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Exchange

on HIV/AIDS, sexuality and gender

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A member of the audience acts her ideas out on stage p. 6

Let us promote gender equality

I thank you ardent readers for the trust you have in this publication. As your new editor, I will endeavour to do my best to ensure that *Exchange* continues to meet its objective of being an avenue through which experiences are shared for improved programming. Also, I want to thank my predecessor, Nel van Beelen, for her able stewardship during her stint as editor.

This issue addresses the link between HIV and AIDS and violence against women. Violence, which is experienced by many women in their lives, increases their vulnerability to HIV in many ways. Rape can contribute to HIV transmission due to tears and lacerations resulting from the use of force whereas violence can prevent women from negotiating safer sex and accessing treatment. Lastly, fear of violence prevents women from learning and/or disclosing their status especially if they are HIV-positive.

There are factors that bring about such scenarios, for example, gender norms that influence women and girls' vulnerability to HIV. These norms, according to the World Health Organisation, allow men to have more sexual partners than women, and encourage older men to have sexual relations with younger women. Women may want their partners to use condoms (or to abstain from sex altogether), but often lack the power to make them do so.

Programmes that invest in the specific needs of women and girls and promote gender equality can reduce their vulnerabilities and also contribute to their overall well-being. In a nutshell, the small steps we take as stakeholders cumulatively lead to women's empowerment and contribute towards helping them avoid both violence and HIV. Let us do more in this regard.

Enjoy reading!

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Gender violence and HIV: Reversing twin epidemics

"Violence against women and girls makes its hideous imprint on every continent, country and culture…it is time to focus on the concrete actions that all of us can and must take to prevent and eliminate this scourge…Member States, the United Nations family, civil society and individuals…women and men. It is time to break through the walls of silence, and make legal norms a reality in women's lives." – Ban Ki-moon, UN Secretary-General, at the launch of the Campaign to end Violence against Women, February 2008.

The situation of women and girls in the context of the HIV and AIDS epidemic in many parts of the world and particularly sub-Saharan Africa continues to be a cause of major concern. Statistics remain highly disturbing, with women accounting for almost 60% of adults (aged 15-49) living with HIV in the region, and 75% of all young people living with HIV being female. HIV prevalence among young women aged 15-24 is three times higher than HIV among their male counterparts. Three quarters of all adult women living with HIV live in sub-Saharan Africa[1].

Meanwhile, with more than 30% of women in some countries reporting their first sexual encounter as forced, and the continued feminisation of the HIV epidemic, violence remains both a cause and consequence of HIV infection. Once infected with HIV, women often face varied forms of violence, particularly driven by stigma and discrimination, within their homes and from their communities. Limited access and control over resources; poor access to education and information; limited access to services (legal, health and social); and subordination due to harmful cultural practices and gender inequalities, only serve to fuel this vicious cycle of the twin epidemics – gender-based violence (GBV) and HIV and AIDS.

Violence as cause and effect of HIV

Gender-based violence is both a cause and effect of HIV infection. Violence against women manifests itself in physical, psychological/emotional, economic and sexual forms. While the international community may view male violence against women as legally intolerable, it is still considered acceptable in many societies, including those that have survived violence.[2] Violence against women both

causes and results in HIV infection among women. In many cultures, wife-beating is justified, and research has revealed that women who are beaten or dominated by their partners are much more likely to be infected with HIV than those in non-violent households[3].

Women's vulnerability to HIV infection, and ability to cope with the impact of AIDS, remain intimately connected to their autonomy in decision-making and choices; freedom of communication; negotiation capacity; partnership mutuality, and overall status within the nuclear setting of society – the household. Gender-based violence feeds on these factors. HIV itself has deepened the furrows of impoverishment in many families, leaving widows and girl-children heading households affected by the epidemic, with little or no skills and employment opportunities to sustain them and their dependants. In a study in Zambia, Human Rights Watch found that hundreds of girls who had been orphaned by AIDS were being sexually assaulted by family members or forced into sex work for survival[4]. Evidently, the issues above reveal a vicious cycle of increasing vulnerabilities to both gender violence and HIV. Both epidemics are driven by power imbalances and gender-based discrimination.

