

HIV Prevention, Treatment, Care and Support – A Training Package for Community Volunteers

Module 9



GENDER AND HIV



SA/AIDS Southern Africa
HIV and AIDS Information
Dissemination Service



International Federation
of Red Cross and Red Crescent Societies

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1 Session one: What is gender?

Purpose: The purpose of session one is to ensure that community based volunteers (CBVs) are able to define gender and understand the role that gender plays in the lives of men, women, girls and boys in their community.

Objectives:

By the end of this session, CBVs should be able to:

1. Define gender.
2. Accurately distinguish between sex and gender.
3. Demonstrate an awareness of the environmental influences on gender including cultural, socio-economic, religious, political and legal factors.
4. Understand and share local context examples of important gender-related terms.

Duration: 5 hours 35 minutes

Required materials: Flipchart, marker pens, sticky-stuff, colour papers/cards

Recommended preparation:

Make copies of the following for participants to share, during activities in this session:

- Handout 9.1.1: What gender-based training is and is not
- Handout 9.1.4: Important gender-related terms
- Handout 9.1.5: Factors that influence gender

Objective	Context	Time	Activity
Define the goal of gender-based training	1. What is the goal of gender-based training?	1 hour	Tool 1 (A) Tool 2 (K)
Accurately distinguish between sex and gender	2. Let's share what we know about gender	1 hour 15 minutes	Tool 3 (K) Tool 4 (K)
Demonstrate an awareness of the environmental influences on gender, including cultural, socio-economic, religious, political and legal factors	3. Culture and gender	2 hours 20 minutes	Tool 5 (A) Tool 6 (K)
Understand and share local context examples of important gender-related terms	4. Factors influencing gender in our communities	1 hour	Tool 7 (K)

1. What is the goal of gender-based training? (1 hour)

Issues related to gender can raise very strong emotions. For this reason it is important to explore the hopes, expectations and fears of CBVs about gender-based training.

a) Hopes, expectations and fears about gender-based training (15 minutes with Tool 1)



Tool 1:

Put up three separate flipcharts titled: 'Hopes', 'Expectations' and 'Fears'.

Ask participants to write down their hopes, expectations and fears related to participating in gender-based training, and place them on each of the respective flipchart sheets. Allow 10 minutes for participants to provide their responses.

Hold a brief group discussion on the common hopes, expectations and fears, and park them for revisiting at the end of the training.

b) Unpack what 'gender' stands for (45 minutes with Tool 2)



Tool 2:

Start a brainstorming session with participants on what they think gender means for their work as CBVs.

Distribute Handout 9.1.1 'What gender-based training is and is not'.

Ask participants to read briefly through the handout and discuss and agree on the different points raised against the earlier brainstorming.

Gender-based training for CBVs:

Is	Is not
<ul style="list-style-type: none"> • Intended to make CBVs aware of gender-related issues in their personal and work lives • Meant to encourage respect and tolerance for the unique challenges of both men and women • Meant to take participants from being 'gender blind' to becoming 'gender aware' • To encourage a thoughtful examination of prevailing cultural traditions and practices • Helping equip participants with the knowledge and skills to reduce harmful gender inequalities through positive action • Allowing us to recognize how our own gender biases may affect our ability to reach those in need of support • Helping participants to understand how gender roles and relations and gender-based violence influence the course and impact of the HIV epidemic – they shape the extent to which men, women, girls and boys are vulnerable to contracting HIV and the kinds of responses that are feasible in different communities and societies 	<ul style="list-style-type: none"> • Intended to be used as a tool for saying men are 'bad' and women are 'good' (or vice versa) • To be used to disrespect or attack any person's religious beliefs • Designed to undermine important cultural traditions, or to convince participants that there exists one 'correct' set of cultural beliefs or practices • Intended to encourage lawlessness or political activism by CBVs

2. Let's share what we know about gender (1hour 15 minutes)

a) Distinguishing between 'gender' and 'sex' (30 minutes with Tool 3)

When beginning a journey of gender-based thinking, it is very important to start by understanding the difference between 'gender' and 'sex'. These two concepts are often confused.

Sex refers to the different biological and physiological characteristics of males and females (e.g. reproductive organs, hormones, chromosomes etc.). Transgender people may also identify themselves as female or male, whether or not this corresponds with their physical appearance.

Gender refers to socially defined differences between behaviours of men and women based on roles, attitudes and values ascribed to them on the basis of their sex. Gender roles vary widely within and between cultures, and depend on the particular social, economic and political context.

Gender can best be understood within the context of gender roles.

Gender roles are the learned behaviour and expectations about what women and men 'do' in a society based upon prevailing gender norms.

Gender norms are the learned and evolving beliefs and customs in a society that define what is 'socially acceptable' in terms of roles, behaviours and status for both men and women. Gender norms tell us what is 'masculine' and what is 'feminine' in many places.



Tool 3: Biology or beliefs? 'Sex' and 'gender' - what is the difference? (30 minutes)

Ask participants to break into groups and assign the groups to work with only one sex, i.e. Group one: Man; Group two: Woman). Providing an example (see below), ask each group to list roles for both men and women that are linked to 'sex' and those which are specific to 'gender'.

Man	
Sex (biological)	Gender (social)
<ul style="list-style-type: none">Voice breakingGrow a beardProduce spermXY chromosomes	<ul style="list-style-type: none">LeaderProviderProtector

Woman	
Sex (biological)	Gender (social)
<ul style="list-style-type: none">MenstruationChildbirthBreastfeedingXX chromosomes	<ul style="list-style-type: none">CarerNurturer

Facilitator's note: If groups incorrectly assign a gender/social characteristic to the sex/biology category, correct them by asking for example: "If a boy or man does not possess that characteristic, is he still considered a male?" If the answer is 'yes' then it belongs in the 'gender' category.

End this section by emphasizing how the exercise has demonstrated that most of the characteristics that make us 'men' or 'women' are determined by society, not biology.

b) Gender roles in our community (45 minutes with Tool 4)



Tool 4: Creating gender lifelines: The gender roles game (45 minutes)

Divide participants into two groups (or more depending on the number of participants) and provide them with flipchart paper and markers.

Ask each group to discuss and record the roles of girls/women and boys/men in their community, from birth to 50+. Ask them to think about how boys and girls are expected to behave; the taboos that surround them; the 'work' of different genders during different stages of life; how each gender is treated by society; the importance and value placed on the individual and so forth.

Allow each group approximately 20 minutes to complete their lifeline. Ask each group to fill in their answers on a flipchart similar to the one below. Encourage the groups to draw from their lists developed in the previous activity, and ask them to include any additional concepts they feel are important to the understanding of sex and gender in their setting.

Gender lifeline

Age	Boys/Men	Girls/Women
0 – 5		
5 – 10		
10 – 15		
15 – 20		
20 – 30		
30 – 40		
40 – 50		
50 +		

Ask each group to provide a five-minute presentation on their work, and allow for feedback and brief discussion with the rest of the participants. Agree on common gender issues for each age group.

Facilitator's note: While groups are presenting, encourage discussion of topics by asking questions such as: who made these roles – god, nature, or people? Why do some groups face hardship and discrimination?

End the exercise by discussing the following key information on gender. Share Handout 9.1.4

The concept of gender:

- **Involves learned behaviours influenced by culture.** People are born male or female biologically, but gender involves what boys and girls learn from their culture through observation and direct teachings from generation to generation, as well as through exposure to modern media and societal norms around us. This learning creates a '**gender identity**', or one's sense of oneself as a man, woman or transgender person.
- **Changes over time.** Consider how ideas in your society about men and women have changed from your grandparent's time to ours.
- **Changes in different societies or within the same society.** Consider how the concept of gender in your community changes across different cultural or religious groups, or between your country and that of other societies, e.g. the western world, Latin America, Africa or Asia.
- **Influences how we see the world and how we act in it.** Gender influences aspects of how a society operates and the relationships we have with others.

Issues of lesbian, gay, bisexual, transgender and intersex (LGBTI) persons are important. Allow for some discussion on this, if it arises.

Transgender person is an individual "who has a gender identity that is different from his or her sex at birth. Transgender people may be male to female (female appearance) or female to male (male appearance). It is preferable to describe them as 'he' or 'she' according to their gender identity, that is, the gender that they are presenting, not their sex at birth."



3. Culture and gender (2 hours 20 minutes)

Before we begin exploring the meaning of the concepts of culture and gender, it is important to personalize the idea within our own experiences as a man, woman or transgender person.

Culture is the learned behaviour of a given society, which acts like a guide that shapes attitudes, beliefs and behaviour which are passed on from generation to generation. Culture is not fixed and can change over time.

The following are some examples of the many influences of culture on our lives. Try and think of examples for each bullet that are specific to your community. Culture is a people's total way of life and includes:

- Our **traditions** – are things we do that have withstood the test of time. For example, the ways in which marriage ceremonies are conducted
- Our **values** – tell us what is acceptable or unacceptable (taboo). For example, the ways communities care for their children
- Our **norms** – are informal rules that tell us what 'normal' behaviour is in our everyday life
- Our **beliefs** – include things that are accepted as true by members of a group or society. For example, spiritual or religious beliefs
- The **forms of communication we use** – involve language, sounds, gestures and writing
- The **types of families we have** – for example, one husband and wife (monogamous), one man with more than one wife (polygamous), the acceptability of extramarital sexual relationships, same sex partnerships, co-habiting, or marriage.



There are several forms of cultural intolerance. This is when cultures are followed so strictly with unwillingness to make changes, that individuals who do not conform to the accepted cultural norms can be isolated or discriminated against for their beliefs or lifestyle. For example, women who do not bear children and people of varied sexual orientation.



Tool 5: How much do we know about culture? (1 hour 10 minutes)

I first realized I was a boy/girl/transgender when...

Ask participants to sit in a comfortable position and close their eyes.

Ask the following questions for their contemplation and sharing (if they wish) and to jog their memories:

- When did you first become aware that you were a boy/girl/ transgender?
- What messages did you receive about gender as a child?
- Where did these messages come from?
- How do you think these childhood experiences shaped your values as an adult?

Allow an additional 25 minutes of open discussion for participants to share their childhood experiences (if they choose).

End this exercise by an approximately five minute emphasis on how we are not born with an awareness of being a boy or girl, but the concept of gender is taught to us in ways specific to our culture and societal norms.



Tool 6: Unpacking 'culture' (1 hour 10 minutes)

You may choose to begin with: *"You grew up hearing the word culture and today you continue to hear culture this and culture that, but have you ever been asked to explain to someone in your own words what this word means?"*

Give each participant a piece of paper and then ask them to think about 'culture' and to write down what he/she thinks it means.

After approximately five minutes, ask participants to place their papers face down, on a table in the centre of the room. Shuffle the papers and ask one participant to pick out a paper at random. One by one, each of the participants reads the statement out loud. Either the facilitator or a fellow participant notes the statement on a flipchart entitled 'Culture means...'. Any statement similar to what is already on the chart should be left out.

When the exercise is finished read out the list of definitions to the entire group, with participants agreeing to either keep a definition or discard it. An agreed definition can be written out and posted up in the training room for everyone to see.

Facilitator's note: To summarize this exercise, review the following and ask participants to think of local examples of each element of culture.

4. Factors influencing gender in our community (1 hour)

Now that we have explored what gender means and the influence of culture on gender norms and roles, it is important to explore other factors which influence gender dynamics in our communities.



Tool 7: Gender fishbowl: Factors Influencing gender (1 hour)

Divide participants into three groups. Cut out the sections of Handout 9.1.5 'Factors that influence gender' and place them in a box or hat. Ask one person from each group to draw a section.

Give the groups approximately 10 minutes to develop a short (approximately five minutes) role play that demonstrates how this factor influences gender in their setting. Find out from the group if there are other important factors in their setting that influence gender dynamics. If yes, the groups are encouraged to develop different role plays than those listed.

Bring all the groups together and have all participants observing role plays sit around in a large circle. The group performing their role play should do so inside this circle while the others watch.

After each role play allow five minutes for the participants who were watching to express and share their feelings about how this factor influences gender in their setting. Discuss any gender stereotypes that were reflected in the role-plays.

Wrap up the session with key points on how each of the environmental factors depicted in the role-plays can influence gender dynamics.



