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Skills-building for Gender Mainstreaming in HIV/AIDS

RESEARCH AND PRACTICE

SEMINAR PROCEEDINGS

From the 3rd African Conference of the
Social Aspects of HIV/AIDS Research Alliance,
Dakar, 2005.

Edited by
Bridgette Prince, Sarah Pugh
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- The Human Sciences Research Council
- Open Society Initiative for Southern Africa
- The Social Aspects of HIV/AIDS and Health Research Alliance
- UNAIDS

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Abbreviations

AAWORD	Association of African Women for Research and Development
ACEWH	Atlantic Centre of Excellence for Women's Health
AIDS	acquired immune deficiency syndrome
ARV	antiretroviral
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
GAD	gender and development
GBA	gender-based analysis
HBC	home-based care
HIV	human immunodeficiency virus
HSRC	Human Sciences Research Council
IDU	intravenous drug user
KHDS	Kenya Health Demographic Survey
KNACC	Kenyan National AIDS Control Council
KNSP	Kenyan National Strategic Plan
MAP	Men as Partners
MKUKUTA	National Strategy for Growth and Reduction of Poverty (Tanzania)
MSM	men who have sex with men
NGO	non-governmental organisation
OSISA	Open Society Initiative for Southern Africa
PLWHA	people living with HIV/AIDS
PRS	Poverty Reduction Strategy
SAHA	Social Aspects of HIV/AIDS and Health
SAHARA	Social Aspects of HIV/AIDS Research Alliance
STI	sexually transmitted infection
THIS	Tanzania HIV Indicator Survey
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNIFEM	United Nations Development Fund for Women
VCT	voluntary counselling and testing
WID	Women in Development

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Preface

This report contains the presentations delivered during the gender and HIV/AIDS-themed sessions at the 3rd African Conference of the Social Aspects of HIV/AIDS Research Alliance, held in Dakar, Senegal from 10–14 October 2005.

The introduction to this collection of papers begins by providing a background explaining why such a focus on gender and HIV/AIDS is necessary. It provides an overview of the partnership between the Social Aspects of HIV/AIDS Research Alliance, the Commonwealth Secretariat, UNAIDS, Dalhousie University and the Atlantic Centre of Excellence for Women's Health, and the events that led up to the Dakar conference. Finally, the introduction describes the format and the key objectives of the gender-based sessions that took place in Dakar.

Section A of the report, 'From theory to practice', chronicles the presentations given during the capacity-building sessions in Dakar, with a look at some critical gender and HIV/AIDS theory as well as a thematic report on one of the 'exchange encounter' discussions that took place at the conference.

Section B, entitled 'Applying gender-based analysis to practice and informing emerging theory', provides the presentations from the capacity-building workshops, including discussions around how to design gender-sensitive research and how to extract gender-relevant data from existing research sets, as well as how to move from research to advocacy to policy.

Section C, 'Building skills and capacity using gender-based analysis to facilitate gender mainstreaming', chronicles presentations that specifically explore how to do gender-based analysis in your own work, as well as discussions around men, masculinities and HIV/AIDS.

The report concludes with a brief summary and a look to future work that needs to be undertaken around gender and HIV/AIDS issues in Africa.

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Introduction

Sharon Kleintjes, Sarah Pugh and Bridgette Prince

Background

Following the recommendations of the UN Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa, there have been deliberate moves to develop national action plans to address issues relating to prevention of infection, education, violence, property and inheritance, care-giving, and access to treatment and care. The recommendations in these action plans complement interventions already implemented across sub-Saharan Africa, by both governmental and non-governmental institutions. What has emerged clearly is the dearth of evidence-based and qualitative gender-focused research on HIV/AIDS to inform the development of effective policies, programmes and advocacy strategies. There has also been an increasing awareness that the closure of the critical gap between theory and practice requires attention to building capacity for mainstreaming gender into HIV/AIDS research and programming.

In response to the need for capacity development, gender mainstreaming was addressed as a multi-day thematic 'stream' at the 3rd annual SAHARA[1] Conference in Dakar, Senegal from 10–14 October 2005, under the theme 'Bridging the gap between policy, research and intervention'. The conference provided a vehicle through which to develop an understanding of the role of gender in the HIV/AIDS pandemic, and to build skills for effectively addressing gender in the work on HIV and AIDS, with a particular focus on capacity building in gender-based analysis (GBA). As an extension of an existing international partnership around gender mainstreaming, the gender-based sessions were convened by SAHARA in collaboration with the Atlantic Centre of Excellence for Women's Health (ACEWH), the Commonwealth Secretariat, Dalhousie University, the Open Society Initiative for Southern Africa (OSISA) and the Joint United Nations Programme for HIV/AIDS (UNAIDS).

An overview of the conference and gender stream

In her Opening Address at the first conference plenary, Dr Olive Shisana, Chief Executive Officer of the Human Sciences Research Council in South Africa and chair of the SAHARA network, noted that gender as a socioeconomic construction is critical to any understanding of HIV/AIDS. She explained that women's increased vulnerability to HIV/AIDS cannot be attributed to a lack of knowledge, but rather can be ascribed to the inferior position in which women often find themselves within the household and in society in general.

In keeping with the conference theme, the gender stream attempted to strengthen the connections between the theoretical concepts and main debates around gender mainstreaming on the one hand, and the practical skills required to integrate a gender-based perspective in policy, research and intervention on the other.

It was clear from the level of interest displayed by delegates, and from the nature and intensity of debate around issues raised, that many organisations and individuals are currently struggling with the application of GBA to their research, policy and programme development. With this in mind, this publication has been compiled to serve as a resource to researchers, programme implementers and policy-makers who would like to start applying GBA to their work or improve on current GBA application. This publication provides an overview of all the gender-specific conference proceedings and outcomes, concluding with a summary of the main gender threads that permeated conference discussions.

Section A of the publication reports on a capacity workshop that focused on the links between contemporary theory and practice. The workshop comprised five presentations. Tamara Shefer's paper addresses the need to challenge uncritical application of gender-stereotypical theory in policy and programme development, which can result in a failure to address endemic inequalities that pervade male and female access to social resources and power. She emphasises the need to critically deconstruct interventions, and the theories which underlie their development, to address the insidious impact of gender issues on policy and programmatic responses to HIV/AIDS.

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Doo Aphane's paper focuses on the need for action to overcome the negative impact of the minor status and differential access of women to social and economic resources in Swaziland. Herman Lupugo's paper argues for the importance of a community-level perspective on gender-related issues. These authors demonstrate how different theoretical points of departure may influence understanding and utilisation of available research, and the policy directives and programmes which emanate from them. Sisonke Msimang's paper highlights the fact that, theory notwithstanding, there are many drivers which influence the shape and direction of policies and programmes. These include a still pervasive tendency to value the views of the North over the South in the application of theory to practice, the power of donors as drivers of policy and programme priorities, and other practical and capacity issues within Africa. Msimang recommends that the application of theory to policy and practice be informed by local knowledge, experience and capacity. She notes that applied theory should at all times be in the service of promoting equal participation of women and men in social discourse and societal transformation. The final paper in this section, drafted by Sarah Pugh, focuses on men who have sex with men (MSM) as a marginalised and stigmatised group in Africa, where HIV is most commonly heterosexually transmitted. The paper outlines the impact of discrimination against MSM on equal access to available prevention and treatment options for HIV/AIDS. This session on MSM clearly illustrates Shefer's notion that narrow, uncritical theoretical constructs of sexuality serve to undermine the appropriate and inclusive approaches and practices in the field of HIV/AIDS. It highlights the need to transform broader societal paradigms which permit exclusion and discrimination in service developments based on ill-conceived theory, research and practice.

Section B illustrates the application of gender-based analysis to research. Jacqueline Gahagan's paper provides an overview of the importance of including GBA throughout the research process, and outlines implementation issues in building GBA into research. The remaining papers in this section provide illustrative case studies of the application of GBA in different settings. Patrick Orega's paper is set within the context of country-level research on gender. He reviews the case for HIV/AIDS as a gender issue, drawing on the national Kenyan experience of the pandemic and the need to forefront GBA within its National HIV/AIDS Strategy. Solange Bandiaky's paper provides an example of the application of GBA to inform priorities for interventions

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within an institutional setting. Levi Mutombo's paper summarises the findings of a GBA-informed qualitative research project conducted in one poor, rural community setting. Masheti Wangoyi's paper reports on the policy and practice implications of a larger action research study on the gender dimensions of HIV/AIDS in four countries, Kenya, Ehtiopia, Eritrea and Somalia. Finally, Nompumelelo Zungu-Dirwayi's paper encourages the use of GBA on data from existing research. She recommends that available research be used to start the process of engendering policy development and practice in settings where the impact of gender has thus far been neglected.

Section C reviews two workshops which provided participants with the opportunity for interactive, hands-on application of GBA technology. The first workshop, co-facilitated by Joseph Amazu (Commonwealth Secretariat) and Dean Peacock (Engender Health) used facilitative discussion and scenario-building to challenge notions of masculinity and to develop new capacity for participants to engage with gender in their own work. Concepts and scenarios drew on strategies used by Engender Health in their Men as Partners Project. The second workshop, co-facilitated by Erika Burger and Barbara Clow, provided participants with practice in the application of GBA using case studies in a small group context.

Finally, the publication concludes with a summation of key lessons for researchers, policy-makers, planners and service providers, and makes recommendations for mainstreaming gender in research policy and practice in HIV/AIDS in Africa.

Endnote

1. The Social Aspects of HIV/AIDS Research Alliance (SAHARA) is a critical response to the HIV/AIDS epidemic in Africa, a vehicle for facilitating the sharing of HIV/AIDS-related research, expertise and knowedge, and for conducting multi-site and multi-country exploratory, cross-sectional, comparative, or intervention-based research projects within an African context. As part of its concerted action, an annual conference is convened to foster effective integration of the activities of the alliance research partners and of other organisations and individuals active in HIV and AIDS control within the African continent and abroad.

Section A
CAPACITY-BUILDING: FROM THEORY TO PRACTICE

Workshop: Taking stock – voices of theory, voices of experience

This capacity-building workshop explored contemporary theory and debate on gender mainstreaming in HIV/AIDS policy and practice, contextualising the development of gender-based thinking and gender mainstreaming in the recent past. Experience-based presentations from East, Central, West and Southern Africa served to link the theoretical inputs to successful techniques and experience in gender mainstreaming, as well as barriers to application, and practical opportunities for engendering research, policy, programmes and community development.

Exchange encounter: Gender, MSM and HIV/AIDS

The exchange encounters were interactive sessions, gathering people living with HIV/AIDS (PLWHA), non-governmental organisations (NGOs), representatives of civil society, state representatives, researchers, agencies of the United Nations and other international organisations. The aim of these encounters was to provide a forum for a wider exchange of views around five themes relevant to the HIV/AIDS crisis in Africa.

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PAPER 1

A critical look at the use of gender theory in HIV/AIDS responses

Tamara Shefer

Introduction

This paper reflects on the way in which gender or feminist theory has been used in both research and practical interventions that have taken place in response to the HIV/AIDS pandemic. It critically explores the understandings of gender and theoretical perspectives on women, gender and sexuality that have been drawn on in the majority of work related to HIV/AIDS. While the paper arguably makes some comments that are relevant in international contexts, it draws predominantly on the experiences of the South African response to HIV/AIDS. In this respect, the paper begins by acknowledging the historical context of work related to gender and sexuality in South Africa.

The historical context of apartheid is infused with patriarchal dominance and the repression of sexuality. It is widely acknowledged that race, class and gender were and continue to be interwoven in the South African context in ways that facilitate particular vulnerabilities to HIV/AIDS, as well as gender-based violence and other social challenges. However, it should also be noted that sexuality was an area of repression in our history, which was also embedded in racism, homophobia and patriarchy. Furthermore, the state collaborated in popular moralistic discourses on sexuality, so that there was little research on sexuality, even less discussion at an educational and life-skills level concerning sexuality, and outright repression in areas such as publishing and media censorship.

In contrast, the focus on gender equality and state commitment to this since 1994, together with the challenges of HIV/AIDS, have opened up a proliferation of knowledge production, popular discourse and educational and other interventions relating to sexuality and gender. This has been viewed as one of the positive spin-offs of the otherwise devastating impact of HIV/AIDS.

However, it has become evident that in our responses to HIV/AIDS we also face the danger of reproducing and legitimising existing gender inequalities as well as gendered (and raced, classed) stereotypes and marginalisation.

What gender theory in HIV/AIDS?

The knowledge, attitudes, behaviours and practices focus used in initial educational and research programmes contributed to the marginalisation of gender as an 'add-on variable'. In research projects, for example, if gender was included at all, it tended to be primarily through a disaggregation of the data or an attempt to define differences on the basis of sex. With a growing understanding of the centrality of gendered roles in addressing the spread of HIV/AIDS, it soon became clear that providing people with information about HIV/AIDS was of little impact outside of an awareness of the central role that gender roles and gender power inequalities play in (hetero)sexual negotiation. As a consequence, a spate of research began emerging in this country, as elsewhere, addressing women's vulnerability to HIV/AIDS, the role of coercive and inequitable practices in the negotiation of (hetero)sex, and the role of gender-based violence in facilitating the spread of HIV. Similarly, attempts at a prevention and care level began focusing on gender roles, skills for negotiation, and the unequal burden that women are carrying with respect to caregiving and so on. While this research and educational shift has been of great value, it has become increasingly obvious that there are some potential dangers for the broader struggle for gender equity inherent in our responses. For example, the initial focus on women and girls (in both research and practice) tended to result in an inadvertent 'blaming' of women for the epidemic. Similarly, the focus on women's vulnerability and men's inevitable power in the negotiation of (hetero)sex may have served to reproduce traditional gender roles: women's stereotypic passivity and vulnerability, together with associating masculinity with power, control and violence.

