

Unit 10 – Gender and HIV/AIDS

Learning Objective

Why is a gender perspective important in addressing HIV/AIDS?

After studying this unit you should be able to:

- Define concepts such as “Gender”, “Gender Equality”, “Femininity”, and “Masculinity”;
- Understand the need for a specific gender perspective and approach in HIV/AIDS responses;
- Understand what is meant by gendered issues in HIV/AIDS programming and responses, including a “rights-based” approach.

Introduction

Gender inequalities are a major driving force behind the HIV/AIDS pandemic, and are not exclusive to women. They reflect widely held beliefs, expectations, customs and practices within a society about what it means to be a “man” or “woman.” Depending on society’s perspective on it, gender can increase an individual’s vulnerability to HIV and influence his or her ability to access information about preventive measures, care, support and treatment.

This unit aims to provide a comprehensive overview of some of the key issues that relate to gender and HIV/AIDS. It will explain why it is imperative to take a gendered perspective in HIV/AIDS mitigation to address the disease as well as the importance of using a rights-based approach when addressing gender inequalities, including those that affect men. This unit will also address the necessity of involving men and how partnerships between men and women can help changing gender norms and reduce vulnerability.

Defining Gender

Gender

Gender refers not to biological differences but to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and between men. These attributes, opportunities and relationships are socially constructed and are context and time-specific. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in the responsibilities that are assigned, activities that are undertaken, the access to and control over resources, as well as decision-making opportunities. Gender is a part of the broader socio-cultural context.

Gender Equality

Gender equality refers to equal rights, responsibilities and opportunities between women and men and girls and boys, for example equal access to schooling. Equality does not imply that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female. Gender inequality is generated both by society's written and unwritten norms, rules and understanding. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration. This includes decision making in the home, but also clearly defining needs, interests, and rights during the development and implementation of policy and lawmaking. Gender equality refers to equal opportunities for all people and equally valued work done by all, irrespective of their sex, identity, or sexuality. Equality between women and men is seen as a precondition for and indicator of sustainable development as the economic and social contributions of each individual is valued equally.

Gender Equity

Unlike gender equality, which demands equal treatment of people, gender equity refers to an acknowledgement that some groups in society are marginalized. Equity is the process of minimizing the unfairness. An example is the under-representation of women in politics. Women play a crucial role in politics as they not only serve as a role model

for future generations, the acceptance of women in a position of authority at the national level has positive effects on the role of women in the community and in the household. Finally, women involved in politics are likely to promote the needs and protection of women through the formulation of policy and lawmaking. Equal representation cannot be instantly achieved without proactive policies. Parity laws or quotas requiring a certain percentage of women candidates on electoral lists with or without mandatory ordering, quotas for seats in the electoral body or voluntary party quotas are some examples of attempts to minimize the inequality gap, which have been used around the world.

Link between HIV/AIDS and Gender

According to the latest (2008) WHO and UNAIDS global estimates, women comprise 50% of people living with HIV. In sub-Saharan Africa, women constitute 60% of people living with HIV. In other regions, men having sex with men (MSM), injecting drug users (IDU), sex workers and their clients are among those most-at-risk for HIV, but the proportion of women living with HIV has been increasing in the last 10 years.

Box 1

Facts About Gender and HIV/AIDS

Higher Infection Rates The highest “gender gap” in HIV infection rates is recorded between young women and men between 15-24 years old. Within this cohort, for every young person infected, three out of four are young women (UNAIDS, July 2008). Understanding why women and girls are more likely to become infected with HIV therefore falls into the domain of gender relations and gender inequality (See Unit 2).

Higher Infection Rates Women and girls make-up a growing proportion of those requiring treatment and care. Past experience shows that there are many social and economic barriers, which increase vulnerability to infection and deny women their rights to medical treatment and health.

Caretakers Women and girls are more likely than men and boys to assume the caretaker responsibility for those who are sick and need care. As a result, girls are more likely than boys to be taken out of school to maintain the needs of the household.

International Spread Nowhere is the epidemic more “feminized” than in sub-Saharan Africa, where 60% of adults infected are women, and 75% of young people infected are young women and girls.

Violence and Abuse Studies across sub-Saharan Africa have confirmed the link between physical and sexual abuse by intimate partners and HIV exposure. For example, a survey of

nearly 1400 women attending antenatal clinics in Soweto, South Africa found significantly higher rates of HIV infection among women who were abused. The study also produced evidence that abusive men are more likely than non-abusive men to be HIV-positive.

Orientation Traditionally, men who have sex with men (MSM) have been identified as a high-risk group, as HIV emerged among this group in North America and Europe. Because of this association, the MSM community has often been met by stigmatization and hostility. It is important to promote a message that HIV infection does not discriminate based on sexual orientation.