2

Session two: Gender and HIV

Purpose: The purpose of session two is to understand how gender and HIV are related and explore how gender inequalities, gender-based violence (GBV) and sexual and reproductive health rights (SRHR) are linked to HIV.

Objectives:

By the end of this session, CBVs should be able to:

1. Demonstrate an understanding of the reasons behind the sex-distribution of HIV in their country.
2. Describe how gender inequality influences the course of the HIV epidemic in their country and their community.
3. Understand the links between GBV and HIV in their community and provide appropriate support and referrals to survivors of GBV.
4. Support the sexual and reproductive health rights of clients.

Duration: 7 hours 40 minutes

Required materials: Newsprint, flipchart, marker pens, sticky-stuff

Recommended preparation

- Make copies of
 - Handout 9.2.8 comprising:
 - Support Card A: GBV safety prevention tool: ask, decide, act and document (ADAD)
 - Support Card B: Helping survivors of abuse
 - Support Card C: Reaching young people and breaking the cycle of violence
 - Support Card D: Working with the police and legal services
 - Handout 9.2.9: Sexual and reproductive health rights
- Invite the Head of the National AIDS agency or government authority to conduct a short presentation on the sex distribution of HIV in your country.
- Obtain the most recent data on prevalence of HIV and AIDS in your country. Make a special effort to collect information on HIV prevalence rates among men/women/girls/boys.
- Copy out the table 'Different levels where inequalities can exist' on a flipchart.
- Have a ball or bean bag available for use in the exercise.

Objective	Context	Time	Activity
Demonstrate an understanding of the reasons behind the sex-distribution of HIV in their countries	1. Why gender is an integral part of the HIV response?	30 minutes	Tool 1 (K)
Describe how gender inequality influences the course of the HIV epidemic in their country and community	2. Gender inequality and HIV	2 hours 40 minutes	Tool 2 (A) Mini-lecture Tool 3 (A) Tool 4 (K) Game Tool 5 (PS)
Understand the link between GBV and HIV in their community and provide appropriate support and referrals to survivors of GBV	3. GBV and HIV	2 hours 50 minutes	Mini-lecture Tool 5 (A/K) Tool 6 (PS) Mini-lecture/Group discussion Tool 7 (ST)
Support the sexual and reproductive health rights of clients	4. SRHR and HIV	1 hour 40 minutes	Tool 8 Role play Tool 9 (ST/A/K) Body mapping

1. Why gender is an integral part of the HIV response? (30 minutes)



Tool 1: Understanding sex distribution and HIV globally and nationally (30 minutes)

Invite the head or representative of the National AIDS agency or government authority to provide a brief presentation on the sex distribution of HIV prevalence in your country. If this is not possible, obtain the most recent data on prevalence of HIV globally and in your country, including related statistics about infection rates, incidence and risk factors for boys and girls and for men and women.

Share a global overview of HIV and links to gender, including statistics. Then provide your country-level (and if available, local level) information on HIV prevalence. Ask participants to offer any additional facts they may know. If a speaker has been invited, offer him/her a 10 minute space for presentation.

Ask how the sex-distribution of HIV in the country compares to that of the rest of the world? Why do you think it is the same or different? If a presenter has been invited to speak, allow for questions and answers from the participants to the presenter and encourage the presenter to share any additional resources or handouts with the group.

Facilitator's note: It is not important to spend a great deal of time exploring the exact influences of gender upon HIV prevalence in your country. The goal of this exercise is to highlight how gender roles and relations influence HIV prevalence.

End the session by handing out copies of handouts on gender and HIV globally (make sure to update this handout with the most recent data from the *UNAIDS Report on the Global AIDS Epidemic* and related global reports).



2. Gender inequality and HIV (2 hours 40 minutes)

In Session One, we explored what gender means and the factors that influence gender dynamics. In the earlier activity we improved our understanding of the statistics around HIV and the different sexes. We will now use this knowledge to explore the relationship between gender and the HIV epidemic in detail.

a) Exploring gender and HIV (30 minutes with Tool 2): how being female or male influences personal experiences, risks and responses in relation to HIV and AIDS. **(30 minutes)**



Tool 2: Talking to the experts first – CBVs

Before we begin looking at what others have to say about gender and HIV, let us first start by exploring our own understanding and experiences of this topic. As some of the most knowledgeable and experienced workers at community level, CBVs will know better than most how HIV and gender are related.

Engage participants in a short (10 minutes), open discussion of personal experiences they have had:

- in their work in the community
- In their own lives or the lives of others around them that they feel demonstrate the link between gender and HIV.

Stress the importance of confidentiality and advise participants to ensure that no names are used when giving examples.

Facilitator's note: There are no 'wrong' answers for this exercise. However, as participants are providing answers, be sure to avoid focusing too much on existing stereotypes such as HIV is associated with sex workers, promiscuity, or drug use. Give prompts for other areas such as... "*What about?... Young girls? Men who are required to travel (such as truck drivers) or migrate seasonally for work? Married women?*" Write down all examples provided on a flipchart.

End by drawing out key themes from the shared experiences that illustrate gender inequalities, for example:

- Women and girls in your community are more vulnerable (this may or may not be true depending on your context) to HIV infection.
- Gender influences power relationships, which are very important in how a person can prevent and/or live positively with HIV.
- Gender norms and roles create challenges (or opportunities) for CBVs to effectively assist with the prevention, treatment care and support of HIV in their community.
- Men and boys make decisions in the household which influence how money is spent (e.g. for health, nutrition, etc.).

Make sure to bring out distinct differences between **individual, family and community inequalities** that are depicted in the experiences the group shares.

b) What is gender equality? (45 minutes with Tool 3)

Gender equality, “exists when both women and men are able to share equally the distribution of power and influence; have equal opportunities, rights and obligations in the public and private spheres, including in terms of work or income generation; have equal access to education and capacity building opportunities; have equal possibility to develop their full potential; have equal access to resources and services within families, communities and societies at large; and are treated equally in laws and policies”. It does not mean that women and men are the same, but that their rights, responsibilities and opportunities do not depend on their sex. Efforts to expand gender equality in national responses should be based on commitment to the realization of human rights, including non-discrimination and freedom from violence.



Tool 3: would rather have been born...

Ask “*Given the choice would you have liked to be born male or female? Explain why*”. Allow participants to provide answers in an open discussion.

This helps to establish issues related to gender roles and inequalities and participants’ perceptions of these prior to exploring the key areas where gender inequalities exist.

Open with a brainstorming session on which reasons, from the ones shared by participants in Step one, are due to gender inequalities. For example, “*I would have liked to be born a man because I want to avoid menstrual pains*” is not a gender inequality. A reason such as “*I would have liked to be born a man because I would have been able to make decisions in my marriage*” is related to gender inequality.

Agree as a group what “gender inequality” entails. Link this with the discussions that took place in Activity 9.2.1.

Five key areas in which gender inequalities exist are:

- legal rights
- education
- health services
- employment opportunities
- civic participation



Did you know...

that gender inequality is the most common form of social inequality and exists in all societies ?

Briefly discuss what ‘gender equity’ and means, and share the definitions on the next page.

A concept related to **gender inequality** is gender inequity. While it is not crucial for CBVs to be able to discuss the difference between these terms, they should be aware of the difference.

Gender equity refers to fairness of treatment for women and men according to their respective needs. It is a needs based approach rather than a rights based approach. This may include equal treatment, or treatment that is different but considered equivalent.

An example of trying to correct a gender inequity would be community leaders holding a meeting with a local clinic to encourage them to seek more funding for their prevention of mother-to-child transmission (PMTCT) of HIV programmes. This is because the leaders have recognized that pregnant mothers who are HIV positive in the community have different and greater health needs than others, to ensure their own health, a safe delivery and to prevent transmission of HIV to their babies.

Linking gender inequality and HIV

More than any other challenge to date, HIV and AIDS have shown the world how gender inequalities and inequities can have devastating consequences. It is now being recognized that in order to deal with HIV and AIDS effectively, the human rights of men, women, girls and boys must be at the centre of every response.

Areas of gender inequality that have been shown to influence the HIV epidemic:

1. harmful gender norms and practices
2. violence (physical, sexual and emotional) against women, men or LGBTI
3. barriers in access to services
4. burden of care
5. stigma and discrimination
6. lack of economic security
7. lack of education for girls.

Gender inequalities work against efforts to prevent HIV infection and support those living with HIV by:

- increasing the vulnerability of men, women, boys and girls to HIV infection
- compromising the effectiveness of HIV prevention strategies
- creating barriers to effective HIV treatment and care

A number of important international human rights instruments, conventions and declarations have been created to help countries address the gender dimensions of HIV and AIDS.



Tool 4: Gender inequalities ball toss (35 minutes)

Gather together in the centre of the room or move outside to an open area and stand in a circle.

Ask participants to toss a ball or bean bag (if neither of these are available a ball of paper will do) to one another. Each person who catches the ball should name one way in which they feel gender inequality influences HIV in their community. Continue to throw the ball around the circle until every group member has had an opportunity to share a response.

If participants are having a hard time getting started, remind them of the different areas of gender inequality that have been shown to influence the HIV epidemic discussed in the previous section.



Tool 5: Gender inequalities and key populations (50 minutes)

Key affected populations are those that are known to have higher rates of HIV in your country or community. They might include:

- married women
- young women
- migrant workers
- truck drivers
- injecting drug users (IDUs)
- sex workers
- prisoners
- LGBTI
- individuals in emergency situations, e.g. those living in or with:
 - poverty
 - food insecurity
 - areas prone to natural hazards
 - conflict or war
 - refugee camps
- internally displaced persons (IDPs)
- others specific to your context.

Ask the group to break into smaller groups and reflecting on the answers provided in the previous activity, address the following:

- identify which groups in the community are most affected by gender inequalities that further places them at risk of HIV
- identify available resources that CBVs could make use of, or to which they could refer community members and clients facing these challenges.

Hold a brief discussion together as one group about the populations affected by HIV in your country or community, and share responses in small group discussions. Wrap up the activity by agreeing on:

- which common gender inequalities are affecting key populations and increasing their vulnerability to HIV infection.
- which outreach or health service resources within your area can be accessed by the CBVs that might help individuals from key populations access gender equality and rights to help protect them from HIV and enable them to live positively.

3. GBV and HIV (2 hours 50 minutes)

a) What is GBV? (40 minutes with Tool 6)

GBV embraces a range of concepts that incorporate an analysis of gender inequality as the root cause of GBV. Essentially, it means any act that results in, or is likely to result in physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. It can encompass sexual violence, domestic violence, sex trafficking, harmful practices such as female genital mutilation, forced or early marriage, forced prostitution, sexual harassment, and sexual exploitation, to name but a few.

GBV is more often than not used as a synonym for violence against women. Such confusion and misuse of terminology is a barrier to acknowledging the existence of violence against men. While GBV primarily and disproportionately affects women and girls, men and boys are also subject to it. Male-on-male interpersonal violence, sexual abuse of men and boys, and rape of male inmates while in prison represent several possible examples. GBV is also directed towards LGBTI people, and men who do not act according to dominant masculine gender roles.

Intimate partner violence – violence perpetrated by a person’s partner and can occur between people who are married, in a relationship, or in a former relationship.

Domestic violence – violence within a family setting, either against a wife, husband, partner or children. Marital rape is both a form of domestic violence and GBV.



Tool 6: Stand-up – sit-down – what is GBV?

Before we explore how CBVs can help reduce and cope with GBV in their communities we should first explore the impact of GBV in our own lives and understand who is at greatest risk for GBV in our communities. It is important to first gain a solid understanding of the various terms surrounding GBV.

Read the statements out for the participants, from the table below. After each statement ask participants who feel that the statement is **true** to stand up. If they think the statement is **false**, they should remain seated. If they are not sure, participants should choose the option they are most comfortable with.

After reading each statement, allow a few minutes for participants to share their reason for choosing the position they did. Give the explanation below each statement on why this statement is true or false, and move onto the next statement.

Facilitator’s note: Facilitators are encouraged to think of local examples that demonstrate how that statement is true or false.