Lack of engagement with contemporary theory

A number of critical points about the perspectives on gender that predominate in research and practice in HIV/AIDS may be made when we dialogue with contemporary critical feminist thinking on gender. Firstly, the current responses

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to HIV/AIDS still hinge on a determinist binarism of masculinity versus femininity. Thus, much of the focus has been on attempts to raise awareness around assumed 'natural' difference and to improve 'communication' and negotiation between men and women, rather than on seriously addressing the structural inequalities between men and women and the way in which these intersect with other forms of social power and difference and operate at a deep, often unconscious level.

Secondly, it appears that much of the literature and many intervention programmes still assume a determinist, heteronormative relationship between sex, gender and sexuality: both intervention and research assume a binarism between heterosexual/homosexual and cater to primarily heterosexual needs. Moreover, even in heterosexual foci, these are arguably also framed within rigid notions of sexual possibilities (for example, penetrative sex is assumed to be a normative practice, with no other alternatives that may also conform to safe sex practices). Thus, our dictum 'abstain, be faithful, condomise' not only assumes heterosexual, nuclear familial types of relationship, but also privileges penetrative forms of sex.

Thirdly, in spite of the growing acceptance of an understanding of the way in which gender is enmeshed with other forms of identity and power, much of the work around HIV tends to see gender and women as unitary, universal categories. The liberal feminist position acknowledges gender difference and strives for 'equal but different'. In so doing, it tends to ignore the centrality of power relations, and the way in which access to social power is implicated in unsafe sexual practices, as well as in gender roles more broadly. Further, gender power and roles do not exist in a vacuum; rather, gender is enmeshed with all other forms of social identity and power, such as 'race', class, and so on. Thus, the attempt to focus on gender and women as just another 'add-on', and to expect women to assert themselves sexually simply because they know they have a right to, is spurious given the complexity of lived realities and the way in which gender is enmeshed with other power inequalities. For example, a young woman refugee who is offered a food package in exchange for sex with an older male relief worker is not only unable to insist on safe sex as a woman in relation to a man, but also faces real economic power difference as well as the authority of age.

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Fourthly, postmodern, post-colonial feminist work has served to destabilise the very category 'women', calling into question any notions of a universal identity or experience, yet much of the work around HIV continues to see gender and gender power as unitary, essential and fixed. Thus, the complexity of gender that has been theorised in contemporary feminist work is ignored, with little understanding of:

- The way in which gender and sexual subjectivities and relations of power are continuously changing and fluid (not only in different contexts and histories, but even in an individual life);
- The way in which gender intersects in multiple, complex and inseparable ways with other forms of subjectivity and location, so that gender cannot be compartmentalised as a separate 'variable'; and
- The way in which social identities frame our personal meanings and subjectivity that is not always conscious to us.

The hiatus between theory and practice

The attempt to dialogue between current dominant practices in HIV research and intervention and contemporary critical theories on gender has highlighted the ways in which theory and practice are 'not talking to each other' in our responses to HIV/AIDS.

There are several key examples in the South African context that are testimony to the fragmented relationship between knowledge production and material interventions, in both education and research:

- Much of the critical work on sexuality, both theoretical and empirical, and especially that which is informed by discourse analytical work, highlights the lack of a positive discourse on female sexuality and desire and argues for the need to develop and/or expose such discourses in order to shift the terrain of gendered unsafe sexual practices. Yet, there is no evidence of an attempt to incorporate this extremely practical recommendation into current interventions. Rather, by all accounts, educational efforts continue to rely on an assumption of inherent and immutable differences between men's and women's sexualities and desires, and do not appear to allow space for alternative voices or role models of assertive female sexuality and desire. The argument that women cannot learn to say 'no' if they cannot say 'yes' is clearly not in evidence where efforts still seem to revolve around

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teaching women (not even men) to say 'no', without any attention to the complexity of negotiating safe sex for women (and men).

- Similarly, it has been argued that we need to move away from deterministic theories of men as inherently sexual, unable to control their sexuality, and prone to coercive practices and violence. Rather, it has been argued by some researchers and theorists that a key strategy to shift traditional masculine roles is to show models of men who 'resist' traditional male power. In this respect, more focus on men who practise alternate masculinities – such as gay men who may resist taking on heterosexual male power, or heterosexual men who express their vulnerabilities and desire for 'love' rather than just sex – seem to be severely undermined by homophobia, heteronormativity and the continued dominant 'macho' pressures on men that prevail in South Africa and many other societies. There appears to be little attempt to challenge such areas of discrimination, which it is argued serve to militate against more equitable sexual practices for men, or to foreground alternative discourses or role models of men performing masculinity and male sexuality.
- There has been a important increase in understanding the need to shift our focus from girls and women, given the victimisation and blaming that has arisen from this, to focus on masculinities and men, who have at some level been neglected and 'let off the hook' in the majority of responses to HIV/AIDS. This has resulted in a proliferation of research and interventions targeting men, but these responses are arguably (possibly even at an unconscious level) still operating within the framework of men as secondary to women, as ultimately in support of women in the struggle of HIV/AIDS. The language of one of the key interventions for men in South Africa, the 'Men as Partners' programme is indicative of this. Yet, the linguistic sidelining of men as simply 'partners', rather than playing the lead role, serves to reproduce the problematic centering of women (and consequent 'blaming discourse') in the epidemic. Moreover, if the current popularity of working on and with men begins to inadvertently marginalise women and impact on spending and resources directed towards women, this may threaten the broader goal of gender equality and women's empowerment.

Conclusions

This short piece of thinking has only touched on some of the challenges we face in trying to ensure that we sensitively and appropriately infuse responses to HIV/AIDS with the broader goal of gender equality. While more rigorous work, drawing on empirical examples of the critiques, is still necessary, there are some things we can do to make sure that we continue to think and act critically in our work.

Clearly, there is a need for more engagement between theorists/researchers and practitioners, which will allow for continuous evaluation of and reflection on what we have achieved directly and the impact of such work at multiple levels. In particular, it is important to always apply a critical, deconstructionist lens to the work in order to expose the more subtle meanings and impacts. Inadvertent spin-offs of approaches to HIV/AIDS that may, in the long run, serve to reproduce, legitimise and/or rationalise existing power inequalities (including gender and other forms of discrimination) need to be explored and challenged. In this respect, self-reflexivity in our research, theorising and practice becomes an imperative for the socially concerned researcher or practitioner. We need to become increasingly aware of the meaning and impact of our theories/research/interventions, as well as continuously cautious in identifying and acknowledging our own theoretical, ideological and moral locations when addressing the complex, fraught arena of gender and sexuality within our responses to HIV/AIDS.

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PAPER 2
Gender mainstreaming and HIV/AIDS in Swaziland

Doo Aphane

Introduction

After situating the experience of Swaziland within an international context of developments around gender thinking and development issues, I would like to provide an overview of how issues of gender equity and equality have advanced in Swaziland over the past 20 years.[1] This is an important context for helping to understand how and why estimated HIV/AIDS prevalence rates among woman of reproductive age in Swaziland have skyrocketed over the last decade to an estimated 42.6 per cent in 2004 (Swaziland Government 2004).

Some of the concerns that have affected women in Swaziland, both historically and in the present, include women's legal status as minors, men's exclusive decision-making roles, and the burden of women's multiple roles as bearers of children, providers of food, home-makers, health caregivers and suppliers of water and fuel. Other issues impacting on women centre around inadequate access to health care, education and formal employment, as well as a lack of any co-ordinating mechanism for the affairs of women. Furthermore, women are faced with an unfriendly political environment, along with restrictive societal attitudes about what constitute appropriate social and economic roles for women.

Tracking some of the changes that have occurred for women on the political front in the past 20 years, there have been insufficient mechanisms to promote the advancement of women at all levels. However, there have been some changes. For example, after the UN's 3rd Conference on Women in Nairobi, in 1985, there was a proliferation of women's NGOs working with women in order to advance and enhance their status. In 1994, a National Steering Committee of Women's Affairs was set up to drive the process of integrating women into the development process. This committee was later renamed the Swaziland Committee on Gender

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and Women's Affairs and launched the Swaziland Platform for Action in 1996, calling for men's and women's equality in legal, social, economic, environmental, cultural and political spheres. Also in 1996, the Gender Co-ordination Unit was established as the national machinery for co-ordinating gender issues. In conjunction with NGOs, the unit began training workshops and seminars around gender issues in Swaziland. Despite this and other advances, including the election of five women to Parliament in the 2003 elections, women still comprise only 18 per cent of parliamentarians in the country. While Swaziland's recent Constitution contains a provision on equality in the section on Rights and Freedoms of Women, it also contains other provisions that detract from the principles of equality outlined in that section. In 2004, Swaziland ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), in what really could be a milestone for Swazi women. Still, the concept of gender at a local level is still widely misunderstood and mistrusted. We saw results of this in our last election, when many electoral candidates chose not to emphasise gender issues in their campaigns.

In terms of the interface between HIV/AIDS and gender issues in Swaziland, it is important to note that women as a whole represent the majority of people living with HIV/AIDS in the country, where our national HIV prevalence rates for 2004 are estimated to be the highest in the world. Women continue to be relegated to minority status in the country, effectively taking much decision-making power out of the hands of women, and leaving them often economically vulnerable or dependent on men. As a monarchy, Swaziland is governed by two sets of laws – traditional law and Roman-Dutch law, and the kinds of rights and powers women have access to depend on their marital status, with their rights increasing with marriage under Roman-Dutch law. In addition, drought has been an increasing problem for the country over the past few years. When added to levels of unemployment that were already high, this has created situations of increased economic stress and instability, with particular impacts on women. When women are fully dependent on men for their economic support, their choices are curtailed in many respects and, significantly, their ability to negotiate around sexual relations is hindered.

While polygamy is legal and still an accepted practice in Swaziland, it is on the decline. The king, who at the time of writing had 12 wives and a fiancée, is one of the most passionate ambassadors for polygamy, arguing that it does not spread HIV as long as all partners are faithful to each other. Still, many Swazi men continue to father children outside marriage, and customs such as *kungenwa*

(where a widow will marry her deceased husband's brother) and *inhlanti* (where a younger niece or sister might bear children on behalf of relatives who are unable to do so) are still practised and contribute to the spread of HIV.

Despite the gloomy picture, there are windows of hope, and if we fail to pay attention to these, we may whittle away an entire nation to extinction. One such window of hope is the UNAIDS Southern African Task Force on Women, put in place to respond particularly to the impact of HIV/AIDS on women and girls. Another is Swaziland's new Constitution, with its promise of free and universal education, through which primary education should be free in the next three years. Hopefully, girls will be able to access this education, though the issue of girls being deputised by their mothers for caregiving at home for HIV-infected people will have to be addressed in order for girls to take full advantage of the new universal access to education. Another window of opportunity is action to support the recent ratification of CEDAW. A very real difference can be made in the lives of Swazi women if this is simultaneously implemented alongside national legislation, accompanied by massive education, and a concentrated building of self-esteem and a sense of rights in women.

Endnote

1. This synopsis has focused on Ms Aphane's account of the Swaziland experience. However, she began her presentation with an overview of feminist and gender theories, followed by a discussion of the evolution and effectiveness of the Women in Development (WID) and Gender and Development (GAD) approaches towards incorporating women's issues and gender concerns into developmental programmes. Ms Aphane then delved into questions around the definitions and goals of gender mainstreaming. Some of the strategies, and implicit challenges, of implementing gender mainstreaming were explored, in order to provide the background for an examination of the contemporary situation in Swaziland. Ms Aphane also provided an interesting comparison with the unfolding of gender mainstreaming in Uganda. Contact Ms Aphane for further details and her expanded presentation.

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PAPER 3

HIV/AIDS and gender from a community perspective

Herman Lupogo

Introduction

Mainland Tanzania is similar to other sub-Saharan African countries in that women outnumber men in the rate of HIV infections. The national prevalence rate stands at 7 per cent (7.7 per cent for women and 6.3 per cent for men). Of 221 896 people treated in 2003 for AIDS, 126 979 were female while 94 917 were male (Tanzania Commission for AIDS 2004). Likewise, more females than males are actively involved in coming forward to seek assistance.

However, both males and females share certain disturbing characteristics that have recently become obvious. In the 2004 *Tanzania HIV Indicator Survey*, the rate of infection was found to increase with wealth. In the same survey, the rate of infection increased with the number of years that the subject had been at school. These two observations call for a modification of our views regarding the extent to which poverty is a determinant in the spread of HIV.

HIV/AIDS and community life

Notwithstanding the high proportion of female people living with HIV/AIDS (PLWHA), we need to look critically at the impact of HIV/AIDS on a given community as a whole. While it is true that life in urban areas tends to centre on the individual, shared facilities such as schools, hospitals, markets and various utilities – not to mention families – make for a shared existence. Therefore, the plight of women will affect men, and vice versa. An ailing wife and mother is a loss to the husband and has an immeasurable impact on the well-being of all the children. The incapacity of a female schoolteacher is keenly felt by many members of the community, both male and female. The same goes for any service provider. When the AIDS process ultimately

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culminates in death, gender *per se* is no longer the central issue, and most neighbours meet, irrespective of family ties.

