

GENDER AND HIV & AIDS

A New Agenda for Change

By working on HIV-specific challenges, addressing the burden of AIDS care and involving men and boys, good progress can be made to bring about change.

(VSO's gender advocacy strategy)



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Gender and HIV & AIDS: A New Agenda for Change

**VSO-RAISA Regional Conference Report Back
Pretoria, South Africa, 29 - 30 June 2009**

Conference organisers

 Bongai Mundeta, Naseem Noormahomed,
Charity Sisya, Angela Makgabo, Janice Manlutac
and all the VSO Volunteers

Report back

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Acknowledgements

VSO-RAISA Regional Conference | South Africa | 29-30 June 09

GENdER ♀♂ AND HIV & AIDS

A New Agenda for Change

VSO-RAISA acknowledges with gratitude the financial support from SIDA, DFID, TMF, Irish AID, and MERCK. Their generosity, both in financial support and in kind, provided us with an opportunity to organise a fruitful conference on Gender and HIV & AIDS. This enabled over 80 participants from different organisations and countries to interact and share experiences and learning from across the Africa region.

VSO-RAISA would also like to thank the National AIDS Council (NAC) Directors from the southern Africa region who officiated at the conference and launch for VSO-RAISA phase 3. The NAC Directors demonstrated commitment to engaging with VSO-RAISA in addressing the impact of HIV & AIDS in southern Africa in line with policies and priorities of their governments, which include recognising the three Ones: one national framework, one coordinating body and one monitoring and evaluation system. Their co-operation and participation provided an insight into critical issues that confront communities affected by HIV & AIDS issues.

VSO-RAISA appreciates greatly the presence of the Minister of Health from Zimbabwe, Dr Henry Madzorera, who officiated as the guest of honour at this occasion. In his speech at the conference Dr Madzorera highlighted the importance of strengthening HIV prevention strategies in southern Africa, a message which was well received and inspiring.

It was a privilege to have a highly committed VSO-RAISA board which assisted and guided with key note addresses and other presentations during the conference.

The VSO-RAISA team from the six countries and at regional level was very helpful and hard working throughout. Thank you.

Colleagues from the UK and abroad shared their experiences, enriching the regional conference.

We would like to thank Dr Stella Anyangwe, WHO South Africa's Country Representative, for always supporting VSO-RAISA.

VSO volunteers from the six countries were helpful throughout the conference, we thank them for their commitment, and we would like to thank the many others who played an important role from behind the scenes.

VSO-RAISA would like to acknowledge all participants at the conference who shared their experiences and views with regard to the implementation of the recommendations on Gender and HIV & AIDS, as well as the issue of the burden of care on women and girls. We hope this conference will make a difference to their work, especially to beneficiaries at community level.










And finally, many thanks go to Ellen Papciak-Rose for great photographs, fantastic layout and design skills, and to Pierre Brouard for accurate and detailed report writing.

Thank you all.

Bongai Mundeta
VSO-RAISA Director



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Acronyms

ADAPT Agisanang Domestic Abuse Prevention and Training	•	NAPHAM National Association for People Living with HIV/AIDS in Malawi
AIDS Acquired Immune Deficiency Syndrome	•	NGO non governmental organisation
ART antiretroviral therapy	•	PF Parliamentary Forum
ARV antiretroviral	•	PMTCT Prevention of mother to child transmission
CBO community based organisation	•	RAISA Regional AIDS Initiative of Southern Africa
CGE Commission for Gender Equality	•	RAANGO Regional AIDS Association of NGOs
CP care provider	•	SA South Africa
CSA Centre for the Study of AIDS	•	SADC Southern African Development Community
DACA District AIDS Co-ordination Advisor	•	SAfAIDS Southern Africa HIV and AIDS Information Dissemination Service
DFID Department for International Development	•	SIDA Swedish International Development Cooperation Agency
GBV gender based violence	•	UK United Kingdom
HAI HelpAge International	•	UN United Nations
HIV Human Immunodeficiency Virus	•	UNAIDS Joint United Nations Programme on HIV/AIDS
INERELA International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS	•	VCT voluntary counselling and testing
LAC Legal Assistance Centre	•	VSO Voluntary Service Overseas
M&E monitoring and evaluation	•	WHO World Health Organization
MSM males who have sex with males	•	ZAN Zimbabwe AIDS Network
NAC National AIDS Council	•	

About VSO-RAISA



RAISA (the Regional AIDS Initiative of Southern Africa) is a VSO initiative seeking to strengthen the response to the AIDS pandemic in southern Africa. It aims to join forces with government institutions and civil society organisations to ensure effective provision of prevention, treatment, care and support for people affected by AIDS, and to mitigate the personal, social and economic impact of the pandemic.

Partnerships lie at the heart of all of VSO and RAISA's work, and the essence of RAISA is to provide in-country partners with building blocks which strengthen their capacity to develop their multi-sectoral programmes and to increase their impact.

RAISA focuses on marginalised groups – particularly people living with HIV, women, children, and youth.

By working with local partners, we aim to:

- ✘ Provide volunteer development workers to build capacity of civil society, NGOs, and governments to address HIV & AIDS. This includes providing technical assistance in areas such as organisational development, management skills training, fundraising, and marketing.
- ✘ Provide health professionals in health education, sexual and reproductive health, clinical treatment, and psycho-social care to support the health sector in responding to the pandemic.
- ✘ Mainstream HIV & AIDS into VSO's work in rural and urban development, education, health, business and social development. To facilitate this, we provide on-going support such as training programmes, small grants, and resources to volunteer development workers and their colleagues.
- ✘ Increase political commitment, combat stigma and discrimination, and improve national and regional responses to the AIDS pandemic by supporting the advocacy and policy work of civil society, NGOs, and governments.
- ✘ Document 'best practice' and lessons learned regionally through information sharing, sectoral workshops, and exchange visits.

Executive summary

The VSO-RAISA director, Bongai Mundeta, welcomed delegates to this conference dedicated to finding new ways to think about, and act on, the compelling challenges of inequality between women and men and the impact of this on HIV & AIDS. As Sara Page of the VSO-RAISA Board noted, gender inequality is embedded in social processes and there is a need for fresh ideas and interventions.

Boemo Sekgoma of SADC PF urged individuals, organisations and networks to lobby parliamentarians for legal and policy reforms and the enactment of international agreements on women to achieve equality between women and men.

Professor Kelly of the VSO-RAISA Board, in a hard hitting presentation, showed the vulnerability of women physiologically, socially and economically and highlighted the burden placed on women and girls to address care and support needs in the SADC region. He expressed optimism about the capacity of communities, cultures and countries to change so that attitudes and actions towards women can be improved.

In highlighting VSO's gender advocacy strategy, Renaldah Mjomba showed that by working on HIV-specific challenges, addressing the burden of AIDS care and involving men and boys, good progress can be made to bring about change.

Pierre Brouard of the CSA offered some challenges to the conference to take gender work into more complex and nuanced territory. This includes avoiding stereotyping women and men, remaining critical of gender theory and its interpretation, locating feminism within an African context, finding ways to work with men which does not threaten them (gender equality should be presented as empowering women AND men) or unintentionally reinforce patriarchy.

Presentations from partners on the first afternoon were divided into the four theme areas of VSO-RAISA: prevention, treatment, care and support, and mitigation. Feedback on the interesting presentations and vigorous discussions was given on day two.

On **treatment** it emerged that there is a need to review the gendered nature of treatment access, to encourage participation of all voices (within and across genders), to avoid conflating gender with "women", to address the power dynamics between men and women, and to see men as vulnerable too, but in different ways.

On **care and support group** the view was expressed that as an increasing number of men show concern for the health of their families and communities, there is an opportunity to enhance their positive role in prevention, treatment, care and support, while at the same addressing the vicious cycle of burden of care on women and girls. The research presentation by Dr Evelyn Isaacs of WHO and Charity Sisya of VSO-RAISA on this topic was a sobering reminder of challenges that remain if this vicious cycle is to be addressed.

On **mitigation** it was felt that the role of history and culture needed to be addressed, while understanding that young people inhabit new cultures, the needs of older people need to be addressed and that governments, civil society actors and people living with HIV &/or AIDS need to work together to meet treatment targets and achieve inclusivity.

And on the theme of **prevention** there is a need to address the issues prisoners face (which would include exploring rights around same sex practice in and out of prison), to aggressively target gender-based violence programmatically and through laws and policies, and to find new and creative ways to involve men in good practice, while not ignoring the importance of exploring "masculinities" and "femininities".

The rest of day two was devoted to the launch of Phase 3 of VSO-RAISA by Bongai Mundeta. Phase 3 will operate through strategic partnerships with NACs in six countries, networks of people living with HIV &/or AIDS, government departments and community-based organisations. This will be done in alignment with the "three ones": one strategic framework; one National AIDS Council; and one monitoring and evaluation system, and will focus on promoting universal access to prevention, care and support, treatment and mitigation.

A number dignitaries was present to support the launch of Phase 3 and these included the Zimbabwean Minister of Health, Dr Henry Madzorera, and representatives of NACs, the WHO, the CGE in South Africa, members of RAANGO and Caroline Simumba of SIDA.

In closing, Bongai expressed her gratitude to all participants and guests for their engagement on the topic of gender and reiterated VSO-RAISA's commitment to collaboration and partnership in the region.



Day One
Monday, 29 June 2009

GENDER AND HIV & AIDS A New Agenda for Change



VSO volunteers with Prof Kelly. From left to right: Thomas Feinson (Zambia AIDS Agenda Advocacy Alliance), Nery Ronatay (Common Vision for Social Development, Malawi), Sumit Bhattacharya (Children on the Move, SA), Frans de Jeu (Soweto Care System, SA), Jared Oriwa (SAT, SA), Bella Ramos (AIDS Consortium, SA), Prof Kelly (VSO-RAISA Board Member, Retired Prof, Univ of Zambia and Catholic Priest), Carolyne Opinde (Volunteer Liaison Group, SA), Bernard Abingo (Akanani Rural Development Association, SA), Natividad Torralba (LoveLife, SA), Sharon Elliot (Power Mozambique), Anouk Berger (St. Joseph Care and Support Trust, SA), Catherine Kalibo (National Association of People Living with HIV and AIDS, SA), Snigdha Sen (NISAA Institute for Women's Development, SA), Caroline Wanene (South African Youth Movement, SA), Martijn Barel (Volunteer Liaison Group, SA), Janice Ian Manlutac (Agisanang Domestic Abuse Prevention and Training, SA) and George Murende (Bophelo HBC, SA).



Welcome **Bongai Mundeta** (VSO-RAISA Director)

Bongai welcomed all guests to a cold Roode Vallei in the province of Gauteng, South Africa, and invited Sara Page of the VSO board to make her opening remarks.

Opening remarks

Sara Page (VSO-RAISA Board, Deputy Director SFAIDS)



Sara noted that while the theme of the conference: Gender and AIDS, a new agenda for change, was timely, we have been addressing this topic for 20 years now. A key lesson has been that social issues are crucial – gender is a critical social issue and reflects social scripts dictating what it is to be a woman or man. Women are vulnerable but so are men because of the social roles they are expected to fill. There were experts at the conference, she said, who would share good practices to assist all to draw up a new agenda which tackled the social roots of gender power relations. Conference delegates were encouraged to network, to make the most of the time together, and to ask the hard questions!

Introductions and setting the scene

Bongai Mundeta (VSO-RAISA Director)

Bongai introduced all stakeholders present at the conference. A special welcome was extended by Sara Page to two members of the Zimbabwean government, the Minister of Health and Child Welfare, Dr Henry Madzorera, and Mr Godfrey Nyoni, and thanks were given to all who helped to organise the conference.

Bongai then reviewed the conference objectives:

- ⌘ to spark new energy and inspiration on gender-focused programmes
- ⌘ to discuss gender and gender relations
- ⌘ to develop ideas to improve, adapt, and refine programme implementation
- ⌘ to empower partners to take specific steps to enhance programmes and to develop links with other partners in the region.

Conference delegates were encouraged to network, to make the most of the time together, and to ask the hard questions!





Regional materials were on display throughout the conference.



Opening remarks

Boemo Sekgoma (SADC PF)



Boemo greeted the conference in a range of Southern African Development Community (SADC) languages in a reminder of the multilingualism and multiculturalism of the VSO-RAISA network. Boemo stressed that it was important to distinguish between SADC (the executive arm based in Gaborone) and the SADC PF (the Parliamentary Forum based in Windhoek). The Forum's roles include monitoring budgets, representation and legislation.

Boemo presented the PF's views on gender: women were more vulnerable and made up two thirds of caregivers; they had traditional roles which limited them; young girls dropped out of school to assume care roles and their ability to earn income was reduced; and older women were burdened when caring for adult children and grand children.

