



# Gender, Sexuality, Rights and HIV

An overview for community sector organizations



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# Executive Summary

HIV and AIDS continue to be one of the most challenging developmental issues in human history. In the early days of the epidemic, HIV was seen as a disease striking mainly men. Today, women account for nearly half of the 39.5 million people living with HIV worldwide. Of the 3.8 million new HIV infections that occurred among adults worldwide in 2006, 50 per cent were among women.<sup>1</sup> In sub-Saharan Africa where HIV transmission is predominantly heterosexual, almost 60 percent of those infected are women. This dramatic rise in HIV prevalence among women is due to gender inequality and blatant human rights violations.

Gender determines the role and status of men and women that is culturally defined and carried on through a process of socialization starting from the early stage of infancy. This creates unequal power balances between men and women and also determines their unequal access to key resources such as information, education, employment, and credit.

Vulnerability to HIV is also influenced by sexuality. Stigma and discrimination of certain sexualities leads to their marginalization and exclusion from mainstream health programs and services. This drives them underground and makes it difficult to reach them with HIV information and services, exacerbating their vulnerability to HIV.

Too often, the gender- and sexuality-based determinants of HIV are either completely omitted or de-emphasized by decision makers and are seldom incorporated into HIV programs. Without addressing issues of inequality and violations of rights, overall efforts to stem the epidemic will be futile.

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This document is a resource for NGOs and CBOs to build greater understanding of how gender and sexuality determine vulnerability to HIV. The document also highlights major human rights declarations, treaties and recommendations that can be used by individuals and associations to advocate for their rights and hold decision makers accountable to their commitments. This document is a summary of a desk-based review of literature that examines the factors that contribute to the vulnerability and risk of HIV infection in men, women, and men-who-have-sex-with-men (MSM). Though other sexual minorities such as transgender are equally vulnerable to HIV, vulnerabilities of transgender and other sexual minorities are outside the scope of this guide.

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photo: Man buys condoms in "sari-sari" shop, Manila, Philippines

Four thematic areas are used to examine the gender- and sexuality-based determinants of vulnerability to HIV; socio-cultural, economic, political, and access to programs and services:

1. **Socio-cultural factors:** Gender prescribes specific roles and status for men (masculinity) and women (femininity) respectively. Beliefs of what constitutes masculinity and femininity are deeply rooted in the socio-cultural contexts of every community and create an unequal balance of power between women and men.

In each society, norms and beliefs of suitable roles for men and women are enforced by that society's institutions and practices, such as marriage, polygamy, and female genital mutilation, among others. This determines the extent to which men and women are able to control the various aspects of their sexual lives, i.e. their ability to negotiate the timing of sex, conditions under which it takes place, and condom usage. This plays a critical role in determining their respective vulnerabilities to HIV. For example, femininity often requires women to be passive in sexual interactions and ignorant of sexual matters, limiting their ability to access information on the risks of sex or to negotiate condom usage. Masculinity on the other hand requires that men be sexual risk takers and condones multiple partners which, without adequate prevention, increase their vulnerability to HIV. The unequal power balance between men and women results in their unequal access to HIV information, resources and services.

Vulnerability to HIV is also influenced by sexuality. Sexual minorities comprise people whose sexualities and sexual behaviors and/or practices do not conform to what is considered to be socially normative (or socially acceptable). This includes gay men, bisexual men, lesbians, bisexual women, transgender persons, and transsexuals, among others. In many societies, these populations are heavily stigmatized and exist in environments of marginalization, inequity, discrimination, criminalization, oppression and violence that increase their vulnerability to HIV.

2. **Economic factors** are critically linked to the HIV epidemic. The disproportionately higher rate of HIV infection among women as compared to men is an expression of the highly unequal socio-economic status of men and women.<sup>2</sup> Economic factors such as poverty, migration, globalization and rapid urbanization influence gender-based vulnerability to HIV infection. For example, poverty may lead an individual to engage in unsafe sex as monetary and material needs might limit an individual's ability to negotiate condom use in such interactions. Socio-cultural norms that enforce women's economic dependence on their male partners also lead to women's vulnerability to HIV.
3. **Political factors** have played a key role in creating vulnerability to HIV since the early days of the epidemic. In many cases these factors reinforce and influence social norms and traditions, and are instrumental in increasing gender inequality. Some of these include government policies and legislation, program strategies, and funding streams that endorse and/or ignore discrimination, promote gender disparity and criminalize certain sexual behaviors. For example, governments promoting ideological agendas over evidence-based strategies, including restricting the availability of male and female condoms, have a detrimental effect on the epidemic and increase HIV vulnerability.
4. **Access to Programs and Services:** Gender and sexuality also affect access to and interaction with key health services for HIV prevention, treatment and care. Socio-cultural norms that define male and female roles and responsibilities also affect women's and men's access to and use of health services. In cultures where there is a preference for sons, families allocate resources for health care to boys and men before girls and women within the same family. In many patriarchal cultures women are confined to their home and cannot travel unless accompanied by a male member of the family. Many traditional practices also require that women are served exclusively by female health care providers and when only male health care providers are available, female patients must do without.



The barriers that men face in using services are often related to socio-cultural norms that ascribe reproductive responsibilities entirely to women and shut men out of parenting and nurturing roles.<sup>3</sup> For example, family planning, prenatal, and child health clinics are typically not designed to reach men or meet men's needs. Given that in many countries HIV information and services are provided only in such clinics, men are less likely to be fully informed about HIV prevention, care, support and treatment options.<sup>4</sup>

Access to available services by sexual minorities is limited by many factors including societal and community exclusion, stigma and discrimination, and human rights abuses. Scaling up interventions for MSM is difficult because doing so often raises the visibility of the men themselves. This has consequences for interpersonal and community relationships and personal safety (especially in contexts where sex between men is taboo, criminalized, or denied).<sup>5</sup> In addition, gender and sexuality also determine the level and quality of care, treatment and support that HIV-positive persons receive and the negative social and economic consequences that they face.

photo: Youth participating in a sexuality workshop, El Salvador © Richard Lord



# 1. Introduction

Discrimination on the basis of gender roles and sexuality continues to be pervasive in terms of legal, social, and economic rights. These inequities include access to and control over economic resources and opportunities, political power, and health services. In addition, individuals often fall victim to violations of their basic human rights, based on gender and sexuality (See Definition Box 1).

An individual's gender and sexuality determine the extent to which she/he will be vulnerable to HIV and her/his ability to access available prevention, treatment, care and other services. Gender inequality also influences the extent to which an individual will be able to cope economically and socially with the burden of living with HIV and AIDS-related illnesses, caring for a family member, or surviving the death of family members.

## Definition Box 1: Human Rights, Gender and Sexuality

**Human Rights** are universal legal guarantees protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. Human rights are guaranteed by international standards and are legally protected so that they cannot be waived or taken away by any person or government. Both human rights and public health share the common goal of promoting and protecting the wellbeing of all individuals. Human rights instruments serve as powerful advocacy tools for protecting the rights of gender and sexual minorities and other marginalized communities.

**Gender** refers to the roles that men and women play and the relations that arise out of these roles, which are socially constructed, not biologically determined (Pan American Health Organization, 1997). Gender prescribes a set of qualities and behaviors expected from a female or male by society. Gender roles are learned and can be affected by factors such as education or economics. They vary widely within and among cultures. Gender roles are socially determined and can evolve over time.<sup>6</sup>

**Sexuality** is distinct from gender yet intimately linked to it. An individual's sexuality is defined by whom one has sex with, in what ways, why and under what circumstances, and with what consequences. 'It is more than sexual behavior; it is a multidimensional and dynamic concept'. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors influence an individual's sexuality.<sup>7</sup> In each society there are a multitude of sexualities.

Gender norms ascribe distinct productive and reproductive roles to men and women through social constructions of masculinity and femininity ('appropriate' roles and behavior for men and women respectively) that vary by class, ethnicity, sexuality and age in every society<sup>8</sup> (See Text Box 1). 'Despite the existence of multiple masculinities and femininities, it is the dominant ideology that most greatly influences women's and men's attitudes and behavior'.<sup>9</sup> Traditionally, this results in an unequal balance of power in favor of men. Dominant ideology favoring men also exacerbates inequitable access to key resources such as income, credit, employment, education, and information. Vulnerability to HIV is influenced by male dominance, and HIV and AIDS are both propelled and entrenched by gender inequality.

Power is fundamental to both sexuality and gender. The unequal power balance in gender relations that favors men translates into an unequal balance in heterosexual interactions, in which male pleasure supersedes female pleasure and men have greater control

## Text Box 1: How are Gender Roles Shaped?

- Gender roles are socially and culturally constructed.
- Gender roles and relations are held in place by ideology (underlying beliefs about the way society should be.)
- Gender is relational, i.e. gender roles and characteristics do not exist in isolation, but are defined in relation to one another.
- Gender roles and relations are unequal and hierarchical.
- Gender relations are institutional because they form a social system which is supported by values, rules, routine activities and divisions of resources in all forms of social organization, including families/households, communities, and specific organizations such as health care systems.<sup>10</sup>



than women over when, where, and how sex takes place.<sup>11</sup> Power dynamics are critical to understanding sexuality as well. The power underlying any sexual interaction, (heterosexual, homosexual, or transgender) determines how sexuality is expressed and experienced. Power determines whose pleasure is given priority and when, how, and with whom sex takes place.

