
# GENDER, POWER AND HIV PREVENTION

## VSO POLICY BRIEF

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POLICY BRIEF PRODUCED BY VSO IN 2007


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Report Author: Nina O'Farrell

Report Editors: Lucy Jenks and Michael Podmore

With thanks for their input to Danielle Alford, Kieran Breen, Sara Cottingham, Phil Hudson, Clive Ingleby, Kate Iorpenda, Michael Kelly, Tamsin Langford, Etelvina Mahanjane, Karen Mingelers, Grace Mukasa, Bongai Mundeta and VSO RAISA, Stephen Nock, Aisatou Ngong, Kevin Osbourne, Fiona Pettit, Stephen Porter, Alan Smith, Barbara Trapiro, Patrick Wajero, Samantha Willan.

# FOREWORD

More than 26 years have passed since what we know as HIV & AIDS came to the attention of the world. These were years of some successes but more numerous failures in getting ahead of the epidemic. Today, more widespread access to treatment means that lives are being saved. This is as it should be and we want to see more of it so that every person who is in need can have access, sooner rather than later, to life-preserving treatment. But in the area of prevention the successes have been less remarkable. HIV transmission continues to grow apace, outstripping each year the numbers being provided with treatment, and even outstripping the numbers who die from AIDS-related illnesses.

One reason for this totally unsatisfactory situation is that prevention responses have tended to focus on short-term pragmatic solutions. Responding to today's emergency prevention needs is effective and necessary as a short-term tactic within the framework of a long-term strategic response. But the tactic should never have become a strategy on its own. The sorry story of the first quarter century of the epidemic is the story of the outcome. It shows that HIV transmission continued almost unabated because we had been missing much that was vital. Specifically, we had been less than half-hearted in our efforts against the fundamental drivers of the epidemic, especially gender inequality, stigma and discrimination, homophobia and poverty. In particular, global, national and local action did not match the many good words about tackling the feminisation of the epidemic.

This policy brief strives to remedy this situation by its holistic and long-term approach. It deals squarely with the power issues that are at the root of gender inequality, proposes a comprehensive range of prevention interventions, and establishes the basics of a conducive environment for comprehensive HIV prevention measures. The three-pronged approach that it advocates – addressing structural inequalities; addressing the immediate needs of women, girls and vulnerable men; and involving men – brings a new dimension to the discourse on HIV prevention.

Careful adoption of the recommendations contained in this policy brief should signal considerable progress in reducing HIV transmission and in hastening the day when equality between women and men will become a lived reality. With the stranglehold of HIV & AIDS being broken and equality becoming a reality, women, men and their children will then be better able to experience a life of dignity, fulfilment and mutual support.

MICHAEL J. KELLY
LUSAKA
1 JULY 2007

# GLOSSARY

| | |
|---|---|
| ABC | ABSTAIN, BE FAITHFUL, USE CONDOMS |
| AIDS | ACQUIRED IMMUNE DEFICIENCY SYNDROME |
| CIDA | CANADIAN INTERNATIONAL DEVELOPMENT AGENCY |
| CSO | CIVIL SOCIETY ORGANISATION |
| EU | EUROPEAN UNION |
| G8 | GROUP OF 8 |
| HIV | HUMAN IMMUNODEFICIENCY VIRUS |
| NGO | NON-GOVERNMENTAL ORGANISATION |
| RAISA | REGIONAL AIDS INITIATIVE OF SOUTHERN AFRICA |
| SADC | SOUTHERN AFRICAN DEVELOPMENT COMMUNITY |
| STI | SEXUALLY TRANSMITTED INFECTION |
| UN | UNITED NATIONS |
| UNAIDS | JOINT UNITED NATIONS PROGRAMME ON HIV AND AIDS |
| UNFPA | UNITED NATIONS POPULATION FUND |
| UNGASS | UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION |
| UNHCR | OFFICE OF THE UN HIGH COMMISSIONER FOR REFUGEES |
| UNIFEM | UNITED NATIONS DEVELOPMENT FUND FOR WOMEN |
| VSO | VOLUNTARY SERVICE OVERSEAS |
| WHO | WORLD HEALTH ORGANISATION |
| YOP | YOUTH OUTREACH PROGRAMME |

# EXECUTIVE SUMMARY

This policy brief builds on VSO's earlier work: *Gendering AIDS: Women, Men, Empowerment, Mobilisation*[1] with a particular focus on the imperative for comprehensive, evidence-based prevention information and services which respond to the needs of women, girls and vulnerable men. It builds on VSO's assertion that gender-sensitive responses to HIV & AIDS will allow HIV & AIDS practitioners, governments, donors and advocates to improve the effectiveness and quality of our work. Without a gendered analysis, our approach to HIV prevention is incomplete and unlikely to succeed.

HIV prevention *must* be a global priority and the HIV prevention needs of women, girls and vulnerable men must be placed at the centre of our response. In 2006, globally there were 17.7 million women living with HIV & AIDS, representing an increase of over one million compared with 2004. With young women (15–24 years) worldwide 1.6 times as likely to be living with HIV & AIDS than their male counterparts, not only are we facing an increasingly feminised epidemic, we are also confronting an international health crisis[2]. If national governments, international institutions, donors and civil society fail to respond to the challenges of HIV prevention, the face of HIV & AIDS will become an increasingly female one; societies will buckle under the strain of HIV & AIDS as more and more women, girls, men and boys become infected; health systems will collapse; and access to treatment, already woefully inadequate, will not be able to keep up with demand from increasing numbers of people requiring life-saving treatment.

This policy brief calls on policy makers and other stakeholders to address the gender inequalities that drive the HIV & AIDS pandemic and demands that they move beyond the rhetoric of gender equality to take firm and fast action. To this end, we provide gender analysis and recommendations for a full range of HIV prevention interventions (see tabulated summary on pages 17-21).

The current predominance of a selective interpretation of the **A**bstain, **B**e Faithful, Use **C**ondoms (ABC) approach has meant that the right to potentially life-saving information has been denied to many groups and individuals vulnerable to HIV & AIDS. Furthermore, lack of gender analysis in the design and implementation of HIV prevention policies and programmes has reduced the effectiveness of those programmes. VSO believes that HIV prevention policies and programmes must respond to the experiences, need, desires and vulnerabilities of women, girls and vulnerable men as expressed by them. Each and every individual has a right to comprehensive, gender-sensitive, evidence-based HIV prevention information and services. Policy makers, national governments, donors and international institutions must ensure that this right is upheld.

VSO calls on the international community, national governments and civil society to deliver policy and programme changes that:

1. Address structural inequalities – including education, social and economic – between women and men that drive the pandemic, through participatory and empowering HIV prevention policies and programmes.
2. Address the immediate needs of women, girls and vulnerable men by tailoring HIV prevention programmes to context, and through appropriate interventions, settings and methods of delivery.
3. Involve men in HIV prevention policies and programmes and in challenging structural gender inequalities.

1 VSO, 2003, Gendering AIDS: Women, Men, Empowerment, Mobilisation.
2 UNAIDS/WHO, 2006, AIDS Epidemic Update.

# INTRODUCTION

## GENDER AND HIV & AIDS

Gender is not just about women. Gender roles are linked to gender inequality, that is, the unequal relations between women and men, with women and girls generally being disadvantaged. Whilst women and girls are most disadvantaged by gender inequality, male behaviour is also regulated by constructions of masculinity and femininity, with men who do not demonstrate predominant male behaviours often marginalised.

Just as gender is multifaceted, so too are the contexts within which HIV & AIDS thrive. The cornerstone of this policy brief is the recognition that **different HIV prevention interventions are needed in different contexts and these must be tailored to different groups**. There are very different epidemics in Africa and Asia, and indeed within Africa and Asia, driven in some contexts by heterosexual relationships and in others amongst vulnerable groups (such as sex workers[3], injecting drug users and males who have sex with males[4]). There are significant differences in the nature of the HIV & AIDS epidemics within continents, countries and even within localities. For this reason, this policy brief focuses on the need for gender-sensitive HIV prevention policies and programmes that are context-specific.

### GENDER AND HIV & AIDS – FACTS AND FIGURES[5]

- In sub-Saharan Africa, for every 10 men living with HIV & AIDS, there are approximately 14 women who are infected with the virus.
- Among males who acknowledged having sex with males in Thailand, studies show HIV prevalence increased from 17 per cent in 2003 to 28.3 per cent in 2005.
- Worldwide, young women (15–24 years) are 1.6 times as likely as young men to be HIV positive.

As the figures above illustrate, HIV & AIDS prevalence rates continue to grow with a disproportionate impact on women, girls and vulnerable men. VSO believes that if HIV prevention programmes are to be successful, HIV prevention policy and practice must incorporate a comprehensive, evidence-based and gender-sensitive approach.

### GENDER SENSITIVITY

Gender sensitive responses to HIV prevention means ensuring that the gender dynamics that drive vulnerability to HIV & AIDS are central to the design and implementation of any HIV prevention policy or programme. This means developing programmes that take account of the different experiences, needs, desires, and vulnerabilities of women and men, girls and boys and transgender people in order to deliver accessible and effective programmes. It means considering how a person's gender might influence choice of prevention options, whether they have the power to use prevention options, or how they access HIV prevention services, and responding accordingly.

### VULNERABLE MEN

Whilst VSO recognises that accepted norms of male behaviour make all men vulnerable to HIV & AIDS, we use the term 'vulnerable men' to describe those men whom society make particularly vulnerable by perceiving them to act outside of the accepted norms of male behaviour, for example men who inject drugs, males who have sex with males, and male sex workers.

3 The term 'sex worker' refers to a person who earns money by providing sexual services.

4 'Males who have sex with males' is a term used to classify males who have sex with other males. We avoid using the term 'men' as, in many communities, 'men' is seen as an identity while 'male' is biology; many males are challenging the traditional identity of 'men'.

5 UNAIDS, 2006, Epidemic Update, p3, p5; UNAIDS, 2006, Report on the Global HIV Epidemic, p88; International Women's Health Coalition, 2006, Gender and HIV/AIDS Fact Sheet; UNAIDS, 2006, Policy Brief: HIV and Sex Between Men, p1.

## STRUCTURE OF THIS POLICY BRIEF

This policy brief begins, in Chapter 1, with an analysis of the gender inequalities that drive vulnerability to HIV infection for women, girls and vulnerable men. Chapter 2 makes recommendations for a comprehensive, evidence-based approach to HIV prevention that takes full account of the gender inequalities that lead to vulnerability to HIV & AIDS. Chapter 3 explores good practice in relation to gender-sensitive HIV prevention policy and programming, and Chapter 4 explores the need for policy accountability, both in terms of holding governments and institutions to account for the policy commitments they have made and in addressing gaps in policy and practice. The brief ends, in Chapter 5, with demands that key stakeholders must respond to in order to enable universal access to comprehensive, gender-sensitive, evidence-based HIV prevention information and services for all.