An economically productive woman is an asset to her family and the entire community. In rural areas, it is common for people to sing the praises of local women (or to lament their plight as 'beasts of burden'). The very important role played by urban women receives no similar attention. It is crucial that this situation changes and that public perceptions shift to acknowledge the role that these women play. Even the role of commercial sex workers, however despised or disapproved of by some sections of society, should not be ignored.

The 2004 survey also draws some obvious conclusions from the manner of HIV transmission in the country. In Tanzania, about 80 per cent of infections occur through heterosexual means. The obvious implication is that both men and women are responsible. Despite this fact, stigma against women PLWHA still reigns; it is a perception based on ignorance and male chauvinism.

Policy and advocacy direction

Purely pinning our hopes on gender policy and advocacy work may not bear the expected fruits. We need to cast our nets more widely and involve whole communities. We should target community empowerment even when we want women's empowerment. Both men and women should be enlightened on gender issues, so that each will better understand his or her responsibilities and duties to the community. It is not enough to ask men not to blame women regarding HIV infection when they do not know how the infection occurs and the part that they play. Though the woman may seem disadvantaged, the man may be more so, and both need education and economic empowerment to uplift their lives. We therefore advocate a policy that leads to the improvement of community life, including education and the economy. In the process, health, education, employment, HIV/AIDS, income-generation, stigma and other concerns will be addressed. Issues such as discrimination against women, harmful traditional practices like female genital mutilation, or hiding disabled children, can be teased out in their community settings.

An undue emphasis on 'gender' (a term that has been adopted by some people in retreat from an overemphasis on feminism) may be a red herring. It still raises male, and sometimes female, eyebrows and in some quarters, hackles

– whatever our public protestations. This emphasis then diverts efforts from the public common good, because it raises petty issues about balancing mere physical representation – rather than ideas – and takes refuge in a numbers game. We should concern ourselves with whether palpable, evidence-based progress is being made, not questionable assertions around who should be doing the work.

This line of thinking has led Tanzania to adopt a second-generation Poverty Reduction Strategy (PRS), called the National Strategy for Growth and Reduction of Poverty (known as MKUKUTA). This strategy has focused on three clusters, namely:

- Growth and reduction of income poverty;
- Improvement of the quality of life and social well-being; and
- Governance and accountability.

Growth and reduction of income poverty aims to improve food availability and increase both urban and rural incomes of men and women. Improvement of the quality of life and social well-being aims to ensure equitable access to quality education for all at all levels, and access to affordable public services. This cluster also promotes the survival, health and well-being of children, women and vulnerable groups in a safe and sustainable environment. Governance and accountability encourages public servants and leaders to promote democracy, social tolerance, peace, political stability and national unity.

Since it is accepted that HIV/AIDS is a social issue and that it is part of the process of development, it is proper that it should firmly take its place among development issues.

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PAPER 4

Developing a research agenda for gender in Africa

Sisonke Msimang

Whose global perspective?

Often the discussions we have about international issues do not incorporate the contribution that Africans have made to global work. This needs to be done, in ways which both promote the development of an African research agenda – one which seeks to examine and explore the issues that are important to Africans – and also facilitate applicable knowledge transfer to the global research and practice arena. There is an unspoken assumption that those in the North have the capacity to speak from a global perspective, while those in the South should restrict themselves to speaking about local issues. This needs to change in all arenas, particularly in relation to research, if findings are to be useful locally and globally, irrespective of their source.

Making better use of research

Beyond these issues at the macro level – regarding who does the research and how it is driven – it is nevertheless important to acknowledge that even research that has been undertaken is often underutilised. This is evident from the fact that despite often knowing what we should do, we do not seem to be doing it.

Two issues inform our understanding of the reasons for underutilisation of research. Firstly, those in decision-making positions are often unable to give the required attention to available evidence. This is either because their decisions are driven by other agendas – political, moral, evangelical, or whatever the case may be – or because they simply do not understand the way in which the information is packaged: the graphs and statistics that researchers present are not always packaged in ways that are appropriate for planning purposes.

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Researchers therefore need to think more clearly about why and how they undertake their research, to ensure that their findings make a tangible difference to policy and practice. The theme of the conference aptly captures the need to bridge the divide between research, policy and implementation, and recognises the need for partnerships between researchers, activists and bureaucrats. Research helps us to understand social phenomena better, but this is pointless if the research does not move beyond a few conference rooms around the continent. Activists need to be able to use the research products, but also to work with researchers to help them frame the right questions. Research is a cyclical process and there are important roles for everyone to play in this regard.

Linking research to action

In terms of gender issues and research, we have known for some time now what the issues are. The Secretary General's Task Force on Women and Girls in Southern Africa provides a useful framework for linking research to action. This includes:

- Prevention: the age gap between girls and older men;
- Girls' education: staying in school and having safe schools;
- Violence against women;
- Home-based care;
- Property and inheritance rights; and
- Treatment.

Across each of these areas more needs to be done. For example, in the arena of prevention, we know how to stop vertical transmission of HIV to unborn children, yet rates of access to the services are very low. Furthermore, in girls' education we are struggling to keep girls safe in schools, even though the teachers who perpetrate violence against girls are often known to the community. In terms of home-based care, evidence indicates that the vast majority of caregivers are female, yet little is done to afford protection and social services to the women who do this difficult work. We need to better understand why so few of our efforts are making a real difference in people's lives.

Secondly, both the practical experiences of women on the ground and the theoretical perspectives developed by academics are necessary when seeking

to work on gender and HIV/AIDS issues. Having recently joined the donor community, it is clear to me that funding priorities are driven by a mix of practical issues (who can spend the money and ensure impact) and theoretical issues (who should have access to and control over resources, and what we are trying to achieve through the work we support and the partners we provide with funding).

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Funding and resource flows

Within the Open Society Initiative for Southern Africa, we are committed to working with marginalised and vulnerable people in addressing HIV and AIDS. This includes paying significant attention to women's rights, but also to work that seeks to alter inequitable gender relations. We are aware of and sensitive to the debates about where funders are putting their resources. We also know that there is concern that much of the work of the women's movement is under threat because people are increasingly interested in gender and less so in women. This awareness often entails a difficult balancing act in practice, because we are not a large funder.

That said, we are also aware that there are larger debates about the global funding architecture and resource flows, as well as about the role of the law in pushing states to implement policies that do not typically sound relevant to the gender discourse. Because these debates are dominant within the AIDS sector, it is important for people engaged in gender work as well as women's rights activists to ensure that their voices are heard in these broader arenas. A guiding principle which informs our funding decisions is that while theory is important in making these decisions, it should be so only to the extent that it is informed by experience; and it feeds into a vision that creates a society in which men and women are able to debate and discuss issues freely, where all people can access the social services they require, and where vulnerability to disease is not determined by race, class, gender, sexuality, ethnicity or any other factor.

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PAPER 5

Sexual identities and men who have sex with men

Sarah Pugh

Introduction

One of the greatest challenges in responding to HIV/AIDS in sub-Saharan Africa is trying to develop a genuine, comprehensive understanding of the complex, multiple ways in which people are infected with HIV and affected by the pandemic. There is not one single causal factor, but rather an intricate, complicated variety of social, geographic, economic and cultural issues that interface in unique ways and give rise to multiple experiences and realities of HIV/AIDS across regions. The development of effective interventions for HIV/AIDS depends on increasing our understanding of these different realities, and ensuring that we are able to recognise and respond to the specific challenges that present themselves. We must identify trends that help us frame and understand HIV/AIDS at a macro level, while not losing sight of the more specific factors that may contribute to the spread of HIV at a regional, local or interpersonal level.

At the 3rd SAHARA Conference in Dakar, one of the most dynamic, interactive and innovative sessions took place in an 'exchange encounter' under the broad theme of Gender and HIV/AIDS, and the specific sub-theme of 'Sexual identity and men who have sex with men (MSM)'. The exchange encounter format was designed to provide an open forum for facilitated dialogue around key issues, and to work towards identifying critical research gaps and practical ways of taking the issues forward. In many parts of the world, MSM issues in relation to HIV/AIDS – which were so prominent in the early days of tracking and trying to understand the epidemiology of HIV – have largely fallen by the wayside. This is especially true in sub-Saharan Africa, where heterosexual intercourse has become by far the most common means of HIV transmission.

The stage for discussions around these issues is set very differently across regions. In South Africa, for example, rights around freedom of sexual

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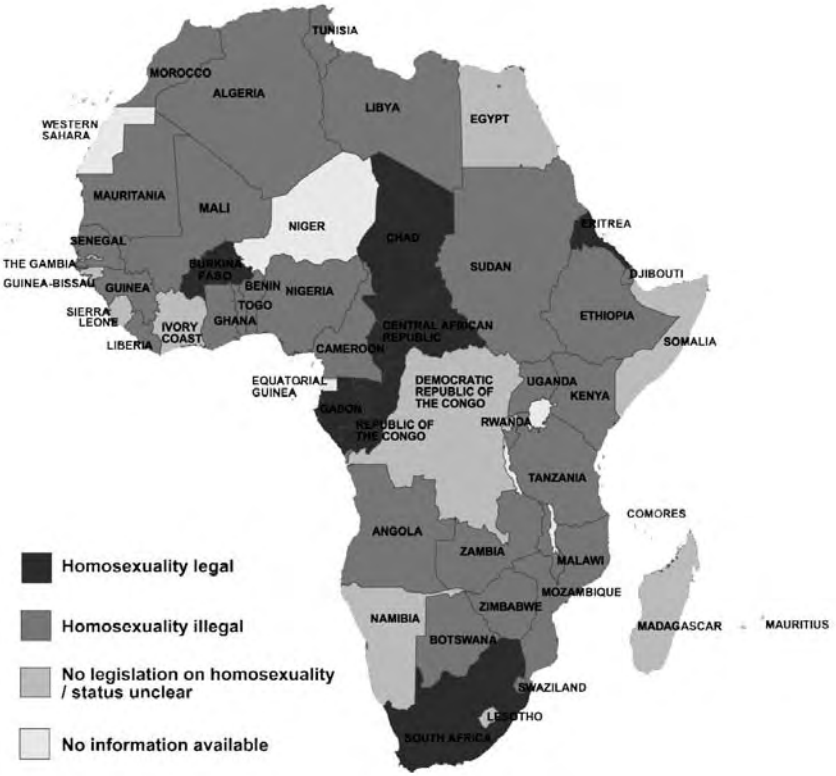
Figure 1: Legal status of homosexuality in Africa



Source: Adapted from afrol News (www.afrol.com)

choice and identity are constitutionally enshrined (though this may be far from the reality of many people's lives). Homosexuality is also legal in a handful of other African countries. In the majority of African countries, however, homosexuality is either illegal or its legality is ill-defined. Regardless of the legal status of homosexuality, social, cultural and religious taboos may hold more influence and regulate people's behaviour more than the law.

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In Senegal, where the 3rd SAHARA Conference was held, homosexuality is very clearly illegal, which made the presence and participation of representatives from the MSM community all the more remarkable. One of the session's chairs said that just being able to speak openly and bring the issues to the table at the SAHARA Conference was a 'watershed' and an 'historic event' for MSM in Senegal. As another of the chairs put it: 'Every count starts with one, and this is the first time we are holding such a gathering. SAHARA has made a vital step forward, because it is the first step.'

Stigma and discrimination

The young men who chaired this particular session were representatives from a Senegalese MSM association called Working Together, which claims 400 members across 11 administrative districts in Senegal. As in many countries in Africa and much of the world, Senegalese MSM can face enormous stigma and discrimination if it becomes known that they are MSM. This is especially true in predominantly Muslim Senegal, where homosexuality is not only illegal according to state law, but also unacceptable in religious terms. While there can be a tendency to think of MSM as a separate group – men who are 'other' and outside the normal, mainstream society – the chairs of this session were quick to point out that MSM are 'your brothers, your colleagues, your uncles, your husbands', and that the ramifications of stigma and discrimination ripple through the entire society in ways that may not be apparent at first. The desire to avoid stigma and discrimination, they argue, forces many MSM to lead double lives, to marry and have girlfriends in order to show the community that they are 'normal'. Indeed, recent MSM research from Senegal revealed that 88 per cent of a survey sample of 250 MSM reported also having had sex with women (Population Council 2002). According to the chairs of the session, HIV prevalence is increasing in the MSM population, and could be as high as 21 per cent, while HIV prevalence in the Senegalese population as a whole is generally accepted to be less than 2 per cent. Within such a context, the potential implications for the spread of HIV/AIDS are significant.

Stigma and discrimination create barriers for MSM in terms of access to testing, care, treatment and support. One MSM present at the session remarked that most MSM 'do not dare to come out openly' with their lifestyles, and are less likely to take HIV tests to determine their sero-status. As a result, HIV-positive

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MSM have less access to knowledge and education, as well as to proper health care and treatment.

'Being an MSM in a country like Senegal is very difficult in terms of the social realities,' said one the chairs. 'This is due to taboo and cultural barriers, so a lot of MSM do not have the possibility to come out clean, because it would be a danger for them to do so. It would be taking a risk vis-à-vis society and even the law.' One MSM who was present explained that when you are subjected to stigma, you tend to retreat and go underground. People's fear and lack of understanding of MSM may play an important role in propagating stigma and discrimination. As one participant put it: 'You can have anything in mind when you don't know the other.'

