MAINSTREAMING GENDER INTO HIV/AIDS ACTION: PRIORITIES FOR INTERVENTIONS FOCUSING ON WOMEN AND GIRLS

By

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ABSTRACT

During the process of formulating the Kenya National HIV/AIDS Strategic Plan (KNASP) of 2000 -2005, some of the gender dimensions of the epidemic had been recognised. It was noted that a striking feature of the epidemic was its impact on women as compared to men. The incidence of HIV/AIDS among women was rising at a shocking rate and women were being infected at an earlier age than men were. However, explicit strategies that focused specifically on gender issues were not included in the development of policies or programmes under the five priority areas of the KNASP.

In 2001, as the gender aspects of the epidemic became clearer and it was recognised that gender was playing a crucial role in the dynamics of the HIV/AIDS pandemic, the National AIDS Control Council (NACC) established a Technical Sub-Committee on Gender and HIV/AIDS. The Technical Sub-Committee's mandate was to formulate guidelines and create a strategic framework through which gender concerns could be integrated into the analyses, formulation and monitoring of policies and programmes relating to the five priority areas of the KNASP. This was to ensure that the beneficial outcomes are shared equitably by all – women, men, boys and girls. Based on the recommendations of the sub-committee, it was agreed that the best approach would be to the existing KNASP because it is the Key document that guides and co-ordinates all responses to HIV/AIDS in Kenya.

The gender analysis and mainstreaming strategies presented in this paper are centrally informed by two NACC commissioned field studies carried out in October, 2001 and May 2002 as well as by the UNAIDS best practice booklet: *Innovative Approaches to HIV/AIDS prevention*.

The findings of the above studies and the resulting gender analyses illustrated that gender roles and relations powerfully influence the course and impact of the HIV/AIDS epidemic. The show that different attributes and roles societies assign to males and females profoundly affect their ability to protect themselves against the scourge and cope with its impacts. The findings show that gender-related factors have shaped the extend to which men, women, boys and girls are vulnerable to HIV infection, the ways in which AIDS affects them, and the kinds of responses that are feasible in different communities and societies.

Their clear conclusion and recommendations is that, because the HIV/AIDS pandemic specifically in Africa is largely fuelled by gender inequalities, a proactive and comprehensive engendered response is required to effectively prevent its spread and minimise its impact. This paper assumes the position that effective and sustainable prevention of the spread of HIV/AIDS and the control of its impacts are therefore, likewise largely possible with the equal recognition of women's rights in all spheres of life and therefore, women's empowerment is an important tool in the fight against HIV/AIDS.

Through presentation and dissemination of this paper, AZTRAMADE, hopes to push the gender dimension of the HIV/AIDS epidemic from merely being an intellectual idea, to a practical tool for guiding policy decisions and programming for all activities under the umbrella of the Kenya National HIV/AIDS Strategic Plan for 2002 – 2005 through the suggested gender mainstreaming strategies.

Introduction

Gender is defined as the set of characteristics, roles, and behaviour patterns that distinguish women from men socially and culturally. Unlike sex which is biologically determined, gender is learned and can be un-learned. Gender refers to widely shared expectations and social norms that influence status accorded to men and women, plus the way they interact, together with the power plays between them.

While it is true that HIV/AIDS is a critical social-economic issue, the epidemic is as well, if not more a gender issue. Available statistics (***see table 2 below***) prove that both the spread and impact of HIV/AIDS is not random. It disproportionately affects women and adolescent girls who are socially, culturally, biologically and economically more vulnerable at the same time than men are.

One of the striking features of HIV/AIDS is its impact on the female gender. At the beginning of the pandemic, women and girls were at the periphery; today they are at the centre. Globally, the incidence of HIV/AIDS among women has risen at a shocking rate. In 1997, 41 per cent of HIV infected adults were women, but this figure rose to 49.8 per cent in 2001. An estimated 15 million women carried the virus, compared to 10.9 million men, in sub-Saharan Africa at the end of 2001. The latest data for Kenya estimates 1.4 million women in the age bracket from 15-49 years compared to 9 million men in the same category.

Of HIV+ pregnant women in Kenya, 30% give birth to HIV+ babies who are likely to die before age five. It is projected that between 2000 and 2020, 55 million Africans, of which 60% to 65% being women, will die earlier than they would have in the absence of AIDS.

Men, and especially young boys, are vulnerable too. Social norms that celebrate promiscuity, hence risky sexual behaviour do reinforce their vulnerability, especially given their lack of understanding of sexual health issues. This vulnerability is further increased by the likelihood of engaging in substance abuse (such as alcohol and other drugs) and of opting for types of work that can entail mobility and family disruption (such as migrant labour or the military).

In Kenya the impact of HIV/AIDS is felt deeply at all levels. As the country loses young productive people, the effects have an influence on all sectors. Households fall into deeper poverty, local economies stagnate or take a nosedive. As a result, women are invariably left bearing even bigger burdens- as workers, educators, mothers and, ultimately as caregivers, as the burden of caring for ill family members is made to rest with women and girls. A recent study found that it takes the work of three females to care for one adult male AIDS patient; usually a multiple team made up of mother, aunt and daughter.