# CHAPTER 1: GENDER INEQUALITY AND HIV PREVENTION

"Cultural norms of sexual ignorance and purity for women block their access to prevention information. Due to lack of awareness, many women in India generally have little ability to discuss or negotiate the use of condoms or their partners' previous and/or concurrent sexual contacts."
RAKHI SARKAR, PROGRAMME OFFICER, VSO INDIA[6]

Deeply entrenched beliefs about female and male sexuality and gender roles mean that women and girls generally have less power than men to decide with whom, how and when they have sex. Power overwhelmingly resides with men in all spheres of life (including personal and sexual relationships) and so women and girls are disproportionately powerless to prevent HIV infection. Power is at the centre of women and girls' social, economic and political marginalisation. This chapter explores the gender inequalities that drive vulnerability to HIV infection.

## ECONOMIC POWER

"If you want me to have sex with a condom, I won't give you any money for food."[7]

Poverty drives the HIV & AIDS pandemic, impacting disproportionately on women, girls and vulnerable men who are often the most marginalised in society. Poverty and women and girls' economic dependence on men feeds power inequalities and reinforces the difficulties women and men have in discussing sex. Poverty affects women's, girls' and vulnerable men's ability to access information and develop skills to protect themselves from HIV transmission.

Women and girls are paid less than men for doing the same jobs, while vital work carried out in the home and caring for family members is devalued. Economic dependency on men is acute in situations of desperate poverty, where there is no social welfare, or where cultural and social pressures make working outside the home difficult for women and girls. Economic power imbalances and consequent fear of abandonment and destitution means women and girls can have extreme difficulty in negotiating sex, even when they know that their partners have multiple relationships.

### INHERITANCE AND ACCESS TO PROPERTY

Difficulty in inheriting property, particularly after a husband's death, makes women and girls extremely economically vulnerable. According to the Positive Women's Network, widows in India are exceptionally disadvantaged, as culturally they tend to be regarded as having very low status in the household.[8] Women and girls widowed (often very young) by HIV & AIDS are further marginalised as a result of stigma. They may be thrown out of their homes, or sent back to their parents' homes without their dowry or jewellery. Alternatively, the property may be sold to finance the husband's health treatment. For example, in 2003 one study found that 46 per cent of landlessness in Cambodia was linked to health care expenditure, ie the cost of health care has been such that land has been lost.[9] Women and girls without access to an income, property or inheritance due to inequalities in economic power are extremely vulnerable to HIV transmission and may be forced into sex work.

6 VSO, 2003, Gendering AIDS, p22.
7 Ibid, p11, quoted by a representative of VSO partner organisation Women Against Women Abuse (WAWA) in South Africa.
8 VSO, 2003, Gendering AIDS, p20.
9 Ibid, p20.

## THE BURDEN OF HIV & AIDS CARE ON WOMEN AND GIRLS

HIV & AIDS in Southern Africa is pushing women and girls further into poverty. As public health systems in most developing countries do not have the capacity to provide necessary care and support, women and girls (as the traditional carers in the home) provide the bulk of care for people living with HIV & AIDS. Due to care-giving responsibilities, many women and girls leave or regularly stay away from the workplace and many of their income-generating activities suffer, resulting in families being pushed further into poverty. Girls often leave school to care for parents and siblings. Lost education and economic opportunities due to this care-giving role significantly increases the vulnerability of female caregivers to HIV & AIDS.[10]

## SEX WORK

"If a woman can't feed herself, why would she worry about a disease that might kill her in 10 years' time? If a client offers to pay twice as much for sex without a condom, the need for money may overtake everything she knows about HIV & AIDS."
REPRESENTATIVE FROM JAGRUTI, AN ORGANISATION WORKING WITH SEX WORKERS, INDIA[11]

Many women, girls and vulnerable men are forced into sex work for economic survival. Female and male sex workers are particularly vulnerable to HIV transmission. For example, in South Asia, excluding India, almost one in two (49 per cent) HIV infections in 2005 were in sex workers and their clients.[12] This may be due to violence and rape (largely overlooked by society) and economic necessity, which make asking clients to wear condoms difficult. Young girls and women who are trafficked for sex work are exceptionally vulnerable, particularly as they may be living in a country where they do not speak the language.

## INTERGENERATIONAL SEX

Intergenerational sex culminating in the 'sugar daddy' and 'sugar mummy' phenomena – older men or women giving school girls or boys money for books and clothes in return for sex – is a significant driver of the pandemic in some countries, particularly evident in Southern Africa. These older men and women have significant economic power over younger girls and boys. One study in Zimbabwe found that almost one-quarter of women in their twenties were in relationships with men 10 or more years older than themselves.[13] This is linked to men's perceptions that these women and girls are less likely to be living with HIV & AIDS. Men usually become infected later in life than women and girls once they have had sex with multiple partners. Therefore, the older the man, the higher the rate of infection – younger girls having sex with older men thus become infected at a much earlier age.[14]

Economic realities and social pressures to have the '3 Cs' – cell phone, cash and car – make refusing these advances difficult, and girls and boys may actively seek out older men and women for this kind of relationship.

## MIGRATION, DISPLACED PERSONS AND REFUGEES

Male migrant workers seeking employment in neighbouring countries or working across borders, as truckers are more likely to have sex whilst away from their families. Often, a man who has contracted HIV in this way will be unaware and pass the virus onto his partner. The wives and partners of male migrant workers,

10 VSO, 2006, Reducing the Burden of HIV & AIDS Care on Women and Girls: VSO Policy Brief.
11 Ibid, p11.
12 UNAIDS, 2006, Epidemic Update, p5.
13 UNAIDS, 2004, Facing the Future Together: Report of the Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa, p22.
14 Ibid, p13.

as a consequence of prolonged absences, are often left extremely economically vulnerable. Men's earnings may come infrequently or in a lump sum at the end of a contract, leaving women and girls to cope for themselves. This can increase the risk of HIV infection for the poorest women and girls who may be subject to sexual coercion and violence in exchange for much needed cash, services or food. Female migrant workers also become vulnerable to HIV & AIDS whilst working abroad whether subject to sexual violence or coercion as domestic workers or pushed into sex work as they arrive in new countries.

Displaced persons and refugees face similar scenarios and may have experienced further trauma and violence, including sexual violence, during conflict and flight. Migrants, displaced persons and refugees may have greater difficulty in accessing services due to their increased mobility or lack of information in their language. In some cases, they may also wish to remain anonymous and thus may be unable to access health and education services.[15]

## SOCIAL POWER

In some societies, dominant interpretations of cultures socialise men into believing that it is integral to being a man to take risks – particularly sexual ones, including having regular sex with multiple partners. Men in some societies are also sometimes expected by their peers and wider society to use alcohol and drugs and to display dominant, sometimes violent, behaviour to women and girls and men perceived to be weak or effeminate. They can also be expected to be sole economic providers for their families. In other societies, where it is not culturally acceptable to openly engage in behaviour such as sex before marriage or outside of marriage or homosexuality, men are often placed under extreme pressure to conform to accepted norms such as early marriage or denial of homosexuality. These norms can make them and their partners vulnerable to HIV transmission.

While it is easy to blame men for behaviour that dismpowers women and girls, understanding the pressures facing men – particularly those who are poor and marginalised – is important. In one survey conducted in Cameroon, over 51 per cent of men aged between 18 and 30 stated that the aspect they most disliked about being male was "too many responsibilities" related to providing an income for the family.[16] While men largely have greater power than women and girls, many men are not powerful, and are deeply burdened by social expectations of providing economically for their families.

However, male and female roles should not be equated. The pressures men and women face are not equivalent, and recognising those faced by men in no way undermines the fact that in virtually every sphere of life women and girls are disadvantaged – especially women and girls who are poor, living with HIV & AIDS, older, from an ethnic or religious minority or who have disabilities.

### MARRIAGE IS NOT A 'SAFE HAVEN'

More than four-fifths of new infections in women and girls result from sex with their husband or primary partners.[17] In Ghana, married women and girls are almost three times more likely to be living with HIV & AIDS than women and girls who have never been married.[18] In India, 27 per cent of male clients of male sex workers are married or living with a female partner.[19] Marriage cannot be seen as a protective safe haven from HIV & AIDS as is implied by the ABC approach to HIV prevention. (See page 14).

15 UNHCR, 2006, HIV/AIDS and Internally Displaced Persons in 8 Priority Countries.

16 CIDA, VSO, Youth Outreach Programme, 2006, Changemakers: Deconstructing Gender: What is Wrong with Cameroonian Men. Changemakers is a project jointly undertaken by Youth Outreach Programme and VSO Cameroon, with financial support from the Government of Canada, through the Canadian International Development Agency.

17 International Women's Health Coalition, 2006, Women and HIV/AIDS Fact Sheet.

18 Ibid.

19 Ibid.

Early marriage can make young women and girls particularly vulnerable to HIV & AIDS. These women and girls may not be fully developed physiologically, and so are physically more vulnerable to HIV infection. They may also have left education early for marriage and may have married older men who are likely to have had more sexual partners. Age and status may mean that younger women and girls have even less power to negotiate sex, and protect themselves from HIV & AIDS within marriage.

Married women and girls can be made further vulnerable to HIV transmission as a result of the expectation, once married, to conceive and thus not use condoms. This, combined with the belief that once married, suggesting the use of condoms implies unfaithfulness, can significantly increase vulnerability within marriage.

## GENDER-BASED VIOLENCE HAS REACHED EPIDEMIC PROPORTIONS

GENDER-BASED VIOLENCE – FACTS AND FIGURES:[20]

- Fearing violence or rejection, 58 per cent of African girls avoid discussing condom use with their partners.
- Women in South Africa who are in abusive relationships are 50 per cent more likely to contract HIV than women not involved in abusive relationships.

Activists have come to refer to 'twin pandemics' of HIV & AIDS and violence against women and girls.[21] Gender violence occurs in all societies and seldom attracts social sanctions or legal punishment. Gender violence is causally linked to HIV & AIDS transmission and may also be a punitive reaction to a positive HIV diagnosis within a relationship. At the extreme end of the continuum of gender violence is rape, when transmission is more likely than during consensual sex, but in many cases the threat of violence is enough to prevent a woman or vulnerable man from discussing condom use or faithfulness with their partner.

The reality or fear of violence makes it very difficult for women, girls and vulnerable men to raise sexual issues. The HIV & AIDS pandemic is itself causing more violence, as fear and frustration is taken out upon partners and relatives. Male rape is a rarely discussed aspect of gender violence, yet also takes place in all societies; the associated shame and stigma makes men who have been raped very reluctant to speak out.