Always Risky Conversely, HIV prevention messages that focus too heavily on heterosexual transmission have left many to believe that sex between men is does not pose a risk of HIV infection, which is false. Such belief and inherent risks will continue to persist unless sex between men is acknowledged and addressed. In many parts of the world, particularly Africa, health intervention for men who have sex with men remains rare or poorly developed.

Source: *Operational Guide on HIV/AIDS – A Rights Based Approach, 2005*

HIV/AIDS and Gender Norms

Gender identities and norms are determined both by individual and societal conceptions of what it means to be female or male. Femininity refers to the qualities or characteristics considered appropriate for women and girls and masculinity refers to the qualities or characteristics considered appropriate for men and boys and are dependent on the cultural context, generational differences, and are not universal.

Gender norms can have a negative impact and increase the vulnerability to HIV infection when they position women in inferior or passive roles and men in dominate or aggressive roles. For example, dominant ideologies of femininity expect women and girls to be subordinate, obedient and dependent; passive in sexual relationships; virgins, chaste and monogamous. On the other hand, dominant ideologies for masculinity expects men and boys to be independent, dominant, aggressive and risk takers; strong and viral providers; sexually experienced, and even to seek multiple sexual partners to show their masculinity.

Impact of Gender Norms on Women

These types of social norms contribute to undermining women's control of their sexual lives, and can cause them to have less power than men to decide with whom, how and when they have sex, including negotiating condom use. The inability to negotiate sexual

relations also affects married women in many societies. The lack of control means that many women become infected by their partner, even if they themselves have remained faithful. Marriage is therefore not necessarily a protective factor against HIV infection as abstinence, monogamy and condom use in such cases are generally a rare option.

Box 2

Factors Influencing the Power for Condom Use in a Marital Relationship

Men:

- Is physically stronger and can impose himself;
- Can use or threaten physical or emotional violence;
- Owns the house;
- Is expected to produce many children;
- Is ignorant about the cause of the spread of HIV;
- Thinks condoms are wasteful or diminish sexual pleasure;
- Condoms are not available;
- Is the breadwinner and decides on all expenses;
- Believes he is entitled to his wife, who has become his property.

Women:

- Women cannot discuss sexual matters with husbands;
- Do not know about HIV and how to protect against infection;
- Do not own the house or the land;
- Earn some money, but is expected to hand it over to her husband;
- Were ridiculed at clinic when she asked for condoms;
- Are expected to have children;
- Condoms are not available;
- Fear husband will become violent or abandon her
- Believes husband is entitled to sex whenever he wants.

Source: Operational Guide on Gender & HIV/AIDS, UNAIDS Interagency Task Team on Gender & HIV/AIDS, 2005

Data from around the world, replicated in sub-Saharan countries, suggest that married women's greatest risk of contracting HIV is through sexual intercourse with their husbands: The implication is that men are acquiring HIV through extra-marital affairs and then infecting their wives (American Journal of Public Health, 2006).

Box 3

HIV Infection Among Married Women

- Studies from Kenya and Zambia suggest higher rates of infection among young married

women (aged 15 to 19) than among their sexually active, unmarried (female) peers;

- In South Africa, infection rates among pregnant women ages 25 to 29 are rising. Infection rates have risen to over 35% among pregnant women aged 25 to 29. Over half of pregnant women are married in this age group. The infection rate is about 30%, among pregnant women 30-34. Over 70% of women are married within this age group;
- In Cambodia, a country with the highest HIV prevalence rates in Southeast Asia, prevalence rates among sex workers are dropping, while those among married women are increasing rapidly;
- In India, infection rates among women accounted for 25% of all cases in 2004 and have been rising among married women. Findings from a couple of recent small sample studies suggest that within married women, 80% of infections were among women who were married and monogamous;
- A national survey in Tanzania revealed that 62% of married women perceived their greatest risk of HIV infection to be the infidelity of their partners.

Source: *The Gender Reality of HIV/AIDS, 2006*

Impacts of Gender Norms on Men

Manhood and masculinity concepts guide boys and men in the world of gender relations. Some men and boys feel obliged to live up to the dominant forms of masculinity, while others struggle to find alternative and more gender equal identities. Gender norms can therefore play a central role in HIV-transmission. They can make it more difficult for men to protect themselves and their partners, if they feel they have to live up to stereotypes on masculinity, for example by thinking visiting health clinics is a sign of weakness or if men's sexuality drives them to have multiple partners or even to rape women/men. These norms can also affect whether men will take on some of the increased burden of care as a result of HIV and AIDS.

In addition, denial and stigmatization of men who have sex with men can in some instances lead them to have heterosexual relations as well to prove their manhood, thus exposing both their male and female partners to HIV risk. Homophobia which continues to persist also exposes men who have sex with men to unnecessary violence at the hands of other community members, health care professionals or law enforcers and is legitimized by weak or discriminatory legislation.

