INTEGRATING GENDER INTO HIV/AIDS PROGRAMMES

A REVIEW PAPER

World Health Organization

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Department of Gender and Women's Health
Family and Community Health
World Health Organization

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1. EXECUTIVE SUMMARY

In the HIV/AIDS epidemic, gender – defined as the array of societal beliefs, norms, customs and practices that define 'masculine' and 'feminine' attributes and behaviours – plays an integral role in determining an individual's vulnerability to infection, his or her ability to access care, support or treatment, and the ability to cope when infected or affected.

Gender norms, for example, often dictate that women and girls should be ignorant and passive about sex, which greatly constrains their ability to negotiate safer sex or access appropriate services. Similarly, gender norms cast women as being primarily responsible for reproductive and productive activities within the home, in sharp contrast to men who are cast as primary economic actors and producers outside the home. Such gender stereotypes account for women having much less access than men to key productive resources such as education, land, income, credit, and employment, which significantly reduces the leverage they have in negotiating protection with their partners and greatly affects their ability to cope with the impact of infection. For men and boys, gender norms create social pressure to take risks, be self-reliant, and prove their manhood by having sex with multiple partners. Such norms expose men and boys to the risk of infection and create barriers to their use of HIV/AIDS prevention, care, or support services. Youth, especially girls, are particularly vulnerable in the epidemic. Furthermore, research indicates that even gender norms which supposedly protect youth, such as those that expect unmarried girls to remain virgins, can put them at risk by restricting their access to full information about sexuality and reproductive health services.

While our collective stock of knowledge about the gender-related determinants of risk and vulnerability to HIV and the consequences of AIDS has grown substantially over the past decade, putting that knowledge to good practice has proved to be a formidable challenge. A framework that categorizes the different approaches to integrating gender into HIV/AIDS programming can be useful to meet this challenge.

Reviewing existing approaches to address gender in HIV/AIDS programmes suggests that there is a continuum of approaches that have been used ranging from harmful to empowering. Interventions can cause harm by

reinforcing damaging gender and sexual stereotypes that perpetuate the epidemic either directly or indirectly. To be useful, interventions must, at a minimum, do no harm. A step up on the continuum are gender-sensitive interventions that recognize that men and women's needs often differ and find ways to meet those needs differentially. The third, gender-transformative interventions are a more sophisticated set of approaches that not only recognize and address gender differences but go a step further by creating the conditions whereby women and men can examine the damaging aspects of gender norms and experiment with new behaviours to create more equitable roles and relationships. Finally, the most evolved set of interventions are structural interventions that go beyond health interventions to reduce gender inequalities by empowering women and girls. By increasing their access to economic and social resources, such interventions can fundamentally change the economic and social dynamic of gender roles and relationships, and in the long term protect women as well as men and families in the HIV/AIDS epidemic.

The challenge of integrating existing knowledge about the impact of gender norms and inequality on HIV/AIDS into interventions, while formidable, can be met. There are several examples of programmes from around the world that have adopted different approaches to integrate gender considerations in their work. It is important to draw upon the lessons learned from these implementation experiences to develop concrete and practical guidelines for national HIV/AIDS programme managers so as to help them integrate gender issues into HIV/AIDS programmes. The need for such guidelines is underscored by a single fact: the effectiveness of HIV/AIDS programmes and policies is greatly enhanced when gender differences are acknowledged, the gender-specific concerns and needs of women and men are addressed, and gender inequalities are reduced.

2. BACKGROUND & RATIONALE

The global pandemic of HIV/AIDS has now entered its third decade. Research conducted over the past decade has revealed that gender roles and relations directly and indirectly influence the level of an individual's risk and vulnerability to HIV infection. Gender is also a factor in determining the level and quality of care, treatment, and support that HIV-positive men and women receive, the burden of care taken on largely by women, and the negative economic and social consequences of AIDS. These realities demonstrate the necessity of comprehensively integrating gender considerations into all levels of HIV/AIDS programming in order to enhance our response to the pandemic. Integration will not only benefit women and girls – who are often the most vulnerable – but men and boys who also experience gender-related risks and vulnerabilities to HIV/AIDS.

➡ While some programme managers and policy makers who design and implement HIV/AIDS prevention, care and treatment programmes recognize the central importance of addressing gender, this recognition is far from universal or even widespread. The depth and breadth of our knowledge about gender-related determinants, barriers and impacts of HIV/AIDS has grown significantly over the past decade, but this knowledge continues to outpace our ability to know precisely how we should respond programmatically to these issues in a comprehensive manner.

➡ In 1999, the Joint United Nations Programme on HIV/AIDS (UNAIDS) published a technical paper entitled *Taking Stock of Research and Programmes on Gender and HIV/AIDS.* The paper reviewed research on gender-related determinants of risk and vulnerability to HIV infection among men and women and the differential impacts men and women experience as a result of actual illness, accessing treatments, or seeking and receiving care and social support. The review also examined programmatic activities that attempted to address gender dimensions in prevention, care, treatment and social support. The findings demonstrated that although limited in scale, HIV/AIDS programmes that address gender equality as a central goal maximize their overall effectiveness.

➡ In order to update and build upon the UNAIDS effort,

the World Health Organization (WHO) has identified the need to develop a set of guidelines to help national level HIV/AIDS programme planners and managers integrate gender-based issues and needs comprehensively within HIV/AIDS policies and programmes. These guidelines are intended to go beyond the 'what' and the 'why' to the 'how' by providing a comprehensive framework for addressing gender in our response to the HIV/AIDS epidemic.

➡ To initiate the drafting of the guidelines, WHO held an Expert Consultation in Geneva in June 2002. This Consultation brought together experts from the fields of HIV/AIDS, gender, health and development, as well as programme managers who implement HIV/AIDS programmes at the national level. Participants at the Consultation reviewed existing types of HIV/AIDS interventions – voluntary counselling and testing programmes (VCT); efforts to reduce the incidence of mother-to-child-transmission of HIV (MTCT); care, treatment and support programmes; and programmes to address the needs and vulnerabilities of adolescents and youth – for the purpose of suggesting a set of recommendations and guidelines to address gender effectively within those programmes and interventions. The Guidelines are meant primarily for HIV/AIDS programme managers in WHO country offices and within national Ministries of Health. They might also be useful for non-governmental organizations (NGOs) that are involved in advocacy, research and service provision. While these specific types of interventions provide key opportunities for the incorporation of gender issues, they are by no means exhaustive. The principles and approaches discussed here can equally be applied to other important intervention areas, such as condom promotion and mass communication strategies.

➡ This Review Paper aimed to provide participants of the Expert Consultation with background information and a suggested framework for considering the issues and challenges of integrating gender into programmatic and policy action. It also offers some programmatic examples of successful HIV/AIDS interventions that have addressed gender issues in a meaningful and significant way. This Review Paper is not intended to be an exhaustive review of literature on gender and HIV/AIDS, but rather to draw from the literature to create a picture, in broad strokes, of the ways in which gender influences women's and men's vulnerability in the epidemic and the range of potential programmatic responses.

3. THE IMPACT OF GENDER ON THE HIV/AIDS PANDEMIC

Epidemiological and biomedical research has long established a link between an individual's sex and his or her risk of HIV infection. It is well known, for example, that physiological factors account for the more efficient transmission of infection from an infected man to a woman than from an infected woman to a man (WHO 1994; Foundation for Women 1997). More recently, however, research has also identified the role that gender plays in determining individual risk and vulnerability in the HIV/AIDS epidemic. Socio-cultural norms about masculinity and femininity, and the unequal power relations between men and women that arise from those norms, conspire with biological and physiological factors to compound individuals' risk of infection, resulting in epidemics of significant size and proportion in different parts of the world.

➡ Whereas 'sex' defines the biological distinction between women and men, 'gender' is a social construct that differentiates the power, roles, responsibilities, and obligations of women from that of men in society. Gender determines to a great extent how we think, how we feel, and what we believe we can and cannot do as women and men. Gender roles, norms and expectations vary over the life cycle of women and men, and vary within and between cultures.

➡ In the HIV/AIDS epidemic, both a person's sex and gender determine the extent to which he or she will be vulnerable to infection and his or her ability to access available treatments. Additionally, gender inequality influences the extent to which an individual will be able to cope with the burden of infection and illness, caring for a family member, or surviving the death of family members, both economically and socially.

➡ Gender is a culture-specific construct. As a result there are significant differences in what women and men can or cannot do in one culture as compared to another. But what is fairly consistent across cultures is that there is always a distinct difference between women's and men's roles, access to productive resources, and decision-making authority. Typically, men are expected to be responsible for the pro-

ductive activities outside the home while women are expected to be responsible for the reproductive and productive activities within the home. In addition, in almost every country worldwide women have less access to and control of productive resources than men, creating an unequal balance of power that favors men. Gender gaps between women and men in literacy, school enrollment, labor force participation, land ownership, and access to credit testify to this imbalance in power (UNIFEM 2000).

3.1 THE ROLE OF GENDER AND SEXUALITY IN DETERMINING VULNERABILITY

➡ The imbalance in power created by a differential access to productive resources translates into an unequal balance of power in sexual interactions in which the satisfaction of male pleasure is more likely to supersede that of female pleasure, and where men have greater control over their sexuality. Sexuality is the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is a multidimensional and dynamic construct. Explicit and implicit rules imposed by society, as defined by gender and age profoundly influence an individual's sexuality (Dixon-Mueller 1993; Zeidenstein and Moore 1996; Parker and Aggleton 1999).

