular, the HIV/AIDS epidemic has increasingly started to spread to women and girls – in Europe as well as globally. While there is a substantial heterogeneity in the epidemic within and among European nations (injecting drug use is the main mode of transmission in eastern Europe, while sexual transmission is more important in the rest of Europe), there is a common factor: more and more newly diagnosed HIV infections are in women, in particular young women.

3. In a way, this should come as no surprise, as the epidemic started spreading from "high-risk" groups (homosexuals, injecting drug users and prostitutes) into the general population a long time ago already. However, the discovery of a treatment able largely to retard the development of the virus – tritherapy – seems to have led many young adults, in particular, to let down their guard. Much of the increase in infections in young women can be explained in this way.

4. However, this is not the only explanation. Physiologically, women are more prone to the virus than men. Coupled with social and economic dependence, sexist attitudes, and domestic violence, a deadly cocktail can develop: for women who are – in one way or another – dependent on the men with whom they have sexual relations, refusing sexual relations or insisting on condom use may not be an option.

5. The empowerment of girls and women in Europe is thus a key factor in the fight against HIV/AIDS. Girls and women in Europe must both be properly informed of the risks associated with certain behaviours, and must be put into a position where they have the power to act on this information. Men also have a role in halting the spread of the epidemic: they must dispense with certain harmful, typically male forms of behaviour, and work with women to break the cycle of gender inequality and gender-based violence.

6. At the same time, it is important to tackle discrimination against HIV-positive women and girls. HIV testing, in particular pre-natal testing, must be confidential, requires informed consent, and should be accompanied with counselling and information on treatment options (including treatment to prevent mother-to-child transmission). Access to such services should not depend on one's gender.

7. The Assembly recalls the recommendations made in its Resolution…(2006) and Recommendation … (2006) on HIV/AIDS in Europe, and recommends that the Committee of Ministers ensure that a gender perspective is taken in all work on HIV/AIDS within the Council of Europe and its member states.

8. The Assembly recommends that the Council of Europe run a European awareness-raising campaign to combat AIDS in the near future, similar to the one being run this year to combat domestic violence.

9. The Assembly furthermore recommends that the Council of Europe and its member states focus their efforts on the following to halt the spread of the HIV/AIDS epidemic to women and girls in Europe:

9.1. promote and develop school programmes, including sex education, which take into account the specificities of both sexes;

9.2. support the introduction of prevention programmes and awareness-raising campaigns on HIV/AIDS, in particular by ensuring the dissemination of adequate and well-targeted information to young adults via the media and other available information outlets;

9.3. implement gender-sensitive and human-rights-based testing and treatment policies, including free access to full medical care;

9.4. fight discrimination against HIV-positive people, in particular women; put into place reinsertion programmes for HIV-positive victims of this type of discrimination;

9.5. and work at national and international levels to establish the requisite legal and institutional frameworks for ensuring the observance, protection and exercise of the fundamental rights of women and girls, including in Europe.

B. Explanatory memorandum by Ms Fautrier, Rapporteur

I. Introduction

1. The Parliamentary Assembly is planning to organise a debate on HIV/AIDS during the January 2007 part-session of the Assembly. The Social, Health and Family Affairs Committee has already adopted a report and tabled a draft resolution and a draft recommendation on HIV/AIDS in Europe (Doc. 11033 of 27 September 2006). The Committee on Equal Opportunities for Women and Men is called upon to prepare its contribution to the debate in the form of a report on the spread of the HIV/AIDS epidemic to women and girls in Europe.

2. The HIV/AIDS epidemic is not a new disease anymore – it is entering its third decade as we write. However, what is more and more striking is that the epidemic has spread from so-called "high-risk" groups into the general population. Women and girls have not traditionally been a "high-risk" group; but over the past years, the epidemic has spread to them, even in Europe.

3. In this report, I intend to try and explain why this shift in the epidemic has happened – which is, in my view, intimately linked to a lack of gender equality that does not allow all women and girls to assert themselves - and thus protect themselves from the virus. I will then outline what is being done and what should be done to stop the epidemic spreading further by empowering women and girls.