Box 4

Homophobia Fuelling the Spread of HIV in sub-Saharan Africa

The persistent and increasing violence against the MSM community in Africa is continuing to jeopardize efforts made to combat HIV among this group. MSM are not the only individuals experiencing threats or real violence, lesbian women, bi-sexual, and transgender individuals (LGBT) also face outdated legislation which leaves them vulnerable to violence and discrimination.

Cases have been reported where the LGBT community has been denied outright their rights to health care services including access to HIV/AIDS prevention and treatment. Social taboos may also deter the group from accessing services in the first place.

On average it is estimated that HIV infection rates among MSM are four to five times higher than the population overall in certain areas. In Bamako, Mali screening tests on a few hundred MSM determined that the infection rate was as high as 37% - national HIV statistics were only reported to be 1.3% of the population, demonstrating the gross overrepresentation of MSM in terms of HIV infections. Similarly in Dakar, Senegal 21.5% of the MSM community tested were infected with HIV compared to the national rate of 0.7%.

According to activists, 38 of 53 countries in Africa still consider same sex acts between men and between women as punishable by law, ranging in severity up to imprisonment.

The fear of social and legal reprimand forces the LGBT community into clandestine activity, and dissuades individuals from seeking HIV information and treatment. Many MSM are not educated or ignore prevention methods, believing that there is no risk of contracting HIV by anal penetration – when in fact the risk is much higher than vaginal intercourse. The hidden existence of the MSM community not only increases exposure to HIV, but serves as a bridge to the general population as well. Many MSM also have sexual relationships with women as social taboos do not allow them to live openly as gay men. In Mali, over 88% of men who had sex with men also reported having sexual relationships with women.

“Social homophobia is legitimized and it increases fear amongst MSM who take further risks to live their lives in secret.” In Senegal, where same sex acts remain illegal, a ‘manhunt’ was said to have taken place, as pictures from a LGBT festival were used to identify individuals. This forced certain members of the MSM community into hiding, including those infected with HIV to hide compromising their access and adherence to treatment.

In Botswana, similar laws have led to the prosecution of lesbian, gay, bisexual and transgender persons despite the legislation's clear contradiction with the International Covenant on Civil and Political Rights. According to the Covenant individuals are protected from discrimination based on sexuality and gender identity, Freedom of assembly and expression are also protected, which contradicts the decision to deny legal status to civil society organizations which advocate for the rights of the LGBT community in Botswana. Finally, the Covenant protects individuals from interference in private, consensual sexual activity – including same sex acts. As of 2008, Botswana has still not integrated this into practical legislation.

Sources: www.irinnews.org/Report.aspx?ReportId=79397; *The Violations of the Rights of Lesbian, Gay, Bisexual and Transgender Persons in Botswana: A Shadow Report, 2008*

Taking Diversity into Account

It is important to remember that not all women, girls, boys, or men are the same. Societies and communities hold different expectations of men and women depending on their age, ethnic background, class, marital status, and sexuality. These factors also influence the extent to which women and men are able to challenge and overcome social expectations. Thus, in addressing commonalities among women and men, it is important not to lose sight of the diverse and specific experiences among them. It also means giving careful consideration to groups that have higher than average vulnerability to HIV infection, for example women and girls from ethnic minorities; sex workers; men who have sex with men; women and men who are exposed to employment/ economic conditions, such as migrant workers. As well as those who are most at risk of social exclusion or disproportionately affected by the impact of the epidemic for example widows and girls in child headed households.

Importantly, men who have sex with men (MSM) should not be thought of as a single contained group, rather they should be considered according to their various ways of thinking about and experiencing sexuality, as not all men that have sex with men consider themselves to be "gay." Although some men identify themselves as such, others consider themselves to be bi-sexual, identify themselves as transgendered, or identify as being heterosexual and engage in sex with other men occasionally. Programs geared towards MSM should focus on the varied lifestyles and sexual behaviors of such men, as well as their sexual identity, taboos surrounding sex between men, and implications for disease transmission into the population more broadly if heterosexual relationships are happening concurrently.

HIV/AIDS and Gender Inequalities

There are many factors contributing to creating and increasing gender inequalities, which in turn can affect the spread of, prevention, care, support and treatment of HIV/AIDS. Some of the primary factors follow:

Gender-Based Violence

Gender based-violence occurs in all societies and takes place in many forms. It rarely attracts social sanctions or legal punishment. Violence has a variety of implications for HIV/AIDS, both in perpetuating the spread of HIV, but also worsening the impacts of the disease. Domestic violence, when women are perpetrated by their partners, is the most common form of gender-based violence. Also known as spousal abuse, or intimate partner abuse, it occurs when a family member or partner physically or psychologically dominates another. Domestic violence occurs in all cultures; people of all races, ethnicities, religions, sexes and classes can be perpetrators of domestic violence. Domestic violence has many forms including physical violence, sexual abuse, emotional abuse, intimidation, economic deprivation and threats of violence.

