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UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS



HIV/AIDS, Gender and Rural Development

HIV/AIDS had its origins and was once thought of as an urban problem. In many rural communities the myth persists that HIV does not affect rural people, though the virus is now rapidly spreading in rural areas and seriously affecting the livelihoods of rural populations. Its spread is accelerated by conflict, population movements and mixing of communities as well as urban-rural migration in both directions. Rural women, who form a major part of the rural economic workforce and the backbone of the care economy, are particularly affected. According to FAO estimates (2000), HIV/AIDS has killed seven million agricultural workers since 1985 in the 25 hardest-hit countries in Africa, and could kill another sixteen million before 2020. Over the next decade, the epidemic is expected to spread even further in developing countries. Those African countries most affected could lose up to 26 percent of their agricultural labour force within two decades.



Key Issues

Poor health service infrastructure and limited mechanisms for promoting HIV/AIDS information make rural areas vulnerable to HIV. Widespread poverty leads to poor nutrition and poor health, fuelling HIV/AIDS infection rates. Rural people are less likely to know how HIV is transmitted, recognise symptoms, or be able to access and afford treatment for related infections. The same is true of STIs thus exposing rural populations to greater risk of HIV infection.

Rural women are particularly hard hit by the pandemic. Women are biologically more susceptible to HIV infection, and as a result of oppressive gender and cultural norms prevalence rates are now higher amongst women than men in sub-Saharan Africa. In many contexts, men are expected to dominate and women to be passive in taking decisions about sexual relationships. Illiteracy amongst rural women is high and this hampers their knowledge and their ability to negotiate when, how and with whom to have sex. Relationships between older men and younger disempowered women have contributed to prevalence rates that are two times higher among young women than among young men.

With farmers dying in the prime of life, before they can pass on knowledge to their children, the pandemic has a long-lasting impact on agricultural practices and food security (see Fact Sheet on Food Security). The declining number of productive family members coupled with a growing number of dependants adds to a vicious cycle of inadequate nutrition and vulnerability to infection.

The phenomenon of child-headed households has also contributed to the under-exploitation of agricultural land as the adult labour force dwindles. According to UNAIDS, there were 13.2 million AIDS orphans in 1999, most of them in rural areas in sub-Saharan Africa. Shrinking incomes available from agricultural production are increasingly stretched



to cover expenditure related to medical bills and funeral expenses. Inadequate labour makes collection of water and fuelwood more onerous and yet the need for water only increases where family members are sick.

The migration of men to towns to seek employment increases the risk of infection for their sexual partners at home, and overall community vulnerability. Urban residents often return to their villages of origin to seek care when they fall ill which increases rural vulnerability, and further stretches rural safety nets. Children are withdrawn from school and families limit the number of times they are able to eat in a day, in the long term further hampering their capacity for productive work. Distress-sales of productive and non-productive assets are made (including livestock, implements and land) further undermining potential production. As women provide care for sick family members and orphans, HIV/AIDS adds to an already heavy workload for women, limiting their ability to engage in income-earning activities and food production.

Despite the essential and major role of women in agricultural production and income-generation, women have significantly less access to financial, physical and social assets than men do. They have fewer opportunities to improve their knowledge and skills, and less voice in public decision-making. This imbalance between what rural women do and what they have makes them particularly vulnerable to rural poverty. Rural women provide most of the work in small-scale and labour-intensive agriculture, and the proportion of woman-headed households reaches almost one third in some developing countries. Yet women receive only five percent of extension services worldwide, and women in Africa access only one percent of available credit in the agricultural sector (FAO 1995).

