Gendering AIDS:

women, men, empowerment, mobilisation

ACKNOWLEDGEMENTS

This position paper was written by Miranda Lewis, and edited by Sara Cottingham, Ken Bluestone and Lara Carim. Additional research was carried out by Ken Bluestone, Melanie Alfonso and Michaela Hendriks. The paper was designed by Marta Rodriguez.

Thanks to Tina Wallace, Alice Welbourne, Sylvia Chant, Graham Lindegger, Alan Smith, Lorna Robertson, Kate Iorpenda, Ian Swartz, Paul Pope, Jane Shityuwete, Matthew Bell, Jonathan Burton and Mark Goldring for their invaluable comments.

We are very grateful to everyone who contributed their time and expertise to the research. Particular thanks to Langi Mphelo and Emma Webb (VSO South Africa), Rakhi Sarkar and Kevan Moll (VSO India), Lisa Davidson and Daan Gerretsen (VSO Namibia), and Matthew Foster and Karen Horton (VSO Cambodia).

The views expressed in this paper are those of VSO alone and not necessarily shared by everyone who took part in the research. Any errors are the sole responsibility of VSO.

October 2003

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EXPLANATION OF ABBREVIATIONS USED IN THIS PAPER

AIDS	Acquired Immuno-Deficiency Syndrome
ARV	Antiretroviral drugs: medicines used to slow the course of HIV and AIDS, still largely unavailable in developing countries
AusAID	the Australian government's Overseas Aid Program
CAFOD	Catholic Agency for Overseas Development
CARAM	Coordination of Action Research on AIDS and mobility
CBO	community-based organisation
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
DFID	the UK government's Department for International Development
DramAIDE	Drama in AIDS Education, South Africa
DVA	Domestic Violence Act, South Africa
EU	European Union
FHI	Family Health International
GAD	Gender and Development
GEZs	Gender Equality Zones
GFATM	Global Fund for AIDS, TB and Malaria
GIPA	Greater Involvement for People Living with HIV and AIDS
HIV	Human Immuno-deficiency Virus
ICPD	International Conference on Population and Development
IEC	information, education and communication
INGO	international non-governmental organisation
INP+	Indian Network of Positive People
IPPF	International Planned Parenthood Federation
LCWRI	Lawyers Collective Women's Rights Initiative, India
MAP	Men As Partners, South Africa
MDGs	Millennium Development Goals
NAA	National AIDS Authority, India
NAC	National AIDS Committee, Namibia
NACO	National AIDS Control Organisation, India
NCHADS	National Centre for HIV and AIDS, Dermatology and STD Control
NGO	non-governmental organisation
PAHA	People Against Human Abuse, South Africa
POWA	People Opposing Women Abuse, South Africa
PTCT	parent-to-child transmission
PTCT+	Parent-to-Child Transmission Plus programmes, South Africa
PPASA	Planned Parenthood Association of South Africa
RAISA	VSO's Regional AIDS Initiative of Southern Africa
SACS	State AIDS Control Societies, India
SANAC	South African National AIDS Council
SPYM	Society for the Protection of Youth and the Masses, India
STIs	sexually transmitted infections
SWAM	Social Welfare Association for Men, India
TRP	Technical Review Panel of the Global Fund for AIDS, TB and Malaria
TKMOAMS	Tate Kalungu Mweneka Omukithi wo 'AIDS' Moshilongo Shetu (translation: Our Mighty Father Protect Our Nation From The Deadly Disease 'AIDS')
UNAIDS	the Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS 2001
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WAWA	Women Against Women Abuse, South Africa
WOWA	Women Opposing Women Abuse, South Africa
WHO	World Health Organisation

Executive summary

Strategically, women must be at the centre of the response to HIV and AIDS; tactically, men have to be involved to address both HIV & AIDS and gender inequalities.

Rakhi Sarkar, programme officer, VSO India

HIV and AIDS continues to afflict communities in developing countries, despite increased international attention and funding and the efforts of people working on the ground. Many women's groups, non-governmental organisations (NGOs), academics and activists have demonstrated that inequalities between women and men fuel the spread of HIV and AIDS.

To reverse the spread and minimise the impact of HIV and AIDS, inequalities between women and men must be reduced. This is not happening yet, partly because policies designed to uphold women's rights are not being implemented effectively. By failing to place gender concerns at the heart of the response to HIV and AIDS, some interventions may actually be exacerbating the impact of HIV and AIDS on women. Another vital component in an effective response to HIV and AIDS that has been frequently overlooked is the constructive involvement of men in addressing gender inequalities and in meeting the specific needs of women, men and children affected by the epidemic.

VSO volunteers witness the impact of HIV and AIDS on friends and colleagues, on the organisations they work with and on countries as a whole. VSO conducted research in South Africa, Namibia, India and Cambodia between February and May 2003 to better understand at national and international levels:

- the overlap between lack of rights, gender inequalities and HIV & AIDS
- what needs to happen in order to strengthen the implementation of policies addressing these issues.

The research draws on the hands-on experience of a range of stakeholders, including VSO partner organisations, groups of people living with HIV and AIDS, and women's and men's organisations. This position paper draws together priorities expressed by these stakeholders, along with VSO's analysis. The recommendations for action aim to strengthen the response of government agencies, donors, civil society organisations, practitioners and NGOs (including VSO).

While many policies and commitments made by national governments and international organisations make the connection between gender and HIV & AIDS explicit, these commitments are not always strongly implemented. The shortfall between policy and practice is sometimes startling. Training and support received by frontline staff – especially those in the public sector – are in short supply. Women and men lack knowledge of the rights and services available to them. These shortcomings undermine the effectiveness of well-intentioned national policies and laws intended to uphold women's rights.

Poverty and entrenched beliefs about female and male sexuality underlie the spread and impact of HIV and AIDS. Partners highlighted key manifestations of gender inequality which need to be addressed.

Key manifestations of gender inequality in relation to HIV and AIDS

- Gender violence is linked to HIV transmission through rape, and reduces the ability of women and vulnerable men to discuss sex with their partners.
- Unequal rights to property mean that women may be forced out of their homes when widowed or diagnosed with HIV. This increases their vulnerability to illness and the need to undertake sex work.
- The burden of caring for the sick falls predominantly on women, compounding their domestic responsibilities and reinforcing stereotypes about gender roles.
- Unequal access to treatment means that fewer women than men are treated for HIV and AIDS-related illnesses, directly increasing the impact of the epidemic on women.
- Unequal access to appropriate prevention information for women, and for men who have sex with men, increases both groups' vulnerability to HIV. Groups targeted by specific prevention interventions risk becoming stigmatised in the larger population.

The principal findings of the research also indicate that emphasis must be placed in three main areas to make responses to HIV and AIDS more effective by addressing gender inequalities.

The 'three-pronged' approach

- increasing the constructive involvement of men in activities and interventions designed to reduce gender inequalities and minimise the impact of HIV and AIDS
- continuing to focus on directly empowering women to attain equality in the family, the workplace and the community by ensuring, in particular, that existing policies and commitments supporting women's rights are implemented
- addressing the immediate needs of women affected by HIV and AIDS, for example, as carers within the family and community; as people suffering from gender violence; and as individuals requiring treatment and attention for HIV and AIDS.

Organisations working in this field also recognise that greater support must be given to men's and women's groups trying to change the perceptions of masculinity and femininity that reinforce gender inequalities and fuel the spread of HIV. Effective ways for constructively involving men include:

- paying greater attention to men's motivations and vulnerabilities when designing policies
- identifying and publicising role models for younger generations
- pre-emptive work with and support for violent men
- using traditional positive roles to enhance men's understanding of the impact of their behaviour on others, and their sense of self-worth.

In response to these challenges, VSO is prioritising HIV and AIDS across its programmes. We will also seek to strengthen the design and implementation of policies that affect our partners' work as part of AIDS Agenda, VSO's international advocacy campaign based on the findings and recommendations in this paper.

Tackling these issues is complex and requires changes in policy and practice at many levels. NGOs and civil society groups have a vital role to play in implementing much-needed services and aid, but should also directly assist in developing and monitoring policies underlying such interventions. National governments and international organisations have already made a wide range of commitments which would go a long way to reducing gender inequalities and their impact on HIV and AIDS if they were effectively implemented. International NGOs, including VSO, must continue to provide direct support to organisations making a difference, while working to strengthen the international policies that most affect developing countries.

VSO makes the following recommendations to all stakeholders as an important starting point for making this happen. (See page 48 for detailed recommendations.)

- Recognise that HIV and AIDS work will only be effective if the inequalities between women and men are taken into account
- Design and plan HIV and AIDS programmes which:
  - increase the constructive involvement of men
  - empower women by implementing existing policies
  - meet the immediate needs of women
- Include in HIV and AIDS programmes a full gender analysis based on the different needs and roles of women and men. This should look specifically at policies and laws, and identify the key areas of interface between HIV & AIDS and gender
- Change the norms of discourse on gender to include men in a constructive way
- Consider the needs of men who have sex with men in HIV and AIDS programmes, and include these groups in project design, implementation and monitoring
- Consider as part of further HIV and AIDS programme research, analysis and planning the following key manifestations of gender inequality: gender violence, unequal rights to property, the burden of care, unequal access to treatment and unequal access to appropriate prevention information
- Prioritise training and support for frontline staff in the public sector – police, nurses and doctors, social workers, magistrates – as an institutional means of addressing gender inequality and HIV & AIDS
- Prioritise changing institutional practice towards giving women and men access to accurate information about rights and services in a way that can be understood by everyone, including the non-literate and those with disabilities
- Ensure that HIV and AIDS programmes do not increase the burden on women.

Footnote: 3. ie a country with a medium Human Development index ranking

Introduction

Nearly one in 100 people worldwide is living with HIV and AIDS, rising to one in three in some parts of Southern Africa. The number of women contracting HIV has surpassed that of men in some areas, and the impact that HIV and AIDS is having on women and girls is becoming greater than the impact on men. Despite increased international attention and funding, many donors and Northern governments have still not fully responded to the crisis. The majority of women and men living with HIV and AIDS lack effective treatment or support. Many people still uninfected do not have the information or skills necessary for self-protection.

Despite the huge amount of work still to be done, the number of successful interventions is growing, as is an understanding of what works. In particular, policy-makers have been able to respond more effectively to the epidemic when they have listened to people living with HIV and AIDS who have led the demand for appropriate services and interventions.

Many actors, including civil society organisations, national governments, academics, international NGOs (INGOs) and other donors, have been working on ways of integrating action focused on gender and HIV & AIDS. VSO hopes to make a distinctive and useful contribution to this debate by strengthening the work that is going on at the grassroots, while placing it in an international and national policy context.

This paper draws together priorities expressed by partner organisations, stakeholders and VSO programme offices, based on research carried out in South Africa, Namibia, India and Cambodia from February to May 2003. Founded on the experience of these stakeholders, the basic premise of the research is that gender inequality lies at the heart of the epidemic. This paper does not aim to provide a comprehensive analysis of HIV & AIDS and gender inequality; it focuses solely upon issues that emerged and were prioritised during the course of the research.

WHAT DO WE MEAN BY 'GENDER'?

When discussing development, 'gender' is often used as shorthand for the social roles of men and women, as opposed to their biological roles in conceiving, giving birth to, and breast-feeding, children. Socially constructed gender roles (for example, bringing up children, growing food, working for the community, trading, caring for the sick, standing for parliament, making family decisions) vary in different cultures, and are subject to change over time.

Gender roles tend to be linked to gender inequality, that is, the unequal relations between women and men, with women generally being disadvantaged. This is because **in many parts of the world, the unequal division of labour, assets, property and other resources are at the core of relations between women and men.** For example, women often have a heavier burden of work in their double roles of managing the household and earning money as a farmer or trader. Women may own less property than men of the same class or caste; they may not have the right to their own home or land when their husband or father dies; and as workers they may be paid less than men and have fewer opportunities to earn money or sell goods.

Gender inequality means women may suffer from domestic violence, which may be sanctioned by society's view that it is men's role to assert their authority through force. Women may have limited choices about entering into sexual relationships or having children. They may also be seen as less worthy of education or medical treatment. **Gender issues are thus not 'women's' issues, but issues arising from this unequal relationship.**

Women and men both experience other forms of disadvantage, such as prejudice against race, class, caste, age and disability. Together with gender, these can result in multiple forms of disadvantage. In the context of economic and social disadvantage, this can deepen the negative impact of poverty on the well-

being of girls and women. It also explains why there are often significant differences in the ways in which women and men experience poverty.

In development, women's right to equality with men is thus both a means – an effective approach to development - and an end – where equality is a benchmark of success in improving the quality of life for both men and women. In the context of HIV and AIDS, this report demonstrates that maintaining the gender status quo also disadvantages men as they become more vulnerable to the virus, and less able to mitigate the impact on themselves and their families.

GENDER INEQUALITY AT THE HEART OF THE EPIDEMIC

Since the early years of the epidemic, women's groups, feminists, academics, NGOs, activists and people living with HIV and AIDS have pressed for recognition of how inequalities between women and men contribute to the spread of HIV and AIDS. **Deeply entrenched beliefs about female and male sexuality mean that women generally have less power than men to decide with whom, how and when they have sex.** These beliefs are reinforced by a number of factors, including poverty, age or disability, but may still affect women who are financially independent, or middle or upper class.