These roles, said Boemo, impeded the rights of women and children and reduced their social and economic potential.

Strategies suggested by Boemo included the following:

- ✘ Children's rights ought to be protected by governments to ensure their survival and development, especially through access to education and health care.
- ✘ There is a need for a human-rights framework to empower women and children and guarantee rights to equality.
- ✘ Because states assume a role for social security, for example through endorsing universal declarations on rights, these declarations can be used for advocacy and lobbying.
- ✘ Parliaments in the region need to enact laws that focus on women and children.
- ✘ There should be a co-ordinated and multi-pronged approach.
- ✘ Health care services should be strengthened.
- ✘ Gender-education programmes should be developed and run and efforts to involve men in care work should be increased.
- ✘ Gender roles should be challenged, with all ages and classes of people.
- ✘ Awareness on stigma and discrimination should be raised.
- ✘ Financial assistance programmes were crucial – women caregivers did not want to abandon their relatives, they wanted more care and support.
- ✘ A social protection programme should be customised according to country needs.
- ✘ In dealing with foreign investors, governments need to speak for local needs.
- ✘ There was a need for more political will at SADC level and VSO should be advocating for this.
- ✘ The matter of payment of health care workers, and counsellors needed exploration and parliaments should be lobbied on career paths and adequate pension arrangements – many health care workers migrated to foreign countries and there is a need to retain this expertise.
- ✘ We need to scale up treatment, address the needs of vulnerable groups and HIV status should not be used to exclude anyone.
- ✘ Country programmes should be tailored and monitored and there should be space for flexibility.
- ✘ Governments need to address poverty.

In conclusion, said Boemo, we need to review laws as these reflect our values and should protect all in a society. These should address inequality of men and women in society and lawmakers need to be integral to the process of building equality between men and women.

There is a need for a human-rights framework to empower women and children and guarantee rights to equality.



Key note address

AIDS and women

Professor Michael Kelly (VSO-RAISA Board, Retired Prof, Univ of Zambia, Catholic Priest)

Professor Kelly indicated that he was focused on AIDS and women as a way of showing the impact of gender. For example Stephen Lewis and James Morris have said that “The incredible assault of the HIV and AIDS pandemic on women has no parallel in human history. ... The pandemic is preying on them relentlessly, threatening them in a way that the world has never yet witnessed.”

While agreeing with this, Professor Kelly suggested that there is a broader context of female disempowerment. He highlighted the global disadvantage women face in poverty, literacy, schooling and care responsibilities. Across the globe women were absent from many parliaments (Rwanda is a good exception but worldwide they are in less than 20% of parliaments) and women everywhere earn less than men for the same work or are over represented in lower paying jobs. The Gender Gap Report of 2008 (covering health and survival, education, economic opportunities and representation) looked at 130 countries in rank order. In VSO-RAISA countries these gaps are stark, although, interestingly,

Mozambique was found to have no gender gap in terms of economic opportunities. In every country in SADC the gap is even wider around health and survival.

So this gender gap is the background context to AIDS. As with poverty, we speak of the feminisation of AIDS, referring to the increasing and disproportionate impact of the epidemic on women and girls:

- ⌘ In sub-Saharan Africa, women are disproportionately affected in comparison with men, with especially stark differences between the sexes in HIV prevalence among young people.
- ⌘ Women and girls become infected and die at younger ages than men and boys.
- ⌘ The negative impacts of the AIDS epidemic are more severe for women and girls than for men and boys.

These factors are leading to a gender reversal in life expectancy, contrary to expectations based on rates from as recent as a decade or two ago. In southern Africa by 2010 the life expectancy for women will be lower than for men. This is an extraordinary phenomenon and has resulted in more orphans and the increasing burden of orphan care on elderly grandparents, often women.

What makes **women** so vulnerable? Women are vulnerable **physiologically** and are more vulnerable to contracting HIV than men.



The Gender Reversal in Life Expectancy in Southern Africa

	Life Expectancy for WOMEN	Life Expectancy for MEN
1998	61	54
2004	48	46
2010	42	44

A slide from Prof Kelly's presentation showing that the life expectancy for women will be lower than men.

But **social and economic factors** are critical too:

- ✘ Few women can negotiate the when and how of sex.
- ✘ Double standards in society, expecting sexual naiveté from women and experience from men (distorted social meaning of masculinity and femininity).
- ✘ Economic and geographic freedom and mobility of her male partner place a woman at risk.
- ✘ A woman is vulnerable if she is married and remains faithful to her husband.
- ✘ A woman is vulnerable if she is single or has no partner – a condom is fine but it is an endgame and does not deal with the forces that construct masculinity and femininity that drive behaviour.

Women are **burdened** in other ways too:

- ✘ Women carry many responsibilities, as household managers, major producers of food, carers for the sick, and caretakers of children, including orphans.
- ✘ Even if personally HIV infected, or ailing from some other illness, women must continue to manage a household, provide care, produce food and generate income.
- ✘ There is massive pressure on women to ensure availability of food for the household, no matter what the cost, even the cost of sex and its risks.
- ✘ Upon the death of a spouse due to AIDS, women are often stigmatised and driven from their communities, losing land and other assets.

As for **girls**, they are often taken from school to assist in a wide range of household activities and this leads to a double loss for them. They lose the education to protect themselves against AIDS as well as prospects which come from a better education. Many are forced to contribute to household survival by being "married off" at a young age, selling sex or working as servants and child labour.

AIDS care is feminised said Professor Kelly. The state does not provide adequate care and so women step in. There is little recognition of this role. It is said that this is a

A slide from Prof Kelly's presentation showing a washing line with no female clothes.



woman's job but this is a sociological not biological burden and we need to move towards remuneration of women involved in care. VSO-RAISA has done well in lobbying for this.

In addition, there is a need to recognise that violence against women adds to their many burdens and is the most pervasive of all human rights violations. Globally this is often seen as normal and up to half of all adult women have experienced violence at the hands of their intimate partners. Often violence is used in armed conflicts and ethnic cleansing and many justice systems are not women friendly, resulting in victim blaming around gender violence.

Violence against children is also deeply worrying, happening in the home, schools and communities. It is a global phenomenon with nearly 50% of all sexual assaults worldwide occurring against young girls 15 or younger. These forms of violence increase the vulnerability of children, and especially girls, to HIV infection.

The basic problem, then, is that AIDS adds to the problems of women and girls and highlights the background discrimination and bias against women and girls. This bias is embedded in our many systems and structures (economic, linguistic, social, political and religious) and the AIDS epidemic casts a very powerful spotlight on this fault-line in all of our societies.

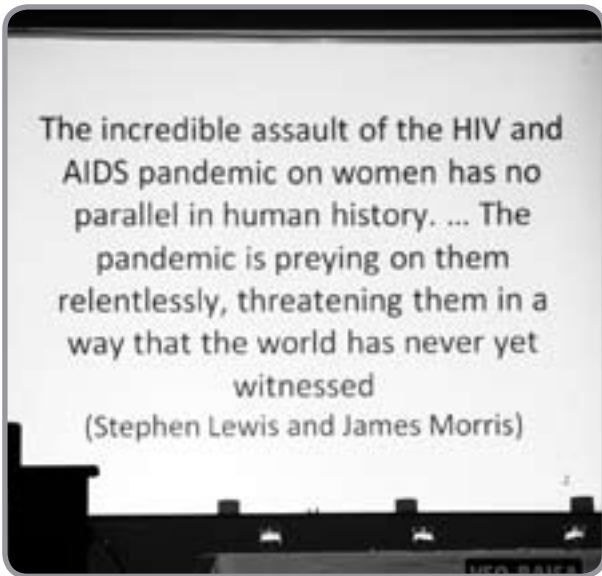
So the central issue is the inferior status of women. As Jonathan Mann said in 1995,

"When women's human rights and dignity are not respected, society creates and favours their vulnerability to AIDS".

So we all need to commit to the equality between women and men, as a goal in its own rights and to fight HIV. Quoting George Bernard Shaw, Professor Kelly left us with the challenge:

"Some look at things that are, and ask why. I dream of things that never were and ask why not?"





A slide from Prof Kelly's presentation.

Discussion

Sara Page (VSO-RAISA Board, Deputy Director SAfAIDS)

Sara summed up Professor Kelly's challenge as akin to the elephant in the living room – why do we ignore gender inequality and the social underpinnings of this when it is glaringly problematic?

In the discussion which followed Boemo was asked a number of questions about accountability, procedures and opportunities. She indicated that the PF has its own mandate and that civil society's mandate was to complement this and to hold parliamentarians to account, she said that there are mechanisms to access parliamentarians to have our voices heard, and that we should attempt to influence parliamentary caucuses. On the matter of criminalisation of HIV infection, these laws go against existing evidence and we should lobby to have them changed. Political parties and parliaments have different systems – and these affect the extent to which they introduce, make and justify new laws. Civil society has a role to play in advocating for changing these laws.

Professor Kelly was asked questions about the impact of modern culture and the role of the church and family in shaping gender attitudes. We don't stop and start cultures, they are always shifting and moving and modern and traditional aspects are fused, he said. Worldwide, there is a lack of gender equality but change is possible, as seen in Nordic countries where they reviewed parenting roles and made changes in the legal system.

Drama presentation

Irene Khumalo and her team (ADAPT)



ADAPT are based in Alexandra and focuses on violence against women, using a community empowerment model. They identified a need to include men as part of the solution and have developed a drama performance performed by young men which shows that violence is a learned behaviour and can be challenged.

The drama addressed themes of bitterness of parents being passed on to their children, the loss of role models for young people living in the streets, the endemic nature of violence in South Africa, the link between poverty and AIDS, AIDS as a war of sorts that disrupts society, men seeking multiple partners to boost their egos, the violent nature of some relationships, the ways in which men released from prison return to violence as they struggle to reintegrate, and women as survivors – and humanisers of men.

In concluding the drama, the young men appealed to us, the audience, to participate in change.



Overview of VSO's gender advocacy strategy

Renaldah Mjomba (VSO policy and advocacy advisor)



The aim of VSO's advocacy programme on gender and HIV & AIDS is to mitigate the impact of HIV & AIDS on women, girls and vulnerable men and to address gender inequalities which drive the epidemic. VSO's definition of advocacy is as follows: "A process that tackles disadvantage by working with communities, and key stakeholders, to bring about changes in policy, process, practice, and attitudes in order to ensure communities' rights are recognised and realised. The aim is to actively support disadvantaged people to influence the decisions that affect their rights and lives."

Many partners at CBO and NGO level need empowerment to do advocacy work and VSO aims to do this will also linking to national, regional and international work. It should be evidence and rights based, reflect the real world, open doors and amplify voices, and facilitate sharing and learning.

VSO's advocacy work on gender focuses on:

- ⌘ gender and HIV
- ⌘ reducing burden of care on women and girls
- ⌘ involving men and boys in HIV prevention (a more recent focus).

Highlights of this work were presented by Renaldah on these three theme areas. On **gender and HIV**, a report in 2003 highlighted five key manifestations of gender inequality. The 2007 publication, *Gender, power and prevention*, called for evidence-based HIV- prevention programmes, the targeting of specific groups and the involvement of men and boys. The 2007 publication, *Walking the talk*, put women's rights at the heart of the AIDS response. It called for: women's participation as the centre of any response; investment in female-friendly health systems; legal protection to guarantee women's rights; and for donors and multilaterals to make this happen and to be accountable to the women their aid is aimed at. In 2008 VSO used this publication to influence DFID's HIV strategy. VSO is also conducting a full review of global gender and HIV indicators in order to develop a recommended core set (to feed into the 2010 UNGASS review).

On **reducing the burden of care**, VSO 2006 produced a 2006 publication. In 2008 it produced a publication asking "What do we really mean by 'HIV Care and Support'?" It asked what could be done to reduce the emotional, mental, physical, psychological and financial stress that care providers suffer as a result of their work, through psychosocial, clinical, socio-economic, human rights, legal and family and community support. In November 2008 VSO fed into the European Community programme for action on HIV, TB and Malaria, producing best-practice case studies on home and community-based care; developed core global indicators on care and support with DFID and UNAIDS; and worked in SADC with WHO and RAISA. As a result of VSO's work, it was able to give input on a UN commission on the status of women and formed a caregivers action alliance with HelpAge International and others.

On **men and boys** VSO operated from the view expressed by Professor Graham Lindegger of the University of KwaZulu Natal that "If the risk behaviours of men are to undergo substantial modification, the very construction of masculinity itself must be called into question and challenged". A recent advocacy strategy aimed to mainstream men and boys in national and international prevention guidelines, promote comprehensive sexuality and life skills education in schools, promote programmes that challenged gender roles and stereotypes, and to include specific vulnerable groups of men in programming and funding plans.