➡ The balance of power in any sexual interaction determines its outcome. In the worst cases, this power imbalance plays itself out in terms of violence against women. An understanding of individual sexual behaviour or sexual risk thus necessitates an understanding of gender and sexuality as constructed by a complex interplay of sociocultural and economic forces that determine the distribution of power.

3.2 SOCIOCULTURAL FACTORS: NORMS OF MASCULINITY AND FEMININITY

➡ Gender norms that create an unequal balance of power between women and men are deeply rooted in the sociocultural context of each society and are enforced by that society's institutions, such as schools, workplaces, families, and health systems (Wingood and

DiClemente 2000). By defining the societal ideals of feminine and masculine behaviour and sexuality, gender norms greatly affect women's and men's access to information and services, their sexual behaviour and attitudes, and how they cope with illness once infected or affected. This section provides an overview of the different ways in which cultural prescriptions for masculinity and male sexuality and femininity and female sexuality influence both women's and men's vulnerability in the HIV/AIDS epidemic by affecting what women and men know, their sexual communication and behaviour within relationships, and their ability to access resources and services when infected or affected by HIV/AIDS.

➡ The dominant ideology of femininity in most societies casts women in a subordinate, dependent, and passive position with virginity, chastity, motherhood, moral superiority, and obedience as key virtues of the ideal woman. In terms of HIV/AIDS, this ideology often assigns to women particular roles (as vectors of disease or merely as bearers of unborn children) that substantially influence the design of HIV/AIDS interventions that are ultimately harmful and counterproductive. In sharp contrast, the dominant ideology of masculinity characterizes men as independent, dominant, invulnerable aggressors and providers, whose key virtues are strength, virility and courage.

➡ It is important to remember, however, that in every society there are many kinds of masculinity and femininity that vary by social class, ethnicity, sexuality, and age. It is also now recognized that the multiple forms of masculinity and femininity are dynamic, subject to change, constructed through social interaction (Gutmann 1996; Rivers and Aggleton 2001). This more nuanced understanding of masculinity and femininity is very useful in terms of HIV prevention because it implies that modifications in the construction of gender identities may be possible over time and that there are alternate forms of gender identities that can serve as models for promoting more equitable gender relationships and safer sex.

➡ Despite the existence of multiple masculinities and femininities, however, it is the dominant ideology that most greatly influences women's and men's attitudes and behaviour, making both women and men more vulnerable in the HIV/AIDS epidemic. Some of the ways in which the dominant and damaging ideologies of masculinity and femininity manifest and influence women's

and men's vulnerabilities are described below.

➡ **Knowledge of Sex and HIV Risk:** In many societies the dominant ideology of femininity dictates that 'good women' are expected to be ignorant about sex and passive in sexual interactions (Rao Gupta and Weiss 1993; Paiva 1993). A recent analysis of levels of knowledge about HIV/AIDS prevention in 23 developing countries found that levels of knowledge are almost always higher among men than among women, with 75% of men, on average, having accurate knowledge about HIV/AIDS transmission and prevention as compared to roughly 65% of women (Gwatkin and Deveshwar-Bahl 2001). This knowledge imbalance greatly hinders women's ability to be informed about risk reduction.

➡ Some studies have shown that a lack of knowledge or incomplete knowledge also fosters the development of fears and myths about condom use. For example, studies conducted in diverse settings – Brazil, Guatemala, India, Jamaica, Mauritius and South Africa – have found that women did not like using condoms because they feared that if the condom fell off inside the vagina it could get lost or travel to the throat, or that a woman's reproductive organs would come out when the condom was removed (Rao Gupta and Weiss 1993). Even when a woman is informed or has accurate information about sex and HIV prevention, the societal expectation that a woman, particularly a young woman, should be *naïve* makes it difficult for her to be proactive in negotiating safer sex.

➡ Simultaneously, prevailing norms of masculinity expect men to be more knowledgeable and experienced about sex. This assumption puts men – particularly young men – at risk of infection because such norms prevent them from seeking information or admitting their lack of knowledge about sex or protection. Many men, as a result, have erroneous information about sexual and reproductive health (Barker and Lowenstein 1997; UNAIDS 1999).

➡ **Fidelity versus Multiple Partnerships:** In many societies the dominant ideal of femininity emphasizes uncompromising loyalty and fidelity in partnerships. It is this ideal that distinguishes a 'good' woman from a 'woman of the street' and defines sexual practices linked to reproduction as moral and those that are linked to pleasure as immoral (Rao Gupta and Weiss 1993).

➡ In sharp contrast, in many societies it is believed

that variety in sexual partners is essential to men's nature as men and that men will inevitably seek multiple partners for sexual release (Mane, Rao Gupta et al. 1994; Weiss, Whelan et al. 1996; Rao Gupta 2000). Results from sexual behaviour studies from around the world indicate that heterosexual men, both married and single, as well as homosexual and bisexual men, have higher reported rates of partner change than women (Sittitrai 1991; Orubuloye, Caldwell et al. 1993; Rao Gupta and Weiss 1993). Recognition and condoning of multiple sexual partnerships for men but not for women sets a double standard for sexual behaviour that seriously challenges the effectiveness of HIV prevention efforts that expect men to be faithful and reduce the number of sexual partners (Rao Gupta 2000). Moreover, breakdowns in men's ability to meet some masculine norms, such as providing for the family, can result in men seeking self-esteem by fulfilling other masculine norms, such as engaging in sex with multiple partners (Silberschmidt 2001). This underscores the need for HIV/AIDS prevention efforts to change the gendered norms of sexuality, if interventions are to be effective.

➡ **Motherhood as the Ideal:** Being a mother is considered to be a feminine ideal in many cultures. Children provide a social identity for many women and guarantee them some status in kinship groups (UNAIDS 1999). In addition, in data from countries in Latin America and the Caribbean and some parts of Africa point to the economic realities that reinforce the value of motherhood for women (Le Franc, Wyatt et al. 1996; Malow, Cassagnol et al. 2000).

In Jamaica, for example, women have children to guarantee economic support from the father. These social and economic realities pose significant hurdles for women in HIV risk reduction because the use of barrier methods or non-penetrative sex prevents conception (Heise and Elias 1995; UNAIDS 1999). These realities have consequences in programmatic terms. In some cases, the priority is placed on preventing transmission to the unborn child without regard for the rights of the mother to be informed and choose appropriately what is best for her and her child. This may include loss of choice over whether to be tested for HIV, whether to accept an intervention to prevent MTCT if it is available, or whether to freely choose pregnancy termination. In addition, these programmes often do not encourage male involvement or male responsibility.

➡ Additionally, programmes that seek to prevent MTCT by encouraging women not to breastfeed may also, in some settings, present significant obstacles for women. Breastfeeding is often an integral part of the ideal of motherhood and in many places women who do not breastfeed are seen as bad mothers or treated as handicapped (Rao Gupta 2000). The avoidance of breastfeeding has also become associated with being HIV-positive and thus can be a significant source of stigma.

➡ **Dependence versus Self Reliance:** Women's economic and social dependency on men greatly affects their use of services and their ability to adhere to treatments and other medical regimens. They are encouraged and sometimes forced to ask for permission from their husband or other family members to access services. Often, women will choose not to ask or will be denied, making it less likely that they will use services. Further, even if women do access services they often must consult their husbands or others in order to act upon the recommendations of service providers, thereby creating a potential barrier to women's adherence to treatment and care regimens.

➡ Unlike women, who are expected to be dependent on others to make decisions and access resources, men in many societies are socialized to be self-reliant, not to show their emotions, and not to seek assistance in times of need or stress (WHO 1999). This expectation of invulnerability associated with being a man runs counter to the expectation that men should protect themselves from potential infection and encourages the denial of risk. Overall, these manifestations of traditional notions of masculinity are strongly associated with a wide range of risk-taking behaviour. Mane and Aggleton (2001) point out that "cultural and societal expectations and norms create an environment where risk is acceptable and even encouraged for 'real' men". It is not surprising therefore that men are less likely to seek health care than women and are much more likely to use illegal substances and engage in unsafe sexual practices (Luck, Bamford et al. 2000).

➡ **Sexual Domination, Homophobia, and Violence Against Women:** Notions of masculinity that emphasize sexual domination over women as a defining characteristic of manhood contribute to homophobia and the stigmatization of men who have sex with men. The stigma and fear that result compel men who have sex with men to keep their sexual behaviour secret and deny their sexu-

al risk, thereby increasing their own risk as well as the risk of their partners, female or male (UNAIDS 1999).

➡ Another disturbing outcome of the emphasis on sexual and physical domination of women as central to masculinity is violence against women. In population-based studies conducted in a wide range of countries worldwide, 10 to over 50% of women report physical assault by an intimate partner. One-third to one-half of physically abused women also report sexual coercion (Heise, Ellsberg et al. 1999). Research conducted in a wide range of countries, including Guatemala, Haiti, India, Jamaica and Papua New Guinea found that violence against women contributes both directly and indirectly to women's vulnerability to HIV. Most obviously, violent sexual acts such as rape are likely to result in vaginal tearing or lacerations, thus dramatically increasing the risk of contracting an STI or HIV from the rapist (Maman, Campbell et al. 2000). Additionally, fear of violence or abandonment often prevents women from discussing fidelity with their partners or asking their partners to wear a condom.