Women and girls experiencing violence or abandonment as a result of their HIV status also face significant obstacles in finding alternative housing. There are simply not enough shelters, especially for women and girls with children, and poverty makes finding somewhere to rent very hard. Thus some women and girls are forced either to stay with the man who is abusing them or to go into sex work to feed and house themselves and their families.

20 Ibid.

21 Germain, Adrienne, 2006, Invest, Protect and Lead: Filling the Glass on Women's Health and Rights and Achieving the MDGs, presentation given at roundtable at the 59th Annual DPI/NGO Conference, United Nations, New York.

## MALES WHO HAVE SEX WITH MALES AND SEXUAL MINORITIES

The needs of males who have sex with males and transgender[22] people remain largely unaddressed. This is often the result of an assumption that sex between men does not take place, or only on an infrequent basis. This can leave males who have sex with males and transgender people exceptionally vulnerable to infection. Beliefs about masculinity place a great pressure on men to behave in a certain 'acceptable' way, a pressure which means that groups of men who do not display dominant behaviours experience high levels of stigma and discrimination, increasing their vulnerability to HIV & AIDS and reducing their access to services by forcing these groups underground.

In addition, men in India traditionally marry late, and many have sex before marriage, often with female or male sex workers. Lack of knowledge about sex, possible risks and prevention methods can put them and their current and future partners at risk. Prevention messages in India have focused heavily on women, particularly female sex workers, as sources of infection. According to organisations working with males who have sex with males, this has led to a fairly widespread belief that sex with another man will not lead to HIV transmission. The majority of males who have sex with males in India are, or will be, married, and lack of appropriate prevention information places them and their wives or partners at risk.[23]

## INFORMATION IS POWER

ACCESS TO INFORMATION – FACTS AND FIGURES:[24]

- In one survey, only 13 per cent of young women in South Asia correctly identified two HIV prevention methods.
- One in four young South Africans believes that sex with a virgin can cure HIV & AIDS.

Related to social and economic power, power is also derived from the ability to use and withhold information. Those most vulnerable to HIV & AIDS – married women and girls; women, girls and young men in transactional sexual relationships; males who have sex with males; and injecting drug users – are often those with the least access to education and health services (including sexual and reproductive health) and frequently do not receive any information about HIV & AIDS. These groups lack both the information and power to demand their right to comprehensive, accurate prevention information and services.

Information about condoms may be kept from women and girls due to cultural norms requiring purity and passivity. Silence around condoms often occurs due to a perceived link between having information and increased promiscuity. Prevention programmes must take account of the gap between receiving accurate information and the power individuals have to use that information in their own lives.

22 Transgender is the state of one's 'gender identity' (self-identification as male, female, both or neither) not matching one's 'assigned gender' (identification by others as male or female based on physical/genetic sex). Transgender does not imply any specific form of sexual orientation – transgender people may identify as heterosexual, homosexual, bisexual, pansexual or asexual.Definition from Wikipedia: http://en.wikipedia.org/wiki/Transgender

23 VSO, 2003, Gendering AIDS, p23.

24 International Women's Health Coalition, 2006, Women and HIV/AIDS Fact Sheet; and UNAIDS, UNFPA, UNIFEM, 2004, Women and HIV/AIDS: Confronting the Crisis, p12.

## EDUCATION IS POWER

EDUCATION – FACTS AND FIGURES:[25]

- Of girls aged 15–18 in Zimbabwe, those in school are more than five times less likely to be living with HIV & AIDS than those who have dropped out.
- If all children received a complete primary education, around 700,000 cases of HIV in young adults could be prevented each year.

Studies have shown that HIV prevalence is twice as high among young people who do not finish primary school as those that do.[26] Access to education is a strong determining factor in vulnerability to HIV infection. Girls comprise 44 million of the 77 million children in the world who are not in school, so there are very real consequences in terms of HIV prevalence in women and girls.[27] Not only does education give young women and girls economic options, it also gives them knowledge and skills to realise a greater range of life options. The effect of education is to open up new possibilities for girls, to enable them to take in information, to evaluate it and take informed action.[28]

Girls often leave school in order to care for sick parents or because HIV & AIDS has reduced the earning capacity in the family. Out-of-school girls, without the knowledge, skills and economic opportunities education can give, are often forced into engaging in transactional sex in order to survive. However, education systems are not always sources of accurate information and often reflect attempts to control behaviour in society through limiting access to information about sex and sexuality and the full range of HIV prevention options.

Incomplete messages about HIV prevention are the norm in many countries and schools and messages too frequently focus on abstinence before marriage, an approach that is not a reality for many girls. Teachers may be poorly trained or provided with incomplete prevention information themselves. Even those who do receive adequate training may be unable to effectively teach about HIV & AIDS due to a hostile environment, for example lack of general awareness raising within communities or parental prejudice that undermines teaching on HIV & AIDS.[29] Incomplete messages can be more dangerous than no messages at all, for example an abstinence before marriage message that may lead girls to believe that there is no HIV risk in marriage. This begs the question, "is bad education better than no education?"

25 The Global Coalition on Women and AIDS, 2005, Educate Girls: Fight AIDS, Issue 1, p1.
26 Ibid.
27 www.unicef.org/girlseducation/index_bigpicture.html
28 From VSO Interview with Professor Michael Kelly, February 2007.
29 Global Campaign for Education, 2006, Teachers for All: what governments and donors should do.

# CHAPTER 2: RECOMMENDATIONS FOR HIV PREVENTION PROGRAMMING

In response to the challenges outlined in Chapter 1, this chapter presents a gender analysis of the range of interventions involved in comprehensive evidence-based HIV prevention programming. It gives good practice principles for gender-sensitive HIV prevention programming.

## ABC DOESN'T WORK

The ABC approach to HIV prevention – **A**bstain, **B**e faithful, and use **C**ondoms – has become the predominant discourse and methodology for HIV prevention. Promoted by many governments, organisations and individuals, ABC has increasingly become interpreted as abstinence before marriage, faithfulness in marriage and condom use for vulnerable groups such as males who have sex with males and sex workers.

Whilst there are some convincing arguments in favour of the ABC approach to HIV prevention (for example that delay in the onset of first sexual experience through abstinence programmes can reduce vulnerability to HIV & AIDS)[30], this is not enough to justify an incomplete HIV prevention message. Whilst ABC has enabled many faith-based groups to actively engage with HIV prevention initiatives, the current predominance of the ABC and often AB first and C second approach to HIV prevention has significantly reduced the effectiveness of this approach. It has further limited access to comprehensive, evidence-based HIV prevention information and services and has led to re-stigmatisation of condoms and groups associated with condom use.

One of many proponents of this approach, The President's Emergency Plan for AIDS Relief (PEPFAR), has had a particularly significant impact in shaping debates around what constitutes 'appropriate' prevention information for different groups. As a $15 billion initiative, PEPFAR's guidance around how prevention monies should be spent has greatly influenced the content of prevention programmes leading to a situation where ABC has become the predominant prevention framework globally.

Furthermore, PEPFAR funding requires recipients to sign an anti-prostitution and trafficking clause. This can mean that PEPFAR-funded HIV prevention programmes do not respect the rights or address the prevention needs of sex workers, trafficked people and groups highly vulnerable to HIV & AIDS.[31] Conditionalities around drug trafficking, terrorism, prostitution, abortion and a lack of support for harm reduction[32] have impacted on both discourse and practice around HIV prevention. Not only have specific groups such as sex workers received just one part of an HIV prevention message, ABC itself has not worked for specific vulnerable groups such as injecting drug users or married women and girls. VSO emphasises the right of all groups and individuals to access the full range of available HIV prevention options. VSO believes that effective HIV prevention must be based on the rights of individuals to access full information and services and not on moral judgements. Whilst lack of resources often means that a full, comprehensive range of services are not available, information must be available and accessible to all, regardless of marital status, drug use, disability, economic status etc.

ABC does not work for the majority of women and girls for whom abstinence may not be an option, where a wife may be faithful but her husband not, and where a woman may not have the power to negotiate condom use. The same can be said for vulnerable men. ABC does not provide women, girls or vulnerable men with

30 SADC, 2006, Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa: Report.

31 Implications of US Policy Restrictions for Programs Aimed at Commercial Sex Workers and Victims of Trafficking Worldwide, November 2005, www.gender-health.org/loyaltyoath.php?TOPIC=PRG

32 Harm reduction refers to a set of policies, strategies and programmes that reduce the negative consequences of drug use, incorporating a spectrum of strategies from safer use such as needle and syringe access to safe injecting sites to drug substitution therapy and information on sexual and reproductive health. Definition adapted from Harm Reduction Coalition, www.harmreduction.org/article.php?list=type&type=62 and Eldis, http://www.eldis.org/index.cfm?objectId=F66941F3-C683-3447-D076A2FE798164CA

the full range of prevention options available to them and does not impart the skills to use this methodology or to challenge the unequal power relations that drive the HIV & AIDS pandemic. ABC does not allow space to address critical needs associated with prevention of parent-to-child transmission[33], injecting drug use, prisoners or prevention for people living with HIV & AIDS.

## PREVENTION OF PARENT-TO-CHILD TRANSMISSION

PREVENTION OF PARENT-TO-CHILD TRANSMISSION – FACTS AND FIGURES:[34]

- Ninety per cent of all children living with HIV & AIDS are infected through parent-to-child transmission.
- Providing mothers with a full range of preventative parent-to-child services can reduce risk of transmission to less than two per cent.

The ABC approach to HIV prevention does not take sufficient account of the need to prevent parent-to-child transmission. It is a tragedy that globally only 11 per cent of women and girls living with HIV & AIDS receive treatment for prevention of parent-to-child transmission.[35] Although around one-sixth of infections occur through parent-to-child transmission, and the means to prevent this is available through the use of anti-retrovirals, there is low take up even when services are available (and often services are not available due to weak health systems).[36] This low take up can result from a lack of information among pregnant women and girls living with HIV & AIDS, fear of stigma and discrimination or attitudes of health staff that alienate pregnant women and girls.

Prevention of parent-to-child transmission has focused on the health of the child rather than that of the mother. Mothers are often made to feel at blame for placing their child at risk of HIV infection. The focus on 'mother' to child rather than 'parent' to child has further placed the burden of responsibility onto mothers. VSO calls for 'parent' rather than 'mother' to child interventions which involve the father, where feasible, in joint testing, provision of treatment, care and support and in referral to other HIV & AIDS related services.

In focusing primarily on the ABC approach to HIV prevention, a hugely effective intervention has been under-utilised and under-funded. Parent-to-child transmission is relatively easy to prevent and yet the roll out of this treatment has been painfully slow.