Issues of sexuality are further compounded by social norms of what is “right” and “wrong” which may result in stigma, discrimination, and even criminalization of certain sexualities leading to marginalization and isolation. In most cultures, socially expected gender norms prescribe that sex is between a man and a woman. Any sexual interaction which is not between a man and a woman is scrutinized culturally and socially, leading to the discrimination and persecution of sexual minorities (See Example Box 1).



photo: 'Khote'/transgender sex workers at a trucking depot © The Condom Project

### Example Box 1: Stigmatization of feminized males

'In some cultures in South Asia, male-to male sexualities, to a large extent, do not fit the heterosexual/homosexual oppositional paradigm that is so commonly used as a discourse to discuss same sex behavior. Rather the primary pattern appears to be that of a gendered framework with specific orientations and sex roles. This framework reflects a belief in a “man/ not-man” duality where the “man” perceives himself as a normative male from the general male society, while the “not-man” perceives himself as a feminized male, self-identifying as a “kothi.” Feminized males are heavily stigmatized in the region and are victims of violence and oppression’.<sup>12</sup>

Sexual minorities are comprised of people whose sexualities and sexual behaviors and/or practices do not conform to what is considered to be socially normative or acceptable. They include gay men, bisexual men, lesbians, bisexual women, transgender persons, and transsexuals, among others. In many societies, these populations have been heavily stigmatized and have existed in an environment of marginalization, inequity, discrimination, criminalization, oppression, and violence that has increased their vulnerability to HIV.

Males who have sex with males (MSM) is a public health term that has emerged in discussions on HIV and AIDS and sexual health. It refers to a behavior and not an identity. Therefore, MSM may not self-identify as being gay, homosexual, or bisexual.<sup>13</sup> In public health terms, MSM includes a number of overlapping groups including gay men, bisexual men and feminized males, among others, and varies from culture to culture. For this document, MSM includes all males who practice sex with another male, regardless of how they identify themselves in terms of sexual orientation.<sup>14</sup> Among sexual minorities, MSM are some of the most vulnerable

to HIV. The diverse sexualities included within MSM make the understanding of vulnerabilities associated with populations and sub populations within this category extremely complex. The social stigma and discrimination attached to male-to-male sex makes it difficult for MSM to be open about their sexual preferences and drives them underground. This makes it challenging for them to access health services or to reach them with critical HIV prevention information which increases their vulnerability to HIV.

Gender and sexuality put women, men and sexual minorities at risk of HIV. Vulnerability to HIV arises from a coming together of biological, structural (socio-cultural, economic and political) and infrastructural (programs and services) factors. 'Vulnerability refers to the likelihood of being exposed to HIV infection because of a number of factors or determinants in the external environment, some of which are beyond the control of a person or particular social group'.<sup>15</sup>

Biologically, women are more susceptible to HIV infection than men. Male to female transmission of HIV is between two and four times more efficient than female to male.<sup>16</sup> Moreover the vagina offers a larger area of mucosal tissue subject to micro-injuries through which the virus can enter the bloodstream.<sup>17</sup> The presence of sexually transmitted infections (STIs), which increases the risk of transmission and acquisition of HIV by up to ten-fold, also increases women's vulnerability because in their case most STIs produce no symptoms, making diagnosis and treatment more difficult.<sup>18</sup> Young women are especially vulnerable to HIV infection through sexual intercourse because the immature genital tract of girls is more likely to sustain tears during sexual activity, creating a higher risk of HIV transmission.<sup>19</sup> Similarly, in male-to-male sex or male-to-female sex, there is an increased risk of HIV infection during penetrative anal sex due to the likelihood of membrane rupture and bleeding.

In addition, biological risk factors are compounded by socio-cultural, economic and political factors. Gender and sexual inequalities also affect access to and interaction with health services, including those for HIV prevention, treatment and care.

These gender- and sexuality-based determinants of vulnerability to HIV are examined in the following sections of this document. This is structured around four thematic factors: socio-cultural (section 2), economic (section 3), political (section 4), and access to programs and services (section 5). Each section contains relevant human rights declarations, treaties and recommendations that can be used to advocate for the rights of gender and sexual minorities and hold decision makers accountable to their commitments. The document ends with some overall conclusions and recommendations (section 6) to ensure that policies and programs adequately address issues related to gender and sexuality to effectively respond to the HIV pandemic.

photo: Woman attending a rural health clinic, Muranga, Kenya © Richard Lord





## 2. Socio-Cultural Factors



photo: Women attending a maternal health clinic, Thieste, Senegal © Richard Lord

The degree to which men and women are able to control the various aspects of their sexual lives (i.e. their ability to negotiate the timing of sex, conditions under which it takes place, and the use of condoms), plays a critical role in determining their vulnerability to HIV infection.

People's control over their sexual lives and choices is in turn shaped by gender-related values and norms defining masculinity and femininity. These culturally-defined gender values and norms evolve through a process of socialization starting from an early stage of infancy. They determine and reinforce themselves through traditional practices such as wife sharing, widowhood related rituals, early marriage, female genital mutilation and the condoning of gender-based violence. These cultural practices, values, norms, and traditions have strong influences on the visible aspects of individual behaviors and are important determinants of men's and women's vulnerability to HIV.

Personal risk of contracting HIV is determined by numerous social and cultural factors that shape gender and sexuality perceptions, attitudes and behaviors. Gender norms are deeply rooted in the socio-cultural context of each society and enforced by that society's institutions and practices. Socio-cultural norms build notions of masculinity and femininity which in turn create unequal power relations between men and women.<sup>20</sup> This power imbalance impacts women's and men's access to key resources, information, and their sexual interactions. It curtails women's sexual autonomy and expands men's sexual freedom and control over sexuality. This results in their different vulnerabilities to HIV infection, as described below.

The gender role prescribed for women, or 'femininity', demands a submissive role, passivity in sexual relations, and ignorance about sex. It also restrains women from seeking and receiving information related to HIV prevention.<sup>21</sup> In some cultures motherhood is a key aspect of femininity, so the use of contraceptives such as barrier methods that prevent pregnancy and HIV present difficult and often insurmountable challenges for women and men in balancing their desire for children against HIV prevention. In cultures where virginity is highly prized, young women attempt to preserve their virginity by practicing alternative sexual behaviors, such as anal sex which increases their vulnerability to HIV. In cultures where women are socialized to please men and defer to male authority, particularly in sexual interactions, women sometimes engage in high risk sexual behavior such as vaginal douching (a process of rinsing or cleaning the vagina by forcing water or another solution into the vaginal cavity to flush away vaginal discharge or other contents) which they believe makes sex more pleasurable for their male partners.<sup>22</sup>

'Masculinity' requires men to be more dominating, knowledgeable and experienced about sex. This assumption puts many young men at risk of HIV infection as such norms prevent them from seeking information or

admitting their lack of knowledge about sex or methods of protection.<sup>23</sup> These norms also promote promiscuity and reinforce risk-taking behavior. In many societies men are socialized to be self-reliant, to conceal their emotions, and to not seek assistance in times of need or stress. This expectation of invulnerability associated with masculinity runs counter to the expectation that men should protect themselves from potential infection and encourages the denial of risk.<sup>24</sup>

Notions of masculinity that emphasize sexual domination over women or feminized males as a defining characteristic of male hood contribute to homophobia and the stigmatization of MSM. Stigma and fear force MSM to hide their sexual behavior and deny their sexual risk, thereby increasing their own risk as well as the risk of their partners, female and male.<sup>25</sup>

Various social and cultural traditions reinforce vulnerability to HIV. These are examined in the context of the following practices and institutions:

## 2.1 Marriage

Gender inequality in marital relations, especially in sexual decision-making, increases vulnerability to HIV transmission. Trends in current data on new HIV infections suggest that the incidence of HIV is rising among married women and girls worldwide, with unsafe and unprotected heterosexual intercourse being the single most important factor in the transmission of HIV among women.<sup>26</sup> Marriage, which greatly increases women's sexual exposure, has in itself become a risk factor for women and girls in many countries. The dramatic rise in the frequency of unprotected sex after marriage is driven by the implications of infidelity or distrust associated with certain forms of contraception such as condoms, a strong desire to become pregnant, and an imbalance in gender power relations. This results in women's increased inability to negotiate safer sex.<sup>27</sup> In spite of having knowledge of their spouse's extra-marital sexual interactions, women are often unable to protect themselves due to an imbalance of power within relationships created by economic and emotional dependence.

## 2.2 Polygamy

The traditional practice of polygamy, which is legally sanctioned in some parts of the world, allows husbands to have more than one wife. This occurs despite international human rights instruments defining equality in marriage and family life through an equal rights and responsibilities framework<sup>28</sup>, violated in polygamous unions because wives have fewer de facto marital rights and their husbands fewer responsibilities<sup>29</sup> (See Rights Box 1).

### RIGHTS BOX 1: HUMAN RIGHTS INSTRUMENTS SUPPORTING EQUALITY IN MARRIAGE

**Article 16 of Universal Declaration of Human Rights (1948):** Men and women of full age, without any limitation due to race, nationality or religion...are entitled to equal rights as to marriage, during marriage and at its dissolution.

**International Covenant on Civil and Political Rights:** States shall take appropriate steps to ensure equality of rights and responsibilities of spouses as to marriage, during marriage, and at its dissolution. (Article 23 (4))

**Convention on the Elimination of All Forms of Discrimination of Women:** Polygamous marriage contravenes a woman's right to equality with men, and can have such serious emotional and financial consequences for her and her dependents that such marriages ought to be discouraged and prohibited.<sup>30</sup> (General Recommendation no. 21)

Polygamy operates to create concurrent sexual networks within marriage between multiple wives and their husband, and in addition to any extra-marital sexual contacts the spouse may have.<sup>31</sup> Direct sexual transmission of HIV can occur in these concurrent sexual networks where the virus is introduced through the spouse's extra-marital sexual contacts or where a new wife who is already HIV positive enters the polygamous union.

