UK Consortium on AIDS and International Development

Gender and HIV and AIDS:
UK Consortium on HIV and AIDS Gender Working Group Briefing Paper

Introduction

The Gender and HIV and AIDS working group of the UK Consortium on AIDS and International Development was formed in 2006. The aim of this working group is to:

- Share and learn from the experiences of members and external organisations in relation to gender and HIV and AIDS;
- To ensure that gender issues are understood and addressed within the Consortium and by external agencies;
- To influence policy and practice, both internally within member organisations and among external stakeholders.

Structure of briefing paper

The aim of this briefing paper is to:

- Introduce readers to the key issues regarding gender inequalities and the different impacts of HIV and AIDS on women, men, girls and boys.
- Make recommendations to AIDS Consortium members to ensure their work is gender-sensitive;
- Encourage debate and engage AIDS Consortium members in issues around gender and HIV and AIDS; the relationships between women, men, girls and boys with regard to HIV and AIDS.

This paper is not intended to be comprehensive, but is a starting point for potential work for the Gender Working Group and other Consortium groups. It begins in section I by outlining why HIV and AIDS policy-makers and practitioners need to make links between gender and HIV and AIDS and provides a working definition of gender. Section II introduces specific interactions between gender and HIV and AIDS in relation to sexual behaviour and HIV prevention; treatment, care and support; violence against women; masculinities; stigma and discrimination; decision-making; nutrition; and property and inheritance. Section III provides guidelines for developing gender-sensitive/responsive programmes and policies and section IV makes specific recommendations for policy makers. The paper ends in section V with key resources for further information.

I. Why we need to understand and incorporate gender in HIV and AIDS work

The HIV and AIDS epidemic is both fuelled by and exacerbates gender inequality. Globally today, women are disproportionately infected and affected by HIV and AIDS. In sub-Saharan Africa, 59% of adults living with HIV are women and young women make up 75% of HIV positive 15-25 year olds in the region, mostly transmitted through sex with HIV positive men.[1] This is due to a complex interaction of factors including the economic dependency of women and girls on men and survival strategies of women and girls, such as intergenerational sex, sex work, and early marriage, in conditions of poverty. Additionally migration for work and migration due to conflict as well as the overarching historic and cultural gender traditions and

[1]Karen Leiter, Senior Research Associate, Physicians for Human Rights, from Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland: An Evidence-based Report on Gender Inequity, Stigma and Discrimination http://physiciansforhumanrights.org/library/news-2007-05-25.html?print=t

contemporary attitudes that shape the sexual behaviours of men and women all impact the spread of HIV. The HIV and AIDS epidemic has fostered further victimisation of males who have sex with males. The specific impact of HIV and AIDS for women and men and the gendered implications of prevention, treatment, care and support are outlined below.

Responses to the epidemic have been radically weakened by a superficial engagement with gender issues. In order to strengthen both our programming and policy work we must focus more meaningfully on the relationships between women, men, girls, boys, transgender and intersex people with regard to HIV and AIDS. There needs to be more engaged analysis and exploration of systemic gender inequalities and how gender norms influence the impact of HIV and AIDS on women, men, girls, boys, transgender and intersex people and increase vulnerability. We must also acknowledge the diversity of experiences and ensure that we engage with a wide audience, particularly people living with HIV and AIDS. The human right to universal access to prevention, treatment, care and support will never be realised unless gender sensitivity is applied in service design and implementation.

II. Gender inequality and HIV and AIDS

Women and girls around the world experience systematic and deep-rooted discrimination because of their sex and gender. Acknowledgement of this fact is crucial – yet often missing - from HIV and AIDS programming and policy work. High HIV prevalence rates among women – and the difficulties they experience in accessing appropriate and quality prevention, treatment, care and support - are all linked to women's political, social and economic disempowerment.

'*HIV and AIDS interventions focused solely on individual behaviour will not address the factors creating vulnerability to HIV for women and men, nor protect the rights and assure the wellbeing of those living with AIDS. National leaders, with the assistance of foreign donors and others, are obligated under international law to change the inequitable social, legal, and economic conditions of women's lives which facilitate HIV transmission and impede testing, care and treatment*.'[2]

What is gender?