Several imams were present at this exchange encounter, sitting together on one side of the room. When the floor was opened, an imam raised his hand and acknowledged the need to encourage people to stop stigmatising those who are HIV-positive. 'At the beginning,' he said, 'AIDS had no name. We need to consider AIDS like any other disease, until we find a drug to cure it.'

The issues at hand were not easy; unsurprisingly, discussions were heated at times. In response to the imam, one speaker prefaced his comments by expressing his surprise that, 'The imam who took the floor didn't say what we expected him to say.' He went on to describe homosexuality as a pathology, and said that while he worked with an organisation that respected individual rights and liberties, men and women were anatomically created for each other, and there was a 'natural order of things' that needed to be restored. One of the chairs responded by asking all participants to set aside all stigma and prejudice for the duration of the session, 'so that together we can try and come up with solutions.' As another speaker from the floor put it: 'The call to action is to realise that we are all in this together – HIV doesn't make moral decisions.'

Sexual identity, rights and choice

The themes of sexual identity, rights and choice surfaced numerous times throughout the discussions. Susan Timberlake, from UNAIDS in Geneva, who was helping to facilitate the session, reminded all participants that sexual identity is really at the heart of the HIV/AIDS pandemic. She expressed the hope that the human rights world would define non-discrimination as

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including the right not to be discriminated against on the basis of sexual identity, and warned of a contemporary political climate in which some of the recent steps taken globally towards non-discrimination were in danger of being rolled back. What is needed, she added, is research around how best to create the conditions to understand and honour different sexualities, and how to reach and respond to their respective needs. Ms Timberlake spoke of the need to reorient funding towards stronger support for capacity-building for MSM associations to organise and fight for their rights. One of the MSM chairs also referred to the issue of human rights, noting that while Senegal is internationally perceived as a nation that upholds rights and the rule of law, this is not enough when some of these laws still discriminate against certain groups. This language of rights further extended to discussions around MSM entitlements to health care, prevention programmes and general protection for themselves and their communities.

Perhaps inevitably, the discussions around sexual identity led participants to question whether homosexuality constituted a personal choice, or whether it was something inherent and beyond choice. One participant from the Open Society Initiative for West Africa remarked on the high levels of sexual violence that many MSM in Senegal have experienced, and argued that while she saw MSM as a choice, she felt it was not a choice for which people ought to be blamed. The Population Council study revealed that 43 per cent of MSM in their study had been raped at least once outside the family home, and that 37 per cent said they had been forced to have sex in the last 12 months (Population Council 2002). A medical doctor related a story about having been called to visit an imam in a village outside Dakar who needed treatment for a sexually transmitted infection (STI). The STI was affecting the rectal area, and the doctor had learned that 'sexual intercourse had been initiated by the uncle when [the imam] was a child of 11 years old, so he then did the same with his own schoolmates'. The doctor explained that he told this anecdote to illustrate that 'MSM are ordinary people and are in all social groups'. Another speaker, from an outreach NGO, commented that in the course of their work with commercial sex workers in Senegal they have met many MSM, some of whom 'are MSM by accident' and some of whom are MSM by choice.

When MSM are associated with free agency and choice, there are implicit dangers that societies and communities will more readily attribute blame and judgement. Yet such discussions may also help to create a deeper

understanding of different behaviours, and especially risk-taking behaviours, in relation to HIV/AIDS. Improved understanding might facilitate the design and implementation of more appropriate and effective interventions to prevent the spread of HIV/AIDS.

Civil society, community response and inclusion

Echoing throughout the discussions was a strong, recurring theme of inclusion. What steps must be taken to cut through the obstructive layers of stigma and discrimination in order to integrate MSM into HIV/AIDS prevention, treatment, care and support programmes? As one of the chairs pointed out, such decisions do not rest only with MSM themselves; rather, they require cooperation from those in research, civil society, government, education and the medical professions. He stated that we now 'need to brainstorm, and call on everyone's good will to develop and nurture the attitude of including MSM'.

A medical doctor who was present illustrated the need for increased understanding and involvement across sectors. He described how, much earlier, he had heard mention of homosexuality, but it was not until this year, when he went for training with MSM leaders, that he 'realised it was a reality in society, and that we need to factor it in to combat the spread of HIV'. The doctor urged everyone present to acknowledge that MSM are a link in the social chain, and like any chain, when there is a link missing, the entire chain is weakened.

Various participants mentioned the need to stop grouping MSM separately, as a distinct category outside 'regular' society, or even pretending that they do not exist. Instead, they emphasised the need to ensure that MSM are firstly acknowledged and accepted as a legitimate segment of society, and then integrated, with equal access to the same rights and services as everybody else. Two speakers from the MSM association indicated that they do not wish to hold Gay Pride parades and rallies, or complicated campaigns, but rather their goal at the moment is simply 'to involve MSM in the fight against HIV, and to enable behavioural change'.

It was emphasised that civil society holds great potential for advocacy and awareness-raising around issues of MSM. Furthermore, one speaker pointed

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out the need for all role-players to share stories of successful interventions, while being mindful of regional differences when designing and sharing intervention strategies.

One of the intentions behind this exchange encounter forum was to provide an opportunity for developing possible points of action, or recommendations for taking forward the issues of MSM and HIV/AIDS in Senegal. There is undoubtedly also wider relevance for the lessons that may be learned. The need to advance these issues in a spirit of cooperation and unity is pressing. As one of the chairs from the MSM association expressed it: 'If we start playing tug of war, there will be no progress.'

Recommendations

The recommendations from participants in this exchange encounter forum can be summarised as follows:

- Engage communities and civil society in advocacy and outreach around MSM and HIV/AIDS issues;
- Work to end stigma and discrimination around MSM issues;
- Involve religious and spiritual leaders in education and outreach;
- Ensure equal access for MSM to HIV/AIDS education, health care, treatment and support;
- Work to integrate MSM as an accepted and acknowledged part of society, rather than regarding them as a separate, hidden group;
- Create a social environment where MSM feel safe and able to be tested for HIV;
- Share stories of successful interventions amongst relevant role-players, keeping in mind regional differences;
- Involve MSM in research, conferences, workshops and policy-making; and
- Explore a human rights approach to sexual identity and choice.

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Section B
CAPACITY-BUILDING WORKSHOP: APPLYING GENDER-BASED ANALYSIS TO PRACTICE AND INFORMING EMERGING THEORY

Pre-conference session: Engendering research – extracting gender-relevant data from existing studies

This session looked at incorporating gender into research design, methodology and analysis. It began with a theoretical overview of the importance of including gender at every level of the research process, followed by examples of how research can be strengthened using a gendered lens. Case studies illustrated how to extract gender-relevant data from existing research. This session highlighted the opportunity to enhance the relevance of existing research by using gender-based analysis (GBA) to gain access to a wealth of available gender-based information. The application of a gendered analytical lens to existing studies added a practical element to the capacity of conference delegates, allowing participants to think about and approach existing research in new and meaningful ways.

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PAPER 6

Gender and research: theory, design and implementation

Jacqueline Gahagan

Overview

This presentation focuses on three key interrelated areas, namely the conceptualisation of gender, the application of theory to gender-focused research, and gender and HIV/AIDS research design and implementation issues.

Conceptualising gender

Gender, along with other determinants of health such as education, age, housing, employment and working conditions, is a critical concept in research design related to HIV/AIDS. We have seen many instances in research where the concept of gender is glaringly absent or is used interchangeably with the concept of biological sex. Clearly, the type of HIV research we undertake, be it biomedical, social or behavioural, will influence the perceived utility of gender as an organising construct for our research design. Precisely because gender is constructed through a variety of imposed cultural norms (Kinser & Lewis 2005), conceptual clarity is a pressing challenge for HIV researchers working from different cultural contexts and from within different disciplinary boundaries. We therefore need to interrogate issues of bias in our HIV/AIDS research and policy design to ensure that we have not lost sight of the significance of gender, not only at the conceptual level, but also with regard to methods, design, implementation and analysis of our work.

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Why does gender matter in HIV research?

Unlike the concept of biological sex, gender is about the socially constructed differential placed on males and females; a differential connected to social, economic, religious, cultural, political and sexual behaviours and expectations of males and females. Gender manifests in a variety of HIV/AIDS research issues, including relative risk of infection, stigma and discrimination, access to treatment, and division of labour in the provision of caregiving within families. The failure of many HIV-prevention programmes can be linked to inadequate attention to unpacking gender relations and the implications of the resultant sexual dynamics between males and females.

The role of theory in HIV/AIDS research

Theory allows us to map out the research landscape at the conceptual level before we begin our research design and implementation procedures. HIV/AIDS prevention literature depicts a long history of social and behavioural theories, primarily from psychology and sociology, which have been used to help us understand the complexity of HIV risk behaviours and HIV risk environments or contexts. Much of the emphasis of early prevention efforts focused largely on changing individual behaviours in an effort to prevent HIV transmission. We have learned through the use of broader levels of analysis, including gender-based analysis, that HIV risk behaviours are often inextricably linked to community or societal level HIV risks. From a research perspective, we need to work at multiple levels simultaneously to understand the connections between micro-level behavioural aspects of HIV alongside broader population-based theoretical approaches. Some would argue that we need to strive for theory-driven or theory-informed HIV research and practice, while others would argue that this is a time-consuming luxury that we can no longer afford in the face of the current HIV/AIDS pandemic.

Research design: what matters most?

Research design, including sample size and recruitment techniques, may be influenced by time, funding or the purpose of the study – be it testing a specific hypothesis or conducting a gender-based evaluation of an existing

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HIV programme. For example, women or girls may be overlooked in sampling designs, or simply not recruited into studies, as cultural expectations emerge which exclude women's participation. It is problematic that research design and research questions related to, for example, women's experiences as caregivers for HIV-positive family members, may be limited by a clash with gender-based cultural norms. Such a clash may result in differential access to or exclusion of certain participants in the project, which in turn impacts on the findings. This gate-keeping function is played not only at the micro level by family members, but also by broader, macro-level organisations and industry. These issues raise many important design questions, including:

- How do we design a study that will ensure the ethical and meaningful representation of women and men, boys and girls?
- How do we accomplish this without causing undue harm or isolation, stigmatisation or discrimination towards participants?
- How do we address issues of HIV-related prevention or treatment policy and the differential impact these may have on males' and females' experiences with HIV/AIDS within the family?
- How do we ensure that we are being explicit about gender as a key variable in our research design rather than treating it as an add-on or afterthought?
- What are the implications for data analysis and uptake of findings where gender is absent?

Implementation issues

Additional issues to keep in mind regarding implementation of a project include whether or not to make use of local expertise in data collection. Some researchers argue that there may be a 'filtering' or biasing of responses if the participant knows the person collecting the data. Are we able to invite local males and females to become involved in data collection, and is the issue of same-sex versus opposite-sex interviewers something to consider? Is there sufficient expertise in gender-based analysis among members of the research team? Are the research team members able to connect with policy and programming sectors to help ensure that gender is not lost in the process once there are data to present from the study?

Co-ordination of research findings

Gender has been included to a varying degree as a research focus over the course of the HIV/AIDS pandemic. It has not been adequately incorporated in the research design of countless studies, which makes it very difficult to undertake a meaningful gender-based analysis of, for example, HIV-prevention research projects and policies. This can lead to some obvious challenges when it comes to informed decisions about health-research planning, policy, programming and funding. How do we triangulate, for example, HIV-prevention research results when the issue of gender is often absent from the design? Clearly there is a pressing need for access to existing data sets, not just where there are sex-disaggregated data. We also need to better understand the gender-based contexts of HIV prevention, risk, treatment and support as we move forward in our research design and implementation.

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PAPER 7

From research to advocacy to policy: the Kenyan perspective

Patrick Orege

Introduction

In many sub-Saharan countries the impact of the epidemic on women and young girls as compared to men is very striking. In the recent *Demographic and Health Survey* (KDHS 2003)(CBS et al. 2003), the prevalence of HIV infection in women was 8.4 per cent and in men 4.2 per cent. There is clearly a need to develop explicit strategies focused on gender issues, to include these strategies in policies and programmes in HIV/AIDS strategic plans, and to ensure that advocacy messages that target gender are developed. No programme should be considered to be effectively in place if it does not adequately address factors that contribute to the high HIV/AIDS prevalence and the large gender differences in prevalence.

The Kenyan National AIDS Control Council (KNACC) set up a Task Force in 2001 which conducted field studies to identify the gaps in the Kenyan National Strategic Plan (KNSP). The findings illustrated that gender roles and relations powerfully influence the course and impact of the HIV/AIDS epidemic, as outlined below.

Women are at greater risk of HIV infection

Various factors increase the vulnerability of women and girls to HIV, including their limited access to economic and educational opportunities and the multiple household and community roles for which they are responsible. Compounding women's vulnerability are social norms that deny women sexual health and knowledge, and practices that prevent them from controlling their bodies.

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There is growing evidence that a substantial share of new cases of HIV infection is due to gender-based violence in homes, schools, the workplace and other social spheres. In a nationwide study of women 12 to 24 years old, 25 per cent said they lost their virginity because they had been forced (KNACC 2003). The study indicated that 4 per cent of HIV infections in the adolescent 13–19 year age group were a consequence of rape. Unwanted sex with an infected partner carries a higher risk of infection, especially for girls. Since force is used, abrasions and cuts are more likely and the virus can find its way more easily into the bloodstream. Furthermore, condom use is unlikely in such situations.