## PREVENTION AMONG PEOPLE LIVING WITH HIV & AIDS

Within the ABC approach to HIV prevention, little attention has been placed on the rights of women, girls and men living with HIV & AIDS to have sex or to have children. It seems too obvious to state, but HIV prevention programmes must directly address the needs of people living with HIV & AIDS. There is a significant lack of prevention interventions providing information on how people living with HIV & AIDS can protect their own health by avoiding new STIs or giving information on how to negotiate safer sex with their partners.

Prevention messages focusing solely on condoms or abstinence do not address the desire, and social/family pressures placed on many women and men to have children. Information and services for voluntary counselling and testing, treatment, prevention and counselling for serodiscordant couples (couples where one person is living with HIV & AIDS and the other is not) must be made available and accessible.[37]

33 Parent-to-child transmission refers to transmission of HIV from the mother to the child that can occur in utero during the last weeks of pregnancy, at childbirth or through breast-feeding. VSO refers to reduction of parent-to-child transmission rather than 'mother' to child interventions as we believe that programmes to reduce transmission should involve the father, where feasible, in joint testing, provision of treatment, care and support and in referral to other HIV & AIDS related services.

34 Adapted from MSF, 2005, Paediatric HIV/AIDS Fact Sheet; and WHO, 2007, Briefing Note: Prevention of Mother to Child Transmission, prepared for the Conference on Retroviruses and Opportunistic Infections, Los Angeles, February 25-28, 2007.

35 WHO, UNAIDS, UNICEF, 2007, Toward Universal Access: scaling up priority HIV/AIDS interventions in the health sector, pp31–34.

36 Ibid pp31–34.

37 International HIV/AIDS Alliance, 2003, Positive Prevention: Prevention strategies for people with HIV/AIDS.

### INJECTING DRUG USERS

ABC does not work for injecting drug users and opposition from some donors and national governments to harm reduction programmes[38] means that the prevention needs of injecting drug users have gone largely unrecognised.[39] In 2006 in South Asia, more than one in five (22 per cent) infections were in injecting drug users.[40] Whilst injecting drug use is a key driver of the pandemic in many parts of Asia, injecting drug use is a factor in the spread of HIV & AIDS worldwide. This group is marginalised and highly stigmatised and consequently very hard to reach to deliver HIV prevention interventions. Moreover, the illegal nature of drug use often means that harm reduction and needle exchange programmes, known to be highly effective, have been denied to this group.

Service providers and policy makers usually perceive injecting drug users as male and there is very little information available on the extent of female-injecting drug use. It therefore becomes even harder to reach women and girls who may be injecting drugs because they become even more 'invisible' to society than their male counterparts. Equally vulnerable to HIV & AIDS are the non-injecting sexual partners (female and male) of injecting drug users. This is particularly true for female sexual partners who are less able to negotiate safe sex because of lack of acceptance or awareness about the rights of women and girls around sex.[41]

### PRISONERS

The ABC approach to HIV prevention does not take account of the needs of prisoners, many of whom are highly vulnerable to HIV & AIDS. Sex between males and drug use can be high in many prisons. In addition, groups vulnerable to HIV & AIDS such as sex workers, injecting drug users and males who have sex with males are more likely to be in prison as their behaviours are illegal in many countries. Prevention services must be available in prisons, including provision of condoms and harm reduction interventions. Voluntary counselling and testing, anti-retroviral treatment and STI treatment must also be available for prisoners.

## BEYOND ABC: THE FULL ALPHABET – COMPREHENSIVE EVIDENCE-BASED HIV PREVENTION FOR ALL

A comprehensive approach to HIV prevention cannot be reduced to a few letters – it requires use of the full alphabet.

The table that follows presents a comprehensive range of HIV prevention interventions that address issues of gender and power. VSO recognises that no one intervention on its own is ever enough; there is no one quick-fix solution. Only if structural gender inequalities are addressed will women, girls and vulnerable men have the power to access and to use HIV prevention interventions within this comprehensive package.

This table does not place interventions in order of importance although it does group interventions into two levels: a) medical and biologically-based interventions, and b) interventions that address the structural gender inequalities that drive the HIV & AIDS pandemic.

38 See footnote 30, for definition of harm reduction.
39 WHO, UNAIDS, UNICEF, 2007, Toward Universal Access: scaling up priority HIV/AIDS interventions in the health sector, pp17–19.
40 UNAIDS, 2006, Epidemic Update, pp24–36.
41 VSO, 2006, Gendering AIDS Bangladesh: Women, Men, Empowerment, Mobilisation.

| HIV PREVENTION INTERVENTION | GENDER DIMENSION |
|---|---|
| **a) medical and biologically-based interventions** | |
| Confidential, voluntary HIV counselling and testing (VCT) and provider-initiated HIV testing and counselling (PITC) | VCT and PITC must be gender sensitive, eg testing sites must be located in areas and open at times when women, girls and vulnerable men are able to access them; women, girls and vulnerable men must have a choice when deciding whether they test; testing must be confidential and HIV status must not be disclosed to partners, husbands or relatives without consent; counselling must be provided and the implications of testing made clear for each and every person undertaking a test; counselling must be available and address women's, girls' and vulnerable men's particular concerns, priorities and vulnerabilities in relation to a positive diagnosis and disclosure; it must take account of women and girls' vulnerability to violence if they are first to disclose; women, girls and vulnerable men receiving a positive diagnosis must be referred to a full range of gender-sensitive services including information on how to prevent HIV transmission. It is recommended that PITC, also known as opt-out testing, adheres to the above guidelines, and in addition should: include women, girls and vulnerable men in its design and implementation; provide women and girls with accessible information to make an informed choice as to whether or not they test; only be conducted with the informed patient's consent; reassure all patients that a positive test would not result in the denial of healthcare. To make all this possible, a significant investment in terms of training of health care workers is needed. VSO opposes all forms of mandatory HIV testing. |
| Abstinence | This can be an option for some, but is not an option for many women, girls and vulnerable men who may not have the choice to abstain, eg due to gender-based violence, rape, social status, economic deprivation etc. Abstinence must only be offered as one of a broad range of HIV prevention options. |
| Faithfulness | This does not work for a woman, girl or vulnerable man if her/his partner is not faithful. As with abstinence, faithfulness must be promoted as just one of a range of HIV prevention options and there must be an emphasis on mutual faithfulness. This should take into account the power relations that mean that women, girls and vulnerable men may not have control over their partners' faithfulness. Alternative HIV prevention interventions must be made available. |
| Male and female condoms | Women and girls may not have the power to negotiate condom use. Female condoms as a female-controlled prevention option (where female condoms are available and where women and girls have the power to negotiate use) must be made cheaper and more widely available. Information on consistent and correct use of both male and female condoms must be made available. |
| Clean needles and harm reduction for injecting drug users | Programmes for harm reduction and needle exchange must be available for injecting drug users (women, girls, men and boys) and must address the specific needs of female drug users (often an invisible group). Programmes must respond to gender implications of drug use and impact on partners of drug users who may not be able to negotiate safe sex. |

| HIV PREVENTION INTERVENTION | GENDER DIMENSION |
|---|---|
| **a) medical and biologically-based interventions** | |
| Pre-exposure prophylaxis (PrEP)[42] | The use of PrEP is a relatively new development and as it is rolled out, a gender analysis must be incorporated into defining who receives PrEP and in ensuring equitable access. |
| Post-exposure prophylaxis (PEP)[43] | PEP must be made widely available and appropriately used. It must be universally available for any emergency exposure including for women, girls and vulnerable men who have experienced gender-based violence, including rape. |
| Prevention of parent-to-child transmission (PPTCT) | Drugs must be available for all pregnant women and girls to prevent parent-to-child transmission. PPTCT programmes must include the husband or partner; ensure blame for HIV transmission is not placed on the mother; and must consider the needs of the mother and father as well as the child. PPTCT programmes must be sensitive to stigma associated with taking drugs at birth, not breastfeeding or exclusive breastfeeding etc. and be sensitive to potential resulting violence. PPTCT information must be provided through confidential voluntary counselling and testing and treatment services. |
| Comprehensive sexual and reproductive health services and STI control, prevention and treatment | Services must be available and accessible for women and vulnerable men, and young people (particularly girls), regardless of marital status. Stigma is a huge obstacle and equitable access may mean locating services in places accessible to women, girls and vulnerable men as well as ensuring confidentiality and being open at suitable times. Women, girls and vulnerable men must be provided access to STI control, prevention and treatment services through existing sexual and reproductive health services and HIV prevention interventions must be integrated into these. |
| Screening blood products and clean medical equipment | This potentially affects all women, girls and men – medical practitioners must adopt safe practices and national health systems must adopt policies for safe blood screening and clean equipment. |
| Safe medical and scarification practices[44] | Medical practices must be safe, for example needles must not be re-used as is sometimes the case, particularly in rural settings. Universal precautions for health care workers in the formal and informal sectors must be available.[45] Gender often determines who is involved in scarification practices and how scarification takes place – safe medical and scarification practices must be ensured, particularly in rural areas where unofficial medical practitioners often perform these. Female genital cutting must be legally banned, and actively discouraged within communities. |

42 Pre-exposure prophylaxis (PrEP) is the long-term use of a prophylactic antiretroviral treatment for HIV & AIDS prior to exposure in order to prevent transmission.

43 Post-exposure prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Definition from the WHO: www.who.int/hiv/topics/prophylaxis/en/

44 Scarification is the process of cutting or branding the skin to produce scar tissue that forms designs on the skin. Scarification is practiced in some cultures, for example, to signify rites of passage.