➡ Fear of violence has also been found to be a barrier to the success of efforts that seek to reduce the perinatal transmission of HIV. In a study of MTCT prevention programmes in six African countries, fear of ostracism and domestic violence were important reasons for which pregnant women refused HIV testing or did not return for their test results. HIV-positive women who have been advised to bottle-feed their babies to avoid risk of HIV transmission have voiced similar concerns (Brown 1998; Nyblade and Field-Nguer 2000).

➡ The nexus between violence, risky behaviour, and reproductive health has been documented by a review of literature on sexual and physical violence, which showed that individuals who have been sexually abused as children are more likely to engage in unprotected sex, have multiple partners, and trade sex for money or drugs (Heise, Ellsberg et al. 1999). This relationship is also apparent from the results of a study conducted in India in which men who had experienced extramarital sex were 6.2 times more likely to report wife abuse than those who had not. In addition, men who reported symptoms of sexually transmitted infections were 2.4 times more likely to abuse their wives than those who did not (Martin, Kilgallen et al. 1999).

➡ The experience of violence has also been found to be a

strong predictor of HIV. In a study conducted in Tanzania among women who sought services in a VCT clinic, the odds of reporting violence was ten times higher among HIV-positive young women than similarly aged HIV-negative women (Maman, Mbwambo et al. 2002).

➡ **Access to Services:** Sociocultural norms that define male and female roles and responsibilities also affect women's and men's access to and use of health services, including HIV/AIDS services. In countries in which 'son preference' is the norm, in times of scarcity, families allocate resources for men and boys first and women and girls later or not at all. For example, in Pakistan, lower income households seek health care more often for boys than girls and are more likely to use higher-quality providers for boys (Alderman and Gertler 1997). Women themselves continue this pattern because of being socialized to sacrifice their own interests. They often put the health of their children and families first and do not seek medical attention until they are seriously ill (Buvinic and Yudelman 1989).

➡ In some regions of the world, women are further constrained from using services because of gender norms surrounding their mobility. Practices such as *purdah*, common in Islamic and Hindu societies, where women are confined to their homes, prevent women from travelling to use services. Such practices also demand that health care services employ women care-givers, and provide the privacy, modesty, and seclusion necessary for women to feel comfortable to use the service (Mehra, Bruns et al. 1992). For example, many women feel uncomfortable interacting with male health care providers or being forced to expose themselves in semi-public wards (Auerbach 1982). Moreover, services often lack characteristics that women find essential, such as emotional support.

➡ The barriers that men face in using services are often related to sociocultural norms that ascribe reproductive responsibilities entirely to women and shut men out of parenting or nurturing roles. For example: family planning, prenatal, and child health clinics are typically not designed to reach men or meet men's needs. Because, in many countries, HIV/AIDS information and services are provided primarily in such clinics, men are less likely to benefit from those services and are thus less likely to be fully informed about HIV/AIDS prevention, care and support, and treatment options

(Mane and Aggleton 2001; UNAIDS 2001). This has significant implications for men's ability to protect themselves from infection and cope with the epidemic.

3.3 ECONOMIC FACTORS: POVERTY AND DEPENDENCY

➡ Poverty and economic dependency greatly increase both women's and men's vulnerability in the HIV/AIDS epidemic. Overall, economic growth has noticeably decreased the numbers of individuals living in absolute poverty worldwide. Women's economic status has also shown significant improvements over the last decade. The gender gap in education is significantly lower and there are more women earning an income today than ever before. Yet, it is also true that the majority of these women are in insecure jobs in the informal sector and those that are employed in the formal sector continue to earn less than men (UNIFEM 2000). Within certain countries, there are also sharp differences between women based on ethnicity, race, and socioeconomic status. Labor market challenges such as unemployment, wage gaps, and occupational segregation are greater for poor women of color and of indigenous descent (Inter-American Development Bank 1998).

➡ A review of women's economic status is important in order to assess their vulnerability to HIV because we have strong evidence to establish a direct link between women's low economic status and their vulnerability and exposure to HIV. Research from the U.S. shows women who have lower incomes and less than a high school diploma were less likely than higher income women who had a high school diploma to use condoms (Pearson, Grinstead et al. 1992; Anderson, Brackbill et al. 1996). Other ways in which women's economic status affects their vulnerability in the HIV/AIDS epidemic are described below.

➡ **Sex as a Marketable Commodity:** Studies from across the developing world indicate that poverty is overwhelmingly the root cause of women bartering sex for economic gain or survival (Weiss, Whelan et al. 2000). When sex 'buys' food, shelter, or safety, it is very difficult to follow prevention messages that call for a reduction in the number of sexual partners. Although commercial sex work is the most well-known way for women to exchange sex for money, there is a range of other types of

'transactional' sexual partnerships that women use as a rational means to make ends meet. For example, in Haiti, faced with trying to balance the multiple demands of family and economic survival, single mothers often enter into a series of sexual relationships, called *plasaj*, in order to obtain food and housing for themselves and their children. Alarmingly, research has shown that women in this setting who entered a sexual relationship out of economic necessity had increased odds of having syphilis and HIV infection (Fitzgerald, Behets et al. 2000).

➡ **Lack of Economic Leverage:** Women who are economically vulnerable are less able to negotiate the use of a condom or fidelity with a non-monogamous male partner and less likely to leave relationships that they perceive to be risky because they lack bargaining power and fear abandonment and destitution (Mane, Rao Gupta et al. 1994; Heise and Elias 1995; Weiss and Rao Gupta 1998). There are data to show that women in high-risk relationships perceive the short-term costs of leaving the relationship much higher than the potential long-term health costs.

➡ **Lack of Access to Information:** Women and men who are economically disadvantaged are less likely to have information about HIV/AIDS than those from higher income levels, and are therefore more vulnerable to infection. A recent analysis showed that knowledge of HIV/AIDS prevention is distinctly higher among the better-off than among the economically disadvantaged in almost every country with available data (Gwatkin and Deveshwar-Bahl 2001). It is important to note that the analysis showed that the gender gap in knowledge (which favours men) persists at all income levels.

➡ **Impact of Migration:** Poverty and the lack of economic opportunity make it more likely that both women and men will migrate in search of income and employment, which can disrupt stable social and familial relationships and expose both men and women to increased risk of infection. Moreover, in most settings, migrant populations are more likely to be socially marginalized, with restricted access to economic assets, information, and services (UNAIDS 1999).

➡ Research from Africa has shown that rural-to-urban migration of men leads them to form new sexual networks in areas where an unequal ratio of men to women and a higher seroprevalence rate is likely to make them more vulnerable to

infection (Bassett and Mhloyi 1991; Sanders and Sambo 1991). When men are engaged in seasonal migration for work, and often return home to their community of origin, the vulnerability of their female partners who are left behind is significant. The situation is often further exacerbated by the fact that wives and other long-term sexual partners of migratory workers find it extremely difficult to insist on the use of condoms when their men have been away for so long working hard to send money home. Migratory women workers face similar risks. Being away from home makes it likely that they will establish new sexual networks or engage in multiple partnerships for economic gain or security.

➡ **Impact of Ethnicity, Caste, and Race:** Gender intersects with ethnicity, caste, and race to create multiple vulnerabilities for those who belong to marginalized ethnic, caste, and racial minorities, who have borne a long history of discrimination and disadvantage. In almost every region of the world, there are large gaps in terms of schooling and employment between those who belong to racial, caste, and ethnic minorities and those who do not. Ethnic, caste, and racial minorities are also disproportionately represented among the poor in every region of the world.

➡ With less economic opportunity and hope, individuals from minority or disadvantaged groups are more likely to resort to risky behaviour such as injecting drug use or exchanging sex as a means of survival. Socially and economically marginalized populations also typically have less access to health information and services, increasing their vulnerability of contracting illness and reducing the chances that their illnesses will get adequately treated. Unfortunately, HIV prevalence rates among minorities are usually politically sensitive data and as a result very few countries disaggregate such data by race, caste, or ethnicity.

➡ **Coping with the Socioeconomic Impacts of the Epidemic:** Gender also affects the way in which women and men are affected by the economic impacts of the epidemic. Research has shown that women are generally more vulnerable to the consequences of AIDS morbidity and mortality, whether they themselves are HIV-positive, or they are living with and caring for others who are HIV-positive within the family, or both – a situation whose prevalence is on the rise. Because women are more likely to wait longer periods of time before seeking services and treatments during the course of an illness, they are more

likely to be at an advanced stage of HIV infection and present related opportunistic infections before they actually seek out treatment and services. Thus, they are far less likely to take advantage of whatever treatments are available. They are also more likely than men to serve as the primary caretakers of others who are infected and to remain silent about their own health problems when other family members are in need of caring – whether ill or not. From data in high prevalence settings in Africa it is known that the combined physical and emotional burdens of caring for sick family members and ensuring their food security under harsh economic conditions often takes a toll on women's own health and well-being (Danziger 1994).

➡ The economic vulnerability of women also exposes them to graver consequences when faced with the stigma and discrimination typically associated with being infected or affected by HIV/AIDS. When faced with the social ostracism and abandonment that often result, women frequently face tragic consequences because they lack the necessary economic resources to cope (Nyblade and Field-Nguer 2000).

