UK Consortium on AIDS and International Development

POLICY BRIEFING March 2012

GIRLS AND WOMEN: MAINSTREAMING HIV AND AIDS INTO DFID'S STRATEGIC VISION

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This paper centres on programmatic targets set by the UK Department for International Development's (DFID) Strategic Vision for Girls and Women and key bilateral and multilateral aid indicators linked to this policy.

It discusses the evidence base that demonstrates the links between the social factors driving the HIV and AIDS epidemic and the gender and development priority areas highlighted in DFID's strategic vision. These priority areas are: delay first pregnancy and support safe childbirth; get economic assets direct to girls and women; get girls through secondary school and prevent violence against women and girls.

This paper demonstrates programmatic approaches which DFID's gender team could include in the implementation of the Strategic Vision programme of work to ensure an effective HIV and AIDS response is mainstreamed into their objectives.

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INTRODUCTION

This paper considers how DFID could better ensure that their efforts to promote gender equality in their work achieve positive changes to address the gendered nature of the HIV epidemic. The short-term aim of this paper is to provide specific DFID staff teams with evidence and learning on the linkages between HIV and AIDS and the DFID *Strategic Vision for Girls and Women*[1] including how this could practically and usefully be reflected in both policy and programming. These interventions could also be applied by other actors, including civil society organisations, involved in the response to HIV and/or gender and development programming.

"Gender based discrimination is pervasive in many societies and limits the benefits that women and girls can gain from social and economic development."

Gender based discrimination is pervasive in many societies and limits the benefits that women and girls can gain from social and economic development. Efforts to achieve better health outcomes are also thwarted by gender inequalities and it is widely recognised that the subordinate social position of women and girls limits their ability to protect themselves from HIV transmission. AIDS-related illness is the number one cause of death among women of reproductive age (15-44 years old) in the world[2] and in high prevalence contexts young women are up to five times more likely to be living with HIV than men their age.

Development actors must consider how their approach to gender programmes can improve these poor health odds. A 'gender transformative' approach is required to transform gender norms and change the conditions that create inequity to give women and girls, as well as men and boys, the same entitlements to the human right to health and the same level of power, influence and resources to shape their own lives and participate in society. This in turn enables women and girls to make informed choices and to better assert decisions regarding their bodies which helps reduce their vulnerability to HIV and increases access to HIV prevention, treatment, care and support.

DFID has traditionally placed attention on the achievement of women's empowerment and addressing gender inequality. In 2011 the UK Coalition Government published their vision for enhancing the UK's development aid and this included a specific focus on investing in girls and women in every area of DFID's work.[3] Subsequently DFID issued a *Strategic Vision for Girls and Women* outlining four development sectors where a focus on gender will be enhanced. It is thought that investment in young women can deliver significant development benefits through a cost effective approach.[4]

HIV programming was not specifically cited in the Strategic Vision though it has been noted that the four areas "have obvious links to HIV interventions".[5] The Parliamentary Under Secretary of State, Stephen O'Brien MP, stated at the UN High Level Meeting on AIDS in June 2011 that, "*in some parts of the world, particularly parts of sub-Saharan Africa, AIDS remains an over-riding emergency, particularly for women. We have also put women and girls, particularly vulnerable in this epidemic, at the front of everything we do.*"

A renewed focus on a multi-sectoral response to HIV has been urged in a new proposal for more targeted and strategic investment to combat the epidemic.[6] The proposed strategic investment framework considers that synergies with other development sectors are essential to reinforce key programme areas and critical social enablers. The sectoral responses the authors of the framework considered to be able to bring the most benefit to HIV programming included "social protection, education, legal reform, gender equality, poverty reduction, gender-based violence, health systems, community systems, and employer practices".[7] The UK Consortium welcomes DFID's engagement in thinking about how it could apply the resource allocation approach suggested in this investment framework.

DFID'S STRATEGIC VISION FOR GIRLS AND WOMEN

This section outlines the four priority areas of DFID's *Strategic Vision for Girls and Women* and how the four themes have been articulated in sectoral policy documents as well as the indicators set in the results framework which DFID will use to monitor and manage delivery of their results. DFID's *Strategic Vision for Girls and Women: Stopping Poverty Before it Starts*[8] refers to four programmatic areas of intervention. Objectives and indicators have been articulated in other policy documents.