VSO's definition of advocacy is as follows: "A process that tackles disadvantage by working with communities, and key stakeholders, to bring about changes in policy, process, practice, and attitudes in order to ensure communities' rights are recognised and realised."



Gender and AIDS

Pierre Brouard (Centre for the Study of AIDS,
Pretoria University)



Building on previous presentations at the conference, Pierre summarised the terrain around gender and AIDS. Not only are men and women differently vulnerable to HIV in term of the biology of sex, there are also other important factors. In most societies appropriate roles, behaviours and choices for men and women are shaped by social, cultural, economic, legal and political forces. **These can affect:**

- ⌘ what men and women understand to be “normal” and acceptable behaviour as a man or a women – these norms can make women AND men vulnerable to HIV
- ⌘ what men and women (and girls and boys) know about sexual matters and behaviours
- ⌘ how they are expected to conduct their sexual lives, including norms around faithfulness and multiple partnering
- ⌘ what negotiating power they have in sexual relationships, leading sometimes to rape and sexual violence against women (or some men)
- ⌘ how the sexuality of men and women may be influenced through practices such as initiation ceremonies, virginity testing and wife inheritance
- ⌘ the economic rights and opportunities women may or may not have, leading to a lack of power and choices and, in some cases, to intergenerational and transactional sex
- ⌘ the way in which women may be expected to take on care roles in families as well as expectations around fertility and child bearing
- ⌘ how men and women may get different access to prevention information and health services, including care, support and ARV services

- ⌘ laws and policies which may or may not protect men and women equally from violence or which do not give men and women equal rights in society
- ⌘ the lives of men and women who do not conform to gender roles or heterosexual expectations, leading to hidden practices and hidden lives where people may not access information, support and health care.

As a result of these forces, men and women are differently vulnerable to HIV. It is important that gender-based interventions in AIDS organisations and programmes understand these gender dynamics, and focus on men and women separately AND together to build agreement, sharing and equity. Power is not a zero-sum game and men need to be persuaded that the empowerment of women leads to a better life for all.

However, there are some caveats which need to be explored in our gender work, Pierre suggested. **Firstly**, we must be cautious in reducing all men and all women to stereotypes. In an interesting paper in *Re-thinking Sexualities in Africa*, Jo Helle-Valle suggests that “sexuality” (and gender) is many different things within the same socio-cultural group. Not only do different people relate to and practise sex in different ways, but sexual mores and practices in fact mean many different things for each individual, depending on the socio-cultural contexts they take place within, over their lifetime.

Secondly, we have used gender theory in limiting ways in the AIDS epidemic. Tamara Shefer in a paper offering a critique of gender theory used in HIV & AIDS responses says:

- ⌘ The initial focus on women and girls resulted in an inadvertent “blaming” of women for the epidemic.
- ⌘ The focus on women’s vulnerability and men’s power may have simply reproduced traditional roles – and it’s patronising to women.
- ⌘ We have focused on seeing masculinity and femininity as opposites and “naturally” different, leading to attempts to improve “communication” rather than addressing structural inequalities between men and women.
- ⌘ Many programmes assume that participants are heterosexual and only practise penetrative sex.
- ⌘ Not enough gender work with women acknowledges the role of class, race and other identities so that women are not viewed as homogenous group.
- ⌘ Despite the emergence of work on positive aspects of female sexuality, pleasure and desire, insufficient attention is paid to this in interventions.
- ⌘ Instead of only focusing on men who seem “unable” to control their sexuality, we need to see what we can learn from men who practice alternative forms of masculinity (who and where are they?).
- ⌘ The idea of focusing on men and masculinity has taken hold but in many ways men are viewed in these efforts as secondary.



But Ms Shefer cautions that we need to be careful not to take the focus (and money!) away from women – other commentators have noted the importance of working with women and men separately and together.

Thirdly, it is useful to examine the role of “western” feminist theory in African work. Mary Kolawole, in *Re-thinking Sexualities in Africa*, comes to a new understanding of feminism in Africa. She argues that gender theory in Africa needs to be more inclusive – it should be more context sensitive and embrace: data collection, interviews, evaluation of opinion leaders’ perceptions of gender, and baseline studies of socio-cultural practices which shape gender relations and perceptions. There is also a meeting space for grass roots women and scholars, between middle and working class women, between theory and practice, and between concept and activism. This is the position that most African women prefer – enhancing women’s conditions and opportunities for participation in development in ways that does not alienate men, does not jeopardise the family system, and celebrates motherhood. “Womanism” seems to her to be the most functional and broad-based approach to gender in Africa because it addresses the plurality of expectations and the multiplicity of viewpoints.

Fourthly, men are threatened by change, experience some of the messages aimed at them as contradictory and need to feel involved in more creative ways. Research conducted by Margrethe Silberschmidt in urban and rural east Africa found that not only had present norms and values become contradictory and conflicting (though still anchored in tradition), men had difficulty in maintaining their expected roles as head of the household and provider. They were aware that they were slowly losing power and were resisting this: they did not welcome traditional safe sex messages, including “sticking to one partner”. Strategies to empower women had to be balanced with addressing increasing male frustration, she argued, suggesting that men resist the erosion of their power through one powerful mechanism, their sexuality.

Fifthly, even when men did find ways to change they lacked support for this. Tina Sideris, in research conducted in the Nkomazi district of Mpumalanga, found there were men who had rejected violence, engaged with human and gender rights, performed “women’s work”, and relinquished control over family income. But their friends and colleagues considered them, at best, mad or bewitched and, at worst, a threat. They were described as “not complete in the head”, “victims” of *khorebela* (a potion given to men by women in order to subdue them), and had been deserted by most of their male friends. “Without broader social support, it is difficult to predict how these men can sustain their responses. Nor is it likely that these emerging configurations of practice can constitute effective resistance to dominant practices. Life in the Nkomazi area offers them no alternative sense of what it means to be a man in relation to women,” said Ms Sideris.

Sixthly, working with masculinity needs to go beyond stereotypes. Louise Rasmussen of the Centre for African Studies at the University of Copenhagen examined two programmes which promoted male involvement and found that both were based on a form of knowledge about “Ugandan culture” which uncritically assumed that all Ugandan men were in a dominant position in their households – the programmes then aimed to teach men to practice their authority “properly”. This approach, she argued, contributed to stereotypical ideas about African men and did not challenge male power and its relationship to female lack of power.

Seventhly, not all development organisations create gender equity in their own internal functioning. If organisations don’t reflect gender equity themselves, then they only pay lip service to equalising power between men and women. So efforts to address men have been challenged by the following:

- ✘ Male dominance is protected by cultural machinery that values and supports hegemonic masculinity.
- ✘ We do not sufficiently see that working with men affects women positively.
- ✘ Donors and agencies have not sufficiently seen men as an area of focus.
- ✘ Men who are different are often isolated and unsupported.
- ✘ Power is seen either as something men have or women have, it cannot be shared to the benefits of both men and women.
- ✘ There is sometimes a lack of gender transparency in development organisations.

Pierre then suggested that interventions on gender change needed to operate at many levels (with individual men and women, with groups, with institutions like schools, workplaces, health centres and cultural and rights organisations, and with all levels of government and parliaments) to be successful. These interventions, he said, should incorporate: the individual level (through biomedical interventions and behaviour change methodologies); the social level and the structural level, in a combined way. However some challenges remain, said Pierre:

- ✘ managing the tension between individual factors on the one hand, and social and structural factors on the other
- ✘ finding the balance between simple, elegant models and complex human factors
- ✘ working with men AND women
- ✘ teasing out the challenges of generalisations
- ✘ finding a balance between theory and research on the one hand and implementing and assessing on the other
- ✘ thinking through the complexities of measurement when using a combination approach
- ✘ finding other organisations and programmes in the region to build alliances with.



Parallel sessions

The afternoon sessions were run in parallel, divided into the four theme areas which VSO-RAISA focuses on: prevention, treatment, care and support, and mitigation. Each session had three presentations followed by discussions to explore gender aspects of the presentations. These sessions were facilitated by a CSA team member and, with a VSO-designated rapporteur and scribe, a report back was compiled and shared with the conference delegates in the first plenary session of day two.



Renaldah Mjomba (VSO), Sima Vallabh (NISAA Institute for Women's Development), Aloysius Katzao (LAC) and Dr Zubeda Dangor (NISAA Institute for Women's Development).



Cletos Masiya (Child Protection Society), Master Mphande (NAPHAM), David Mutambara (Zimbabwe Business Council on AIDS) and Rafa Machava (Forum Mulher).



Front row: Mary Manda (Mazabuka Municipal Council), Ndhlovu Kenani (Mazabuka District AIDS Task Force) and Nyembezi Nkunika (Thandizani Community Based Care Organisation).



Kavutha Mtuvi (HelpAge International), Sara Page (VSO-RAISA Board Member and SAfAIDS) and Jeffer Mxotshwa (NAP+SAR).

Parallel session ONE: Prevention

Presentation 1 Legal issues on gender and HIV & AIDS and prevention

Aloysius Katzao (Legal Assistance Centre, Namibia)

The **Legal Assistance Centre (LAC)** is a public interest law centre which strives to make the law accessible through education, law reform, research, litigation, legal advice, representation and lobbying, with the ultimate aim of creating and maintaining a human rights culture in Namibia. Through its AIDS Law Unit, the LAC promotes a human rights-based response to the AIDS pandemic. The LAC recognises that the formal entrenchment of human rights in Namibian law does not guarantee that these rights will have real meaning in the lives of all people, particularly children, marginalised rural communities and people living with HIV &/or AIDS.

The focus of this presentation was on a new venture within the AIDS Law Unit: it joined YELULA-Ukhai, a coalition of NGO's working at grassroots level with people living with HIV &/or AIDS, to strengthen their resources and support systems through networking, training, grants, mentoring and outreach. The LAC's contribution to this was an access to human rights focus, and through this it has been able to:

- ⌘ encourage people to stand up against injustices
- ⌘ promote access to services, education and work
- ⌘ promote treatment literacy
- ⌘ generate recommendations on reducing stigma and discrimination, and other human rights violations at public health institutions
- ⌘ work closely with schools who have established programmes for orphans and other vulnerable children
- ⌘ assist with the development of HIV workplace policies
- ⌘ interpret laws and take cases to courts – these included, for example, cases on:
 - breaches of confidentiality (the daughter of a deceased woman alleged that a clerk of a Magistrate's Court had stated publicly that her mother died of AIDS, thus subjecting her family to harassment and trauma)
 - pressure to test for HIV (a medical doctor was pressurising a young and newly diagnosed HIV-positive mother to have her child tested for HIV after the child allegedly bit another child at school – she was reluctant to have her child tested as she was only just coming to terms with her own status).

The Unit also dealt with complaints about: discrimination and harassment of people living with HIV &/or AIDS; dispossession of property following the death of a family member; delayed processing of social grants; challenges in accessing social grants due to lack of necessary documents (death, birth, and marriage certificates); undermining of the authority of people living with HIV &/or AIDS following deaths in a family; and children being denied enrolment in schools because their parents could not afford contributions to school development funds.

In looking to the future the LAC noted challenges in: outreach to rural areas; ongoing stigma and discrimination in families, communities, schools, churches and health care facilities; violation of property rights (disinheritance was closely associated with gender imbalances); access to life insurance policies and housing loans; defaulting on medication use due to side effects; poverty, impacting on nutrition and transport to health facilities; the reliance of government on foreign funding for ARV's; and refusal by the state to protect the rights of some vulnerable groups on the basis of "morality", for example the provision of condoms to prisoners and clarification of the legal position of commercial sex workers.

The LAC recognises that the formal entrenchment of human rights in Namibian law does not guarantee that these rights will have real meaning in the lives of all people, particularly children, marginalised rural communities and people living with HIV &/or AIDS.

Presentation 2 Gender-based violence and prevention

Dr Zubeda Dangor (the Nisaa Institute for Women's Development, South Africa)

Started in 1994, the **Nisaa Institute for Women's Development** is an NGO which is opposed to all forms of oppression, exploitation and violence against women. It offers counselling and shelter, training, advocacy and research, and conducts networking to enable women and children to live in a world free of violence.

Nisaa's focuses on gender-based violence because there is a link between this and risks related to HIV & AIDS in the following ways: rape, abuse, the social acceptance of multiple partnering for men and childhood experience of sexual abuse can make a woman more vulnerable to HIV; in addition having an HIV test and disclosing a test result may also increase



the risk of abuse. A South African survey quoted in the presentation reported that 33% of young women were afraid of saying no to sex; 55% had sex when they did not want to; and between 20 and 48% of adolescent girls aged 10-25 reported their first sexual encounter was forced.