> When the inability of poor women to negotiate their sexual relationships was mentioned during a consultative workshop in Delhi, a female lawyer stood up and (very bravely) stated that this had nothing to do with poverty. She gave her own example as an articulate and educated professional from a privileged background, but she still had no say nor power in her sexual relations with her husband.

Rakhi Sarkar, programme officer, VSO India

Poverty and women's economic dependence on men do however reinforce the difficulties women and men have in discussing sex. **Poor women and men are less likely to possess the information, awareness and skills to be able to protect themselves from HIV transmission.**

Financial constraints also mean governments in developing countries are less likely to be able to provide the information, treatment and care necessary to reduce the spread of HIV and AIDS and alleviate their impact. In turn, HIV and AIDS deepen the effects of poverty and disadvantage, which are experienced differently by women and men.

> A major issue in my experience (linked to unequal property rights, I guess) is women's economic dependence on men. It is culturally accepted that men pay for their women, whether outright payment in money for food or sex, or more sustained support of girlfriends or wives. I often heard boys at school complaining that their girlfriends were always asking for money or cool drinks; that all women are after is money. In my experience here, this is indeed often the case, but what choice do the women feel they have?

Clare Argyle, VSO teacher, Namibia

Many women's unequal access to, and control over, resources means they are much more vulnerable than men in economic terms. This further reduces their ability to discuss sex with their partners. The fact that women are paid less than men for doing the same jobs, while vital work carried out in the home and caring for family members is devalued, is apparent in the countries studied as part of the research. Economic dependency on men is acute in situations of desperate poverty, where there is no social welfare, or where cultural and social pressures make working outside the home difficult for women. Fear of abandonment and destitution means women can have extreme difficulty in negotiating sex, even when they

know that their partners have multiple relationships. A representative of Women Against Women Abuse (WAWA) in South Africa quoted a woman she'd worked with, saying that her husband told her: 'if you want me to have sex with a condom, I won't give you any money for food'.

Social norms about female and male sexuality make women especially vulnerable to contracting HIV in the context of poverty and inequality. According to local women's organisations, the vast majority of women living with HIV in India contract the virus through sex with their husbands. Namibian and South African organisations are concerned that the growth of the 'sugar daddy' phenomenon – older men giving school girls money for books and clothes in return for sex – is linked to men's perceptions that these girls are less likely to have HIV. Economic realities and social pressures to have the '3 Cs' – cellphone, cash and car – make refusing these advances difficult, and girls may actively seek out men for this kind of relationship.

Female condoms (and hopefully microbicides in the future) may be able to give women some power to protect themselves from HIV and AIDS. At present, the only realistic prevention method for the vast majority of women and men is a male condom, which requires male consent.

Last year a man tested positive for HIV at our clinic, and his wife tested negative. The wife came back to the clinic to be tested again because the husband gets angry when she asks him to use a condom.

Representative from CORRE, a centre for HIV and AIDS, Cambodia

SEX WORK

Partners in all four research countries say that HIV and AIDS is leading to growing numbers of women who have to turn to sex work as their husbands die or their property is taken. Women and men working as sex workers are particularly vulnerable to HIV transmission. This may be due to violence and rape (largely condoned by society) and economic necessity, which makes asking clients to wear condoms difficult. Young girls and women who are trafficked for sex work are exceptionally vulnerable, particularly as they may be taken to a country where they do not speak the language. For example, many of the sex workers in Cambodia are Vietnamese, and although some are literate, few can read or speak much Khmer.

If a woman can't feed herself, why would she worry about a disease that might kill her in ten years' time? If a client offers to pay twice as much for sex without a condom, the need for money may overtake everything she knows about HIV and AIDS.

Representative from Jagruti, an organisation working with sex workers, India

In general, sex work is more formal in India and Cambodia than in South Africa and Namibia. Sex work in India mainly takes place in brothels or on the street, where male sex workers are most often based. Dalit women (from the lowest caste) are among the most vulnerable to being forced into sex work as a result of the extreme disadvantages they face. In Cambodia, the crackdown on brothels as part of the government's 100% Condom Use campaign, and the closure of some karaoke bars, have now contributed to the development of a less formal sex work sector, leading to an even less safe environment for sex workers. Sex work in South Africa and Namibia tends to be less formal, with blurred boundaries between 'transactional sex' for food or rent and more formal sex work. These issues apply equally to male sex workers, who may be especially vulnerable due to stigma surrounding male-to-male sexuality.

VSO'S RESPONSE TO HIV AND AIDS

VSO volunteers working in Sub-Saharan Africa, and increasingly in Asia, see the impact of HIV and AIDS and gender inequalities, whether they are teachers,

fundraisers or health professionals. They witness the effect HIV and AIDS is having on friends and colleagues, the organisations they work with and countries as a whole. While VSO recognises that responding effectively to HIV and AIDS is a huge challenge, we have made HIV and AIDS an organisational priority. VSO aims to combat stigma, support prevention efforts and increase the availability of treatment, care and support for those infected and affected by HIV and AIDS in the countries where we work. The role of VSO volunteers, as skilled professionals working alongside colleagues and living in the community, provides the core of support that VSO offers.

VSO's Regional AIDS Initiative of Southern Africa (RAISA) involves all VSO volunteers in HIV and AIDS prevention, with colleagues in the workplace and friends in the communities in which they live. Volunteers also see the effects of gender inequality first hand in their relationships with colleagues and friends. VSO is striving to address gender inequalities as an integral part of our work on HIV and AIDS and supports volunteers working in a wide range of organisations addressing gender issues, from People Against Human Abuse (PAHA) in South Africa to Men for Change in Namibia.

Sam Mwaura is a VSO volunteer from Kenya. He works as a management adviser at PAHA (People Against Human Abuse), a community-based organisation (CBO)in Mamelodi township outside Pretoria, South Africa. PAHA was set up to address the rising rates of violence against women in Mamelodi, and helps women who have been abused to seek legal advice and support. Sam is helping PAHA to develop and gain increased funding. PAHA now also addresses HIV and AIDS – which it believes to be inextricably linked to gender violence – by holding community meetings in the local church hall. Women and men from the different communities in Mamelodi come together to discuss HIV and AIDS, how to support those infected or affected, and how to prevent further infections.

VSO is building on the RAISA programme and our international advocacy work to address HIV and AIDS work across our programmes. We believe that people living with HIV and AIDS are the real experts on the epidemic, and we endeavour to put into practice the principle of the greater involvement of people living with HIV and AIDS (GIPA). VSO has carried out advocacy work on increased access to treatment for HIV and AIDS We firmly believe that equal global access to treatment is a human right that must be prioritised urgently by donors, pharmaceutical companies and Southern and Northern governments[1].

1: Under its Treatment for Life campaign, VSO advocated for greater access to treatment for HIV and AIDS-related illnesses. Three publications were produced as part of this campaign – *Drug Deals*, *Street Price* and *Beyond Philanthropy* – all of which are available on our website: www.vso.org.uk/advocacy/hivaids_papers.htm

RESEARCH METHODOLOGY

The purpose of the research captured in this paper is to provide a basis for advocacy at national and international levels. VSO ran a workshop with partner organisations and programme offices to refine the research parameters, then conducted qualitative research in South Africa, Namibia, India and Cambodia from February to May 2003. These country programmes were selected on the basis of programme office interest, the need to represent both Asian and African experience, the programme focus and the country situation. Organisations and individuals consulted during the research included VSO partner organisations, groups of people living with HIV and AIDS, women's and men's organisations, activists, VSO volunteers and other stakeholders. For a full list of organisations consulted during the research please see the Appendix on page 50. The VSO RAISA conference on Men, HIV and AIDS, held in South Africa in February 2003, made a valuable contribution to the research.

Organisations participating in the research were interviewed or took part in roundtable discussions. They were asked where lack of rights, and HIV & AIDS and gender inequality overlap, and what needs to happen to strengthen the implementation of policies. VSO then analysed the findings for common themes at national and international levels. The organisations taking part in the research were very diverse, and this analysis does not necessarily represent all their views.

THE STRUCTURE OF THIS PAPER

This position paper is divided into three chapters. The first lays out the areas where organisations involved in the research believe inequality between women and men must be addressed as a matter of priority in order to halt and mitigate the spread of HIV and AIDS. The second maps out the international and national policy environments in which efforts to address these issues take place, and describes the shortfall between commitments and their implementation on the ground. The third chapter describes the responses that organisations taking part in the research believe are necessary to address these issues. Finally, there is a summary of recommendations for different groups of stakeholders.

Chapter 1
HIV & AIDS and gender inequality

If there was equality between women and men, this epidemic would not have occurred.

Representative from UNIFEM, India

KEY POINTS

- Social expectations about women's and men's behaviour reinforce gender inequalities and exacerbate the HIV and AIDS epidemic.
- Specific manifestations of gender inequality need to be addressed as a matter of priority in order to reduce the spread of HIV and AIDS:
  - Gender violence is linked to HIV transmission through rape, and reduces the ability of women and vulnerable men to discuss sex with their partners.
  - Unequal rights to property mean that women may be forced out of their homes when widowed or diagnosed with HIV. This increases their vulnerability to illness and sex work.
  - The burden of caring for the sick predominantly falls on women, increasing their domestic responsibilities and reinforcing stereotypes about gender roles.
  - Unequal access to treatment means that fewer women than men are treated for HIV and AIDS-related illnesses, directly increasing the impact of the epidemic on women.
  - Unequal access to appropriate prevention information for many women, and for men who have sex with men, increases their vulnerability to HIV. Groups targeted by specific prevention interventions risk becoming stigmatised in the larger population.

This chapter examines the issues of gender inequality that affect the spread of and treatment for HIV and AIDS, as described by the organisations and individuals taking part in the research. Participating organisations argue that some of the ways that boys are socialised into becoming men and certain social constructions of masculinity undermine HIV and AIDS prevention efforts. Together with issues surrounding sexuality, poverty and economic dependence outlined in the introduction, women and men are consequently more vulnerable and at greater risk of contracting HIV and AIDS.

This chapter examines the specific manifestations of these issues identified during the research. They are gender violence, unequal rights to property, the burden of care, and unequal access to treatment and to appropriate prevention messages. These are causally linked to the spread of HIV and AIDS and compound the impact of the epidemic on women.

It is assumed that these issues are played out in a broader developmental context of widespread poverty, North–South inequality, poorly resourced public services, poor coordination between donors, civil

society and government, and, for various reasons, civil society's difficulty in raising concerns with governments and donors.

THE CONTEXT OF THE RESEARCH COUNTRIES

The four countries where research took place differ widely regarding:

- the respective stages of the HIV and AIDS epidemic
- how inequality between women and men manifests itself
- how governments and donors have responded.

Although it is important to take these differences into account when designing responses, there is much valuable experience that can be shared between the countries, and taken to an international level.

In a school in the Caprivi that I recently visited, out of a student population of 200, over 90 students had a close family member – mother, father, brother or sister – who had died of AIDS.

Daan Gerretsen, country director, VSO Namibia

Namibia

Namibia has one of the highest HIV and AIDS prevalence rates in the world, with 22.5% of all adults (aged 15–49) living with HIV or AIDS, and 24.3% of women aged 15–24 living with HIV or AIDS[2]. However, these figures hide dramatic differences between and even within regions.

The HIV and AIDS epidemic is highly visible in Namibia, with the majority of hospital beds now occupied by AIDS patients. Despite this level of visibility, stigma is still high; there are often extremely difficult repercussions for those brave enough to speak about living with HIV and AIDS. For example in April 2003, *The Namibian Newspaper* reported the suicide of a young woman who felt that she could no longer cope with the stigma of being public about her HIV status.

South Africa

South Africa has the highest number of people living with HIV and AIDS in the world – currently 20.1% of the total adult population[2]. This overall figure masks some alarming disparities: when the figures are disaggregated for sex and age, the prevalence rate of HIV in girls and young women aged 15–24 is almost twice that of boys and young men of the same age[2].

India

India has a rapidly growing HIV and AIDS epidemic, with cases in all States and Union Territories. UNAIDS figures state that 0.8% of the total adult population (15–49) is living with HIV or AIDS, with 1.5 million women aged 15–24 living with HIV and AIDS[3]. However, many organisations and individuals interviewed for the research disputed these figures, suggesting that insufficient surveillance sites have been set up to portray the real picture. Their experience suggests that the true figures are higher, and certainly the overall figures mask localised epidemics. The stigma surrounding HIV and AIDS in India, for example, is so extreme that a representative of Social Welfare Association for Men [SWAM] in Chennai says that his sisters are unable to marry because he is known to be living with HIV and AIDS.