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Linkages to harmful practices

Sexuality remains a 'taboo' topic, especially when raised by women, yet it is the crux of both epidemics. Intergenerational sex fuelled by the socialisation that young women need to be in a relationship or married to attain a 'dignified' status in society, exposes young women to HIV infection by older more sexually-experienced men. Economic dependence on men often keeps women within abusive unions, and at continued risk of infection. Limited access to education, and subsequently employment opportunities, by women, impede their ability to attain economic independence, further making them dependent on male partners. This is closely linked to limited access to treatment and food security, which limit women's ability to practice positive living when HIV-positive.

Multiple concurrent partnerships in the belief that "men can have many sexual partners", defeats the practice of 'faithfulness' as a prevention method. Violation of women's reproductive and sexual rights (female genital cutting; dry sex; making autonomous infant feeding choices and decisions; choosing whether to have sex, when and with whom; forced pregnancy), jeopardise women's reproductive and sexual choices, placing them at risk of HIV infection. Negotiation of safer sex is grossly curtailed by violence, as is premised upon existing gender power imbalances that define sex as a male-controlled domain.

Special groups of women

Disclosure of HIV status and revelations that an HIV test has been sought often triggers violence (beating; socio-economic sanctions), based on the gender-discriminatory 'blame' factor. Fear of violence deters many women from getting tested for HIV, and/or revealing their HIV status and accessing treatment and care on time[5]. While special groups of women and girls, already socially marginalised irrespective of HIV status (lesbians; institutionalised women; women and girls living with disabilities; migrant and refugee women; and sex workers), have a lesser chance of negotiating safer sex, and are at higher risk of sexual abuse, they lack capacity to cope with AIDS when HIV-positive.

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The socially-constructed status of women is not the only contributing factor to fuelling both epidemics. The socialisation (norms and expectations) around masculinity and male behaviour has also been shown to increase men's and boys' risk of being infected with HIV, as often they also equate risky behaviour with 'manliness' and regard health-seeking behaviours as 'unmanly.' Socially-driven expectations that men are sexually experienced, self-reliant and more knowledgeable about sexuality and health-related issues than women, inhibits boys and young men from seeking information on HIV prevention, care and treatment. Pervasive gender roles further limit men's options regarding their own behaviours and what is expected of them by society: encouraging early sexual activity; multiple sexual partners; use of alcohol; use of violence and aggression to maintain dominance.

Several best practices have been recognised. In Botswana, the Women Against Rape organisation provides round-

the-clock medico-legal services to survivors of violence. The group offers training in schools on the linkages between gender-based violence and HIV and human rights and enables rural women to access legal redress for violence. Meanwhile, the Men as Partners (MAP) programme undertaken by Engender Health works across the whole African continent (also in some countries in Asia, Near East and the Americas) to engage men (including ex-perpetrators of violence against women), through empowering them to share responsibility of reproductive and health rights, participate in PMTCT programmes, prevent violence, HIV and STI infections[6]. Other interventions include microfinance efforts that have increased women's self-efficacy, negotiation skills, and economic independence, thus reducing their risk of HIV infection and exposure to violence[7]. Several communities, in the hope of reducing the likelihood of HIV infection following rape, have rolled out programmes to provide post-exposure prophylaxis to rape survivors within 72 hours of attack.

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Prevailing Gaps

Gender-based violence remains one of the most unyielding and fundamental stumbling blocks towards the realisation of the objectives of the Convention on the Elimination of All Forms of Discrimination Against Women, the Beijing Platform For Action, the Millennium Development Goals and other commitments made by States to enable women and girls to enjoy their rights and realise their full potential in society. Silence and shame persist around gender-based violence and HIV by partners, families, custodians of culture, religious leaders and communities.

Service provision and responses to violence and HIV – distinctly – remain conventionally dichotomised. Survivors of violence often access services at gender or women-focused institutions, and access HIV and AIDS-related information and services at separate institutions. This parallel (often disparate) service provision for gender-based violence survivors and persons infected or affected by HIV perpetuates the burden – emotional and financial – on the client.