Girls are often removed from school, not to specifically care for the sick and dying, but to take up “home duties” in order to release older women in the family for “care duties”. It is reported that in some standard eight classrooms in South Nyanza, there are no girls enrolled in this grade.

Table 1 below shows stack estimates of People Living with HIV/AIDS between the years 1999 and 2001.

		Total Adults and Children	Adults (15 – 29)	Women (15 – 49	Men (15 – 49)	Children (0 – 14)
Global Millions	**End 1999**	**34.3**	**33.0**	**15.7**	**17.3**	**1.3**
	End 2001	**40.0**	**37.1**	**18.5**	**18.6**	**3.0**
Sub-Saharan Africa Millions	**End 1999**	**24.4.**	**23.4.**	**12.0**	**11.4**	**1.0**
	End 2001	**28.5.**	**25.9**	**15.0**	**10.9**	**2.6.**
Kenya Millions	**End 1999**	**2.1**	**2.0**	**1.1**	**0.9**	**0.078**
	End 2001	**2.5.**	**2.3**	**1.4.**	**0.9**	**0.22**

Source: HIV/AIDS in Kenya: National HIV/AIDS/STD Control Programme, September, 2002

Women are also infected at an earlier age than men are. For example, in 1998 most HIV+ women in Namibia were in their 20s, while most men carrying the virus were in their 30s. In Kenya HIV prevalence by age and sex has been well documented and it's generally accepted that the infection levels for women are higher than for men. One study found that in the 15-49 age group, infection rates for women are five times that of men. In the 20-24 age group, infection rates for women are estimated to be three time that of men.

TABLE 2: HIV Prevalence in Kisumu District by age and sex 1997.

Distribution		Age Groups – Years				Total
	15-19	20-24	25-29	30-39	40-49	
Men	4.2%	13.4%	29.4%	34.0%	29.9%	21.0%
Women	22.3%	39.0%	38.6%	31.7%	19.4%	30.9%
Ratio	5.3	2.9	1.3	0.9	0.6	1.5

Source: HIV/AIDS in Kenya: Situation Analysis for National HIV/AIDS/STD Control Programme, September, 1998.

Why are women often at greater risk of HIV infection and AIDS impacts?

A variety of factors have been known to significantly increase the vulnerability of women and girls to HIV infection. These include:

- Their limited access to economic and education opportunities,
- The numerous and multiple household and community roles they are responsible for,
- Social norms that deny women sexual health knowledge,
- Practices that prevent then from controlling their bodies,
- There is growing evidence that a large share of new cases of HIV infection is due to gender-based violence in homes, schools, the workplace and other social spheres.
- Not all young people have sex because they want to. In a nationwide study of women 12 to 24 years old, 25% said they lost their virginity because they had been forced to, a recent Nairobi study indicated that 4% of HIV infections in the adolescent 13-19 year age group were consequence of rape.
- Unwilling sex with an infected partner carries a higher risk of infection, especially for girls. Since force is used, abrasion and cuts are more likely and the virus can more easily find its way into the blood stream. What's more, condom use is likely in such situations.
- Research has also shown that in up to 80% of cases where women in long-term stable relationships are HIV positive, they acquire the virus from their partners (who had become infected through their sexual activities outside the relationship or through drug use).
- In a variety of contexts, research shows that women's attitudes towards sex and sexual behaviour differ considerably from those of men. According to Long & Ankrah, 1996, women reported a preference for sexual relations based on mutual fidelity, intimacy and open communication.
- Studies have shown that, when women do express a desire for safer sex, men are often obstructive. Perhaps not surprisingly, therefore, the major HIV risk for women is their regular sexual partner or husband (goodridge & lamptey, 1999). On the other hand, dominant ideologies of masculinity promote the display of sexual prowess, and encourage men to have multiple partners (rivers and aggleton, 1999).
- It is AZTRAMADE's submission that many existing HIV prevention programmes fail to take adequate account of the social vulnerability of women or the unequal power relations between men and women in many, if not all Kenyan communities. These inequitable relations make it difficult for women to influence decision-making in their sexual relationships as well as in the creation of equal socio-economic opportunities.
- Women also find themselves discriminated against when trying to access care and support when they are HIV positive. In many communities, men are more likely than women to be admitted to health facilities. Family resources are more likely to be devoted to buying medication and arranging care for ill males than females.

- According to Goodridge, (goodridge & lamprey, 1999), the key elements of many HIV/AIDS programmes, including: – partner reduction, condom use and STI treatment – are not necessarily appropriate for women, who do not have multiple partners, cannot always influence the decision to use condoms, and may be asymptomatic for STIs. Indeed, open and honest verbal communication is one of the most difficult aspects of heterosexual relationships (rivers et al, 1998).