Cambodia

Prevalence rates in Cambodia dropped significantly from 3.3% in 1997 to 2.6% in 2002[2]. In 1997, groups categorised as 'high risk' were identified – sex workers and their clients, the military and the police – and transmission rates within these groups have significantly declined. For example, the number of men who contract HIV from sex workers, as a percentage of the total number of people contracting HIV, has declined from over 80% in 1990 to under 20% in 2000. Over the same time, however, the epidemic has become more generalised. The number of women who contract HIV from their husbands has increased from

2: UNAIDS, WHO, UNICEF, Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 Update
3: Human Rights Watch (2001) *Scared at School – Sexual Violence Against Girls in South African Schools, Section VI*

10% of the total to over 50%, and parent-to-child transmission (PTCT) has increased from being 1% of the total to 20%[4]. In both India and Cambodia, the epidemic has reached the stage where people are becoming visibly ill, and the need for effective care is becoming acute.

MASCULINITY AND ISSUES FOR MEN

Almost all research respondents prioritised involving men to combat and deal with the effects of gender inequalities on HIV and AIDS. Organisations consulted during the research in all four countries agree that the way that many men are expected to act by their peers is a major barrier to involving men in efforts to reduce the spread of HIV and AIDS. It also makes men and women more vulnerable to the virus.

Most cultures socialise men into believing that it is integral to being a man to take risks – particularly sexual ones, including having regular sex with multiple partners. For example, there is a belief among truckers in India that sexual release is vital after every 400km of driving to relieve tension. Men are also often expected by their peers and wider society to use alcohol and drugs; to display dominant, sometimes violent, behaviour to women and men perceived to be weak or effeminate; and to act as breadwinners for their families.

In conjunction with HIV and AIDS, these beliefs about masculinity make it much more difficult for men to protect themselves and their partners, or to take on much of the increased burden of care as a result of HIV and AIDS.

Lack of local, visible and 'positive' male role models makes redefining masculinity more difficult for men who would like to challenge these restrictive beliefs. Men's organisations in South Africa and Namibia argue that social change is leading to greater pressures on men, as traditional masculine roles change and appear threatened by greater female freedoms.

Assumptions of male superiority appear to be threatened by the new South African constitution, and by female success, and boys are perceived to be extremely vulnerable to humiliation by girls in schools.

Professor Graham Lindegger, University of Natal, VSO conference: Men and HIV & AIDS

It is also important to recognise that not all men's behaviour is problematic, as the majority do not place themselves or their partners at risk[5]. Many men resist the more negative behaviours associated with these ideas about masculinity, but the pressures are very real and difficult to withstand, particularly for young men. Again, this highlights the need for positive and accessible male role models.

It would be wrong to assume that men are responsible for the spread of HIV. To do so would be to repeat the mistake of blaming other sections of society for AIDS, just as homosexuals, prostitutes and foreigners have been made scapegoats for the epidemic before. The risk of contracting and passing on HIV is high among men who have unprotected penetrative sex with multiple sexual partners. But other sections of society who do not necessarily behave this way can also run a risk of contracting and passing on HIV.

David Lush, Lirongo Eparu, a Namibian organisation for people infected and affected by HIV and AIDS

While it is easy to blame all or some men for their behaviour, understanding the pressures facing men – particularly those who are poor and marginalised – is more difficult. While men largely have greater power than women, many men are not powerful, and are deeply burdened by social expectations of providing economically for their families.

4: National Centre for HIV/AIDS, Dermatology and STDs, Cambodia, HIV Sentinel Surveillance 2002 www.NCBI.NLMINIH.gov

5: Martin Foreman (1999) *AIDS and Men: Taking Risks or Taking Responsibility* London: Panos/ Zed Books

However, male and female roles should not be equated: the pressures men and women face are not equivalent, and recognising those faced by men in no way undermines the fact that in virtually every sphere of life women are disadvantaged – especially women who are poor, older, from an ethnic or religious minority or who have disabilities.

Men who have sex with men may be particularly vulnerable to HIV and AIDS, and may transmit the virus to both their female and male partners as a result of discrimination and secrecy about male-to-male sexuality. Men perceived to be effeminate, particularly those known to have sex with other men, may face violence and threatening behaviour from other men. Detailed data about the extent to which HIV and AIDS affects communities of men who have sex with men in the research countries does not appear to be available, as stigma and secrecy makes it difficult for many men to come forward. In India particularly, women's and men's organisations feel that male-to-male sexual activity is having a marked impact on the course of the epidemic, but that communities are hard to reach, or in some cases even to identify. This issue is discussed further under Unequal access to appropriate prevention information on page 22.

MANIFESTATIONS OF GENDER INEQUALITY

Poverty, economic dependency, and negative constructions of masculinity are manifested in specific ways. VSO's research shows that these need to be tackled in order to reduce the spread of HIV and AIDS and to bring about longer-term change in relations between men and women. These manifestations are gender violence, unequal rights to property, the burden of care, unequal access to treatment, and unequal access to prevention information.

Gender violence

I think that the effect of violence against women is the most urgent issue that needs addressing in relation to HIV and AIDS. I experienced cases of female colleagues being beaten by their husbands, and don't doubt that they are sometimes also forced to have sex. I also heard of a lot of stories of girls in the school hostel being beaten and coerced into having sex.

Clare Argyle, VSO teacher, Namibia

Gender violence occurs in all societies and seldom attracts social sanctions or legal punishment. According to a recent study, 21% of women in the Netherlands and 39% of women in the USA have experienced intimate partner violence at some point in their lives[6]. **Gender violence is causally linked to HIV and AIDS transmission and may also be a punitive reaction to a positive HIV diagnosis within a relationship.** At the extreme end of the continuum of gender violence is rape, when transmission is more likely than during consensual sex, but partner organisations argue that in many cases the threat of violence is enough to prevent a woman from discussing condom use with her partner.

We are experiencing a civil war against women.

Representative from Women Against Women Abuse, VSO roundtable meeting, South Africa

The reality or fear of violence makes it very difficult for women around the world to raise sexual issues. **Organisations in Namibia and South Africa in particular highlighted violence against women as a major concern, and a driver of the epidemic.** A survey of 37,000 young men in South Africa in 2000 found that one in four had had forced sex without the woman's consent by the age of 18; eight out of ten thought women are responsible, or partly responsible, for

6: The British Council Study (1999) *Violence Against Women: A Briefing Document on International Issues and Responses* page 9

sexual violence; and two in ten thought that women being raped enjoyed it[7].

Family Life Centre in South Africa argues that relations between women and men, particularly young women and men, are now almost at breaking point. Organisations and individuals interviewed for the research were uncertain whether overall levels of violence were in fact rising, or whether more cases are being reported. However, most agreed **that the HIV and AIDS pandemic is itself causing more violence, as male fear and frustration is taken out upon their partners and female relatives.** Male rape is a rarely discussed aspect of gender violence, yet also takes place in all societies; the associated shame and stigma makes men who have been raped very reluctant to speak out.

Sexual violence in schools: Namibia

Sexual violence in schools appears to be on the rise, with date rape and gang rapes of young women taking place frequently in Namibia. Most young people at school in Namibia stay in hostels and so may be particularly vulnerable. Boys are reported to form gangs and, as a result of peer pressure, influence each other to gang rape the girls – a practice known as 'tournaments' or 'hunting'. In some cases, to join a gang a boy must let the rest of the group rape his girlfriend.

Gang rapes in schools are an epidemic.

Representative from Women's Solidarity Namibia

Partners in India agree that violence is an issue and one of the underlying causes of the pandemic, but feel that there is simply not enough research to know the extent of the problem. Incidents of gender violence and gang rape in Cambodia are rising, as social controls are perceived to be breaking down. One study suggests that as many as 75% of Cambodian women have experienced gender violence[8].

Common to all four countries is the pressure and blame faced by women if either they or their partner receive an HIV positive diagnosis. In South Africa and Namibia, where the majority of diagnoses are made during pregnancy, a particular concern is violence against women who are diagnosed HIV positive antenatally. This is leading to increased violence and abandonment. One Namibian organisation interviewed, which counsels rape and gender violence survivors, said that some men's response on diagnosis is to say, 'I'll find the nearest woman and rape her'. **Men tend to be diagnosed before women in India, because in the current stage of the epidemic they are mainly getting ill first. Women are still generally blamed for the infection and are frequently subject to violence and property grabbing** (see Unequal rights to property on page 20).

Women experiencing violence or abandonment as a result of their HIV status in all four countries face huge difficulties in finding alternative housing. There are simply not enough shelters, especially for women with children, and poverty makes finding somewhere to rent very hard. This can lead to women being forced either to stay with the man who is abusing them or to go into sex work to feed and house themselves and their families.

Unequal rights to property

Women living with HIV and AIDS, particularly widows, are very vulnerable to property theft from their relatives.

Representative from Positive Women's Network, India

Unequal access to and control over property is one aspect of women's economic dependency raised during research in all four countries. **Difficulty in inheriting**

7: Tina Sidaris (2003) Negotiating 'Culture' and 'Rights' in Intimate Relationships: Changing Men's Practices in a Rural Area of South Africa WISER. Unpublished draft of preliminary findings of ongoing research

8: Elisabeth Rehn and Ellen Johnson (2002) 'Women War-Peace: The Independent Experts Assessment', *Progress of the World's Women Volume* I UNIFEM

property, particularly after a husband's death, makes women more vulnerable to HIV transmission and reduces women's ability to access care and treatment. This is of particular concern in India, especially in relation to property inheritance. According to the Positive Women's Network, widows in India are exceptionally disadvantaged, as culturally they tend to be regarded as having very low status in the household. A woman whose husband has died in the first year of marriage may be regarded as particularly unlucky. Women widowed (often very young) by HIV and AIDS are doubly marginalised as a result of stigma. They may be thrown out of their homes, or sent back to their parents' homes without their dowry or jewellery. Alternatively, the property may be sold to finance the husband's treatment.

If a woman turns to legal channels, the relatives may slow down the proceedings in the belief that she will die soon anyway. Accessing legal services in India is particularly difficult for women who earn a daily salary, as it means missing out on wages. Access to and control over property in Cambodia is also deeply unequal, and is linked to the HIV and AIDS epidemic, with one study indicating that 46% of landlessness in Cambodia is linked to health care expenditure[9].

Partners and stakeholders in Namibia feel that unequal property inheritance is relevant to the HIV and AIDS pandemic, but that it also needs to be seen in the wider context of the Namibian debate over land redistribution and extreme inequality of income distribution. Widows in Sub-Saharan Africa may also be vulnerable to a wider range of abuses, including 'widow inheritance'[10] from the husband's relatives and being turned out of their homes on receiving a positive HIV diagnosis. This is clearly particularly serious when diagnosis is made as part of routine testing during pregnancy, resulting in homelessness for the woman.

The burden of care

As in most places, it was always the women/girls who were expected to take care of ALL sick people, not just AIDS sufferers; this became evident in absences from school.

Clare Argyle, VSO teacher, Namibia

In all four countries, women are shouldering a disproportionate burden of care. Women are more likely to give care and less likely to receive it. Women's traditional domestic roles are being expanded by having to care for sick relatives or members of the community. The increased poverty associated with HIV and AIDS means that many women are undertaking additional jobs as breadwinners. Organisations in Cambodia say that women are more stigmatised by HIV and AIDS than men, and receive less support.

African men in general and Namibian men in particular still believe that there is always a division between men and women. That means men regard light work as for woman while heavy work is for them. Therefore, since HIV and AIDS work doesn't involve visible physical work, they think that's women's work. In Owambo culture, a man who works with or among women is regarded as a woman with a man's skin. From that belief or kind of behaviour, men are under pressure from other men as well as from women.

Representative from TKMOAMS (Tate Kalungu Mweneka Omukithi wo 'AIDS' Moshilongo Shetu – translation: Our Mighty Father Protect Our Nation From The Deadly Disease 'AIDS'), Namibia

Older women in all countries are particularly affected, as they often have to care for grandchildren after their own children have died:

9: Robin Biddulph (2000) *Cambodia Development Review*, Volume 4, Issue 3

10: a practice common in some parts of Africa where a widow may be taken in to one of her husband's brothers' homes to be one of his wives, or may have to have sex with one of her husband's relatives in order to 'cleanse' her of his spirit.

Grandmothers are bearing the largest burden of the epidemic, especially as sick male family members come back to be cared for.

Maria Breeuwsma, VSO volunteer, Catholic AIDS Action, Namibia

Very little material or psychological support is available to help relieve this burden of care, which is undermining the extended family system in much of Southern Africa. Men's lack of involvement in caring responsibilities may also mean that they are somewhat removed from the gravity of the situation, while stereotypes about gender roles are increased.

Unequal access to treatment

Access to health care – in the broadest sense – is not equal. Where treatment is available, women are less likely to access it than men. VSO believes that global equal access to treatment and care is a human right. **Equal access to treatment (including antiretroviral drugs (ARVs)), care and accurate prevention messages are crucial to slowing down the HIV and AIDS pandemic.**

Economic dependency means that poor women are even less likely than poor men to be able to afford to access treatment, and cultural norms may dictate that men's treatment is a priority. Organisations in South Africa say that women are less able to afford treatment than men, and as a result more women are now dying than men. Care organisations in India say that on average only 25% of hospital beds are taken by women, partly because men are seen as a treatment priority due largely to their role as breadwinners. Women in India may also face pressures not to travel alone – yet another barrier they face in accessing treatment and care. Much of the focus to date in India has been on prevention rather than care, with the result that women are even less likely to be able to access the treatment that is available, as care services are under resourced.