1 Delay first pregnancy and support safe childbirth

DFID has stated that, for example, they will support programmes to increase access to contraception, prevent early marriage and increase births with skilled attendants. DFID's overall strategy for pre-pregnancy interventions is framed in *The UK's Framework for Results for Improving Reproductive, Maternal and Newborn Health in the Developing World*.[9] Health service interventions include post-abortion care; safe abortion – where legal; family planning; and management of sexually transmitted infections and HIV. Community interventions include adolescent and pre-pregnancy nutrition, sexuality education and prevention of unintended pregnancies, STIs and HIV.

Indicators for UK Bilateral aid
Number of births delivered with the help of nurses, midwives or doctors through DFID support.
Number of additional women using modern methods of family planning through DFID support.
Number of maternal lives saved through DFID support.
Number of neonatal lives saved through DFID support.

Indicators for UK Multilateral aid
Proportion of countries with service delivery points offering at least three methods of contraception (through UNFPA).
Number of HIV positive women provided with treatment to prevent transmission to their babies (through GFATM).

There is a second indicator for UK Multilateral aid to HIV: the number of people receiving treatment for AIDS (not gender disaggregated – through The Global Fund to Fight AIDS, TB and Malaria – GFATM).

2 Economic assets direct to girls and women

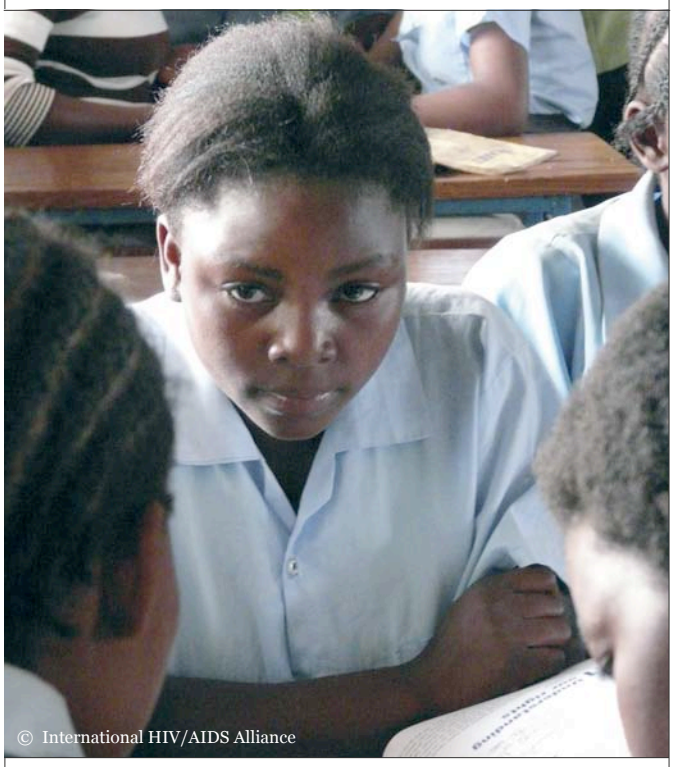
DFID have stated that they will support programmes to increase cash transfers and improve access to land. In The Reproductive Maternal and Newborn Health (RMNH) *Framework For Results Interventions to Support Women Seeking Reproductive Health Care* included making services free at point of delivery; cash incentives; subsidised family planning products and vouchers for family planning. In the 2011 *Towards Zero Infections: The UK's Position Paper on HIV in the Developing World*[10] DFID indicated that they will provide cash transfers in at least five high-prevalence countries reaching at least 120,000 people affected by HIV and that they are planning innovative work promoting women's control over assets to strengthen their position in the household, give them a greater say in decisions, and make them able to protect themselves from HIV.

Indicators for UK Bilateral aid
Number of people and/or firms with access to financial services as a result of DFID support (gender disaggregated).
The number of people supported through DFID programmes to improve their rights to land and property (gender disaggregated).

Indicators for UK Multilateral aid
Number of microfinance loans (through World Bank/IFC).
Number of active borrowers in micro-finance (through International Fund for Agricultural Development).
Number assisted with microfinance (through Asian Development Bank).
Number of jobs created (through Private Investment Development Group).

3 Getting girls through secondary school

DFID seeks, for example, to increase completion of primary school and increase the number of female teachers. Education indicators in DFID's *Human Development Operational Plan*[11] includes an initiative on girls' education to increase the participation and achievement of girls and stimulate diversity and innovation in education service provision to achieve improvements in levels of access, retention and achievement for girls. The 2011 DFID *HIV Position Paper* also states DFID's intentions to improve access, particularly of girls, to comprehensive sexuality education.



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Indicators for UK Bilateral aid
Number of children supported by DFID in primary education (per annum, gender disaggregated)
Number of children supported by DFID in lower secondary education (per annum, gender disaggregated).
Number of children completing primary education supported by DFID (per annum, gender disaggregated).