II. Facts and figures

4. The HIV/AIDS epidemic is 25 years old now, and has infected 65 million people. Worldwide, 50% of HIV-positive persons are women, 60% of them African women. There is thus undoubtedly today a feminisation of the epidemic. 10 years ago, tritherapy was introduced in rich countries – but 95% of AIDS patients live in poor countries. In Southern Africa, 46% of pregnant women are HIV-positive.

5. More than two million people live with the disease of HIV/AIDS in the European Region according to the World Health Organisation (WHO)[1]. Though this figure is low compared to that in the worst affected area, sub-Saharan Africa, it represents an unprecedented increase in new cases (including among women and girls), to the tune of 80.000-250.000 new cases a year[2]. In a context in which the authorities in the European region appear to know how HIV is transmitted and which behaviours are associated with transmission[3], the lack of ability to control the spread of the disease in Europe is worrying.

6. There is a substantial heterogeneity in the HIV/AIDS epidemic within and among European nations, with injecting drug use the main mode of transmission in eastern Europe, while sexual transmission is more important in the rest of Europe. Despite these differences, a substantial proportion of newly diagnosed HIV infections throughout Europe are in women (37%, 31% and 38% respectively in western, central and eastern Europe in 2003)[4], which also has to do with the fact that, biologically, women are more prone to infection. In particular, young girls and women aged 15-24 are affected. In France, 150.000 people are bearers of the HIV virus and they are about 7.000 new cases per year. 43 % of these new cases concern women.

7. HIV/AIDS is an exceptional epidemic. While it is not unique – there have been many other deadly epidemics and other sexually-transmitted diseases – it is exceptional in that it lends itself too well to moralistic debates. The position of the Holy See, for example, with regard to condom use – which, together with abstinence, is known to be the only way of effectively fighting the evolution of the pandemic – is a case in point. Once non-sexual transmission of the disease had been minimised (e.g. through improved personal hygiene or effective public health interventions like disposable needles and blood screening), HIV/AIDS became the disease of those engaging in "promiscuous pleasure seeking through sex or drug use, usually in

[1] Marc Danzon: Providing treatment, preventing transmission - the challenge of HIV/AIDS in Europe today, in: Srdan Matic, Jeffrey V. Lazarus and Martin C. Donoghue (ed.): HIV/AIDS in Europe, WHO 2006, p. xii.
[2] Srdan Matic: Twenty-five years of HIV/AIDS in Europe, in: Srdan Matic, Jeffrey V. Lazarus and Martin C. Donoghue (ed.): HIV/AIDS in Europe, WHO 2006, p. 3.
[3] Marc Danzon: Providing treatment, preventing transmission, op. cit., p. xii.
[4] Charlotte Watts, Cathy Zimmermann and Brenda Roche: Violence against women and trafficking: a priority for HIV programmes?, in: Srdan Matic, Jeffrey V. Lazarus and Martin C. Donoghue (ed.): HIV/AIDS in Europe, WHO 2006, p. 216.

some sort of private space"[5]. The public health response in many countries, including in Europe, was thus often one which was discriminatory and violated the rights of the infected and the sick.

8. It appears that the lack of ability of European authorities to control the spread of the disease is to some extent linked to these moralistic debates. For example, like injecting drug use or unprotected homosexual sex, female prostitution was quickly recognised as a "high-risk" activity. However, in many European countries, the initial focus was on HIV transmission by prostitutes, despite the fact that two other groups play a decisive role in such transmission: the clients who demand unsafe sex, and the pimps (and, to a certain extent, traffickers) who impose unsafe sex[6]. It is only recently that the WHO has started imposing a non-discriminatory attitude towards prostitutes as the only way HIV/AIDS can be successfully prevented and cared for in sex work settings[7].