Because of lack of money, a woman who used nevirapine successfully to prevent HIV transmission to her child was forced to breast-feed, and her child later contracted HIV and AIDS.

Hans van der Windt, VSO volunteer, Lirongo Eparu, Namibia

Individuals and organisations consulted during the research in India feel strongly that the emphasis must shift towards a more balanced approach to treatment and prevention, as the epidemic has reached the stage where people are becoming ill. Access to post-exposure prophylaxis for rape, and supplies of drugs to prevent parent-to-child transmission are unreliable in all four countries.

Unequal access to appropriate prevention information

This lack of behaviour change stems from the total imbalance between men and women.

Representative from Family Health International, Namibia

Prevention messages are not translating to generalised behaviour change in any of the countries where research took place. Prevention messages take place against a background of a lack of awareness about reproductive health – Namibian women's group Sister Namibia say that many Namibian women are unsure of how their bodies function and to whom their bodies belong, with, for example, little knowledge of how conception takes place.

The factors that predispose women to ill health in general also increase their vulnerability to reproductive ill health and HIV. The majority of women in India enter sexual relationships at an early age, coupled with ignorance, a lack of formal education and basic health information.

Rakhi Sarkar, programme officer, VSO India

In South Africa it appears that awareness-raising campaigns and prevention programmes are beginning to have an impact. However, there is concern that **despite all the prevention efforts, there are still many misconceptions about HIV and AIDS.** HIV prevalence rates fell from 21% in 1998 to 15.4% in 2001 amongst pregnant women under 20. However, HIV prevalence is continuing to rise among older pregnant women[11]. The same survey states that 24.3% of South Africans either have incorrect knowledge or don't know that HIV causes AIDS. Knowledge about transmission via breast-feeding is poor, with 46.8% of South Africans either uncertain or unaware that HIV can be transmitted through breast-feeding.

In South Africa, level of education is the social category that most strongly differentiates those with good and poor knowledge. For example, 59.9% of women and men with no education know that HIV transmission is not possible from touching an HIV-infected person, compared to 81.3% with primary level education and over 90% with high level school or higher education[12]. This is particular cause for concern given the growing gender gap in access to education[13].

Cultural norms of sexual ignorance and purity for women block their access to prevention information. Due to lack of awareness, many women in India generally have little ability to discuss or negotiate the use of condoms or their partners' previous and/or concurrent sexual contacts.

Rakhi Sarkar, programme officer, VSO India

There is very little sex education in Indian schools. As a result, organisations taking part in the research say that most Indian schoolchildren do not know what HIV is and children, particularly girls who do not attend school, are very unlikely to be able to access appropriate prevention information. Condoms are still not always available, particularly in India and in Cambodia where they have become strongly associated with sex work. Contraceptive messages in India to date have focused on sterilisation, and starting a discussion on barrier methods is difficult as a result. **Organisations involved in the research stress the need for female-controlled prevention methods, as a means of increasing women's power in relation to sex.** Prevention messages also need to be seen in the light of other issues which make discussing sex difficult for women and men.

Little information in the research countries addresses the needs of HIV positive women and men who want to have healthy children. Prevention messages focusing solely on condoms or abstinence do not address the desire of many women and men to have children, for a wide variety of reasons. For example, in some communities in South Africa, men are not considered to be fully adult until they have a child and are not able to take part in men's discussions. This lack of information emphasises the global inequality of access to treatment and care. In the North doctors routinely discuss eliminating parent-to-child transmission as a route of infection, while in the South around one-third of women give birth to children who are either already HIV positive or who become infected through breast-feeding, and have to watch their children die. This is contributing to a sense of hopelessness and inevitability about infection among young women in South Africa and Namibia, as the personal and social pressures to have children are so strong. Catholic AIDS Action in Namibia say that applications to join convents are on the rise, as young women see no other way of escaping infection.

Organisations in all research countries state that **the needs of men who have sex with men remain largely unaddressed.** This is often the result of an assumption that male-to-male sexual activity does not take place, or only on an infrequent basis. This can leave men who have sex with men exceptionally vulnerable to

11: UNAIDS, WHO, UNICEF, Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 Update] The groups most affected by the pandemic in South Africa are youth, African communities, the poorest and women, although a recent study suggests that no communities are untouched.

12: Nelson Mandela/HRSC Study of HIV/AIDS South African National Prevalence, *Behavioural Risks and Mass Media: Household Survey 2002*

13: Human Development Report 2003, UNDP

infection. Men who have sex with men are frequently subject to harassment from other men, who perceive them to be effeminate, and therefore less dominant. This kind of harassment, along with outright discrimination in many countries, means that men who have sex with men may be driven underground, making them harder to reach with prevention messages and condoms.

Indian culture puts pressure on homosexual men to be married in line with social norms as much for their family's 'respect' as their own.

Rakhi Sarkar, programme officer, VSO India

Men in India traditionally marry late, and many have sex before marriage, often with female or male sex workers. Lack of knowledge about sex can put them and their current and future partners at risk. Prevention messages in India have focused heavily on women, particularly female sex workers, as sources of infection. According to organisations working with men who have sex with men, this has led to a **fairly widespread belief that sex with another man will not lead to HIV transmission.** The majority of men who have sex with men in India are, or will be, married, and lack of appropriate prevention information places them and their wives or partners at risk. Indian NGOs see prevention work with men who have sex with men as a vital component of tackling the wider epidemic. Lack of recognition and services for men who have sex with men in South Africa and Namibia are also barriers to increasing men's constructive involvement and personal responsibility about HIV transmission.

Chapter 2
Gaps between policy and implementation

In Namibia we have good written policies and guidelines concerning HIV, but the problem is the implementation. You may have good policies and guidelines, but if you are not practically implementing them, they are worthless.

Representative from TKMOAMS (Tate Kalungu Mweneka Omukithi wo 'AIDS' Moshilongo Shetu – translation: Our Mighty Father Protect Our Nation From The Deadly Disease 'AIDS'), Namibia

KEY POINTS

- **Donors, governments and civil society do not take sufficient account of gender inequalities when planning programmes, although this forms part of their policy discourse.**
- **Some interventions reinforce existing gender roles and increase the impact of HIV and AIDS on women.**
- **Existing international commitments to address gender inequality are not being honoured, and may be overshadowed by new commitments. Separate international commitments on HIV and gender do not always link up.**
- **Strong national laws and policies are not always implemented, undermining attempts to reduce the spread of HIV and AIDS and to work towards gender equality.**
- **Lack of training and support to frontline staff – especially those in the public sector – undermine implementation of national laws and policies.**
- **Women and men lack knowledge of their rights and the services available to them. This undermines implementation of national policies and laws.**

This chapter examines international and national commitments to HIV and AIDS, gender equality and the specific issues outlined in Chapter 1. It looks at the extent to which these policies and laws are being implemented on the ground, and considers areas where implementation could be strengthened.

INTERNATIONAL COMMITMENTS

The international community and national governments have signed up to binding commitments and conventions, which, if implemented, would help ensure effective and lasting responses to HIV & AIDS and gender inequality. The main, binding, conventions relevant to both HIV & AIDS and gender inequality are:

- the Convention on Elimination of all forms of Discrimination Against Women (CEDAW)
- the 2001 Declaration following the United Nations General Assembly Special Session on HIV and AIDS (UNGASS)
- the Beijing Platform for Action.

While efforts are being made to meet the commitments laid out in these conventions, lack of policy coherence and effective enforcement

mechanisms mean that commitments are a long way from being met. The attention of the international community is now largely focused on the Millennium Development Goals (MDGs). It has been agreed that there will be a concerted effort to meet these in order to halve the numbers of people living in poverty by 2015. Unfortunately, the MDGs on HIV & AIDS and gender do not necessarily link up in the practice of the international community; the gender MDG is largely interpreted to be education related, instead of being analysed in relation to the other goals. There is a danger that the international community may not see these as mutually reinforcing goals, and may not link them into efforts to meet previous commitments.

The international community has paid greater attention to male roles and masculinity in recent years, highlighted by the UNAIDS World AIDS Day campaign 2000/01: Men Make a Difference. This reflects the Gender and Development (GAD) approach in development theory and practice, which examines the power relations between women and men, and echoes the priorities laid out in the 1994 International Conference on Population and Development (ICPD) held in Cairo:

> **Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning...prevention of sexually transmitted diseases, including HIV...control and contribution to family income...Special emphasis should be placed on the prevention of violence against women and children.**
>
> ICPD Programme of Action, paragraph 4.27

The need for gender interventions to include a focus on men was also emphasised at ICPD+5, and in the Beijing Platform for Action. **All major international organisations and donors acknowledge the links between HIV & AIDS and gender in their work.** UNAIDS, United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and of course United Nations Development Fund for Women (UNIFEM) all recognise the vital importance of gender in their efforts to tackle HIV and AIDS, and have acknowledged the need to involve men in their work. UNIFEM's Gender Equality Zones (GEZs) programme aims to mainstream gender equality and HIV & AIDS behaviour change in specific sectors. In India, UNIFEM is working with the Indian Railways, the world's third largest employer, to target women and men through a number of different entry points, including the railway schools, the unions and the management colleges. Other donors making explicit links between gender inequality and HIV & AIDS include the World Bank, the UK government's Department for International Development (DFID) and the Global Health Fund.

INGOs

International NGOs have been at the forefront of policy and practice concerning gender inequality and how it relates to HIV and AIDS. Among the many examples of INGO work in this area are:

- Catholic Agency for Overseas Development (CAFOD) with Men Against Violence in Nicaragua. Together they address the *machista* culture in Latin America, examining and challenging beliefs about male identity
- HIV/Gender Continuum, a tool developed by the International Planned Parenthood Federations (IPPF), allowing organisations to monitor the gender sensitivity of their HIV and AIDS interventions
- Oxfam GB's support to Lifeline Rape Crisis in South Africa for recruiting, training and supporting 12 HIV and AIDS counsellors to address practical immediate needs
- Stepping Stones' community-based approach, used by grassroots organisations around the world and supported by a network of practitioners, has always

emphasised the need for changes in gender, as well as intergenerational, relations.

DONOR DISCOURSE AND PRACTICE

Despite international commitments and explicit linkages between HIV & AIDS and gender inequality, policy often evaporates during implementation, making gender commitments appear weak at grassroots levels. This may be due to lack of commitment, will, understanding, or of a full gender analysis at all stages of planning cycles. It may also result from no one having overall ownership over implementation of gender policies.

> **Just because some men won't listen, doesn't mean that all men won't. Ignoring the responsible men increases stereotyping of male behaviour and undermines the men that genuinely want to be involved.**
>
> Representative from White Ribbon Campaign, Namibia

Despite the increased debate about men's involvement in academic and development discourse described above, **there is still a tendency among donors, governments and NGOs to assume that a gendered approach means a focus on women.** There are numerous reasons why some donors, NGOs and governments still largely retain a focus on women, rather than on relations between women and men. Some of the reluctance can be attributed to the fear that resources will be cut from projects aimed at empowering women in order to fund men's projects. This concern is understandable given the perceived decline in resources allocated to tackle gender issues. Fear of increasing negative impacts on women if men 'take over' women's projects also exists. The White Ribbon Campaign in Namibia argues, however, that policy-makers sometimes use received beliefs about men's actions as an excuse for inaction. This means that the needs of the many men who do not act irresponsibly are not met, and perpetuates racist stereotypes about African male behaviour.

In reality many interventions focusing on women emphasise their subordinate roles instead of seeking to address gender relations and empower women. This can actually add to the burden on women while losing out on men's potential contribution to HIV and AIDS work. For example, respondents in both South Africa and Namibia feel that the traditional focus on women as recipients of development projects has sometimes placed an even greater burden of response to HIV and AIDS on women, while making men feel marginalised and disempowered. They argue that this actually increases violence, and hence HIV and AIDS transmission. At one roundtable discussion in South Africa, People Opposing Women Abuse (POWA) said that **women perceived to be empowered are now more likely to be attacked, because work with men has not taken place alongside work with women.**

Interventions may reinforce existing gender roles without reducing immediate needs, such as:

- interventions which increase the burden on women by focusing solely on their domestic roles, for example by supporting home-based care as a solution, without considering the impact this will have on women, and their existing burden of care
- interventions which suggest that women are vectors of disease, for example by focusing on sex workers as the main source of transmission
- interventions which increase men's perceptions of exclusion, for example by supporting women's groups without offering men's groups any support.

Examples of these types of intervention and weak implementation of international commitments are given within the country contexts below.

COUNTRY CONTEXTS AND NATIONAL POLICY FRAMEWORK

As a result of hard work on the part of national governments and civil society organisations, policies and laws addressing international commitments (such as CEDAW) and the issues described as priorities by partners are largely in place. Common issues raised by partners in all countries are the extent to which:

- HIV and AIDS is mainstreamed throughout and coordinated by government departments
- gender inequality is understood to be at the heart of the epidemic.

HIV and AIDS is still largely seen as a health issue by many donor agencies and national governments, and the links between HIV & AIDS and gender are often made either superficially or not at all. Where grassroots action is taking place – for example, with the burgeoning men's movement in Southern Africa – it is hard to ascertain how far policy has influenced action. Power relations between North and South, donors and national governments are complex and vary greatly between the four countries where research took place.