The concept of gender has been well defined in academic terms but not well understood in a general and practical context.

The term 'gender' is often confused with sex and (wrongly!) used to mean 'women.' In fact, the term describes a bigger picture – a set of qualities and behaviours expected from women, men, girls or boys (or someone assumed to be a woman, a man, girl or boy) by society. The experience of being of one gender or another is affected by factors such as education, division of labour, economics, gendered beliefs about and attitudes to the sexuality of women and men and social customs and expectations. Gender roles vary widely within and among cultures. They are socially determined and can evolve over time.

People are generally said to be of the female or the male sex. This refers to a person's biology and anatomy. However, societies also make gendered assumptions about bodies and anatomy so it is recognised today that these interpretations of the body and an individual's actual sense of identity are not always the same. This is particularly true for transgender or intersex 'women' and 'men.'

[2] Ibid.

II. i Sexual Behaviours and HIV Prevention

The main route of HIV transmission is through sex. The sexual behaviours of both women and men are shaped by desire as well as assumptions about what is inherently acceptable and/or attractive and often whether behaviour is considered appropriately feminine or masculine. The inability that many women and girls experience in negotiating sex safely and pleasurably is part of this – informed by beliefs on both sides about the power and entitlements each party has. While women and girls are biologically more vulnerable to infection, harmful traditional practices – dry sex, virginity testing, early forced marriage, bride inheritance and Female Genital Mutilation – all increase the risk of HIV infection and are daily violations of the human rights of women and girls. Poverty and women's economic dependence upon men reduces choices about sex and may force women to engage in paid or transactional unsafe sex as a means of survival.

The 'Abstain, Be Faithful and use a Condom' (ABC) slogan has been promoted worldwide as a key preventative behavioural model to combat the spread of HIV. However, due to unequal power relations, ABC does not work for the majority of women and girls for whom abstinence may not be an option, where a wife may be faithful but her husband not, and where a woman may not have the power to negotiate condom use. The same can be said for vulnerable men and boys. There is an urgent need for increased investment in prevention education and programming that challenges and changes individual attitudes and behaviours.

Once such intervention, the Stepping Stones training, is well known and highly regarded for its effectiveness in starting these shifts in individual behaviours. Training involves working in sex and age-based peer groups over a period of 3-4 months, and can be conceived '*as a journey, building up confidence over time to enable people to learn how to negotiate and cope with HIV and AIDS, through self realisation, learning, sharing and caring for those most affected. Behaviour change, because it is difficult, is best achieved through individual change, peer support and wider community changes, which include rethinking negative social and cultural norms together.*'[3] Maintaining investment in female-controlled prevention technologies – vaccines, new generation female condoms and vaginal microbicides – could d increase women's agency in relation to sex and enable them to safeguard their health and that of their families. Again prioritising these approaches is crucial in addressing the shortcomings of prevention programming particularly the ABC approach.

II. ii Violence against women and girls

Violence against women and girls is a significant contributing factor to the transmission of HIV and a feature of life for many positive women. In countries where the incidence of rape is high, the risks of contracting HIV are clear. Violence, or the threat of, inhibits women's ability to negotiate safe sex and obviously to choose to abstain from sex. Women and girls who have been sexually abused are more likely to engage in unsafe sex in the future.[4] Women who have experienced sexual assault may also be unwilling to access VCT for fear of how their partners and families will

[3] Evaluation Stepping Stones: a review of existing evaluations and ideas for future M&E work. Tina Wallace for Action Aid International, June 2006 Cited in 'Joining Hands: Integrating HIV and AIDS.' An ACCORD HASAP publication, June 2006

[4] HIV/AIDS and Violence Against Women and Girls: Southern Africa, Fact sheet, UNAIDS (2004), http://womenandaids.unaids.org/documents/factsheet_violence.pdf

react. Links between rates of violence against women and HIV infection in emergency and conflict situations are particularly high.

Women and girls' experiences of HIV and AIDS treatment, care and support services are different from what men and boys experience.

II. iii HIV Testing
Many women first discover their HIV positive status through testing at ante-natal services. However, sexual and reproductive health and rights (SRHR) and HIV and AIDS services are still largely managed in isolation from each other which discourages wider uptake of VCT and does not mitigated the stigma surrounding HIV.