Meanwhile, research has inadequately explored the concerns around high prevalence of HIV or gender-based violence, and related predominant risk factors. Though much research has examined GBV as a factor in HIV infection, very little has been done to examine HIV as a cause of GBV or the perpetuating cycle that GBV and HIV create. As a result, little evidence exists to support placing a rights-based approach at the centre of a response to both epidemics. The paucity in defining context-specific constructs of gender and sexuality awareness, and linking them to international human rights frameworks, has led to persistently missed opportunities in gaining in-depth understanding of how these epidemics are linked and could be jointly addressed.

Men's involvement in supporting women's empowerment is critical

Furthermore, there has been little documentation and sharing of best practices and interventions concurrently addressing violence and HIV in an effective, innovative and sustainable fashion. A concentrated scale-up in cross-sharing of lessons learnt – defining what works and what does not work – in responding to the twin epidemics is paramount for replication of successful interventions.

It is vital to invest in promoting female controlled prevention methods, training of health professionals to address violence against women, sensitising and empowering legal and policy-making institutions to challenge and halt the discrimination that instigates and propagates both violence and HIV. Thus the fundamental gap in addressing the relationship between the epidemics lies in recognising the need for a multifaceted response that considers cultural and environmental contexts of women, girls, men and boys, involves health care service providers, socio-legal services, programmers, researchers and policy makers.

Creating a response paradigm of urgency

As both research and programming at the intersection of GBV and HIV expand, it is important to further examine the intricacies of the relationship between these issues, including their association with vulnerability and risk-taking

A lady from Seke Rural area, Harare, Zimbabwe in a women's empowerment meeting

behaviours[8]. Sexuality and human rights constitute useful frameworks currently under-utilised in addressing this critical intersection. Given the importance of gender as a determinant of both GBV and HIV, it is important that further research explores these dimensions with sufficient attention to local context.

Women shall continue to demand sovereignty over their bodies, health and rights. To support them to realise this autonomy and reverse both epidemics, it

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is critical to enhance political commitments that are feasible and measurable, and enable social and legal changes to support women and girls, by bringing states and legislators to account for all commitments and promises made towards the attainment of gender equality over the past decade. These commitments should also be domesticated. There is need to follow women's rights-related legal reform, and establish sustainable monitoring, evaluation and surveillance mechanisms to keep them in check, and embark on intensive sensitisation of the criminal justice systems on links between GBV and HIV and AIDS.

Civil society needs to pursue access to affordable and quality legal, health, education and economic services to women and people living with HIV, over-riding unnecessary protocols and bureaucracies. There is also the need to harness the mass media and advertising sectors towards systematic, factual and persistent sensitisation of the public on the two epidemics: bringing to the fore violations, driving debate and dialogue, and mobilising a public demand and desire to contribute towards their reversal.

There is need to keep in mind the constant promotion of the Meaningful Involvement of Women Living with or Affected by HIV and AIDS principles, and building on the current programmes that examine attitudes and behaviours of men and boys, and involving them in shouldering responsibility and organising effectively towards upholding women's rights.

Attention is needed in determining innovative methods to use monitoring and evaluation data to raise consciousness around the scope and urgency surrounding both epidemics, as well as expanding processes of documentation and sharing of best practices, to simultaneously inform both GBV and HIV programming.

Women must not be regarded as 'victims' since in many places, they are leading the way by taking action to increase knowledge on HIV and AIDS, expanding access to related services, increasing their ability to prevent infection; coping with AIDS, litigating around the epidemic, and combating stigma, discrimination and violence[9]. Unless the link between gender-based violence and HIV is broken, it will be hard to reverse the latter epidemic[10], an epidemic that has sapped massive portions of the world's wealth, energies and resources.

Attainment of women's equality depends on honouring global promises. It depends on unswerving steadfastness of advocates. This is not a struggle for triumph in sustainable development, peace and security. This is a struggle for survival! Until this reality is engraved in our very beings as traditional and religious leaders, law defenders, parents, policy makers, PLHIV, activists and community members, reversing the feminisation of the twin epidemics – HIV and AIDS and GBV – shall remain a pipe dream!

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