Namibia

Donors play a major role in Namibia's economy, despite its classification as a middle-income country. Increasing amounts of aid focus on reducing the spread of HIV and AIDS. The World Bank and the European Union (EU) are major multilateral donors, while the bilateral donors are represented by USAID, DFID, the Netherlands, Sweden and Germany. Namibia's application to the Global Fund for AIDS, TB and Malaria (GFATM) has been approved, and this, together with increased USAID money, will bring substantial aid into the country. Research participants welcome this, but express concerns over lack of capacity to spend the money, and problems around coordinating the response.

Partners report a genuine political will to tackle HIV and AIDS in Namibia, with relatively effective mechanisms in place to address underlying causes, including gender. The management of the pandemic through the National AIDS Committee (NAC) is placed outside the Ministry of Health and Social Services. This has led to a fall in the perception that HIV and AIDS are simply health issues.

The National Strategic Plan on HIV and AIDS (Medium Term Plan II) 1999–2004 lays out priority areas for action, and structures to implement them. Focus areas are:

- increased information
- information, education and communication (IEC) materials
- increased condom supply
- provision of care and support.

The recent creation of the Ministry of Women and Children's Affairs has expanded the focus on gender within HIV and AIDS. However, some women's and men's organisations feel that this has increased perceptions among men that not only are resources being unfairly channelled to women, but that responding to HIV and AIDS can be left to women – despite the Ministry's work with men's groups. This reinforces men's perceptions that gender means women, and that they do not need to get involved – a view that is particularly damaging in relation to HIV and AIDS.

Global Fund for AIDS, TB and Malaria in Namibia

The Global Fund for AIDS, TB and Malaria is now a significant feature in the HIV and AIDS donor landscape. While it does not (and should not) exert significant direct control over the proposals submitted to it, the Fund can shape the way gender is mainstreamed into HIV and AIDS work. The guidelines used by the Technical Review Panel (TRP) for approving proposals require a gender analysis, **and the TRP can play an important role in ensuring that the**

differing needs of women and men are met through the activities laid out in the proposals. However, these policies are not always put into practice. For example, the Namibian proposal for HIV and AIDS approved in the second round of funding falls far short of these explicitly stated criteria. In describing the overall situation in Namibia, there is no analysis of how the epidemic may be affecting women and girls differently from men and boys. Specific interventions about behaviour change and increased community care do not explain the need for targeting different groups of women and men, nor what the impacts of these interventions may be, for example on women as carers. The TRP is in a position to ensure that such matters are considered, without, however, imposing conditionality over national country governments.

South Africa

Bi- and multilateral donors in South Africa are largely focusing on technical assistance to the government. HIV and AIDS is the expressed reason many donors continue to be active in South Africa. Despite the huge disparity in income, South Africa is officially classed as a middle-income country. Some partner organisations express discomfort over the policy of upstream budget relief (where funding is only given to governments), arguing that having to apply to the government for funding reduces their ability to take an independent advocacy stance.

South Africa has one of the most progressive constitutions in the world, which is clearly committed to all forms of equality. The constitution requires respect for African legal heritage, but also states that the right to culture, and hence customary law, is subordinate to the right to equal treatment. Organisations in the other research countries commented on the South African constitution, saying that it makes lobbying on issues – such as the rights of men who have sex with men – much easier than in their countries, and that the **strong laws create an environment in which grassroots work can reinvigorate international policy agendas.**

South Africa has set up comprehensive mechanisms to address HIV & AIDS and gender. The South African National AIDS Council (SANAC) advises government on HIV and AIDS and includes government ministers, reflecting political commitment to tackling the epidemic. It oversees the other components of the HIV and AIDS response, including technical task teams and the Inter-Ministerial Committee on AIDS. The HIV/AIDS and STD Strategic Plan 2000–2005 explicitly mentions that the status of women needs to be addressed; however, organisations involved in the research say that this is not reflected in its implementation. Similarly, complex systems have been set up to address gender issues. These are managed by the Office on the Status of Women, with ultimate responsibility in the President's office. **A key component of the gender machinery is having 'gender focal points' in all the Ministries to represent gender issues**; however, women's organisations interviewed feel that the focal points were not always easy to identify, and in some cases were unsure of their roles.

DFID in South Africa

The UK Department for International Development has a good reputation for the high quality of its work on gender. Its 'twin track' approach to gender focuses on women's empowerment while also addressing gender relations. DFID policy also makes the link between HIV & AIDS and gender in both its *HIV/AIDS Strategy* and *Poverty Elimination and the Empowerment of Women* papers.

However, it is interesting that the view of gender relations expressed in these documents is biased towards a focus on women. The role that men must play in addressing gender inequalities, as well as the particular vulnerabilities of certain groups of men, does not receive much attention apart from a reference in the *Empowerment of Women* strategy. The need to involve men in the fight against HIV and AIDS,

as well as tackling all forms of gender inequality, does not appear in its list of priorities for meeting these challenges. This may be linked to the impact of DFID's approach to mainstreaming gender within the organisation; a bilateral donor in South Africa comments that the external perception of DFID is that 'gender is being mainstreamed out of existence', echoing comments from DFID staff. This is apparent in DFID's most recent Southern Africa strategy, where gender is barely mentioned. At the time of writing, DFID was recruiting a senior gender and rights adviser in the UK, which may address some of the mainstreaming issues.

India

While India receives substantial funds from donors, all multilateral funding represents only 1% of India's budget. **India is widely seen by donors as a priority country for achieving the MDG of reducing HIV and AIDS prevalence among 15–24 year-olds.** Donors have largely focused on the south of the country to date. As a result, services are now of a higher standard than those in much of the rest of the country. Many donors are now shifting their attention to the east and north, where prevalence rates are rising.

In India, different ministries are widely perceived not to prioritise HIV and AIDS because it is seen as a health issue, and there are few mechanisms to ensure a coordinated response across ministries. India's National AIDS Control Organisation (NACO) is decentralising its response to HIV and AIDS to State level, and has created State AIDS Control Societies (SACS). Partners say that while this could offer an opportunity to respond to the needs of different States and Union Territories, the commitment and effectiveness of the SACS varies widely, and is largely dependent on the commitment of the individuals in charge.

A strong women's movement in India has contributed to the formation of State bodies to oversee issues of gender equality. Both Central and State governments are responsible for gender issues, with ultimate responsibility lying with the Department of Women and Child Development. In 1992 the Department set up the National Commission for Women, which has responsibility for promoting women's empowerment and safeguarding their rights.

Cambodia

Cambodia's response to HIV and AIDS has been very strong, with much attention successfully focused on the reduction of prevalence rates. This achievement has taken place in the context of extreme poverty and severe human resource limitations; international donors and NGOs have therefore played a very important role in supporting these efforts.

The Royal Cambodian Government has clearly prioritised tackling HIV and AIDS in both its political commitment and policy development. A comprehensive National Strategic Plan makes specific reference to gender inequalities and guides all of the government's work, with practical implementation falling within the remit of individual ministries. The National AIDS Authority (NAA) is responsible for leading on this policy and for encouraging a multisectoral approach across all ministries. Unfortunately, the NAA is extremely understaffed and has little power over the separate ministries to ensure that the strategic plan is carried out in practice. Coordination efforts at national level are not always carried through to provincial and local levels of government. The Health Ministry, through the National Centre for HIV and AIDS, dermatology and STD control (NCHADS), bears the largest responsibility for implementing the AIDS strategy, including budgetary issues.

With the passing of the Law on Prevention and Control of HIV/AIDS in 2002, the Royal Cambodian Government has given women an important legal tool for protecting themselves and fighting gender inequality. The law contains many protections and assurances for people

living with HIV, particularly with reference to stigma, and criminalises any behaviour linked to the intentional transmission of HIV. A further domestic violence act is being considered by Parliament. The Ministry of Women's Affairs also oversees the National Policy on Women, the Girl Child and HIV/AIDS, which makes explicit the government's commitment to tackling gender inequalities and HIV & AIDS.

A willingness to address HIV and AIDS on a number of different levels and to work closely with civil society partners is hampered mostly by financial and human resource constraints, and insufficient capacity to carry through the coordination and implementation of plans to the grassroots.

PUTTING NATIONAL POLICY INTO PRACTICE

Together with the policy evaporation and lack of full gender analysis described above, **the research identified lack of training for frontline staff – especially those in the public sector – and lack of knowledge of rights, as key barriers to effective national policy implementation** in relation to the issues described in Chapter 1. Much responsibility for policy implementation lies with the staff (including medical, police, judiciary) who have face-to-face contact with members of the public. Organisations working with frontline staff feel that inadequate training and support is given to the scarce and poorly resourced staff expected to implement policies. These organisations also feel that **gender bias within public services means that issues seen to be particularly relevant to women receive less attention.** This results in continued gender discrimination, and difficulty implementing laws and policies designed to increase women's rights. In turn, this reinforces negative gender stereotypes for both women and men, as society is not seen to hold men responsible for their actions.

Often respondents felt that 'human rights' or 'legal issues' were entities beyond their comprehension.

Survey by the Indian Network of Positive People

Lack of information about rights and accurate prevention information mean that women are particularly disadvantaged, as they are even less likely to be able to access services. Research from all countries stressed the need for information in appropriate local languages about laws and rights and HIV & AIDS. Women with disabilities are particularly affected, as less access to education and stereotypes about the sexual needs of people with disabilities mean little information is available to them. **Lack of knowledge about their rights and about HIV and AIDS means that men, and particularly women, are less likely to expect or demand services, because they are not sure what they are entitled to.**

POLICIES RELATING TO SPECIFIC ISSUES AND THEIR IMPLEMENTATION

Gender violence

The Domestic Violence Bill in Namibia was passed by the National Assembly on 27 March 2003, and is expected to pass by the National Council to become law. Implementation plans were being discussed with civil society and the relevant ministries at the time of writing. Organisations interviewed for the research expressed concern over the level of the debate in parliament, and the fact the some MPs are opposed to the Bill – and as a result, the extent to which the Bill reflects genuine political commitment.

The Protection from Domestic Violence Bill in India was tabled in 2001, but came under criticism from the women's movement, and in particular the Lawyers Collective Women's Rights Initiative (LCWRI), which had drafted a model law on domestic violence in 1992. The government held a consultation, and the resulting report accepted almost all the demands of the

women's groups. The LCWRI and the women's movement are now demanding that the Government accept the report and pass the Bill immediately.

A potential domestic violence act is currently under debate in Cambodia following lobbying by women's organisations. Coordination of Action Research on AIDS and Mobility (CARAM) in Cambodia says there is confusion about rights and services, and quoted a man attending an awareness-raising workshop who said: 'I can beat my wife now because I have rights'. The case study below demonstrates in more detail how the gap between the intentions of policy-makers and what happens on the ground can become very wide.

The Domestic Violence Act and its implementation: South Africa

The Domestic Violence Act (DVA) in South Africa was passed in 1998. While organisations involved with the research raised problems with its implementation, few issues with the Act itself were discussed. It is widely viewed to be a good policy, but disillusionment is growing about its effectiveness and the will to implement it. The South African Law Commission has produced a Sexual Offences Discussion Paper, incorporating a proposed Sexual Offences Bill. This proposes repealing the common law offence of rape (which is restricted to penetration of the vagina by the penis) and replacing it with a new gender-neutral statutory offence, centring on 'unlawful sexual penetration' under coercive circumstances. This has been welcomed by civil society organisations.

The weak implementation of the DVA in South Africa has meant that gender inequalities in relation to violence and security are entrenched, as political commitment to the issue is perceived to be low. Community-based organisations working with survivors of gender violence discussed the issue of 'secondary victimisation', in which women going to the police with cases of abuse are frequently not believed, sent home, or sent to several different centres. This reflects a wider sense that rape or physical abuse is not a serious issue.

People Opposing Women Abuse (POWA) describe how female police officers call them for advice when they are abused, because they are uncertain of the correct procedures to follow. Loss of legal dockets relating to rape or gender violence is a particular problem: in one case the dockets had been lost for eight years. In addition, police transport is not reliably available to women who have been abused, and discrete police administrative systems mean that perpetrators cannot be traced between districts.

In combination with such systems failures, reporting gender violence becomes hugely problematic for women. This is echoed in the experience of women who have to see medical staff who do not always treat them seriously, and in particular do not consistently know how to take forensic evidence or fill in the J88 forms relating to rape.

Clearly this is not always the case – all community-based organisations pointed to pockets of good practice, and to individuals within the support services who are working hard to implement the DVA.

> Women who have been abused lose hope after visiting the trauma clinics.
>
> Women Opposing Women Abuse, South Africa

In South Africa, partners noted that the lack of consistent training given to police, magistrates and health staff about the DVA is preventing effective implementation. NGOs expressed anger against the government, which has been writing the training manual for three years.

There have been some very successful pilot schemes in which NGOs work with police on the Acts. These have resulted in direct improvements to the services given to women. However, these schemes are resource intensive and local, and depend on lengthy staff retention in one district, which is an issue within the police service.