Statement	T Stand up	F Sit down
<p>1. The most common form of violence experienced by women globally is intimate partner violence.</p> <p>Explain:</p> <ul style="list-style-type: none"> - In a 10 country study, between 15 per cent and 71 per cent of women report physical or sexual violence by their husband or partner. 	True	
<p>2. Because they are more physically powerful, men do not experience GBV and sexual violence at the hands of women.</p> <p>Explain:</p> <ul style="list-style-type: none"> - Boys are vulnerable to abuse (physical, emotional and sexual) just like girls. In fact, worldwide up to 1/5 women and 1/10 men report experiencing sexual abuse as children. - Men are also subject to intimate partner violence. Remember that 'abuse' also includes verbal and emotional abuse. "Just because you are not battered and bruised it does not mean you are not being abused". 		False
<p>3. Women aged 15 to 44 are more at risk from rape or domestic violence than from cancer, motor accidents, war and malaria.</p> <p>Explain:</p> <ul style="list-style-type: none"> - This is true for women of all walks of life. <ul style="list-style-type: none"> o Violence by an intimate partner is the leading cause of non-fatal injuries to women in the USA. o 48 per cent of girls surveyed in the Caribbean reported their first sexual intercourse experience was forced. 	True	

Wrap up the session by sharing the definitions of GBV, intimate partner violence, domestic violence and violence against women and girls (VAWG) outlined below.

b) GBV in our communities (50 minutes with Tool 7)



Tool 7: Mapping resources to address GBV in our community

Part 1: Identifying those who are at greatest risk of GBV

Have a 10 minute open discussion on what groups are at greatest risk of GBV in communities.

Are these groups at greatest risk of GBV? If so, what type of GBV?

- married women or unmarried women
- orphans or vulnerable children – are boys or girls more affected
- adolescent males or females
- sex workers – male and female
- substance users (alcohol or IDUs)
- mothers or women without children
- people living with HIV (PLHIV). Do you think male PLHIV or female PLHIV are at greater risk?
- women, men, boys or girls living in poverty
- displaced women and boys and girls
- LGBTI
- any other groups?

Emphasize that **GBV is most often a result of perceived difference in status**. GBV happens in rich and poor families of all races, religious and ethnic backgrounds and is most commonly caused by the **lack of value and worth given to the victim** (male, female, boy, girl or transgender). Such status differences might be exacerbated by poverty or substance abuse, but drinking alcohol or struggling to meet basic needs do not *cause* GBV.

Part 2: Mapping community resources for GBV in our community

Now that we have mapped what specific groups are at highest risk of GBV in our community, we need to determine what we can do to protect them. Break participants into groups. Ask the groups to list the:

- legal, medical, psychosocial, traditional and spiritual resources available in your communities to assist the group
- referral systems and processes that CBVs can engage in to assist the groups at risk to prevent GBV or mitigate GBV

Wrap up the session with feedback shared from each group

c) How does GBV increase vulnerability to HIV? (30 minutes)

Open with a brainstorming session on how GBV makes men and women vulnerable to HIV, in terms of prevention, care and support and treatment.

Share the information below:

GBV and HIV have a reciprocal relationship, in that:

- GBV increases the vulnerability of survivors of violence to HIV infection
- PLHIV are often more vulnerable to GBV.

Four main reasons why GBV and HIV are closely interlinked include:

- 1. Injury:** forced or coercive sex may cause injuries and bleeding that can lead to a higher risk of HIV entering the body and causing infection.
- 2. No safe sex:** it is difficult for men, women, boys and girls in abusive relationships to negotiate for safer sexual practices, meaning that sexual activity most **often takes place** without the use of male or female condoms.
- 3. Risky behaviours:** sexual abuse as a child is associated with higher rates of sexual risk-taking (sexual debut at an early age, sexual concurrency (having more than one sexual partner) and unprotected sex), substance abuse and additional victimisation.
- 4. Stigma and discrimination:** women, girls, men and boys who know their HIV status or who are believed to be living with HIV, may be at increased risk of intimate partner violence or violence from other members of their family or community.

Perpetrators of GBV are also placing themselves at risk. Survivors are not the only ones placed at risk through GBV. GBV also places perpetrators at risk of HIV infection/re-infection. For example, forced sex with an HIV positive woman, girl, man or boy increases the opportunity of the infection being transmitted to the perpetrator. This means that reducing GBV is a strategy for HIV prevention for both sexes.

b) The role of CBVs in preventing and mitigating GBV (50 minutes)



Tool 7: Exploring the role of CBVs

In groups, ask participants to briefly go over Handout 9.2.8 Support Cards (four handouts):

- GBV safety prevention tool: Ask, decide, act and document (ADAD)
- helping survivors of abuse
- reaching young people and breaking the cycle of violence
- working with the police and legal services.

Give the groups 15 minutes to review and discuss any special considerations to be added in your context.

Randomly select volunteer participants from each group to present in their own words how each handout can be used in the field. Cover all four Handouts.

Wrap-up the session by summarizing the core support skills of each handout with a special focus on the completion of the ADAD as a critical referral and documentation tool.

The special role of CBVs in addressing GBV is not limited to the issues discussed in the GBV support cards. As respected members of the community, other areas where CBVs have a role to play in GBV and HIV include:

- Encouraging **custodians of culture**, such as community elders or leaders to address traditional and cultural practices that once served a function, but now act negatively to condone GBV, or to safeguard protective traditional practices.
- Being **change agents and role models** in your community by encouraging an ethos that 'violence against women will not go unchecked in our community' by engaging in community-based discussions.
- Emphasising that **men are protectors** and have a key role in preventing HIV and GBV and should be actively involved in campaigns to end GBV.

The role of CBVs as 'change agents' in their communities through awareness raising, providing information and referrals, is a powerful one in mitigating the impact of GBV and HIV.



4. SRHR and HIV (1 hour 40 minutes)

a) What are SRHR and how do they relate to HIV? (50 minutes with Tool 8)

Tool 8: Making the links between gender, SRHR and HIV



Open with a brainstorming session asking the following questions:

- What is sexual and reproductive health?
- What are sexual and reproductive health rights?
- Who has SRHR?

Record responses on a flipchart.

Share copies of Handout 9.2.9 “Sexual and reproductive health rights for all”

Write out each of the headings on the handout on separate pieces of paper and place in a hat or box:

- good quality and non-judgmental referral
- prevention information
- disclosure assistance
- treatment information and access
- family planning information and support
- antenatal care
- safe and satisfying sex.

Divide participants into seven groups. If there are not enough participants to make seven groups, break up into fewer groups and each group can pick out two slips from the box/hat.

Ask one member of each group to draw a slip from the box/hat. Provide groups with 15 minutes to develop a short (three minute) drama or role-play that addresses:

- any **group (or groups) that may face barriers** in accessing this sexual and reproductive health right (e.g. men, women, adolescent boys and girls, LGBTI)
- any **barriers faced by PLHIV** in accessing this sexual and reproductive health right
- **community-based resources or referrals** that could help individuals to achieve this aspect of their SRHR.

Facilitator’s note: Emphasize that a person’s gender or HIV status does not overrule any SRHR. The role of CBVs is to recognize which individuals may be facing barriers to achieving their SRHR due to their gender or sexual orientation, and assist them through referrals and support.

End the exercise by sharing that if all our SRHR were met and not violated, the HIV epidemic would be rapidly reversed in many communities and countries, particularly those where unprotected sexual contact and mother-to-child transmission are the main modes of transmission. Make sure that the information below has been shared during this activity.



SRHR refers to the rights of individuals to control and safeguard their own bodies and to enjoy satisfying and safe sex.

SRHR include the rights of couples and individuals **whether HIV positive or not** to:

- decide freely and responsibly on the number, spacing and timing of their children, or if they even wish to have children
- have access to information and education that allows them to control their sexual and reproductive health
- attain the highest standard of sexual and reproductive health possible, inclusive of treatment of sexually transmitted infections (STIs), access to contraception, and safe pregnancy and childbirth
- make decisions about sex and reproduction free of discrimination, coercion and violence.

It is clear that SRHR are not just part of, but intricately woven into issues surrounding HIV and AIDS. To illustrate this, consider the following:

- Globally, the leading cause of death among women of reproductive age is HIV.
- The most important risk factors for death and disability among women of reproductive age in low- and middle-income countries are lack of contraception and unsafe sex resulting in unsafe abortions, complications of pregnancy and childbirth and STIs including HIV.

b) Understanding sexuality and gender (50 minutes with Tool 9)



Tool 9: Telling the body's story of sexuality and gender

Part 1: Individual body maps and client education

Give each participant a blank piece of A4 paper and encourage them to spend 10 minutes drawing an individual body map that tells the story of their own experience of sexuality and gender.

Discuss how participants can encourage their clients to create personal body maps to help them understand how their experience of sexuality is related to sexual reproductive health, including HIV prevention and how these are linked to being either a woman, man, girl or a boy.

Part two: Gender

Divide participants into two groups and assign each group with a group

Group one: Men

Group two: Women

Tape together two pieces of flipchart paper together and ask a member from each of the groups to volunteer to have an outline of their body-form made (in pencil to avoid staining clothes). Mark the body-form with the title of their group at the top. Trace over the pencil form with marker so that the image is clearly visible once displayed.

Ask each group to illustrate and write words related to:

- Physical
- Emotional
- Spiritual
- Traditional aspects of puberty and sexual intercourse

These may include scars/wounds/positive experiences/sources of pride people may have had that are related to their experience of sexuality in their society and communities. Offer 25 minutes to draw their body maps.

Once the two body maps are created, display them on a wall where they can stay for the remainder of training. Ask participants to point out any linkages between the experience of **sexuality and the risk of infection/re-infection with HIV** and **being either a woman or man**. Spend 10 minutes in open discussion ensuring the following points below are addressed.

Facilitator's note:

1. This exercise is intended to **expose and explore taboos** related to sexuality in your setting that might make achieving SRHR and HIV prevention more difficult. For example, how willing are participants to indicate the female genitalia in their body map even though the vagina and sexual reproductive organs of the woman are central to SRH, including transmission of infection, reproduction and sexual pleasure in women?
2. Did participants take note of **different sexual orientations** in their body maps? What about LGBTI persons and issues? Make note that the failure to include these groups in our body maps demonstrates the often disenfranchised status of these groups in society. Ask participants to spend a moment to think about the experiences of LGBTI and other key populations and how their different stages of sexual development and gender identities might make them more or less vulnerable to HIV infection. For example, how does availability of information and health services directed to their sexual health needs influence their risk of HIV infection? If there is a large transgender community in your setting, it is a good idea to create a separate body map for this group.

Part three: Applying our knowledge about gender and HIV to the rest of training

This session has explored how gender and HIV are linked and the ways in which gender inequalities, GBV and SRHR are linked to HIV. These important gender-related influences on HIV should be kept in mind in the following sessions, which look at the role of gender in HIV prevention, treatment, care and support.

Sexuality refers to how people experience and express themselves as sexual beings. This can include behaviours, actions and thoughts which are influenced by factors such as gender norms, that govern acceptable behaviour.

Ensuring SRHR and discussing important concepts related to HIV prevention requires open and honest discussions about sex and sexuality. Participants should be encouraged to explore how gender norms and roles influence the perception of their own bodies and sexuality in the society in which they live. These concepts will be critically linked to sexual and reproductive health and HIV prevention, treatment and care in their country and community.

Facilitators should reflect upon the following questions in your setting:

- Are there any culturally specific ways in which gender influences how sex and sexuality are approached in your communities?
- Do you feel this affects the uptake of health-seeking services that are critical to sexual and reproductive health, such as diagnosis and treatment of STIs, HIV testing and counselling or accessing prevention methods such as condoms?
- How does this influence the work of CBVs?



3

Session three: Gender and HIV prevention

Purpose: The purpose of this session is to explore the ways in which gender influences the vulnerability of women, men, girls and boys to HIV infection/re-infection and the role of CBVs in providing information and support.

Objectives:

By the end of this session CBVs should be able to:

1. Describe how the three main modes of HIV transmission are influenced by gender.
2. Demonstrate an understanding of how gender influences one's vulnerability to HIV.
3. Describe the role of CBVs in addressing gender-specific factors that increase risk of HIV infection/re-infection.