9. But it would be rash to presume that these epidemics are still limited to specific populations at the present time. Most injecting drug users are young and many are sexually active, courting a double exposure to the virus. In some countries a large proportion of sex workers, male and female, also inject themselves with drugs. Besides, among their male clients a fair proportion have other sexual partners including wives and steady girlfriends. In each region there is moreover a significant proportion of men and women having occasional unprotected sexual intercourse with persons other than their regular partners – such sexual behaviour is considered high-risk. In France, for example, there are estimated to be 40.000 HIV-positive people who are unaware of their HIV-positive status. The more entrenched the AIDS epidemic becomes, the more infected women there are.

10. It is my firm belief that the European authorities need to deal with the HIV/AIDS epidemic in a pragmatic but holistic way if the spread of the epidemic is to be stopped in Europe. In other words: we will have to agree to disagree on the morals of the question, and move forward to implement those best practices that have been proven to work, while at the same time effectively fighting the underlying societal problems such as gender inequality which make it possible for the HIV/AIDS to continue its deadly spread. All over the world, the epidemic's increasing impact on women occurs in a context of serious gender, class and other inequality.

III. The link between HIV/AIDS and gender inequality

11. Women are physiologically more prone and thus more exposed to the virus than men, as well as being more vulnerable owing to their social and economic dependence and to sexist attitudes. (Their risk of becoming infected with HIV during sexual relations is at least double that of men). In most societies, even though things are evolving in Europe today, men often have more power than women. Thus when women are dependent on the men with whom they have sexual relations, they run particular risks. The immediate danger of refusing sexual relations may be worse for them than the risks they run by acquiescing.

12. Violence against women also plays a certain role, in particular in Eastern Europe, where the sub-population of drug addicts is the fastest-growing cohort of the disease, but also in other countries where domestic violence against women is rampant. It is necessary to place domestic violence against women within a spectrum of other male dominating behaviours and socially sanctioned environments to make the link more apparent: Women and girls who suffer abuse are usually subjected to more than just physical or sexual violence; they are often controlled in many other ways, and may live in fear of a perpetrator who reigns over fundamental aspects of their lives, including finances, contact with others and sexual and reproductive choices[8].

13. Furthermore, there is often a dangerous ignorance of sexual matters among girls and young women. This lack of knowledge heightens the risk of their being infected. It is therefore essential to introduce basic sex education programmes for girls to make them act responsibly and encourage the use of condoms. It is also important to continue research into microbicides as a female-controlled prevention device (as opposed to the male-controlled condom). Women have to be able to take charge of their own prevention with regard to the virus. It is true that a female condom exists today, but it is not very widely available because of its price and its low appeal to women in practical terms.

[5] Srdan Matic: Twenty-five years of HIV/AIDS in Europe, op. cit., p. 3.
[6] Ruth Morgan Thomas, Licia Brussa, Veronica Munk and Katarína Jirešová: Female migrant sex workers: at risk in Europe, in: Srdan Matic, Jeffrey V. Lazarus and Martin C. Donoghue (ed.): HIV/AIDS in Europe, WHO 2006, p. 205.
[7] World Health Organisation: Toolkit for targeted HIV/AIDS prevention and care in sex work settings, WHO 2005.
[8] Ibid, p. 220.

14. Besides this, in most countries of Europe, the discovery of tritherapy has to a large extent turned HIV into a chronic illness not posing insuperable problems. The popular belief – particularly amongst young adults and adolescents - is that tritherapy has tamed the virus. As a result, young people in particular are not protecting themselves as much, in particular young girls who prefer to use the pill in those countries where it is widely available because their main fear is becoming pregnant. With the development of a vaccination against cancer of the uterus, young people risk using condoms less and less as the vaccination is being marketed as a new treatment which could eradicate a number of sexually transmitted diseases. Whereas our generation grew up in fear of AIDS, this one seems very uncaring about risks with which it no longer reckons. But that is a mistake because tritherapy is a stringent major treatment and above all, let it not be forgotten, only retards – but does not eliminate - the development of the virus. An extra effort should therefore be made to reactivate and improve prevention, specifically among young people of both sexes, encouraging use of condoms and avoidance of the risks inherent in unprotected intercourse.