This presentation highlighted some key Nisaa HIV-prevention activities. **Change the Tune** is a series of radio episodes on gender and gender based violence which broadcasts to over 54 African countries through Channel Africa on topics such as HIV & AIDS, disability and trafficking. The programme has had a good response but is time consuming and expensive to produce. Apart from logistical challenges, some of the more controversial topics were met with resistance from older and more traditional folk.

Intersectionality workshops for community members and service providers increase their knowledge about gender, stereotypes, gender and culture, power and abuse, rape, basic information about HIV & AIDS and the intersectionality between gender-based violence and HIV & AIDS in 16 hours over two days. It was reported that these workshops empowering people to take charge of their lives, raised awareness, lifted some of the taboos around talking about sex and encouraged critical re-thinking on gender beliefs and perceptions. However it was sometimes difficult for people to open up, the issues covered are sensitive and viewed as private matters which should remain so.

A **Consent is Sexy campaign** was piloted at the University of Witwatersrand in Johannesburg to: encourage young people in intimate relationships to be mutually respectful; increase knowledge and understanding on the dimensions around sexual rights; get people talking about sex, sexual and reproductive health; provide information on where to get help; and promote sustainability of the campaign. Some key activities of this campaign were exhibitions, pledges, an interactive website, a voting event – is it always ok to say no? – and competitions and debates. Based partly on the understanding that the incidences of reported rape is high at all campuses and there is a need to encourage young people and tertiary institutions to take the issue on, the campaign was well received and the university now has in place an improved sexual harassment policy and wishes to continue with the campaign.

In conclusion, the presenter noted that funding of HIV & AIDS work largely focuses on treatment, care, support and mitigation and called for an equal prioritisation of prevention programmes.

A South African survey quoted in the presentation reported that 33% of young women were afraid of saying no to sex; 55% had sex when they did not want to; and between 20 and 48% of adolescent girls aged 10-25 reported their first sexual encounter was forced.

Parallel session TWO: Treatment

Presentation 1 Advocacy and gender and HIV & AIDS

Ms Rafa Machava (Forum Mulher, Mozambique)

Forum Mulher was established in 1993 by 10 organisations and is now a coalition of 80 member organisations, co-ordinated by a secretariat and management team of 15. The coalition was established partly in response to the identification of violence against women as a priority area at the Beijing conference on women. It also saw a need for more research on violence against women; a reduction of women's poverty and exclusion; a reversal of the spread of HIV among women and girls; and support for women's leadership.

Its activities include:

- ✂ training on gender and human rights
- ✂ support for the establishment of the "Gender Machinery" in Mozambique
- ✂ lobbying for women's rights regarding land and family laws
- ✂ co-ordinating the Women's World March in Mozambique
- ✂ a campaign titled "All Against Violence"!

Encouragingly, Forum Mulher has noted the significant impact of its work. This includes: increased awareness about gender-based violence at national level; greater involvement of media in disseminating messages on gender-based violence; and the fact that women's voices are increasingly being heard in the communities.

However there have been challenges. Parliament has delayed the approval of proposed laws (announcement on a particular law was expected the day of the conference); there have been difficulties in implementing laws which have been approved; there is limited capacity in organisations which monitor the dissemination and application of laws; and there are limited resources to reach out to rural communities.

It [the coalition] also saw a need for more research on violence against women; a reduction of women's poverty and exclusion; a reversal of the spread of HIV among women and girls; and support for women's leadership.



Presentation 2

Two approaches to treatment and gender

A joint presentation by the Child Protection Society and the Zimbabwe Business Council on AIDS

The **Child Protection Society's** vision is for a child-friendly society which facilitates the achievements and full potential of every child, supported by its mission to protect and promote the well being of children and to assist them to be self reliant and responsible citizens. They do this with a focus on rights, holistic support and community strengthening.

Motivation for the work of the Society came primarily from a desire to offer a more integrated approach to community health; one which would recognise the high burden of care on caregivers, the economic challenges in Zimbabwe, the power of partnerships, and poor referral systems from local clinics.

The Society has a number of programmes which carry out the vision and mission:

- ✘ early childhood education development in play centres
- ✘ support for children living with HIV (including training on ART and palliative care)
- ✘ education assistance and support
- ✘ livelihood and nutrition assistance (including gardens and feeding schemes)
- ✘ advocacy and lobbying (for example on birth registration)
- ✘ psychosocial support (through clubs, camps, discussions, groups)
- ✘ reunification and reintegration of children into the community
- ✘ residential care of children in need in a home for children.

These interventions have shown a reduction in burden of care for carers, an improvement in the quality of life of orphans and other vulnerable children, an increase in basic knowledge of the health needs of children, improved access to health services and an increased willingness of caregivers to have their children tested.

Nevertheless, some challenges remain. Caregiver fatigue and burden, economic hardship, costs of medicine, poor pharmaceutical support, a lack of venues for support work, insufficient community volunteers, and vague referral policies continue to impact on the work of the Society.

The **Zimbabwe Business Council on AIDS** was formed as a trust in 2004, developed its first strategic plan in 2007, and adopted a business risk model in 2009. It has a membership of 35 corporates and its broad mandate is to scale up the business response to AIDS in Zimbabwe.

Motivation for the work of the Society came primarily from a desire to offer a more integrated approach to community health; one which would recognise the high burden of care on caregivers, the economic challenges in Zimbabwe, the power of partnerships, and poor referral systems from local clinics.

Currently, workplace interventions are reasonably limited, they are externally driven, there is a narrow focus on individual health, there is not a common approach, there is a greater emphasis on activities than strategy, and monitoring and evaluation is weak, as is alignment with national imperatives.

What is unique about the Council is that it is business run, it focuses on the health of the whole company not just the employee, and it views AIDS as an opportunity to manage organisational assets. It also starts where organisations are and promotes their interests, while using research as a key tool for innovation.

One interesting strategy has been the development of a volunteer programme with VSO. Started as a pilot in 2008, the vision is to test it in all 35 Council member companies in 2010 and beyond that to integrate it into the business risk model. Findings of the pilot were that volunteers played a key role, they allowed a more fun element to come into the work – thus assisting to destigmatise AIDS, they enhance the corporate social responsibility function of companies and thus contribute to sustainability of the organisations being supported by the company.

Where gender is concerned the business risk model acknowledges that:

- ✘ the special needs of men AND women need to be addressed
- ✘ a gender focus allows for better HIV risk entry points
- ✘ responses can be better tailored and more practical
- ✘ greater trust and organisational cohesion can be developed.

A gender survey in 2007 found that gender is recognised at policy level; care, treatment and support were reaching both sexes; gender-neutral reporting may mask specific needs of men and women; and there was a predominance of men in workplaces, thus giving a useful entry point for risk-reduction work.

As a result of this survey, companies were advised to make their responses more gender sensitive, develop guidelines on implementation of gender policies, and conduct more research, especially on the impact of a male dominated work force.



Presentation 3 ART issues

The National Association for People Living with HIV/AIDS in Malawi (NAPHAM)

With a population of just over 13 million, Malawi has a national HIV prevalence of 12%, with more of this community (53%) being women than men in the category of 15 years and older. **NAPHAM** works in this context to provide quality care and support services to people living with HIV &/ or AIDS, while also aiming to prevent new infections. It also conducts advocacy work, engages in capacity building and promotes livelihood activities. Founded in 1993, **NAPHAM** works through support groups in 15 out of the country's 28 districts. The majority of its membership is women.

What are the core activities of NAPHAM?

- ⌘ Prevention, treatment, care and support: community outreach; workplace programmes; home-based care; group therapy; child therapy; voluntary counselling and testing (VCT); and promoting access to antiretroviral therapy (ART).
- ⌘ Livelihoods: food security and income generating activities.
- ⌘ Advocacy: lobbying policy makers, community leaders and service providers; and radio programmes.

Through this work, **NAPHAM** has increased its membership, reduced reported stigma and discrimination, promoted greater involvement of people living with HIV &/or AIDS in decision-making bodies, and influenced policy. However stigma (self and enacted) continues to thrive, laboratory services to monitor immune levels remain inadequate, ART is not always available to those living in more remote areas, and girls and women remain vulnerable to HIV infection for social reasons. As an organisation, **NAPHAM** also faces challenges around resources, funding and stigma.

However stigma (self and enacted) continues to thrive, laboratory services to monitor immune levels remain inadequate, ART is not always available to those living in more remote areas, and girls and women remain vulnerable to HIV infection for social reasons.

Parallel session THREE: Care and Support

Presentation 1 A joint presentation on care and support in Zambia

Mary Manda (Mazabuka Municipal Council), on gender and AIDS – **Ndhlovu Kenani** (DACA) and on home-based care – **Nyembezi Nkunika** (Thandizani home-based care programme)

Mazabuka is located along a railway line in the Southern Province of Zambia and its HIV prevalence is estimated to be 15%. This high level is due to the town being on a transit route, the existence of fishing camps and recent industrial developments which brought many new workers into the town.

The **Mazabuka Municipal Council** recognises the gendered nature of AIDS and has taken a number of steps to mitigate impact from a gender perspective. It also sees a need to empower women through land ownership and to address the social and cultural roots of gender imbalances.

What has the Council done, then to address these gender phenomena? It has:

- ⌘ allocated and issued plots to women
- ⌘ empowered women through community projects
- ⌘ changed titles of certain position to make them gender neutral
- ⌘ employed widows whose husbands were Council employees
- ⌘ adopted an equal-opportunities approach
- ⌘ developed sensitive workplace policies
- ⌘ assigned "focal point persons" to deal with AIDS issues at work
- ⌘ set up a women's advisory committee to discuss gender inclusivity.

Through this work many women have indeed been empowered through land ownership, women are better represented and recognised in the Council, and women have felt freer to express themselves and learn about methods to protect themselves from HIV infection. However some women have been reluctant to take up land ownership for cultural reasons – and culture, along with educational and economic impediments, has also proved to be a challenge for women in more traditional relationships where men have greater power.

So the Council has also learned that gender empowerment is not a simple linear process. Gender mainstreaming



is a long term project and attitude change takes a long time to have an impact. In addition, the Council recognised the importance of reviewing good practices to find out what can be learned from them.

The **DACA** (District AIDS Co-ordination Advisor) works closely with the District AIDS Task Force in Mazabuka – and the task force aims to create an enabling environment for the prevention and mitigation of AIDS at a local level. It does this through a blend of co-ordination, facilitation, mobilisation and support of multi-sectoral responses to AIDS by all stakeholders.

The DACA offers support to the mandate of the task force through joint planning, support, liaison with all relevant structures at community, municipality and district level and, most pertinently for this conference, by mainstreaming gender in all development plans.

The gender work which the DACA and the task force conducts includes supporting women-led organisations which empower women and address gendered aspects of AIDS and working with community structures to hear from and give support to grassroots initiatives.

Some of the challenges noted around gender:

- ⌘ rape and sexual assault
- ⌘ early marriages in the poor
- ⌘ low school enrolment levels for girls
- ⌘ lack of harmony between customary and state marriages
- ⌘ exchange of sex for employment and training opportunities
- ⌘ low levels of representation of women in decision-making positions
- ⌘ the marginalisation of women.

One challenge around addressing the needs of women is traditional beliefs and traditional authority, both of which privilege male power and dominance. In addition, funding constraints, the absence of focal point persons on gender at lower levels, a lack of institutional frameworks for gender activities, and the need for women to get married to achieve any form of socially acceptable status continue to bedevil gender work. It is clear that addressing patriarchy, mainstreaming gender and looking for synergies between gender and AIDS agendas are still needed to move this work forward.

Thandizani was started in 1999 by a group of people who had undergone VCT – it forms community-based support groups based on knowledge of HIV status. It operates in eastern Zambia and its vision is for an improved standard of living for all through preventing diseases and mitigating the impact of AIDS: it hopes to strengthen communities in the Lundazi district to respond effectively to AIDS. Thandizani offers VCT, PMTCT, care and support, counselling, gender programmes, food security initiatives, community mobilisa-

tion, home-based care, youth-friendly services and sub-grants to other NGOs.

While its caregivers offer a range of much needed services, and benefits are tangible, Thandizani has encountered some core challenges: inadequate professional skills and knowledge to enable the care giver to deliver effectively; lack of stress management for caregivers; high client demand in the face of limited resources; high poverty levels and hunger in communities; and inadequate resources to support caregivers' mobility. This affects effective monitoring of clients at community level by caregivers.

Nevertheless the organisation has learnt that: empowering community care givers is more sustainable than hand outs; if home-based carers are not helped to manage their stress, it compromises the quality of service being offered; in order for care to be holistic, it must involve nutrition, ART and income activities for both the client and their immediate families.