Duration: 3 hours 45 minutes

Required materials: flipchart, marker pens, sticky-stuff, pencils for gender portraits

Recommended preparation

Make copies of

- Handout 9.3.1: Factors influencing safe sexual behaviour in the context of HIV and AIDS
- Handout 9.3.3: Gender-specific factors increasing risk of HIV infection
- Handout 9.3.4: Influence of gender and HIV prevention – the role of CBVs.

Objective	Content	Time	Activities
Describe how the three main modes of HIV transmission are influenced by gender.	1. Review of the main modes of HIV transmission through a gender lens	1 hour 20 minutes	Tool 1 (K) Group discussions
Demonstrate an understanding of how gender influences one's vulnerability to HIV.	2. How does gender make people more or less vulnerable to HIV infection?	1 hour 40 minutes	Tool 2 (ST/A)
Describe the role of CBVs in addressing gender-specific factors that increase risk of HIV infection/re-infection.	3. Gender specific approaches to HIV prevention	45 minutes	Tool 3 (PS) Group discussions Mini-lecture

1. Review of the main modes of HIV transmission through a gender lens (1 hour 50 minutes)

How gender influences HIV transmission (50 minutes with Tool 1)

To address HIV prevention from a gender perspective, there is a need to understand how gender might influence the three main modes of HIV transmission, including unsafe sexual behaviour, blood transmission and mother-to-child transmission.



Tool 1: Factors influencing safer sexual behaviour through a gender lens

Part 1: Making a mural – Unprotected sexual contact

Distribute copies of Handout 9.3.1 on factors influencing safer sexual behaviour and ask participants to review the handout through a gender lens.

Divide participants into seven working groups (or give a smaller number of groups more than one topic) and provide each group with a flipchart and marker. Allocate the topics as follows.

- Group one: Social norms and/or values**
- Group two: Knowledge and information**
- Group three: Skills**
- Group four: Power, coercion, violence**
- Group five: Access to services and resources**
- Group six: Emotions**
- Group seven: Pleasure**

Ask each group to draw a large circle on a flipchart with the name of the factor they have been assigned at the top. Then groups should list examples of how they feel gender might influence this factor in their community.

In the centre of an empty wall, put up the diagram on the handout 9.3.1. Groups should make a brief (two to three-minute) presentation on their factor. Arrange the factors around this central circle. Keep this mural up for the remainder of the session.

Facilitator's note: Be aware of any 'hot topics' regarding the influence of gender upon safer sexual behaviour in their setting. In particular, participants should be encouraged to explore the gender perspective of any key affected populations, and/or those that may be particularly vulnerable (e.g. LGBTI or young women).

The following examples may apply:

- Group one: Social norms and/or values** – intergenerational sex, early marriage, sexual concurrency, discordant couples
- Group two: Knowledge and information** – knowledge of how to use male or female condoms, about how HIV is transmitted, myths and misconceptions

Safer sexual behavior:
CBVs using awareness of gender to assist community members to reduce the risk of HIV infection/re-infection for oneself and/or one's sexual partner(s).

- Group three:** **Skills** – to negotiate safer sex, including condom use
- Group four:** **Power, coercion, violence** – GBV, intimate partner violence
- Group five:** **Access to services and resources** – access to condoms, microbicides, male circumcision, gender-friendly health services for treatment of STIs, gay-friendly health services, services for sex workers, migrant worker access to health care
- Group six:** **Emotions** – pressure to bear children and prove fertility, stigma and discrimination regarding disclosure, inability to ask about partner’s HIV status
- Group seven:** **Pleasure** – and condom use, and practices such as ‘dry sex’.

Understanding HIV transmission through a gender lens (30 minutes)

Part 2: Blood transmission

During a general brainstorming session, ask participants if any specific group in their community setting is at particular risk of HIV infection through blood contact. Consider:

- IDUs
- availability of harm reduction services for IDUs
- exposure to infected blood through care giving duties
- traditional male/female circumcision practices
- rites of passage (cultural practices)
- tattoo or body piercings
- traditional birth practices/unsupervised home births
- involvement in traffic and other accidents
- physical violence where skin is broken.

Part 3: Mother-to-child transmission

Mother-to-child transmission (MTCT) – transmission of HIV from HIV infected mothers to their babies during pregnancy, childbirth or after birth through breastfeeding.

Hold a brief discussion on gender and MTCT by asking “*How might gender norms or gender roles influence the likelihood of MTCT of HIV in your community?*”

In exploring this question, you may want to consider the following points:

- the education level and/or awareness of MTCT of both women of childbearing age and their partners
- the availability of HIV testing for pregnant mothers
- the availability of antiretroviral drugs in your community
- traditional birth practices or likelihood of childbirth in a clinic, hospital or with a trained birth attendant
- family planning options for women of childbearing age, including HIV positive women
- traditional breastfeeding practices
- stigma associated with HIV
- other issues specific to your community.



Some quick facts about unprotected sexual contact and gender:

- Globally, heterosexual transmission through unprotected sexual contact is the **most common** form of HIV transmission.
- In the countries most affected by HIV (where unprotected sexual contact is the main mode of transmission) **women and girls** are worst affected.
- **Biological factors** such as sensitivity of skin and larger surface area on the vagina and anus influence how easily HIV can enter the body.

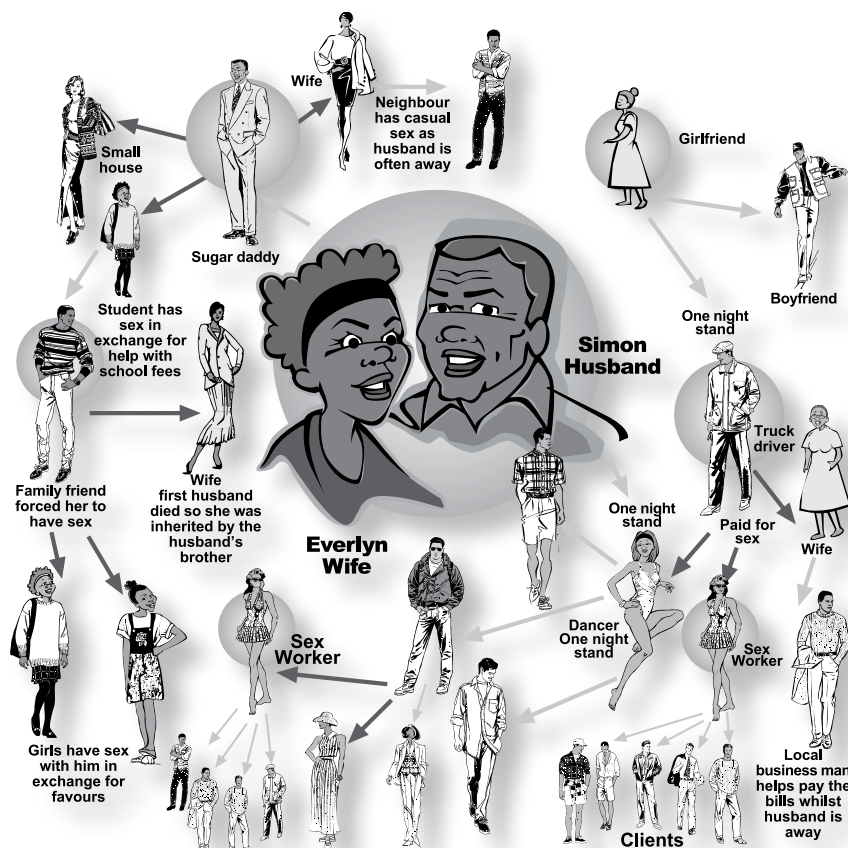
Some important terms to know when discussing HIV and prevention:

Intergenerational sex – age gap of greater than 10 years between sexual partners. This can be young women with older men, young men with older women, young men with older men, young women with older women. Intergenerational sex can occur as a form of transactional sex or the ‘sugar daddy effect’ (older partners often have needed or desired resources), or can be related to childbearing practices (older men continuing to father children by taking younger wives).

Sexual concurrency – practice where men or women have more than one sexual relationship at a time. These relationships can be long or short term. They vary in nature and meaning, ranging from one night stands with a sex worker, a stranger or even a friend, to long term relationships (for example, called ‘small houses’ or ‘spare wheels’ in some southern African countries), or men having extra marital affairs with other men.

Discordant couples – when one partner tests HIV positive and the other HIV negative.

Gender inequalities – lead to power differences that can make some genders more vulnerable to HIV infection through unprotected sex and/or the inability to negotiate safer sex.



2. How does gender make people more or less vulnerable to HIV infection? (1 hour 40 minutes)

This section will explore the known reasons related to gender and sex that make certain groups (men, women, LGBTI) more vulnerable to HIV infection.

A reminder on what being vulnerable to HIV infection means:

Vulnerability is the environmental aspects influencing 'who we are' (such as gender) that may impact on a person's risk of transmitting or contracting HIV. Examining vulnerability from a gender perspective means looking at the unique ways in which boys, girls, women and men are vulnerable to HIV infection.

Risk is defined as the exposure to HIV or the likelihood that a person may become infected with HIV. Certain behaviours create, increase or perpetuate risk. It is behaviours, not membership of a group (e.g. not being a woman or an LGBTI or a sex worker), that place individuals in situations where they may be exposed to HIV.

a) Understanding how gender influences vulnerability (1 hour 40 minutes with Tool 2)

Tool 2: Gender portraits of personal risk

We have explored the role gender might play in the three modes of HIV transmission (unprotected sexual contact, blood transmission and MTCT) and gender-specific factors which increase risk of HIV infection. Now it is time to 'synthesize' this and make a 'portrait of personal risk' for (a) yourself and (b) groups in your community.

Part one: Creating self-portraits (40 minutes)

Ask participants to draw a body (representing themselves) and develop a self-portrait of personal risk on a regular A4 sheet of paper and reflect on ways that gender may influence their own risk to HIV infection/re-infection and sexual behaviour. This is a very personal exercise and participants may or may not choose to share their self-portraits.

Ask participants to find a partner and practice how they would use this exercise to encourage clients, client family members or the general community, to create their own self-portraits and explore how gender influences their own risk to HIV infection/re-infection.

Facilitator's note: The description of how gender influences personal risk to HIV infection/re-infection using self-portraits should be assessed as a core skill at the end of the training module.

Part two: Creating a gender portrait of personal risk in my community (1 hour)

Split the participants into four groups:

Group one: Men Group two: Women Group three: Boys Group four: Girls

Provide each group with a flipchart and markers. Ask them to write their assigned gender at the top of the flipchart and as a group, draw a 'portrait' of their gender, including visual elements that might help identify this group in their setting (e.g. particular style of hair of this gender group, head wear, clothes, etc.).

Once the silhouette has been created using words or pictures, ask each group to reflect upon the information discussed for each of the three modes of transmission (unprotected sexual contact, blood transmission and MTCT) to create a portrait of personal risk for that gender group in their community.

Have each group display their portrait and give a three minute presentation on why their group is at risk of HIV infection/re-infection in their setting.

Facilitator's note: Encourage participants to add culturally specific elements. For example, they may want to give their portrait a common name in their setting to personalise it when presenting.

Wrap up the session by sharing copies of Handout 9.3.3 Gender specific factors increasing risk of HIV infection. Ask participants to examine gender specific factors that may increase risk of HIV infection in their local context. The factors are:

1. religion
2. culture, tradition, social, norms
3. economy – poverty versus sustainable development
4. lack of education
5. violence
6. environmental instability – emergency situations, political upheaval, war, high level of militarization, disasters, prisons
7. unemployment
8. lack of health care, counselling and social services
9. biology
10. media

Portraits should be displayed in the training environment for the remainder of the training. They can be referred back to as a reminder of the unique ways in which gender places people in your communities at risk for HIV infection.

Encourage participants to think about (instead of around) their role as CBVs to help clients to address these gender-specific factors that increase risk of HIV infection among key populations in their community.



3. Gender-specific approaches to HIV prevention (45 minutes)

So far this session has looked at the different ways in which gender influences the factors that increase risk of HIV infection or re-infection such as:

- the role gender plays in the main modes of transmission (unprotected sexual contact, blood transmission, MTCT)
- the gender-specific factors increasing risk of HIV infection among women, men, boys and girls.

a) Exploring the role of gender in effective HIV prevention strategies

This section will use this knowledge to explore the role of gender in creating effective HIV prevention strategies in our communities, or in strengthening existing strategies.