Indicators for UK Multilateral aid
Number of teachers recruited or trained (through World Bank/IDA).
Number of teachers trained (through Asian Development Bank).

4 Preventing violence against women and girls

DFID will support efforts to strengthen data, provide support services to survivors of violence, and support security and justice systems to prevent and respond to violence. Tackling violence against women is also part of the strategy to put the *Framework for Results* in the context of a wider multi-sectoral response. DFID's *HIV Position Paper* sets an intention to fund social research to understand the underlying causes of the epidemic and how to address gender based violence.

Indicator for UK Bilateral aid
Number of women and girls with improved access to security and justice services through DFID support.

The enabling environment for the *Strategic Vision* includes DFID's intentions to challenge discrimination against girls and women and build effective legal frameworks to protect girls' and women's rights; increase the value given to girls and women by society and men and boys; increase the power of girls and women to make

informed choices and control decisions that affect them; enable women's participation in politics; and sustain political commitment to services and opportunities for girls and women.

As asserted by the Structural Drivers working group of the AIDS 2031 research consortium[12], the key dimensions of the social, political and economic context, referred to as structural factors, are essential in shaping HIV and other health outcomes. Looking at this through the perspective of gender and development there are clearly greater opportunities for development actors to consider the addition of key interventions to existing indicators in order to address gender, HIV and AIDS.

EVIDENCE FOR INTEGRATING HIV INTO DFID'S STRATEGIC VISION

This section synthesises the links between HIV and AIDS and each pillar of the social and economic development objectives of the DFID *Strategic Vision on Girls and Women*. It will consider what synergies could be suggested to DFID drawing on existing programmatic evidence mindful of compatibility with the ways DFID is working.

Delay first pregnancy and support safe childbirth

A 'dual protection'[13] approach to delay first pregnancies and prevent HIV must address the risks that young women face in hyper-endemic countries. With the acceleration of the HIV epidemic in the early 1990s, there was a slowing in the decline of global maternal deaths.[14] In southern, western and central Africa it is estimated that without HIV, there would have been 60,000 fewer maternal deaths in 2008.[15] In Swaziland, for example, survey data released in 2009 indicates that HIV prevalence among pregnant women has increased since 2006, reaching 42%.[16] A five-year study in Johannesburg, South Africa, a country in which 29% of pregnant women are living with HIV, revealed that the maternal mortality ratio was more than six times higher in HIV-positive women than in HIV-negative women.[17 18 19]

In clinical settings it has been observed that pregnant, HIV-positive women may see HIV related disease progression worsen during their pregnancies and thus is a cause of maternal morbidity. Further research is required to confirm HIV as a major contributor to maternal morbidity as well as strengthen the evidence base on maternal mortality. There is concern that correlation between HIV and maternal morbidity[20] and mortality can be used as an argument to discourage women living with HIV from pursuing pregnancy and childbirth. Therefore DFID should fund clinical research on these health dynamics which includes investigation of the human rights dimensions that women living with HIV who are pregnant experience in health care settings. The need to enhance the sexual and reproductive health and rights (SRHR) of women living with HIV must address concerns about forced testing, coerced sterilisation and abuses by health workers.[21]

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DFID stated in the *RMNH Framework for Results* that it will "deliver services that women need, together"[22] including family planning with other reproductive and maternal care; sexual health with reproductive and maternal health services; nutrition for adolescents, pregnant women and babies; malaria as part of antenatal and postnatal care; responding to survivors of sexual and other violence; and provision of HIV services with reproductive, maternal and newborn health services.[23]

A further articulation of how DFID will support integration of HIV in a broad set of sexual and reproductive health services would be useful. The accumulating evidence base[24] around the effectiveness of the approach demonstrates positive effects for decreased HIV incidence, sexually transmitted infection incidence, condom use, contraceptive use, uptake of HIV testing and quality of services. There has been

significant political consensus which the UK has endorsed.[25] [26]

The *Framework for Priority Linkages*[27] highlights how specific programmatic linkages can optimise the approach taken including scaling up key HIV prevention services, especially the provision of voluntary counselling and testing and female/male condoms; expanding 'positive prevention' services for people living with HIV; making sexual and reproductive health services youth-friendly and gender-sensitive; providing tailor-made, non-stigmatising sexual and reproductive health services for 'key populations'; introducing/enforcing comprehensive national legislation that protects the rights of girls, young women and people living with HIV; increasing economic options, including developing innovative partnerships; promoting approaches that address gender inequality and providing a full range of HIV prevention options; strengthening leadership skills and involvement in decision making; outlawing child marriage in all areas of national legislation, enforcing supportive legislation and working with gatekeepers to change social norms.[28]