Domestic abuse can both result in, or is a consequence of HIV infection. The threat of violence can influence a woman's expectations in a relationship, influence her ability to negotiate when and how sex takes place and whether or not to use a condom, which in turn increases the risk for HIV transmission. Gender violence can also be a punitive reaction to a positive HIV diagnosis within a relationship. As most diagnoses are made during pregnancies, women often find out their status before their partner and thereby risk facing discrimination, abuse at the hands of their partners, or even abandonment. Many women are therefore faced with the choice of staying in an abusive relationship or homelessness, or remaining silent about their HIV status.

Box 5

Case Study – Zambia

In Zambia, the HIV prevalence rate among the adult population is 17%. Unfortunately, Zambian women often bear a double burden of domestic violence, which also hinders their ability to access and adhere to life saving HIV treatment.

Despite Zambia's extensive roll-out of universal HIV treatment, its treatment policy does not clearly articulate the needs of women, as health-care systems and legal frameworks fail to address women's barriers to access. Resultantly, women are being denied their rights to treatment, health, dignity and life.

To explain, Human Rights Watch has observed high levels of gender-based violence at the hands of husbands and intimate partners. It was revealed that women were often beaten, verbally abused, or subjected to marital rape upon discussing or disclosing HIV testing and treatment. Some women felt compelled to hide their HIV treatment or make up excuses for side effects, causing them to miss doses of treatment or clinical appointments. A 2006 report by the Victims Support Unit of the Lusaka Division of the Zambia Police Service, the YWCA, Women in Law in

Southern Africa, and the government's Child Justice Forum showed that almost half of married women aged over 15 reported being battered or physically abused by their husbands, and 53 percent of women overall experienced physical violence.

Despite high levels of sexual and gender-based violence, Zambia has no specific legislation criminalizing domestic and sexual abuse. Furthermore, Zambia's penal code has no provision for marital or psychological abuse. In addition, Zambia's health care system is ill equipped to address instances of gender-based violence reported or suspected in clinical settings. There are currently no government protocols or training programs that address gender-based violence in HIV-testing and treatment facilities.

According to Human Rights Watch, violence against women, including domestic violence and marital rape, raises a range of human rights abuses that governments and parliamentarians of all nations have a responsibility to address. Although Zambia has ratified many international human rights conventions, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), steps need to be taken to ensure that women enjoy full protection under law.

To respect its obligations under CEDAW, Zambian parliamentarians should pressure governments to develop and enforce legislation that guarantees that no law or custom grant men a right to a greater share of property or finances at the end of a marriage, or de facto relationship. This will allow women great autonomy to leave abusive relationships.

Source: www.hrw.org/english/docs/2008/05/05/global18753.htm;
www.irinnews.org/report.aspx?reportid=61665

Sexual abuse and rape also occur worldwide. Sex trafficking and harmful cultural practices are other examples of gender-based violence that can substantially increase the risk for HIV infection.

Box 6

Sex Trafficking and HIV in India and South Asia

The underground nature of sex trafficking makes accurate assessment of its magnitude extremely difficult. However, it is conservatively estimated that between 600,000 to 800,000 people are trafficked across international borders annually, with 150,000 estimated to come from South Asia alone. The vast majority are women and girls, an estimated 50 percent of whom are under the age of 18, both in India and worldwide.

The threat of HIV/AIDS among prostituted women has *not* slowed down the sex trafficking and prostitution trades. Rather it has increased the sex trafficking of younger girls, that is, girls who will be perceived by clients to be "virgins" and therefore uninfected by the virus are becoming an increasingly popular commodity to trafficking syndicates. Major studies of HIV prevalence and risk among commercial sex workers, as well as the HIV-related interventions aimed at this group, have not sufficiently taken the situation of young women and girls who end up in the sex industry due to trafficking into account. This group faces several known barriers to HIV prevention, treatment and care programs, such as stigma and discrimination, which is also compounded by restrictions on movement, physical confinement, and social isolation.

A report by the BBC News indicates that sex trafficking of young girls in India has led to a rapid increase in HIV/AIDS within the country. India has one of the highest incidences of HIV in the world, with 2.5 million living with the disease (UNAIDS, 2007). In big red light districts, such as Sonagachi in Calcutta, where at least 10,000 prostitutes make a living, some men continue to insist on sex without condoms. The trafficked girls are forced to oblige. Many come from rural villages and do not know what Aids is before they are sold to pimps. As they are moved around the country, they can unwittingly spread the disease. In eastern India, Calcutta has emerged as a hub for the trafficking of girls, who also arrive from Nepal, Bangladesh and Burma. From Calcutta they are often sold again to brothels in Mumbai (Bombay). Some will go on to the Middle East, Africa and Europe.