Tool 3: Influence of gender on prevention strategies (45 minutes)

Distribute copies of Handout 9.3.4 Influence of gender and HIV prevention – the role of CBVs.

In groups, ask participants to use information covered in this session to complete the blank sections for each area on the handouts. They should do this separately for men, women, girls and boys as well as the role of CBVs.

Facilitator's note: Many of these prevention methods have been covered in detail in Module 1: Basic facts on HIV and AIDS. These include:

1. HIV testing and counselling
2. male and female condom use
3. PMTCT
4. harm reduction
5. partner reduction
6. male circumcision
7. treatment of sexually transmitted infections
8. precautions against infection
9. positive prevention
10. encouraging behaviour change
11. increasing access to services
12. reducing/ending GBV
13. meeting SRHR

They can also draw from the gender portraits completed in the previous activity.

Offer participants an opportunity to share any key issues identified

As an end to the overall session, share the information below and hold a brief discussion with the group using trigger questions such as:

- Can you think of any examples from your work in the community of how the different gender groups might approach positive health, dignity and prevention, differently?
- How do you think gender presents unique challenges for CBVs promoting positive health, dignity and prevention in your communities?
- As a group, brainstorm ways in which CBVs can help to address gender-related constraints to positive health, dignity and prevention.

b) Positive health, dignity and prevention for all

Positive health, dignity and prevention focuses on improving and maintaining the health and well-being of PLHIV which, in turn, contributes to the health and well-being of partners, families and communities. This is in direct contrast to previous approaches to 'positive prevention', which could be construed as treating PLHIV as vectors of transmission. By focusing on the journey experienced by PLHIV from testing to support, care and treatment, 'positive health, dignity and prevention' positions the health and social needs and experiences of PLHIV within a human rights framework.

Aspects of positive health, dignity and prevention include:

- **Promoting holistic health and wellness**, including universal access to voluntary HIV testing, care and support and timely access to voluntary treatment and monitoring.
- **Addressing vulnerabilities** (psychosocial, economic, educational and sociocultural) and **issues related to gender and sexuality**.
- Being **responsive to the needs of key populations** and respecting and tailoring responses to specific contexts and diversity among PLHIV.
- Being **responsive to the particular and specific needs relating to gender**, including the needs of women and girls.

Gender considerations are clearly at the centre of achieving positive health, dignity and prevention for PLHIV.

Ask participants to brainstorm about the key gender considerations that should be at the centre of achieving positive health, dignity and prevention for PLHIV.

4 Session four: Gender and HIV treatment

Purpose: The purpose of this session is to build knowledge and skills to understand how gender influences the ability of people to access, prepare for and adhere to antiretroviral therapy (ART) and the role of CBVs in providing gender-responsive support.

Objectives:

By the end of this session CBVs should be able to:

1. Discuss how gender influences HIV treatment in their communities.
2. Help clients of different genders to prepare for ART.
3. Understand the role of gender in creating barriers to ART adherence, and know how to use gender-responsive strategies to support treatment adherence.
4. Support the attainment of nutritional goals that address the special needs of men, women and children living with HIV.
5. Help clients to address any gender-related constraints to positive health, dignity and prevention as part of comprehensive ART.

Duration: 4 hours

Required materials: Flipchart, marker pens, sticky-stuff

Recommended preparation:

Review of other modules

While key definitions will be made available as a refresher to participants, facilitators should review Module 2 *Treatment literacy*; Module 3: *Treatment preparedness*; Module 4: *Adherence* and Module 6: *Nutrition* (session four) prior to facilitating this session.

Make copies of

- Handout 9.4.1: Ways gender may influence HIV treatment
- Handout 9.4.2: Preparing PLHIV for ART – A checklist for CBVs
- Handout 9.4.3: Factors that influence adherence and non-adherence
- Handout 9.4.4: CBV strategies to address influence of gender on adherence
- Handout 9.4.5: Nutritional goals for men and women – A gender perspective

Note to Facilitators before starting training on session four: If participants have not received training on Module 2: *Treatment literacy*, Module 3: *Treatment preparedness* or Module 4: *Adherence*, facilitators should have these modules on hand to assist in the understanding of treatment-related terms used in this session.

Objective	Content	Time	Activities
Discuss how gender influences HIV treatment in their communities	1. How does gender influence HIV in my community?	20 minutes	Tool 1 (A)
Help clients of different genders to prepare for ART	2. How does gender influence treatment preparedness?	1 hour 15 minutes	Tool 2 (K) Tool 3 (PS) Checklist/Role-play Tool 4 (PS)
Understand the role of gender in creating barriers to ART adherence and use gender-responsive strategies to support treatment adherence	3. Gender and treatment adherence	1 hour 25 minutes	Tool 5 (K) Tool 6 (PS)
Support the attainment of nutritional goals that address the special needs of men, women and children living with HIV	4. Influences of gender on other aspects of ART	40 minutes	Tool 7 (K)
Help clients to address any gender-related constraints to positive health, dignity and prevention as part of comprehensive ART	5. Positive health and ART through a gender lens	20 minutes	Group discussion

1. How does gender influence the treatment of HIV? (20 minutes)

How does gender influence HIV treatment in my community? (20 minutes with Tool 1)



Tool 1: Gender influences in my community

Ask participants to think of ways in which HIV treatment might be influenced by gender (being male, female, an adolescent boy or girl, or transgender) in their communities. Write down responses on a flipchart entitled: Influences of gender on HIV treatment in your setting.

Distribute Handout 9.4.1 Ways gender may influence HIV treatment. Review as a group and ask participants to discuss any specific ways in which each point may influence HIV treatment in different gender groups in their setting.

Facilitator's note: This list does not need to be exhaustive, as specific elements of how gender influences treatment preparedness, initiation, adherence, monitoring and support will be explored in the following sessions.

2. How does gender influence treatment preparedness? (1 hour 15 minutes)

Treatment preparedness is a process of preparing PLHIV and their surrounding community to start ART and related therapies. The aim of treatment preparedness is to ensure that PLHIV have all the support necessary to take their medications, including antiretroviral (ARV) and TB medications, as prescribed by the clinical team at the health facility.

Individual preparedness for ART should begin from the time a person is diagnosed with HIV as part of pre- and post-test counselling.

Because an entire module has been devoted to the discussion of *Treatment Preparedness* (Module 3), we will not spend a lot of time exploring specific issues. Rather, we will be exploring the ways in which gender might influence this stage for PLHIV. Specific attention should be paid to the role that CBVs should play in taking a gender-sensitive approach to treatment preparedness in their communities.



Tool 2: A review of treatment preparedness through a gender lens (30 minutes)

Discuss some ways that gender might influence community mobilization in your setting:

- Religious or cultural norms regarding the behaviour of different gender groups (e.g. breastfeeding practices, use of traditional versus 'western' medicine to treat infections, ability of women to speak openly about issues of sexuality, women dependant upon male's approval to get treatment or to go to the clinic).
- Barriers to treatment access faced by different gender groups (e.g. ensuring availability of LGBTI or youth-friendly health services).
- Stigma and discrimination towards men/boys or women/girls living with HIV influencing ability to disclose or find treatment buddies.
- Prioritization of health care for people of a certain gender.

Discuss briefly the different ways in which CBVs can provide targeted support to help women, men, boys and girls prepare for ART.

a) Integrating gender into the preparing PLHIV for ART checklist. (25 minutes)



Tool 3: The checklist

Distribute copies of Handout 9.4.2 Preparing PLHIV for ART – A checklist for CBVs. Ask groups to split into pairs. Give the pairs 10 minutes to practice how they would use this checklist differently for different gender groups affected by HIV in your community (men, women, girls or boys, transgender, other), based on the different considerations of gender in treatment preparedness identified in the previous exercise.

Ask for two pairs to volunteer to demonstrate the use of the checklist to prepare a man and a woman for ART in their community.

Facilitator's note: Facilitators may choose to alter the gender for demonstration to 'adolescent girl or boy', LGBTI, or any other gender group you feel is most affected by HIV in your community (or one that is most isolated).

Following each role play, ask participants observing the role play to add any additional considerations they feel are important for this gender group and make notes in the space provided on the handout.

Facilitator's note: Facilitators should take careful note of the key considerations for each gender group identified and use these notes for assessing this core skill. Community preparedness is addressed in detail in the *Treatment preparedness* module and this should be referred to, adding specific reference to the gender aspects of community preparedness.

b) The role of gender in peer support (20 minutes)



Tool 4: Analysing peer support networks in your community

Hold a brief discussion about some relevant peer support groups in your community based upon identified gender-based influences on preparing for ART.

Expand the discussion to explore the role of gender in other support structures such as 'buddy systems' and locally relevant support systems/structures.

End the activity by re-stating the role of CBVs in ensuring that peer support systems and structures in their community are gender sensitive.

Facilitator's Note: Participants expressing interest in helping to start a peer support group in their community should be provided with appropriate support through training on session three. Peer Support and Group Education (pp. 37 to 40) of Module 3: *Treatment preparedness*.



Peer support or support for people by people in the same situation, is a wonderful strategy for a gender-based approach to treatment preparedness.

Peer support groups are an excellent way for people facing the same challenges and opportunities connected to their gender, to openly discuss and develop solutions to shared problems. CBVs should promote and support the formation of peer support groups in their communities, particularly among individuals belonging to a gender group facing recognised challenges towards effective HIV prevention, treatment, care and support.

The possibilities for variations of the peer support group are endless and depending on your context could include:

- women living with HIV
- men living with HIV
- mothers living with HIV
- fathers living with HIV
- parents (mothers and fathers) living with HIV
- mixed peer support (for example, HIV negative friends/relatives supporting HIV positive men, women, girls, boys or LGBTI)
- wives of migrant workers/truck drivers living with HIV
- sex workers living with HIV
- adolescent support groups for boys or girls
- LGBTI living with HIV.

3. Gender and treatment adherence (1 hour 25 minutes)

Adherence means sticking to or being devoted to something. In ART, adherence involves taking medications in the correct amount, at the correct time and in the way they are prescribed.

Training in this module has shown us that gender influences all aspects of our life including how each of us:

- accesses socially valued goods, tools and resources, including ART
- interacts with the same and opposite sex
- cares for our children
- values oneself or has time to attend to our own needs
- spends our working life – the types of jobs we do (both paid and household duties), how much, or if we are paid.
- worships or expresses our faith

Each of these factors also influences a person's ability to adhere to ART. In this way, it can be said that issues of ART adherence and gender are not just related, they are inseparable.

The following are some ways that gender may influence adherence as identified by the World Health Organization. How many of these apply to your setting?

- With a few exceptions, ARVs have to be taken with food. The lack of food may particularly affect adherence for women because in many settings women are expected to eat after feeding their children and families, or nutritionally rich foods are preferentially given to male members of the household.

- Pregnant or breastfeeding women may face additional barriers in adhering to ART due to:
 - worries about their HIV status being discovered by the husband, the family-in-law or the larger community through enrolment in treatment programmes or not breastfeeding while on treatment when breastfeeding is the norm
 - the effects of drugs on their babies
 - additional nutritional requirements associated with pregnancy and breastfeeding
 - conditions such as nausea and vomiting during pregnancy that may be exacerbated as side-effects of ARVs.
- The side-effects of certain ARVs are specific to women or men and may differ between puberty, the teen years, childbearing age and the postmenopausal years. Coupled with the social norms and expectations associated with women's SRH functions, these side effects can affect adherence to treatment.

Facilitator's note: Comprehensive adherence training is outlined in Module 4: *Adherence* of this training package. The purpose of the following exercises is to explore how gender influences adherence, in order to promote gender-sensitive problem-solving with clients and their families. If facilitators or CBVs require more information on any of the topics covered in this session, refer to Module 4.

a) Adherence for men and women – two stories (40 minutes)



Tool 5: 'A day in the adherence life' drama

Divide participants into two groups.
Group one: Male (men/boys) and Group two: Female (women/girls)

Facilitator's note: If there is another gender group that is disproportionately affected by HIV in your community, you may choose to change the gender groups assigned (i.e. LGBTI, young male IDUs, female sex workers, adolescent girls, men working outside of the country).