How then, should HIV/AIDS initiatives mainstream gender issues and factors?

There is now increasing recognition that prevailing ideologies of masculinity and femininity facilitate HIV transmission. There is also widespread agreement that the promotion of more equal gender roles is the key to preventing HIV infection and ultimately the negative AIDS impacts.

It is crucial therefore not only to address stereo-typed gender roles, but also to redress some of the stark structural inequalities between men and women, including the unequal distribution of economic resources and differentials in access to education and health provision.

However, it is important to recognize that women's empowerment cannot be achieved by women alone but requires the support of men for its successful realization (gupta, weiss & Mane, 1996).

An understanding of gender issues and dimensions must be seen as central to all aspects of HIV/AIDS programming. It is important to mainstream gender in all programme stages by ensuring that gender related factors are taken into account in planning, implementation, monitoring and evaluation.

Findings by UNAIDS show that, in HIV/AIDS programming focusing on women and girls, there is need to note some key aspects including:

- Use of a multifaceted approach that addresses economic and other women which may take priority over HIV/AIDS in the daily lives of women living in poverty in developing countries;
- Focusing on improving communication between sexual partners which acknowledges the difficulties women encounter in talking and negotiating with men about sex;
- Increasing awareness of the importance of including men in work for the prevention of HIV among men, women and girls;
- Addressing the need for improved health services for women;
- Acknowledging the importance of a gendered approach to HIV prevention work, which includes discussions of power relations between men and women;
- Providing access to voluntary counselling and testing services, along with appropriate referrals;
- Acknowledging the support that women can provide to each other through open discussion and the development of networks.

In line with the five priority areas of the KNASP, gender mainstreaming can be incorporated as follows:

Priority # 3: Mitigation of Social and Economic Impacts Ensuring the reduction of Social and Economic Impacts of HIV/AIDS on women and men by:	3.1 Assessing the gender dimensions of discrimination and stigma related and associated with HIV/AIDS and advocate and crate awareness to reduce them.
	3.2 Empowering and creating awareness among women and men affected and infected by HIV/AIDS on how to improve their welfare
	3.3 Supporting men in their initiatives to mitigate the social and economic impact of the epidemic as they have power to positively determine its outcome.
	3.4 Developing an engendered understanding of both the holistic needs of women & girls and the programmes designed to address their psychological, psychosocial, education and welfare needs.
	3.5 Ensuring equal participation of men and women in income generating activities designed to reduce poverty to support for men and women living with HIV/AIDS.
Priority # 4: Monitoring, Evaluation and Research Ensuring that all gender strategies have gender sensitive indicators by:	4.1 Developing appropriate gender-sensitive indicators to measure the impact of all HIV/AIDS interventions.
	4.2 Conducting periodic reviews of the progress achieved in implementing gender-sensitive programmes and disseminate the findings.
	4.3 Allocating adequate resources for research into gender and STI HIV/AIDS initiatives.
	4.4 Monitoring resource allocation to all HIV/AIDS programs to ensure an equitable distribution of resources to men, women and children.
	4.5 Addressing the bio-ethical issues that are related to HIV testing, including those that involve women, infants and the welfare of society.
	4.6 Developing protocols to ensure that all participants in all HIV/AIDS related research, especially vulnerable groups of women and children, have given informed consent and know that their rights are protected.
	4.7 Ensuring that all members of the community, especially women, children and marginalized groups, benefit from the findings of the research conducted within Kenya and specific communities

	4.8 Developing and implement a gender-sensitive surveillance system including disaggregated data collection, processing and dissemination. Including women in national surveillance data collection and national calculations.
	4.9 Conducting regular gender audits of all HIV/AIDS strategies and activities
Priority # 5: Management and Co-ordination Establishing gender sensitive policies & guidelines to ensure that management systems provide an enabling environment for gender mainstreaming by:	5.1 Lobbying the government to continually Develop gender responsive policies & guidelines for the implementation of HIV/AIDS programmes.
	5.2 Building the capacity of all institutions including the NACC, line ministries, NGOs, CBOs, FBOs and other CSOs to engender HIV/AIDS projects /programmes by providing gender training at all levels.
	5.3 Establishing links and identify mechanisms for collaboration with other partners to share information on effective responses to gender-related HIV/AIDS issues.
	5.4 Creating a referral and networking system to allow monitoring of the coverage and quality of the dissemination of information process.
	5.5 Engendering all project budgets to ensure equitable resources are available to all HIV/AIDS initiatives including those for women & girls
	5.6 Developing simple to use and adaptable gender sensitive curriculum for community & management training to build capacity for all institutions and sectors.
	5.7 Building the capacity of the project administrators to ensure it has gender expertise available to support the engendering process.
	5.8 Developing a range of tools to support the engendering of projects and programmes. These include gender audit tools, a gender equity strategy, sexual harassment policy in the workplace, and the inclusion of gender within all job descriptions.

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