Research found that in up to 80 per cent of cases where women in long-term stable relationships are HIV-positive, they acquired the virus from their partners. Women are also discriminated against when trying to access care and support when they are HIV-positive. In many institutions, men were more likely than women to be admitted to health facilities. Family resources are more likely to be used to buy medication and arrange care for ill males than for females, contributing to greater vulnerability among women.

Linking gender, sexuality and HIV infection

Sexual behaviour – and therefore transmission risk – is also influenced by sexual orientation, knowledge and cultural expectations. Due to social norms, people may find it difficult to discuss sexuality and sexual activities frankly. Therefore, they may remain unaware of the risks associated with specific sexual activities such as unprotected vaginal or anal intercourse and with other high-risk behaviours such as injecting drug use.

Men, and especially young boys, were found to be vulnerable too. Social norms were found to reinforce their lack of understanding of sexual-health issues and at the same time encouraged them to celebrate promiscuity. This vulnerability was further increased by the likelihood of engaging in substance abuse (such as alcohol and other drugs) and of opting for types of work that entail mobility and family disruption (such as migrant labour or the military).

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Facts supporting HIV/AIDS as a gender issue

Although HIV/AIDS affects both men and women, it does so differently, with recent trends showing that more women are becoming infected and at very young ages. This pattern is very clear in Kenya, where statistics suggest that HIV/AIDS disproportionately affects women and adolescent girls, who are socially, culturally, biologically and economically more vulnerable than men or adolescent boys. Even where women have a degree of economic autonomy, social and cultural expectations may make it extremely difficult for them to set the terms of sexual encounters.

Table 1 outlines some of the prevailing social and economic dynamics that make women vulnerable to contracting HIV at a faster rate than men. Women are often not in a position to say no to sex, to enforce the faithfulness of their partners or to insist on condom use. Silence surrounding sexuality within societies also stigmatises women who seek treatment for sexually transmitted infections (STIs). Research has also shown that younger women are especially vulnerable to HIV because their immature genital tracts are more likely to tear during sexual activity, creating a higher risk of HIV transmission during unprotected sex (KNACC 2003). Young women tend to have older, more experienced sexual partners who usually have more control in the relationship and are more likely to have STIs due to their previous sexual experiences.

Table 1: Factors influencing HIV infection among women

Unequal power relations result in less control over their sexuality by women.	• Earlier age of marriage and assumptions of maturity and adulthood work against women, who are infected 5–10 years earlier than men. • Violence against women is common and inhibits women's ability to protect themselves in situations of rough sex, incest and rape. • There is a low availability of female-controlled methods of contraception – the female condom or vaginal microbicides. • Legal frameworks and customary laws often discriminate against women. • Existing laws are used to discriminate against commercial sex workers, but not their clients.

Physical vulnerability	• Heterosexual transmission is about twice as efficient from males to females as vice versa. • An STI increases the likelihood of HIV transmission. As women with STIs have no symptoms, they are less likely to receive treatment, and therefore more likely to suffer from chronic STIs.
Cultural factors	• Cultural practices such as female genital mutilation, child marriage, wife-sharing and widow inheritance put women at increased risk. • Sexual double standards inhibit women from seeking STI care, blame them for HIV infection and stigmatise them once infected.
Economic factors	• Lack of education for girls results in poverty and economic dependence on men, which may force women into risk situations they would otherwise not choose, e.g. unsafe relationships, sex work. • Few opportunities for girls/women to access jobs or careers. • Lack of education for girls results in low exposure to HIV/AIDS education messages due to low literacy rates.

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Mainstreaming gender into policy strategies

Gender mainstreaming is a strategy that addresses the different needs, roles and responsibilities of women and men. It ensures that the special needs and priorities of women and girls, as well as men and boys, are considered at all levels and stages of development activities. This includes the design, implementation, monitoring and evaluation of any planned action, including legislation, policies or programmes, at any and all levels. Gender mainstreaming ensures more equitable and appropriate policies, programmes and outcomes for both men and women. However, it recognises that for reasons of gender and sex, women are much more affected by HIV/AIDS than men, and there remains a continuing need for special interventions to assist women and girls.

Gender analysis is an important tool that supports gender-mainstreaming processes. Gender analysis examines the roles of men and women and

relationships between them. It can assess how proposed development programmes may impact differently and unequally on women and men. Good gender analysis helps to ensure that women and men benefit equitably from HIV/AIDS policies and interventions.

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Mainstreaming gender into the National HIV/AIDS Strategic Plan

The purpose of gender mainstreaming in Kenya is to support the aims of the National HIV/AIDS Strategic Plan (KNSP) to reverse the HIV/AIDS epidemic and reduce its negative social and economic effects on all people. It is expected that mainstreaming gender into the KNSP will help to achieve the following objectives:

- Ensure that all prevention and advocacy strategies and programmes are gender-sensitive, in order to reduce the vulnerability and risk of women and men;
- Promote health and quality of life for people infected with and affected by HIV/AIDS;
- Reduce negative social and economic impact of HIV/AIDS on women and men;
- Measure the success of engendered HIV/AIDS programmes; and
- Establish gender-sensitive policies to ensure that management systems provide an enabling environment for gender mainstreaming.

Table 2 outlines the steps followed to mainstream gender into the KNSP.

Table 2: Steps followed to mainstream gender in the KNSP

Step	Activities
Needs assessment/ problem identification	Women and men are involved in a gender needs assessment, using gender-analysis tools such as activity profiles, access and control profiles and social-mobility mapping. Assessment of the different roles and responsibilities of women and men is conducted.
Project planning and design	Gender-related objectives and indicators are set to measure women's and men's participation in and access to project services and benefits. Redress of previous inequalities experienced by women is considered to ensure that women will benefit equitably. Strategies to empower women are selected.

Project management	Careful project management ensures gender responsiveness in all management activities, including staff recruitment, job descriptions, progress reports, annual plans and all project-related committees. Gender training is provided to all staff, starting with senior managers. Women are involved in all project-related decision-making.
Project implementation and monitoring	Women are regularly consulted to ensure that their needs and concerns are addressed. Constraints that restrict women's and men's participation and the equitable distribution of benefits are monitored and responded to where necessary. Sex-disaggregated data on access to and allocation of project resources and services are routinely collected. Adverse effects of strategies on women and men are monitored.
Evaluation	The different impacts of the project on women and men are measured. Monitoring and evaluation teams are gender-balanced. Data measuring the project's impact on both women and men are collected in order to evaluate whether women and men have received an equitable share of the benefits. The project's impact on women's practical and strategic needs is assessed, as well as whether women's overall status has improved.

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Conclusion

Gender-related factors shape the extent to which men, women, boys and girls are vulnerable to HIV infection and the kinds of responses likely in different communities and societies. Control of the epidemic is dependent on the recognition of women's rights in all spheres of life, and hence women's empowerment is an important tool in the fight against HIV/AIDS. Men, too, need to understand how traditional views of masculinity have contributed to the transmission of HIV infection, and need to take responsibility for change.

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PAPER 8

Gender relations, sexual negotiations and HIV prevention at Senegal university: Dakar and Saint Louis campuses

Solange Bandiaky

Introduction

This study, conducted in 2003, was sponsored by the Association of African Women for Research and Development (AAWORD). The study was undertaken to address the dearth of available research into sexual activity among university students. It is an important area of enquiry because these students are particularly vulnerable due to their youth and current dislocation from their usual family networks. Also, the students are sexually active. The objectives of the study were:

- To study and analyse gender relations in students' sexual life and in HIV/AIDS prevention;
- To evaluate and analyse students' knowledge, representation, perceptions and interpretations of HIV/AIDS;
- To analyse students' sexual practices and behaviour; and
- To study their mechanisms of prevention.

The study viewed the university campus as a micro-society, much like a city, with its own economic and socio-cultural patterns acting as influential factors on student life, sexual expression, risk-taking and protection.

Study design and methodology

Two stages of enquiry were used in the study. The first was a quantitative survey among 1 000 students at Cheikh Anta Diop and Gaston Berger university campuses, chosen randomly from their dorm rooms. An analysis of student knowledge and perceptions of HIV/AIDS was conducted, including level of student seniority as a factor. The second stage was a qualitative study,

involving interviews and focus groups conducted on campus. These focused on variables such as gender, and whether participants were international or domestic students. The main participants in the study were students and some university staff (nurses, doctors, managers of dormitories and of the campuses).

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Results

It was found that student knowledge was insufficient to enable them to make informed decisions that would protect them and lower their risk of HIV transmission. Some students did not acknowledge or believe in the existence of AIDS, while others believed that it was not present on campus. A percentage of students were also unaware of treatments available for HIV/AIDS and related conditions. There was random testing of HIV status of 11.4 per cent of the sample. Many students did not know their status. A percentage of students in the medical faculty were also included in the student group who were unaware of their status. The university medical staff knows through blood donation that some students are HIV-positive, but they never talked about that publicly due to concerns about outsiders' comments and the principle of medical confidentiality. Students were also concerned about the costs of being HIV-positive, both socially and economically.

The overwhelming majority of male students stated that they wanted their partners to be virgins, expressing the view that partner virginity was highly valued by them as an expression of love and an indication of good upbringing. Male students complained that many of the women had lost their traditional ways and were sexually active. Male students did not value abstinence in themselves, and were active in heterosexual relations with women, yet seemed to be unaware of the contradiction in this behaviour and their expectation that women were to be valued for their virginity.

Recommendations resulting from the study

The study clearly revealed the need for information campaigns, sexual education and gender-related attitudinal and behavioural change among students. As future health practitioners, it was felt that the training of medical students should include a focus on their own sexual behaviour, the impact of

their status on their future work as health practitioners, the value of knowing their status and seeking life-promoting treatment to preserve available human resources for health care in Africa, and their role in the prevention and treatment of HIV/AIDS.

HIV/AIDS should not be a mystery on campus: the administration should take the lead in making information, testing and behavioural counselling easily accessible to students and staff. An HIV test should be part of the registration procedure, and documentation on HIV/AIDS should be available in university libraries. More research on HIV/AIDS should be carried out in universities, including faculty, students and staff.

Note

This paper is a synopsis of the original, which was presented in French.

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PAPER 9

Women, poverty and vulnerability in the face of HIV/AIDS

B Lévi Tshizubu Mutombo

Introduction

A small study was conducted in one of the poorest neighbourhoods of Kinshasa, in the Democratic Republic of Congo, where the HIV prevalence appears to be among the highest in the country. Such high prevalence is common in poorer areas where people are more susceptible to contracting HIV. The area selected for the study was a new quarter that came into being after the civil disturbance that took place in the country in 1991 and 1992. Some of the poorest families were not able to afford rents in the popular quarters and came to build their makeshift homes in this neighbourhood.

Profile of participants and responses to the survey

Twenty-six heads of households were interviewed. Participants were between the ages of 19 and 50, with low levels of education. They lived in small houses, measuring only about 4.5 m by 2.9 m by 1.7 m. The households lacked adequate access to safe water, and had electricity only where families had illegally connected to electrical outlets available in the vicinity. Families depended on charity for their survival, and most eked out a living through marginal subsistence activities such as growing and selling vegetables. Children were often also deployed to seek income for the family, for example by shining shoes, selling firewood or begging. There were many children, but few attended school, as their families had no money for school fees. Many of the participants revealed that they were infected with HIV.

The majority of respondents were women, many of whom were widows because their husbands had died of AIDS-related illnesses. Very few of these men had used the available voluntary testing service, and respondents reported

that medical staff would not inform them of their spouse's or relatives' HIV-positive status or even, when treatment became necessary, tell them that their relative had AIDS. Invariably, the spouse or family member deduced from the opportunistic illnesses that a loved-one had AIDS, or discovered the positive HIV status just before their husband or relative died. Some of the respondents were orphans who had lost both parents.

Participants reported that there was still a great deal of stigma attached to the disease. Generally, HIV-positive people would not speak of their status or admit that they were sick with AIDS; or they might refer to their status indirectly or using euphemisms, often in a mocking tone. The reaction of people with the disease varied from resignation to indifference, or even violence.

Many of the surviving spouses knew that they were HIV-positive, and acknowledged that they continued to have sexual relations without protection – either to satisfy their sexual needs or to meet economic needs.

In this particular community the issue of the distribution of goods after the death of a spouse was rarely an issue for consideration, primarily because in this poverty-stricken community there was very little to distribute. However, in instances where there were goods of value, women were seldom able to keep these after their husband's death, as they were distributed to other family members.

Conclusion

HIV/AIDS adds to the substantial burden of poverty already experienced by members of this community. It increases the preoccupation of heads of households with issues such as providing basic nutrition for their family, paying their rent, finding resources to send their children to school and obtaining access to HIV testing and medical care. These heads of households are primarily women, on whom children and the broader community are dependent for their health and well-being. Therefore, donors should engage with these women and make them the focus of programmes aimed at reducing the burden of HIV/AIDS-related disease and poverty in their communities.

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Note

This paper is a synopsis of the original, which was presented in French.

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PAPER 10

Engendering action research to influence policy and practice

Masheti Wangoyi

Overview and study objectives

This presentation focuses on sharing the results of a study on the gender dimensions of HIV/AIDS care in four countries: Kenya, Ethiopia, Eritrea and Somalia. It also outlines policy and practice recommendations that emerged from the study.

The study explored the gender dimension of care at policy, operational, community and household levels in the target countries, with the following aims:

- To describe conceptual and operational elements of care;
- To assess the gender dimensions of HIV/AIDS care policies and practices;
- To identify gaps, challenges and opportunities; and
- To provide recommendations for policy formulation and programming in HIV/AIDS care.