15. It is important to be well aware of the overriding need today, if we are to break the vicious circle of infection, to combat the ignorance, silence, taboos and myths that make the disease impossible to curb by their all too frequent obfuscation of veracity and efficiency in fighting it. Preventive education therefore has a crucial part to play as today's best preventive and curative medicine against the disease, by forming attitudes, imparting expertise and creating the necessary motivation to instil new behaviour patterns favouring lesser risks and vulnerability.

16. Thus, the positioning of women in society, their right of self-determination, and combating violence against women all become lines of approach for protecting women against the pandemic.

IV. The role of men in halting the spread of the epidemic

17. These considerations make it obvious that men must also use their *de facto* position of power and privilege in discharging responsibilities and authority. They must act at all levels of society from top to bottom, involving themselves personally and involving the communities to which they belong in this struggle, particularly by dispensing with certain harmful, typically male forms of behaviour. If men so decide, they can speed up the regression of HIV/AIDS. This means that men must face up to realities of sexual experiences, gender stereotypes and the coercion of women – often through violence – to act against their will.

18. To achieve sustainable change, we must focus on boys; the values they learn and the way they develop – starting before they are sexually active and drawing on their openness, their creativity and their willingness to take responsibility for themselves and others.

19. WHO thus encourages attention to the gender implications of each of the strategies to be pursued for combating the scourge: this may mean different approaches for men and women[9].

20. Of course it will not suffice simply to carry out prevention and awareness-raising in order to combat discrimination. We absolutely must work at the national and international levels to establish the requisite legal and institutional frameworks for guaranteeing protection of the rights of the individual and advancing the development of society.

V. Access to treatment for all, including women and girls, and the fight against discrimination and stigmatisation

21. Today, the shame associated with AIDS, a major obstacle to its prevention, the opprobrium surrounding HIV-positives, are heightened by discrimination against women. Hundreds of thousands of HIV-positive women avoid the screening and treatment services for fear of desertion and everything that they could bring upon themselves at the hands of their husbands, families, communities and health care providers. Women are sometimes the last to discover their HIV-positive condition – after the husband and the in-laws. Only 5% of HIV-positives are informed of their condition, and screening during pregnancy is often the only way for a family to learn that HIV has infected one of its members. On occasion, health care providers withhold from HIV-positive women the appropriate care during and after confinement. It can also happen that women refuse treatment or stop taking it if the medical staff have not behaved well towards them.

[9] Statement WHO/11 of 28 November 2000.

22. Hence the importance of organising debates on the disease, an essential step for encouraging everyone to undergo a screening test, have treatment if required, and save sufferers from stigmatisation and casting out of normal society. Better social acceptance of HIV-affected people has direct implications for prevention, not only leading to improvement in the well-being of sufferers but also prompting them to ensure fuller medical attention, closer compliance with treatment requirements and enhanced preventive behaviour. Conversely, discrimination heaped upon discrimination can bring about processes of desocialisation and drive people to risk-taking behaviour. Thus it is plainly necessary to advance the cause of tolerance, in particular through a highly visible awareness-raising campaign, improve the image of HIV-positive persons, and save them from censure. The survey "Vespa" (HIV – survey of affected persons) undertaken by the National Agency for AIDS Research (NAAR) has shown the many difficulties HIV-positive persons face. Fighting these difficulties is one of the pivotal points of the fight against AIDS. Many HIV-positive people risk losing their jobs: twenty-four months after having discovered their HIV-positive status, 50 % had lost their job.

23. With the urgency of the situation before us, it is crucial that infected persons' right to care be fully secured and that affordable and effective treatment be offered without discrimination to all men and women in need of it. Access to treatment enables all who are HIV-positive to lead productive lives for long years, provided they receive treatment and psycho-social assistance. The public authorities have a decisive role to play here by putting into place – with the assistance of associations – measures to help HIV-positive people in their daily lives (financial assistance for those unable to afford their rent burden and/or medical expenses, also giving them access to culture and recreation).