➡ **Access to and Use of Services:** Economic factors also affect women's access to and use of services. Economic constraints such as the lack of money to pay for services or transportation, or the high opportunity costs of lost time, create significant barriers for women's use of health services (Leslie and Rao Gupta 1989; Moses, Manji et al. 1992).

➡ The larger workloads of women who live in poverty or in low-income settings make it more difficult for them to take the time to access services. Worldwide, women spend between 10 and 16 hours a day doing housework, collecting water and firewood, caring for children, and producing their family's food (Buvinic and Yudelman 1989). This daily burden of work is significantly larger than men's. For example, African women perform about 90% of the work of hoeing, weeding, processing food, and providing water and firewood, 80% of food storage and transport and 60% of harvesting and marketing (World Bank 1989). Taking time to use services is particularly difficult for rural women because they also have to take time to travel to urban areas or village centers where services are located.

➡ Women's economic vulnerability further constrains their time. Women are concentrated in more insecure jobs with longer hours, poorer pay, and little or no benefits (United

Nations 2000). These long hours are added to women's already large burden of domestic work, leaving less time in the day to use health services. Additionally, in such jobs women have little control over the hours or conditions of work, making it difficult to take time off. Further, smaller incomes make the cost of services more prohibitive for women and the insecure and small, but critical income make the opportunity cost of missing work larger for women. Thus, reducing waiting times in clinics and ensuring that the timings during which services are provided are convenient for women's work schedules are key to increasing their access to those services.

➡ In families where income and resources are pooled from multiple individuals, women are still at a disadvantage in accessing funds for health services because families typically allocate resources for men and boys first and women and girls later or not at all (Buvinic and Yudelman 1989; International Center for Research on Women 1989). As a result of these factors, the formidable cost of HIV/AIDS treatments in most developing countries are more likely to constrain women's access than that of men.

➡ Experience of providing free and universal access to antiretroviral therapy for treatment of HIV/AIDS in Brazil, shows that even when services are free there are noticeable gender differences in the seeking and use of services. One of the challenges that remains in Brazil's treatment programme is that, despite a large network of anonymous voluntary counselling and testing units throughout the country, women are not being diagnosed until the late stages of infection (Bastos, Kerrigan et al. 2001; Luppi, Eluf-Neto et al. 2001). One of the explanations offered is that for women, testing is offered in prenatal clinics, even though many poor women do not typically use prenatal care until late in their pregnancy (Bastos, Kerrigan et al. 2001). Another possible explanation is that women do not perceive themselves to be at risk of HIV and therefore do not seek testing. Other data suggest that women's lack of use of services could also be the result of the discrimination they face at the hand of health workers, who treat them as if they were prostitutes or injecting drug users (Ventura-Felipe, Bugamelli et al. 2000).

➡ In summary, gender-related factors increase women's economic vulnerability and dependency, which in turn increases their vulnerability to being infected, restricts their access to much-needed information and services, and

exposes them to severe consequences when infected or affected by HIV/AIDS. For men, gender-related norms and economic need force them to migrate without their families in search of work, creating situations that foster multiple sexual relationships that may lead to HIV infection. Overall, poverty greatly exacerbates both women's and men's vulnerability by restricting access to information and services and making it more difficult to cope with the impact of the epidemic.

3.4 THE SPECIAL VULNERABILITIES OF ADOLESCENTS AND YOUTH

➡ This section presents the ways in which gender plays a particularly significant role in the experience of adolescents in the HIV/AIDS epidemic and affects their sexual risk and vulnerability. Because age intersects with gender in determining the distribution of power in any society, younger members of a society, typically, have less power than older individuals and younger women or girls have less power than younger men or boys.

➡ Moreover, the power imbalance characteristic of gender relations among women and men – within and outside relationships – has many of its roots in adolescence. At the same time, in most societies adolescents are no longer fully under the protection and guidance of their adult parents, yet, they are also not endowed and entrusted with the rights and responsibilities of adult men and women. As they enter a new world of social relationships, young people face the challenge of reconciling cultural and family-based expectations and norms of behaviour with their own emerging sexual feelings and desires (Weiss, Whelan et al. 2000). When the challenges of adolescence occur concurrently with emerging gender-related norms and expectations, a set of special vulnerabilities arise for youth – vulnerabilities that are especially salient for the design and implementation of youth-oriented HIV/AIDS policies and programmes.

➡ Most statistics on adolescent sexual health tend to focus solely on age of sexual initiation, the incidence of sexually transmitted infections (STIs), and the health, social and economic consequences of early motherhood. What these statistics do not reveal is the context in which risk behaviour takes place, including the factors that contribute to early sexual initiation and unprotected sex, and how these factors differ for

young males and females (Weiss, Whelan et al. 2000).

➡ Among the most important factors are gender differences in socialization of young people. Early in adolescent life, roles are assigned to boys and girls in matters regarding freedom of mobility, time use, types of education, and decision-making responsibilities within the home (Weiss, Whelan et al. 2000). This includes the early assignment of sexual 'privileges' for young men, including those that introduce and subsequently reinforce the idea that sex is a male 'necessity'. In contrast, a set of sexual 'responsibilities' are assigned to young women, including the maintenance of virginity, responsibility for birth control, or exhortations that passivity and ignorance about sex is the best 'protection' a girl can have from sexual interactions.

➡ Although delayed sexual debut is a legitimate core element of many HIV prevention efforts for adolescents, it is important to note that the severe negative social sanctions associated with the loss of virginity, paradoxically, increase young women's risk of infection in many ways. It restricts young unmarried women's ability to ask for information about sex or reproductive health out of fear that they will be thought to be sexually active. Also, in cultures where virginity is highly valued, some young women practice alternative sexual behaviours, such as anal sex, in order to preserve their virginity, regardless of the fact that these behaviors may place them at increased risk of HIV (Weiss, Whelan et al. 2000). Particularly strong norms that reify virginity and a culture of silence about sex makes accessing treatment services for sexually transmitted diseases highly stigmatizing for adolescent and adult women (de Bruyn, Jackson et al. 1995; Weiss, Whelan et al. 2000).

➡ Recent data on the norm of virginity notes a shift in young people's attitudes toward premarital sex. Studies on the attitudes and behaviors of adolescents found that there is a 'rupture in the salience of virginity' as a normative ideal for adolescent girls (Dowsett, Aggleton et al. 1998). The researchers attribute this change to an increasing sexual assertiveness by young women and the acceptance by some young men of more equitable gender roles for women. It is notable, however, that these changes have not created a dent in other attitudes about gender roles, such as women's 'natural' inclination to get married and have children, and men's 'natural' need to be sexually assertive.

➡ Data also indicate that despite the norm of virginity, young women and men are having sex prior to marriage and early in their teens. The percentage of adolescent girls who have had sex before the age of 18 years varies greatly between countries, ranging from 66% in Ghana to 20% in Mexico (Alan Guttmacher Institute 1998; PAHO, WHO et al. 2001).

➡ Young people's risk of infection is also greatly affected by their lack of economic options. Frustrated youth with few economic opportunities are more likely to engage in a range of risk behaviours, such as using drugs and engaging in unprotected sex in exchange for gifts, money, or favours (Mathur, Malhotra et al. 2001). A notable trend is the number of young women who are having sex with older men for money, material goods, or gifts (Rao Gupta and Weiss 1993; National AIDS Programmes of Trinidad and Tobago 1995; Zelaya, Marín et al. 1997). This is a troubling trend because older men are likely to have had more previous sex partners and therefore are more likely to have been exposed to HIV or other sexually transmitted infections.

➡ While the lack of economic opportunities increases the risk of transmission of HIV, the converse is also true. AIDS fuels youth's lack of economic opportunities because of the overall economic impact of the epidemic in weakening local economies. Yet, often, youth's need for economic options is greatest in the epidemic. When parents or other family members become ill or die, adolescents become providers and even heads of households, forced to take on the economic responsibility for themselves and their families.

➡ Increasingly, programmes have attempted to respond to this situation by creating 'linked' services that attempt to meet both the reproductive health and livelihood needs of young people. Such programmes have clearly emerged in response to community need and frequently adopt innovative and creative strategies to serve youth's needs (Esim, Malhotra et al. 2001). However, these linked programmes face formidable challenges. Currently, there are no 'model' programmes and optimal methods for 'linking' in a way that provides additional value are still unclear (Esim, Malhotra et al. 2001).

➡ As this section underscores, adolescence is a particularly vulnerable time. But it is equally true that the adolescent years provide a window of opportunity to bring about changes in levels of knowledge, attitudes and behaviours before they are fully formed. In order

for HIV/AIDS interventions to use this window of opportunity to reduce young people's vulnerability to HIV and address their needs within this epidemic, it is critical not only to ensure that boys and girls get accurate information and skills but that interventions also help them develop more equitable and respectful gender norms of behaviour.

4. INTEGRATING GENDER INTO HIV/AIDS PROGRAMMING AND POLICIES

Gender norms that pressure women and men to adhere to dominant ideals of femininity and masculinity and restrict women's access to economic resources fuel the spread of HIV/AIDS and negatively affect individuals' experience when infected or affected by the disease. By curtailing women's sexual rights and autonomy, encouraging irresponsible and risky sexual behaviour among men, restricting women's access to and use of economic resources and fostering homophobia, gender norms have contributed to creating a culture of silence and shame that surrounds sexuality and an unequal balance of power between women and men. Together these pose a significant challenge for policies and programmes that seek to contain the spread of the HIV/AIDS epidemic.