45 Universal precautions are a set of precautions designed to prevent transmission of HIV amongst health care workers. Universal precautions include protective barriers such as gloves, gowns, aprons and masks as well as post-exposure prophylaxis. Universal precautions can also involve precautions to prevent injuries caused by needles, scalpels and other sharp instruments or devices. Definition adapted from Aid on AIDS: www.ranbaxy.com/aidonaids/fordoctors/universal-precautions.htm

| HIV PREVENTION INTERVENTION | GENDER DIMENSION |
|---|---|
| **a) medical and biologically-based interventions** | |
| Access to treatment | There must be equal access to treatment for women, girls and vulnerable men – full access to treatment is linked to more women, girls and vulnerable men testing, therefore knowing their status, accessing services and protecting themselves and their partners. Treatment also reduces likelihood of transmission. Universal access to treatment will only be sustainable if the number of new HIV infections is significantly reduced.[46] Preventive counselling and information must be provided as part of treatment programmes. |
| New prevention technologies including cervical barrier methods, microbicides and vaccines as they become available | Investment in new prevention technologies that increase women and girls' control must receive increased funding and support. It is important, however, to recognise that many of these technologies are still a long way off and, once developed, must be rolled out in an equitable way that will allow women, girls and vulnerable men to access and use them. In the meantime, alternative HIV prevention interventions must be made accessible and available to women, girls and vulnerable men. |
| Male circumcision | Male circumcision as an intervention must be rolled out with caution – evidence around long-term impact is still incomplete and there are issues around consent. Women and girls remain vulnerable, as male circumcision does not provide full protection. If delivered, male circumcision must be part of a comprehensive package, limitations must be carefully communicated, referral to other services should be made and it should be used as an opportunity to deliver HIV & AIDS and STI prevention messages. Male circumcision must be safe and voluntary, counselling must be provided, including the need to maintain safe sex practices, and information regarding sexual and reproductive health should be given. More research is needed on whether male circumcision benefits women, girls and males who have sex with males. |

46 UNAIDS, 2007, Practical Guidelines for Intensifying HIV Prevention, p5.

| HIV PREVENTION INTERVENTION | GENDER DIMENSION |
|---|---|
| **b) interventions that address structural gender inequalities** | |
| Reducing gender-based violence | Through training and education, the attitudes of magistrates and families, police and law enforcement officers must be changed and schools must promote anti-violence in their practices – eg charters, assemblies, staff behaviour etc. Anti-violence education must take place from an early age. Gatekeepers of society, particularly traditional and religious leaders, should also receive training in order to challenge gender-based violence. Programmes addressing the causes and impact of violence must be widely available to both perpetrators and women, girls and vulnerable men who have experienced violence. |
| Programmes to challenge structural gender inequalities[47] | HIV prevention programmes must be developed to work with women and men, girls and boys, to challenge gender norms that reduce women and girls' power to negotiate safe sex. This must include information, training, and education accessible to women and men, girls and boys. It must involve communities and leaders challenging women and men, girls and boys to address structural gender inequalities. Governments and service-providers must ensure that their policies and programmes actively address these inequalities and do not increase them. |
| Comprehensive sexual health and rights education for girls and for boys | Girls and boys must receive the full range of comprehensive, evidence-based HIV prevention information. Information and lessons must go beyond presenting the facts to providing a space for girls and boys to discuss, challenge and analyse gender relations. This should include gender equality, girls' empowerment, mutual respect, gender awareness education for boys and girls, and empowerment training for girls. Gender norms that prevail in school systems, eg listening to boys rather than girls, teaching girls and boys different subjects and sexual harassment in schools, must be challenged by teachers, pupils and parents/guardians. Out-of-school girls and boys must also receive sexual health and rights education through accessible outreach programmes. |
| Peer education | A full range of HIV prevention options must be provided, which include girls as well as boys as peer educators and address the different prevention needs of boys and girls. The power balance inherent in peer education and its potential to be abused must be acknowledged and addressed. |
| Behaviour change strategies such as correct and consistent condom use, reduction of multiple concurrent partnerships and delayed sexual debut | Comprehensive behavioural interventions must take account of the social context when mounting individual-level programmes, which attempt to modify social norms to support uptake and maintain behaviour change, and tackle the structural factors that contribute to risky sexual behaviour. Strategies such as reduction of multiple, concurrent partnerships must target both women and men. Men must be involved in challenging the gender stereotypes that make them and their partners vulnerable to HIV & AIDS. Governments must support social movements for behaviour change and deliver gender-sensitive locally appropriate public information campaigns. |

47 This includes programmes addressing gender-based violence as above.

| HIV PREVENTION INTERVENTION | GENDER DIMENSION |
|---|---|
| **b) interventions that address structural gender inequalities** | |
| Women and girls' economic empowerment | Economic stability reduces the need for survival strategies such as sex work, early marriage, or staying with an abusive partner due to economic necessity, which increase women and girls' vulnerability to HIV & AIDS. Economic empowerment can challenge the 'sugar daddy and mummy' phenomena of inter-generational sex that increase vulnerability of young women and girls in particular. Income-generating activities, credit schemes, skills and vocational training, access to loans and banks and social protection[48] must be available to women and girls. Governments must take responsibility for women and girls' economic empowerment and address the overriding economic inequalities that increase vulnerability to HIV & AIDS. |
| Reduce the burden of HIV & AIDS care on women and girls | Women and girls are made vulnerable to HIV & AIDS due to the excessive load that home-based care places on them. Women and girl caregivers must be recognised, supported and remunerated. Men must be involved in care-giving and public health systems must be strengthened in order to reduce the burden placed on women and girls in communities.[49] |
| Addressing unsafe practices which make women and girls vulnerable | Practices such as early marriage, wife sharing, widow inheritance and dry sex (where the vagina is dried using herbs, soil or other substances often resulting in vaginal abrasions during sexual intercourse) must be addressed through community dialogues. Working with community leaders and institutions, policies and laws that make early marriage, property grabbing and widow inheritance legal must be changed. Female genital cutting must be legally banned, and actively discouraged within communities. Sensitivity and care must be taken when addressing cultural and religious practices that make women and girls vulnerable to HIV & AIDS. |
| Reduction of HIV & AIDS related stigma and discrimination through awareness-raising and other programmes | Women, girls and vulnerable men are particularly subject to HIV & AIDS-related stigma and discrimination that may reduce access to VCT services or discourage risk reduction behaviours such as use of condoms or disclosure to sexual partners. Knowing one's status reduces the spread of HIV & AIDS and by challenging stigma, HIV transmission is reduced. Stigma-reduction programmes must include: training for medical professionals, broad awareness-raising campaigns including media campaigns, testimonials from people living with HIV & AIDS etc.[50] |

Table 1[51]

Which of these interventions are prioritised depends, in any given circumstance, on context and choice of those individuals accessing services. There may be other interventions not included here – VSO welcomes suggestions for additions from organisations and individuals working on HIV prevention programming and policies.

The interventions in Table 1 above should be delivered in line with the good practice principles outlined in the next chapter and summarised in Table 3 (page 32-33).

Donors, national governments, civil society and the international community must work together to ensure that their programmes address the full range of comprehensive, gender-sensitive HIV prevention options.

48 The term 'social protection' can be used to describe a range of public, private or informal interventions to reduce vulnerability and risk faced by the poor. These interventions can be described under terms such as social security, social assistance, safety nets and social policy. Such interventions include, but are not limited to: cash transfers, social pensions, and cash or food for work. For full definition, see VSO, 2006, Reducing the Burden of HIV & AIDS Care on Women and Girls: VSO Policy Brief, pp 15–16.

49 VSO, 2006, Reducing the Burden of HIV & AIDS Care on Women and Girls: VSO Policy Brief.

50 VSO-RAISA, 2005, Regional Conference, Stigma and Discrimination Report Back.

51 This table was developed from a conversation in 2006 with Professor Michael Kelly who presented a spectrum of HIV prevention interventions.

# CHAPTER 3: ENABLING COMPREHENSIVE HIV PREVENTION - GOOD PRACTICE

Building on the gender analysis of HIV prevention interventions given in Chapter 2, this chapter outlines how HIV prevention programmes, practises and policies must respond to the gendered nature of the pandemic through adopting a 'three-pronged approach'.

## STRONG PUBLIC HEALTH SYSTEMS

In order to deliver the comprehensive package of HIV prevention interventions outlined in Table 1 (see pages 17-21), strengthening of both formal and informal health systems is necessary. Many public health systems in developing countries are weak and the HIV & AIDS pandemic has brought an already simmering crisis to the boil. A comprehensive response to HIV & AIDS must include strengthening public health systems to increase the capacity of governments to respond better to HIV prevention needs. This must include strengthening patient-centred health systems with:

- increased training for all health care workers (including community caregivers) on the full range of HIV prevention options and on reducing HIV & AIDS-related stigma and discrimination;
- improved conditions of service and promotion opportunities;
- improved supply and distribution of prevention commodities including condoms (male and female), needles and equipment for confidential voluntary counselling and testing, drugs and equipment for prevention of parent-to-child transmission, harm reduction (clean needles and drug replacement), treatment for STIs, post-exposure prophylaxis and clean and effective medical equipment;
- improved management systems and better infrastructure including clinics, hospices, laboratories and hospitals;
- integration of HIV & AIDS services into sexual and reproductive health services.

Improved health systems that are able to deliver a full and effective package of HIV prevention interventions require increased, predictable, long-term funding, and donors must make this available. In addition, more funds must be allocated to health budgets from national budgets. African governments should meet the target set in Abuja in 2001 to allocate 15 per cent of the national budget to health.[52] This 15 per cent commitment must be expanded to non-African governments. G8 leaders must provide funds to fully realise commitments made to universal access to HIV & AIDS prevention, treatment, care and support made at Gleneagles in 2005.[53] In order for improvements in health systems to be meaningful and enable access to comprehensive, evidence-based HIV prevention information and services, barriers to accessing available health care must be removed and user fees must be abolished. There must be greater coordination between health systems and community health initiatives to ensure accurate and accessible information and services.

## MAINSTREAMING[54]

An important tool in implementing this comprehensive package of HIV prevention interventions is mainstreaming HIV prevention. All development interventions must incorporate HIV prevention information and services into their policies and programmes – whether government, NGOs, CSOs or donors. Moreover, HIV prevention interventions must be incorporated into the plans of all government departments and into legislation (see Chapter 4 for more information). Mainstreaming interventions must be comprehensive and based on evidence.

52 African Union, 2006, Africa's Common Position to UNGASS, June 2006, Abuja
53 G8, Gleneagles Communique, 2005.
54 VSO, 2004, HIV & AIDS Mainstreaming Guide for VSO Offices.

In the livelihoods sector, for example, this may mean making sure people are fed well and are therefore healthy and less likely to transmit HIV. Women and girls' participation in governance and decision-making increases their ability to raise their issues and report abuse. Integrating HIV prevention information into the school curricula provides children and young people with the information they need to make choices about sex. Health interventions create a healthier person that, again, reduces vulnerability to HIV & AIDS.

## THE 'THREE-PRONGED APPROACH'

In 2003, VSO's publication, *Gendering AIDS*, outlined a 'three-pronged approach' to tackling the gender inequalities that drive the HIV & AIDS pandemic.[55] The 'three-pronged approach' states that:

1. HIV prevention programmes and policies must address the structural inequalities between women and men that are driving the pandemic.
2. HIV prevention programmes and policies must address the immediate needs of women, girls and vulnerable males in terms of their vulnerability to infection.
3. HIV prevention programmes and policies must involve men – men must be included as a part of the solution and should not be stigmatised as the 'vectors of disease'.