It is clear that addressing patriarchy, mainstreaming gender and looking for synergies between gender and AIDS agendas are still needed to move this work forward.

Presentation 2 **Gender status in AIDS Service Organisations**

Chiratidzo Mariwo (the Zimbabwe AIDS Network)

The **Zimbabwe AIDS Network (ZAN)** is a national network of over 450 civil-society organisations and institutions responding to AIDS since 1992. ZAN programmes are designed to strengthen the civil-society response to AIDS through six core objectives:

- ⌘ strengthening organisational development
- ⌘ building membership competence
- ⌘ resource mobilisation
- ⌘ information sharing
- ⌘ advocacy
- ⌘ networking.

The primary targets of these objectives are the ZAN membership and secretariat, to facilitate increased access to improved quality services by people affected by or living with HIV &/or AIDS.

One aspect of ZAN's work is a project entitled "Promoting Gender Equity in HIV and AIDS" with support from the Canadian International Development Agency (CIDA), given the gendered nature of the Zimbabwean epidemic.



ZAN is focusing on ensuring that their policy framework on gender is implemented by members of the network. This will be done through facilitating organisational gender-policy development among members based on the national policy framework, supporting its implementation and monitoring. Gender and HIV workshops will also include sessions on unpacking relevant national policies.

ZAN conducted a gender-needs assessment and baseline study in 2008 to establish the status of gender mainstreaming in member organisations, establish gender gaps in HIV & AIDS programming and assess gender needs. Subsequently ZAN convened a national training of trainers in gender and HIV mainstreaming. By end of May 2009, two provinces, Midlands and Mashonaland East had successfully cascaded the training. Still challenges remain:

- ⌘ Participants were concerned that mainstreaming gender would “upset” traditional views and divide communities and families.
- ⌘ Concerns were raised over whether mainstreaming gender would not eventually disempower and isolate men from development.
- ⌘ There was a lack of resources and commitment in organisations.
- ⌘ Sometimes there were conflicting agendas and fighting for turf amongst the communities served.

Nevertheless ZAN is committed to ensuring that skills dissemination continues and hopes to support members in institutionalising gender in their organisations and projects. It also notes that we need to appreciate that society at present has a gender imbalance with the scale tilted in favour of men – and that gender is not just about women, but about women and men and how to enable both to play a role in development equitably.

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Presentation 3 Male involvement

Nixon Nembaware (Padare/Enkundleni/Men’s Forum on Gender, Zimbabwe)

The **Padare/Enkundleni/Men’s Forum on Gender** is an anti-sexist male-based organisation founded in 1995 which takes its name from the Zimbabwean tradition of men gathering to discuss community issues – in this tradition women and children were excluded from this process. Padare has decided to subvert this male exclusivity: its mission is to involve men in gender equity, through redefining men and masculinity, mainstreaming gender in all aspects of development and adopting a non-sexist and non-violent approach to women.

Padare’s work has the following components, with AIDS as a cross-cutting focus:

- ⌘ **Men as Partners** programme: this is an advocacy campaign to work with men and boys to prevent gender violence which could contribute to the spread of HIV. This includes working in schools and tertiary colleges to build the capacity of young men to deal with gender inequalities – this involves a process of challenging norms and roles which make women and men vulnerable to HIV.
 - **Schools** programme: this started in the Allan Wilson High School in Harare and Padare is particularly proud of the way in which young men and women collaborate in forums, peer education and exchange visits to promote gender justice.
 - **Tertiary** institutions: this work involves students in teacher and agricultural colleges through networks which mobilise and engage young men on violence, sexuality, sexual health, reproductive health and AIDS. Padare’s aim is to create a generation of positive role models on gender relations.
- ⌘ **Workplace** programme: this creates platforms for men to engage on gender issues through teach-ins, discussion forums, community engagement and peer education. Workplaces are natural places for this kind of work because of the numbers of men in the work force, because men can be mobilised in this way, and because Padare had found that male breadwinners had been excluded from domestic violence campaigns.
- ⌘ **Counselling:** services are provided to male perpetrators of gender violence.
- ⌘ **Advocacy:** Padare lobbied effectively around the Domestic Violence Act.
- ⌘ **Representation:** Padare sits on the Domestic Violence Council which monitors the implementation of the Domestic Violence Act in Zimbabwe.
- ⌘ **Care** programme: located in a quest for gender justice, this work addresses the burden of care on women due to patriarchy – even though care is valued by society it is unequally allocated. Where men are involved, it is usually in positions of authority in care organisations. Padare has succeeded in getting many more men into care work in four provinces.



Padare has of course found that there are challenges in its work. Social attitudes in general, male attitudes in particular, and insufficient donor support, has meant that not all 10 provinces can be serviced. There is also a lack of incentives for volunteers and their equipment challenges. Padare has thus recognised that this kind of work needs to take a long term vision.

In spite of these challenges, Padare has found that the support from VSO has been invaluable. It has begun to document its work, developed a volunteer management system, has networked with other organisations, received mentoring from VSO-Zimbabwe, been involved in national processes on policy on volunteers, and received materials and literature to support its work.

In conclusion, Padare leaves us with at least two useful slogans:

- ⌘ Men of quality are not afraid of equality.
- ⌘ Real men care for the sick.

Social attitudes in general, male attitudes in particular, and insufficient donor support, has meant that not all 10 provinces can be serviced. There is also a lack of incentives for volunteers and their equipment challenges.

Presentation 4

Research on reducing the burden of care on women and girls through the greater involvement of men in home-based care

Dr Exnevia Gomo (University of Malawi)

Dr Gomo contextualised the research with a review of the global AIDS epidemic and the burden of AIDS placed on women and children. Our global response to this has not resulted in greater male involvement. Our prevention work, the way treatment has been configured and made available, and especially our care and support interventions (which have burdened women or focused on women in ways which did not draw in men) have increased the feminisation of the epidemic. Social, cultural and economic factors, along with varying access of men to health services and AIDS information, have complicated the picture.

While the global community has recognised the burden of care on women and children, its response has been limited

Our prevention work, the way treatment has been configured and made available, and especially our care and support interventions (which have burdened women or focused on women in ways which did not draw in men) have increased the feminisation of the epidemic.

or insufficiently effective. So there is an opportunity here – especially an opportunity to build on male concerns about their families and communities – which has not been fully exploited and explored. VSO-RAISA is particularly concerned about this issue and its research, policy work, conferences, learning opportunities, capacity building and advocacy have been well received, and have created a useful space for research on male involvement. The study under discussion aimed to:

- ⌘ develop an understanding of partner projects on male involvement in home-based care
- ⌘ provide an analysis, based on SADC guidelines, of the effectiveness, ethical soundness, cost effectiveness, relevance, replicability, innovativeness and sustainability of interventions that aim to enhance male involvement
- ⌘ comment on how VSO-RAISA's horizontal-learning approach enabled partners to enhance their activities on male involvement.

Focusing on partners in Malawi, Zambia and Zimbabwe, the data was collected mainly through key-informant interviews and focus-group discussions, as well as document reviews. The key lessons which emerged from this research are as follows:

- ⌘ Men can participate as home-based care volunteers as effectively as women and add physical and emotional support.
- ⌘ Addressing gender issues and risky cultural and traditional practices can be more effective when men and traditional leaders are involved.
- ⌘ Targeting traditional leadership is critical in mobilising men to become more involved in care and support.
- ⌘ The increased participation of men in home-based care and other AIDS-related activities contributes to reducing stigma and discrimination.
- ⌘ Male involvement provides an opportunity to improve information dissemination in the community.
- ⌘ Involving men and community leadership at all stages of programme planning and implementation promotes mutual respect between men and women, as well as ownership and sustainability.



Addressing gender issues and risky cultural and traditional practices can be more effective when men and traditional leaders are involved.

As a result of these lessons, a number of recommendations were made by the researchers. These adopt a rights-based approach and include the following:

- ✘ Identify and document gaps in national policies and legislation governing care and support, particularly relating to male involvement.
- ✘ Advocate for increased involvement of men in home-based care and other responses.
- ✘ Develop and/or strengthen the IEC materials and strategies for mobilising men.
- ✘ Expand content and context of gender training and IEC within the NGO/CBO sectors.
- ✘ Extend male involvement campaigns to youth.
- ✘ Provide adequate equipment, materials and training incentives required for care provision.
- ✘ Conduct further research to understand more about men and women's beliefs, attitudes and practices towards the rights of care providers and the promotion of male involvement.

Parallel session FOUR: Mitigation

Presentation

Older people, gender, HIV & AIDS and mitigation measures: what do you need to know

Kavutha Mutuvi (Regional Advocacy Co-ordinator, HelpAge International)

If the UN definition of "older" is adopted (people older than 60), demographers estimate that this could include 40 million people in Africa and in fact Africa will continue to age despite the impact of AIDS. Ageing, gender and sexuality intersect in a number of ways:

- ✘ The biological and physiological aspects of ageing affect men and women differently.
- ✘ Social constructions of gender manifest in power differentials.

If the UN definition of "older" is adopted (people older than 60), demographers estimate that this could include 40 million people in Africa and in fact Africa will continue to age despite the impact of AIDS.

- ✘ Older men and women approach a number of matters differently – these include: vulnerability, risk, adventurousness, condom use, VCT uptake, health-seeking behaviour – and these factors are exacerbated by inappropriate health care services which are not old-age friendly.
- ✘ In multi-generational households where older people, especially women, may be burdened by care, their needs may be neglected.
- ✘ The epidemiological categories of AIDS research and programmes may exclude certain ages from interventions (people 50 and older for example) and assume they are no longer sexually active. This would exclude intergenerational sex as an issue – and intergenerational sex affects genders differently.
- ✘ Loss of a spouse may affect older women differently from men.

As a result of these important challenges, HelpAge International has developed a number of recommendations. In general: there needs to be better **disaggregation of data** for older people; policies and programmes need to be more **supportive** of older people; **poverty** needs to be addressed; **child-care** issues need to be addressed more urgently; and the needs and **rights** of older people must be advocated for.

More specifically on gender aspects: the disproportionate **impact of care** on older women needs looking into; a more **multi-faceted mainstreaming** framework which incorporates gender and age should be adopted; **traditional practices** which affect older women need to be addressed; and **male involvement** in care needs to be promoted.

The epidemiological categories of AIDS research and programmes may exclude certain ages from interventions (people 50 and older for example) and assume they are no longer sexually active.





Thomas Feinson (VSO Volunteer, Zambia) and Eric Mamboue (VSO Mozambique).



Saara Mupupa (VSO Namibia) and Rute Muchine (VSO Mozambique).



Chiratidzo Nyangu Mariwo (Zimbabwe AIDS Network), Dr Ellen Sithole (Zimbabwe AIDS Network) and Dairai Manyarara (FACT Rusape).



Dr Evelyn Isaacs (WHO) and Dr Stella Anyangwe (WHO).



Bernard Abingo (VSO Volunteer, SA) and Natividad Torralba (VSO Volunteer, SA).



Menzi Hlongwa (Centre for the Study of AIDS, University of Pretoria), Forster Matyatya (VSO Zimbabwe) and Jeter Mxotshwa (NAP+SAR).



Nicky Mathews (Country Director, VSO Namibia) and Idah Banda (Midlands AIDS Caring Organisation).



Day Two
Tuesday, 30 June 2009

GENDER ♀♂ AND HIV & AIDS A New Agenda for Change



Dignitaries and speakers. Back row, left to right: Dr Henry Madzorera (Minister of Health, Zimbabwe), Dr Yohane Kamgwira (NAC), Dr Stella Anyangwe (WHO), Dr Evelyn Isaacs (WHO), Dr Joana Manguera (Chief Executive, NAC), Dr Chama Chanda (NAC), Tapiwa Magure (NAC), Godfrey Nyoni (Ministry of Health, Zimbabwe) and Prof Kelly (VSO-RAISA Board Member, Retired Prof, Univ of Zambia and Catholic Priest). **Front row, left to right:** Bongai Mundeta (Director, VSO-RAISA) and Ndileka Loyilane (Commission for Gender Equality).

Feedback from the parallel sessions

Because of time constraints the feedback presentations from the four groups were limited to about five minutes each and the discussion on the feedback was also limited to about 5 – 10 minutes.