II. iv Treatment
Women and girls are less likely to have the economic means to pay for ART. Even when treatment is free, positive women may be less able to gain access to treatment programmes, due to costs involved with transportation to clinics, permission needed from male relatives to attend a clinic or time constraints caused by family and care commitments. Members of the International Community of Women Living with HIV and AIDS have reported sharing their ARVs with family members.

II. v HIV and AIDS Care
Women and girls also continue to carry the burden of care for infected and affected orphans and extended family. This work is often unpaid and still unrecognised by most national health systems. It is well recognised that fewer young girls than boys enrol in and complete primary and secondary schooling. Drop-out rates of both girls and boys caring for sick parents or siblings denies them an important, and often the only, source of information and awareness about HIV and how it can be prevented. Traditional gender roles mean that girls are often the ones to drop out of school to care for the sick whilst boys face pressures to generate income.
Girl heads of households are particularly vulnerable to sexual exploitation. Prevention programmes must extend to young people out of school – for example young girls forced into early marriages – as well as those in school, in order to be effective and protect the most vulnerable.

II. vi Gender, masculinities and HIV and AIDS

To better understand men's sexual behaviour, understanding the construction of masculinity—the social production of what it means to "be a man" is key. The standard qualities required to "be a man" are that men be strong, unemotional, heterosexual, in control and aggressive. Masculinity in most cultures is based on the subordination of women, and also on hierarchies among men themselves, which leads to hostility against men outside the norm including homophobia[5].)

.Men's attitudes, identities and relations – all shaped by the gender norms that both men and women reproduce - are part of what sustains and makes up gender inequalities and also contributes to the behaviours that spread HIV infection. The involvement of men who are engaged in critical discussion and reassessments of gender norms is crucial to the building HIV and AIDS awareness and prevention programming that is transformative for both men and women.

[5] The work of Australian sociologies Bob Connell citing in Flood, 1995

II. vii Males who have sex with males, Transgender and Intersex people and Sexual Minorities

It should also be clearly recognised that because of denial, invisibility, stigmatisation and illegality (often under both religious and civil laws and codes), males who have sex with males already face considerable risks of harassment, violence, and perhaps imprisonment, if not death. HIV and AIDS has fostered further marginalisation. Appropriate material must be developed and targeted at males who have sex with males; and to include these men must be included as part of the solution. For such a prevention strategy to be successful, appropriate and accessible sexual health services would need to be in place which would build their respect, confidentiality and anonymity and build their trust and respect.

Among communities throughout the world the HIV and AIDS epidemic has reconstructed homosexual men's sexuality but increasingly men do not define themselves exclusively as heterosexual or homosexual. Unfortunately, invisibility of such men may limit uptake of VCT and impeded access to HIV prevention and other services and put both their male and female partners at risk.

II. viii Stigma and Discrimination
The stigma, discrimination and blame that women and girls experience once their HIV positive status is known can be more acute and threatening due to the particular social and moral value put on women's chastity and faithfulness. HIV positive status thus increases women's vulnerability to violence, rejection and abandonment. Vulnerable men such as males who have sex with males and injecting drug users, often experience stigma and discrimination that limits their access to services. . HIV and AIDS programmes must address the stigma and greater risk of violence that people living with HIV and AIDS experience and work with communities to challenge attitudes including gender norms that condone it.

II. ix Women and girls' participation in decision-making, service delivery and design
Worldwide women and girls remain largely excluded from decision-making fora and public leadership roles. At decentralised and national level, health and HIV and AIDS policies and budgets are still determined largely by men. Women, particularly HIV positive women, and other marginalised groups must be meaningfully involved in l decisions around HIV and AIDS for prevention, treatment, support and care provision in order to meet their needs. Policy-makers should consult with women's movementsand movements of women living with HIV and AIDS to ensure that funding and services reflect their priorities.

II. x Land and Property Rights and Inheritance Laws
Land and property rights and inheritance laws often do not recognise the equal rights of women and thus prevent women and girls from inheriting houses or land after the death of a husband or father. In families that experience an AIDS related death of the male head of household this results in widows or girl orphans being left with little with which to survive on. Where women and girls are already struggling to provide for themselves and/or their families in the absence of a male breadwinner, this can drive women and girls further into poverty and increase their vulnerability to HIV and AIDS.