Central to all three elements of this approach is meaningful involvement of people living with HIV & AIDS. This section illustrates how the 'three-pronged approach' can be used to implement the comprehensive, gender-sensitive, evidence-based approach to HIV prevention outlined above in Table 1 (pages 17-21).

### 1. HIV PREVENTION PROGRAMMES AND POLICIES MUST ADDRESS THE STRUCTURAL INEQUALITIES BETWEEN WOMEN AND MEN THAT ARE DRIVING THE PANDEMIC.

VSO believes that HIV prevention interventions are failing because the current focus is on technical solutions. Prevention technologies are, of course, important in reducing HIV prevalence, but they will not work in isolation. These technologies are rendered useless if women, girls and vulnerable men do not have the power to use them. If structural gender inequalities are to be addressed, those who hold power within society, such as traditional and community leaders, must be central in the design and implementation of HIV prevention policies and programmes and these interventions must be located in and owned by communities.

#### EDUCATION AND SOCIAL POWER

Barriers to attending school must be removed for girls. This means removing school fees and costs involved in attending school, such as books and uniforms. It means addressing the broader economic vulnerability of women and girls which lead them to drop out of school, including the burden of care for people living with HIV & AIDS which continues to fall on women and girls. As highlighted in our *Policy Brief: Reducing the Burden of HIV & AIDS Care on Women and Girls*[56], VSO calls for social protection for caregivers and for girls and boys who are at risk of dropping out of school.

Comprehensive sexual and reproductive health education and programmes that foster the development of communication skills for young women and girls must be given priority and resources channelled accordingly. This must go beyond comprehensive, evidence-based information about HIV & AIDS to include skills

55 VSO, 2003, Gendering AIDS.
56 VSO, 2006, Reducing the Burden of HIV & AIDS Care on Women and Girls: VSO Policy Brief.

around negotiation and equality within relationships, discussion around an end to physical and sexual violence and the right to consent.[57] The results of holistic education for girls and boys, which includes gender awareness, will be felt in years to come as today's pupils become tomorrow's mothers and fathers, overseeing their daughters' and sons' education in a different way.

Teachers must be trained on how to conduct lessons and open discussions around sexual and reproductive health and rights and high priority must be given by national governments to training teachers to teach about HIV & AIDS. Both in-service and pre-service teacher training should include compulsory HIV & AIDS components that are examinable and certifiable. Training programmes must be based on accurate and appropriate information that goes beyond simple HIV prevention messages and the ABC approach.[58] Furthermore, programmes must be designed to reach out-of-school children and young people – a highly vulnerable group.

## ECONOMIC POWER

VSO calls for programmes that support women and girls' economic empowerment as a strategy for challenging gender norms which drive women and girls' vulnerability to HIV & AIDS. This must include educational and employment opportunities for women, income generation activities, support for small business enterprises amongst women, access to financial institutions for loans and bank accounts, and social protection for vulnerable women and girls.

### ECONOMIC EMPOWERMENT AND HIV PREVENTION AMONG RURAL WOMEN IN MOZAMBIQUE

In 2006, VSO gave a small grant to the Association of Agriculturalists and Livestock Technicians (ATAP) and 10 women who looked after children affected by AIDS, some of whom engaged in high risk sexual activities for income, received training on HIV prevention. They also received training on how to run small businesses. The women used this training to raise awareness in their communities about HIV & AIDS and used business skills training to run two community shops.

Resulting from this intervention, five of the women have joined a traditional saving scheme through which they get 1500 Meticais (£30) every three months. The community is now more open to discuss HIV prevention. Men now ask for condoms to be sold in the community shops run by the women and for those that can read there are leaflets on HIV & AIDS and STIs available. A follow-up evaluation found that the women's increased income has meant that they have more bargaining power in decisions at home – including negotiating safer sex with their partners – as their families have seen the benefits the increased income has brought.

Governments must address broader issues around poverty, gender inequality and violence which make women and girls particularly vulnerable to HIV & AIDS – individuals alone cannot be expected to address the root causes of poverty.

## PARTICIPATORY AND EMPOWERING HIV PREVENTION

Not only does gender often determine who has access to health services, most decisions about service delivery and design are made by men who often dominate management within government, NGOs, health systems and communities. This bias may mean that norms of male identities are reinforced in service delivery

57 International Women's Health Coalition, 2006, 'Realizing the Reproductive Health Rights and Needs of People Living with HIV/AIDS'. A panel at the XVI International AIDS Conference, Toronto, Canada, 2006.

58 Global Campaign for Education, 2006, Teachers for All: what governments and donors should do.

whilst women's, girls' and vulnerable men's priorities are not addressed in programme design.

By involving women, girls and vulnerable men in the design and implementation of prevention programmes and policies, not only are these groups able to make their own choices and decisions, they also ensure that interventions reflect their realities. Involvement of vulnerable women, girls and men, including people living with HIV & AIDS, improves the services they are expected to access and can give them the skills and confidence to be able to act on their own choices in their own relationships and lives. However, it is not enough to sit at the table. Participation must be meaningful and representation must be equitable with different vulnerable groups involved and a balance between the sexes in representation.

## 2. HIV PREVENTION PROGRAMMES AND POLICIES MUST ADDRESS THE IMMEDIATE NEEDS OF WOMEN, GIRLS AND VULNERABLE MEN IN TERMS OF THEIR VULNERABILITY TO INFECTION.

Whilst addressing the underlying structural causes of gender inequalities, the scale and urgency of the HIV & AIDS pandemic requires a response that addresses the immediate needs of women, girls and vulnerable men. These immediate needs vary from context to context and responses will only be effective if tackled hand-in-hand with the structural gender inequalities that prevent women, girls and vulnerable men from accessing available information and services.

### AUDIENCE AND CONTEXT

HIV prevention programmes must be tailored to their specific contexts. Thus, in low prevalence settings, it is often (although not always) most appropriate to target prevention programmes and policies at particular groups. In high prevalence settings, however, it may be more appropriate to target the wider population.

Within vulnerable groups, there are many different identities and needs with regard to HIV prevention. HIV prevention policies and programmes must recognise the diversity of experiences and requirements of specific groups. For example: for injecting drug users, harm reduction and needle exchanges must be available; for males who have sex with males, information about HIV transmission and condoms must be available; and for pregnant women and girls living with HIV & AIDS, and their partners and husbands, information and services around prevention of parent-to-child transmission must be universally available.

Whilst specific vulnerable groups may require specific information and services, they also have a right to access the full range of services outlined in Table 1 (see pages 17-21). It is important to re-emphasise that no single prevention intervention is likely to work on its own. And, of course, all HIV prevention interventions must incorporate a gender analysis, in order to respond to the gender inequalities that drive vulnerability to HIV & AIDS.

### SETTINGS AND METHODS OF DELIVERY

Settings and methods of delivery must be appropriate for different audiences. For example, drama and pictorial representations delivered in an area where women and girls gather may be appropriate in rural areas where many women and girls may be illiterate and/or not speak the national language.

## PAPUA NEW GUINEA: TOKAUT AIDS PROJECT – USING THEATRE FOR HIV PREVENTION

"Sorry for us women. We work too hard; we look after our families, our children, the garden. Men go out and sleep around, catch the sickness, then come home". FEMALE INTERVIEWEE PARTICIPATING IN TOKAUT AIDS EVALUATION

Tokaut AIDS is a four-year VSO-supported project funded by Big Lottery in Papua New Guinea. The project provides education awareness to 40 communities through repeated community theatre visits, while implementing basic HIV & AIDS training for community health workers and educators. Forum theatre, image theatre and theatre performance are used as tools to share information, promote community discussion and identify the need for behaviour change. In-depth peer group discussions give all members of the community, young and old, men and women, an opportunity to ask questions within a safe and supportive environment.

In some communities, women and girls may not be permitted to leave their homes without a male family member. In these circumstances, visits from outreach workers to homes or awareness raising around HIV prevention options through radio programmes may be a preferred option. For men, market places or bus stops passed on the way to work, truckers' stops, bars and sports grounds may be appropriate settings for delivery of HIV prevention information and services.

Central to this approach is responding to what works for different groups, adapting settings and methods of delivery accordingly. The emphasis is thus on the service provider to make the service accessible, not on the individual who may face multiple obstacles to accessing HIV prevention services.

## SEX WORK IN BANGLADESH

Rizwana, an 18-year-old sex worker, attends a drop in centre for street-based sex workers in the Chittagong City Corporation area, Bangladesh. The drop in centre is run by VSO partner, Young Power in Social Action, a social development NGO that has been delivering HIV prevention programmes in Bangladesh for the past decade.

Rizwana says:
"I heard about the drop in centre from peer educators and outreach workers who came to our cruising spot. Normally STI medication is very expensive but at the drop in centre it's free. They even have games. It's better than staying in the streets because we can sleep at the drop in centre in the daytime."

## PREVENTION INFORMATION AND SERVICES THAT TARGET EVERYONE

There is a need, particularly in high prevalence settings (although also in low prevalence settings) for HIV prevention information and services that are accessible to all. HIV prevention messages must be comprehensive and based on evidence around what works. They must present the full range of interventions outlined in Table 1 (pages 17-21). Condoms (male and female) must be widely available to women, girls and men and not just for key vulnerable populations. Interventions must also highlight the gendered nature of HIV transmission and support women, girls and men to challenge gender norms that increase vulnerability to HIV & AIDS.

### FEMALE-CONTROLLED HIV PREVENTION TECHNOLOGIES

There is a continued need for female-controlled HIV prevention technologies, as a means of increasing women and girls' power in relation to sex. Policy-makers must continue to support the development of microbicides[59] and vaccines. However, this must be coupled with research to ensure that lessons are learnt from the poor take-up of other women and girl-friendly interventions such as female condoms and prevention of parent-to-child transmission. It is also the case that these technologies may still be some time off and so the immediate needs of women, girls and vulnerable men must continue to be addressed in our prevention programmes and policies as outlined above.

New HIV prevention technologies are not a solution in themselves; as long as gender inequality remains so HIV will continue to be transmitted, whether or not microbicides or vaccines exist. Technologies will not solve social inequalities and gender inequalities in themselves, but if developed and rolled out in a gender-sensitive manner, they have huge potential to reduce HIV transmission.

## 3. HIV PREVENTION PROGRAMMES AND POLICIES MUST INVOLVE MEN – MEN MUST BE INCLUDED AS A PART OF THE SOLUTION AND SHOULD NOT BE STIGMATISED AS THE 'VECTORS OF DISEASE'.