A formal recognition of polygamous unions in various countries amounts to reinforcement of the patriarchal notion that women should passively accept their partners' sexual decision making. It broadens the scope of masculine sexual freedom.<sup>32</sup> In addition to reinforcing patriarchy, studies have shown that the typically discordant nature (relationships that are characterized by friction and disagreement) of polygamous co-wives and husband-wife relationships also aggravates domestic violence.<sup>33</sup> These strong patriarchal notions increase the risk of HIV transmission by undermining women's ability to negotiate condom use, to insist on partner fidelity, and to leave high-risk sexual relationships. Negotiating safe sexual practices and insisting on partner fidelity becomes further complicated in polygamous households given that multiple wives are often reliant on one husband for material survival. The economic hardship and lack of emotional attention associated with polygamy can lead women to engage in extramarital sexual relationships.<sup>34</sup>

## 2.3 Early Marriage

The majority of sexually active girls aged 15-19 in developing countries are married.<sup>35</sup> Child marriage (marriage before age 18) remains a fact of life in South Asia, portions of Latin America, and many sub-Saharan African countries.<sup>36</sup> Eighty-two percent of girls in Niger, seventy-five percent in Bangladesh, sixty-three percent in Nepal, fifty-seven percent in India and fifty percent in Uganda marry before the age of 18.<sup>37</sup> If the present trend continues, over 100 million girls will be married worldwide before the age of 18 years in the next decade.<sup>38</sup>

Early marriage severely increases young girls' vulnerability to HIV as they are most likely to be forced into having sexual intercourse with their (usually much older) husbands. Young girls have softer vaginal membranes which are more prone to tear, especially on coercion, making them susceptible to HIV and other STIs. Older husbands are more likely to be sexually experienced and HIV infected. The dramatic rise in young married girls' exposure to unprotected sex is driven by pressure to bear children and their inability to negotiate safe sex. The significant age gap in spouses also further intensifies the power differential between husband and wife, which in turn discourages the open communication required to ensure uptake of voluntary counseling and testing for HIV, sharing test results and planning for safe sexual relations throughout the marriage.<sup>39</sup>

“I hate early marriage. I was married at an early age and my in-laws forced me to sleep with my husband and he made me suffer all night. After that, whenever day becomes night, I get worried thinking that it will be like that. That is what I hate most.”

- 11-year-old girl from Amhara, Ethiopia, married at age 5; first had sex at age 9<sup>40</sup>

Early marriage also curtails girls' socio-economic development and results in their social isolation which is increasingly identified as a predisposing factor for HIV risk. This is because it curtails the social contacts and networks that play a vital role in transmitting HIV prevention information and supporting behavior change.<sup>41</sup> Girls who are married at an early age also have low educational attainment and limited or no schooling options, limited control over resources, and little or no power in their new households.<sup>42</sup>

Child marriages must be viewed within a context of force and coercion, involving pressure and emotional blackmail, as children lack the choice or capacity to give their full consent.<sup>43</sup> Child marriage is a violation of human rights as it violates the right to freedom and growth of children (See Rights Box 2). Gender inequality is both a cause and a consequence of child marriage.



## RIGHTS BOX 2: CHILD MARRIAGE AS A VIOLATION OF HUMAN RIGHTS

**Article 16 (2) of Convention on the Elimination of All Forms of Discrimination of Women** states that the betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, should be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory. In their general recommendations of 1994, the Convention considers that the minimum age for marriage should be 18 years.

## 2.4 Multiple Sexual Partners

Gender inequality and patriarchy (social structures where men take primary responsibility and dominate in their households) encourage multiple sexual partners for men inside and outside of marriage, while women are required to be faithful and monogamous. Such socio-cultural practices and norms make men and their partners especially vulnerable to HIV. In a study in Zimbabwe, one in eight married men said they had casual sex (more than one sexual partner in the previous twelve months), but only one in one hundred women said they had sex outside marriage.<sup>44</sup> In these circumstances marriage puts women at the greatest risk of HIV infection instead of protecting them.

In many countries, MSM also have sex with women. In a study of MSM in South Asia, thirty-nine percent of respondents who were married stated that their wives knew that they had sex with other men, but claimed that their wives accepted it, or were incapable of doing anything about it as divorce is highly stigmatizing for women and often leads to ostracism.<sup>45</sup> Further, masculinity demands that men be sexual risk-takers. With lack of knowledge of HIV and reluctance to use condoms, these practices put men and their male and female partners at risk of HIV. In this context, the dangers of multiple sexual partners relates to the fact that if one person in a 'circle' of partners gets infected with HIV, there is a very high likelihood that all persons involved will become infected.<sup>46</sup>

## 2.5 Harmful Cultural and Traditional Practices

Harmful cultural practices such as widowhood-related rituals, sexual cleansing and female genital cutting (See Example Box 2) heighten the risk of HIV transmission. These practices are often justified in the name of cultural values and traditions. No doubt cultural values and traditions are important to community identities, but it is important to realize that they cannot be continued at the cost of the right to health of the individual.<sup>47</sup>

### Example Box 2: Female Genital Cutting

Between 100 and 140 million women and girls have undergone mutilating operations on their external genitalia, suffering permanent and irreversible health damage.<sup>48</sup> Every year, two million girls are subject to mutilation, which traditional communities call "female circumcision" and the international community terms "female genital mutilation" (FGM), or "female genital cutting" (FGC). According to WHO, FGM/FGC comprises all procedures involving partial or total removal of the external genitalia or injury to the female sexual organs.<sup>49</sup> This could be either for cultural, religious, or other non-therapeutic reasons. FGC is practiced in a large number of countries and cultures.

FGC/FGM places girls and women at increased risk of HIV infection through several routes. Firstly, the use of unsterilized instruments, such as razors or knives, to carry out the procedure among a number of girls risks passing the virus from one girl to the next.<sup>50</sup> Secondly, FGM renders the female genitals more likely to tear during intercourse. In cases of sewing up of the vaginal entrance, penetration is bound to lead to bleeding, which in turn makes sexual transmission of the virus from an HIV positive partner much more likely.<sup>51</sup> Thirdly, difficulties with intercourse may make a woman less likely to welcome the partner's advances and

lead him to a more violent approach to sex; or to engage in sexual practices with his wife (such as unprotected anal intercourse) which might place her at increased risk of HIV infection.<sup>52</sup> The perpetuation of this practice is a clear example of gender-based discrimination and a violation of the right to health

## 2.6 Gender-based Violence

Gender-based violence has become commonplace in almost all societies. Acts of violence greatly increase vulnerability to HIV, especially for women and marginalized groups such as MSM. Violence has many facets. Within the household this can include battering by an intimate partner, marital rape, dowry-related violence, and sexual abuse. Violence outside the home can include rape, sexual abuse, sexual harassment and assault. Violence against MSM in many societies is often targeted at feminized MSM, who are often the sexually 'receptive' partners, not the 'penetrating' partners.

Various social, cultural, and religious norms produce and reinforce gender inequality and the stereotypical gender roles that underpin gender-based violence. Gender-based violence is a key factor in increasing risk of contracting HIV. For millions of women, the experience or fear of violence is a daily reality and, increasingly, so is HIV/AIDS.<sup>53</sup> Studies from various countries have shown up to three fold increases in risk of HIV among women who have experienced violence as compared to those who have not.<sup>54</sup> Gender based violence is a violation of human rights and is identified as such by international human rights treaties (See Rights Box 3).

### RIGHTS BOX 3: VIOLENCE AGAINST WOMEN

**Committee on Elimination of Discrimination Against Women:** General Recommendation 19 states that gender based violence against women is discriminatory because it is directed against a woman because she is a woman and it affects women disproportionately. (Paragraph 6)<sup>55</sup>

**Commission on Human Rights Resolution 2003/45 on Elimination of Violence Against Women:** Violence against women constitutes a violation of human rights and fundamental freedoms of the women<sup>56</sup>

...Violence against women and girls, including rape, female genital mutilation, incest, early and forced marriages, violence related to commercial sexual exploitation, including trafficking, as well as economic exploitation and other forms of sexual violence, can increase their vulnerability to the HIV/AIDS and aggravate the conditions fostering the spread of HIV/AIDS.<sup>57</sup>

Violence increases vulnerability to HIV infection in several ways. Sexual violence can result in 'direct transmission' of HIV which can be the result of forced or coercive sexual intercourse with an HIV infected partner. The biological risk of transmission in a violent sexual encounter is determined by the type of sexual exposure (vaginal, anal or oral). Transmission of HIV is higher for anal, followed by vaginal, and then oral sex.<sup>58</sup> Risk of direct transmission in forced and coerced sexual encounters is also dependent upon the degree of trauma, such as vaginal or anal lacerations and abrasions, which occurs when force is used. For example, where sexual violence occurs in girls and young women, risk of transmission is likely to be higher because girls' vaginal tracts are immature and tear easily during sexual intercourse. Sexual violence can also result in 'indirect transmission' of HIV infection among women or men: violence or the threat of violence affects the individual's power and ability to negotiate the conditions of sexual intercourse, especially condom use.<sup>59</sup>

In a study from South Africa, women who experienced coercive sex were found to be nearly six times more likely to use condoms inconsistently than those who did not experience coercion and, in turn, women with inconsistent condom use were 1.6 times more likely to be HIV infected than those who used condoms consistently.<sup>60</sup>

“My husband hated condom use. He never allowed it. He used to beat me when I refused to sleep with him... He said ‘when we are man and woman married, how can we use a condom?’...It’s a wife’s duty to have sex with her husband because that is the main reason you come together. But he didn’t listen to me. I tried to insist on using a condom but he refused. So I gave in because I really feared [him].”<sup>61</sup>

- Woman from Uganda in Human Rights Watch Report

Violence is also directly and indirectly associated with men’s increased vulnerability to HIV. Several studies highlight that men’s use of violence is linked to their own sexual risk-taking.<sup>62</sup> One study showed that Indian men who had experienced extramarital sex were 6.2 times more likely to report wife abuse than those who remained faithful; and those who reported STI symptoms were 2.4 times more likely to abuse their wives than those who did not.<sup>63</sup> Violence or the fear of violence is also considered to be a barrier to women seeking HIV testing, and for those who seek testing it acts as a barrier to disclosure of their HIV status to their male partners.<sup>64</sup> For example, more than half of the women surveyed in Kenya who knew they were HIV infected said that they did not disclose their HIV status to their partners because they feared violence or abandonment.<sup>65</sup> Many community organizations are working in this area to build awareness on the issue (See Example Box 3).