Ask each group to develop and enact a short (approximately five to seven minutes) '*a day in the adherence life*' drama (starting from the time one wakes up through to bedtime), that illustrates all of the moments in this group's day that might make adhering to ART challenging, manageable and possible.

Distribute Handout 9.4.3 Factors that influence adherence and non-adherence to provide groups with some thinking points that they might wish to include in their dramas.

Facilitator's note: Facilitators should write down key issues identified for each gender during drama presentations. At the end of each drama, ask participants to identify any additional factors that may interfere with ART adherence for this group.

Gender, body image and adherence

- Women may face difficulties in adhering to ART because of a lack of independence or ability to make decisions for themselves (financially, how they spend their time, control over their own bodies, etc).
- Reports from some settings suggest that HIV-positive pregnant women have returned their drugs because their husbands believed that the drugs might harm their unborn children.
- Research has also indicated that some women or men may be forced to share their drugs with their partners, who use their partner's HIV status as a proxy for their own.
- Factors such as substance abuse (i.e. alcohol and drugs), migrant non-resident status, and an absence of social support from family members, friends or communities, also present barriers to adherence for women, men, adolescent girls and boys, or LGBTI persons.

Gender, body image and adherence

Some ARVs may, in the long term, cause fat accumulation in certain parts of the body. This could potentially affect adherence, particularly in cultures where sexual attractiveness of certain genders is linked to a certain body image. Does this apply to your setting?

b) The role of CBVs in monitoring and supporting ART (45 minutes)

The activity above should have resulted in the identification of a number of important areas where gender influences the ability of men and women to adhere to ART.



Tool 6: Problem solving gender-related adherence issues

Distribute copies of Handout 9.4.4 CBV strategies to address influence of gender on adherence.

Facilitator's note: If there are certain groups within each gender – such as LGBTI or young male IDUs, or people living with disabilities – that are affected by HIV in your setting, make sure to address any specific needs they may have.

Ask each group to fill in their allocated column by identifying referrals to community resources, information or support they could provide to avoid each gender-related adherence issue.

Refer to the following adherence enhancing tools and ask participants to integrate them in their solutions, through a gender lens:

- preparation to adhere
- pill boxes
- electronic devices (beepers, alarm clocks, watches, mobile phones)
- buddy system/treatment supporter
- medication diaries
- support groups
- pill charts

To trigger this step, ask *“Based on your knowledge of the barriers to adherence faced by people of different genders in your community, which adherence enhancing tools are most appropriate for PLHIV of different genders?”*

Facilitator's note: Facilitators should take time at the end of this activity, to fill in their own table extensively, as it will be used for core skill assessment. In assessing this core skill, facilitators can choose an identified area for non-adherence influencing a particular gender (for example, lack of literacy in women, for understanding dosage timing), and ask the participants to explain how they would assist this person to overcome their adherence barrier. Explanations by participants should include the suggestion of a gender-appropriate adherence-enhancing tool to help their client adhere to ART.

Remember that because ART is a lifelong process for PLHIV:

- adherence levels change over time
- no one factor influencing adherence (including gender) acts alone
- adherence is influenced by many inter-related factors
- adherence requires team support. Doctors, nurses, counselors, pharmacists, treatment buddies, friends, family members and CBVs are all members of an individual's adherence team
- adherence requires a combination of adherence strategies, which can change depending on a person's needs at any given time.

Key role of CBVs: Community home-based care (CHBC) as an important gender-responsive method for increasing adherence

Where women and men find it difficult to make frequent visits to health facilities because of childcare responsibilities, work obligations or lack of transport, arrange to make home visits, or deliver drugs closer to where clients live, through peripheral facilities, community outreach workers, or home-based care volunteers.

The following are some gender-responsive strategies identified by WHO for increasing adherence:

- While obtaining information about missed doses, recognize and acknowledge difficulties in adherence, without making any judgement.
- Identify barriers to adherence, probing for factors related to women's roles and norms.
- Pregnant or breastfeeding women may need support for adherence that addresses cultural beliefs/practices linked to food and medicine intake during pregnancy.
- Help clients plan their medicine intake if they are expecting changes in routine (e.g. travel, coping with a new baby, or starting a new job).
- Emphasize the importance of not sharing ARVs with anyone, including family members.
- Offer adherence support tools that protect the confidentiality of clients. For example, offer reminders such as calendars, marked pillboxes, diaries, alarm clocks, or mobile phones, ensuring that they can be hidden and are non-stigmatising in form.
- Provide suggestions for storing ARVs discreetly in the home or at work.
- Be aware of and address the concerns that different gender groups may have about the side effects of drugs, on issues such as body shape and weight, fertility and sexuality, and pregnancy or menstrual cycle (women of child bearing age).

4. Influence of gender on other aspects of ART (1 hour)

ART is not just about taking ARV medicines, but should be a holistic treatment that involves supporting other ways that PLHIV can improve their health and wellbeing. Some important aspects of treatment for PLHIV that can be influenced by gender are nutrition and positive health, dignity and prevention efforts.

Gender and nutrition (40 minutes with Tool 7)

Good nutrition is an important aspect of healthy living for all people, HIV positive or not. Benefits of good nutrition include:

- improving the functioning of the body's immune system to fight off illness/infection
- having sufficient energy available when the body needs it
- good mental functioning
- having required stores of energy in case of illness or times when the body has additional energy requirements (such as during pregnancy, when recovering from opportunistic infections, or when starting ARVs)

Seven nutritional goals for PLHIV

Goal one: Be aware of the importance of good nutrition if you are living with HIV

Goal two: Eat a healthy and balanced diet to keep your immune system strong

Goal three: Adjust food intake to deal with HIV-related symptoms

Goal four: Prevent food-borne illnesses by practicing good hygiene and food and water safety

Goal five: Manage the symptoms of HIV that can affect food intake by getting early treatment for opportunistic infections

Goal six: Keep a healthy weight

Goal seven: Understand the way that any medications you are taking (including ARVs) may affect your nutrition.



Tool 7: Setting nutritional goals through a gender lens

Facilitator's Note: The goal of this section is to make participants aware of how gender might influence nutrition needs and access to good nutrition. For a comprehensive look at the nutritional needs of PLHIV and the role of CBVs, refer to Module 6: *Nutrition*.

Hold a brief brainstorming session about the links between nutrition and gender, and subsequent links with ART for women, men and transgender persons.

Distribute Handout 9.4.5 Nutritional goals for men and women – A gender perspective

Ask participants to get into pairs and complete the blank spaces on their handout, reflecting on gender issues related to each of the seven nutritional goals.

Request volunteers to share their responses with the group and end the session, by agreeing together, on the key gender issues linked with each nutrition goal.

Broad areas where gender may influence nutrition for PLHIV may include:

- **Lifestyle factors** that influence the diets of women and men based on gender roles, norms, culture or religion. For example, alcohol intake, long working hours, eating times and type of food eaten.
- **Food insecurity** experienced by men or women and how this influences how much, how often, and what kinds of food men and women might eat. Women are more likely than men to go without food in food insecure households. Increased intake of foods such as refined rice, bread or maize meal that are high in carbohydrates (energy) but low in micronutrients (immunity boosting).
- **Reproductive roles** place different nutritional needs on men and women at different times of their lives. For example, women require additional nutrients and energy while they are pregnant or breastfeeding.
- **Poverty** may influence the ability of individuals to access nutritious food and their ability to keep food 'safe' through appropriate storage and cooking.
- **Educational** differences between women and men may influence their understanding of the relationship between HIV and nutrition.
- **Common opportunistic infections (OIs)** can differ between men and women, be influenced by food and/or influence the ability of men and women to eat.
- **Nutritional needs of children living with HIV, or HIV positive mothers,** are most commonly the responsibility of mothers or female caregivers, requiring additional knowledge, skills and resources.

5. Positive health and ART through a gender lens (20 minutes)

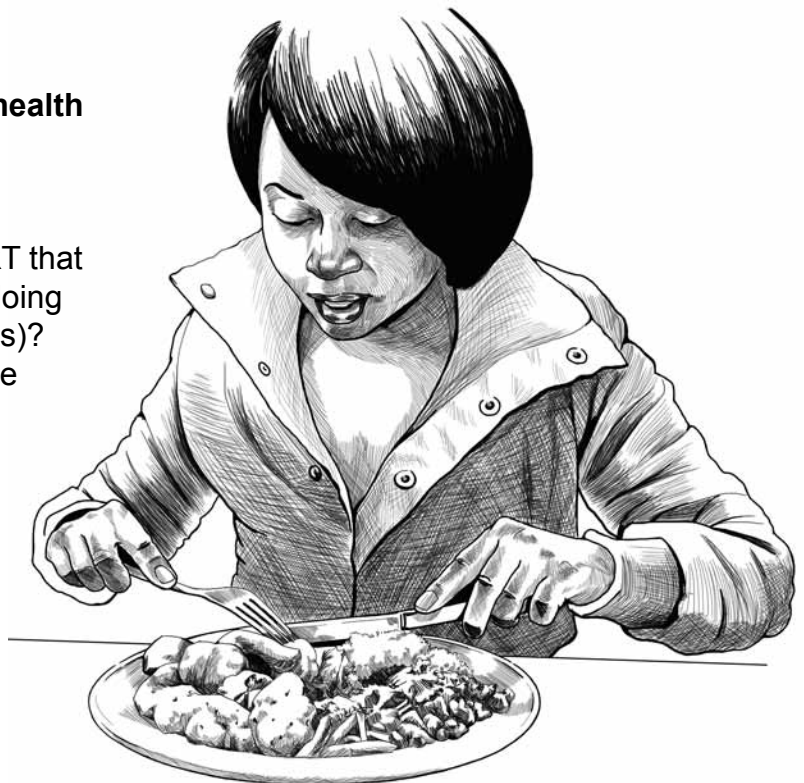
Role of CBVs in supporting positive health among PLHIV (20 minutes)

Hold a brainstorming session on

- What are the other aspects of ART that help treatment work better (e.g. doing regular exercise, controlling stress)?
- How does gender affect the above identified aspects?

Ask participants to get into buzz groups of three and discuss:

- What would be the role of CBVs in ensuring positive health among PLHIV?
- How would CBVs address gender issues related to positive health?



5

Session five: Role of gender in care and support

Purpose: The purpose of this session is to provide participants with the knowledge and skills to understand how gender influences the ability of CBVs to provide care for others and to care for themselves.

Objectives:

By the end of this session, CBVs should be able to:

1. Discuss the role of gender in providing care for PLHIV.
2. Identify and act upon opportunities for CBVs to address gender inequalities related to the care and support of PLHIV in their community.
3. Use locally relevant strategies to overcome gender-based challenges to providing good quality palliative care.
4. Describe the role of CBVs in overcoming gender-based stigma and discrimination towards PLHIV.
5. Use and promote gender-sensitive caring for carers in their community.

Duration: 4 hours 40 minutes

Required materials: flipchart, different coloured marker pens, cards, sticky-stuff

Recommended preparation:

Review of previous modules

While key definitions will be made available to serve as a refresher for the participants, facilitators should review Module 5: *Community based counselling*, Module 7: *Palliative care*, and Module 8: *Caring for carers*

Make copies of

- Support card: Experiences of gender in palliative care card
- Handout 9.5.1: Influence of gender on palliative care
- Handout 9.5.2: Journal of gender-based stigma and discrimination
- Handout 9.5.3: Role-plays on role of gender in caring
- Handout 9.5.4: A gendered approach to the signs of stress and burnout.

Objective	Context	Time	Activities
Discuss the role of gender in providing care for PLHIV	1. A gendered approach to the care and support of PLHIV	25 minutes	Tool 1 (A) Tool 2 Group Discussions
Identify and act upon opportunities for CBVs to address gender inequalities related to the care and support of PLHIV in their community	2. Male involvement in CHB care and support	40 minutes	Tool 3 Tool 4 (PS)
Use locally relevant strategies to overcome gender-based challenges to providing good quality palliative care	3. Palliative care	40 minutes	Tool 5 (PS)
Describe the role of CBVs in overcoming gender-based stigma and discrimination towards PLHIV	4. Gender-based stigma and discrimination	1 hour	Tool 6 (A) Tool 7
Use and promote gender-sensitive caring for carers in their community	5. Gender and caring for carers	1 hour 30 minutes	Tool 8 Role-play Tool 9 (A/KM)
Concluding Session	6. CBVs as gender-responsive agents of change	20 minutes	

1. A gendered approach to the care and support of PLHIV (25 minutes with Tools 1 and 2)



Tool 1: Gender and caring for PLHIV (10 minutes)

Read the following statement aloud:

“Perhaps no other aspect of HIV is as “gendered” as care and support”

Ask participants if they think the statement is true or false, and why or why not.