Through policy engagement the UK must ensure that *The Global Plan Towards the Elimination of New HIV Infections Among Children by 2015* and keeping their mothers alive (referred to here as *The Global Plan – PVT (Prevention of Vertical Transmission)*[29] is operationalised and that the *UN Global Strategy on Women's and Children's Health*[30] overcomes existing women's rights violations.[31] There are concerns that the Global Plan – PVT does not assert the importance of voluntary HIV testing and assuring confidentiality. Efforts to expand access and uptake of services must address the issues that women have faced including mandatory or coerced HIV testing in antenatal care, enforced sterilisation, coerced abortion, involuntary disclosure of HIV status, and negative consequences of an HIV-positive diagnosis within families and communities. Overall there is a limited focus on quality of care and DFID should fund research into what women living with HIV seek from a good service.

DFID must ensure that PVT programme funds are used to implement the current clinical treatment guidelines covering all four pillars and end the use of single dose nevirapine prophylaxis which leads to ARV resistance in mothers and babies as HIV progresses. As DFID has set a multilateral aid indicator on GFATM's provision of funding for PVT, it has an oversight role in ensuring that GFATM grantees include programming in all four pillars of PVT and to support women and their families in the long term.[32] The multilateral aid indicator that the UK has set on the number of people receiving treatment for HIV is also problematic. The associated data demonstrating that more women than men are on ART is used as an argument to demonstrate that gender equality has been achieved in HIV services. Yet in the indicator (and data) there is no qualitative insight into care or human rights dimensions in service delivery.[33] Furthermore, ART statistics published by GFATM are not gender disaggregated.

DFID is increasingly interested in addressing efforts to end the practice of female genital mutilation (FGM). Evidence of the role that FGM plays in the transmission of HIV has focused on risks associated with the repeated use of surgical or other equipment used to perform multiple incisions on girls[34] and the recurring tissue damage and bleeding during vaginal intercourse which women who have been infibulated experience, thereby increasing transmissibility of HIV.[35]

Preliminary findings of recent analysis in seven sub-Saharan African countries did not show a strong association between HIV and FGM except for the small sample of women having undergone FGM and living with HIV who were more likely to live in urban areas; be unmarried, younger and sexually active; have one child; and have had more than one sexual partner in the previous year.[36] An integrated health system approach to the treatment of sexual and reproductive health issues that women who have undergone FGM experience could also support counselling and testing for HIV and other STIs. There is greater research needed in this field as well as sensitivity throughout health services to address the concern that male circumcision[37] and FGM are regarded as equivalent in practicing communities.[38]

Between 1995 and 2005 UNICEF estimated that over 58 million girls were married before the age of 18 years and 15 million of those were 10-14 years of age[39]. Globally between 11 and 45% of girls younger than 15, including those considered 'child brides', are likely to be forced into their first sexual encounter[40] at an age when they are not physically and sexually mature. This results in negative health consequences and strong correlations between early pregnancy and maternal mortality and morbidity including complications such as haemorrhage, fistula, anaemia, and eclampsia.

Girls and young women who are married typically lack the ability to make decisions in their families and are less able to negotiate with partners about sexual behaviours, putting them at high risk of HIV infection.[41] Child brides are particularly vulnerable to harmful traditional practices and myths such as men marrying virgins in the hope of being 'cured' of HIV, 'widow cleansing' where in some parts of Africa and Asia widows are required to have sexual relations with strangers or relatives whilst in other cultures widows are forced to marry a dead husband's brother.[42]

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Economic assets direct to girls and women

The social position of women is often undermined by a lack of economic independence or ability to engage in supportive, sustainable livelihoods. There have been many efforts in the field of gender and development which have focused on improving the economic empowerment of women to improve their bargaining position in their families and social position in their communities. Some efforts have worked to improve vulnerable girls' social, physical, human and financial assets and control over economic assets – though there is a dearth of evaluations of girls' economic empowerment programmes and it is difficult to get a sense of the utility and benefits of different methodologies.[43]

Structural interventions[44] that tackle factors such as poverty or low educational attainment are attracting increased attention in the field of HIV prevention.[45] One such intervention is conditional cash transfers (CCTs) where cash is transferred to beneficiaries on the condition that they comply with a set of requirements. These programmes were designed to act as a powerful incentive for households to adopt behaviours that would positively impact on their well-being.[46]

As a key target for addressing HIV care and support needs DFID committed to providing cash transfers to poor and vulnerable households in at least five high-prevalence countries benefiting over 1.7 m people, including orphans and vulnerable children.[47] Unpaid female caregivers including young girls and grandmothers require sustainable financial support but have not been explicitly indicated within the UK's commitments.[48] The UK Consortium Policy paper *Past Due: Remuneration and Social Protection for Caregivers in the Context of HIV and AIDS* provides recommendations on the actions the UK and other development actors should take to support caregivers.