"Men should think not about what we stand to lose but about what we stand to gain."[60]

By constructively involving men, VSO means ensuring that interventions and policies address how concepts of masculinity increase both women and girls' and men's vulnerability to HIV & AIDS and proactively attempt to mitigate the impact of the pandemic. Policy-makers need to acknowledge explicitly how current beliefs concerning masculinity can increase women's, girls' and men's vulnerability to HIV & AIDS and conversely, how these beliefs must be addressed in order to reduce vulnerability. Policy-makers must also emphasise how channelling positive aspects of masculinity can tackle the epidemic, and create more equal relationships between women and men by involving men. Men are heavily involved in designing and implementing policies, but are often overlooked when the focus of policies and projects is at grassroots level.

Men's groups in South Africa and Namibia, such as the White Ribbon Campaign and Men for Change, hold men's meetings in bars, football grounds and other places where men gather. Here they discuss subjects such as HIV & AIDS, violence against women and girls and unemployment. They allow men space to think about their own behaviour, and to develop ways to change it if they wish. In relation to HIV & AIDS, these organisations encourage men to get involved at the grassroots level by taking responsibility for their actions, whether by using condoms or reducing the number of their sexual partners. In turn, this reduces the burden of responsibility on women and girls. They also create more visible role models for other men and boys, who may find it easier to relate to members of the community than to politicians or sports stars. In some contexts, local chiefs and village headmen have an important role to play in bringing issues about masculinity into the open.[61]

Involving men is one central strand of a wider strategy to address gender inequality and reduce the spread of HIV & AIDS and must not be overlooked.

59 A microbicide is a product used vaginally to prevent infection by HIV or other sexually transmitted infections (STIs). Microbicides may be presented in many forms, including gels, creams, suppositories, films or impregnated in a sponge or vaginal ring. Definition from the Microbicides Development Programme, www.mdp.mrc.ac.uk/what.html.

60 Participant at RAISA conference quoted in VSO, 2003, RAISA Men, HIV & AIDS Conference Report.

61 VSO, 2003, Gendering AIDS, p39.

## VSO'S RESPONSE

VSO sends international volunteers to build local capacity where requested by communities or governments. These volunteers are recruited from Kenya, Uganda, India, the Philippines, the Netherlands, Canada and the UK. VSO volunteers support a range of HIV prevention interventions such as the delivery of HIV prevention messages through street theatre (see page 26); training teachers in HIV & AIDS; supporting curriculum development; reducing stigma and discrimination; and working with organisations that challenge social norms. In Malawi, for example, VSO volunteers and their colleagues at Gemmacadett Youth Organisation in Rumphi have been using sport as a means of communicating HIV & AIDS prevention and behaviour change messages. Life-skills training is offered before sporting events begin and, although it is difficult to directly attribute to this initiative, increasing numbers of young people are accessing voluntary counselling, testing and sexual and reproductive health services in the area.

In China, VSO volunteers supported HIV & AIDS training in five teacher training institutes which resulted in 5000 students receiving HIV & AIDS education and 100 per cent of those trained naming accurate ways of preventing HIV transmission. In Kenya, through delivery of small grants, VSO helped three partners to start school-based HIV & AIDS prevention clubs, developing interactive youth forums using website technology and through providing training in HIV & AIDS peer education for youth groups. In Vanuatu, as a result of VSO support from volunteers to develop new services, voluntary confidential counselling and testing has been established on the second largest island, Santo. In Santo, VSO volunteers worked with sexual and reproductive health care managers to integrate HIV counselling and testing into their work. Seventy people a week are now counselled and confidentially tested for HIV.

VSO's strengths include supporting national advocacy initiatives of partners, working with networks of people living with HIV & AIDS and supporting interventions that meet the needs of vulnerable groups.

As development professionals in their sectors, volunteers are encouraged to think about how they can respond to HIV & AIDS and mainstreaming interventions are prioritised. Volunteers are also encouraged to reflect on and change their own behaviour where necessary.

### RWANDA – PREVENTION OF HIV & AIDS IN RWANDA THROUGH EDUCATION (PHARE) PROJECT

VSO volunteers have worked through the PHARE project to develop standard HIV & AIDS programmes for anti-HIV & AIDS clubs. This has involved developing a 'training of the trainers' manual on HIV prevention in schools. Volunteers trained 37 school head teachers and 62 teachers in basic HIV & AIDS awareness. The trained teachers will take a lead in future activities on HIV prevention in schools, using the training manuals developed by the PHARE project. The PHARE project has widened the space for debating HIV & AIDS in schools and in neighbouring communities. As a direct result of the training of head teachers, it is becoming good practice for schools to develop guidelines around HIV & AIDS workplace policies at school and, to date, 10 have been developed.

# CHAPTER 4: RECOMMENDATIONS FOR INTERNATIONAL AND NATIONAL BODIES

Providing access for women, girls and vulnerable men to comprehensive, evidence-based, gender-sensitive HIV prevention information and services, as outlined above, requires policy change. Where strong policies exist, governments, as duty bearers, and international institutions must be held to account for ensuring meaningful implementation of those policies.

Key policies operate at multiple levels, from local to international, and may be in the form of: declarations, commitments, conventions, charters, guidelines, national HIV & AIDS plans or ministerial plans. Many of these policies could be effectively used to realise comprehensive, evidence-based HIV prevention for all, but most are not being implemented and, as such, become meaningless. At the same time, there are also many significant policy gaps where reform and change is needed.

However, we do have significant opportunities to hold governments, donors and international institutions to account. Below we highlight key international targets in relation to HIV prevention.

| INTERNATIONAL AGREEMENT | KEY COMMITMENTS |
|---|---|
| *International Conference on Population and Development (ICPD), Cairo, 1994 ICPD+5, 1999*[62] | Universal access by 2015 to reproductive health care, access for 90% of young people aged 15 to 24 by 2005 and 95% by 2010 "to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection." |
| *Fourth World Conference on Women, Beijing Platform for Action, September 1995*[63] | Review and amend laws and practices which contribute to women and girls' vulnerability to HIV & AIDS, develop gender-sensitive programmes including involvement of men in HIV prevention, provide all women and girls with "all relevant information and education about sexually transmitted diseases including HIV/AIDS". |
| *UNGASS Declaration of Commitment (2001)*[64] | Commitment to a "wide range of prevention programmes". |
| *2005 G8 Communiqué*[65] | Commitment to a "package for HIV prevention, treatment and care" and to "as close as possible provide universal access for all who need it by 2010". |
| *EU Prevention Statement, 2005*[66] | Commitment to "evidence based HIV prevention", opposed "partial or incomplete messages on HIV prevention", commitment to reaching vulnerable groups including injecting drug users and males who have sex with males. |

62 UNFPA, 1994, Programme for Action, International Conference on Population and Development, paragraphs 8.28–8.35; and UNFPA, International Conference on Population and Development +5, 1999, paragraph 70.
63 UN, 1995, Fourth World Conference on Women, Strategic Objective C3, paragraph 108.
64 UN, 2001, Declaration of Commitment on HIV/AIDS, paragraph 52.
65 G8, 2005, Gleneagles Communiqué, paragraph 18d.
66 EU, 2005, EU Statement on HIV Prevention for an AIDS-Free Generation.

| INTERNATIONAL AGREEMENT | KEY COMMITMENTS |
|---|---|
| *2006 G8 Communiqué*[67] | "implementation of comprehensive, evidence-based strategies for prevention, and the development of new and innovative methods of prevention". |
| *Africa's Common Position to UNGASS, Abuja 2006*[68] | "prioritise gender equality, women's social and economic empowerment and prevention of gender-based violence".<br>Eighty per cent of pregnant women and girls to have access to prevention of mother-to-child transmission services by 2010, 80% of target populations to have access to condoms, voluntary counselling testing and services for STIs. |
| *UNGASS Political Declaration (2006)*[69] | "comprehensive, evidence-based prevention strategies for young people", "eliminate gender inequalities", commitment to involving men and empowerment of women and girls. |

TABLE 2

## POLICY GAPS AND IMPLEMENTATION

A review of existing policies and targets reveal an uneven commitment to access to comprehensive, gender-sensitive and evidence-based HIV prevention information and services. Many of the international commitments above do not make specific time-bound targets, or where made, these have not been met. Clear targets must be set if commitments are to be meaningful.

VSO would like to see **incorporated into the G8 commitment to universal access** to prevention, treatment, care and support, a specific recognition and commitment to universal access to **comprehensive, evidence-based, gender-sensitive HIV prevention information and services**. We believe that political leadership is needed to re-affirm that universal access also means access to the full (universal) range of prevention information and services available. VSO also calls for clear international and national targets for achieving this.

UNAIDS has developed Practical Guidelines for Intensifying HIV Prevention. VSO urges national governments to adopt these guidelines and UNAIDS to maintain momentum and support to ensure that these guidelines are fully supported.[70]

An overview of national policies provides a similarly patchy commitment to the comprehensive, evidence-based approach to HIV prevention that governments have signed up to at the international level. For example, programmes providing information to injecting drug users about safe injecting are undermined by policies to jail drug users for the possession of clean needles whilst those imprisoned for drug use or sex work are placed at greater vulnerability to HIV in prison. Similarly, programmes working with males who have sex with males and transgender people are undermined by violence, harassment and imprisonment of these groups.[71]

Human rights abuses, including the denial of comprehensive evidence-based prevention information, violence against women and girls and harassment of males who have sex with males are often endorsed by the state contributing to stigmatisation of women, girls and vulnerable men and enhancing their risk of HIV infection further. For example, efforts to work with communities of males who

67 G8, 2006, Heiligendamm Communique, paragraphs 48–57.
68 Africa Union, 2006, Africa's Common Position to UNGASS, Abuja, p2, p5–6.
69 UN, 2006, Political Declaration on HIV/AIDS, paragraphs 20, 22, 26 and 49.
70 UNAIDS, 2007, Practical Guidelines for Intensifying HIV Prevention.
71 UK Civil Society on HIV/AIDS response to EU Statement on HIV Prevention, November 20, 2005.

have sex with males in India are made difficult due to the harassment of peer educators by members of the police, and the reluctance of some state AIDS control societies to fund activities with males who have sex with males. In Chennai, India, peer educators report being arrested and harassed by members of the police for carrying condoms. It has become clear that police carrying out arrests and harassment are not necessarily aware of the law in relation to homosexuality, but are driven to act because of the stigma surrounding male-to-male sexuality. Similarly, violence against female sex workers and peer educators is on the rise in Karnataka in India – VSO partner organisations say this is because sex workers increasingly challenge why they are arrested.[72]

Support for work with vulnerable groups such as males who have sex with males; injecting drug users; and sex workers and their sexual partners is critical to HIV prevention. There must be changes to official policy and practice which restrict access, and appropriate health interventions.