Recent studies by the Harvard School of Public Health on the prevalence and predictors of HIV infection among sex-trafficked South Asian women and girls to India show that those trafficked at younger ages were more likely to be infected with HIV, as they are more likely to serve in multiple brothels and be confined for longer periods. Each additional month of captivity increased the risk of HIV infection by 2 to 4 percent.

Although a small scale study, these findings suggests that trafficked women and girls face extreme levels of vulnerability to HIV infection and should constitute a priority population for HIV prevention efforts.

Source: www.globalhealth.org/reports/printview-text.php3?id=358;
http://news.bbc.co.uk/2/hi/south_asia/4055143.stm

Gender violence also affects men. Although prevalent in all societies, male rape is rarely discussed, as the associated shame and stigma for men who have been raped makes them reluctant to speak out. Forced sex in all male communities, as well as in prisons is an unfortunate reality which needs to be more openly and proactively addressed (See Unit 2).

Economic Inequalities and Gender

Economic dependency and poverty contribute towards increasing gender inequalities. Limited access to and control over economic assets can also contribute to vulnerability to HIV infection in several ways, as it increases the likelihood of:

- The inability to negotiate safe sexual practices;
- Exchanging sex for money; and
- Staying in a relationship that is violent and risky.

Gender-discriminatory legal and regulatory frameworks in the areas of access to property rights and land tenure, and inheritance and succession, can increase gender-based vulnerability. Only 15% of land worldwide is owned by women and in the context of AIDS, the lack of ownership can leave women destitute. For example, after a husband's death, his widow might have difficulties inheriting the property, which might be taken over by male relatives of the husband. This can result in her and her children becoming homeless. Alternatively, in cultures where 'widow inheritance' is common, she will automatically become the wife, and hence the "property" of this male relative. However, if it is known that she is HIV positive, she and her children risk being turned away from the home and becoming socially isolated. In some African countries where legal frameworks have been amended to reduce gender inequalities with respect to property rights, these laws are not properly enforced often because:

- Civil laws contradict traditional laws;
- Women are not aware of their legal rights; and
- Women, particularly in rural areas, do not have access to legal representation and courts.

In most societies, it becomes the responsibility of women and girls to care for sick family members. This disproportionately burdens women over men can also influence a woman's financial situation, as it limits women's ability to participate in income generating activities and girls' possibilities to attend school. Grandmothers are particularly affected, as they often have to care for their children as well as the grandchildren when they become sick. In societies where men are not involved in caretaking responsibilities, they can easily become removed from the gravity of the HIV/AIDS situation, while contributing to reinforcing the stereotypes of gender roles.

Unequal Access to Preventive Measures

Research has shown a strong link between educational level and knowledge about HIV and AIDS. In many parts of the world, more boys than girls have access to education or stay in school longer. This is even more so in areas with high HIV/AIDS prevalence, as girls are made to stay home for financial reasons or to help care for sick relatives. This

can affect their ability to access important information on how to protect them from HIV infection when they become sexually active or later in life. Research has also shown that adolescents who receive quality sexuality education are more likely to delay sexual activity and practice safe sex. They also tend to have fewer sexual partners.

The communication of HIV/AIDS messages can also have negative implications on gender definitions. For example, an HIV prevention program for young people in Africa used different slogans for young men and women. The message communicated to young women read "Smart girls say no to sex before marriage", whereas the poster for young men read "Smart guys say no to casual sex." These messages, although well intended, reinforce the notion that virginity and chastity is a female virtue, but not as strongly valued among young men. Programming that target the joint involvement of men and women may help to shift these entrenched notions among these and other examples.

In addition, many prevention campaigns adhering to the "ABC"-approach, (i.e. abstain, be faithful and use a condom), do not take into full consideration HIV transmission within marriages or long-term relationships. An increased focus on HIV counseling and testing for couples, combined with legal reforms to reduce child marriages and to protect women and girls against sexual coercion and violence in marriage can help mitigate their specific challenges. There is also a lack of female controlled preventive measures. The only currently available method is the female condom. However, they tend to be more expensive than male condoms and are also poorly marketed in many places. Research to develop an effective microbicide is taking place, which could increase women's power to control these situations further.

Box 7

Recommendations to Increase Female Controlled Preventive Measures

In endorsing the Millennium Development Goals, the U.N. Declaration of Commitment on HIV/AIDS and other international development agreements, world leaders have committed to a series of critical steps needed to stop the spread of HIV. Prominent among these steps is the need to reduce the vulnerability of women and girls to HIV. World leaders have recognized that, unless the rising tide of new infections among women and girls is addressed, the

realization of global and national efforts to curb the spread of HIV and to make progress toward other key development goals will be impossible. Ultimately, significantly reducing female HIV infections will require the development and improvement of female-initiated and controlled prevention options. As part of a comprehensive prevention package, microbicides and expanded access to improved female condoms would dramatically enhance women's ability to protect themselves from HIV and, in turn, would go a long way to stop the global spread of HIV.