➡ To meet this challenge, WHO is committed to integrating gender considerations into all HIV/AIDS programming. This is in keeping with WHO's overall goal of integrating gender into all aspects of its broad mandate to assure health for all (World Health Organization 2002). This goal includes analyzing and addressing gender issues in planning, implementation, monitoring and evaluation of policies, programmes, projects and research. WHO recognizes that integrating gender considerations is essential for:

- Increasing coverage, effectiveness and efficiency of interventions;
- The promotion of equity and equality between women and men, throughout the life course, and ensuring that interventions do not promote inequitable gender roles and relations;
- The provision of qualitative and quantitative information on the influence of gender on health and health care; and
- Supporting Member States in undertaking gender-responsive planning, implementation and evaluation of policies programmes, and projects.

➡ Gender integration in HIV/AIDS programming, as in all development programming, has two aspects:

- technical/substantive; and
- structural.

The technical/substantive aspect of gender integration refers to the specific approaches or strategies used to address gender differences and constraints in HIV/AIDS programmes and policies. But these technical approaches are unlikely to be adopted without attention to the structural aspects of gender integration; to fully integrate a gender perspective into all programming within an institution requires institutional systems, processes, and structures that routinely, continuously, and comprehensively identify and respond appropriately to the different ways in which gender affects programming (**see Box 1**). The different technical and structural approaches to integrating gender in HIV/AIDS programming within institutions are described in the sections below.

4.1 TECHNICAL APPROACHES FOR GENDER INTEGRATION

➡ The HIV/AIDS epidemic is highly complex in its reach and impact. These complexities are magnified when we examine them through the lens of gender. A conceptual framework that sorts through the different types of gendered responses to the epidemic and differentiates one approach from the other can greatly facilitate the development of guidelines to assist programme managers and policy makers to integrate gender in HIV/AIDS programming.

➡ Existing approaches to address gender in HIV/AIDS programming fall along a continuum from 'harmful' (i.e., making discriminatory distinctions between men and women that actually negate any real or potential programme successes) to 'empowering' (i.e., fostering the ability of men and women to become free of gender-related constraints and power imbalances, and improving women's capabilities to organize, make choices and decisions, take positions of leadership, and shape their own destinies). While this continuum may in many cases seem 'linear', some interventions may be successfully gender-integrative in one aspect, yet more harmful in another. It is therefore important to consider the full range of activities in each intervention and assess them in terms of the following levels.

4.1.1 'DO NO HARM'

➡ The most basic and fundamental aspect of a gendered set of policies and programmes requires the elimination of those assumptions, suppositions and stereotypes that are damaging

Box 1: Is Schooling A Risk?

A recent study carried out in a government-run, co-educational secondary boarding school in Kampala, Uganda demonstrated that even a well-designed and implemented HIV/AIDS education programme can be thwarted by the overall gender-discriminatory environment within which the programme is conducted. This evidence was corroborated by data collected from 21 other schools around the country.

The main finding of the study showed the school to be a site of an extensive set of gendered practices, which constituted a risk in themselves in terms of sexual health. In particular, four patterns or forms of 'control' emerged from the study: hegemonic masculinity; gendered discipline patterns, sexual harassment, and 'compulsory''heterosexuality.

In the first instance, the AIDS education curriculum addresses the power disparities between male and female but the mechanisms used to gain power within the school – defining 'leadership' as a male preserve, for example – compromises that part of the curriculum that seeks to change gender norms.

In terms of gendered discipline patterns, school officials defined differential levels of discipline for boys and girls, for example, by reinforcing the idea of girls as 'victims' – where rules and regulations for them were designed 'for their safety'. Thus girls were more 'policed' than boys, including treating girls as if they might 'tempt' boys sexually. Girls were urged thus to be 'obedient' in a manner not required of boys. These practices negated parts of the curriculum designed to encourage boys and girls to 'question' gender role stereotypes as a means of empowerment.

Sexual harassment in this environment meant that boys controlled the language space and physical space of the girls, forcing them into silence. Harassment of the girls ranged from having to put up with verbal slights and insults to actual physical abuse – even adult female teachers experienced verbal abuse from boys in their classes.

In Uganda, social and sexual interaction within a co-educational setting is the norm – students do not self-segregate. In some cases, there were reports by girls of 'forced relationships', that they conformed in order to 'be safe' despite their dislike of the situation. The boys were pressured by their peers to take on girlfriends, lest they be teased. Boys were also expected to 'prove' themselves and often dared to 'do something' with a girl. Failure to conform can lead to disciplinary measures by peers.

All these findings suggest that even well-designed, 'Best Practice' school-based prevention programmes for youth may fail if the gendered environmental context is not taken into account.

Source: (Mirembe and Davies 2001).

to women's and men's ability to benefit from interventions and policy responses to HIV/AIDS.

➡ Programming sometimes provides women and men the same interventions when their needs are different and/or provides women and men different interventions when their needs are the same. The most important lesson for doing no harm is that in order to be gender sensitive health programmes must offer different services for women as compared to men when their needs differ but must ensure that services do not treat women and men differently when their needs are the same. This does not mean that supporting programmes for women exclusively when it is appropriate to do so must present a 'trade-off' that excludes the necessity of programming exclusively for men.

➡ Many of our past, and unfortunately, current HIV prevention efforts have fostered violent, predatory and irresponsible images of male sexuality, while at the same time portraying women as powerless and passive 'victims' of male power and domination. In addition, women are often seen as 'repositories' of infection and disease, responsible for bringing illness and death into their households and communities. Particularly vivid examples of these stereotypes are prevention efforts that portray sex workers as harbingers of death, and condom promotion efforts that employ macho stereotypes of male virility in order to promote condom sales. Although such efforts may result in short-term gains through, for example, an increase in condom sales, in the long-term they erode the very foundations upon which HIV prevention activities are based, namely responsible, respectful, consensual, and mutually satisfying sexual partnerships.

➡ Another common mistake made in HIV/AIDS programming that seeks to be gender-sensitive is when women and men are provided different interventions or information based on stereotypes of women's and men's roles when, in fact, their needs and responsibilities are the same. A common example is when basic information about the prevention of perinatal transmission of HIV is provided only to women, with the assumption that it is women who are mothers and must therefore be the only ones informed about ways to prevent MTCT of infection. This has many harmful outcomes. First, it undermines any efforts to encourage parenting as the responsibility of both mother and father. Second, it makes it more likely that men will block their female partner's use of MTCT prevention services

because they are not fully informed about the value of the intervention. Third, it reinforces the stereotype of women as 'vectors of disease'. Finally, it contributes to the social (and sometimes physical) harm that women experience as a result of being the 'first' to 'take home' an HIV-positive test result. Thus, providing women and men with different interventions and information when their needs and responsibilities are the same is just as deleterious as providing women and men with the same interventions when their needs and constraints are different.

➡ In order to avoid doing harm or further reinforcing the very norms that a gendered response to HIV/AIDS must change, it is important to design interventions based on data on women's and men's lives in a particular community or setting, rather than presuming to know the reality based on stereotypical notions of gender roles. **Box 1** provides an example of how an overlooked contextual aspect of an intervention can totally negate any gains made in the intervention, and ultimately can destroy an intervention's credibility entirely.

➡ Data on the inequalities and injustices that women face can sometimes lead to another harmful practice that could undermine the ultimate success of HIV/AIDS efforts. Blaming men for perpetuating injustices against women is not a productive way to resolve the unequal balance of power in gender relations. Such an approach runs the risk of shutting men out of the process of finding feasible solutions and significantly constrains the ability of programmes to work with women and men as equal partners in promoting reproductive and sexual health. Statements that see men as the major or sole problem to deal with in HIV/AIDS programmes run the additional risk of oversimplifying social, economic and political structures. They fail to acknowledge that gender, class, race, sexuality and age (among other factors) oppress men as well as women – albeit in different ways and with different consequences (Mane and Aggleton 2001).

➡ Although the idea that policies and programmes must do no harm may seem like second nature to those working at the programme and field levels, it may be the most pervasive shortcoming of many existing programmes. More comprehensive efforts cannot succeed unless HIV/AIDS programming first and foremost does no harm. It is important to remember, however, that the elimination of damaging assumptions and stereotypes about women and men does not constitute

the only way to respond to gender considerations in programming. Although necessary, 'doing no harm' is only the first step along a continuum.

4.1.2 'GENDER-SENSITIVE' PROGRAMMES

➡ A second approach recognizes that the prevention, care, treatment and support needs of men and women are often different, not only because of their distinct physiology, but more importantly, because the context of gender roles and relations substantially influences how women and men will respond to initiatives designed to reduce risk or vulnerability or to alleviate the impact of AIDS.

➡ Programmes that foster the development of female-controlled prevention technologies are one example of this type of programming. Another example would be educational messages about prevention that recognize the unequal power balance between men and women that is prevalent in all contexts and settings. Programmes that recognize the unique vulnerabilities that men face – such as the *Healthy Highways Project* in India – represent another important and often overlooked aspect of gender-sensitive programming. In this case, the project seeks to lower the risk and vulnerability to HIV infection of truck drivers, their young crew members, and their paid sexual partners (**see Box 2**). Another example of this type of programming is the integration of STI diagnosis and treatment interventions into family planning clinics to help women access such services without fear of social censure. Providing women with a female condom or advocating for the development of microbicides are other examples of gender-sensitive interventions. Such efforts recognize that the male condom is a male controlled technology and take account of the imbalance in power in sexual interactions that makes it difficult for women to negotiate condom use, by providing them with (or advocating for) an alternative – a woman controlled prevention technology.