Methodology: action research

Stakeholders were involved in all aspects of research, including the conceptualisation (deconstruction of research questions, objectives and methods), participation in the development of research tools, and engagement in the actual research. Thus, linkages were promoted between research, policy and practice. The research aimed to introduce the possibility of change within the community, and in the broader social system, through a process of dialogue that questioned existing mindsets and identified effective action points. This process served as a mechanism for enhancing the community's 'voice' and encouraging their participation in improving their own situation, through dialogue between the community and policy-makers. It also strengthened

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the researchers' roles as agents of change, able to apply research as a catalyst within the community. There are several phases involved in an action-research process, namely:

- Entry – gate-keepers, decision-makers, and actors are identified and invited to participate;
- Building capacity for research – facilitating the process of accessing, unpacking and analysing the 'organised voice' of the community;
- Feedback to the community and planning for action in an iterative cycle, enhancing the use of results at all levels;
- Documentation and dissemination of findings and recommendations; and
- Scaling-up of findings, leading to broader policy changes where possible.

Key findings

African women significantly contribute to household and national economies but their role in accessing or controlling services and care resources is limited.

There is a disproportionate burden of care on women from childhood to old age, added to the existing disparities in gender roles. Yet policies and programmes on HIV/AIDS care still inadequately define care elements and the mechanism of delivery, and the gender implications of these, and do not provide for redress of these disparities either in budgeting or in actual service delivery. Gender disparities go beyond the imbalance in the burden of providing care, and include differentials in quality of care received by males and females.

Culture and religion also hold central places in defining the gender roles and maintaining the gender disparities in HIV/AIDS care, yet these structures have not actively tried to eliminate the disparities.

Conclusions and recommendations

Policies on HIV/AIDS care should be explicit in their definition of the elements of care, the mechanisms of delivery and the role of stakeholders at all

levels, with gender threaded into the fabric of this process, rather than added as a separate consideration.

Policies and programmes should have mechanisms to redress gender disparities in the burden of care provision and inequities in the quality of care, and to promote gender-responsive budgeting to enhance the social and economic entitlement of women. To ensure sensitivity to age patterning in gender-related disparities, a life-cycle approach should be used to address HIV/AIDS care in the state's engagement with all stakeholders involved in HIV/AIDS care. There should be a well-coordinated network of stakeholders in the region to carry out action research to inform work on gender-based social aspects of HIV/AIDS.

Programmes on HIV/AIDS care should engage cultural and religious leaders and structures in dialogue to eliminate perceptions and practices that promote gender disparities, stigma and discrimination.

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PAPER 11
Extracting gender-relevant data from existing research

Nompumelelo Zungu-Dirwayi

Introduction

The absence of a gender focus in research can result in incomplete research outcomes and inappropriate recommendations being applied in the formulation of policy and practice. It has become increasingly obvious that gender cannot be overlooked in policy and programme development, yet governments and other organisations may have difficulty in generating resources to adequately research gender-related questions that have previously been overlooked in policy and programmes. One way to address this problem is to apply gender-based analysis to existing databases. This approach has several advantages, for example, large databases exist, which allow for sub-sample multiple analysis, and comparison over time is possible via repeat surveys. Existing research also provides access to a wide range of research areas that are of interest to researchers, as indicated by the following examples:

- Demographic data (age, race, educational qualification, locality, marital status and socio-economic status of women, dependants);
- Sexual behaviour (number of partners, sexual debut, age of sexual partner, access to and use of contraceptives);
- Knowledge of HIV/AIDS (HIV risk perception, access to information, use of different media);
- Stigma related to HIV/AIDS;
- Impact of HIV/AIDS on women and households;
- Women's views on policy issues (access to ARVs, performance of government, etc.);
- Mental health, substance use (alcohol and drugs); and
- Access to social support.

Example from a national educators' survey

Objective

To determine the differences in socio-economic status between males and females.

Methodology

A sample of 1 766 schools was randomly selected from a cross-sectional national survey of South African educators in 26 713 public schools. In total, 21 358 educators were present during the research day, and were required to complete questionnaires and an HIV test. Of these educators, 97 per cent agreed to be interviewed and 83 per cent provided a specimen for HIV testing.

Findings

Data revealed the following trends:

- Slightly more males than females had degrees and diplomas;
- A greater proportion of females were among the teacher ranks, while senior and managerial posts at schools were more likely to be occupied by men;
- More women than men reported having less money than they needed for basic household needs, and less access to medical aids and housing subsidies; and
- A greater proportion of men moved to a post in another area, and when women moved, they were more likely than men to be married and to have their family move with them, whereas men were more likely than women to move at a time when they were single or, if not single, to leave their family behind.

Discussion

Newly analysed, the data from this study reveal gender disparities in educational base, income range and promotional opportunities. Consideration for household well-being appears to have a greater influence on the mobility

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and career choices of women educators than their male counterparts. This is perhaps not surprising given that there is still a greater expectation that the roles of child-carer and homemaker should primarily be the responsibility of women, even when women hold down full-time work outside of the home. It may be that the dual role of homemaker and worker impacts on the amount of time and resources available to women to pursue further studies, and to compete for promotional opportunities in the workplace, contributing to the finding that women generally have lower career mobility than males. These assertions highlight issues for further investigation that might not have come to light without a gender-focused re-analysis of the data. The new findings point to the need for gender-sensitive support in human resource development in the educational field.

Conclusion

Existing databases are good resources for exploring gender-based issues in research as they facilitate the tracking of certain trends over time. At the same time, not all gender-specific data are available in existing data sets, and incorporating important demographic variables such as race, age and sex will be crucial in new studies to allow for future analysis of data from a gendered perspective.

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Section C
CAPACITY-BUILDING WORKSHOPS: BUILDING SKILLS AND CAPACITY USING GENDER-BASED ANALYSIS TO FACILITATE GENDER MAINSTREAMING

Workshop: Men as partners

The first workshop in this section was an interactive session facilitated by the Commonwealth Secretariat, in conjunction with the EngenderHealth 'Men as Partners' programme. In the two presentations, notions of masculinity were questioned and challenged, and the specific and differential roles of men in the HIV/AIDS epidemic were explored. Through facilitated discussion and scenarios, participants were asked to look at their own notions of masculinities and femininities, the processes through which men and women are all socialised into gender roles, and what the impacts of this socialisation are in terms of HIV/AIDS and relevant responses.

Workshop: Gender and HIV/AIDS – the nuts and bolts of gender-based analysis

The second workshop was a skills-based session focused on promoting a gender-based approach to HIV/AIDS policies, programmes and research. Following an introduction to the key concepts and ideas behind gender-based analysis (GBA), participants worked in small groups. They used prepared scenarios and worksheets designed to bring forward complex issues around how GBA can be applied within HIV/AIDS and health-related contexts. Participants identified potential gender issues within the scenarios, and provided suggestions for policy responses. Following these discussions, results were shared in plenary.

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PAPER 12

Masculinities: implications for the HIV/AIDS epidemic

Joseph Amuzu

Introduction: some telling statistics

The predominant faces of the HIV/AIDS epidemic are often perceived as the faces of women and young girls. For most of us, when we think or read about gender, we think and read about women. We must understand, though, that the invisibility of men and masculinity in the gender equation produces gender inequality that is a major driving force behind the spread of the HIV/AIDS epidemic.

Thus, any initiative to improve the condition of women and young girls, to stem the tide of the epidemic, must include efforts to involve men. In fact, we believe that any effort to further gender equality that does not include men is doomed to failure. Achieving committed male support in advancing women is increasingly urgent.

This paper will address stereotypical masculinities and their implications for the HIV/AIDS epidemic.

Defining masculinities

The term *masculinities* includes many different definitions and understandings of what it means to be a man within various cultural contexts around the world. Men and masculinities are not the same thing: men are human beings, each individual uniquely different, whereas masculinities are stories or discourses about men and how they should ideally behave in a given setting.

What would an ideal man be in your society? What is expected of men? What do we teach boys in schools, on the street, through the media, in our communities and in families? There are many answers to these questions.

But when we look for commonalities, some of the shared characteristics of dominant masculinity around the world describe a man as being strong, a breadwinner, attractive, heterosexual, sexually successful, a protector, a leader, a decision-maker, a ruler of his world – both within the household and in public.

So men are expected to be physically strong, emotionally robust, daring and virile; to think of themselves as independent, not needing to be nurtured by others, unlikely to ask others for help and willing to face danger fearlessly. These expectations translate into attitudes and behaviours that endanger the health and well-being of men and their sexual partners, even more so with the advent of HIV/AIDS.

In many parts of the world, we are constantly fed images of men being violent – through films, books, television, magazines and video games. Violent men are revered as role-models and even heroes, and there is pressure for ordinary men to behave in the same way. On the other hand, men who take up behaviours thought to be 'feminine' are viewed by others to be 'lesser men'.

These viewpoints of masculinities are major obstacles to women's improved health care. For example, women who seek to improve access to health care, to avail themselves of existing methods of contraception, to practise safer sex or visit voluntary counselling and testing (VCT) centres often run into a wall of non-cooperation from men.

Men's sense of their own masculinity also affects many aspects of public health. For example, a 'real man' must have a job and work hard to support the family. A 'real man' should not be unemployed. The experience of unemployment can destroy a man's personal and social identities, especially his 'breadwinner' identity. Unemployment also often has negative impacts on diet and other basic needs, or increases family poverty, resulting in higher levels of stress, risky behaviour, psychological problems and even family breakdown.

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The implications of masculinities for HIV/AIDS prevention

Traditional images of masculinity

While it is important not to reinforce stereotypes that portray men as universally uncaring and self-centred, it is important to acknowledge that almost everywhere men are under pressure to conform to ideologies that emphasise sexual prowess, and encourage them to have multiple sexual partners and exercise authority over women. Traditional images of masculinity not infrequently encourage men to force sex on unwilling partners, reject condom use, and view drinking and drug abuse as a confirmation of manhood. These behaviours are major driving forces behind the spread of HIV/AIDS.

Addressing masculinities in HIV/AIDS prevention

The challenge is to identify and reinforce the kinds of oppositional and alternative masculinities that lead to greater equality in gender relations, and which are associated with lower levels of HIV-related risk.

HIV/AIDS prevention and care programmers must respond equitably to the needs of both men and women. Too often, the gender perspective has led to a focus on women's and girls' needs at the expense of men's and boys' needs. Involving men more fully in preventing HIV infection is essential if rates of HIV transmission are to be reduced. Successful HIV risk-reduction programmes have targeted men's behaviour in such diverse countries as Senegal, Uganda, South Africa, Thailand, Australia, the UK and the USA. National governments and development institutions can build on examples from these countries, recognising that involving men in work on gender equality and health must look beyond programmes targeted only at men's behaviour.

There is a need to initiate dialogues between women and men about the structures of inequality that determine the distribution of morbidity and mortality, and the role that the politics of masculinity plays in maintaining such structures. Attention needs to focus on the ways in which boys are brought up. All members of the family have an important role in raising boys. Fathers and male family members, in particular, need to lead by example

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and offer a positive role by showing more respectfulness in relationships with women, and developing a flexible vision of manhood.

Furthermore, it is necessary to break the silence that still surrounds sex, sexuality, drug use and HIV/AIDS, and to talk more openly about them.

Conclusion

It is important that men take greater care of themselves, their partners and their families, as dominant ideologies of manliness – which emphasise daring, aggression and not showing feelings – can also encourage men to ignore their own health needs and responsibilities.

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PAPER 13

The Men as Partners programme in South Africa: reaching men to end gender-based violence and promote sexual and reproductive health

Dean Peacock and Andrew Levack

Introduction

Eleven short years after celebrating the end of apartheid, South Africans now find themselves faced with yet another bitter struggle. This time the battle is against HIV/AIDS and violence against women – twin epidemics that are both driven in critical ways by social norms about gender, power and violence and that currently threaten the lives of millions of South Africans.

The HIV/AIDS epidemic disproportionately affects women's lives, in terms of both rates of infection and the burden of care and support they carry for those with AIDS-related illnesses. Young women are much more likely to be infected than men. A recent study by the University of the Witwatersrand indicates that women make up 77 per cent of the 10 per cent of South African youth between the ages of 15 and 24 who are infected with HIV/AIDS (Pettifor et al. 2004). Women's greater vulnerability to HIV/AIDS is partly explained by the very high levels of sexual and domestic violence reported across the country.

The Men as Partners approach

The central foundation of the 'Men as Partners' (MAP) programme has historically been the implementation of workshops that explore gender roles. However, over the past few years the programme has expanded its activities substantially and now works more broadly to promote gender equality and to reduce the spread and impact of HIV/AIDS. At present the programme works to effect change using the following strategies:

- Workshops aimed at changing knowledge, attitudes and behaviour;
- Mobilising men to take action in their own communities;
- Working with media to promote changes in social norms;
- Collaborating closely with other NGOs and grassroots community-based organisations to strengthen their ability to implement MAP programmes; and
- Advocating for increased governmental commitment to promoting positive male involvement.

Using a human-rights framework

MAP workshops use a human-rights framework to enable men to recognise the ways in which contemporary gender roles mirror the oppressive relations of power characteristic of apartheid. This oppression has devastating health consequences for women: it places them at risk for violence, limits their ability to negotiate the terms and conditions of sex, and severely compromises their sexual and reproductive health, including increasing their vulnerability to HIV/AIDS. It also places the burden of care and support for people living with AIDS squarely on women's shoulders. In the service of promoting gender equality and protecting women from HIV/AIDS, MAP draws the connections between sexism and racism and other forms of oppression and strives to get men to see the ways in which gender equality is a fundamental human right of comparable importance to those fought for during the anti-apartheid years. This approach connects gender equality to South Africa's rich tradition of social-justice activism and situates it squarely within human rights discourses and traditions embraced by most South African men. Many MAP educators come from activist backgrounds and apply their expertise to devising strategies that get men to take a proactive stand for gender equality and against women's oppression.