The following are some of the recommendations the UNAIDS-led Global Coalition on Women and AIDS makes to increase female controlled preventive measures:

- International partners should promote international leadership by supporting and financing a comprehensive approach to HIV prevention for women that includes microbicides and the female condom, as well as provide technical assistance to strengthen regulatory systems in developing countries, as well as the advocacy and policy research that underpins such efforts.
- Political and social support among stakeholders – including donors, clients, service providers, researchers, and policymakers – to increase public awareness, acceptance, and supply of female condoms should be developed and strengthened.
- Female condoms should be integrated into the core service package of existing HIV prevention and reproductive health programs
- Political support for microbicide research and development should be strengthened by increased funding and collaboration with product developers and local research institutions to undertake ethical and open clinical trials, both in developing and developed countries.
- Available national mechanisms to promote awareness of microbicides among women and men, and to expand community engagement with microbicide clinical trials at the country level should be used.

Source: http://data.unaids.org/pub/BriefingNote/2006/20060530_FS_Women's%20HIV%20Prevention%20Control_en.pdf

Unequal Access to Treatment

Together with accurate prevention messages, equal access to treatment and care are crucial to slowing down the HIV/AIDS pandemic. In 2005, treatment was only available to 20% of those in need globally and 17% of all HIV-infected people in sub-Saharan Africa. At that time, approximately 9% of pregnant women living with HIV in low and middle-income countries had access to ARVs to prevent transmission to their unborn children. Where treatment was available, women were less likely to access it than men. This was partly due to cultural norms that dictated that men's treatment is a bigger priority as they traditionally are seen as the breadwinners. Although women's participation in paid, non-agricultural employment has continued to increase slowly,

women in developing regions are more likely than men to work in agriculture, and as contributing but unpaid family workers. For example, in sub-Saharan Africa women only make up 1/3 of the population engaged in paid non-agricultural employment. Economic dependency and affordability also played a role, as poor women were even less likely than poor men to be able to afford ARVs, even if the fees were substantially reduced. However, in countries where important steps have been taken to provide free HIV treatment to those in need, for example in Botswana, Brazil, Ethiopia, Senegal, Thailand, Tanzania and Zambia, the number of women accessing ARV treatment tends to rise significantly (Keeping the Promise, 2006).

Since then, combined efforts of countries and international partners have resulted in substantial and ongoing progress towards providing ARVs for all in need. Recent figures from WHO, UNAIDS and UNICEF positively show that access to treatment increased by 42% in 2007 alone. A recent international study representing 87% of the people receiving antiretroviral therapy and 88% of those in need globally suggests that women are no longer disadvantaged in access to antiretroviral therapy compared with men. For example, data from 32 countries in sub-Saharan Africa showed that only 61% of the people receiving antiretroviral therapy in this region were female, while they represent 57% of the people in need. It is also estimated that 33% of HIV positive pregnant women in low- and middle-income countries received ARVs to prevent HIV transmission to their children in 2007. However, in some countries pregnant women have problems receiving ARVs for their own health. In addition, it is estimated that 6.7 million people in need of treatment still don't have access to ARVs.

HIV/AIDS, Gender and International Commitments

The linkage between gender and HIV/AIDS has been acknowledged by the international community and the world's governments by the adoption of a number of human rights instruments and policy documents. These documents provide a framework for addressing the gender dimensions of HIV/AIDS, and are also tools for monitoring progress towards the realization of these rights.

Box 8

International commitments on Gender and HIV/AIDS

1979 - UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

Currently 185 countries have ratified CEDAW and are hence legally bound to put its provisions into practice.

1994 International Conference on Population and Development

States agree to share the costs needed to make basic reproductive healthcare available to all by 2015.

1995 Fourth World Conference on Women

States agree that the human rights of women include the right to decide freely and responsibly on matters related to their own sexuality and recognize that social vulnerability and unequal power relations block efforts to control the spread of HIV.

2000 UN Millennium Development Goals

MDGs include promoting gender equality and the empowerment of women, eliminating gender disparity in primary and secondary education and reversing the spread of HIV.

2001 United Nations Declaration of Commitment on HIV/AIDS

Member States agree that gender equality and women's empowerment are fundamental to ensuring an effective response to AIDS and commit themselves to a set of time-bound targets, a number of which relate specifically to women.

2005 World Summit

Global leaders commit to a massive scaling-up of HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it.

2006 High Level Meeting on HIV/AIDS

All member states of the United Nations pledged to:

- Eliminate gender inequalities, and gender-based abuse and violence;
- Increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and full access to comprehensive information and education;
- Ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health; and to
- Take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence; and in this context, reiterate the importance of the role of men and boys in achieving gender equality.