➡ An adaptation of the traditional model of prevention of MTCT is another example of a gender sensitive approach. The traditional MTCT prevention package consists of voluntary counselling and testing of pregnant women, the provision of antiretrovirals for pregnant women who are infected in order to protect the unborn child from infection, and the provision of breast milk substitutes to reduce the risk of infection to the baby once it is born. This standard protocol treats the woman as merely a carrier

Box 2: Addressing Male Vulnerability in India

The Healthy Highways Project *was planned and implemented by the Department for International Development, UK (DFID) and the Government of India's National AIDS Control Programme (NACO). The project aims to reduce the number of new HIV infections among inter-city truck drivers, their crew and paid sexual partners. Two regional units manage the work, which has been mainly implemented through more than 30 NGOs, 18 transport companies and a number of transport-related associations.*

In 1999, estimates suggested that almost 3.5 million people in India had become infected with HIV. Although there have been no studies to determine seroprevalence among truck drivers, there have been alarming increases in HIV infection among antenatal women in the areas where high concentrations of truck drivers live. There are up to five million truck drivers in India, and behavioural surveys show that 75% of truck drivers report extramarital sex, mostly with sex workers (among whom HIV infection is up to 60% in the worst affected areas). Truck driving involves long periods of separation from spouses and families, dangerous and exhausting work, and relatively high earnings. Commercial sex partners are usually extremely poor and are mobile rather than brothel-based, making them difficult to reach with HIV prevention messages and technologies. Since condoms are usually associated with family planning, this type of 'recreational sex' is usually unprotected.

The Healthy Highways Project *offers STI care and counselling, condom promotion and distribution, dissemination of educational materials and face-to-face behaviour change communication. While the mobility of drivers made conventional peer education impractical, training has been given to some who come into close contact with truckers, including petrol attendants, tobacco retailers and tea-shop owners. Beyond the 3.5 million men who have been reached through the project's activities, work has taken place with more than 33,000 sex workers, more than 2,000 of whom have been treated for STIs.*

Men have reacted positively, welcoming services and expressing eagerness to obtain more information. The NGOs working with the men have established excellent networks and links with gatekeepers, but have not always had prior experience working specifically with men.

This should be kept in mind in any attempts to replicate this kind of intervention elsewhere.

Source: (UNAIDS 2001).

or vessel for the baby, giving no importance at all to the baby's need for its own mother or the woman's own right to treatment, care, and support. Cost considerations, among other factors, are cited as the reason for not including antiretrovirals for the infected mothers as part of this traditional regimen. Increasingly, however, programmers are including treatment for opportunistic infections, care, and support for the infected mother as additional elements to the standard regimen, to help the mother through the pregnancy and to maintain her health and well-being, not just that of the baby (**see Box 3**). Such an adaptation responds to women's needs and treats them as equally important as those of the child.

➡ The bulk of HIV/AIDS programmes that have successfully addressed gender have done so by acknowledging gender differences and designing services to meet the different needs of women and men. Although effective, it is important to remember that gender-sensitive programmes do very little to change those conditions that create gender-related barriers in the first place. If we are to think in terms of a long-term set of goals for the creation of successful and sustainable HIV/AIDS programmes, we must recognize that gender-sensitive interventions, while critically important for meeting the needs of women and men in the epidemic, cannot be the 'end of the line'.

4.1.3 'TRANSFORMATIVE' INTERVENTIONS

➡ Programmes that seek to transform gender roles and create more gender-equitable relationships are more advanced than gender-sensitive approaches because they seek to change the underlying conditions that cause gender inequities. They also transform HIV/AIDS initiatives by reaching both women and men and recognizing both as critical players in ensuring the effectiveness of HIV/AIDS programming.

➡ Transformative interventions use a variety of methods to work with men and women to facilitate an examination of gender and sexuality and its impact on male and female sexual health and relationships, as well as to reduce gender-related violence against women. One example is *Stepping Stones*, a well-known life skills training programme that uses transformative methods to address HIV/AIDS as well as broader community issues (**see Box 4**). Through a curriculum that includes group participation, ways to change, and examination of why people behave the way they do, participants are

Box 3: MTCT Interventions

While prevention of MTCT has advanced significantly in recent years, care and support services for HIV-infected women have not moved forward with sufficient emphasis, despite the burden of HIV disease borne by women of reproductive age. Programmes for prevention of HIV infection in infants and young children (MTCT prevention) allow identification of HIV-infected women and delivery of short course antiretrovirals and other interventions to prevent HIV transmission to infants. They also offer an opportunity to provide care and support to HIV-infected women, children and their families. For the large part, MTCT prevention programmes have tended to focus only on children, offering very limited direct benefit to HIV-infected women.

There is increased recognition and increased attention of the need for interventions for women who are identified as HIV-positive through such programmes. In particular, recent treatment breakthroughs and their application in resource-constrained countries have led to demand for expanded care and support interventions that can benefit the health of the women themselves during and after pregnancy, as well as the health of their children and families.

We must face many challenges in ensuring care of HIV-infected women identified through MTCT prevention and other service. The complex interactions between HIV prevention and care, treatment and support interventions point to shortcomings inherent in offering a single intervention, such as ARV drugs alone, to HIV-infected women. To date, however, there is very little normative and strategic guidance on the comprehensive HIV-related care, treatment and support needed by women in resource-constrained settings.

Some progress has been made that will require continued advocacy and support. Advances have been made in highly active antiretroviral therapy (HAART) with simpler regimens and lower prices. The World Health Organization and its collaborative partners are developing guidance on a comprehensive approach to HIV-related care, treatment and support of HIV-infected women and their children in the context of Reproductive Health and Maternal and Child Health Services in resource-constrained settings. This guide will assist policy-makers and programme managers of HIV/AIDS and reproductive health programmes. The manual will present a menu of key interventions that includes medical, nutritional, and psychosocial interventions, based on an inventory of existing recommendations, a review of evidence, and experience of what works in different settings. It will also provide related norms and standards, highlight information gaps and establish research priorities. Several countries are proposing programmes for extending MTCT prevention efforts to care and support for women, to improve their own survival. Health workers are encouraged to recognize the needs of HIV-infected women and refer HIV-infected mothers and infants for related services, as available.Timely and adequate referring not only includes relevant care and medical services, but fostering of partnerships between maternal and health care programmes and social, psychological, legal, and community based support systems.

Box 4: The Challenges and Opportunities of Changing Gender Norms: The Stepping Stones Curriculum

Stepping Stones *is a life skills training package that encourages participants to find their lives, and those of others, worthwhile enough to look after themselves and each other. The original* Stepping Stones *package was designed as 18 sessions over 3-4 months, for at least four parallel groups of older and younger women and men, meeting simultaneously. Sessions were grouped around four main themes:*

- *group cooperation;*
- *why we behave in the ways we do;*
- *HIV and safer sex; and*
- *ways in which we can change.*

During workshop sessions, participants explore the range of factors that determine the quality of their lives and discuss their hopes and fears. Through this process, participants are encouraged to take control and responsibility for their own lives and form a strong bond by recognizing the equal value and contribution of each part of the community. It is on this basis that behaviour change – not only for HIV prevention, but a wide range of other community development issues–can begin to take place.

Experience has shown that Stepping Stones *requires time, good training, skilled facilitation, care, negotiation, prolonged follow-up and more time. A wide range of factors can prevent the successful transfer of* Stepping Stones *from one context to another. Strategies to promote its success include:*

- *Ensuring high quality implementation.*
- *Promoting regular attendance.*
- *Reducing barriers to attendance for poor men.*
- *Bringing peer groups together.*
- *Meeting special requests.*
- *Challenging gender and age norms.*
- *Working with issues of difference within the community.*
- *Including ongoing participatory monitoring.*

Ongoing challenges – and potential programmes failures – include familiar concerns about condoms among participants and non-participants, in addition to objections about the 'open' discussion of sexuality and family planning, particularly with young, unmarried people. However, the most important obstacle is achieving sustainability. As Baron Oron from Uganda stated, "[when follow up is lacking, and the community expects it] it leaves a gap and may destroy all that has been created".

Source: (Gordon and Welbourn 2001).

encouraged to take responsibility for themselves and others to promote safer, more productive, behaviour in the future. What is novel about projects like *Stepping Stones* in particular is that they actively target men for something other than promoting condom use or generic 'safer sex' messages. These projects foster an environment that works with both men and women to redefine gender norms and encourage healthy sexuality.

➡ Programmes such as these have grown out of a belief that the dominant form of masculinity can be changed and replaced with more gender equitable models of malehood. Research conducted by Gary Barker (2000) in Brazil and by others was influential in establishing that alternative, more equitable masculinities do exist (Necchi and Schufer 1998; Yon, Jimenez et al. 1998). Each of these studies identified young men who showed some degree of gender equity in their intimate and sexual interactions with young women. Barker (2000) went a step further and also identified the factors associated with gender equitable attitudes among the young men who were different. The key factors he isolated include acknowledgement of the costs of traditional masculinities to their own health and well being, access to adults who do not conform to traditional gender roles, rejection of domestic violence within their families, and the presence of a gender equitable male peer group.