### BANGLADESH – NATIONAL POLICIES LIMIT ACCESS TO HIV PREVENTION INFORMATION AND SERVICES

In Bangladesh, there is a wide range of policies that VSO partners have found to restrict their HIV prevention programmes. These include the following:

- Banning of the sale of condoms to minors, which means that sexually active youth have no means of protecting themselves against HIV infection.
- The status of sex workers in Bangladesh is unclear and legislation is sufficiently ambiguous to allow individual police officers to arrest sex workers at will.
- The National Vagrancy Act (1942) allows law enforcers to arrest sex workers and males who have sex with males and place them in vagrant homes that are in reality similar to prisons.
- The lack of sufficient safeguards regarding inappropriate police action with these vulnerable groups has resulted in abuses including rape, levying of fines against sex workers and accepting bribes to look the other way as underage girls are passed off as adults.[73]

## A CALL TO ACTION FOR GOVERNMENTS, DONORS AND INTERNATIONAL INSTITUTIONS

The examples given above illustrate the extent of stigma and discrimination against women, girls and vulnerable men seeking to access HIV prevention information and services, whether officially endorsed through policy, lack of implementation or social norms. They also illustrate the need for HIV prevention interventions based on a practical analysis of what actually works.

VSO calls on national governments to re-appraise their HIV prevention policies in light of an analysis of the specific needs of women, girls and vulnerable men and taking account of the evidence around what works. National governments must change policies that make it difficult for women, girls and vulnerable men to access prevention information and services or increases their vulnerability to HIV & AIDS. For example:

- reverse legislation which makes homosexuality illegal;
- reinforce women and girls' rights to property and inheritance;
- ensure girls' right to education is realised;
- legalise needle exchanges; and
- harm reduction programmes.

72 VSO, 2003, Gendering AIDS, p36.
73 Adapted From VSO, 2006, Gendering AIDS Bangladesh.

VSO calls on all governments and national and international policy makers, donors and institutions to include a gendered analysis in every prevention programme and policy development (see Chapter 2). All HIV prevention policy makers must commit to providing access, in response to the specific needs of women, girls and vulnerable men, to the full range of comprehensive, evidence-based and gender-sensitive HIV prevention information and services.

## RECOMMENDATIONS TO ALL STAKEHOLDERS

These recommendations outline key demands for all stakeholders (including donors, national governments, international institutions and civil society) to make the good practice HIV prevention programming outlined in the previous chapters a reality. Governments have committed to providing access to comprehensive, evidence-based HIV prevention information and services for all in the 2001 UNGASS Commitment, the 2006 Gleneagles Communiqué and in other international commitments. The demands listed below for all stakeholders outline the steps that they can take to make these commitments a reality. This good practice outlined below and above in Chapter 3 must be reflected in policy formulation, international guidelines and policy implementation.

| **Stakeholders must incorporate good practice principles for gender-sensitive HIV prevention programmes into policy formulation and implementation:** |
|---|
| All HIV prevention programmes must address gender and power within relationships, whether between women and men, males who have sex with males or transgender relationships. |
| HIV prevention messages should be designed to target specific groups' needs. There must be HIV prevention messages which target everyone, however particular emphasis must be placed on delivering specific messages to: married women; girls; young people; people with disabilities; people living with HIV & AIDS; males who have sex with males; injecting drug users; prisioners; and sex workers. |
| All HIV prevention messages must embrace a comprehensive, gender-sensitive, evidence-based approach; and must promote a full range of HIV prevention options as outlined in Table 1 (see pages 17-21) in order provide individuals with the right to choose which HIV prevention method is most appropriate for them. |
| All HIV prevention information must be tailored to audience and context in terms of the message, method and place of communication. |
| Appropriate settings and methods of delivery of HIV prevention information must be used. |
| HIV prevention messages must be rooted in participatory activities that empower all, especially vulnerable groups such as males who have sex with males; injecting drug users; people with disabilities; and migrant workers many of whom are marginalised and stigmatised by current strategies. |
| Women, men, girls and boys living with HIV & AIDS must be involved in the design and delivery of HIV prevention programmes which must be provided for both people living with HIV & AIDS and those who are not. |

| Stakeholders must incorporate good practice principles for gender-sensitive HIV prevention programmes into policy formulation and implementation: |
|---|
| Countries and communities living with HIV & AIDS must be involved in the design and delivery of HIV prevention programmes to ensure that these programmes respond to national and local realities rather than priorities set by donors. |
| HIV prevention must be mainstreamed across development interventions. |
| New female-controlled HIV prevention technologies must receive full funding and must be developed and rolled out in a gender-sensitive way. |

TABLE 3

In addition, all stakeholders must:

- adhere to the key HIV prevention principles outlined above in the design and implementation of HIV prevention programmes;
- design, implement and fund HIV & AIDS programmes which a) increase the constructive involvement of men, b) empower women and girls by implementing existing policies and c) meet the immediate needs of women and girls;
- include in HIV prevention programmes a full gender analysis based on the different needs and roles of women and men, girls and boys, including specific vulnerable groups of women, girls and men. This should take account of policies and laws, which may increase vulnerability and identify the key areas of interface between HIV & AIDS and gender;
- ensure access to treatment, care and support once an HIV positive diagnosis is made;
- support legal literacy programmes and publicise information about rights and services in language accessible to all people including in non-written form.

**RECOMMENDATIONS TO THE UNITED NATIONS:**

UNAIDS should:

- build on the UNAIDS Practical Guidelines for Intensifying HIV Prevention[74] to provide guidance and support to national governments for the development of clear, measurable and realistic international and national targets for achieving universal access, ensuring that these targets are gender-sensitive and include access to comprehensive, evidence-based HIV prevention information and services for all;
- as suggested at the UNAIDS Expert Consultation on Behaviour Change, develop 'a systematic process to review the gender-responsiveness of HIV programmes';[75]
- publicly challenge HIV prevention interventions that are not built on evidence;
- in supporting treatment roll out, provide guidance on the links between HIV prevention and treatment.

**WHO SHOULD:**

- provide gender-sensitive guidelines and technical support on prevention of parent-to-child transmission that includes men;
- provide guidance and leadership around integration of HIV prevention interventions into sexual and reproductive health interventions/services.
- acknowledge and promote, through providing guidelines and leadership, the centrality of responding to the HIV prevention needs of people living with HIV & AIDS.

74 UNAIDS, 2007, Practical Guidelines for Intensifying HIV Prevention.

75 UNAIDS, 2007, UNAIDS Expert Consultation on Behaviour Change in the Prevention of Sexual Transmission of HIV: highlights and recommendations.

## RECOMMENDATIONS TO DONORS AND DONOR GOVERNMENTS

Donors and donor governments should:

- fund partners who have a comprehensive, evidence-based approach to HIV prevention that goes beyond the ABC approach;
- do no harm – ensure their funds do not increase women's, girls' and vulnerable men's vulnerability to HIV & AIDS;
- fund health system strengthening to ensure that quality, comprehensive HIV prevention services and commodities are widely available;
- introduce longer funding periods for NGOs and CSOs and allow core costs and salaries to be covered to ensure more effective and sustainable HIV prevention programmes;
- allocate funds to support poverty reduction programmes that empower women and girls including social protection, microfinance, access to loans and banks, vocational training, formal and informal education, training around legal rights and income-generating activities.

**The UK government, other European donor governments and the EU** should provide a counter-balance to conservative approaches to HIV prevention.[76]

**The World Bank** must ensure that sexual and reproductive health and rights are central to its health, education and HIV & AIDS policies and funding.

## RECOMMENDATIONS TO NATIONAL GOVERNMENTS

National governments should:

- integrate international commitments (as outlined in Chapter 4) to comprehensive, gender-sensitive, evidence-based HIV prevention into the national level;
- revise policies which limit access to HIV prevention information by vulnerable groups, eg those which outlaw homosexuality or sanction harassment of sex workers;
- undertake gender assessments of national AIDS plans – building on the assessments supported by UNAIDS planned for completion by June 2007 in Cambodia, Honduras and Ukraine;
- ensure equitable access to HIV prevention technologies and commodities for all, free at the point of delivery;
- abolish user fees for health and education;
- address women's economic vulnerability by introducing social protection programmes, microfinance[77], access to loans and banks, and vocational training;
- provide comprehensive sexuality education that goes beyond sex education to explore power relations between women and men, addresses gender violence, attitudes and behaviours, and trains girls to make choices. This must include policy change and curriculum development as well as additional budget commitments;
- ensure compulsory and examinable in-service and pre-service teacher training on HIV & AIDS that enables teachers to conduct lessons and discussions around HIV & AIDS – training programmes must be based on accurate and comprehensive information;
- train justice/legal and law enforcement personnel on responding to and reducing gender-based violence in order to enforce existing policies and, where necessary, to revise laws relating to violence;
- prioritise training and support for frontline staff in the public sector – police, nurses and doctors, social workers, magistrates – to reduce stigma and discrimination; provide complete and accurate HIV prevention information and to ensure protections against rights violations of vulnerable groups are upheld.

76 UK Civil Society on HIV/AIDS, Response to EU Statement on HIV Prevention, November 30 2005.

77 Microfinance is a term for the practice of providing financial services, such as microcredit, microsavings or microinsurance to poor people. Definition from Wikipedia, www.en.wikipedia.org/wiki/Microfinance#_note-0

**RECOMMENDATIONS TO CIVIL SOCIETY:**

Civil society should:

- support, monitor and, where necessary, challenge governments to undertake their responsibilities in relation to the provision of comprehensive, gender-sensitive, evidence-based HIV prevention information and services.

## CONCLUSION

Social transformation must take place if we are to reduce the vulnerabilities discussed in Chapter 1 and if women, girls and vulnerable men are to be empowered to access the HIV prevention interventions outlined in Table 1 (pages 17-21). This means social transformation in terms of women and girls' empowerment; social transformation on stigma and discrimination; social transformation against homophobia; and for poverty reduction. In order to create an environment where women, girls and vulnerable men can have equal rights to HIV prevention information and services it is essential to invest in how women and men relate to one another and in order for this to occur – deep-seated beliefs and practices around power must be challenged and social transformation must take place.[78] This is not just idealism. This policy brief has outlined practical ways for making comprehensive, gender-sensitive prevention information and services available to all. Policy makers and activists must seek opportunities to take this challenge forward.

**FOR MORE INFORMATION PLEASE CONTACT:**

Nina O'Farrell, VSO HIV & AIDS Policy and Advocacy Advisor
nina.ofarrell@vso.org.uk

Mike Podmore, VSO HIV & AIDS Policy and Advocacy Advisor
mike.podmore@vso.org.uk

78 Germain, Adrienne, 2006, Invest, Protect and Lead: Filling the Glass on Women's Health and Rights and Achieving the MDGs, presentation given at roundtable at the 59th Annual DPI/NGO Conference, United Nations, New York.

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AIDS