For their part, police and magistrates feel overwhelmed by the sheer burden of stressful work related to abuse and HIV & AIDS. Very little support is available to police or health staff to learn how to cope with rising stress levels. One magistrate spoke of the difficulty of remaining detached and not being able to use her 'softer skills' to work with communities. Police and public prosecutors also feel that NGOs and CBOs do not always have the necessary legal expertise to inform their clients of their rights.

Many NGOs in South Africa work on legal literacy and rights knowledge about the DVA, but say that it is very difficult to reach many people - particularly the poorest, who may be unable to access centres where training is held. In particular, protection orders appear to be widely misunderstood as a means of legal protection, with men applying for counter protection orders against their wives. Little information is available in languages other than Afrikaans or English, and minimal information is available for people who use non-verbal forms of communication. NGOs say this is leading to a culture of 'lack of demand' in which people are deeply uncertain of their rights. The demand for detailed information in all official South African languages is experienced by Tshwaranang, a South African organisation offering legal advocacy and advice, which holds information sessions about the Act in different languages on community radio stations. The organisation is always inundated with telephone calls asking for more information the following day.

The Acts are there, but people don't know their rights or sometimes that they even exist'

Sedibeng, a South African research consultancy

Unequal rights to property

Most women in India are landless. They are seldom given a share in parental property or able to own other assets. The Hindu Succession Act 1956 recognised the right of women to inherit the property of their father, and an amendment of the Act to confer these property rights in a joint family is under consideration. However, this Act does not apply to women belonging to non-Hindu religious communities, and is rarely implemented even in the case of Hindu women. VSO partner organisations in India say that lawyers do not always have the necessary legal expertise to advise women who have been disinherited from their property following a positive HIV diagnosis or the death of their husband. In particular, they feel that lawyers are not always aware of the fact that legal processes can be accelerated in cases involving people living with HIV and AIDS.

In South Africa and Namibia, women are given the same land rights as men, in contrast to the situation in some other African countries. However, the situation is made more complex by the distinction between

customary law and the constitutions, which people are sometimes unsure about[14]. Men's rights to property are often assumed, in the absence of knowledge about constitutional law.

The burden of care

Through our community mobilization work, we found out that among 100 people who are doing HIV/AIDS work only two are men, and the rest are women. These two men were elderly men.

Representative from TKMOAMS (Tate Kalungu Mweneka Omukithi wo 'AIDS' Moshilongo Shetu – translation: Our Mighty Father Protect Our Nation From The Deadly Disease 'AIDS'), Namibia

As discussed in Chapter 1, the burden of care for HIV and AIDS is felt most by women, who look after relatives and extended family – frequently when they are ill themselves. The vast majority of volunteers in home-based care programmes are women, who are increasingly having to replace formal health care, as services buckle under the strain of HIV and AIDS. This is not always taken into account in policy design, which can lead to an increased burden on women. For example, in its framework for action on community home-based care in resource-limited settings, the World Health Organisation only briefly acknowledges the fact that the majority of carers are women and young girls, and does not examine the implications of this. The key planning questions put forward did not recognise that women and young girls may have particular needs related to their role, nor did it prompt policy-makers to consider how to support men who may wish to take on a more proactive role in this area.

The increased burden of care on women is a major problem in South Africa and Namibia. VSO partner organisations in India and Cambodia warn that policy-makers in their countries need to deal with this now as the epidemic progresses to the stage where people are becoming ill. Programmes focusing on palliative or home-based care risk adding to the burden on women unless these gender roles are acknowledged in programme design. In South Africa and Namibia, where some support is available in the form of grants, there is often little knowledge of how to access them, or even that they exist.

Women struggle so much to stay alive – to keep food on the table. Much more can be done to give them income generation support and nutritional support. If a woman's male partner is still alive – regardless of whether he is incapacitated or even present – she cannot access government financial support.

A disability grant from the government for people with a CD4 count of less than 200 can be accessed in as little as three months. A funeral grant has also been available since August 2002, but no one knows anything about it.

Maria Breeuwsma, VSO volunteer, Catholic AIDS Action, Namibia

Unequal access to treatment

The debate over the massive global inequality in treatment has highlighted the fact that **women are less likely to receive treatment and more likely to give care than men.** However, policies to address this appear not to be in place.

Health staff are at the forefront of delivering services to people living with HIV and AIDS, and ensuring that the equal right to health is honoured, yet their support needs are often overlooked. Nurses in Namibia are described as being dangerously close to 'burn-out' as a result of the increased burden HIV and AIDS places on the health service; more beds in hospitals are being used as people become ill; nurses themselves become ill, and most of them are women who have to cope with extra caring responsibilities at home.

14: South African Law Commission (1998) Issue Paper on Succession in Customary Law under auspices of Project 90

In India, organisations working in care, such as the Society for the Protection of Youth and the Masses (SPYM) say that many doctors and nurses do not have the necessary knowledge to treat women and men living with HIV and AIDS, and that stigma towards HIV and AIDS patients reflects negative social attitudes rather than medical knowledge. Doctors and counsellors are widely perceived to be particularly discriminatory regarding women living with HIV and AIDS: the Positive Women's Network reports that pregnant women have been advised to have an abortion immediately on being diagnosed positive, or have been told they have only a few months to live. Medical confidentiality is not always upheld, for example, a husband may be told of his wife's status before she is. This is also an issue for men who have sex with men: according to the Social Welfare association for Men, there is little knowledge about how to treat oral or anal sexually transmitted infections in men, and wives or families are often called in when one is discovered.

Organisations in India say that this behaviour is partly due to the need for further training on HIV and AIDS, and also reflects the absence of universal precautions in hospitals and clinics, which makes medical staff fearful of transmission. Similarly, in Cambodia some midwives are afraid to treat women living with HIV and AIDS for fear of infection.

In all four countries, respondents argue that women and men should be actively involved in decisions about testing. However, VSO partners in Namibia say that women and men are unsure of their rights regarding testing, and whether their results will be kept confidential. Partners in India noted that the quality of counselling is generally poor. This leads to additional fear, confusion and ignorance following a positive HIV diagnosis, and does not help people to access the services they are entitled to.

Unequal access to appropriate prevention information

Respondents had no knowledge about where to address human rights violations. Most respondents suffered from low self-esteem due to lack of information about human rights and life after infection.

Survey by the Indian Network of Positive People

Prevention policies in the research countries differ as a result of the different stages of the epidemic. The policy of targeted interventions in India and Cambodia has led to a fall in prevalence rates among target groups. However, it has also meant that certain groups have become stigmatised through their association with HIV and AIDS, while other groups remain ignorant of the risks. The World Bank supports the National AIDS Control Organisation in India in its prevention programme. This has come under criticism from NGOs and CBOs in India for focusing exclusively on very specific target groups, and overlooking the needs of women and men who fall outside those groups. **The group least targeted in India – and in some respects most vulnerable – is married women, who rarely know about HIV and AIDS as a result of a lack of education and targeted messages.**

Efforts to work with communities of men who have sex with men in India are made difficult due to the harassment of peer educators by members of the police, and the reluctance of some SACS to fund activities with men who have sex with other men. Peer educators in Chennai report being arrested and harassed by members of the police for carrying condoms. Organisations working with men who have sex with men feel **that police carrying out arrests and harassment are not necessarily aware of the law in relation to homosexuality**, but are driven to act because of the stigma surrounding male-to-male sexuality. In Chennai, NGOs work with the Chief of

Police, who accepts their activities, but frontline police staff are not all aware of this. Similarly, violence against female sex workers and peer educators is on the rise in Karnataka in India – partner organisations say this is because sex workers increasingly challenge why they are arrested.

In Cambodia, there are concerns regarding human rights violations – such as mandatory testing of sex workers – in the 100% Condom Use Campaign, which targets men having sex with sex workers. There are also concerns about unexpected outcomes from the campaign that mean general prevention information is now more difficult to disseminate. These are:

- the stigmatisation of condom use and association of condoms with sex workers
- a rise in the number of indirect sex workers
- a rise in sexual violence.

One organisation interviewed in Cambodia raised the issue that police ask for payment from brothel owners when implementing the 100% Condom Use Campaign. In turn, this leads to greater debt for sex workers, which can make discussing safer sex even more difficult. Again, NGOs say that training is needed to support frontline staff, such as police, to carry out their roles.

According to Namibian organisations and individuals taking part in the research, one reason why women and men are not changing their behaviour is due to the promotion of abstinence, faithfulness and condom use (the ABC message). This assumes more individual choice than the majority of women actually have, and does not address the realities of what women and men want from their lives.

Chapter 3
Responses and recommendations

If there was equality between women and men, this epidemic would not have occurred.

Representative from UNIFEM, India

KEY POINTS

- The principal findings of the research indicate that emphasis must be placed in three main areas. This will make responses to HIV and AIDS more effective at addressing gender inequalities, in what could be called a 'three-pronged' approach:
  - Increasing constructive involvement of men in activities and interventions designed both to reduce gender inequalities and minimise the impact of HIV and AIDS.
  - Continuing the focus on directly empowering women to attain equality in the family, workplace and the community by ensuring, in particular, that existing policies and commitments supporting women's rights are put into practice.
  - Addressing the immediate needs of women affected by HIV and AIDS, for example, as carers within the family and community; as people suffering from gender violence; and as individuals requiring treatment and attention for HIV and AIDS.
- Men's involvement must not be at the expense of projects focusing on women's empowerment.
- Women living with HIV and AIDS need to be involved at all levels of policy and decision-making.
- Training and support must be provided to frontline staff to implement policies and laws addressing gender inequalities and HIV & AIDS
- Women and men require access to appropriate information in order to demand and receive services.

This chapter lays out responses intended to address the issues described in Chapters 1 and 2. Here VSO argues that the overall design and planning of programmes combating HIV and AIDS should take into account a 'three-pronged approach'. This multi-faceted response offers a greater likelihood of realising the recommendations expressed in this paper.

The chapter looks at how this approach can be implemented in general, then examines the specific issues raised in the research. It also considers how policies and programmes designed to address these issues can be strengthened using the holistic three-

pronged approach. Ways to overcome barriers to policy implementation identified in the previous chapter – the need for training and support for frontline staff, and the lack of knowledge of rights and services available – are interwoven as recommendations throughout.

THE THREE-PRONGED APPROACH

- Increasing the constructive **involvement of men** in activities and interventions designed both to reduce gender inequalities and minimise the impact of HIV and AIDS.
- Continuing to focus on directly **empowering women** to attain equality in the family, workplace and the community by ensuring, in particular, that existing policies and commitments supporting women's rights are put into practice
- **Addressing the immediate needs of women** affected by HIV and AIDS, for example, as carers within the family and community; as people suffering from gender violence; and as individuals requiring treatment and attention for HIV and AIDS.

Involving men constructively

Involving men means that firstly they will get wiser and make informed choices because they will start to understand the full extent of the problem. Secondly, with increased understanding comes dual responsibility and ownership.

Langi Mphelo, programme officer, VSO South Africa

By constructively involving men, VSO means ensuring that interventions and policies address how concepts of masculinity increase both women's and men's vulnerability to HIV. Involving men constructively can build on the many 'positive' constructions of masculinity, such as the desire to protect the weak and to be strong and healthy. Any attempt to work towards involving men constructively to a greater extent should not treat men as a single category, any more than women should be. Men have different roles: as decision-makers and service providers; as beneficiaries of the development process; and as vulnerable parties, such as men who have sex with men[15]. These varying roles must be addressed appropriately, as one means of working towards women's empowerment.

Men have always been present in some form to neglect, dismiss, encourage, or simply observe women's activities related to development. What is novel, then, has to do with involving men intentionally and directly, as gendered persons in their own right, and because they are involved in socialising others into gender roles and identities.

Sylvia Chant and Matthew Gutmann (2000), *Mainstreaming Men into Gender and Development: Debates, Reflections and Experiences*, Oxfam Working Paper

Policy-makers need to acknowledge explicitly how current beliefs concerning masculinity can increase women and men's vulnerability to HIV and AIDS. **Policy-makers must also emphasise how channelling positive aspects of masculinity can tackle the epidemic**, and create more equal relationships between women and men. Men are heavily involved in designing and implementing policies, but are often overlooked when the focus of policies and projects is at grassroots level.

Work with men is already underway through interventions with truckers, men in prisons or men who have sex with other men. This work is increasingly carried out by men's groups at the grassroots. Development and academic discourse is also paying greater attention to the role of men and gender equality. However, organisations involved in the research argue that there is a long way to go before this is substantially reflected in policy design and implementation. Increasing men's sense of personal

15: James Lang (2002) *Gender is Everyone's Business: Programming with Men to Achieve Gender Equality* Oxfam Workshop Report, 10–12 June 2002

responsibility will help ensure that women and men are at less risk of HIV transmission. In contrast to men's involvement in the broader struggle for gender justice, **involving men in relation to HIV and AIDS has immediate and concrete benefits to all men:** they are less likely to contract HIV in the first place, and less likely to progress to AIDS if already infected.

Partners in South Africa say that HIV and AIDS is having such a devastating impact on South African society that social change is happening extremely rapidly. While this is currently having a negative impact on relations between women and men (as described earlier), partners believe that this rapid social shift also provides an opportunity for constructive change. In the words of one participant at the VSO conference Men, HIV and AIDS: 'men should think not about what we stand to lose but about what we stand to gain.'