➡ In addition to *Stepping Stones*, examples of other programmes that seek to foster constructive roles for men in gender relations are the *Men as Partners* (MAP) programme in South Africa; the interventions that target young men, men in prisons, and a wide range of professional and working class men, designed and implemented by *Salud y Genero*, a small nongovernmental organization based in Mexico; and *Project Papai* in Recife, Brazil that targets young men on themes related to fatherhood.

➡ Transformative approaches with youth attempt to shift the gender-power imbalance during a time when many patterns of adult behaviors are being formed. Some initiatives, such as the *Mid-Peninsula AIDS Prevention Programme* (**see Box 5**) have been piloted or field tested with promising initial results. This transformative approach was used in a school-based prevention programme on HIV for youth in California. The intent of the programme was to encourage youth to examine and challenge culturally prescribed expectations and norms that lead to behaviours that foster risk of HIV infection.

Box 5: Challenging "Sexual Scripts" with Youth in California, USA

The Mid-Peninsula AIDS Prevention Programme*, a project supported by the* Center for AIDS Prevention Studies *(CAPS) in San Francisco, recently tested an innovative school-based programme with more than 500 racially-diverse ninth graders (average age = 14 years). The programme educated youth on HIV and its transmission and worked to empower youth by teaching them to think critically about 'sexuality scripts' (sets of ideas and norms that prescribe ways of thinking and acting in terms of sex and sexuality) and how enacting these scripts can result in self-damaging behaviour. Many of these scripts prevent the empowerment of young women, and disempower young men in ways that they are not consciously aware of but which they assume to be normal and natural. Students participated in the programme for one hour each day for a week. Activities included an interactive game on HIV facts, discussions of how sexual scripts affect experiences and expectations in sexual and romantic relationships, and brain-storming about strategies to resist internalization of such scripts in sex-specific groups.*

In an evaluation, researchers found that knowledge on HIV and STDs had increased significantly after the programme, but they were unable to demonstrate significant change in sexual behaviour. This lack of significant behaviour change was partially due to the low level of risk behaviour at baseline and the relative short time period of three months from baseline to evaluation. However, there was some change for sexually inactive girls; more of those in the study group delayed sex compared to those in the control group. Additionally, the evaluation demonstrated that the approach could have significant behavioural impacts in future. In the baseline study, there was a strong correlation between risky sexual behaviours with stereotypical beliefs about sex and gender, especially for boys. After the programme, the majority of participants said that the workshop helped them become more aware of gender pressures and better able to protect themselves from HIV and pressure to have sex.

Source: (Somera and Laub 1998).

➡ Other programmes that seek to transform gender relations include efforts to work with couples as the unit of intervention, rather than with individual men and women. Couple counselling in HIV testing clinics to help couples deal with the results of their tests and in family planning programmes to promote dual-protection against both unwanted pregnancy and infection are recent examples of efforts that seek to reduce the negative impacts of the gender power imbalance by including both partners in the intervention. The challenge these programmes face is not being able to recruit couples who are willing to participate. Although many couples who do participate describe couple counselling as a positive experience, so far the numbers who participate have remained low (Becker 1996). Further research is needed to identify ways to overcome barriers to couple counselling and to test the effectiveness of this method in creating more gender-equitable relationships between women and men.

4.1.4 INTERVENTIONS THAT EMPOWER

➡ At the other end of the continuum from damaging policies and programmes are those that empower women and girls. These types of interventions seek to equalize the balance of power between women and men in order to reduce their vulnerability in the epidemic. Interventions that see empowerment as an end goal also tend to treat HIV/AIDS within a larger context of social and economic development. Once example of this is a project carried out in Sonagachi, a red-light district in Calcutta, India. Initially designed as an intervention to reduce the level of STDs and increase condom use among sex workers, the programme has expanded to empower sex workers by enabling them to control their own lives and solve their own problems, as both a goal in and of itself and as a way to prevent the spread of HIV (**see Box 6**).

➡ To design interventions to empower women requires us to first deconstruct the sources or components of power that are amenable to project or policy intervention. The first, most fundamental source of power for individuals in society is access to information, education, and skills. We must give women and men basic information about their bodies, sexuality, disease, and reproduction. Access to information is vital for individuals to protect themselves in the HIV/AIDS pandemic and, more importantly, it is a basic human right. In addition, providing women with basic skills such as increasing their con-

Box 6: Sonagachi: Empowering Sex Workers to Prevent HIV/AIDS in India

In 1992, the All India Institute of Hygiene and Public Health *(AIIH&PH) in consultation with the* National AIDS Control Organization *(NACO) of India, the* Ministry of Health and Family Welfare *of West Bengal, and* WHO *initiated an HIV intervention targeting sex workers in Sonagachi, a red light district in Calcutta. In the beginning, the project was largely directed towards reducing the level of STDs and increasing condom use among sex workers. However, the programme has expanded to empower sex workers by enabling them to control their own lives and solve their own problems, as both a goal in and of itself and as a way to prevent the spread of HIV.*

As of 2000, the programme had reached over 8,000 street-based sex workers, out of an estimated 12,000 living in Calcutta, in a wide variety of activities. Several health care clinics have been built and staffed to provide ongoing health care, distribution of condoms, HIV testing and counselling, and the like. Many women also participate in peer education during six-week training sessions where they learn about health issues and where and when to go for health care. Through the peer education groups, an acting group developed that performs plays about STD and HIV prevention, as well as additional sex work issues. The group has performed at many venues, including the Twelfth World AIDS Conference *in Geneva. In 1998, the sex workers initiated a* Positive Hotline *for counselling and support for HIV-positive individuals,including both sex workers and the larger community. Perhaps most significantly, in 1995, the sex workers began a registered cooperative where they save money, provide loans and small investment schemes for members, and market condoms. With the profits, members have started a* crËche *for sex workers' children and purchased land for a training center outside of Calcutta where older sex workers produce handicrafts. Other activities have included legal aid and training and literacy classes for the sex workers and sensitization training for police.*

Despite challenges, including police raids and internal adjustments with the close integration of project staff and sex workers, the project has become a well-known success. Evaluations have consistently found significant improvements in knowledge of AIDS, condom use, and even STD and HIV incidence. For example, in 1992, 1.1% of sex workers surveyed reported always using condoms. By 1995, this rose to over 50%. Similarly, while HIV prevalence rose dramatically among sex workers in most parts of India, only 5.5% of randomly sampled women at Sonagachi were HIV-positive in 1998.

While Sonagachi continues to expand and grow, complete with ongoing challenges, they attribute their continuing success to placing the control of the intervention with the community, building capacity among both staff and sex workers, treating sex workers as whole persons, and meeting the sex workers' felt needs.

Source: (UNAIDS 2000).

dom literacy and providing them with the skills to communicate with their partners about sex helps to reduce their risk and vulnerability to infection.

➡ Another important source of power for women is access to economic resources and assets. Ensuring the implementation and protection of women's property and inheritance rights; ensuring their access to sources of credit; ensuring equal pay for equal work; fostering the provision of business, financial and marketing skills necessary for the success of their enterprises; providing access to agricultural extension services to ensure the highest yield from their land; promoting access to formal sector employment; and ensuring their rights to be free of abuse and exploitation in the informal employment sector are all ways by which women's access to economic resources can be facilitated.

➡ Social capital is another critical source of power. Increasing social support for women who are struggling to change existing gender norms and helping them to expand their social networks by providing them opportunities or meeting in groups and raising awareness in communities is yet another important ingredient for building social capital and empowering women. Strengthening grass-roots women's organizations by providing them with adequate resources also helps build social capital for women.

➡ In the final analysis, empowered women have the political agency to make decisions and shape their own destinies. Providing women with leadership opportunities, the opportunity to problem-solve and organize are well-tested ways of increasing women's political power and could go a long way toward empowering women to cope with the varied demands that the HIV pandemic burdens them with. Beyond direct interventions, we need to pay attention to the contextual factors of empowerment as well. Working to protect women from violence and moving the problem of gender-related violence out of the personal sphere and into the public sphere are other ways to facilitate their political empowerment.

➡ In the ultimate analysis, reducing the imbalance in power between women and men requires policies that are designed to empower women. Policies that aim to decrease the gender gap in education, improve women's access to economic resources, increase women's civic and political participation, and protect women from violence are key to empowering women. HIV/AIDS programme experts and

researchers must advocate strongly for creating a supportive policy and legislative context for women because such a context is crucial for containing the spread of HIV/AIDS and mitigating the impact of the epidemic.

4.2 STRUCTURAL ELEMENTS FOR GENDER INTEGRATION

➡ Since the mid-1990s, programme designers and implementers have struggled with turning knowledge about the gender-related determinants of risk and vulnerability to HIV/AIDS into effective programmatic interventions. Beyond the constraints that are part and parcel of addressing gender within any particular public health programme, the very nature of the epidemic (i.e., its economic, social, cultural and political dimensions) has meant dealing with another set of constraints – those that are deeply structural. If integration of gender concerns at the technical level is to succeed, these structural constraints and barriers have to be addressed as well.