From the **treatment group** (facilitated by Pierre Brouard of the CSA) the following ideas for the way forward were articulated:

- ⌘ We need to do a more comprehensive review of gender and treatment
- ⌘ We need to explore the unique challenges of the female child (e.g. schooling)
- ⌘ We need to review the special needs of children from PMTCT programmes (e.g. infant feeding)
- ⌘ We need to assess special needs of caregivers with HIV, AND affected caregivers
- ⌘ Participation of all voices (within and across genders) is key – how do we promote this?
- ⌘ Where children are concerned, a prior question is the role of reproductive health issues – and the issue of treatment of women living with HIV
- ⌘ Is there a gendered dimension to disclosure which our programmes don't acknowledge – and what are the implications of this for women and men on treatment?
- ⌘ There is still a tendency to conflate gender with "women" and few of the presentations addressed the power dynamics between men and women – how can this be taken back into organisational thinking and planning?
- ⌘ How do we move beyond stereotypes of men and women?
- ⌘ Is it possible to view men as vulnerable too, but in different ways?

There is still a tendency to conflate gender with "women" and few of the presentations addressed the power dynamics between men and women – how can this be taken back into organisational thinking and planning?

From the **care and support group** (facilitated by Menzi Hlongwa of the CSA) the following ideas for the way forward were articulated:

- ⌘ With an increasing number of men showing concern for the health of their families and communities (men as partners), this is an opportunity to enhance their positive role in prevention, treatment, care and support.
- ⌘ What needs to be done to break the vicious cycle of burden of care on women and girls?
- ⌘ How can interventions be sustained?
- ⌘ What is the role of the state and political office bearers?

From the **mitigation group** (facilitated by Tsitsi Masvaure of the CSA) the way forward and key questions articulated on **policy** were:

- ⌘ Understanding the epidemic from a gender and cultural perspective is imperative if any change is to be effected.
- ⌘ Working from a results-based approach is key to realising results in gender mitigation.
- ⌘ Are our programmes addressing subcultures that young people identify with?
- ⌘ Do we understand the importance and role that culture plays particularly where men are concerned?
- ⌘ Are historical constructs that shape cultures considered when programmes to address them are designed?
- ⌘ Are we realistic about the time frames that we set for achieving our desired "changes"?
- ⌘ Do we also have achievable and realistic indicators for our programmes to be guided by?

On **older people**:

- ⌘ Supportive programmes and policies to address poverty must be addressed.
- ⌘ Both the child and care giver must be protected and kept healthy.
- ⌘ An enabling environment for accessing health care services by older people must be created.
- ⌘ Cultural practices are not necessarily risky but they need to be practiced in a safe manner.
- ⌘ Men must also be acknowledged as "potential" care givers to the sick.

For **people living with HIV &/or AIDS**:

- ⌘ Policies to capture data on treatment roll out in the private practice must be created.
- ⌘ Countries with good policies on ARV roll out must be pushed to meet their targets.
- ⌘ Immigration policies also need to be looked at to make treatment available to all.
- ⌘ How does civil society contribute to the government's plan of making treatment available?
- ⌘ As role players, are we creating a situation of working towards a common goal with one strategy or are we competing with each other?



From the **prevention group** (facilitated by Sydney Montana of the CSA) the way forward on **prisoners**:

- ⌘ Table the issue as an “HIV prevention in prison” programme as a way of deflecting attention away from same-sex relations and sodomy in HIV transmission.
- ⌘ Also adopt a human rights approach to the issue and explain that prisoners have a right to access HIV-prevention services and be protected from rape and other forms of violence that can facilitate transmission of HIV.
- ⌘ Civil society must strengthen its voice on this matter:
 - For example make use of ARASA and other existing documents on the extent of the problem and why interventions are needed.
 - VSO can take lead in developing a policy brief on prisoners and MSM.
- ⌘ Legal reform is necessary so that sodomy laws are done away with; this will open space to discuss MSM (men who have sex with men) and LGBT (lesbian, gay, bisexual and transgender) issues more openly.

... prisoners have a right to access HIV-prevention services and be protected from rape and other forms of violence that can facilitate transmission of HIV.

On **gender-based violence**:

- ⌘ Aggressively target gender-based violence (GBV) within the home by:
 - Identifying, and working with and through, key people who traditionally have influence within the home, for example counsellors.
 - Identifying, and working with and through, those individuals and institutions that have easy access to the home, such as midwives.
 - Getting everyone involved: messages should be clear that those who keep silent about GBV are just as violent e.g. Ring the Bell campaign in India gets neighbours and even young children involved; or the Bang the Pots campaign in Cape Town.
 - Identifying key people that men trust and work with and through them.
- ⌘ Develop clear protocols to be followed by relevant service providers (for example police and medical personnel) when attending to a case of GBV; clearly spell out what information is to be collected for more effective documentation.
- ⌘ There is a need for legal-protection programmes for girls who are abused in educational institutions.
- ⌘ Create stronger partnerships between CSOs and government institutions.

And on **male involvement**:

- ⌘ Expand the definition of “vulnerable men” to include the homeless, elderly men and various groups of migrant populations (truckers, construction workers) – nationally and regionally.
- ⌘ Work on “prostitution” needs to start focusing on who drives the phenomenon, and not just what drives sex work:
 - For example who are the men behind the scenes who benefit from it: pimps, clients, powerful men?
- ⌘ We need to involve men in good practice:
 - Male-focused interventions should be clear that the idea is to get men to respect women’s human rights rather than to advocate for “men’s” rights.
 - Possible models for engaging men more proactively in prevention work:
 - Develop partnerships with men-focused organisations, institutions and individuals (for example ex-prisoners, rehabilitation experts who work with prisoners and other potentially sympathetic men.
 - Make communities directly take on male involvement.
 - “Menstream” men into existing programmes.
 - Train health care providers to be more youth friendly so that all young people have easy access to sexual and reproductive health services.
 - ASOs need more education on the benefits of male involvement.
 - Target institutions and powerful structures, such as religious and traditional bodies, over and beyond individuals.
 - Develop a register of sex offenders that is publicised.

Questions arising from the discussion:

- ⌘ What do we mean by male involvement?
- ⌘ How do we focus more on the gender aspects of criminalisation of HIV transmission?
- ⌘ Why are organisations reluctant to address issues of men and masculinity?
- ⌘ How can we ensure that we keep the win/win focus if gender equity is achieved?
- ⌘ What about the voices of middle class men and women?

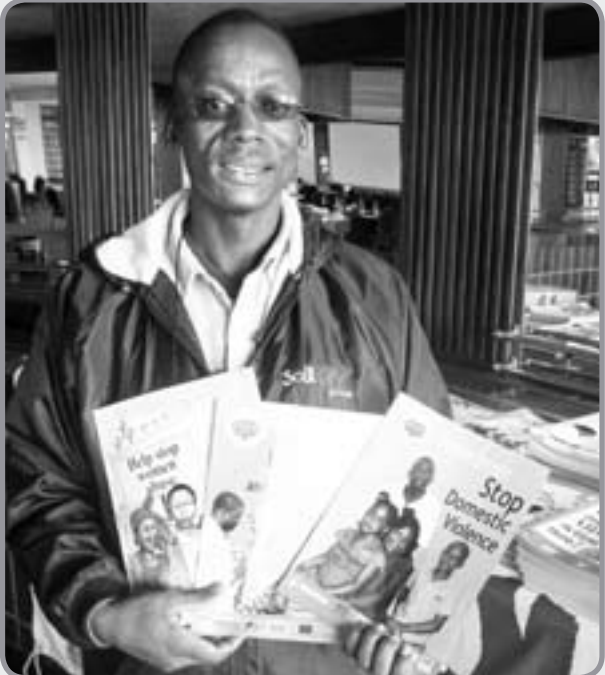
Male-focused interventions should be clear that the idea is to get men to respect women’s human rights rather than to advocate for “men’s” rights.



Ms Traifine Pofu of Kubatsirana in Mozambique said:
 "Stigma and Discrimination is also a disease that makes people die".



Above: Frans de Jeu, a VSO Volunteer and Lucky Ngwenya – both of Soweto Care System – gave a presentation on how the Soweto Care System database works. Below: Staff members being trained on Soweto Care System.



Themba Motaung of Soul City was on-hand throughout the conference with their publications.



Launch of Phase 3 of VSO-RAISA

Professor Kelly introduced the various dignitaries who were present to support the launch of Phase 3 of the VSO-RAISA programme. These included: the Zimbabwean Minister of Health and Child Welfare (Dr Henry Madzorera); the NAC representatives from Malawi (Dr Yohane Kamgwira), Mozambique (Dr Joana Manguera) and Zimbabwe (Mr Tapiwa Magure); the WHO country representative for South Africa (Dr Stella Anyangwe); and Ms Ndileka Loyilane of the Commission for Gender Equality (CGE) in South Africa and Caroline Simumba of the Swedish International Development Cooperation Agency (SIDA).

Bongai also introduced members of the Regional AIDS Association of NGOs (RAANGO) to the dignitaries, as well as a World Health Organization (WHO) technical advisor on HIV and AIDS working with Zimbabwe Ministry of Health who was here to acknowledge its partnership with VSO-RAISA, Dr Evelyn Isaacs.

Following the introductions, a number of speakers were invited to make brief remarks on gender aspects of HIV & AIDS, and to offer their support for the work of VSO-RAISA in Phase 3. **Ms Ndileka Loyilane** of the CGE said that the Commission supported the aims of the Constitution, was a “juristic person” and could act legally in terms of its mandate to carry out policy and legislative initiatives on: gender and poverty; gender-based violence; democracy and good governance; gender, culture, religion and tradition; gender and HIV & AIDS and the NGM (National Gender Machinery). She congratulated VSO-RAISA on its work and wished it well.

The Minister of Health from Zimbabwe, **Dr Henry Madzorera**, extended warm greetings from the people of Zimbabwe. He was extremely pleased to be at the launch of Phase 3 of VSO-RAISA today because its core business, capacity building to mainstream HIV & AIDS was critical – many countries had lost skills to other parts of the world. Zimbabwe was no exception and he urged VSO to send volunteers there, especially to support the health sector. His ministry was at VSO’s disposal, he said, adding that the launch of Phase 3 of VSO-RAISA was a sign of good planning.

On the conference theme, Dr Madzorera acknowledged that AIDS had particularly affected women, that they often experienced greater stigma, bore the burden of care, and were less likely to be educated. He believed that appropriate inheritance laws needed to be enforced, men had to be mobilised, and governments needed to provide more support to women and girls. Zimbabwe was making good progress on these aspects he said: policy on women and girls around care had been developed and men were being mobilised.

On the conference theme, Dr Madzorera acknowledged that AIDS had particularly affected women, that they often experienced greater stigma, bore the burden of care, and were less likely to be educated.

Dr Madzorera said the decision to partner with NACs was an excellent one and in line with the “three one’s” strategy. He extended his gratitude to all NAC representatives present and offered his support for country action plans for Zimbabwe.

Professor Kelly, in thanking Dr Madzorera, stressed the importance of a win/win approach to gender power so that the empowerment of women was neither at the expense of men, nor should it ignore the special needs of women. Regional work would be strengthened by partnerships with NACs, he said, arguing for a “fourth one”: a united civil society.

Lorna Robertson of VSO-UK then gave the background to Phase 3. VSO was established 50 years ago and the RAISA programme started in 2000, coming from a strong call from partners for HIV & AIDS work. After a feasibility study the regional programme was established – RAISA’s capacity building has worked through an HIV & AIDS lens and addressed the whole continuum of needs, work with governments and communities.

This work has involved volunteer placements, small grants, mainstreaming, exchange visits, training and workshops, conferences and strengthening monitoring and evaluation (M&E) systems. Volunteers were core to this work and they were acknowledged by Lorna specifically. The average age is 45 and just over 50% are now recruited from the south, especially Kenya and Uganda. Small grants have helped organisations fund aspects which they cannot afford and VSO develops its partnership with these organisations to grow them (much of this has been livelihoods work). The mainstreaming of HIV & AIDS has helped the development of workplace policies and supported people living with HIV &/or AIDS in VSO and its partner organisations. All organisations have been asked to address HIV & AIDS in their work.

Professor Kelly, in thanking Dr Madzorera, stressed the importance of a win/win approach to gender power so that the empowerment of women was neither at the expense of men, nor should it ignore the special needs of women.



Exchange visits have been an added bonus of a regional programme and have promoted learning and the sharing of ideas. Training and workshops have always been a key part of the work, regional work gets taken into national processes, and a highlight has been a focus on disability in 2003. Lorna also commended Bongai on taking the conferences to a very high level. Finally, much M&E work has been done to improve outcomes.

Bongai Mundeta then officially launched Phase 3, but first thanked Lorna for her hard work, and especially the M&E system she had put in place, making VSO-RAISA a leader in this area.

Following wide consultation, Phase 3 operates through:

- ⌘ strategic partnerships with:
 - National AIDS Councils in six countries
 - networks of people living with HIV &/or AIDS
 - government departments
 - community-based organisations.