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Helping men see the double-edged nature of contemporary gender roles

To challenge men's power and control over women and to promote gender equality, MAP workshops utilise a second strategy – helping men to see that the benefits and privileges conferred upon them in a sexist society come at a prohibitively high cost. MAP makes this point in a number of ways. First, contemporary gender roles can compromise men's health by encouraging men to equate a range of risky behaviours – violence, alcohol and substance use, the pursuit of multiple sexual partners, the domination of women – with being manly, while simultaneously encouraging men to view health-seeking behaviours as a sign of weakness. Second, MAP workshops encourage men to reflect on the ways in which they, too, are affected by men's violence against women. Men are encouraged to consider the ways in which they and countless other men are affected by the pain suffered by victims they know and care about – their daughters, mothers, sisters, friends and colleagues. They are also given the opportunity to consider the ways in which they, and men in general, are cast as potential perpetrators and have their relationships with intimate partners and acquaintances infused with fear and distrust by women's pervasive fear of violence.

In workshops and community activities, MAP helps men to see that the use of violence and the domination of women may grant some men a fleeting sense of power, but that, in the long run, the values and attitudes endorsing this behaviour inevitably also produce men who are disconnected from their own humanity, isolated, and often hell-bent on a futile and self-destructive quest to prove their manhood. Successfully addressing public health problems, especially endemic problems like HIV/AIDS and violence against women, requires going beyond individually focused solutions.

Lessons learned

Present postive male role models

Despite high levels of male violence against women, it is important to recognise that many men care deeply about the women in their lives, including their

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partners, family members, co-workers, neighbours and community members. Given the opportunity and the know-how, many men are eager to challenge customs and practices that endanger women's health and to support the well-being of women. Asset-based approaches that redefine men's involvement in the promotion of gender equality as examples of strength, courage and leadership have been especially useful in this regard.

Encourage men to care for and support those with HIV/AIDS

Much attention has been paid to the ways in which contemporary gender roles condone men's violence against women and compromise women's ability to make choices about their sexual and reproductive health. Similarly, there is tremendous pressure on men to conform to traditional gender roles. There are, for instance, many prohibitions on men being visibly involved in 'domestic' activities (EngenderHealth 2005). However, less attention has been granted to the ways in which gender roles also create the expectation that women will assume the burden of responsibility for taking care of family and community members weakened or made ill by HIV/AIDS. A household survey conducted in South Africa in 2002 reported that in more than two-thirds of households women or girls were the primary caregivers, almost a quarter of caregivers were over the age of 60 and just under three-quarters of these were women (Henry Kaiser Family Foundation 2002). To date, then, little has been done to develop interventions that explicitly encourage men to play a more active role in care and support activity. Therefore, it is imperative that men begin to share this burden of care and support. Results from MAP focus-group discussions suggest that it is essential for interventions to focus not only on increasing men's awareness of the need for their involvement in care and support, but also on the need to explore and shift social norms at the community level so that more men can provide the support their conscience tells them is necessary.

Build organisational cultures that work with men

No amount of training and capacity-building is likely to be effective without the buy-in of senior leadership within partner organisations. To ensure that each organisation remains committed to working with men to prevent HIV/AIDS and violence against women, the MAP programme includes workshops

with senior management and other key staff within each organisation. These workshops focus on the relationship between gender equality, violence against women and HIV/AIDS. To ensure that MAP programmes complement the other work being done by each of the organisations, EngenderHealth assists partner organisations to integrate male involvement strategies into their existing efforts so that these are enhanced and made more effective.

Provide ongoing support to gender activists

Given that the MAP methodology asks educators to talk about violence and abuse in every workshop, it is important to provide educators with the support that they need to process their own experiences with violence. In addition, educators run the risk of experiencing secondary trauma resulting from constant exposure to other people's stories of violence.

Develop coherent, co-ordinated and strategic programming

Consumed with the task of reconstructing the country after years of apartheid rule, the South African government's response to the HIV/AIDS pandemic and violence against women has been inconsistent, characterised at times by inadequate resource allocation, confusing public statements, and poor co-ordination with and inclusion of the NGO sector. This lack of coherence has also at times been true of both civil society and the private sector.

Existing within this context, the already inadequate social service infrastructure inherited from the apartheid regime has quickly become overwhelmed. To address this, and to improve the cohesion of NGO and private sector responses to HIV/AIDS and violence against women, the MAP methodology now includes a focus on facilitating relationships between collaborative partners. The MAP Network meets on a monthly basis to learn from each other's successes and challenges, to benefit from diverse skills, and to avoid duplication and wasting scarce resources. More recently, EngenderHealth worked with a range of national government departments to establish the National Co-ordinating Committee on Men and Gender Equality, consisting of key stakeholders from civil society, government and business, which will promote greater collaboration among government departments and between government and civil society.

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Note

EngenderHealth's 'Men as Partners' programme has worked very closely with the Commonwealth Secretariat in finding innovative and practical ways of involving men in addressing gender and HIV/AIDS issues. The full version of this paper, appears in the *International Journal of Men's Health*, Volume 3, 2004 and has been adapted for inclusion in this publication with permission from the authors.

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PAPER 14
Gender and HIV/AIDS: the nuts and bolts of gender-based analysis

Erika Burger and Barbara Clow

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What exactly is gender-based analysis?

When people speak of doing gender-based analysis (GBA), what exactly do they mean? How can concepts of GBA be translated into practice and incorporated into daily life, in ways that make sense for everyone? More particularly, how can GBA help efforts to combat the HIV and support those living with AIDS?

GBA is an analytical tool. It uses sex and gender as an organising principle or a way of conceptualising information; that is, as a way of looking at the world. GBA helps to bring forth and clarify the differences between women and men, the nature of their social relationships, and their different social realities, life expectations and economic circumstances. It identifies how these conditions affect women's and men's health status and their differential vulnerability to HIV and AIDS.

GBA provides a framework for analysing and developing policies, programmes and legislation, and for conducting research and data collection – a framework which recognises that women and men are not the same.

GBA is a systematic process that takes place throughout the course of a given activity, whether it is the analysis or development of policy, programmes, research or legislation. As it becomes standard practice to integrate a gender-based perspective into our work, from beginning to end, GBA should become an essential tool in our work on HIV and AIDS (Health Canada 2000).

Integrating GBA in HIV/AIDS work performs the challenging function that is essential to sound policies and programmes. It challenges the assumption that everyone is affected in the same way by policies, programmes and legislation, and the assumption that health issues such as causes, effects and service

delivery are unaffected by gender. GBA probes concepts, arguments and language used, and makes underlying assumptions and values transparent and explicit. Where these are revealed to be biased or discriminatory, GBA points the way to more equitable, inclusive and effective options.

The checklist on page 65 provides a core set of questions that might be applied in GBA.

Background: identifying a need

There is clearly an urgent need to demystify the language and concepts around GBA, and to build a better understanding of what it entails. This need is especially relevant in the face of a global crisis such as HIV/AIDS, where gender issues lie at the heart of the epidemic – both in terms of understanding how and why the virus is spread, and also in terms of developing adequate and appropriate responses and interventions. Feedback from previous work in gender and HIV/AIDS carried out by the Atlantic Centre of Excellence for Women's Health (ACEWH) has been provided through such events as the launch of the International Institute on Gender and HIV/AIDS in Johannesburg, 2004, and the 7th AIDS Impact Conference in Cape Town, 2005. Participants have consistently expressed the idea that while most people now feel they have a reasonable grasp of the concepts around gender and HIV/AIDS, they feel unsure about how to put GBA into practice in their own work.

With this in mind, ACEWH developed this particular workshop, looking at the 'nuts and bolts' of GBA and providing hands-on tools for demystifying the concepts and learning how to apply them in a practical way. Working together in small groups, participants were given an opportunity to look at a variety of prepared scenarios, each with implications for policy, programming and research related to HIV/AIDS. Participants analysed the scenarios, and provided policy recommendations using a gendered lens – that is, they considered how girls and women or men and boys would be differentially affected by each scenario, and what the implications for each group might be in terms of recommendations made by policy-makers and those involved in intervention programmes or research.

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Setting the context

To set the global stage for these discussions, it is important to note that even in relatively low-prevalence countries like Canada, the patterns of HIV/AIDS epidemiology are shifting. Trends in new infections in 2004 indicated a differential vulnerability among women, in particular, young women and women living in poverty or in marginalised communities. Since the early 1990s, the rate of new HIV infections in Canada has declined among men who have sex with men (MSM) and intravenous drug-users (IDUs). In earlier years of the HIV/AIDS epidemic, these were generally considered to be the main population groups at risk. In contrast, infections arising from heterosexual contact have risen steadily in Canada, and the greatest increase in new infections has been among young women between the ages of 15 and 29 years (Health Canada 2004).

GBA in practice: using scenarios and the GBA checklist

GBA aims to make make policies, programmes and research more equitable. Rather than simply ensuring equal numbers of men and women in the workplace, for example, or equal representation on advisory boards, GBA delves deeper and provides a transformative approach to addressing gender issues at their heart. GBA systematically applies gender-specific principles at every stage of a project or policy, using sex and gender as an organising principle or a way of looking at the world. It provides a framework for analysing and developing policies, programmes and legislation, and for conducting research and data collection.

Participants at the workshop divided into small groups, and were given prepared scenario documents (see pages 66–70) and the GBA checklist. The scenarios were specifically designed to highlight some of the complex issues around how GBA can be applied to HIV/AIDS-specific contexts. Participants were asked to identify the potential gender issues within their respective scenarios, and to provide possible recommendations and suggestions for policy responses. The five scenarios are presented below and can be reused, together with the GBA checklist on page 63, as a self-training exercise or in workshops for training others in GBA.

GBA checklist

- ☐ Are men, women, boys and girls considered separately in the policy, programme or research?
- ☐ Does the data collected distinguish between girls and boys, men and women?
- ☐ Are both women and men at the local level involved in decisions about the policy, programme or research?
- ☐ Is the policy, programme or research presented in a language and format that is accessible to both local women and men?
- ☐ Does the policy, programme or research address differences in social and economic power between women and men?
- ☐ Does the policy, programme or research reflect an awareness of and sensitivity to what is already known about gender differences in this area?

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Scenario 1: Home-based care programme

Scene

A family is living together in a rural area. The father, Maurice, is quite ill. Helen, the mother is also sick, and has been receiving TB treatment. They have three children: the older daughter, Gift, is 13 years old; the son, Lovemore, is 12; and the younger daughter, Mercy, is 7. The father is now bedridden. He needs assistance to sit up and has to be carried to move. A local community volunteer, Mr Saidi, is responsible for identifying those in the community who should receive care through a local home-based care (HBC) programme. He has identified Maurice and his family as potential clients.

Programme

The Helping Hands HBC programme operates out of a local church. It is staffed mostly by volunteers, but the nurse and co-ordinator are paid from charitable donations. They visit families in their community who are looking after sick family members at home. They offer advice about medical care, as well as providing some counselling services. The programme staff have very few supplies, but do distribute whatever they receive as donations, such as latex gloves, cotton wool or panadol. As with many HBC programmes, Helping Hands staff cannot be exact about what time they will visit. They do send a message through a community volunteer stating the date on which they will come. The family then tend to wait all day, putting on hold other things such as school, gardening and visits to the clinic. On the first visit, the nurse will teach the wife and daughters how to care for the patient: giving bed baths; preparing nutritious foods; and dressing the patient's wounds. On subsequent home visits, the nurse will check on the patient, discuss medical tests and treatment and counsel the patient and his family as necessary.

STEP 1

From the information given, do you think this programme considers gender? Explain your views and discuss them in your group.

STEP 2

Using the GBA tool, make five recommendations that will strengthen the programme so that it meets the needs of women and men, boys and girls.

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Scenario 2: Orphans and vulnerable children policy

Scene

An elderly woman, Amai Khoromani, is living in her daughter's house with her six grandchildren. The children became orphans when both of Amai's daughters died. The children range in age from 16 months to 11 years. The fields outside lie empty, as Amai is too old to wield a hoe and the little ones are not strong enough yet for such labour. There has been a lot of news on the radio about the national government's new policy on orphans and vulnerable children. Amai Khoromani has been waiting, hoping that it will bring some news of relief for her dependants. In the meantime, she has joined her local support group for those caring for orphans and vulnerable children (OVC). She enjoys chatting with the other grandmothers and they compare stories of the grief and hardships of losing their children and caring for the youngsters left behind. All the grandparents struggle to find school fees and uniforms for the children, money for medicine and enough food to feed their households. The director of the support group, Mr Bhana, says there is no money.

Policy

'The national plan focuses on empowering households to build their capacity to take in orphans and vulnerable children from their extended families for the sustainability of our communities. Families grow and thrive best when they are kept together.'

The state has also launched an educational campaign on radio, encouraging affected families to join their local OVC community support groups.

STEP 1

From the information given, do you think this policy considers gender? Explain your views and discuss them in your group.

STEP 2

Using the GBA tool, make five recommendations that will strengthen the policy so that it meets the needs of women and men, boys and girls.