In addition, individuals and organisations involved in the research explained how positive constructions of masculinity can be reclaimed. According to Pro-me-tra, a Southern African organisation examining the constructive use of cultural beliefs and traditional medicines, the traditional role of men as protectors of their families can be used to kickstart discussion about HIV & AIDS and men's behaviour. Beliefs surrounding men's need to be strong can provide a starting point for discussing how some behaviour may lead to HIV transmission. In Namibia, partners say that local chiefs and village headmen have an important role to play in bringing issues about masculinity into the open.

Harnessing positive constructions of masculinity: South Africa

Men As Partners (MAP) in South Africa is a collaboration between EngenderHealth and the Planned Parenthood Association of South Africa. It emphasises the risks that certain constructions of masculinity pose to men, and uses analogies with the anti-apartheid struggle to discuss strategies for changing behaviour. The success of these interventions relies on emphasising existing positive constructions of male identities, rather than blaming men.

Personal responsibility is linked to aspiration and a sense of futurity, of personal and community hope. It is also linked to understandings of risk, a need for skill development and personal and social ability to maximise wellness on personal and community levels. Understanding of the self in relation to risk and the future needs to be contextualised by feelings of self-worth and social affirmation.

Representative from DramAidE (Drama in AIDS Education), South Africa

Men's and women's groups believe that **the concept of men's personal responsibility towards others and themselves must be developed.** This will reduce high-risk behaviour and lead to greater equality within intimate relationships. 'Zero-grazing' promotes consecutive rather than simultaneous relationships. It was used in Uganda, and is one response currently under discussion in Namibia[16].

If the risk behaviours of men are to undergo substantial modification, the very construction of masculinity itself must be called into question and challenged.

Professor Graham Lindegger, University of Natal, VSO conference: Men and HIV and AIDS

16: USAID (2002) *What Happened in Uganda? Declining HIV Prevalence, Behaviour Change and the National Response*

Involving men in thiss way entails challenging ideas about gender roles that are set early in childhood. There are of course numerous and highly complex influences on the way girls and boys perceive their roles, including the home environment, the wider community, the media and religious leaders. Partner organisations and national governments are increasingly focusing on work in schools to allow girls and boys to discuss gender issues and to challenge restrictive ideas. Often called 'life skills', these classes may also cover sex education and HIV & AIDS information. While organisations working on life skills in schools report some problems concerning poor coordination and lack of training and support for teachers, this kind of intervention offers a real opportunity to engage with young people and to discuss gender roles and HIV & AIDS.

Teaching life skills in schools:South Africa

Addressing life skills in schools is an important aspect of South Africa's HIV and AIDS strategy[17]. The government collaborates with NGOs, which are implementing much of the work. The Planned Parenthood Association of South Africa (PPASA) works in schools throughout South Africa. It also runs youth clubs and information centres targeting young people to support the work in schools and to attract girls and boys not included in the formal education system.

In PPASA's experience, the most effective interventions involve work with parents so that they also have the knowledge and vocabulary to talk about these issues with their children. PPASA has found that young people want to be able to discuss what they have learned in life skills classes with trusted adults.

Cambodia provides a further example of how to challenge gender roles. Relations between women and men in Cambodia are partly based on Khmer codes of conduct laid out in ancient religious texts. These describe appropriate roles and behaviour for women and men, and are restrictive in the way that they are currently interpreted. Cambodian monks and scholars are engaged in examining how these texts could be interpreted to provide a more equitable basis for gender relations.

Restrictive ideas about masculinity need to be challenged at grassroots levels. Men's groups in South Africa and Namibia, such as the White Ribbon Campaign and Men for Change, hold men's meetings in bars, football grounds and other places where men gather. Here they discuss subjects such as HIV and AIDS, violence against women and unemployment. This is the first opportunity many men have to talk about these issues. The organisations aim to reclaim constructive ideas about what being a man means. They allow men space to think about their own behaviour, and to develop ways to change it if they wish.

In relation to HIV and AIDS, these organisations encourage men to get involved at the grassroots level by taking responsibility for their actions, whether by using condoms or reducing the number of their sexual partners. In turn, this reduces the burden of responsibility on women. It also creates more visible role models for other men and boys, who may find it easier to relate to members of the community than to politicians or sports stars.

17: Strategic Plan for the Department of Education (2002–2004), South Africa

There needs to be affirmation of positive role modelling and a description of the valuable contribution men make in relationships, socially and politically. This is of course mindful of the process of transformational affirmative action. Men often feel alienated by social issues which 'seem to be dominated' by women. Communication forums which address gender issues need to be developed so that 'transformational ideas' can be implemented in practice and become socially normative.

Representative from DramAidE (Drama in AIDS Education), South Africa

Addressing issues of capacity in grassroots men's organisations is key to expanding men's involvement in HIV and AIDS prevention. Men's organisations often have weak capacity and as a result, find it difficult to attract funding and share experience with other men's groups. Some organisations involved in the research for this paper argue that there is an opportunity for women's and men's organisations facing similar difficulties to share their experiences. Others, however, believe that men's groups must be informed by the priorities of the women's movement, but that there is a danger that supporting men's groups could take valuable resources from already overstretched women's organisations. Scaling up and replicating grassroots men's and women's movements – particularly groups of people living with HIV and AIDS – is a vital part of tackling the HIV and AIDS pandemic. The Southern African men's movement can provide many lessons to Asia, where there are few equivalent organisations.

There was consensus from the research that men's organisations need to be kept separate from women's groups at present. This should ensure that women's groups are not taken over by men and should give men a space in which to discuss their needs. It will also help reduce the burden of the response to HIV and AIDS on women. However, organisations involved in the research agreed that men's and women's groups do need to work together towards common objectives, and should meet to share experiences and support.

It cannot be stressed enough that **men must not be involved at the expense of projects focusing upon women and women's empowerment**. It is vital to ensure that work with men does not lead to a loss in funding or political will for work targeting women. Involving men is one strand of a wider strategy to address gender inequality and reduce the spread of HIV and AIDS. Therefore, **programmes targeting men must possess the long-term goal of transforming gender relations, and should reflect priorities expressed by organisations working with women.** It is also important to highlight that each organisation working on HIV and AIDS must determine the appropriate emphasis to place on these three priorities within their own work, according to their capacity and strategic focus. In order for work with men to be scaled up whilst continuing to focus on women, clearly increased funding for HIV and AIDS needs to be available by international donors.

Empowering women and meeting the immediate needs of women affected by HIV and AIDS

Men's direct involvement at the grassroots needs to be complemented by continued work with women, and ensuring that women – particularly those living with HIV and AIDS – are involved at all levels of policy-and-decision making. The history of the struggle for women's rights shows that women have won huge battles for equality in the face of much opposition; **HIV and AIDS interventions must ensure that women have the tools to continue to strive for equality.** These might focus on service delivery – working specifically with women, for example, on reproductive rights – or, they might concentrate on strengthening the implementation of policies designed to address the rights of women, as emphasised in this report. According to women's groups participating in the

research, it is most pressing to ensure that:

- existing laws designed to address women's rights are implemented effectively
- policies are implemented in a gender-sensitive manner.

Achieving these objectives will strengthen the ability of community-based organisations to work on grassroots projects with women, as their rights will be increasingly protected and clearly related to their everyday lives.

Providing accurate information about rights and services – in appropriate languages and media – helps women protect their rights and access services to which they are entitled. NGOs in all the research countries provide legal literacy assistance and information about rights and services, but some argue that governments need to take on a more proactive role in ensuring that information is available and accessible. Community radio is one means of reaching a wide audience, particularly women, in appropriate languages. Information dissemination by the media can work well: social media organisation Soul City in South Africa links its media launches in different communities to government programmes offering information and support in accessing various social grants.

The need to supply support and training to frontline staff – especially those in the public sector charged with implementing laws and policies – is another area raised in the research. Partners argue that **staff in charge of delivering services are not always given the skills, knowledge or support they need to implement policies and laws effectively.** Addressing this issue would help ensure that women's rights were safeguarded. In addition, men's involvement would grow, as 'positive' male role models become more visible and social acceptance of violent or abusive men falls.

Scaling up NGO involvement with training programmes for frontline staff is one means of combining accurate HIV and AIDS information and gender sensitisation with ongoing training on laws and policies. According to the research, women and men delivering services require ongoing training in:

- gender sensitisation, to help them identify their own attitudes and beliefs
- accurate information about HIV and AIDS
- specific details of the laws and policies they are implementing.

Some of these areas – for example, HIV and AIDS training for health staff – may be particularly relevant for older staff, as the curriculum may have changed since their training. This also supports staff who may be unsure of the facts relating to HIV and AIDS, and their own role. More generally, staff must be supported in coping with the huge impact HIV and AIDS is having on the health services and on their own lives.

Working with women and men: India

The Sonagachi Project in Calcutta is an example of a highly successful intervention with sex workers. It had three fundamental operating principles: respect, recognition and reliance, and was led by sex workers. Enrolled as peer educators, the sex workers went from house to house with information on sexually transmitted infections (STIs), HIV and AIDS, and ways to access care. They discussed power relations and negotiation techniques to encourage clients to use condoms. As nearly all brothels in the Sonagachi area were involved, there was little possibility of clients moving to another brothel to have sex without a condom.

A vital aspect of the project was the inclusion of regular clients, who formed a support group. They attended meetings and realised the importance of condom use to protect themselves, their wives, partners and sex workers. The group now supports the sex workers in encouraging new clients to use condoms. HIV and AIDS rates have dropped substantially as a result of the project. Women began to see themselves as having rights, while men were encouraged to take responsibility.

Some NGOs cautioned against the belief that the success described is replicable everywhere; according to local organisations, the sex work in Bangalore is street based and informal, so the networks of sex workers or clients needed to run a similar project do not exist. One organisation also felt that use of female condoms in street sex work situations could put clients and their wives or partners at risk, as there would not be time or facilities to wash the condoms between each use.

TACKLING MANIFESTATIONS OF GENDER INEQUALITY USING THE THREE-PRONGED APPROACH

The manifestations of gender inequality raised in the research – gender violence, unequal rights to property, the burden of care, unequal access to treatment and to appropriate prevention information – are now examined in the light of the three-pronged approach. Clearly, not all programmes would be able to (or wish to) use this approach, but all three aspects should be considered where there is an opportunity to plan a large programme holistically or to coordinate with others. The recommendations for action are based on partner organisations' priorities and VSO UK's analysis. As stated earlier, for effective national level implementation, common priorities raised by organisations in all research countries are:

- training frontline staff
- ensuring that women and men have appropriate information about rights and services.

Gender violence

Grassroots men's organisations in Namibia and South Africa are addressing violence through programmes in bars, churches and workplaces. The White Ribbon Campaign (a VSO partner organisation in Namibia) asks men who sign up to pledge 'never to commit, condone, or remain silent about violence against women'. Their Father's Day march against gender violence in Windhoek involved over 1,000 men and boys who publicly announced an end to violence against women, and attracted widespread media coverage.

Organisations working against gender violence in South Africa and Namibia raised the need for pre-emptive work with violent men, and for counselling for men imprisoned for violence. Women Against Women Abuse runs a perpetrator programme which supports men who have been violent to change their behaviour and understand the effects of violence upon their families. The organisation reports that men who have

completed the programme are less likely to reoffend. Subjective studies are needed to investigate violent men's attitudes towards their offences and what is required to put an end to such violence. In particular, such studies should look at the relationship between violence and male unemployment.

In all countries, stakeholders feel that **there is potential for partner testing and family counselling to reduce violence against women testing positive for HIV,** particularly during pregnancy. Partner testing is beginning to be encouraged in Namibia and India. However, some organisations feel that this is not being prioritised by policy-makers, partly due to a sense of fatalism about men's behaviour. Pilot family counselling schemes in Tamil Nadu, India, have been successful in expanding women's and men's knowledge of the facts in relation to HIV, and in reducing levels of violence following diagnosis. In turn, this has led to falling numbers of women abandoned following diagnosis and helped build more equitable family relationships. Counselling protocols in Namibia now say that both partners should be offered tests. However, more women come forward for testing than men, and organisations involved with voluntary counselling and testing feel that some men may not want to know their status for fear of stigma and appearing weak.

Partner testing during pregnancy also provides one way in which men can become more involved in their role as fathers. Through pre- and post-test counselling, partner testing can emphasise to fathers the risk to unborn children if HIV transmission takes place during pregnancy or breast-feeding. Given that viral loads increase dramatically immediately after transmission, HIV is more likely to be passed to the child in this situation than if the mother were living with HIV from the start of the pregnancy. Such awareness-raising will also help women avoid being reinfected with a different strain of HIV.

Greater involvement of fathers provides constructive role models for boys and young men, and may also help share the child-caring role. The Parent-to-Child Transmission Plus (PTCT+) programmes trialled in Southern Africa use antenatal diagnosis as an entry point for treatment of both parents and the child. However, partners in both Namibia and South Africa say that programmes are being undermined because insufficient numbers of men are coming forward for treatment. They believe that public education campaigns aimed at men must highlight the advantages of treatment and testing to all members of the family.