In sub-Saharan Africa, there is growing evidence demonstrating positive effects of CCTs on behaviour change or the uptake of health services (e.g. increased uptake of HIV testing or STI treatment services[49]). Thus there is significant interest in exploring potential applications of CCTs in HIV prevention efforts. In Malawi, a CCT programme was designed to motivate individuals to collect the results of their HIV tests. The study results found that conditional cash incentives increased the percentage of individuals collecting HIV test results and that the effect increased with a larger amount of the cash transfer[50]. In addition, the study found that those diagnosed as HIV positive were more likely to purchase condoms if they have a spouse or sexual partner.

Another individually randomised controlled study, *Rewarding STD Prevention and Control in Tanzania* (RESPECT), provided rewards to sexually active males and females aged 18-30 (and spouses aged 16 or over) for remaining free

of certain sexually transmitted infections, including chlamydia, gonorrhoea and syphilis.[51] The study recorded a 25% drop in the incidence of STIs. After one year 9% of individuals in the treatment group were positive for one of the STIs compared to 12% in the control group.

The Intervention with Microfinance for AIDS & Gender Equity (IMAGE) programme in South Africa[52] integrates HIV prevention and training to combat violence into a microfinance programme for rural women. It provides women with small loans to start a business and gain greater economic independence combined with training on HIV prevention to empower women to stand up to violence, stay safe from HIV and change the way they are perceived by their families and communities.

The initial project was evaluated after two years and the microfinance intervention (control group) and the combined microfinance plus training intervention were associated with higher levels of economic well-being. However, only the combined intervention including training was associated with a wider range of benefits encompassing women's empowerment, reduced risk of intimate partner violence, and protective HIV-related behaviour. These findings support the approach of adding a health component to a poverty reduction programme so that synergies can be cultivated which may be critical for achieving broader health and social benefits.[53]

Analysts suggest that different microfinance programme outcomes stem from gender-based obstacles that exist within the context of the intervention from inception and thwart women's attempts to achieve financial objectives e.g. illiteracy, educational achievement, or money management skills. Microfinance projects alone cannot affect the gender obstacles women face as a result of national or cultural enabling environment factors such as land ownership and property inheritance.[54] The potential of microfinance programmes to empower young women and adolescent girls in the longer term is promising but sustainable changes cannot be achieved unless the focus is the community, household and individual level.[55] Economic and agricultural policies, job creation and foreign trade agreements negotiated at the state level undermine the existence of sustainable livelihoods for the entire population.

It has been argued that microfinance could maximise its potential by integrating other complementary services, such as reproductive health education for targeted community education and demand creation for health services. Donors have been called on to provide financial resources to microfinance organisations whose work revolves around outreach to the poor and poorest, a focus on women, and achievement of financial self-sufficiency.[56]

Getting girls through secondary school

Universal access to primary school education is a key development goal but globally the group most likely to miss out on this basic service are girls living in rural areas. Though the male/female gap is narrowing, two-thirds of those who have never been to school or are currently out of school are female.[57] Girls education, particularly levels of participation during adolescence is considered a cost effective investment as educated girls are more likely to marry later – at the age of 18; have better maternal and child health outcomes; are more able and inclined to invest in the health and education of their children both boys and girls - with especially high returns to the education of girls; and develop self-confidence which is important in their intimate relationships.

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Strategies for retention of adolescent girls in secondary school must be approached from a multi-sectoral approach. For example, poor sanitation and hygiene in schools has serious repercussions wherein girls are unable to attend

because their schools lack private and decent sanitation facilities, especially in regards to menstruation.[58] Retention is also important for girls and boys as secondary school can serve as a site for key HIV prevention messages and potentially as access to HIV prevention commodities, including male and female condoms, as well as the introduction of microbicides and other forms of new HIV prevention technologies. It is important to note that schools can also be dangerous places for girls. Donors should support Education Ministries to develop and enforce zero tolerance policies towards sexual harassment and violence in schools.