This will be done in alignment with the “three ones”:

- ⌘ one Strategic Framework
- ⌘ one NAC
- ⌘ one M&E system.

And will focus (with support from WHO and RAANGO) on promoting universal access to:

- ⌘ prevention
- ⌘ care and support
- ⌘ treatment
- ⌘ mitigation.

Prevention priorities for Phase 3 are: multiple and concurrent partnerships; inter-generational sex; gender issues (gender-based violence, and socio-economic and cultural drivers); and male circumcision. Phase 3 will operate with financial aid from SIDA for Phase 3 over the next four years, in conjunction with funding from the Dutch government and Irish Aid.

Prevention priorities for Phase 3 are: multiple and concurrent partnerships; inter-generational sex; gender issues (gender-based violence, and socio-economic and cultural drivers); and male circumcision.

At this point Lorna read out the commitments of VSO-RAISA Phase 3, the official document then being signed by NACs and government officials present. During the signing ceremony, slides which showcased the work of VSO-RAISA were shown to the delegates.

Bongai thanks all for their support and expressed a wish for all parties to honour the commitments made.

Caroline Simumba of SIDA, the key funder for Phase 3, then praised VSO and VSO-RAISA for its rich experience and dedication it brought to its work. SIDA would remain a dialogue and analysis partner to explore the real roots of AIDS and to assess if the work was making a difference. SIDA supported the Paris Declaration on aid effectiveness, said Caroline, and she was very happy about the signing of the commitment to Phase 3.

Caroline went on to stress the huge importance of partnerships – noting that VSO-RAISA’s engagement with SADC was key to the integration of its work and an opportunity to influence policies. VSO-RAISA, in its involvement with RAANGO and civil society, could make a difference. In partnering with WHO, VSO-RAISA could assure SIDA that it would get value for its investment, and an assurance of quality. We are all challenged to measure impact, said Caroline, stressing that it was critical to tap into the human and qualitative stories on how lives were changed. Her presentation concluded with a special “thank you” to Bongai.

Dr Stella Anyangwe of WHO SA also acknowledged Bongai’s commitment to VSO-RAISA by saying that she supported any women doing something worthy. While the WHO had over the last 50 years supported ministries of health, it required civil society to also play a role. Partnerships, such as with VSO-RAISA, were always preceded by country consultations and a formal agreement was forged in 2008. Dr Anyangwe commended the WHO representative for her study with VSO-RAISA (see below) and said this was a good example of what collaboration could bring about. The study was remarkable, she said, and was to be shared in August 2009 with SADC and in September with the WHO regional committee. The WHO was committed to offering ongoing technical support to VSO-RAISA in Phase 3 and she made a public pledge to do this to the conference. She concluded by congratulating VSO-RAISA for its unique expertise on capacity building through volunteering, and wished them a successful launch of Phase 3.



Plenary presentation

Findings and recommendations on reduction of the burden of care on women and girls

Dr Evelyn Isaacs (WHO) and Charity Sisya (VSO-RAISA Programme Manager)

Charity contextualised for the conference the background to the study on care. VSO-RAISA conducted partner consultations on regional advocacy priorities in 2006 and decided to focus on the reduction of the burden of care on women and girls. A regional strategy was developed in 2007 and in 2008 VSO-RAISA launched, jointly with Merck, the Clean Glove Campaign. It has held conferences on the challenges of care (2007) and developed a manual on male involvement in 2008. *Walking the talk* on realising women's rights was produced with Action Aid in 2007, and VSO attended the HIV & AIDS working group at the SADC Partnership Forum in February 2008. A six country study on the burden of care was conducted in partnership with WHO and funded by Merck.

The study involved consultation in eight countries (including non RAISA countries); meetings with major stakeholders, including NAC focal persons on care and support; a desk study and literature review; interviews with care providers, midwives and health professionals; and focus-group discussions. Dr Isaacs then presented the key findings and recommendations of the study. The findings can be summarised under five key themes.

1. Overview of the burden of disease and scaling up of HIV prevention, treatment, care and support:

there has been real progress in scaling up ART at community level and one report suggests that more women than men are in fact accessing treatment.

2. Findings on the burden of HIV & AIDS care on carers:

there were debates about the concept of "burden of care" when care was regarded as normal, not an abnormal and unexpected burden. Real stresses existed for carers – and in many cases they received little support from outreach and support services as they dealt with referrals from the formal health care system. Who and where are the carers? Women aged 15 – 49 predominated but girl children aged 4 – 14, older persons (50+), some boys and men, nurses, midwives and community health workers (CHWs) made up the balance. This work happened mainly in the home but also in health centres. Carers were not being well supported

by district teams. The work they did involved prevention (condom distribution, family planning, infant feeding guidance, education and testing), treatment (adherence, filling prescriptions, dealing with minor ailments, follow up, referrals and palliative care), and care and support (emotional, physical, chores, nutrition, referrals and resource mobilisation). There was a great need for skills building.

Why are women and girls burdened? Societal expectations, ongoing referrals due to new infections, the scale up of ART, the decline in formal health systems, limited support from men, poor or no remuneration for services, poor and inadequate training, and no caring services for carers created a context of burden for women and girls.

Children too were burdened. Children are denied leisure and other rights that go with childhood, they experience trauma (especially when their parents are dying), stigma and discrimination, they lose out on schooling, and they are forced to undertake household duties.

Older care providers (CPs), who are also called upon for assistance, do not have skills and resources for care. They become indebted and poverty stricken, experience abuse and they also suffer from their own physical illnesses, some related to age and others due to the burdens of care.

Women in particular were found to carry the major burden. Women who themselves were ill were expected to provide care and carry out household duties. Many women faced abuse in homes because their work was unpaid and unrecognised. There was much confusion about stipends across the region and wide variety in amounts paid.

Other evidence on the burden of care was provided by the study:

- ✘ *Increase in workload:* CPs combined care giving with normal household and other activities – on average, 4-6 hours a day were spent providing care.
- ✘ *Walking long distances on foot:* this was up to 10 km a day on average by CPs, on bare foot and in unfavourable weather conditions.
- ✘ *High CP/client ratio:* an average of 1:19; this compromises quality of care.
- ✘ *Materials and medicines were often inadequate:* Up to three 3 CPs share one HBC kit, which is not replenished often, thus compromising the quality of care and putting them at higher risk of infection.
- ✘ CPs were unrecognised, unsupported and unpaid. *Many were poorer because of their role.* Most CPs were unpaid and already quite poor, and the additional burden of care frequently pushed them into destitution.
- ✘ CPs reported unacceptably *high levels of stress.*
- ✘ *There was abuse of CPs by some organisations:* for example there were no care systems for CPs and the absence of quality training exposed them to infection.



Male involvement was also a focus of the research. Men were less involved but their complementary role was acknowledged. There was some evidence of good practices and these need to be scaled up. Male involvement can increase if men are given specific tasks and there is a need to involve traditional leadership to mobilise men. Men should also be encouraged to get involved in testing and counselling. Men saw incentives as important but they also wanted to be valued as men for the work they did.

3. The existing situation on the ground and gaps:

What exists on the ground? Policy guidelines, useful studies, local forums on care, the many NGOs, CBOs and faith-based organisations (FBOs) involved in care, voluntary community groups, professional volunteers, good practices, and a rich variety of models of care were encouraging findings of the study.

However policies needed to integrate TB management, should be filtered to grass roots level, lacked clear guidelines for volunteering and volunteer management, and were not written in consultation with CPs. Services were limited by the following factors: CPs were not equipped with knowledge, skills and resources to cope with the scale up of ART, there was limited involvement of the private sector, remuneration of CPs was not standardised, there was no clear definition of compensation for services by CPs, transport to reach clients was often limited, and appropriate and culturally acceptable training and information materials was not easily accessible at lower levels. From a human resources perspective, there were negative perceptions around volunteering, universal definitions of voluntarism did not exist, the role of community health workers in ART scale-up was not clearly understood, and there was limited knowledge of service delivery models and resources required for scaling-up ART.

4. Training of care providers was also explored in the research: there is a need for a standardised training package and the following recommendations were made: the continuous updating of training packages; refresher training for CPs; training for primary CPs and other family members to reduce reliance and burden on secondary CPs; improving the supervision of CPs by health workers; strengthening “caring for carer” programmes; lobbying of donors and governments to recognise and offer appropriate rewards to CPs; training on rights, managing stress and burnout and resource mobilisation; bigger budgets to roll out training; formal certificates after attending training so that participants can use certificates to obtain formal employment; and in each country training institutions should have standardised curricula.

Men saw incentives as important but they also wanted to be valued as men for the work they did.

5. Proposed action framework document: a number of recommendations were made as a result of the study:

On policy:

- ✘ Safety policies should be put in place or enforced to curb cross infections among CPs, and support those infected during the discharge of their duties.
- ✘ Care providers and umbrella organisations should be actively involved in the development and review of policies and guidelines on care.
- ✘ National CP policies and clear definitions of volunteerism and its added value to care provision should be developed.

On partnerships:

- ✘ Governments should allocate resources for the purchase of kits, training and support to CPs.
- ✘ Pharmaceutical companies and other private sector players should be encouraged to support care – for example through donations and subsidisation of drugs, medical gloves, other consumables, care kits, bicycles, stipends and training.
- ✘ Linkages should be established with other partners and assistance provided for women, children and older persons burdened by HIV & AIDS care.

On human resources:

- ✘ Trained CPs should be recognised for their added value to reducing the burden of HIV & AIDS care and remunerated accordingly by applying standardised remuneration and benefits, improved working conditions and other rights.
- ✘ Certified trained CPs should become part of the formal health delivery system.
- ✘ Resources should be provided for training and equipping CPs with the necessary skills that will enable them to deliver a quality and safe service, without prejudicing their clients or their own health and well being, and for supervising their work by registered and certified health professionals.
- ✘ Initiatives should be encouraged to mobilise and educate males to actively participate in care to reduce the burden of HIV & AIDS care on women, girls and older persons.

On communication and co-ordination:

- ✘ In-country task groups and a regional forum on care should be established or strengthened to share best practices and co-ordinate interventions among implementers.
- ✘ Resources should be allocated to document and share good practices on reducing the burden of HIV & AIDS care on women, girls and older persons. All documentation should be translated into local languages, as appropriate.
- ✘ A strong mechanism for monitoring and evaluation should be developed.



Vote of thanks

Bongai Mundeta (VSO-RAISA Director)

Bongai thanks all dignitaries, guests, volunteers, partners and delegates and officially concluded the launch of Phase 3.

Country plans

Each country was invited to present its key activities for the forthcoming year and to reflect on the support they would need for this.

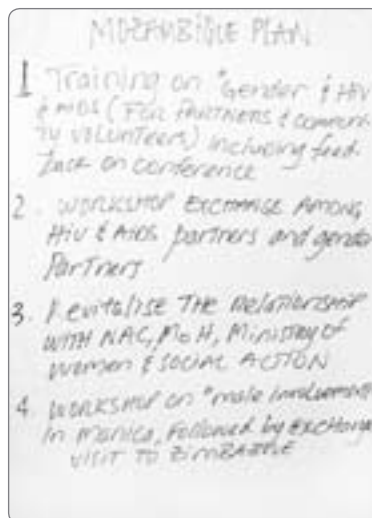
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Priorities and resources needed

- ⌘ Prevention. Inclusion of vulnerable men. Provide a baseline for advocacy, for example HIV in prisons. Collate studies on MSM in Malawi and southern Africa, for example on male sex work. Advocacy for the inclusion of men in prevention and VCT.
- ⌘ Care and support. Provide research on a standardised minimum-support package for care workers. Need administration and support costs and technical expertise to do this.
- ⌘ Mitigation. Focus especially on the girl child and child-headed household. Two VSO-RAISA grants can offer support to these households. Resources would be RAISA grants, good volunteers and technical support.

MOZAMBIQUE



Priorities

- ⌘ Training on gender and HIV & AIDS (for partners, community volunteers), including feedback on the conference.
- ⌘ Workshop exchange among HIV & AIDS partners and gender partners.
- ⌘ Workshop on "male involvement" in Manica, followed by an exchange visit to Zimbabwe.
- ⌘ Revitalise the relationship with NAC, Ministry of Health and Ministry of Women and Social Action.

Support

- ⌘ National volunteer management system training.
- ⌘ M&E training.
- ⌘ Support networks and people living with HIV &/or AIDS advocacy.

NAMIBIA



Priorities and support

- ⌘ Start networking and collaboration, especially those working in gender and HIV. Do this with support from VSO in Namibia, and the RAISA regional representative.
- ⌘ Challenge the gender inequalities through training and awareness raising. Do this with support from VSO international and regional.
- ⌘ Advocacy on gender issues – with a special emphasis on male involvement. Translate national documents into local languages so that people like traditional headmen can engage with them. Do this with support from VSO regional and international.