II. xi Food and Nutrition
Lack of access to land also impacts on the ability of women and girls to meet their own nutritional needs or those of dependents. Effectiveness of ART directly correlates with a well-balanced diet. Despite the fact that women gather, prepare and serve food in almost every society, research from multiple sources indicates that women eat last, after ensuring their partners and children are fed. In situations of

famine, this often means that women may not eat adequately or at all, compromising their adherence to ART.[6]

III Recommendations for Developing Gender-Sensitive/Responsive HIV and AIDS Programmes and Policies

III. i Make programmes and policies gender-sensitive/responsive
Gender-sensitive responses to HIV and AIDS necessitate recognition that gender dynamics drive vulnerability to HIV and AIDS are central to the design and implementation of HIV and AIDS services. This means taking account of the different experiences, needs, desires, and, vulnerabilities of women and men, girls and boys, transgender and intersex people, in order to deliver accessible and effective programmes.

It means considering how a person's gender might influence choice of prevention options, whether they have the power to use prevention options, or how they access HIV prevention services, and responding accordingly.[7] This must include recognition of the wide diversity of sexualities, identities and sexual behaviours. Programme development that is gender sensitive must also ensure that the delivery of HIV and AIDS programmes does not increase the vulnerability of women and girls or of vulnerable men and boys by considering the potential adverse impacts, i.e. not further entrenching gendered stereotypes.

III. ii Develop and fund programmes that challenge structural gender inequalities
Over the last decade, numerous programmes, many developed by women themselves in response to frustrations about the gaps in the approach of HIV and AIDS programming, have started to do just this. Like the Stepping Stones training programme, these have been proven to make some important shifts in gender relations and increased respect for women, including self-respect and reductions in gender violence.[8] It will be important to try to scale up the success of such interventions like the IMAGE study in South Africa, - a pilot that evaluated the impact of micro-finance based poverty alleviation and gender empowerment strategies on behaviour change and prevention of HIV and gender based violence. The findings demonstrated that the risk of intimate violence was reduced by more than half and women participants also reported a consistent pattern of improvement in indicators of empowerment.[9]

III. iii Involve men in addressing gender inequality and HIV and AIDS
Including men in solutions to integrate gender, development and HIV and AIDS has benefits. Given that many women interact with men on a daily basis in their households and public lives, involving men can make interventions more relevant and workable and increase men's participation in and responsibility for change[10]. Explicitly involving men in gender discussions related to HIV and AIDS issues can increase men's belief that they too will benefit from equalising gender relations and thus builds a platform for men to engage in renegotiation of power and gender relations. Ensuring male inclusion can mitigate men's sense of anxiety of loss of 'traditional' roles. .

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[6] ActionAid, VSO, Walking the Talk: Putting Women's Rights at the Heart of the HIV and AIDS Response, p33.
[7] VSO Mainstreaming Guide: http://www.vso.org.uk/Images/mainstreaming_guide_tcm8-4795.pdf
[8] Joining Hands: Integrating HIV and AIDS. An ACCORD HASAP publication, June 2006
[9] http://www.wits.ac.za/radar/IMAGE_study.htm and http://www.lshtm.ac.uk/genderviolence/reports/imagebrochforweb.pdf
[10] Chant and Guttman 2000

When targeting men the following broad areas need to be considered to ensure success,: (1) working with male decision makers and service providers; and (2) targeting groups of men and boys when and where they are vulnerable. Men must be included in all efforts to challenge HIV and AIDS stigma and discrimination as part of clear messages that neither men or women should be stigmatised as 'vectors of disease' and that vulnerable men should not be further stigmatised especially by combating homophobia in society overall.