Women are rarely the owners of productive assets such as land and livestock although they may be the main producers and the principal carers/users of these same assets. Rural women are particularly vulnerable to the impacts of the epidemic because if widowed they often have no legal rights to retain their husband's property. Family assets may be grabbed by relatives of the deceased husband upon his death and the widow chased away, particularly if she is already exhibiting symptoms herself. Rural women and girls are often forced to adopt risky survival strategies, such as engaging in transactional sex. Girls living in child-headed households are particularly likely to seek adult protection in exchange for sex, or to marry early to try to gain stability for their siblings. Sibling abuse amongst child-headed households is a growing problem, in particular where a young brother assumes leadership and adopts masculine norms observed in the wider community. Increasingly, elderly women are faced with the need to take on the heavy burden of caring for large numbers of orphaned grand-children without adequate economic, social and physical resources.

Thus, HIV/AIDS is fuelled by gender inequalities and is also creating new gender inequalities.

Key Actions Required

Since HIV/AIDS affects every sector in rural development, an integrated and gender-sensitive approach must be used that combines elements including labour-saving and improved food production technologies, HIV/AIDS awareness and prevention campaigns, vulnerability assessment and mapping systems, education, and social analysis. For these to be effective, rural women's participation and empowerment is an essential precondition.

HIV/AIDS is a root cause of labour shortage and deteriorating agricultural production in some rural areas. To meet the limited availability of labour, **labour-saving technologies** are needed. These may include for example lighter ploughs that can be used by youths, women and the elderly, and animal-drawn weeders. Improved access to potable water, the means to transport it in quantity and fuel-efficient stoves can also greatly alleviate women's workload. New technologies introduced need to be context-specific and tested for their physical, agro-ecological and cultural relevance. Together FAO and IFAD (2002) have identified how labour-saving technologies and practices assist in overcoming labour shortages and recommended key factors to improve their adoption and sustained use by poor rural women.

HIV/AIDS has obliged some farm households to shift their production systems, for example from cash to subsistence crops, or to sell off livestock and other resources to finance medical expenses. **New practices and technologies** are needed to meet the challenges within this changing context. These include the provision of low-input, low-risk, early-maturing and disease-resistant crop varieties and new practices such as the raising of nutritious vegetable crops close to home using household waste and water (sack gardening). Agro-processing technologies and agribusinesses could also provide rural women with much needed income. An IFAD-supported project in Uganda promotes crops that are more easily managed by HIV/AIDS affected populations; sunflower production is particularly suitable, as it is not labour-intensive, requires little weeding and matures early. The FAO is also supporting adapted programmes of small-scale animal production and medicinal crops in AIDS-affected areas.

Given low levels of literacy, limited access to mass media, and insufficient health and education services, **HIV/AIDS education** is difficult in rural areas. The outreach capacities of agricultural extension services have broken down as the disease has affected government workers. In addition, IFAD found that project beneficiaries in some countries could not attend training activities due to their caring responsibilities. There are several ongoing initiatives to provide HIV/AIDS education to rural areas. In Cambodia, FAO is supporting an innovative participatory method called Farmer Life Schools, combining active learning of agricultural subjects with AIDS prevention. The FAO is also supporting Ministries of Agriculture in a number of countries to prepare field manuals that can be used to adapt extension systems to the new needs.

Many children lose their parents before learning basic agricultural skills or obtaining nutrition and health-related knowledge. Therefore, **knowledge** needs to be preserved and the new generations have to be reached by extension services. Key actions include support to training programmes for households fostering orphans; apprenticeship programmes for adolescent orphans; and training in agricultural skills for orphans. IFAD has been engaged in such rehabilitation work through its *Uganda Women's Effort to Save Orphans (UWESO)* project. FAO supports several orphanage projects, and provides agricultural education to primary schools.

In addition, new **social and economic safety nets** are needed and rural institutions need to be strengthened. This includes the need to provide rural financial services specifically for women. Support is also needed to allow adolescents to take over the business (and the loan) from a sick parent. IFAD supports a rural finance programme in Tanzania that offers its clients insurance coverage through a fund, covering loan defaulting for a variety of reasons, including non-repayment due to AIDS-related incapacitation or death. Insured clients pay half of the insurance premiums, and the programme will pay the rest.

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