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### Example Box 3: Gender-based violence

**The Group of Men Against Violence (GMAV)**, founded in Nicaragua in July 1993, originally began educating male staff of participating NGOs about gender issues and violence. They then organized workshops, courses on masculinity, and support activities for men in various communities. By 1998, GMAV was conducting seven youth groups in the capital city of Managua led by adults who had completed the training. The young male participants were enthusiastic, suggesting their own topics for discussion such as the influence of drugs and alcohol on their sexual behavior. An impact evaluation in late 1997 of one of the participating NGOs courses showed changes in gender norms among the adult men who are important in educating their adolescent counterparts.<sup>66</sup>

Violence is also inflicted on sexual minorities such as transgender people, lesbians, gay men and other MSM in almost all countries. Violence against homosexual men and women is particularly rampant in countries where laws prohibit same sex relationships. In these circumstances violence takes many forms such as high levels of abuse and rape. The social, legal and judicial environment in these countries has a detrimental impact on sexual health interventions, where even staff members of NGO MSM agencies are victimized by law enforcement agencies. In a study of Kenyan MSM, victims of physical, verbal, or other forms of violence were significantly more likely to not use a condom at last receptive anal sex, have unprotected sex at last insertive anal sex, and to never use condoms. This indicates that MSM whose lives are characterized by violence are less able to negotiate condom use than other MSM.<sup>67</sup>

Feminized males who do not perceive themselves, nor are perceived, as “men” within MSM are doubly stigmatized because even though biologically they are males, they express a feminine identity and a sexual practice which is seen as being feminine, i.e. they are penetrated. Their feminization reinforces their stigmatization leading to exclusion, harassment, violence and rape. Feminized males face similar levels of violence as women due to social constructions of masculinity and femininity.<sup>69</sup>

This leads to disempowerment of feminized males and increases the vulnerability of MSM to HIV where violence and the violation of human rights obstruct social justice redress. This creates an atmosphere of fear where implementation of sustained HIV risk reduction programs is very difficult, if not impossible<sup>70</sup> (See Example Box 4).



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**Example Box 4:** Homophobia in Jamaica

“In Jamaica, state-sponsored homophobia and discrimination against homosexual men and women ....and the conflation of HIV/AIDS with homosexuality ... are undermining an effective response to HIV/AIDS. Police not only harass and persecute people suspected of homosexual conduct but also interfere with HIV/AIDS outreach to them. Men who have sex with men and people living with HIV/AIDS face serious violence and are often forced to abandon their homes and communities. Many are denied health care and past experiences of discrimination, coupled with the fear that their HIV status or sexual orientation will be disclosed and publicized, keep many people from seeking health care in the first instance”.<sup>71</sup>

- Human Rights Watch Report

“Police always harass me. . . . They stop you and hear you talk a bit feminine [and] they ask you personal questions like are you top or bottom and like that. . . . The last time this happened . . . two police came over and said ‘Battymen mus dead. You should be under the ground. You should not be living in Jamaica.’ ...Some police officers say it is not legal so you should curtail your behavior. But most of them, once they hear you talk feminish they begin to [verbally abuse] you and a crowd comes around.”<sup>72</sup>

- A gay man in Jamaica, Human Rights Watch Report

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## 2.7 Stigma and Taboos

Cultural stigma and taboos (social bans), especially related to sex and sexual activities, increase men's and women's vulnerability to HIV. The taboos associated with sex and knowledge of sex act as barriers to seeking knowledge of HIV prevention and to providing the treatment care and support needed by those infected and affected by HIV.

HIV- related stigma (See Definition Box 2) is triggered by many forces such as a lack of understanding of HIV, myths about how it is transmitted, prejudice, lack of treatment, irresponsible media reporting, social fears about sexuality, fears relating to illness and death, and fears about illicit drugs and injecting drug use. HIV and AIDS possess all the characteristics associated with stigmatized diseases. AIDS is incurable, degenerative and fatal. HIV infection has come to be associated with socially condemned sexual behaviors and drug use for which individuals are often considered responsible.<sup>73</sup> Besides the stigma arising out of connotations of immorality associated with HIV and AIDS, ignorance about the disease also generates stigma.

### Definition Box 2: HIV-related stigma

HIV-related stigma can be described as a “process of devaluation” of people either living with or associated with HIV and AIDS. The stigma often stems from the underlying stigmatization of sex and intravenous drug use - two of the primary routes of HIV infection.<sup>74</sup>



photo: Challenges of access to services in a slum in Dhaka, Bangladesh  
© Richard Lord

“It [HIV] might be transmitted through breathing, we do not know. So being careful is necessary: avoiding eating food, coming from patient's home, not sharing clothes and not drinking with the glass that the patient used. This is what I think.”

- Man from Ethiopia<sup>75</sup>

“I asked, “Please give me a cup of sugar cane drink” and the vendor said: “If you drink in the cup, other persons will see you drink from that cup and they won't dare to use it. So take the drink in a [plastic] bag.”

- A man living with HIV/AIDS, Vietnam<sup>76</sup>

HIV- and AIDS-related stigma and discrimination can take the form of anger and negative feelings towards people living with HIV (PLHIV), avoidance and ostracism, expressions of blame and shame (belief that they are responsible for their infection and deserve their illness), loss of livelihood, loss of housing, physical and emotional abuses, and disruption of family relationships.<sup>77</sup>

Studies have shown that gender clearly plays a role in the nexus between HIV and AIDS and related stigma.<sup>78</sup> Women are much more stigmatized than men when they are infected. This is because there is close association in many cultures between HIV and sex and hence moral impropriety, and women in most cultures are expected to uphold and preserve the moral values of their communities. In these circumstances, HIV is regarded as evidence that they have failed to fulfill their social duties.

The stigma and discrimination based on HIV status, in combination with deeply rooted stigmatizing attitudes and discriminatory practices towards women and girls, gay men and other MSM, transgender people, sex workers, and drug users, among others, creates conditions for HIV to flourish. For example, fear of stigma and discrimination prevents people vulnerable to HIV from seeking testing. Ignorance about one's HIV status increases the person's and their intimate partners' vulnerability to HIV infection. Fear of stigma and discrimination also adversely affects people's ability and willingness to disclose their positive test results to others. Stigma is also linked to power and domination throughout society as a whole. Ultimately stigma creates and is reinforced by social inequality.<sup>79</sup> It causes some groups to be devalued and ashamed, and others to feel they are superior.<sup>80</sup>

Due to the stigma associated with HIV and the discrimination that often follows, the rights of people living with HIV and their families are often violated (See Rights Box 4). Freedom from discrimination is a fundamental human right. Various international and regional human rights instruments prohibit discrimination based on race, color, sex, language, nationality and other statuses. The United Nations Commission on Human Rights has declared that the term "other status" in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV and AIDS (resolution 1999/49). It states "discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing human rights standards" (resolution 2001/51).

#### RIGHTS BOX 4: ELIMINATING STIGMA AND DISCRIMINATION

##### United Nations Declaration of Commitment on HIV/AIDS

Stigma, silence, discrimination and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations. (Paragraph 13)

By 2003, [nations should] enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups...; and develop strategies to combat stigma and social exclusion connected with the epidemic. (Paragraph 58)

**Guideline 9 of the International Guidelines on HIV/AIDS and Human Rights** says that states should promote the wide and ongoing distribution of creative education, training and media programs explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

## 2.8 Religion

Religion and religious beliefs are the foundations of community life in a majority of societies. Religion prescribes ethical guidelines for many aspects of daily life and also navigates belief systems and norms surrounding sexuality. The majority of religiously tailored belief systems condemn premarital sex, contraception including condom use, and homosexuality. Some religions also advocate a submissive role for women, foster gender inequality in marital relations, and promote women's ignorance in sexual matters as a symbol of purity. The sexuality and gender stereotypes constructed by religion can inhibit prevention efforts and increase vulnerability to HIV infection.



HIV vulnerability caused by religious beliefs and practices is the result of religious institutions' denunciation of HIV infection as sinful.<sup>81</sup> Such religious judgments play a significant role in generating HIV- and AIDS-related stigma which increases vulnerability.

The religious construction of sexuality, with its emphasis on virginity, has led women to engage in anal sex in an attempt to preserve their virginity, which also increases their vulnerability to HIV. Research has shown that religion also influences men's and women's exposure to HIV prevention messages, knowledge and perception of risks, and the practice of prevention.<sup>82</sup> Women have been found to be disadvantaged in seeking information about HIV/AIDS due to their religious beliefs.<sup>83</sup> Religions advocating against condom use pose a serious challenge to preventing the spread of HIV in the communities where they operate. Similarly, religions that denounce homosexuality tend to fuel stigma against those who engage in same sex behavior, thus indirectly increasing their vulnerability to HIV (as noted in section 2.7).

Religion, in spite of being a social determinant of vulnerability, has great potential for preventing HIV and reducing HIV- and AIDS-related stigma. Because of the influence religious leaders have on the community, they can play a significant role in behavior change interventions, including the promotion of condom use, to reduce HIV transmission and de-stigmatize HIV and AIDS (See Example Box 5).