➡ First and foremost is the need to foster and develop the political will and leadership at the level of state institutions that is necessary to create a policy environment amenable to the wholesale integration of gender into HIV/AIDS programmes. This requires, among other things: directly engaging policy makers with the tools and materials that make a case for the value of integrating gender (especially the use of sound research data that demonstrate the incontrovertible evidence of the gender dimensions of HIV/AIDS), and providing them with guidelines on how to make that possible, supported by evaluation-based evidence from the field that demonstrates that addressing gender increases the effectiveness of HIV/AIDS programming.

➡ There are many rationales in making a case for gender integration into HIV/AIDS programmes. In particular, initiatives to integrate gender can and should rely on equity and efficiency rationales, or at least be willing to alter rationales to meet the needs of those to whom advocacy for integrated programming is targeted. By equity, we are referring to advocacy based on human rights, appeals to justice, or other fairness-related arguments. The more instrumental efficiency approach maintains – and rightfully so – that gender integration maximizes the effectiveness of programmes by reaching more people and reducing con-

straints to accessing and using information, technologies and services for all. It yields more sustainable long-term results in terms of lowering the incidence of infection and mitigating the negative consequences of AIDS. Both rationales should be used, as appropriate for particular settings or audiences, to justify integration.

➡ The allocation of financial resources is clearly a key structural determinant of the success of any integration effort. However, this goes beyond simply providing money for 'gender initiatives', which often is funding that is sporadic and narrowly targeted at a highly specific project or programme. Successful integration of gender requires that funding for all programme areas be increased to match the overall programmatic goals of an HIV prevention, care and support, or treatment programme, with gender-analysis and gender-disaggregated goals and indicators for evaluation woven in throughout.

➡ Successful integration requires that technical knowledge and understanding of and expertise on gender-analysis and the gender-specific realities of women and men exists at all levels and departments of the institution, not merely at the level of service provision. Gender must not be seen as an add-on or appendage, but rather a core element to be addressed in order to maximize the effectiveness of the programme. To ensure that the response to gender considerations is integrated not grafted on, it is critical that all institutional gender expertise not remain centralized in one department or with one 'key' gender 'point-person'. Integration must extend outward to ensure that all programme staff understand the gender-differentials related to: risk factors of HIV infection; access to information, education, services and technologies; differences in progression of HIV infection and distinctions between men and women as to the type and severity of opportunistic infections; the different roles that men and women play as formal and informal care providers; and the differential social and economic burdens of AIDS morbidity and mortality. The training used to promote such knowledge and understanding should be hands-on, practical, related to a specific type of intervention, and presented in the context of maximizing a programme activity's effectiveness.

➡ As with almost any kind of programmatic activity, the need for data that provide direction to an institution as to where funds should be prioritized and what kind of response

would be best is crucial. While the data gap on women and HIV infection has more or less been bridged, there is still a need for sex-disaggregated data on a host of other socioeconomic indicators of women's status that are essential in order to understand the direction, scope and impact of the epidemic in different parts of the world. Therefore, sex-disaggregated data collection and analysis is an important element for understanding and addressing gender.

➡ Part and parcel of data collection is the effective monitoring and evaluation of integration into programmatic activities. Again, this cannot be an 'add-on' or secondary goal of the project. Sound monitoring and evaluation criteria and tools need to be integrated into programme design from the outset, to ensure that the wide variety of gender-specific elements – technical and structural – is being addressed.

➡ In order to ensure that gender is integrated comprehensively throughout a programme, there should be an institutional incentive system that rewards employees who pay attention to gender issues. Without such incentives, programmes are likely to continue treating gender as a marginal aspect of 'mainstream' projects and programmes and pay lip-service to the issue rather than treat it as important for the efficiency and effectiveness of projects.

5. THE CHALLENGES THAT LIE AHEAD

As with most areas of public policy and action, what we know about the relationship between gender and the HIV/AIDS pandemic is far ahead of our knowledge – and in many instances, capabilities and commitments – about how to respond effectively. Since the mid-1990s, programme planners and implementers, policy makers, and donors have recognized the gender dimensions of the HIV/AIDS pandemic. It has been recognized that for effective results, the incorporation of gender considerations must permeate programmes and policies at all levels. Integrating gender into existing and new HIV/AIDS programmes and policies must not be considered to be a 'side show', luxury 'accessory' or a second-thought 'add-on'. Consideration of gender must form the very centerpiece of all policies and programmes aimed at slowing the spread of HIV and mitigating the impact of AIDS.

➡ However, to date the majority of initiatives to integrate gender into effective programming have been small and experimental. Where pilot initiatives seemed to show promise, navigating the uncharted waters of 'scaling-up' remains a significant challenge to overcome.

➡ The acknowledgement of how deeply gender permeates the enormous scope of the HIV/AIDS pandemic has forced many to admit that this is more than a 'health matter'. The incorporation of a comprehensive gender framework to address HIV/AIDS issues goes far beyond the standard or traditional set of HIV/AIDS interventions to include a wide range of social and economic interventions. The realities of gender inequalities within the social and economic context of any given country can prevent or negate even the best HIV/AIDS interventions. These contextual factors cannot be ignored. Ultimately, to address economic and social gender inequities that lie at the root of the pandemic requires a multisectoral response that must increase women's and girls' access to productive resources such as education, employment, land, and credit, end the culture of silence and shame that surrounds sexuality, and protect girls and boys from the corrosive effects of gender stereotyping.

➡ This recognition that HIV/AIDS is more than a health matter is a critical step forward in addressing the pandemic.

However, the questions of who should implement such non-health interventions and how it should be done naturally arise. Should institutions with health mandates engage in non-health interventions to address health outcomes, or should health institutions partner with non-health institutions through linked programmes and other mechanisms? Or should entirely new methods be used? These are not easy questions to address, yet the countries that have been the most successful in reducing the number of new infections (e.g. Senegal, Thailand and Uganda) are those that have used a multisectoral approach to HIV/AIDS. In the case of Uganda, programmatic and policy foci that included elimination of gender-damaging programmes, a commitment to gender sensitive HIV prevention, gender-transformative innovations and efforts to empower women (especially in the area of women's human rights) have been cited as key to the success of Uganda's approach to HIV/AIDS (Garrett 2000; Sittitrai 2001).

6. CONCLUSION

This review of issues and approaches to address individuals' vulnerability in the HIV/AIDS epidemic reinforces the conclusion that success is contingent upon integrating gender considerations. Clearly, if gender issues are ignored, programmes run the risk of minimizing their effectiveness or even causing harm. However, it is also clear that there is no single way to address gender, nor is there one approach that can guarantee success. Programmes must address individuals' vulnerability in a variety of ways within both short and long term timeframes. In the short term, gender-sensitive programmes are our best hope. We must continue to address women and men's vulnerability by continually adapting to and meeting women's and men's gender and age-specific needs within the current social and cultural context. But we must also plan for the long term. Gender-sensitive programming will not change the gender-based realities that fuel the epidemic and make women and men vulnerable. Transformative and empowering programmes must be implemented alongside gender-sensitive programmes in the hope of ultimately challenging the very foundation of the epidemic. This is the broad direction we must take, but to follow this road map there is a great need for building the capacity of programmes and policy experts in integrating gender and for providing them with specific programmatic guidelines that specify 'how' gender considerations can be integrated into different types of HIV/AIDS policies and programmes. This is the next important step that WHO will take with others in order to ensure that gender norms and gender inequality do not continue to fuel the HIV/AIDS epidemic.

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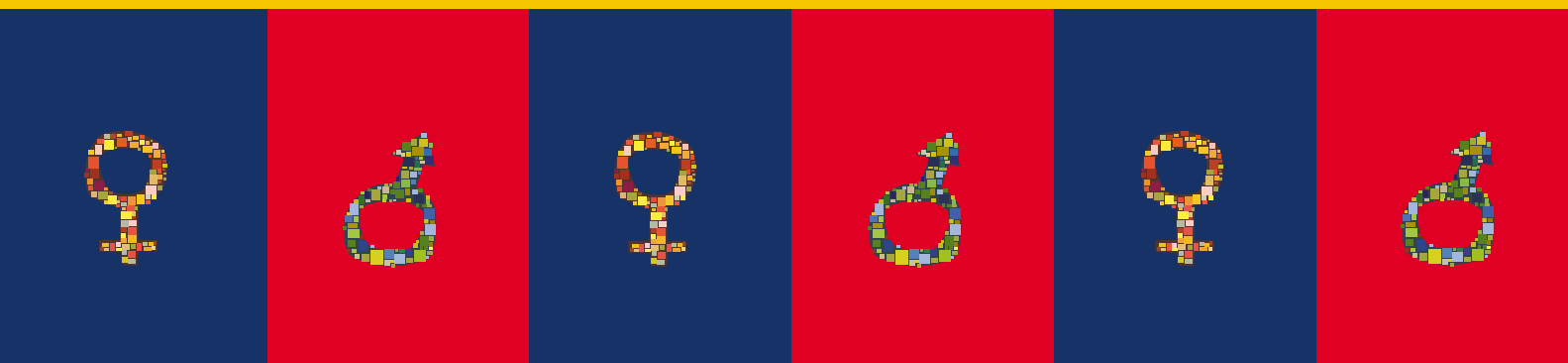
Department of Gender and Women's Health
Family and Community Health
World Health Organization
Avenue Appia 20
CH-1211 Geneva 27
Switzerland
E-mail: genderandhealth@who.int
http://www.who.int/gender/

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