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Scenario 3: Social and behavioural research

Scene

A youth group, Youth in Action, in Mongu township has been approached by some American researchers to participate in a study on sexual abstinence. The researchers offer football and netball equipment to the young men and women of the group if they all agree to be participants in the study. The group has been trying unsuccessfully for many years to find a donor for equipment so their teams can participate properly in the district league. The team captains, George and Victoria, tell the others that this offer seems like a dream come true!

Research

The University of North America researchers have worked long and hard to get funding for their proposal to look at abstinence programming amongst youth in East Africa. They are using a model which they feel is evidence-based, and is very similar to research done in their own country. The focus of the research is on peer-group behaviour change, so the entire youth group must consent to the programme. All they have to do is pledge abstinence in a public ceremony and wear a symbolic bracelet for the duration of the research – an eight-month commitment. Each person must report on his or her sexual behaviour, in four interviews and two focus-group discussions over the course of the study. Youth in Action must also give up another peer education project that involves distributing condoms. Lastly, all team members must wear team jerseys provided by the research project, bearing the slogan, 'Kicking out HIV/AIDS through abstinence!'

STEP 1

From the information given, would you say this research considers gender? Explain your views and discuss them in your group.

STEP 2

Using the GBA tool, make five recommendations that will strengthen the research so that it meets the needs of women and men, boys and girls.

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Scenario 4: ARV programme

Scene

A mother, Beauty, and her two young children are living in a rural area. The children's father, Thabo, is away working on a mine about 1 500 km north of the family home. Thabo sends money each month-end to his wife and has always been a reliable provider for his family. Beauty feels lucky that she never has any of the trouble that other wives have. When Thabo tested HIV-positive two years ago, both he and Beauty were devastated. But the company doctor told him not to worry – drugs would be provided for all mining employees according to company policy. A year later, Beauty tested positive herself and became very ill. She and Thabo decided to sell some of their property to raise the funds for her treatment. It is a struggle to make ends meet, but they manage, especially since Beauty started on ARVs six weeks ago and is starting to feel like her old self again. She can play with the children, work in the fields and carry water, just like she used to. But now the time has come for her to go back to the clinic to get her next supply of drugs. This is always a problem for Beauty, as she lives 45 km away from the clinic over unpaved roads and the transport is expensive and unpredictable. She also has to find someone to look after the children while she is away. Furthermore, it is only the 11th of the month, and a long time until month-end when the money will come from Thabo.

Programme

The Chikondi Clinic was established by an NGO committed to providing ARVs to those needing them in the district. This is a challenge because the need is always greater than the supply of drugs available. The clinic staff must decide who on the waiting list will be chosen to enrol in the programme. There are strict criteria that must be met before someone can enrol in the subsidised ARV programme: the patient must demonstrate financial need, pay a modest cost-recovery fee, come to the clinic every two weeks, and spend a few hours working in the community garden to demonstrate his or her commitment and adherence to the regime – surely this is not too much to ask when life-saving drugs are being dispensed?

STEP 1

From the information given, do you think this programmes considers gender? Explain your views and discuss them in your group.

STEP 2

Using the GBA tool, make five recommendations that will strengthen the programme so that it meets the needs of women and men, boys and girls.

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Scenario 5: Virginity-testing programme

Scene

Mr Nkopi is very proud of his teenage daughter, Margaret. She is very bright and always ranks among the top learners of her Grade 12 class. Mr Nkoki just wishes that he was richer and could afford to send Margaret to a better school. One day he reads a newspaper article about a bursary programme for girls entering college. To be eligible, girls need only demonstrate academic excellence and high moral character. It is the answer they have been waiting for! Mr Nkopi knows that Margaret is a smart girl and also a good one. He declares to Margaret that she must apply! But Margaret doesn't know what to say; she feels shaky and her stomach is queasy. She wants desperately to go to college, so that she can study to become a women's health researcher. But Margaret has never told anyone about the rape which took place three years ago. At a medical test, people would find out; she feels so ashamed.

Programme

An MP has been canvassing his wealthy constituents to create a bursary programme for young girls in their area to attend college. Many wealthy business-owners have pledged money for this valuable programme. The requirements are twofold: excellent grades in the high-school leaving exam, and a positive virginity test – to be administered by older women in the community. Local people are very excited about this programme; it will help the best girl students to get ahead and make their district proud.

STEP 1

From the information given, do you think this programme considers gender? Explain your views and discuss them in your group.

STEP 2

Using the GBA tool, make five recommendations that will strengthen the programme so that it meets the needs of women and men, boys and girls.

Synopsis and conclusion

Participants in this session looked at the different scenarios (around HBC, OVC policy, social and behavioural research, ARV programmes and the practice of virginity-testing) with an eye to the specific gender-based considerations arising out of each. A GBA checklist was provided as a tool to help in the analysis of each particular scenario. With this critical, analytical approach, participants pulled out aspects of each scenario that might be problematic from a gendered perspective, and provided suggestions as to how to improve the policy, programme or research scenario in question.

At the end of the session, all groups reconvened to share with each other the results of their discussions, as well as their recommendations. For example, the group working on Scenario 1 noted that the male child in the family was being left out of caregiving training provided by the hypothetical HBC programme, and that training only girls for caregiving duties in the household would reinforce unequal gender roles, put undue burdens on the girls, and might even result in their not being able to attend school. The group recommended that boys and men also be included in the caregiving training.

Participants looking at the fourth scenario noted that while the mining company provided ARVs for the husband who worked for them, they provided neither testing nor treatment for the wife. Among other things, they recommended that the company include spouses, children and dependants in their ARV programmes, and begin to consider the social contexts that lead to sexual risk-taking behaviour among their employees.

Those working on Scenario 5, in which virginity-testing is a prerequisite for a bursary programme for young women, pointed out that virginity testing contravenes girls' rights and autonomy and reinforces unequal gendered beliefs and expectations relating to sexuality. This group questioned the equation of virginity with moral character, as well as the validity of the practice itself. They also felt that girls who refused to take the test would be likely to face stigmatisation, as would those who 'failed' the test. They recommended that different criteria be developed for awarding the bursary, and that the girls be involved in developing the criteria for the award.

The discussions that arose out of these scenarios were inspired and fascinating, and could have lasted much longer. We hope that this interactive and capacity-

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building workshop helped to remove GBA from the realm of theory and place it firmly and concretely in the hands of participants – as a new or improved skill in the broad repertoire of skills needed to prevent the further spread of HIV/AIDS, and to mitigate its impacts amongst us all.

Note

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CONCLUSION
Keeping gender in the mainstream

Sarah Pugh and Bridgette Prince

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Key issues and lessons learned

The gender and HIV/AIDS seminars and workshops at the 3rd SAHARA conference in Dakar presented a wide range of issues and challenges for everyone involved, but also pointed to practical suggestions and ways forward at every level – from theory and research design to policy, practice, monitoring and evaluation. Despite the diversity of the topics of discussion and the range of opinions that surfaced within these debates, there was a variety of important common threads that wound their way throughout all sessions.

These discussions made it abundantly clear that gender considerations must be placed at the heart of all responses to the HIV/AIDS pandemic in sub-Saharan Africa. Many speakers and participants echoed the call for gender to be incorporated from the beginning stage into every level of prevention, care, treatment and support, as opposed to being an 'add-on' or afterthought to a given strategy. Included in this is the need to be sensitive and effective in addressing social constructs of gender without simultaneously perpetuating and reinforcing gender stereotypes.

Presenters and discussants also highlighted the need for 'gender' programmes and policies not to focus strictly on women and girls, but to simultaneously look at the importance of addressing the many challenges faced by men and boys in the age of HIV/AIDS. Those working in gender and HIV/AIDS within a sub-Saharan African context must be conscious of the differential impact the pandemic has not just on women and girls, but also on men and boys. This inclusiveness opens up important avenues in preventative programming and policy by addressing some of the gendered expectations of men and masculinities that are currently helping to drive the pandemic.

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Throughout the gender sessions, in keeping with the theme of the overarching SAHARA conference, participants called for a 'bridging of the gap between policy, research and intervention' and for a need to formulate all of this with an eye to the lived realities of people infected with and affected by HIV/AIDS – in other words, a call was put forth for researchers, policy-makers and practitioners to work more closely with each other, and to be accountable to the people on whom the pandemic has the biggest impact. Included in this was the call to make use of existing research, and to strengthen and develop Africa's own agenda for HIV/AIDS and gender research. Clearly, one of the key lessons learned through these discussions is that there is a distinct and immediate need for researchers, policy-makers and practitioners to work together to share their findings and experiences with each other, and to inform each others' work in meaningful and productive ways.

Another key thread running through all gender sessions was a focus on the importance of addressing stigma and discrimination. This clearly is one of the most difficult and multi-faceted subjects to address practically, but also one of the most important, as it cuts across all dimensions of HIV/AIDS prevention, treatment, care and support. Participants noted the many forms of stigma and discrimination as it is directed against women and girls (including sexual violence), men who have sex with men or other individuals of a non-heterosexual orientation, sex trade workers, people living with HIV/AIDS, and those caring for them (usually women), and even against children left orphaned by the death of relatives and caregivers. Stigma and discrimination remains one of the biggest problems in the formulation of successful strategies and interventions around HIV/AIDS, and researchers, policy-makers and practitioners must work to develop creative and effective strategies to challenge the social attitudes that create such a climate of hostility.

Research presented from the Democratic Republic of Congo reminded participants that HIV/AIDS hits extremely hard in impoverished communities, exacerbating and exacerbated by the cycle of poverty, with an especially significant impact on women and girls. Research from Senegal pointed out the dangers of assuming that HIV/AIDS education and awareness is widely accessible, or that young men and women really do have the knowledge and education they need to protect themselves against HIV/AIDS. These presentations pointed to the need to include poverty eradication in debates around HIV/AIDS and gender, and also stressed that any interventions and

strategies being implemented need to be locally appropriate and contextually specific.

The gender sessions at the 3rd SAHARA conference clearly illuminated some important and relevant debates, and in bringing together a wide and diverse range of participants, a forum was created for precisely the kind of interdisciplinary and inclusive sharing of knowledge and experience that is so necessary for seeking out the best ways of moving forward towards the larger goals of stopping the spread of HIV/AIDS, and mitigating the impacts on those currently affected or infected. While there are many other topics and discussions to be had, the following section provides a short synopsis of some of the key recommendations that may be drawn from the sessions at SAHARA.

Recommendations

Throughout the presentations, various common threads and recommendations for moving forward in successfully incorporating gender concerns into HIV/AIDS prevention, care, treatment and support were put forward. Recommendations include:

- Developing and implementing effective programmes and policies that focus on men and masculinities;
- Advancing issues of gender without perpetuating gender stereotypes;
- More cooperation and integration of work between researchers, policy-makers and practitioners;
- The incorporation of gender concerns at all levels of theory, research, policy and practice;
- The need for theorists, researchers, policy-makers and practitioners to be mindful of lived realities of HIV/AIDS-infected and/or affected individuals;
- Effectively utilising existing research, including the revisiting of existing data sets to extract gender-related data;
- A focus on ending stigma and discrimination, especially against HIV/AIDS-infected and/or affected individuals;
- A focus on curbing sexual violence and discrimination and sexual coercion; and
- The development and advancement of an African agenda for further research.

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Future actions

The impact that gender issues have in fuelling the HIV/AIDS epidemic has emerged as a fundamental aspect in addressing HIV/AIDS. It is imperative that we consistently question the role of gender in relation to transmission, prevention, care and treatment strategies, programmes and interventions. An inability, or unwillingness, to consider gender in relation to HIV/AIDS continues to undermine the work of governments, organisations and civil society in their efforts to implement and scale up initiatives and responses to the epidemic. Gender plays a pivotal role in how women and men respond to questions of VCT, treatment, care and prevention interventions and programmes. The SAHARA network provides a vehicle for ongoing dialogue and sharing of scientific research and information through conferences, workshops and other fora. It provides a platform for scientists, policy-makers, programme implementers and communities in Africa to jointly discuss ways of finding answers that will improve gender equity and equality and ensure gender-sensitive policies, programmes and strategies.

For this reason the SAHARA network will continue to utilise upcoming national, regional and international conferences to provide a platform through which this debate can be highlighted. Partnerships are fundamental to the network so, together with our partners, we will arrange sessions focusing on gender to facilitate open and honest dialogue on how best the African region can address these issues. The SAHARA website will serve as a critical vehicle for disseminating discussions and reports that emanate from these very important sessions.

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USEFUL RESOURCES

Gender reference group

A gender reference group was established at the conference to ensure the sharing of gender-related information. This group comprises:
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Useful websites

UNAIDS: www.unaids.org
Commonwealth Secretariat: www.thecommonwealth.org
Click on 'What We Do'/'Gender' and 'Gender and HIV/AIDS'
Atlantic Centre of Excellence for Women's Health: www.acewh.dal.ca
Click on 'Gender & HIV/AIDS'
Human Sciences Research Council: www.hsrc.ac.za
Under 'Research' click on 'Social Aspects of HIV/AIDS and Health'
Social Aspects of HIV/AIDS Research Alliance: www.sahara.org.za
EngenderHealth: www.engenderhealth.org
Under 'Women's Health' click 'HIV/AIDS & STIs'
Men as Partners: www.engenderhealth.org/ia/wwm/wwmo.html
Open Society Initiative for Southern Africa: www.osisa.org
Click on 'HIV/AIDS'
The UNIFEM Gender and HIV/AIDS Electronic Library: www.genderandaids.org

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