24. It is also urgent to invest in research on vaccines limiting mother-child transmission and thus carry ethical principles into codes of professional conduct. When a HIV-positive woman becomes pregnant, there is a 35% chance of her transmitting the virus to her child unless she takes the necessary precautions. Every year more than 700 000 children become HIV-positive through mother-child transmission of the virus. Between 15% and 20% of children are infected before birth, 50% at delivery and 33% while being breast-fed. Expectant mothers who are HIV-positive can halve the risk of contaminating their babies if they take treatment based on antiretroviral drugs and if they receive information, together with the antenatal and obstetrical care needed to head off pregnancy and mother-child HIV transmission (eg prevention and immediate treatment of breast infections in themselves or, in the infant, of any lesions and inflammations of the mucous membranes of the mouth). Furthermore, freely accepted family planning should form part of all strategies designed to curb the epidemic: ethics and human rights demand that HIV-positive women be able to make informed choices concerning family planning, especially that of forestalling an unwanted pregnancy. However, if the father of the unborn child is HIV-negative, and the mother takes the necessary precautions, the chance of passing the virus to the baby can be brought down to 2%.

25. We must realise the negative economic and social implications of denying people who live with HIV/AIDS their human rights in respect of work, education and other social services, and be aware that women and children are often the hardest hit by the economic and social consequences of the pandemic.

26. Since access to the best treatment available is one of the fundamental rights of patients, the countries where AIDS research is comparatively advanced should do everything in their power to enable less fortunate countries, where the disease is rapidly spreading, to make proper use of that research.

VI. Conclusions and recommendations

27. There is no doubt that the HIV/AIDS epidemic has started to spread to women and girls – in Europe as well as globally. While there is a substantial heterogeneity in the epidemic within and among European nations (injecting drug use is the main mode of transmission in eastern Europe, while sexual transmission is more important in the rest of Europe), there is a common factor: more and more newly diagnosed HIV infections are in women, in particular young women.

28. This should come as no surprise, as the epidemic started spreading from "high-risk" groups (homosexuals, injecting drug users and prostitutes) into the general population a long time ago already. In France, more than half of newly-diagnosed cases of HIV infection are due to heterosexual relations, 22 % to homosexual relations and only 2 % are due to the use of injected drugs. However, the discovery of a treatment able largely to retard the development of the virus – tritherapy – seems to have led many young adults, in particular, to let down their guard. Much of the increase in infections in young women can be explained in this way.

29. However, this is not the only explanation. Physiologically, women are more prone to the virus than men. Coupled with social and economic dependence, sexist attitudes, and domestic violence, a deadly cocktail can develop: for women who are – in one way or another – dependent on the men with whom they have sexual relations, refusing sexual relations or insisting on condom use may not be an option.

30. The empowerment of girls and women in Europe is thus a key factor in the fight against HIV/AIDS. Girls and women in Europe must both be properly informed of the risks associated with certain behaviours, and must be put into a position where they have the power to act on this information. Men also have a role in halting the spread of the epidemic: they must dispense with certain harmful, typically male forms of behaviour, and work with women to break the cycle of gender inequality and gender-based violence.

31. At the same time, it is important to tackle discrimination against HIV-positive women and girls. HIV testing, in particular pre-natal testing, must be confidential, requires informed consent, and should be accompanied with counselling and information on treatment options (including treatment to prevent mother-to-child transmission). Access to such services should not depend on one's gender.

32. The Parliamentary Assembly should build on the recommendations contained in the report by the Social Affairs Committee on HIV/AIDS in Europe, and recommend that the Committee of Ministers ensure that a gender perspective is taken in all work on HIV/AIDS within the Council of Europe and its member states.