Facilitator’s note: In guiding the discussion, refer to the list of aspects of caring for PLHIV from Module 7. Ask participants to think of an example from their work as a CBV that demonstrates the influence of gender on this aspect of caring for PLHIV.

If not already addressed, end the exercise by asking if participants think that gender influences who provides care for PLHIV in their community.



Tool 2: Gender inequalities and care and support (15 minutes)

In buzz groups of three, ask participants to discuss the following:

- men and women’s experience of HIV
- access to HIV- and AIDS-related care and support
- differences in the way care and support is provided to different genders
- forms of stigma and discrimination faced by PLHIV
- who provides care and what type of caring activities are undertaken
- type of support caregivers receive.

Ask volunteers to share key issues raised in the above discussions

The remainder of this session will explore specific actions to address gender-inequalities in home-based care programmes as identified by WHO which include:

- male Involvement in CHBC and support
- palliative care
- caring for carers
- care and support of children
- addressing stigma and discrimination.

Women and girls provide the vast majority of care for PLHIV in the home worldwide. Is this the case in your community?

2. Male involvement in CHB care and support (40 minutes with Tools 3 and 4)



Tool 3: Reality and opportunities – roles of men and women in caring (20 minutes)

Explore the following questions with participants in an open discussion.

“Who does most of the caring in your community?”

“What opportunities does this show us that exist for increasing the involvement of men or women in your community?”

Emphasize that the issue of caring often depicts stereotyped roles related to the broad gender norms and roles held in that community or culture. Typically, this involves women and girls taking on the majority of caring duties.

Why do women and girls provide more care?

Reasons why women might provide more care and support to PLHIV in your community may include:

- The role of carer is seen as an extension of a women’s role as care provider and mother within the home - the idea that CHBC is “women’s work”.
- In households where one or both parents have died, young girls may be put in the role of caregiver without any training or support.
- Due to gender stereotypes and lack of opportunity, men may not have the knowledge or skills required to provide care and support for PLHIV.
- For cultural or religious reasons, it may be considered ‘inappropriate’ for men to provide CHBC for women outside of their own household.



Tool 4: Opportunities – Addressing inequalities and improving our reality (20 minutes)

Using a gender lens, ask participants to think of opportunities for engaging men to provide care and support to PLHIV in their community.

Record their responses on a flipchart. End the activity with a brainstorming session on the ways in which CBVs can encourage and engage men in their community to provide care and support for PLHIV in the:

- family/home setting
- community
- workplace, religious setting and other social spaces

Wrap up the session by summarizing the key action areas where male involvement in care and support of PLHIV can be made a reality.

Facilitator’s note: Facilitators should make note of some of the following points with participants during the discussion.

Why are women and girls more engaged in care work?

- Reasons why women and girls are more engaged in care and support work with PLHIV.
- Identifying households where boys or girls are taking on caring roles and linking them to services that can help (such as CHBC programmes) or providing other forms of needed support or information.
- Encouraging male involvement in home-based care and providing the required skills and knowledge training.
- Identifying groups providing the majority of care (women and girls) and specific forms of additional support they may require ('caring for carers').
- Involvement of male traditional and community leaders to act as role-models and raise awareness about the important role of men in the care and support of PLHIV.
- Others specific to your context.

3. Palliative care (40 minutes with Tool 5)

Refer to module 7:

Palliative care involves symptom management during both acute and chronic care and at the end of life.

Did you know... that over 80 per cent of AIDS-related deaths occur at home? While with increasing treatment availability, HIV no longer needs to be linked with 'death and illness', this figure means that CHBC remains one of the most important forms of support people living with HIV and AIDS will receive during the course of their illness.



Tool 5: Experiences of gender in palliative care card sort (40 minutes)

Distribute a blank card and marker to each of the participants.

Ask participants to write down one example of how:

Their own gender, or the gender of a CHBC client, has made it difficult to provide good quality palliative care.

Facilitator's note: If participants are having problems thinking of what 'good palliative care' involves, refer to section 1 a) Role of gender in care and support and review the list, 'Caring for PLHIV can include'.

While participants are filling in their cards, write down each of the headings below on separate cards and stick them up in a horizontal line on a wall in the training environment.

Once they have filled in their card, ask participants to stick their card under one of the following headings:

- knowledge or skills
- gender norms and roles
- physical experience of illness and pain

- emotional experience of illness and pain
- legal issues
- other (which they can label as appropriate).

Distribute copies of Handout 9.5.1 Influence of gender on palliative care. In groups ask participants to complete the table.

Offer three to five minutes for the groups to present, and review each of the responses and problem-solve ways in which this gender-related constraint to palliative care could be dealt with, using existing community resources.

Facilitator's note: While the answers provided to this exercise will vary depending on your setting, the facilitator can add to the list in the Handout, any additional key issues that should be problem-solved for CBVs in your context. Facilitators should take particular note to record the community-based solutions to each constraint identified and use this information for core skill assessment.

4. Gender-based stigma and discrimination (1 hour with Tools 6 and 7)



Tool 6: Personal reflection – gender-based stigma and discrimination in your community (15 minutes)

Distribute copies of Handout 9.5.2 Journal of gender-based stigma and discrimination and a pen/pencil to all participants.

Ask participants to spend a few minutes writing down a journal-style entry reflecting on:

- Ways they feel gender-based stigma and discrimination have influenced PLHIV in their community.
- Encourage participants to think deeply about how they may have held stigmatizing beliefs or discriminated against PLHIV either in their personal lives, or through their work as CBVs.
- Any personal experiences of stigma or discrimination.

Facilitator's Note: Emphasize that while participants will not be required to share their journal entries, they should try and be as honest with themselves as possible. This exercise is meant to acknowledge how we have all held stigmatizing beliefs at one time and how gender-based stigma and discrimination is prevalent in all communities.

A quick review: The difference between stigma and discrimination

Stigma is negative attitudes toward people who belong to a different group, or who have different characteristics from others.

Examples and impact of gender-related HIV stigma might be:

- belief that women who are HIV positive are 'promiscuous' or 'loose'
- belief that HIV is a punishment for 'immoral' behavior (e.g. sex work, sexual intercourse outside of marriage, same sex relationships).

Discrimination is a term used to describe treating other people differently or unfairly because they are different from others. Examples of gender-based discrimination linked to HIV might be:

- rejection of women who are HIV positive by their husbands, partners friends or families
- health workers providing different quality of care for PLHIV who are LGBTI than others.

Stigma linked to HIV and AIDS can enhance gender inequalities, further restricting the access of these groups to prevention, treatment, care and support.

Examples of the impact of gender-based stigma and discrimination surrounding HIV and AIDS may include:

- discouraging particular gender groups from accessing TB/ HIV counselling and testing services to find out their **HIV status**
- limiting the **disclosure** of HIV status, limiting opportunities for TB, HIV prevention, treatment, care and support
- encouraging or reinforcing feelings of **self-blame and depression** ('self-stigmatization') in PLHIV, limiting steps towards positive living resulting in the **isolation** of certain affected populations (young women, sex workers, LGBTI, IDUs, MSM), limiting their access to specific forms of care and support
- **preferential caring** by health workers, or CBVs to provide care and support for some affected groups over others
- **discouraging PLHIV involvement** in care and support activities, to act as positive examples in their own communities.



Tool 7: The role of CBVs in reducing gender-based stigma and discrimination (45 minutes)

Hold a group discussion regarding types of stigma and discrimination faced by PLHIV in your community. Write down answers on a flipchart.

For each example provided, identify a **specific appropriate action** that could be taken by CBVs in their communities to help reduce this form of stigma or discrimination.



Facilitator's note: The root of stigma and discrimination in a society can be embedded within sensitive cultural and religious beliefs and practices. CBVs should not feel responsible for 'changing every mind' and confronting people holding such beliefs. Instead, the role of CBVs is to provide **information and support**, including referrals to services that can provide specific help.

Actions that CBVs may take to address stigma and discrimination in their communities can include:

- **Breaking the silence** about stigma and discrimination in client households by openly asking clients and their families about any stigma or discrimination they may be facing.
- **Respecting the privacy** of clients and family members and ensuring confidentiality of sensitive information at all times.
- **Offering counselling** (only if trained in community-based counselling – see module 5) or link clients and families to counselling services.
- **Sensitizing community leaders**, such as traditional and religious leaders, about gender-based stigma and discrimination and encouraging them to lead by example.
- **Sensitizing community members**, including family and caregivers of PLHIV about the importance of providing care and support for PLHIV.
- **Addressing harmful gender norms and practices** that result in discriminatory practices against gender groups (e.g. abandonment or blame of HIV positive women).
- **Provide referrals** to PLHIV support groups, religious groups, women's groups, youth groups and other support networks.

5. Gender and caring for carers (1 hour 30 minutes with Tools 8, 9 and 10)



Tool 8: How gender influences the burden of care (40 minutes)

We have already explored the different roles that men and women in our communities play in caring for PLHIV. We will now take a different look at this same issue, by thinking about “who does the most caring in our communities?”

A gender-role play: Exposing the role of gender in the ‘burden of care’

Make copies of Handout 9.5.3 – Role plays on the role of gender in caring

Ask participants to break into pairs. Assign each pair with one of the following role-plays and ask each pair to prepare a quick role-play (not more than two to three minutes) for the group. Emphasize that pairs should **not alter** their role-play to make it more ‘gender appropriate’ but enact it exactly as it is on the slip of paper.

Role-plays:

- man giving a woman a bed bath
- woman demonstrating condom use to a man
- man fetching firewood for a female client
- woman providing comfort and support to a child whose mother has died
- woman assisting another woman to get dressed
- man cooking a meal for a female client.

Facilitator's note: Facilitators should review the list of role-play scenarios above prior to this exercise and determine which may not be relevant in your setting and omit these from the exercise (e.g. collecting firewood in an urban setting).

Once role plays are complete, ask the group: *What did your reactions to role-plays tell you about the role of gender in caring?* Discuss as a group using the following trigger points:

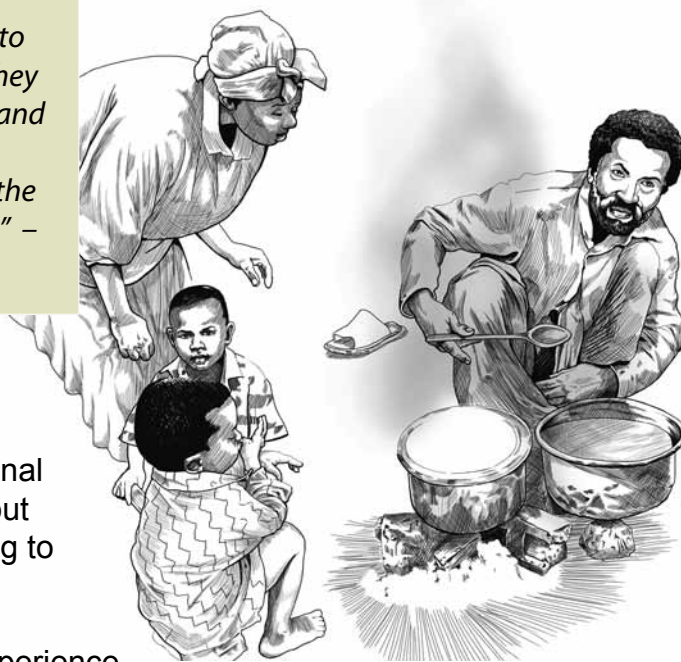
- role-plays which participants found funny or difficult to perform believably expose the different roles of men and women in caring
- role-plays likely demonstrated that most caring roles are considered 'natural' for women, illustrating how women and girls end up providing the majority of care in the households and why most CBVs are women.

