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USAID ASSIST Project
Applying Science to Strengthen and Improve Systems

ADDRESSING THE NEEDS OF MEN, WOMEN, BOYS, AND GIRLS IN HIV AND ART SERVICES

Background

Patient centered anti-retroviral therapy (ART) and HIV care supports the ongoing productivity and quality of life for an individual based on his or her needs, lifestyle preferences, and interactions with family and community. Tolerance of and adherence to specific antiretroviral drugs also differs between individuals since treatment is life-long and often brings unpleasant side effects.

Although patients' needs cannot be generalized, certain attributes of men, women, boys, and girls play an important role in a patient's experience with ART and in determining the highest quality care for each person. Men, women, boys, and girls may differ in access, acceptance, and utilization of care, as well as, self-efficacy (i.e., a person's belief that he or she can complete a particular task), roles and responsibilities, and perceived stigma surrounding HIV status. These factors all affect how ART fits into their lifestyles. Men and women also have different physiological manifestations of the disease and different biological reactions to ART, requiring considerations for treatment and accompanying nutritional needs. By making care acceptable, appropriate, and accommodating to the lifestyles of women, men, girls, and boys, we can improve the delivery of ART and improve patient health outcomes.

Gender issues in ART and HIV services:

- Lower utilization of and retention in HIV services among men
- Vulnerabilities and challenges for women and girls
- Risks of gender-based violence associated with status and testing

Gender Issues to Consider in ART and HIV Services

Utilization and retention among men

While the prevalence of HIV is higher among women in sub-Saharan Africa, proportionally more men die from HIV and AIDS, indicating a gap in treatment utilization and compliance among men. Research in sub-Saharan Africa indicates men tend to start ART at a later stage of infection than women (Mills et al. 2012 PLoS Med 9(2)). Men also have higher rates of drop-out from ART programs and non-adherence to treatment. This gender-related gap affects everyone: men not receiving and adhering to care not only increase their risk of morbidity and mortality, but can become less economically productive and more likely to spread the disease. Furthermore, women and girls often become the caretakers of those infected; increasing numbers of sick men adds to the burden on women and girls.

Reasons for this gender gap in male adherence and retention are socially driven, and to be overcome, require increased awareness and actions of providers and communities. While not all of these apply to every community and every man, some social themes and perceptions that deter men from treatment include:

1. The perception of seeking healthcare as being weak and "non-masculine"
2. The belief that HIV is "a women's issue." This is perpetuated in settings where HIV and AIDS services are only provided in reproductive and maternal health care clinics
3. Some men do not want to allocate resources away from the family to personal care
4. Avoiding the opportunity costs of missing work to get to services
5. Inaccessibility of long-term treatment to men who travel or migrate for work

MAY 2013

This brief report on integrating gender considerations in HIV services was written by Caitlyn Lutfy and Taroub Faramand of Women Influencing Health Education and Rule of Law, LLC (WI-HER) for the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is funded by the American people through the United States Agency for International Development (USAID) Bureau for Global Health, Office of Health Systems. The USAID ASSIST Project is managed by University Research Co., LLC (URC) under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. URC's global partners for USAID ASSIST include: Broad Branch Associates; EnCompass LLC; FHI 360; Harvard University School of Public Health; Health Research, Inc.; Institute for Healthcare Improvement; Initiatives Inc.; Johns Hopkins University Center for Communication Programs; WI-HER, LLC; and the World Health Organization Patient Safety Programme. For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com. For more information on integrating gender considerations in HIV services, please contact tfaramand@wi-her.org or clutfy@wi-her.org.

6. Not wanting his wife or partner to know his status, particularly in polygamous relationships

These issues can be addressed through making accommodations at clinics, such as creating a section for men or providing testing and counseling outside of the typical workday hours, and through disseminating messages to encourage male involvement through media, public announcements, and social networks.

Vulnerabilities and challenges of women and girls

Women face additional biological and social risk factors for contracting HIV and challenges for undergoing treatment. Overall in sub-Saharan Africa, the highest HIV prevalence exists among the adolescent girl population, with a rate 3–7 times higher than that among men (Karim et al. 2010 CID Supp 3). Gender inequalities like the early marriage of girls, sexual abuse, sexual exploitation, and male sexual activity outside of marriage contribute to these higher prevalence rates to varying degrees in different communities. At the same time, it is estimated that the virus spreads eight times more efficiently from male-to-female than female-to-male (Karim et al. 2010).