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#### Example Box 5: Role of Religious Leaders in the HIV Response in Senegal

Senegal is a country with two predominant religions; Islam and Christianity. The associations affiliated with these religions are involved in diverse social institutions such as schools, health facilities and youth movements that affect every aspect of people's lives. Recognizing the importance of involving religious leaders in HIV prevention efforts, Senegal's National AIDS Control Programme (NACP) planned, supported and pursued strategies for establishing policy dialogues on HIV/AIDS with Senegalese religious leaders.

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The objectives of the policy dialogue were to increase awareness and understanding of Senegalese religious leaders about HIV prevention strategies, and to build support among them for an effective comprehensive HIV prevention program.

The program drew messages from religious texts to mobilize religious leaders in HIV prevention. The participation of religious leaders legitimized HIV and AIDS interventions at the community level. NGO's and local organizations' involved in information, education and communication activities added a religious element to their HIV related messages. These efforts contributed to an increase in the level of knowledge of HIV/AIDS and an increase in the use of condoms as a means of protection against HIV.<sup>84</sup>

## 2.9 Recommendations:

- HIV programs must address the root causes of gender-based vulnerability to HIV.
- HIV programs must focus on greater sensitization and education of men and women on the traditions and cultural practices that increase the risk of HIV infection.
- Governments must adopt policies and enact legislation against harmful traditional practices that increase vulnerability to HIV.
- Governments must take stronger measures to prevent the rising incidences of violence against women and sexual minorities.
- Measures must be taken to introduce sex education curriculum in schools, and boys and girls should be provided with information on HIV prevention.
- Outreach programs must involve the use of positive role models (male and female) in the media that break existing stereotypical images and beliefs of HIV.
- Opinion leaders and religious leaders must be engaged in behavior change interventions such as promoting condom use.

### 3. Economic Factors

Economic factors are intrinsic to the HIV epidemic. It has been established that a disproportionate burden of the disease exists in less developed countries and among resource-poor communities. For example, sub-Saharan Africa accounts for little more than ten percent of the world population but it is home to sixty-four percent of all people living with HIV.<sup>85</sup>

The economic determinants that are described below (poverty, migration, and lack of access to productive resources, education and training) influence HIV vulnerability in several direct and indirect ways. They stimulate risky behaviors that are responsible for HIV transmission, create obstacles to prevention, and impede efforts to cope with the impact of the epidemic. Socio-cultural norms, such as lack of inheritance rights and access to productive resources, which reinforce women's economic dependence on their male partners, also lead to women's higher vulnerability to HIV. The excessively higher rate of HIV infection among women as compared to men in certain epidemics is also an expression of high gender-based socio-economic inequity.<sup>86</sup>

#### 3.1 Poverty

Studies have established that the poor and marginalized are disproportionately vulnerable to HIV and AIDS<sup>87</sup> (See Rights Box 5). Poverty impacts men and women differently and is a key factor leading to behaviors that expose people to the risk of HIV infection. Poverty increases susceptibility to contracting HIV through several channels, including increased migration to urban areas; limited access to health care, nutrition and other basic services; limited access to education and information; sexual exploitation; and gender inequality.<sup>88</sup>

#### RIGHTS BOX 5: HIV AND POVERTY

**U.N. Declaration of Commitment:** Recognizing that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner (Paragraph 11)

Poverty increases the risk of HIV transmission by limiting access to information related to HIV prevention. Data available from various countries show that men and women of high economic status know more about HIV prevention than those economically worse off.<sup>89</sup> Under conditions of poverty, sex may at times take place in overcrowded areas (for example, a one room home in a crowded slum accommodating many members of one family), which makes it difficult for partners to communicate freely to negotiate safe sex.<sup>90</sup> For many poor and marginalized MSM, clandestine sex often takes place in public places making condom negotiation difficult, if not impossible. Poverty can also pressure women and men to exchange sex for food or other material favors in order to ensure daily survival for themselves and their families.

“Poverty and HIV infection are deeply intertwined. As the burden of caring for the sick, the dying and the orphaned forces millions of African women deeper into poverty and batters their energy and self-esteem, so it increases the pressure to resort to high risk ‘transactional’ sex – sex in exchange for money or goods – or sex with older ‘sugar daddies’ who offer the illusion of material security. And as more and more women and girls take to the streets as their only means of survival, the need to confront gender inequality becomes inescapable.”<sup>91</sup>

## 3.2 Migration



photo: Haitian migrant sugar cane worker, Luperon, Dominican Republic © Richard Lord

Research shows that rural-to-urban migration increases vulnerability to HIV/AIDS.<sup>92</sup> Migrant men and women have been found to be more likely to engage in risky sexual behavior than non-migrants.<sup>93</sup> Increased rates of risky sexual behavior among male labor migrants can be attributed to spousal and partner separation and post-migration exposure to new social and economic environments.<sup>94</sup> The disruption of regular sexual relationships with spouses, coupled with post-migration economic marginalization and social isolation, leads migrants to engage in casual and commercial sex as a way of escaping loneliness, releasing sexual frustration, or generating income.<sup>95</sup>

The social constructs of masculinity and the lack of family and community norms that govern sexuality and fidelity allow for migrant men's participation in risky, casual sex with multiple sexual partners. Migration also fuels the epidemic when migrants living with HIV return to their households and re-establish sexual relations with their spouses and partners (See Rights Box 6).

Studies have also shown that gender inequality combined with migration increases female migrants' involvement in risky sexual behavior, increasing their vulnerability to HIV.<sup>96</sup> A study on the interaction between migration and gender in China suggests that female migrants are more likely to experience casual or transactional sex. Gender inequalities in education and job training restrict female migrants to low-status jobs merely paying a living wage with no job security. Living with the impact of these gender inequalities coupled with loss of family support mechanisms, many female migrants exchange sex for money or enter into sexual relationships in the hope of securing economic and emotional support.<sup>97</sup>

### RIGHTS BOX 6: COMMITMENTS TO SUPPORT MIGRANTS

#### Declaration of Commitment on HIV/AIDS

By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provisions of information on health and social services. (United Nations General Assembly Special Session on HIV/AIDS, 2001, DoC Paragraph 50)

By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors, and take measures to provide a supportive work place environment for people living with HIV/AIDS. (United Nations General Assembly Special Session on HIV/AIDS, 2001, DoC Paragraph 49)

## 3.3 Lack of Access to Productive Resources

Gender norms play a significant role in determining access by men and women to economic resources. Women, often lack access to productive resources and therefore have weaker negotiating power (including during sex) and hence higher vulnerability to HIV.

Laws and practices based on gender norms greatly limit women's access to productive resources such as land, property, and credit.<sup>98</sup> These practices secure women's financial, material, and social dependence on men. This unequal power balance favoring men in the economic sphere translates into an unequal power balance in sexual relations.<sup>99</sup> Research has shown that women who raise the issue of condom use with the men on whom they are economically dependent risk violent conflict, loss of support, or even abandonment.<sup>100</sup> Dependent women are reluctant to leave risky relationships as they fear dire economic consequences.



Lacking access to land, property and income, women are more likely to sell or exchange sex in unsafe ways for money, goods and favors.<sup>101</sup> Sex work offers not only a means of survival for some, but a route out of poverty for others. Consequently, there is a need to provide and enhance access to HIV prevention, treatment, care and support for all sex workers, and to provide opportunities for sex workers who wish to change their situation to move on within and/or from sex work.

### 3.4 Lack of Education and Training

Gender norms that restrict women's access to educational and vocational training, and the sexual division of labor that puts women in lower status jobs, increase women's vulnerability to HIV.<sup>102</sup> These two determinants limit women's access to employment opportunities. The vast majority of women are employed in low paying, seasonal, and insecure jobs in the informal and semi-formal sectors of the labor market.<sup>103</sup> An unequal standard in employment and channeling the majority of women into low status occupations perpetuates and reinforces their inferior status in economic relations.<sup>104</sup> International human rights conventions provide for governments to address these discriminatory practices (See Rights Box 7). These circumstances also make it more likely that women will augment their income by selling sex, and without access to legal, social and HIV prevention services, this limits their ability to negotiate safer sex.

### 3.5 Recommendations:

- Greater resources must be allocated to supporting income generating activities for women and marginalized groups in order to empower them.
- Support programmes for male and female sex workers must be created to address the structural determinants that increase sex workers' vulnerability to HIV, violence and exploitation within sex work settings, including providing sex workers with accurate information about safer sex practices.
- Educational and vocational training programs for women must be prioritized.
- Governments must take progressive steps to ensure the economic empowerment of women and marginalized communities.

#### RIGHTS BOX 7: ELIMINATING DISCRIMINATION OF WOMEN

**Article 10 of the Convention on the Elimination of All Forms of Discrimination of Women** provides that States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:

(a) the same conditions for career and vocational guidance, for access to studies and for the achievement of diplomas in educational establishments of all categories in rural as well as in urban areas....

...(c) the elimination of any stereotyped concept of the roles of men and women at all levels and in all forms of education by encouraging coeducation and other types of education which will help to achieve this aim and, in particular, by the revision of textbooks and school programs and the adaptation of teaching methods....

...(h) access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

**Article 11 (1) of the Convention on the Elimination of All Forms of Discrimination of Women** provides that States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women the same rights....

#### **International Guidelines on HIV/AIDS and Human Rights – Guideline 5:**

States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

## 4. Political Factors

Political factors have influenced HIV vulnerability since the early days of the pandemic. In some cases legislation, government policies, program strategies, and funding streams perpetuate discrimination against those most vulnerable to HIV, promote gender inequality, and even criminalize some sexual behaviors like homosexuality. When political factors sanction social norms and traditions that promote discrimination, gender-based vulnerability to HIV increases as does the vulnerability of those who are sexually marginalized.