Ineffective sexual health education is prevalent as analysed by the *Living for Tomorrow* programme.[59] Their experience has examined problematic characteristics of sexual health education strategies. It has been widely assumed that young people can translate the facts regarding risk into personal behaviour decisions when educators present negative consequences of sexual risk behaviours, the modes and symptoms of sexual transmission of infections, and basic strategies for prevention; abstinence, condoms, monogamy and/or fewer partners. This approach is based on "*the wrong assumption that fear or anxiety automatically triggers rational reactions that can be refined and channelled into particular behaviour (safer sex), and that once awareness and concern is established, a 'logical', predictable train of reactions can be set in motion.*"[60]

A lot of sex education fails to include clear, detailed education about safe behaviours - even correct condom use is often left vague and abstract. The effectiveness of school based sexual health education is further eroded by factors such as limited time or flexibility in the curriculum, other education and recreation priorities, moralistic messages and reluctant or untrained teachers.[61] These programmes obviously do not reach youth who have left school early and are often those who have been made most vulnerable by HIV and AIDS in families and communities.

Social and gender norms which sabotage internalisation of advised behaviours are minimally discussed, if at all. Few teachers are informed by gender or feminist-informed analysis needed to understand and facilitate discussion of these broader issues whilst young people usually do not have the chance to engage in discussions that help them become literate and critical about traditions that reinforce inequality in the culture around them. DFID and other development actors' efforts to scale up comprehensive sexuality education must overcome these significant limitations. DFID could also seek to encourage greater numbers of openly HIV positive teachers to be retained in schools in their efforts to address stigma and discrimination.

As discussed, conditional cash transfer interventions are a powerful motivator for the uptake of services including education. Several CCT programmes have targeted adolescent women to improve school attendance/ enrolment and positively affect the sexual behaviour of young women. A pilot study in Kenya reduced the cost of education by paying for school uniforms. In Kenya, schools have also provided free sanitary towels (girls had been missing a quarter of their education through absence during menstruation). After 2 years, there were lower rates of school dropouts (15% reduction), teen marriage (12% reduction) and childbearing (10% reduction) among girls who received free uniforms.[62]

The Schooling, Income and HIV Risk (SIHR) programme in Zomba, Malawi was a 2-year individually randomized CCT intervention. The intervention included the provision of incentives (in the form of school fees and cash transfers) to current schoolgirls and recent dropouts (between 13-22 years of age) to remain enrolled or return to secondary school. An average offer of US $10/month conditional on satisfactory school attendance and direct payment of

Study results demonstrate the effectiveness of CCTs in reducing transactional sex among adolescent girls, improving educational retention and preventing HIV and genital herpes (HSV-2).

secondary school fees were offered. Study results demonstrate the effectiveness of CCTs in reducing transactional sex[63] among adolescent girls, improving educational retention and preventing HIV and genital herpes (HSV-2)[64]. The authors concluded that girls who were receiving cash payments were more likely to be having fewer sexual partners and sex with younger partners instead of older men.[65]

Preventing violence against women and girls

Based on available data, between 15 and 71% of women will experience physical or sexual violence or both from their intimate partners in their lifetime[66]. UN Women has called for greater investment in gender equality and women's empowerment to tackle the root causes of violence against women and girls.[67] They consider the strategic areas as being girls' secondary education, advancing women's reproductive health and rights, increasing women's political and economic participation and leadership, and addressing the inter-linkages of violence with HIV and AIDS. There is an increasing recognition that gender based violence is a pandemic parallel to HIV and numerous studies have demonstrated that women who have experienced violence are at higher risk for HIV. Research in Rwanda, Tanzania, and South Africa indicate that the risk for HIV among women who have experienced violence may be up to three times higher than among those who have not.[68]

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The DFID *Strategic Vision* has outlined intentions to address many of these issues. An internal DFID working paper[69] explored multi-sectoral approaches to combatting violence against women and girls.

DFID noted that there is compelling programmatic examples but that few of these had been taken to scale. A complex interplay of factors associating violence against women and HIV risk has shown that men who perpetrate intimate partner violence take other risks which put themselves and their female partners at risk of STI and HIV transmission.[70] Male involvement is therefore also essential in challenging gender inequities and for an effective HIV and AIDS response by identifying and valuing positive aspects of masculinity, while at the same time developing leadership skills to challenge and change aspects of masculinity that perpetuate violence and violate the rights of women and girls.[71]

Women living in such circumstances of violence are less able to negotiate sexual contact leading to more unwanted sex and less use of safer sex behaviours.[72] It is important not to overlook that women who have sex with women also experience sexual violence. The context of high rates of sexual violence in South Africa has given rise to specific attacks against women who have sex with women known as 'corrective/curative rape'.[73] This form of violence and unprotected sex presents a high risk for HIV transmission. Data from a recent South African report also asserts that unprotected sex between women who have sex with women can lead to HIV transmission[74] and thus calls for HIV prevention strategies tailored to their needs.[75]

DFID's working paper on good practices to address violence against women and girls highlighted programme features implied by a UNIFEM/ActionAid International report. A recommended matrix of activities includes community mobilisation, including men and boys; engagement of marginalised groups; building an integrated approach in the health sector and beyond, involving training health care workers and; advocacy for greater accountability among funding agencies and policy makers.