33. Furthermore, the Assembly should recommend that the Council of Europe and its member states focus their efforts on the following to halt the spread of the HIV/AIDS epidemic to women and girls in Europe and:

i. promote and develop school programmes, including sex education, which take into account the specificities of both sexes;

ii. support the introduction of prevention programmes and awareness-raising campaigns on HIV/AIDS, in particular by ensuring the dissemination of adequate and well-targeted information to young adults via the media and other available information outlets;

iii. implement gender-sensitive and human-rights-based testing and treatment policies;

iv. fight discrimination against HIV-positive people, in particular women;

v. work at national and international levels to establish the requisite legal and institutional frameworks for ensuring the observance, protection and exercise of the fundamental rights of women and girls, including in Europe;

vi. and run a European awareness-raising campaign on the fight against AIDS similar to the one being run this year to combat domestic violence.

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Members of the Committee: Mrs Minodora Cliveti (Chairperson), Mrs Rosmarie Zapfl-Helbling (1st Vice-Chairperson), Mrs Anna Čurdová (2nd Vice-Chairperson), Mrs Svetlana Smirnova (3rd Vice-Chairperson), Ms Birgitta Ahlqvist, Ms Elmira **Akhundova**, Mrs Željka Antunović, Mrs Aneliya Atanassova, Mr John Austin, Mr Denis Badré, Ms Marieluise Beck, Mrs Gülsün **Bilgehan**, Mrs Oksana **Bilozir**, Mrs Raisa Bohatyryova (alternate: Mr Ivan **Popescu**), Mrs Olena **Bondarenko**, Mr Krzysztof Bosak, Mrs Mimount **Bousakla**, Mr Paul Bradford, Ms Sanja Čeković, Mrs Ingrīda **Circene**, Ms Diana Çuli, Mr Ivica Dačić, Mr Marcello Dell'utri, Mr José Luiz Del Roio, Mrs Lydie Err, Mrs Catherine **Fautrier**, Mr Adolfo **Fernández Aguilar**, Mrs Maria Emelina Fernández Soriano, Ms Sonia **Fertuzinhos**, Mrs Margrét Frímannsdóttir, Mr Piotr Gadzinowksi, Mrs Alena Gajdůšková, Mr Pierre Goldberg, Mrs Claude Greff, Mr Attila Gruber, Mrs Carina **Hägg**, Mr Poul-Henrik Hedeboe, Mr Ilie **Ilaşcu**, Mrs Halide Incekara, Ms Danuta **Jazlowiecka**, Mrs Eleonora **Katseli**, Baroness Knight of Collingtree, Mrs Angela Leahu, Mrs Minna Lintonen, Ms Assunta Meloni, Mr José Mendes Bota, Mrs Danguté Mikutiené, Mrs Ilinka Mitreva, Mr Burkhardt Müller-Sönksen, Mrs Christine **Muttonen**, Mrs Hermine Naghdalyan, Mr Hilmo Neimarlija, Mrs Vera Oskina, Mr Ibrahim **Özal**, Ms Elsa Papadimitriou (alternate: Ms Maria **Damanaki**), Mr Jaroslav Paška, Mrs Fatma Pehlivan (alternate: Ms Marie-José **Laloy**), Mrs Maria Agostina Pellegatta, Mrs Antigoni Pericleous-Papadopoulos, Mr Leo **Platvoet**, Mrs Majda Potrata, Mr Jeffrey Pullicino Orlando, Mrs Marlene Rupprecht, Mrs Klára Sándor, Mrs Giannicola Sinisi, Mrs Rodica-Mihaela Stănoiu, Mrs Darinka Stantcheva, Mrs Elene **Tevdoradze**, Mrs Ruth-Gaby Vermot-Mangold, Mrs Betty Williams, Mrs Jenny Willott, Mr Gert Winkelmeier, Ms Karin S. Woldseth, Mrs Gisela Wurm.

N.B. The names of the members who took part in the meeting are printed in bold.

Secretariat of the Committee: Ms Kleinsorge, Ms Affholder, Ms Devaux