### 4.1 Laws and Policies

Laws and policies create the environments in which HIV prevention, treatment, care, and support services are delivered. Politics and policies that are driven by conservative and traditional ideologies have dire consequences on the epidemic and further fuel infection rates among key vulnerable populations such as women and girls, transgender people, MSM, injecting drug users, and sex workers. National prevention policies pursued by governments have a profound impact on the way in which the HIV epidemic plays out in a country.

Governments, by agreeing to the various international human rights treaties and conventions, are accountable for promoting and protecting the human rights of their people. Human rights relevant to HIV/AIDS include (but are not limited to) the right to non-discrimination and equality; to health; to the liberty and security of the person; to privacy; to seek, receive and impart information; to marry and found a family; to work; and the right to freedom of movement, association and expression.<sup>105</sup> Implementation of these rights is absolutely essential in the context of HIV to ensure that services are reachable and accessible to those infected and most affected by the epidemic.

#### 4.1.1 HIV Prevention Policies

There is an impressive body of evidence to guide effective HIV/AIDS prevention policy making. Given that prevention efforts reach fewer than one in five of those at risk, a significant challenge is to scale-up prevention efforts to reach millions of people at risk worldwide.<sup>106</sup> However, many governments propagate ideological agendas over evidence-based strategies which exacerbate the epidemic.

In sub-Saharan Africa, a majority of young adults lack adequate knowledge of HIV transmission yet some governments emphasize abstinence-only approaches and promote inaccurate information about the effectiveness of condoms. For example, in Uganda the government promotes “virginity parades” and restricts the availability of condoms to youth while the epidemic – in a country once considered a success story – has worsened dramatically.<sup>107</sup> (See Example Box 7).

Programs that promote sexual abstinence and fidelity within heterosexual marriage to the exclusion of all other HIV prevention strategies deprive young people of life-saving prevention information. They ignore the plight of countless Ugandan women and girls who abstain until marriage and are faithful within it but nevertheless become infected with HIV because of their husbands’ infidelities.<sup>108</sup> They provide scant information or assistance to those at highest risk of HIV infection such as street children who trade sex for survival, children affected by conflict, and lesbian, gay, bisexual, and transgender youth.<sup>109</sup> They distort factual information about condoms and safer sex strategies, placing young people at higher risk of HIV and other sexually transmitted diseases.<sup>110</sup>

“As an activist and woman living with AIDS, it makes me feel judged. You are supposed to abstain and be faithful. Condoms are only for those who are promiscuous. I got HIV in marriage. I was faithful in my relationship. The battle to come out and be open was a struggle. Now, instead of moving forward, we are moving strides back.”

- Ugandan woman living with AIDS<sup>111</sup>

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#### Example Box 7: Condom promotion in Thailand

The rise in HIV infections among married Thai women prompted the public health authorities to review its HIV prevention strategy. Officials believe the reason for this increase was because married women were engaging in unprotected sex with their HIV infected husbands. More than thirty percent of the estimated 17,000 new HIV cases last year were married women, followed by men having sex with men (twenty percent), according to the Thai Public Health Ministry. The Ministry urged hospitals nationwide to run the Partner Notification Project, which encourages married couples to get tested regularly and promotes the ‘Abstinence, Be faithful and Condom use’ principles. Under the project, five million condoms would be distributed to married couples by the end of 2006 in a bid to control the transmission of HIV between husband and wife. Activists blamed the government’s discontinuation of a campaign to promote condom use as a reason for an increase in HIV infections. The government was called upon to show its political will to prevent HIV transmission by stepping up sex education and the condom use campaign. (Adapted from The Bangkok Post; September 9, 2006)

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### 4.1.2 Discriminatory Laws

Discriminatory laws and policies enhance women’s vulnerability to HIV. Laws and policies that prevent women from owning land, property, and other productive resources are examples of legislation that supports and increases gender discrimination. Other forms of gender-based and policy-supported discrimination in the areas of employment, education and access to health care services and information further exacerbate women’s vulnerability to HIV.<sup>112</sup> Research has shown that legal and political gender-based discrimination contributes to the feminization of poverty, promotes women’s economic susceptibility to HIV, and creates significant barriers to women’s ability to seek and receive care and support when they themselves are living with HIV.<sup>113</sup> Legislation condoning gender-based violence through light court or prison sentences, or policies that consider intimate partner violence or marital rape as personal domestic matters not requiring state interference, are other examples of political and legal discrimination which increases women’s vulnerability to HIV. International instruments have recognized that discriminatory laws and policies increases women’s risk of contracting HIV and the need for governments to take corrective measures to promote the advancement of women (See Rights Box 8).

Similarly, laws and policies that perpetuate stigma and discrimination based on sexual behavior enhance vulnerability to HIV. Criminalization of homosexuality in many countries, including as examples India, Jamaica and Nigeria, exacerbates vulnerability of MSM to HIV. The impact of such legislation is severe. It is often used as an exploitative tool by law enforcement agencies against MSM and is used to extort money, threaten, harass, and perpetrate violence against MSM.<sup>114</sup> Due to their legal status, MSM are seldom able to report cases of rape and violence.

## RIGHTS BOX 8: DECLARATION OF COMMITMENT ON HIV/AIDS

By 2005, bearing in mind the context and character of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection. (United Nations General Assembly Special Session on HIV/AIDS, 2001, DoC Paragraph 59)

By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, and other forms of sexual violence, battering and trafficking in women and girls. (United Nations General Assembly Special Session on HIV/AIDS, 2001, DoC Paragraph 61)

Such laws foster negative attitudes and discrimination against MSM in all settings, including health care, which consequently drives MSM underground and impedes their access to HIV and AIDS services (See Rights Box 9). These laws make it extremely difficult for HIV activists and service providers to reach MSM with AIDS awareness information and HIV prevention tools. There have also been cases in countries where NGO staff working with MSM have been targeted by law enforcement agencies and illegally confined and threatened (See Example Box 8).

### Example Box 8: Criminalization of sex between men in India

**Section 377 of the Indian Penal Code (IPC)** was enacted by the British in 1860. It criminalizes what it calls, 'sexual offences against the order of nature.' It does not define what constitutes the order of nature, but the judicial pronouncements that have come over the past one and half centuries has extended the application of this section to all forms of sexual expressions that is possible between two male persons.<sup>115</sup> Homosexuality in India stands criminalized because of a mid-19th century colonial law. Section 377 is rarely applied but it is an excuse that the police and other law enforcement agencies use to harass, blackmail, and extort money from MSM.<sup>116</sup> It marginalizes MSM and drives their activities underground. In these circumstances it is difficult for MSM to have stable relationships, negotiate safe sex or access information and medical services without discrimination.<sup>117</sup>

The law has also been used to disrupt the work of NGOs working on HIV/AIDS. For example, in July 2001, an NGO carrying out sexual health awareness programs with the MSM population was raided and its workers were arrested.<sup>118</sup> This was done on the grounds of abetting a crime under Section 377, and obscenity laws for publishing safe sex and AIDS awareness messages and distributing condoms among MSM.<sup>119</sup> The Naz Foundation (India), in its attempt to sensitize government on HIV/AIDS issues, filed a Public Interest Litigation challenging the Constitutional validity of Section 377 IPC.<sup>120</sup>

The validity of the Law was challenged on the ground that it violates Article 21 (right to life), Article 14 (right to equality), Article 15 (right against sex based discrimination), and Article 19 (right to freedom of speech and association) of the Constitution of India.<sup>121</sup> It was also argued that by criminalizing homosexual behavior, Section 377 drives same sex relations underground, and creates social conditions that significantly impede HIV/AIDS prevention efforts among MSM.<sup>122</sup> The matter is pending in the court. However, the challenge has generated media and public interest, and created awareness among the people and the government about the abuse of law by police and the impediments it creates in HIV prevention efforts.

Due to the advocacy efforts of civil society organizations, the National AIDS Control Organisation has included prevention programs for MSM into its National AIDS Control Plan III and has also recommended to the Law Ministry that Section 377 be repealed as it impedes HIV outreach work.



**RIGHTS BOX 9: PROTECTING HUMAN RIGHTS OF VULNERABLE GROUPS****International Guidelines on HIV/AIDS and Human Rights – Guideline 4:**

States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.

**International Guidelines on HIV/AIDS and Human Rights – Guideline 5:**

States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors .....

### 4.1.3 Lack of Implementation of Policies

By ratifying various international treaties, resolutions, and declarations governments are committed to implementing them. However, studies have indicated that adopted policies often remain on paper and are seldom implemented. Political leadership to implement new policies is still lacking in most countries and there are significant gaps between what is promised and what is delivered.<sup>123</sup> Governments have done little to implement international human rights agreements that they have ratified for the advancement of women and more equitable gender relations (See Rights Box 10).