End the session by emphasizing that in addition to being assumed to be 'natural' carers, women carers at the household and community-level are also expected to perform other functions (child care, collection of water/fuel, working in the fields, domestic duties, contribute to household income through formal employment). Therefore the term the 'burden of care' does not only reflect the responsibility of caring, but the multiple roles expected of carers, both within their clients' households and within their own households. Use examples from the information provided below.

The multiple roles expected of women and girls as carers reveal a series of issues related to the stresses of caring:

- **Not just 'caring' in the home.** CBVs and primary caregivers are also responsible for other household activities such as collecting water and firewood, in addition to traditional CHBC activities such as basic nursing, cleaning and food preparation.
- **Not just illness but livelihood insecurity.** Households affected by HIV and AIDS often face the added stress of economic and food insecurity, which poses additional strains upon caregiving. CBVs live in the same communities in which they work and are also facing hunger, poverty and illness in their own lives.

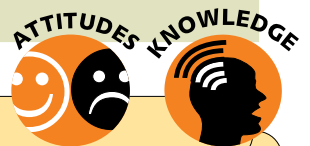
"Tell me how you would feel if you had to tell a client to take medication that increases their appetite when they have nothing to eat, and then you go home at night and eat while you know he is suffering? Many of us bring food from our own homes, food which is taken from the mouths of our own children - what else are we to do?" – Red Cross Care Facilitator, Soweto, South Africa



- **Vulnerability of carers.** Many carers, including CBVs, are also HIV positive and facing their own set of physical and emotional strains related to dealing with illness, without receiving the type of care they are providing to others.
- **Stress of caring.** Care-giving places considerable strain on carers, who may experience depression, exhaustion and anxiety, leading to burnout.
- **Breadth and level of skills required.** Such individuals are not only looked to for basic nursing skills, but also for information on HIV and AIDS, treatment, nutrition, to act as community-based counselors and provide palliative care.

- **Coping with death and dying.** Each of the homes in which CBVs work is, in some way, dealing with issues surrounding death and dying which can be emotionally and legally complex (issues of property/wife inheritance). In addition, CBVs may be dealing with issues of death and dying in their personal lives as well.
- **The stigma of caring.** CBVs often report stigma associated with caring, directed at client households and towards themselves. In periods of grief, carers may be blamed for the deaths of clients, by family members.

“Especially at the beginning of the programme, stigma and discrimination was a real problem for care facilitators. If the community became aware of the Red Cross conducting home visits, that home would be labelled an “AIDS house” and its members stigmatised in the community. Because of this, initially care providers requested that they not wear uniforms so they could not be identified as ‘Red Cross caregivers.’ This was very stressful for them, as working with PLHIV also carried with it allegations of infection. While things have gotten better, it is still a stress for care providers, who work daily with a topic that most others try to avoid in their lives.” – CHBC Facilitator, Port Elizabeth, South Africa



Tool 9: Caregiver burnout through a gender lens (30 minutes)

Open a discussion by asking participants *“Based on our discussions so far and knowledge from your community, how do you think gender might influence the likelihood of caregiver burnout?”*

Facilitator’s Note: The responses to this will vary according to your context.

Discuss how CBVs can recognize burnout.

Divide participants into two groups and ask them to list key differences related to this statement: *“The ways in which men and women show signs of stress are based upon both individual physical, emotional and behavioural characteristics and gender roles.”*

Distribute copies of Handout 9.5.4 A gendered approach to the signs of stress and burnout. As a group, review the handout and indicate signs of stress that may be more common in male or female caregivers. Do not spend a great deal of time discussing individual items, it is likely participants will find both men and women can exhibit each sign of stress.

Discuss any culturally specific ways in which men and women may exhibit stress in your environment and write them down in the space provided.

Facilitator’s note: It is very important for the facilitator to emphasize that participants should not *only* view stress through a gender lens, but should be aware that all signs of stress may apply to both men and women. However, it is important to understand the influence of gender norms and roles upon how we behave, including the way we exhibit stress.

Now that we have explored the different reasons why male and female carers might experience stress and the different ways this stress may be shown, it is important to understand the role of gender in caring for carers.

The strains of care giving can cause **caregiver burnout**, which results from stress that is built up over time until a carer is no longer able to cope. Burnout is not something that happens in one moment or even in one day. It is the result of feeling stress over a period of time. If not dealt with, this stress can combine to impact negatively on a caregiver's mental or physical health; damage his or her relationships; and ultimately, his or her ability to care for PLHIV effectively. Gender also affects how male and female caregivers experience stress and it is important to recognize these differences.

Male caregivers: emphasis on masculinity, denying men the opportunity or forum to speak about emotions/grieve openly.

Female caregivers: multiple roles and hardships in their own lives compounding the stresses of caring.

There are three important elements for CBVs to be aware of in caring for carers:

1. **Self-care-thoughts** and activities that people use on their own to deal with stress
2. **Caring for carers programme design** - ensuring the needs of carers are built into CHBC programmes where possible.
3. **Knowledge transfer to primary carers in the home** of both community resources and self-care techniques.



1. Self-care techniques were explored in Module 8: *Caring for Carers*. Distribute Handout 8.2 from the original training package and review the appropriateness of each self-care technique from both a male and a female perspective. Are there any other important elements of self-care that would be useful to CBVs or primary caregivers at household level in your community, either for men or for women?

It is important to emphasize that each of the self-care techniques is appropriate to carers of any gender. The purpose of this exercise is to highlight techniques that might be more useful to certain carers, based on identified stresses and strains unique to their gender, not to exclude any form of support due to gender.

2. Programme design - CHBC programmes should consider the specific needs of both men and women carers when incorporating caring for carer elements into their CHBC care activities such as:

- **Debriefing sessions** provide a forum for caregivers to discuss:
 - logistical issues (e.g. reports, monitoring, stipends)
 - specific problems faced by clients requiring support or guidance
 - personal issues (e.g. illness, need for respite care)
- **Monitoring caregiver workload**
 - travel distances from home/transport
 - number of clients and needs of clients
 - considering personal challenges (e.g. CBV illness, care required in the household, livelihoods insecurity)
- **Psychosocial counseling** CBVs should make use of the same community resources that are part of the client referral network, during times of need

- **Training** provides CBVs with the feelings of self-efficacy required to reduce stress and increase confidence in their caring abilities. Types of training that can reduce CBV stress include:
 - initial training on CHBC including: HIV and AIDS, basic nursing care, infection control, referral systems, etc.
 - stress management training to provide caregivers with the skills and knowledge to identify stress and burnout in themselves and their fellow caregivers, and to provide them with tangible methods of coping with stress and problem solving.
 - refresher trainings on topical issues (such as ART, PMTCT) to ensure caregivers maintain feelings of efficacy and learn new knowledge and skills that will benefit their work.
- **Carer support groups** for male and female carers provide an opportunity for CBVs to discuss and problem-solve specific challenges that are gender-linked.
- **Spiritual support** - CBVs indicate accessing spiritual support mechanisms as a critical element of reducing stress.
- **Special events** - celebrating events such as World Red Cross Day, World AIDS Day, 16 days of activism to eliminate GBV and others provide CBVs with an opportunity to celebrate their work in the community and receive much deserved recognition.



Tool 10: Gender-sensitive caring for carers in our community (20 minutes)

Knowledge transfer to primary carers in the home – of both community resources and self-care techniques, is an important way CBVs can provide gender-sensitive caring for carers within their entire community.

Divide participants into three groups, with assigned topics for discussion.

- Group one: Self-care
- Group two: Programme design
- Group three: Knowledge transfer

Ask each group to develop a short presentation on how this element of caring for carers should be dealt with in their community, with specific emphasis on the different needs of male and female carers.

Following each presentation, agree on a **list of key actions** for this aspect of gender-sensitive caring for carers in their communities.

Facilitator's note: The key actions identified during this exercise should be recorded, as they will be used to assess this core skill at the end of training.

6. CBVs as gender-responsive agents of change (20 minutes)

This is the final part of this module. End the module by discussing as a group:

- What are the key characteristics that a CBV should adopt to be an effective gender-responsive agent of change?
- How can CBVs become effective in this role?
- What steps participants will take after the module to integrate gender into their work and activities (allow voluntary commitments from participants)?

Congratulations. You have reached the end of your training on Gender and HIV.

Participants should now be equipped with the knowledge and skills to engage in gender-responsive HIV prevention, treatment, care and support. They will undoubtedly find that this new gender awareness will make them more effective in their work in the community.

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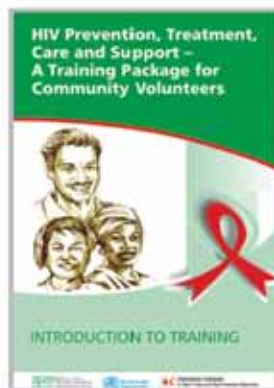
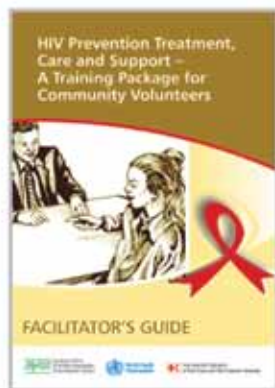
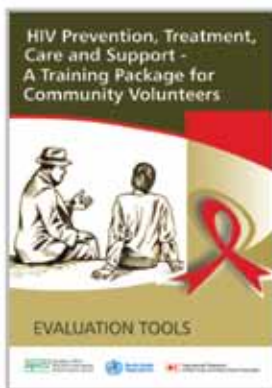
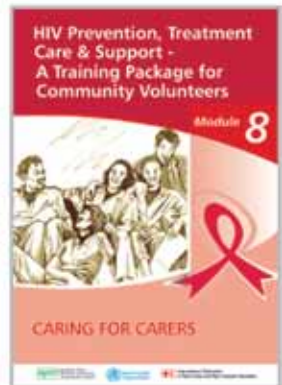
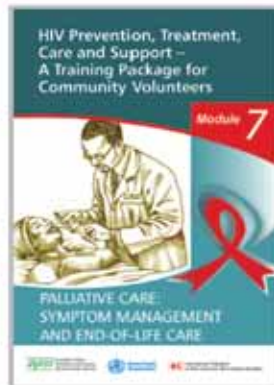
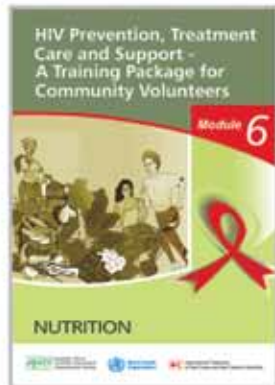
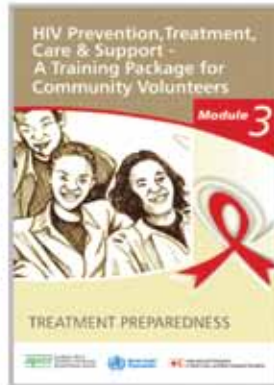
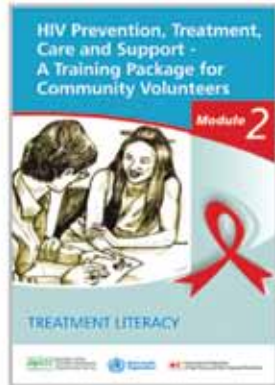
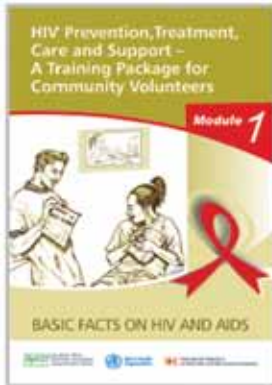
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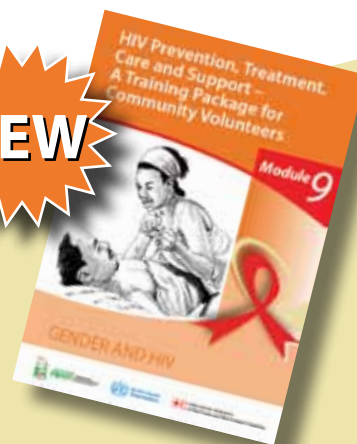
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