In case identification, programs should target adolescent girls for testing and education. Younger women married to older men are often in positions of suppressed autonomy and power. When treating female patients, it is critical to acknowledge and address these gender differences in risk.

HIV among pregnant women increases the risks of maternal and infant mortality. It is critical that pregnant women with HIV are identified, enrolled, and maintained in prevention of mother-to-child transmission (PMTCT) services. Mother and infant feeding is also critical at this time. Studies show that a mothers' commitment for her child's health may decrease stigma and strengthen her adherence to treatment (Merten et al. 2010 Trop Med Int Health 15 Sup 1). However, the cascade of PMTCT services can be burdensome and complex. In many programs, including men in PMTCT services improves the health outcomes for both mother and child. HIV-positive mothers also have special nutritional needs and prescribed feeding practices for their infants.

Many women with HIV also suffer from gynecological co-morbidities, such as increased vaginal yeast infections and pelvic inflammatory disease. Women with HIV are also at increased risk of other sexually-transmitted infections. For this reason, it is important to make available female health workers who can assess and address these issues, which women may not initially verbalize.

Gender-based violence

Gender-based violence (GBV) is both a risk factor for HIV and a potential consequence of HIV positive status. It is important that this mutual relationship is understood and addressed at all levels of care. Furthermore, most at-risk populations, such as men who have sex with men, commercial sex workers, and injection drug users, face the compound cyclical burden of increased risks of HIV and increased susceptibility to stigma and GBV. Fear of societal and health worker-inflicted violence, impedes access to ART and care (Program on International Health and Human Rights, 2006). Gender-related power inequalities introduce implications and risks for caring for women and girls: 1) the patient may be dependent on her husband or partner for her health care decision-making, access, and expenditures; 2) women may lack self-efficacy due to the way they are treated in their family and community environments; and 3) revealing a woman's status may put her at risk of abuse or abandonment from her husband or partner. It is important that when a woman's treatment plan is in development, providers ask and determine the roles and capabilities of the woman and her family members. Providers must also acknowledge that revealing a person's status can instigate partner violence that victimizes both men and women. Counselors can take routine precautionary steps to determine whether partner testing could pose a threat to a patient (Box 1). Providers who suspect a patient is experiencing or at risk of experiencing violence can intervene with by assisting in case-specific safety planning (Box 2).

Box 1. Counseling and testing protocol from Family Health International, Asia-Pacific Region

1. Counselor asks: "There are some routine questions that I ask all of my clients because some are in relationships where they are afraid that their partner may hurt them. What response would you anticipate from your partner if your results came back positive?"
2. If the client indicates that she or he is fearful or concerned, then the counselor asks, "Have you ever felt afraid of your partner? Had your partner ever pushed, grabbed, slapped, choked or kicked you? Threatened to hurt you, your children or someone close to you? Stalked, followed or monitored your movements?"
3. If the client responds affirmatively to any of these points the counselor adds, "Based on what you have told me, do you think telling your partner will result in a risk to you or your partner?"

The client is then encouraged to make a decision to disclose based on a realistic appraisal of threat.

Source: WHO 2009 Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs.

Box 2. Safety planning with women at risk for violence

- Ask about violent or controlling behaviors
- Show sympathetic attitudes
- Inform a women of her rights and the services available to her
- Discuss the risks of violence against women with regard to the risk of HIV and to living with HIV and how to make their own choices in their own relationships
- Discuss formal options for support, including police, social workers, community-based organizations, etc., if available
- Discuss informal options like friends, neighbors, and relatives
- Key messages to give women about disclosure:
  - Decide the best time and place to have a conversation
  - Choose a time when you expect that you are both comfortable, rested, and as relaxed as possible
  - Think about how your partner may react to stressful situations
  - Consider your safety first; if there is a history of violence, plan the situation with a counselor or case manager
  - Imagine several ways your partner might react. Write down things he may say or do, and plan how you will respond.

Source: WHO 2009 Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs.

Considerations for Integrating Gender into ART and HIV Services

If you recognize any gender issues in your ART and HIV programs or identify that male access and retention, female vulnerability, or gender-based violence are a problem, consider taking some of the steps suggested below. A list of tools and manuals to address these issues is provided on page 4.