III. iv *Empower Women and Vulnerable Men and Ensure their Participation in Decision-Making*
National commitments must be in line with international women's human rights agreements, particularly the Beijing Platform for Action and Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) to continue to empower women to attain equality in all socio-economic and political spheres. Women, males who have sex with males, transgender and other vulnerable groups participate in all decision-making regarding HIV and AIDS policy and programming. Greater efforts to engage networks of women living with HIV and AIDS and ensure their meaningful participation in the development of all prevention, treatment, care and support programming and in policy consultations with their national governments. Increased funding must also be made available for research to evaluate and promote interventions that work with and or address different aspects of women's disempowerment.

III. v Legal Reform
National governments must reform laws that discriminate on the grounds of gender and sexuality and pass legislation that combats violence against women and promotes women's rights; including inheritance and land ownership, sexual and reproductive health and rights. Political will and the necessary resources must be in place to ensure effective implementation. Donors and national governments must increase funding for local women's groups that disseminate knowledge and understanding of these laws and all associated rights within communities.

III. vi Address the Specific HIV Prevention Needs of Women, Girls, Men and Boys
Instead of focusing on individual behaviour change (especially given the problematic ABC message) HIV interventions can and should target the broader 'risk environment' that women inhabit; including poverty, gender inequality and intimate partner violence. HIV prevention policies and programmes must set clear and measurable gender indicators for measuring the success of HIV prevention interventions, including indicators on the intersection of violence against women and HIV and AIDS.

III. vii Integration of SRHR and HIV and AIDS Services
There is a need for increased investment in integrated and linked HIV and AIDS and sexual and reproductive health programming, including strengthening the capacity of SRH providers to deliver HIV and AIDS interventions, and of HIV and AIDS programmes and services to address the sexual and reproductive health and rights of people living with HIV/AIDS, marginalised vulnerable groups including males who have sex with males and young people. Where possible, sexual and reproductive health and HIV and AIDS services should include greater support for survivors of violence within health services. Integrated programming should extend to humanitarian relief programmes, to routinely incorporate SRHR and HIV and AIDS responses to provide refugees and internally displaced people the essential package of health services that WHO has mandated.

IV. Areas Requiring Further Research

The UK Consortium on AIDS and International Development Gender Working Group members have identified the following areas requiring research:

- Undertake research which provides qualitative information on socio-sexual histories and behaviours amongst males who have sex with males, the impact of locality, economics, religion, and so on, on these behaviours.
- Undertake research which provides qualitative information on socio-sexual histories and sexual behaviours amongst men who have sex with women, the impact of locality, economics, religion, and so on, on these behaviours – and bring the fruits of this research into discussion with men and women in related communities and in positions of power and policy making.

V. Resource Information

ICW: Fact sheets on Violence Against Women; SRHR; Access to Treatment and Care and Vision Papers on for example Positive Women and Drug and Alcohol use: http://www.icw.org/publications

The Positive Woman's Survival pack:
http://www.icw.org/files/Survival%20Kit.pdf

The VSO Mainstreaming Guide:
http://www.vso.org.uk/Images/mainstreaming_guide_tcm8-4795.pdf

BRIDGE Cutting Edge Pack, 2002:
http://www.bridge.ids.ac.uk/reports_gend_CEP.html#HIV

Stepping Stones: http://www.steppingstonesfeedback.org.
See also 'Joining Hands: Integrating Gender and HIV and AIDS. Report of an ACCORD project using Stepping Stones in Angola, Tanzania and Uganda.' An ACCORD HASAP publication, July 2006

Comprehensive list of Gender resources:
http://www.wid.msu.edu/resources/biblios/Gender%20and%20HIV-AIDS.htm

SRHR and HIV and AIDS integration:
http://www.interactworldwide.org/objs/563021320-intimatelinkspaper1.pdf

Men, masculinities and gender politics
http://www.xyonline.net

Harvard Literature Review – HIV and AIDS and Gender-based Violence
http://www.hsph.harvard.edu/pihhr/files/Final_Literature_Review.pdf

Doyal, Lesley: 2001. Sex, Gender, and Health: The Need for a New Approach. British Medical Journal 323:1061-3. http://archives.hst.org.za/gender-aids/msg00032.html.

VSO, Gender, Power and HIV Prevention, 2007

VSO, Reducing the Burden of HIV and AIDS Care on Women and Girls, 2006

ActionAid, VSO, Walking the Talk: Putting Women's Rights at the Heart of the HIV and AIDS Response, 2007