Source: *Keeping the Promise: An Agenda for Action on Women and AIDS, 2005*

A Gender and Rights-Based Approach

The realization of human rights – and more specifically of gender equality – is imperative regardless of the scale and stage of the HIV/AIDS epidemic. In countries and communities with a low HIV prevalence rate, the promotion of gender equality and human rights is integral to HIV prevention.

The UNAIDS Inter-agency Task Team on HIV/AIDS and Gender has documented concerns that gender and rights are integral, and that the inadequate realization of human rights and gender concerns can facilitate the spread of HIV and worsen the impacts of HIV/AIDS. In response, with the help of the Royal Tropical Institute (KIT) in the Netherlands, the Task Team has developed an Operational Guide. It aims to give a practical understanding the linkages between gender, human rights and HIV/AIDS to development practitioners and policy makers. It also offers suggestions on how to respond strategically to these challenges, as well as a set of guidelines, checklists and tools for program implementation.

According to the *UN Common Understanding on the Human Rights Based Approach to Development (2003)* a rights-based approach has three core features:

1. It contributes to the realization of human rights as reflected in the Universal Declaration of Human Rights and other international human rights instruments;
2. It adheres to international human rights standards and principles; and
3. It supports the development of the capacities of 'duty-bearers' to meet their obligations and/or of 'rights-holders' to claim their rights.

An essential feature of a rights based approach is to focus on strategies for empowerment, which support these so called "rights holders", in this case, men and women irrespective of gender. Support includes power, knowledge, and resources to ensure that they can be involved in the development process, such as HIV/AIDS mitigation. A rights based approach is underpinned by a careful assessment of which social groups are marginalized in a particular context (for example women and girls, men who have sex with men), and what strategies are required to mobilize these groups to change their lives for the better.

Achieving a rights based approach is also dependent on the extent to which historical precedence is challenged and changed among individual and community ideologies. It is not enough to simply allow equal access to opportunities and services by law (formal equality), this action must be paired with the removal of institutional, social, and economic barriers which serve disadvantage groups based on gender distinctions (substantive equality).

Box 9

Implications for a Rights-Based Gender Perspective to HIV/AIDS Mitigation

In relation to HIV/AIDS, a gender and rights-based approach implies:

- Understanding the nature and extent of vulnerability to HIV infection of women, girls, men and boys and the gender-related barriers to HIV prevention (including lack of power, resources, skills and information), and putting the rights of women and girls central to programmatic responses aimed at curbing HIV spread;
- Understanding the social, cultural, economic, political and institutional barriers experienced by women, men, girls and boys living with HIV/AIDS in accessing and benefiting from treatment and care and putting this understanding central to programmatic responses aimed at providing universal treatment and care;
- Understanding the differential implications of HIV/AIDS on women and men, girls and boys at household, community, societal and economic level and ensuring that programmatic responses equally support the coping capabilities of women/girls and men/boys in a manner that challenges and changes gender stereotypes.

Source: *Operational Guide on Gender & HIV/AIDS – A Rights-Based Approach, 2005*

Men Matter!

It is increasingly recognized that in order to combat gender-based discrimination, more power needs to be placed in the hands of women. However, it is also apparent that more responsibility needs to be given to their male counterparts when fighting gender inequalities. Gender based violence and stereotypes continue to persist based on socially constructed norms and values that place expectations on men and women. However, men need not be seen only as perpetrators and irresponsible transmitters of HIV, but

should rather be positively engaged in HIV prevention by challenging the gendered expectations that shape their lives.

The Role of Parliamentarians

Parliamentarians have a responsibility to address gender inequalities wherever they find them, whether among the citizens they represent in their constituencies, in a lack of government programs and funding for certain marginalized groups, in legislation and policies or even within parliament itself. Reducing gender inequalities in the context of the HIV/AIDS pandemic requires changing social norms, attitudes and behaviors through a comprehensive set of policies and strategies. It is important that parliamentarians take a leading role by:

- **Speaking Out** Publicly speaking out against stigma, discrimination, gender inequality and women's empowerment in general as well as in the context of HIV/AIDS;
- **Increase Female Representation** Striving for increased female representation in Parliament and ensuring that women are adequately represented in policy-and decision-making on HIV/AIDS in the various committees;
- **Gender Includes Men** Refraining from treating "gender issues" as "women's issues", but ensure male participation in addressing the challenges they pose;
- **Legally Protecting Women** Proposing and enacting laws and policies that protect women and girls against sexual violence, disinheritance and gender discrimination of all kinds, including harmful traditional practices and sexual violence in and outside of marriage, as well as overseeing that these laws and policies are publicized and enforced;
- **Legally Addressing Bias** Proposing and enacting laws and policies that directly address gender inequality and bias against people perceived to be at heightened risk for HIV, including sex workers and men who have sex with men;
- **Funding Gender Equity** Ensuring that there is sufficient funding available to address gender inequalities in HIV/AIDS prevention, treatment, care and support programs. Some examples are programs that ensure expanded access to sexual and reproductive health care, initiatives addressing gender-based abuses, and

economic empowerment schemes for women, including women care-givers;