A set of actions for development partners working on HIV and violence against women has been recommended by the Global Coalition on Women and AIDS (GCWA)[76] including the need to support programming that recognises and addresses the full scope of needs and rights of those experiencing violence against women; that

communicates the links between gender based violence (GBV) and HIV[77] prevention and GBV as a consequence of HIV diagnosis; and that ensures the involvement of women living with HIV. GCWA urged development actors to facilitate access for women who use drugs, including support groups, harm reduction, care and support, and to provide services that are woman-friendly, including trained women staff members and volunteers that are sensitive to their needs.

Considering recent multilateral global health initiatives, GCWA also pointed out that violence against women should be fully integrated into *The Global Plan – PVT* and *The UN Global Strategy on Women's and Children's Health*. DFID's sole multilateral aid indicator for HIV-related financing does not indicate whether the UK expects GFATM to provide gender disaggregation on the number of people receiving ART.[78] The indicator is not enough for a quantitative analysis of evidence of gender-based violence that women living with HIV have experienced from health care workers, other service providers and communities.[79] Worryingly a recent survey of women's organisations showed limited engagement with Global Fund Country Coordinating Mechanisms (CCM) and called on GFATM to take action to ensure women's equal access and meaningful participation in decision-making processes within all of its governance structures, to improve gender balance in CCMs, and to provide training to all CCM members on gender equality issues in the context of HIV in their country.[80]

As most efforts have focused on how violence against women increases women's vulnerability to HIV and negatively impacts on HIV prevention there has been a lack of understanding of violence as a major issue women face after an HIV positive diagnosis. A new definition has been framed in a report commissioned by the International Community of Women Living with HIV Global and UN Women: violence against positive women is any act, structure or process

"Violence against positive women is any act, structure or process in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV."

in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV.[81]

Programmatic approaches to address these violations were outlined in the UN report and included highlights of the following programmes: *Stepping Stones*,[82] *Community Life Competence Process*[83] (The Constellation), *SASA!*,[84] *Puntos de Encuentro*[85] (Nicaragua) and *Men as Partners*.[86] The need to support civil society responses comes out strongly as a key part of programme implementation and recommendations for development actors suggested by GCWA[87] including:

- Supporting women living with HIV, sex workers, women's organisations and others with experience of working on violence to continue developing skills and confidence, so that those directly affected are able to participate actively and widely at both policy and community level.
- Supporting youth leadership and engagement in HIV prevention that specifically incorporates gender-based violence prevention and supports human rights.
- Supporting civil society partners and host governments to develop and implement initiatives aimed at engaging men and boys, including through primary prevention and secondary interventions aimed at addressing trauma related to exposure to violence.
- Providing funding for advocacy and activism aimed at advancing women's rights and addressing violence against women in the context of HIV.

Additionally, the meaningful involvement of women living with HIV is important in efforts to address GBV. The UK has previously demonstrated commitment to the Greater Involvement of People Living with HIV and AIDS (GIPA) Principle which aims to realise the rights and responsibilities of people living with HIV, including their right to participation in decision-making processes that affect their lives.

RECOMMENDATIONS

The specific recommendations emerging from the programmes reviewed in this brief are:

Delay first pregnancy, uphold women's SRHR, including those of women with HIV, and support safe childbirth

- Utilise synergies in the reproductive health and HIV programme streams to meet multiple objectives, for example, support integrated family planning services as an entry-point for HIV testing and counselling and dual protection.
- Review *The Global Plan – PVT* to identify issues which the UK could re-emphasise and ensure UK funding, where delivered through other development partners, adheres to clinical guidelines and incorporates a comprehensive 4 pillar approach to PMTCT.
- Expand the reproductive, maternal and newborn health centred support to women seeking reproductive health care including making services free at the point of delivery; introducing cash incentives; subsidising family planning products and introducing vouchers for family planning to HIV programming.
- Consider whether the planned cash transfers in at least five high-prevalence countries could reach farther than the planned 120,000 people affected by HIV and consider how to ensure the approach is gender equitable.
- Specifically identify settings where provision of cash incentives could be made available to young women likely to engage in transactional sex/material exchange for sex to fill resource gaps in the household or in their own personal resources.