Alongside involving men in preventing gender violence, legal systems and policies must protect women's rights. Where they do not already exist, **laws on gender violence should be passed to fulfil commitments under CEDAW and other international agreements.** Where laws have been passed, the police and judiciary may need to have ongoing training into these laws and their role in implementing them, as well as training on how violence, HIV & AIDS and gender inequalities are linked.

Accurate information about rights and services in relation to gender violence must be made available in appropriate languages so that women know – and can demand – their rights. Information about services will help service providers make appropriate referrals and coordinate services effectively. This will also facilitate alleviating women's immediate needs in terms of a place of safety and treatment of injuries.

At the same time, specific work with women needs to take place. For example, Women's Solidarity in Namibia aims to build the self-esteem of young women so that they do not feel they have to go out with older men. Workers from the organisation spend a week at a time in schools, holding discussions with pupils about violence, rape and HIV & AIDS. This helps girls and boys discuss fears and the pressures they

face, and starts to build respect between them. Girl Child Organisation in Namibia also works in schools. It has a network of 'big sisters': older girls support younger girls in making decisions about sex and issues such as relationships with older men. Much greater attention needs to be paid to violence in schools – particularly gang rapes – through open discussion and life skills, starting at primary age.

Unequal rights to property

Legal staff may need specific training to understand how property control relates to HIV and AIDS. For example, in India, cases involving HIV and AIDS can be prioritised in court so that judgements can be reached faster. Again, publicising information about the law and rights in local languages and through community radio raises the profile of this important issue. Family counselling and partner testing as described above may also help women retain property, as they may be less likely to be thrown out of their homes or subject to abuse by relatives.

The burden of care

> **In our communities men remain always the head of the family irrespective of whether they are the breadwinners or not. They regard women as their subordinates. Therefore, if a woman heads any activities, or an organization, men are reluctant to join such organization or activities having in mind that they cannot be led by women.**
>
> Representative from TKMOAMS (Tate Kalungu Mweneka Omukithi wo 'AIDS' Moshilongo Shetu – translation: Our Mighty Father Protect Our Nation From The Deadly Disease 'AIDS'), Namibia

VSO's partner organisations are experimenting with different ways of encouraging men to become involved in care. Organisations from Zambia and Malawi at the VSO conference Men, HIV and AIDS shared their successful strategies for involving men in home-based care and HIV prevention work. These include:

- working through institutions such as churches and workplaces
- being sensitive to men's other economic activities, and scheduling voluntary work around these
- involving local role models such as church leaders or footballers in the prevention work.

According to these organisations, not only has the burden on women been reduced as a result, but HIV and AIDS prevention work is also benefiting men – as many men are more comfortable discussing sex with other men, and find it easier to ask men for condoms. Expanding men's role in care might also raise the numbers of men who gain help from support groups of people living with HIV and AIDS (which women currently dominate in terms of numbers). Policy-makers designing home-based care programmes must actively attempt to involve men, and to ensure that programmes are not based on assumptions about women's unpaid labour.

Information about any available financial support must be made accessible, and women must be eligible for all grants, regardless of marital status or male dependents.

Unequal access to treatment

Specific ongoing training in HIV and AIDS must be given to frontline health staff. This will enable them to carry out their jobs safely and effectively, and reduce their fears about contracting HIV and AIDS. Prioritising the PTCT+ model will assist the move towards equal access to anti-retroviral drugs. However, it is likely that **women will still have less access to treatment than men unless medicines are made freely available through public health services.**

In India, the Society for the Protection of Youth and the Masses is running a pilot project in New Delhi. Two

hundred nurses have been trained on HIV and AIDS; 26 of these form a core team in charge of care of patients with HIV and AIDS, and challenging discrimination within the health service. They are already seeing a fall in stigmatising behaviour, and aim to support more women in using their services by discussing the importance of women's treatment with the families.

Unequal access to appropriate prevention information

> **What is really needed now is a prevention campaign aimed at the general public.**
>
> Representative from Indian Network of Positive People

Organisations in Cambodia and India argue that **whilst some prevention information must continue to be targeted (for example unequal access to appropriate prevention information with sex workers), information needs to be made public as the epidemic becomes more generalised.** Information should be disseminated in appropriate languages and media, and be made available in schools. Samraksha in India say that focusing on negotiation skills for married women, in conjunction with information about HIV and AIDS, helps them discuss sex with their husbands.

According to NGOs in India, the police could be much more effective if work were scaled up with members of the force who patrol areas where men go to have sex with men. This could be done by increasing the training about HIV and AIDS. In South Africa and Namibia, where knowledge of HIV and AIDS is high, the emphasis is on a new level of detail required on prevention and care.

Information must also be available concerning the rights of women and men living with HIV and AIDS who want to have children. This must be supplemented with accurate information about parent-to-child

Conclusion

Changes needed in policy and practice

The research findings have focused on three main areas:

- **the need to involve men constructively in tackling HIV & AIDS and gender inequality**
- **the shortfall between often excellent international and national policies designed to address women's rights and their implementation on the ground**
- **the importance of meeting women's immediate needs.**

To overcome these challenges, VSO has developed a series of recommendations requiring action from a broad range of actors at national and international levels. Some actions are specific and can be applied to the design and implementation of HIV and AIDS programmes in developing countries. Advocacy work is necessary to secure the political will, funding and prioritisation of these issues against other needs. Influence must also be exerted on policy and policy discourse to ensure a gender-sensitive approach.

Together with its partners, VSO will therefore advocate for long-term systemic change, recognising the complex relationship between international and national decision-making that makes change at all levels essential. NGOs and civil society groups will be vital in implementing much-needed services and aid, but should also participate in developing and monitoring the policies underlying such interventions.

The following recommendations for action are a synthesis of the responses detailed in Chapter 3. They build on existing programmes and priorities expressed by partner organisations. They reflect not only the need to influence other actors, but also challenges in ways of working with partners and people affected by HIV and AIDS in developing countries. VSO will endeavour to put them into practice within our own work as part of a long-term approach to development.

ALL STAKEHOLDERS SHOULD:

- **Recognise that HIV and AIDS work will only be effective if the inequalities between women and men are taken into account**
- **Design and plan HIV and AIDS programmes which:**
  - **increase the constructive involvement of men**
  - **protect the rights of women by implementing existing policy**
  - **meet the immediate needs of women.**
- **Include in HIV and AIDS programmes a full gender analysis based on the different needs and roles of women and men. This should look specifically at policies and laws, and identify the key areas of interface between HIV & AIDS and gender**
- **Change the norms of discourse on gender to include men in a constructive way**
- **Consider the needs of men who have sex with men in HIV and AIDS programmes, and include these groups in project design, implementation and monitoring**
- **Consider as part of further HIV and AIDS programme research, analysis and planning key manifestations of gender inequality: gender violence, unequal rights to property, the burden of care, unequal access to treatment and unequal access to appropriate prevention information**
- **Prioritise training and support for frontline staff in the public sector – police, nurses and doctors, social workers, magistrates – as an institutional means of addressing gender inequality and HIV & AIDS**
- **Prioritise changing institutional practice towards giving women and men access to accurate information about rights and services in a way that can be understood by everyone, including the non-literate and those with disabilities**
- **Ensure that HIV and AIDS programmes do not increase the burden on women.**

In addition, multilateral, bilateral and non-governmental donors should:

- Support national governments and civil society organisations in focusing on the specific recommendations to all stakeholders raised in this paper
- Ensure that monitoring and evaluation mechanisms for HIV and AIDS programmes prioritise gender-specific indicators
- Ensure that gender analysis is integrated into approaches to the all Millennium Development Goals, not solely the Goal on gender
- Include groups of women and men living with HIV and AIDS in their consultation processes
  Increase the focus on men to tackle gender inequalities.

In addition, national governments should:

- Demonstrate leadership at all levels on the need to address gender inequalities and HIV & AIDS
- Meet domestic and international commitments, and work towards effective HIV and AIDS policy implementation, with a priority on policies impacting on gender inequality.

Recommendations to national governments relating to manifestations of gender inequality

Gender violence

- Train and support the police, magistrates and the judiciary to put existing laws and policies into practice in a way that is respectful of women's and men's needs
- Consider including as part of a comprehensive approach to HIV and AIDS and gender inequalities:
  - partner testing counselling for families and for violent men
  - life skills education in schools
  - support for men's groups
  - support for women's refuges
  - promoting male role models.

Unequal rights to property

- Support legal literacy programmes
- Publicise information about rights and services in languages accessible to all people
- Ensure legal staff are trained in existing laws
- Undertake test cases to establish legal precedents.

The burden of care

- Actively seek to involve men in palliative and home-based care programmes to reduce the burden on women
- Ensure that all carers have access to all available financial support.

Unequal access to treatment

- Ensure that women and men have equal access to treatment
- Properly train and support health and community-based staff to understand and meet the differing needs of women and men affected by HIV and AIDS.

Unequal access to appropriate prevention information

- Ensure that the needs of vulnerable groups, such as married women and men who have sex with men, are reflected in prevention messages
- Make available information about parent-to-child transmission and its prevention
- Train police to deal with prevention efforts aimed at men who have sex with men
- Continue to prioritise getting accurate information to all members of society.

In addition, civil society should:

- Recognise and support groups of women and men endeavouring to create a more positive environment in which gender inequalities can be eliminated
- Support, monitor, and, where necessary, challenge governments to undertake their responsibilities as described above under the recommendations to all stakeholders
- Press for support and training for frontline staff
- Factor the needs of frontline workers, especially those in the public sector, into project planning.

Appendix

Organisations consulted during the research

South Africa

AusAID

Centre for the Study of AIDS, University of Pretoria

Department For International Development, South Africa

DramAidE (Drama in AIDS Education)

Family Life Centre

GIPA (Greater Involvement of People Living with HIV and AIDS), UNAIDS

HIV/AIDS Unit, Department of Social Development

Lungelo

Men for Change

Men's Forum

Midlands Women's Group

Oxfam

PAHA (People Against Human Abuse)

Population Department, Department of Social Development

POWA (People Opposing Women Abuse)

PPASA (Planned Parenthood Association of South Africa) /Lovelife

Pro-me-tra

SANGOCO (South African NGO Consortium)

School of Psychology, Natal University (Professor Graham Lindegger)

Sedibeng/Mvunu Research Consultants

SOCA Unit, Thoyandou

Soul City

Thoyandou District Police (SAPS)

Thoyandou District Prosecutors Office

Thoyandou Legal Aid Clinic

Thoyandou Magistrates Office

Thoyandou Maintenance Forum

Thoyandou Prosecutors Division

Tshwaranang Legal Advocacy Centre

TVEP (Thoyandou Victim Empowerment)

UNAIDS Genderlinks

WAWA (Women Against Women Abuse)

Women's National Coalition

Youth for Christ

India

Accept

ActionAid

Centre for Advocacy and Research

Delhi Network of Positive People (DNP+)

Family Health International

Freedom Foundation

Gender Training Institute

HIV and AIDS Alliance

Indian Network of Positive People (INP+)

Jagruthi

Karnataka Network of Positive People (KNP+)

Lawyers Collective, HIV and AIDS Unit

Lawyers Collective, Women's Rights Initiative

Naz Foundation India

Oxfam India

Positive Women's Network

Samraksha

Snehadaan

SPYM (Society for the Protection of Youth and the Masses)

SWAM (Social Welfare Association for Men)

UNIFEM (United Nations Development Fund for Women)

VHAI (Voluntary Health Association India)

WHO (World Health Organisation)

YRG Care

Namibia

AIDS Care Trust

British Council

Catholic AIDS Action

Department For International Development, UK

Family Health International

IBIS

ICD/CIIR

Legal Assistance Centre

Lirongu Eparu

Ministry of Health and Social Services

Ministry of Women and Children's Affairs

MISA (Media Institute of Southern Africa)

Namibian Girl Child Organisation

National Federation of People with Disabilities

Sister Namibia

Social Marketing Association

Take Control Campaign

The Rainbow Project

TKMOAMS (Tate Kalungu Mweneka Omukithi wo 'AIDS" Molishongo Shetu)

USAID (United States Agency for International Development)

White Ribbon Campaign

Women's Solidarity

Cambodia

Angkor Children's Hospital

Cambodian Midwives' Association

Cambodian National AIDS Authority

Cambodia People Living with HIV/AIDS Network (CPN+)

Cambodian Red Cross

Cambodian Women for Peace and Development

CARAM Cambodia

CARE Cambodia

CHEC (Cambodian HIV/AIDS Education and Care)

CORRE

Family Health International

HIV/AIDS Coordinating Committee

Interagency Project on Trafficking in Women and Children in the Mekong Sub-Region

Khana

Medicins Sans Frontières

NCHADS (National Centre for HIV and AIDS)

Policy Project

RHAC

Save the Children UK

SHARE

Stung Treng Women's Development Centre

UNAIDS Cambodia

WHO

South-East Asia Regional Offices, Bangkok

Department For International Development, UK

UNAIDS (The Joint United Nations Programme on HIV/AIDS)

UNESCO (United Nations Educational, Scientific and Cultural Organisation)

UNFPA (United Nations Population Fund)

UNIFEM

USAID

WHO

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