**RIGHTS BOX 10: ADVANCEMENT OF WOMEN AND ELIMINATION OF ALL FORMS OF DISCRIMINATION**

**Beijing Platform for Action:** The advancement of women and the achievement of equality between women and men are matters of human rights and conditions for social justice and should not be seen in isolation as a women's issue. They are the only way to build a sustainable, just, and developed society. Empowerment of women and gender equality are prerequisites for achieving political, social, economic, cultural, and environmental security among all peoples. (Fourth United Nations World Conference on Women, Beijing, 1995, Paragraph 41)

**Declaration of Commitment:** Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS: By 2003, enact, strengthen, enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment information. (United Nations General Assembly Special Session on HIV/AIDS, 2001, DoC Paragraph 58)

### 4.2 Political Instability

Political instability, particularly conflict situations, creates conditions that disproportionately increase women's and girls' vulnerability to HIV.<sup>124</sup> Where governments are weak and conflict is prevalent, women and girls are at increased risk of physical and sexual violence and harassment, even subjected to rape including gang rape, forced marriages with enemy soldiers, sexual slavery and other forms of violence.<sup>125</sup> Such physical violence against women and girls has been a feature of all recent conflicts, including Sudan, Democratic Republic of Congo, Rwanda, Sierra Leone, Liberia, northern Uganda and Chechnya.<sup>126</sup> In Rwanda, the HIV prevalence rate in rural areas dramatically increased from one percent before the start of the conflict in 1994

to eleven percent in 1997.<sup>127</sup> Addressing violence against women in conflict settings is a challenge due to the breakdown of law and order. At the very least, medical services should be provided that include treatment for STIs, voluntary HIV testing and counseling, and using rapid HIV test kits to promote HIV testing. Where feasible, health workers should also discuss with patients the risks and benefits of HIV post-exposure prophylaxis (a course of antiretroviral drugs to reduce the risk of sero-conversion after events with high risk of exposure to HIV), especially for those who have been raped.<sup>128</sup> In 2001, governments committed to actions to respond to emergency situations including situations of political conflict (See Rights Box 11).

#### RIGHTS BOX 11: RESPONSE TO EMERGENCY SITUATIONS

**Declaration of Commitment:** By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programs or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons and in particular, women and children, are at increased risk of exposure to HIV infection; and, where appropriate, factor HIV/AIDS components into international assistance programs. (United Nations General Assembly Special Session on HIV/AIDS, 2001, DoC Paragraph 75)

### 4.3 Recommendations:

- HIV policies must be informed by evidence.
- Broad-based advocacy is needed to protest against policies that perpetuate gender and sexual inequality.
- Human rights policies and legislation are not enough – well-functioning structures and systems are needed for the redress of all human rights violations.
- Governments must allocate adequate resources towards HIV programs that meet the unique needs of women, men, and vulnerable populations.
- Communities need to advocate for governments to implement their existing national and international policy commitments.

## 5. Program and Services Access Factors

Socio-cultural norms that define male and female roles and responsibilities affect women's and men's access to and use of health services, including HIV/AIDS services. In cultures where there is a preference for sons, families allocate resources to boys and men before girls and women within the same family. This extends to health care where the interests of men and children are prioritized over women. In such cases, women's health issues are often neglected making them more vulnerable to HIV.

In some regions of the world women are further constrained from using services because of gender norms surrounding their mobility. In many patriarchal cultures women are confined to their homes and can not travel unless accompanied by a male member of the family. Similarly, many traditional practices demand that health care and HIV services employ female health care providers for women. Where there are only male providers, women are unable to access health services making them more vulnerable to HIV. Consequently, there is a need to develop programs and provide services that directly meet the needs of women (See Example Box 9).

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### Example Box 9: Increasing access to services for women in the Philippines

In Quezon City, Philippines, a group of physicians, lawyers, and business people were deeply dissatisfied with existing health services for women. They decided to set up the Women's Health Care Foundation (WHCF), which delivers integrated health services, including services for HIV and STIs, for women of all ages and conditions.

The Foundation conducted an assessment of existing health care services in order to develop appropriate strategies that effectively addressed the needs of women of all ages. It found that providers favored married women of reproductive health age and had negative attitudes toward young and single women who sought family planning advice and other reproductive health services.

After conducting a thorough needs assessment, the WHCF developed several strategies to increase accessibility to services. In addition to low cost services and staff training, one of the main strategies has been to keep clinics open after normal hours, long after government clinics had closed. This has increased the number of clients by fifty percent. Another approach was to set up clinics in strategic locations to attract potential clients who can walk in at any time:

- Cubao Clinic, a modest centre with a small reception area, an even smaller laboratory and a screened-off examination room, attracts a considerable number of women patients because it is within walking distance of the commercial district.
- Alabang Clinic, located in a poor suburban area, attracts clients from neighboring communities and serves as a base for women who cannot afford transportation fees or are too busy to visit a clinic in the city.
- Quezon Avenue Clinic, situated in a business and commercial establishment area, serves workers from nearby offices.<sup>129</sup>

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The barriers that men face in using services are often related to socio-cultural norms that ascribe reproductive responsibilities entirely to women and shut men out of parenting and nurturing roles.<sup>130</sup> For example, family planning, prenatal, and child health clinics are typically not designed to reach men or meet their needs. Because in many countries, HIV information and services are provided primarily in such clinics, men are less likely to benefit from those services and are less likely to be fully informed about HIV prevention, care, support, and treatment options. This has significant implications for men's ability to protect themselves from infection and cope with the epidemic.<sup>131</sup>

Sexual discrimination is another factor that limits access to available services by sexual minorities. Current indicators suggest that less than ten percent of MSM and transgender people globally have access to the HIV prevention and AIDS care services they need. Many factors contribute to this situation, including societal and community denial, stigma and discrimination, and human rights abuses. Scaling-up interventions for MSM is difficult because doing so often raises the visibility of the men themselves. This has consequences for interpersonal and community relationships and personal safety (especially in contexts where sex between men is taboo, criminalized, or denied).<sup>132</sup> Access to HIV services remains limited for MSM which increases their vulnerability to HIV.

International Human Rights instruments have recognized the right of every individual to the highest attainable standard of health irrespective of gender or sexuality (See Rights Box 12).

#### RIGHTS BOX 12: RIGHT TO HEALTH

**International Covenant on Economic, Social and Cultural Rights: Article 12:** The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: ...(c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.<sup>133</sup>

**Declaration of Commitment:** Recognizing that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (Paragraph 15)

Gender and sexuality also determine the level and quality of care, treatment and support that HIV positive persons receive, and the negative social and economic consequences that they face. Access and availability issues contribute to HIV vulnerability in the context of the following programs and services such as voluntary counseling and testing, prevention services and treatment.

### 5.1 Voluntary Counseling and Testing (VCT)

In many parts of the world affected by HIV and AIDS, as few as one in ten know they are infected.<sup>134</sup> VCT is not only a gateway to treatment, care and support for people living with HIV, but it is also a critical component of HIV prevention. Although VCT is available in most countries now, access is often restricted to a few centers in the larger cities. In places where long distances must be traveled, women's access is restricted due to mobility and difficulty in accessing transportation. Stigma and the consequent discrimination associated with HIV also act as a deterrent to getting tested. In a study of mother to child transmission (MTCT) prevention programs in six African countries, fear of ostracism and domestic violence were important reasons given by pregnant women for refusing HIV testing or for not returning for their test results.<sup>135</sup> Also, attitudes of VCT staff towards women who get tested have often been cited as being extremely negative.

Stigma and discrimination are disincentives from getting HIV tests for men as well. Fears about confidentiality discourage both men and women from seeking testing. Stigma and discrimination and even criminalization of male-to-male sex in some countries prevent MSM from getting tested. Seeking HIV services for MSM often requires disclosing their sexuality which puts them at risk of exclusion and harassment by families, communities, and legal structures. This not only increases the vulnerability of MSM but also puts both male and female partners of MSM at risk of HIV infection.



## 5.2 HIV Prevention Services and Tools

AIDS is the third largest killer in the world, but HIV is preventable. Every day 14,000 people become infected with HIV, the majority through sex.<sup>136</sup> It has been estimated that as many as two-thirds of the new infections expected to occur in the next ten years could be averted by the implementation of a comprehensive range of evidence-based prevention measures including the promotion and usage of condoms and providing information on HIV and AIDS.<sup>137</sup>

### 5.21 Condoms

Cultural and religious notions of morality that equate condom use with promiscuity both limit the availability of condoms and create psycho-social barriers to using them. In some countries, condoms are primarily associated with marginalized groups such as sex workers. For example, until recently in Morocco, the possession of condoms was seen as proof of soliciting sex.<sup>138</sup>

“The fact of using a condom is not even contemplated unless having sex with a sex worker. And this is the mentality of men and women: which somehow reflects the difficulties our women have to go through ... ‘how can we ask them (male partner) to wear a condom...he will think I’m a prostitute.’”<sup>139</sup>

- Fundacion Santa Clara (FSC Representative), Venezuela



photo: Youth involved in school HIV prevention education, El Salvador  
© Richard Lord

Even when condoms are available, many men are reluctant to use them due to the perceptions that condom use reduces sexual pleasure. Due to cultural and religious constructs, married women are often not able to negotiate condom use for fear of being accused of infidelity or resistance to bearing children. Gender and sexuality affect the power dynamics in any relationship, heterosexual or homosexual. Women, MSM, feminized men and transgender people experience difficulties with condom negotiation and experience high levels of sexual violence.<sup>140</sup>

Prevention tools such as the female condom can empower women to take control of their sexuality. However the high price of the female condom and its lack of availability and awareness by women increase their vulnerability to HIV.

Lack of proper guidance to men and women on the importance of correct and consistent use of condoms may increase HIV vulnerability. In too many countries, a shortage of personnel trained to provide quality counseling means that condoms may be wasted even when they are available and accessible. The need for direct interaction with salespeople for condom purchase also acts as a barrier to widespread condom use.

## 5.22 Information on HIV and AIDS

Lack of knowledge about sex and HIV and AIDS is a contributing factor to vulnerability. Gender norms that demand passivity of women in sexual matters often restricts their access to prevention services even when available. Similarly, men are conditioned in many cultures to believe that they are entitled to adopting risky sexual behavior, but without adequate knowledge of HIV prevention that behavior puts an increasing number of men and their partners at risk. Providing information specifically aimed at women and girls, and men and boys, is therefore critical (See Example Box 10).