Getting girls through secondary school

- UK support to comprehensive sexuality education should draw from the experience of both effective and ineffective HIV prevention programming. Where necessary DFID should provide gender training for sex educators.
- Take a multi-sectoral approach to consider

how school settings can be improved in order to retain young women, e.g. ensure they are safe and clean.

- Use conditional cash transfers to offset school related fees and personal expenditure so that young women are more likely to complete school and avoid sexual relationships formed around economic incentives.

Economic assets direct to girls and women

- Expand the RMNH centred support to women seeking reproductive health care including: making services free at point of delivery; cash incentives; subsidized family planning products and vouchers for family planning to HIV programming.
- Consider whether the planned cash transfers in at least 5 high-prevalence countries could reach farther than the 120,000 people affected by HIV.
- Specifically identify settings where provision of cash incentives could be made available to young women likely to engage in transactional sex/material exchange for sex to fill resource gaps in the household or in their own personal resources.

Preventing violence against women and girls

- Ensure that the needs of women living with HIV and female sex workers are considered and involved in efforts to prevent violence against women, including within the health sector.
- Address violence and discrimination that prevents access for women who use drugs to harm reduction and other drug related and health services that are sensitive to their needs.
- Include women who have sex with women in violence prevention strategies and assess their needs for HIV prevention services, particularly in southern Africa.
- DFID has the opportunity to challenge legal reform in order to address inequitable property ownership and inheritance rights within the bilateral indicator on preventing violence which focuses on access to security and justice services.

As the DFID gender team operationalises the Strategic Vision they should identify opportunities for an effective HIV and AIDS response to be mainstreamed into the objectives. Gap analysis should be undertaken to point to existing or potential gaps between sectoral plans. GCWA analysis of the DFID RMNH *Framework for Results* and the *HIV Position Paper*[88] noted that, for example, enhancing reproductive and maternal health including promoting access to safe abortion care is not mentioned in the HIV position paper.

As DFID engages with civil society to implement the Strategic Vision it is important to reflect on a set of principles for donor engagement to better support women's rights organisations suggested by the Pathways of Women's Empowerment research consortia.[89]

- Let women's rights organisations own the agenda.
- Provide medium to long term support.
- Ensure organisations are representative of the communities they serve.
- Understand the dynamic political context of the organisations' work.
- Invest in the quality of the relationship with women's rights organisations.[90]

Other development actors and civil society organisations should similarly undertake gap analysis between existing plans for RMNH, HIV and gender and development programming to identify areas where multiple objectives could be reached in a cost effective manner.

CONCLUSION

Effective responses to HIV and AIDS have been seen in countries which have been supported to develop a wide multi-sectoral approach to support biomedical efforts for prevention, treatment, care and support. Long term success in lowering the incidence of HIV, and thus the most cost effective approach, has required deeper understanding of ways to address the social vulnerability driving risk

" A focus on the impact of HIV on women and girls has been prominent at a global level for many years but there have been limits in translating rhetorical recognition of the importance of engendering the response to the global epidemic into implementable actions."

taking in health and human behaviour. A focus on the impact of HIV on women and girls has been prominent at a global level for many years but there have been limits in translating rhetorical recognition of the importance of engendering the response to the global epidemic into implementable actions.

Countries still require more technical and financial support to consider how they could introduce gender transformative programming to address the structural drivers of vulnerability to HIV in their communities. This requires more than a response to women and girls but also a more sustainable effort to challenge gender norms. The wider field of gender and development and programmatic interventions designed to address sexual and reproductive health and rights, economic empowerment, completing education, and addressing gender based violence can be excellent spaces from which to launch efforts to address HIV vulnerability.

Donors are encouraged to see the interconnectivity of their strategic aims and think across the spectrum to ensure a more integrated approach between programmatic elements particularly in countries heavily burdened by HIV and AIDS. It is hoped that this discussion and recommendations are useful for the DFID gender team as well as other actors grappling with the widest benefit of development aid allocations in a performance based, cost effective paradigm.

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FURTHER INFORMATION

The UK Consortium on AIDS and International Development is a network of over 80 not-for-profit, faith-based and academic agencies. Based in the UK, with strong links to governments, international and multilateral agencies, the Consortium has been working at the heart of the response to HIV and AIDS for 25 years.

For more information visit: www.aidsconsortium.org.uk

The Gender Working Group of the UK Consortium was formed in 2006 with the aim of deepening debate and discussion and to share expertise on issues related to gender and HIV and AIDS in order to better influence more effective policy and practice.

For more information visit: http://aidsconsortium.org.uk/working-groups/working-group-on-gender-and-hiv/