- **Monitor** Incorporating gender dimensions into monitoring and evaluation activities, and ensure that data is disaggregated by sex, age and marital status.
- **Increase Girls Schooling** Urging governments to put programs in place to increase school enrolment for girls as well as incentives to keep them in school longer, including making schools free of sexual violence and exploitation;
- **Advocate for Reproductive Rights** Advocating for and taking part in awareness campaigns which emphasize women's reproductive and sexual rights, including access to health care, and HIV testing and treatment; and
- **Talking About it** Promoting community dialogue to change harmful gender norms and involving women's and gender equality organizations during the development of HIV/AIDS and gender related laws and policies.
- **Hold Governments Accountable** Parliamentarians have an important role to play in ensuring that their respective governments live up to the commitments they have made to address gender equality, for example by signing the Millennium Development Goals.

Unit 10: Questions

Please answer each of the following questions. If you are taking this course in a group you may then meet to discuss your answers.

1. What is the difference between "sex" and "gender"?
2. What are the negative implications of gender identities and expectations for both men and women?
3. How does gender inequality affect the spread of, prevention, care, support and treatment of HIV/AIDS? Give concrete examples from your country.
4. Explain the risk of infection among women who are married or who have long-term intimate partners. What can be done to decrease their risk of HIV infection?
5. Why is a rights-based approach important when addressing HIV/AIDS from a gender perspective? How can parliamentarians contribute to this approach being implemented in practice?

Selected Bibliography:

Africa: Homophobia fuelling the spread of HIV, IRIN, 2008

Fact sheet Gender and HIV/AIDS, United Nations Special Session on HIV/AIDS, 2001

Gender-Based Abuses in the Context of HIV, Human Rights Watch, 2008

Gendering AIDS: women, men, empowerment, mobilization, VSO, 2003

The Gender Reality of HIV/AIDS, Center for Health and Gender Equity, 2006

HIV/AIDS & Gender Equality - Gender and Development Briefing Notes, PREM Gender and Development Group, The World Bank, July 2003

HIV/AIDS and Gender Relations – Men Matter! AIDS, Gender, and Masculinities, SIDA, 2007

The implications of early marriage for HIV/AIDS policy, by Judith Bruce and Shelley Clark, 2004

Keeping the Promise: An Agenda for Action on Women and AIDS, The Global Coalition on Women and AIDS, 2006

Marriage does not protect women and girls from infection, Center for Health and Gender Equity, 2005

The Millennium Development Goal Report 2007, United Nations, 2007

Operational Guide on Gender and HIV/AIDS: A Rights Based Approach, UNAIDS Interagency Task Team on Gender & HIV/AIDS, 2005

Parliamentary Oversight of Gender Equality - Handbook, the World Bank Institute and the Parliamentary Centre, 2006

Rapid Assessment and Response Adaptation Guide on HIV and Men Who Have Sex With Men, WHO, 2004

Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector, WHO, UNAIDS and UNICEF, 2008

The Violations of the Rights of Lesbian, Gay, Bisexual and Transgender Persons in Botswana: A Shadow Report, the Botswana Network on Ethics, Law, and HIV/AIDS (BONELA), 2008

Internet Resources:

http://news.bbc.co.uk/2/hi/south_asia/4055143.stm

www.genderandaids.org

www.genderhealth.org

www.globalhealth.org/reports/printview-text.php3?id=358

www.hrw.org/english/docs/2008/05/05/global18753.htm

www.irinnews.org/report.aspx?reportid=61665

www.irinnews.org/Report.aspx?ReportId=79397

www.unaids.org/en/PolicyAndPractice/Gender/default.asp

www.who.int/gender/hiv_aids/en/

Suggestions for further reading:

Transforming the National AIDS Response – Mainstreaming Gender Equality and Women’s Human Rights into the “Three Ones”, UNIFEM, 2006

Integrating Gender into HIV/AIDS Programmes – A Review Paper, World Health Organization, 2003

Cross-generational and Transactional Sexual Relations in Sub-Saharan Africa: Prevalence of Behavior and Implications for Negotiating Safer Sexual Practices, by Nancy Luke and Kathleen M. Kurz, 2002

Epidemic of Inequality - Women's Rights and HIV/AIDS in Botswana & Swaziland: Evidence-Based Report on the Effects of Gender Inequity, Stigma and Discrimination, Physicians for Human Rights, 2007

Gender Responsive Budgeting and Women’s Reproductive Rights: A Resource Pack, UNFPA and UNIFEM, 2007

Women and Girls living with HIV/AIDS: Overview and Annotated Bibliography, by Emily Esplen, BRIDGE (development – gender) and Institute of Development Studies, 2007