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### Example Box 10: Prevention programs for girls in India

In Mumbai, India, practitioners designing HIV prevention programs for girls found that it was crucial to first launch an awareness program in the wider community to gain the support of parents and others prior to the initiation of the work targeting girls. Program designers also learned that those young women and girls had heavy domestic workloads, including responsibility for the care of younger siblings. Therefore, they provided crèche facilities to ensure that young women would be free to attend the program. Rather than concentrating solely on HIV and AIDS, the program designers included a range of topics on reproductive and sexual health as well as discussions on gender issues. The program proved very popular with young women and participation increased throughout its duration. A follow up survey found that sixty-two percent of the girls who took part in the sessions reported that they had subsequently discussed HIV and AIDS with others.<sup>141</sup>

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photo: Port workers participating in peer-education condom promotion, Tanzania © Richard Lord.



### 5.3 HIV Treatment

Gender and sexuality determine the economic and social implications of how an individual will be able to access treatment, cope with infection, care for a family member, and survive death of family members.

There are several barriers to accessing HIV treatment. Barriers to treatment are rooted in the psycho-social constructs that create stigma and obstruct confidentiality. Barriers to treatment can be lack of money for medicines, lack of transport, and the inability to take time off from work to attend a clinic. In rural areas, physical barriers exist such as bad roads and inadequate transport options. These factors play out differently for women, men, and sexual minorities.

Women are often unable to access health centers and treatment due to their lack of mobility and domestic duties.<sup>142</sup> Social and religious constructs often require women to put the needs of their family, namely their spouse and children, before themselves. Families may allocate resources for men and boys first, and women and girls later. Because women are more likely to wait for longer periods of time before seeking services and treatments during the course of an illness, they are more likely to be at an advanced stage of HIV infection with complex opportunistic infections before they first present for treatment.<sup>143</sup>

The stigma associated with HIV in many communities translates into HIV positive women being accused of promiscuity. For this reason many women will not seek voluntary counseling and testing, they will try to keep their HIV status a secret, and they are unlikely to seek care, treatment and support. If the woman is experiencing domestic violence, the possibility of taking care of herself and/or seeking help is even more restricted.<sup>144</sup>



photo: HIV and AIDS community outreach, Thailand © Richard Lord

“If you do not have the resources to pay for a medical visit, it is very hard to find a good doctor, a clean and decent place, where personnel do not treat you badly, or call you ‘the woman with AIDS’ in front of the rest of the patients....or leaves you last even if you were first in line....”

– Fundacion Santa Clara (FSC) Representative <sup>145</sup>

Economic factors also influence women’s access and use of treatment services. As discussed earlier, women who are economically dependent on men often are unable to pay for the high costs of drugs, treatment, and even transportation. In countries, where treatment centers are located in urban centers, rural women’s access is further limited by their ability to afford transportation costs.

Even when there is free access to HIV treatment there are significant gender differences in terms of uptake. Testing services for women are offered predominantly at pre-natal clinics, which preclude non-childbearing women who might be vulnerable to HIV. Women who are not reached through HIV and AIDS education and information programs do not perceive themselves as being at risk of HIV and therefore they do not seek testing. The stigma and discrimination of women at testing and treatment sites is also a disincentive. This occurs despite International Human Rights instruments guaranteeing the elimination of all forms of discrimination against women (See Rights Box 13).



### RIGHTS BOX 13: ELIMINATION OF DISCRIMINATION IN HEALTH CARE

#### The Convention on the Elimination of All Forms of Discrimination Against Women, Article 12:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period...

**The Beijing Declaration and Platform for Action**<sup>146</sup> states that [t]he social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases need to be seen from a gender perspective. (paragraph 98)

Inevitably, people with low incomes, in low-resource areas, and marginalized social groups experience the most restricted access to health care. Access to treatment for MSM is constrained by their marginalization and routine violations of their rights which make it difficult for them to be informed of available treatment options as well as to access necessary treatment services. This happens even though the International Guidelines on HIV/AIDS and Human Rights have issued recommendations to states to ensure access to quality HIV services for all (See Right Box 14).



photo: Sundanese refugees who lack access to HIV prevention and treatment services, Kenya © Richard Lord.

### RIGHTS BOX 14: ACCESS TO QUALITY HIV SERVICES FOR ALL

**International Guidelines on HIV/AIDS and Human Rights, Guideline 6 (as revised in 2002):** States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including anti-retroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions. States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.



## 5.4 Recommendations:

- Prevention programs should be designed with the involvement of men and women so that they meet their unique needs. Prevention programs should address the needs of those most marginalized and vulnerable to HIV infection.
- Training and counseling is required for men and women on consistent and correct condom use.
- VCT staff should be trained on ethics and human rights. Stigma reduction strategies must be adopted at VCT sites.
- Investments should be made towards increasing knowledge and education on sexuality and HIV.
- Governments must guarantee access to health as a human right and remove legal barriers that impede access to HIV programs and services.
- Treatment programs should be:
  - Rights-based (access is part of the human right to health)
  - Community-based (informed, prepared with full participation of the community, enabling individuals to play a full and informed role in their treatment)
  - Gender-sensitive and focused on the needs of specific communities (women, men, MSM, transgender, sex workers and others)
  - Technically appropriate (free of discrimination, accessible information, effective diagnosis and treatment, management, legal support for the protection of rights).

photo: Youth sex education and safe sex role play, Uganda © Richard Lord



## 6. Overall Conclusions and Recommendations

Gender inequalities are a major driving force behind the HIV epidemic. The different attributes and roles that societies assign to males and females profoundly affect their ability to protect themselves against HIV and cope with its impact. Gender-based inequalities intersect with other social, cultural, economic and political inequalities affecting women and men of all ages. Gender creates an unequal power balance between men and women, favoring men, which influences an unequal access to key resources including income, credit, employment opportunities, education, and information. All these factors work together to create a world where women and girls are more vulnerable to HIV than men and boys. Social norms make men and boys vulnerable to HIV by promoting risky sexual behavior accompanied with little or no knowledge of HIV prevention which increases their vulnerability to HIV.

Sexuality is also a key determinant of vulnerability to HIV. An individual's sexuality is defined by whom one has sex with, in what ways, under what circumstances and with what consequences. In most cultures, social norms require that sex should be between a man and a woman. Any sexual interaction outside this norm is perceived as deviant and is morally scrutinized. This leads to stigma, discrimination and even criminalization of sexual minorities which tends to drive sexual minorities underground. This makes it extremely difficult to reach them with HIV information and services and increases their vulnerability to HIV. MSM are one of the most vulnerable population cohorts who are routinely and heavily stigmatized; they exist in an environment of marginalization, isolation and inequity. In many cultures, feminized males face similar levels of inequality and discrimination as women.

To successfully address HIV/AIDS, the gender and sexuality-based causes of vulnerability must be addressed. Some of the key recommendations that have emerged from this study to mitigate the determinants described above include the following:

1. Most communities share values, beliefs and norms on sexuality that create vulnerability to HIV transmission such as widowhood-related rituals, FGM, and early marriage. Many of these practices have never been questioned and their association with HIV is not well understood. There is a need for HIV programs to draw the links between local traditions and HIV transmission both at the national policy and community intervention levels. At the community level, there is a need to strengthen community-based participatory strategies that allow for awareness raising, analysis, and questioning of underlying factors that predispose communities, particularly women, to HIV.<sup>147</sup>
2. Most HIV interventions have not taken into full consideration cultural values, societal norms and traditions that strongly influence individual behavior. This has at times made programs ineffective in reaching targets. All HIV programs should be developed through participatory processes involving women, men and sexual minorities and should take into account societal norms and traditions. This will ensure that these programs are accessible to them and meet their unique needs.
3. Gender should be a key component in the design of any HIV/AIDS program. The empowerment of women is absolutely critical and becomes a prerequisite if communities are to reduce both women's and men's vulnerability to HIV. HIV policies, programs and interventions that target the income, livelihood, literacy, health, and legal needs of women must be enforced.<sup>148</sup>
4. Governments must develop laws, policies, institutions and processes that promote and protect the human rights of all its citizens. The promotion and protection of human rights are necessary to empower individuals and communities to respond to HIV/AIDS, to reduce vulnerability to HIV infection, and to lessen the adverse impact of AIDS on those affected. A guarantee of human rights for all

and the removal of legal barriers to accessing HIV services are necessary especially for gay, lesbian, bisexual and transgender communities and other vulnerable sexual minorities.<sup>149</sup>

5. Given that cultural traditions are deeply entrenched in societies and are extremely sensitive issues, HIV/AIDS programs must utilize community-based entry points for interventions targeted at bringing about social change. These include engaging community leaders and religious leaders as spokespersons for social change.<sup>150</sup>
6. In some communities, there is a prevailing association of HIV with high risk groups such as sex workers, injecting drug users, or truck drivers. There is a need for re-defining risk groups both at a policy and programmatic level so that they do not give a false sense of security to women and men in the general population. Information, education and communication approaches should target women and girls since traditionally their access to information is considerably limited.
7. HIV treatment programs and services should be developed in a participatory manner and should include issues of gender and sexuality to meet individual community needs. Preparing communities for ARV treatments requires respect for rights, helping individuals to be effective users of effective drugs and clinical care, and ensuring that they have accessible and appropriate information. Accessible information means that it must be conveyed in language that the user can understand. An individual needs comprehensive treatment information to ensure adherence and effective management of side effects.



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This document is a resource for NGOs and CBOs to build greater understanding of how gender and sexuality determine vulnerability to HIV. The document also highlights major human rights declarations, treaties and recommendations that can be used by individuals and associations to advocate for their rights and hold decision makers accountable to their commitments.

This document is a summary of a desk-based review of literature that examines the factors that contribute to the vulnerability and risk of HIV infection in men, women, and men-who-have-sex-with-men (MSM). Though other sexual minorities such as transgender are equally vulnerable to HIV, vulnerabilities of transgender and other sexual minorities are outside the scope of this guide.



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