A nursing aide in Masaka, Uganda, administers an HIV test to a participant in a community HIV/AIDS awareness event.

© 2012 Uganda National Volunteers Link, Courtesy of Photoshare

1. Make services more accommodating for men

- Both male and female counselors should be available, when feasible, to work with patients of their respective gender on ART. Counseling should start individually; inclusion of partner's should be based on the patient's decision.
- Male and female expert patients can provide important insights to facility managers and care providers while also providing gender-specific support to other patients
- Disassociate ART and HIV from "maternal health" and correct the assumption that they are "women's issues" by:
  - Notifying men about available services
  - Establishing a separate area for men in the clinic when necessary, feasible and appropriate
  - Sending letters of invitation to men whose partners were tested to facilitate couple-based HIV counseling
- Care regimens should be designed around men and women's work and household activities (for example, connecting patients with peer support groups or expert patients with similar situations)
- In the monitoring and evaluation activities of a clinic or program providing ART, disaggregate data by sex to continue to observe trends in the gender gap and any outcomes from gender-integration changes made in services
- Include men in PMTCT services when women give permission for their husband or partner to know their status
- Use faith-based organizations and role models to counter "feminine" and "masculine" perceptions of health care

2. Address the vulnerabilities and challenges of women

- Increase testing and prevention education for adolescent girls
- Consider literacy levels when developing educational materials. In many settings, females have lower literacy rates than men. Consider using announcements and role plays at religious gatherings, radios, community meetings, etc.
- Assure that pregnant women are linked to and enrolled in PMTCT services

3. Take steps to prevent gender-based violence

- Patient confidentiality must be assured at clinics. This includes providing enclosed examination rooms and counseling areas when feasible, proper filing of records and clinic notes, and established standards to protect patient information facility-wide
- Integrate gender-based violence screening and services into ART programs. Consider using a counselor protocol like the example in Box 1 and establishing a plan like the example in Box 2.

Resources to learn more

Bott S, Guedes A, Claramunt MC, Guezmes A. 2010. Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries. New York: International Planned Parenthood Federation. Available at: http://www.ippfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf. *This manual is based on experiences in the Caribbean and Latin America and provides tested strategies, policies, and evaluation plans for health care managers and organizations to integrate responses to gender-based violence into health care.*

Khan A. 2011. Gender-based Violence and HIV: A Program Guide for Integrating Gender-based Violence Prevention and Response in PEPFAR Programs. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1. Available at: http://www.aidstar-one.com/focus_areas/gender/resources/pepfar_gbv_program_guide. *This guide, available in English, French, Portuguese, Spanish, and Swahili, serves as a tool for program managers to not only begin to address gender-based violence within their programs, but also to plan for greater integration and coordination within country teams when designing work plans and budgets. It provides guidance on HIV testing and counseling, PMTCT, adult treatment, care and support, and services for vulnerable children.*

Program on International Health and Human Rights, Harvard School of Public Health. 2006. HIV/AIDS and Gender-Based Violence (GBV) Literature Review. Available at: http://www.hsph.harvard.edu/pihhr/files/resources_and_publications/literature_reviews/Final_Literature_Review.pdf *A review of the literature provides evidence and synthesizes findings on the intersection between GBV and HIV. The literature cited and summarized presents studies and academic articles on the relationship between GBV and HIV in the following eight categories: 1. General and Theoretical Examinations of the Intersection of GBV and HIV; 2. Interrogating and interpreting the associated risks of HIV/AIDS and GBV; 3. The role of men; 4. GBV and HIV testing and disclosure; 5. GBV as a risk factor for HIV; 6. HIV as a risk factor for GBV; 7. The increased susceptibility of sub-populations to the linked risks of HIV/AIDS and GBV; 8. Effective approaches for addressing the joint risk factors of GBV and HIV/AIDS. Sections 4, 7 and 8 may be the most helpful for program facilitators and clinical providers.*

World Health Organization. 2009. Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs. Available at: http://www.who.int/gender/documents/gender_hiv_guidelines_en.pdf. *This tool focuses on interventions to address gender inequalities and systemically mainstream gender into HIV care, including testing, counseling, PMTCT, treatment, and home-based care. It draws from tools and experiences of several organizations and governments and was field tested in Tanzania and Sudan. It maintains several job aids, checklists, and guiding documents.*