SOUTH AFRICA



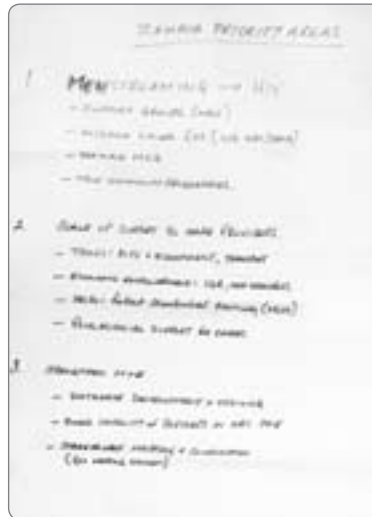
Priorities

- ✘ Prevention. Need to intensify campaigns on working with men, especially the uptake of treatment. Prevention of new infections: seek co-operation with organisations doing work with men. Address MCP in marriages and for single people.
- ✘ Mitigation. Need to review current laws regarding their implementation in rural versus urban ART centres (for example to deal with stock outs of drugs). Waiting periods for grants need to be shortened. Children living with guardians struggle with official documentation. Enlist involvement of institutions in changing and challenging cultural stereotypes.
- ✘ Care and support. Need for recognition of carers, such as certificates. Standards-generating bodies need to play a role. Standard remuneration should be explored. Empowerment of caregivers – there is a need for training on new legislation, for example on children’s rights.

Support

- ✘ RAISA to offer communities training on advocacy strategies, especially those in rural areas.
- ✘ Help in conducting workshops in communication and in M&E.
- ✘ VSO could assist with exchange visits inside SA and in the region.

ZAMBIA



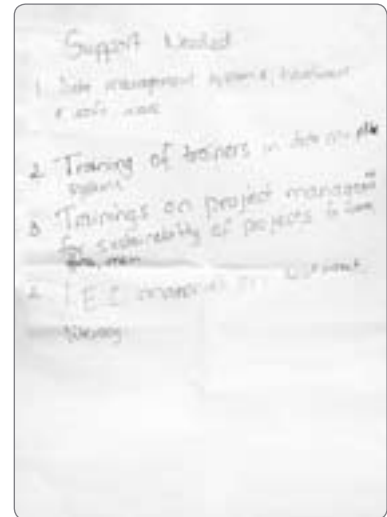
Priorities

- ✘ “Menstreaming” HIV in all aspects beyond care, support and training for men. Include males in aspects of care and get traditional healers on board.
- ✘ Scaling up support for care providers. Empower caregivers. There is a good training programme available in Zambia but it must be rolled out and be shifted from government offices. Psychosocial support for caregivers.
- ✘ Strengthening M&E. Need more data and information, for example a VCT database developed here in SA. Build capacity of partners on the national M&E system. Need to do stakeholder mapping so that services go where they are needed.

Support

- ✘ Financial (small grants) from donors.
- ✘ Joint proposals, aligned with NAC systems, and with district support.
- ✘ Technical support from VSO and RAISA, exchange visits and study tours (for example to Zimbabwe to view their excellent male-involvement programmes).
- ✘ Co-ordination of activities, ensuring organisations think together and sustaining the impetus.

ZIMBABWE



Priorities

- ✘ Strengthening of M&E systems for organisations to enable them to measure and improve results.
- ✘ Care for the carers – exploring sustainable-livelihoods options for volunteers and care givers. Need for refresher courses.
- ✘ Advocacy:
 - Treatment literacy and access to treatment for clients in marginalised areas and groups (for example older people), as well as psychosocial support.
 - National level advocacy to mobilise leadership
- ✘ Partnership strengthening:
 - For example with NAC at all levels including implementation levels, as well as with health workers.
 - Resources mobilisation through partnerships.

Support

- ✘ Data management system hardware and software.
- ✘ Training of trainers on data use.
- ✘ M&E systems and training.
- ✘ Training on project-management skills to support sustainable livelihoods.
- ✘ Information, education and communication (IEC) materials for distribution to remote areas.
- ✘ Workshop funding.





Left to right: Bella Ramos (VSO Volunteer, SA), Dr Joana Manguera (NAC), Godfrey Nyoni (Ministry of Health, Zimbabwe), Anouk Berger (VSO Volunteer, SA), Caroline Wanene (VSO Volunteer, SA), Mary Njuguna (VSO Volunteer, SA), Chama Chanda (NAC), Snigdha Sen (VSO Volunteer, SA) and Carolyne Opinde (VSO Volunteer, SA).



Charity Sisya (VSO-RAISA).



Lorna Robertson (VSO UK).



Left to right: Jonathan Limbo Lufwela (Integrated Rural Development Nature Conservation), Bonface Lutitezi Sangwali (Traditional Chief of the Sangwali Community in the Caprivi Region), Herbert Chali Ntema (Ministry of Gender, Equality and Child Welfare, Namibia) and Unia Nalugya (VSO Volunteer, Friendly Haven, Namibia).

In closing

Bongai asked the conference to offer a moment's silence in tribute to Lynde Frances – long an ally of VSO-RAISA and a sterling campaigner for people living with HIV &/or AIDS – who passed away earlier this year.

Bongai reminded all not to exclude food-security issues in their country plans. Dr Isaacs remarked that it was noteworthy that the plans had taken into account the deliberations of the workshop. She encouraged partners to also focus on gaps in NAC programmes and try to fill these, for example by targeting age groups that NAC programmes were not reaching. This would allow NACs to acknowledge the work of the partners in their own reporting. Partners should consider linking their activities to indicators that NACs need to report on. She also suggested that the image of volunteers needed to be polished so that the power of volunteerism could be showcased and impact on policy.

Gifts, thanks and song – by now a tradition of VSO-RAISA conferences – brought this successful and fascinating two days to an end.



Songs and dancing, led by the team from Namibia, ended the conference.



GENDER AND HIV & AIDS A New Agenda for Change

Delegates

VSO-RAISA Regional Conference | South Africa | 29-30 June 09

Guest of Honour

Dr Henry Madzorera
Minister of Health, Zimbabwe

Botswana

Boemo Sekgoma
SADC
Phillimon Simwaba
Disability, HIV and AIDS Trust

Kenya

Renaldha Mjomba
VSO Kenya
Mtuvi Kavutha Mwikali
HelpAge International

Malawi

Grace Chikwatu
NAPHAM HBC
Dr Exnevia Gomo
University of Malawi
Dr Yohane Kamgwira
NAC
Master Mphande
NAPHAM
Roreen Mzembe
VSO Malawi
Cuthbert Nyirenda
Network of Organisations
Working with OVC
Nery Ronatay
VSO Volunteer (Common Vision
for Social Development)
Steve Tahuna
VSO Malawi

Mozambique

Ferdinando Almeida
VSO Mozambique
Sharon Elliot
VSO Volunteer (Power Mozambique)
Rafa Machava
Forum Mulher
Eric Mamboue
Country Director, VSO Mozambique
Dr Joana Mangureira
NAC
Rute Muchine
VSO Mozambique
Maria Clara Mutamba
Organizacao da Mulha
Educadora de Sida (OMES)
Traifine Pofo
Kubatsirana

Namibia

Penina Ita
VSO Namibia
Aloysius Katzao
Legal Assistance Centre
Jonathan Limbo Lufwela
Integrated Rural Development
Nature Conservation
Nicky Mathews
Country Director, VSO Namibia
Saara Mupupa
VSO Namibia
Unia Nalugya
Friendly Haven
Herbert Chali Ntema
Ministry of Gender, Equality
and Child Welfare
Bonface Lutitezi Sangwali
Integrated Rural Development
Nature Conservation

South Africa

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VSO Volunteer (Akanani Rural
Development Association)
Martijn Barel
VSO Volunteer (Volunteer
Liaison Group)
Anouk Berger
VSO Volunteer (St. Joseph
Care and Support Trust)
Sumit Bhattacharya
VSO Volunteer (Children on the Move)
Pierre Brouard
Centre for the Study of AIDS,
University of Pretoria
Lois Chingandu
SAfAIDS
Chipo Chiwarawara
St. Joseph
Dr Zubeda Dangor
NISAA Institute for
Women's Development
Frans de Jeu
VSO Volunteer (Soweto Care System)
Deepak Diar
NISAA Institute for
Women's Development
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Prevention and Training
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Agisanang Domestic Abuse
Prevention and Training
Irene Khumalo
Agisanang Domestic Abuse
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Children on the Move

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NAC

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Alfred Kamphonje
VSO-RAISA

Prof Michael Kelly
VSO-RAISA Board Member, Retired
Prof, Univ of Zambia, Catholic Priest

Ndhlovu Kenani
Mazabuka District AIDS Task Force

Mary Manda
Mazabuka Municipal Council

Nyembezi Nkunika
Thandizani Community Based
Care Organisation

Maurice Shakwamba
VSO Zambia

Sizwile Sibindi
VSO-RAISA

Caroline Simumba
SIDA

Zimbabwe

Idah Banda
Midlands AIDS Caring Organisation

Dr Evelyn Isaacs
WHO

Tapiwa Magure
NAC

Dadirai Manyarara
FACT Rusape C&HBC coordinator

Nyangu Chiratidzo Mariwo
Zimbabwe AIDS Network

Cletos Masiya
Child Protection Society

Forster Matyatya
Country Coordinator, VSO Zimbabwe

David Mutambara
Zimbabwe Business Council on AIDS

Nixon Nembaware
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Ministry of Health

Prof Francis Onyango
WHO

Dr Ellen Sithole
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Mike Podmore
VSO UK

Lorna Robertson
VSO UK

Rebecca Sinclair
VSO UK



Dedication to Lynde Francis



Lynde Francis at the 2006 VSO-RAISA Regional Conference: "Food Security in a World of HIV & AIDS".

Lynde Francis, a long time friend of VSO-RAISA, died on March 31 aged 62. She was diagnosed with HIV in 1986 and became an example to many Zimbabweans on how to live positively, with a unique blend of nutrition, self acceptance and *joi de vivre*, long before ARVs were available and when stigma was at its height.

Lynde was unique and unconventional: Zimbabwe's first woman builder, a music promoter, fun lover, AIDS activist. Her disclosure as a person living with HIV in 1992 changed the face of AIDS. She taught the lessons she learnt at The Centre, which she set up in Harare in the mid-1990s, and across Africa.

Over time Lynde made links between AIDS and inequalities (from class to gender), AIDS and relationships (between spouses, parents and children), and AIDS and public health. She believed in empowering people through knowledge about healthy eating, healthy living and healthy relationships, and saw ARVs as a last resort. Because so many people in Africa do not access ARVs, even when they need them, her advice was a lifeline.

Despite a setback in 2002 after a poisonous spider bite put her in a coma for six weeks, Lynde regained her health and zest for life. In March 2009 she celebrated 23 years with the virus, but had been battling since December 2008 with serious health problems.

She is survived by two biological and four foster children, six grandchildren, and thousands of people living with HIV who learned her survival skills.

(With thanks to Mercedes Sayagues, journalist and friend of Lynde Francis).

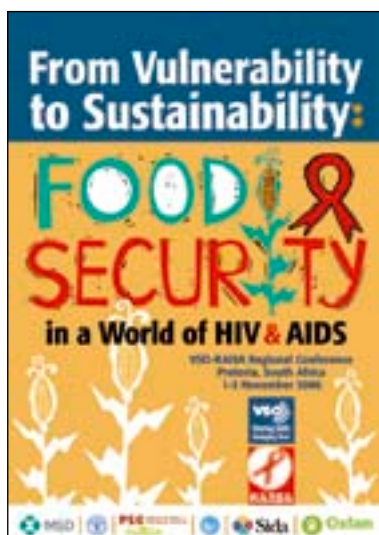
VSO-RAISA contacts



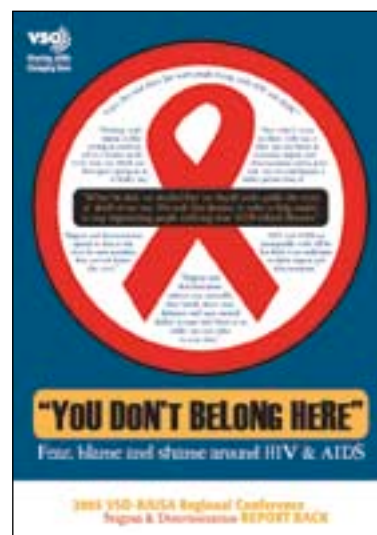
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*Quoting George Bernard Shaw,
Professor Kelly left us with the challenge:*

“Some look at things that are, and ask why. I dream of things that never were and ask why not?”

