## Table of Contents



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# *Mission[1] of the International Institute on Gender and HIV/AIDS:*

**The International Institute on Gender and HIV/AIDS (IIGH/A)** creates opportunities for young and experienced leaders from all sectors to understand the differing vulnerabilities and impacts of HIV/AIDS on women and men, girls and boys around the world.

The IIGH/A will prepare leaders from public, NGO and private organizations to address inequities and increase their capacity to influence and shape policies, programs and practices across all sectors e.g. agriculture, health, education that affect the HIV/AIDS epidemic.

Through training, gender-based action research and an international multi-sectoral network of faculty and participants, IIGH/A will inspire leaders to engender policies and programs that reduce the spread of HIV and mitigate the impact of AIDS-related illnesses.

IIGH/A programs and initiatives are based on the principles of social justice, collaboration, commitment, capacity building, accountability and authentic involvement of persons infected and affected by HIV/AIDS.

*(Revised mission statement with input of partners – March 2003)*

[1] Our mission is a statement of purpose, mandate. It tells us why the Institute exists or is being created. The mission also describes who the IIGH/A is for and how it's different and unique from other initiatives. And finally it describes the criteria we will use to know that we're doing a good job.

## Introduction to the Curriculum for the International Institute of Gender and HIV/AIDS

Part A. An Overview of the Issues

*HIV/AIDS – The International Picture*

According to the UNAIDS and WHO *AIDS Epidemic Update: December 2002*, there are 42 million people globally living with HIV. The worst affected region is sub-Saharan Africa, where 29.4 million people are currently living with HIV/AIDS. However, the epidemic is also rapidly expanding in new areas. The world's fastest growing HIV/AIDS epidemic is located today in Eastern Europe and the Central Asian Republics. In 2002, there were an estimated 250,000 new infections there, bringing the total for the region to 1.2 million people living with HIV/AIDS. In addition, several

countries in Asia and the Pacific, including China, Indonesia and Papua New Guinea, may also face huge growth in their epidemics unless concerted and effective action is taken to increase access to HIV prevention and care in the region, where the epidemic is still in its early phases. Best current projections suggest that an additional 45 million people will become infected with HIV in 126 low- and middle-income countries between 2002 and 2010 unless the world succeeds in mounting a drastically expanded, global prevention effort.[1]

Fifty percent of HIV positive adults are women (ibid). Globally, the main mode of HIV transmission among adults is heterosexual intercourse, with women and young people particularly at risk. A growing proportion of adults are acquiring HIV through injection drug use which in turn also has the potential for sexual transmission. In many countries, HIV/AIDS is a humanitarian crisis characterized by food shortages and loss of shelter and basic security. As the impact of the epidemic becomes more severe, it strips households and communities of labour power, education and other systems of security and sustainability. To effectively deal with the epidemic, it is necessary to conceptualize and respond to HIV/AIDS as a gender, human rights issue and development issue requiring a multi-sectoral response.

## *Gender*[2]

In order to be effective, HIV/AIDS programs and policies must take into account the realities and constraints of women and men, boys and girls, including balances of power and respect in relationships and sexual decision-making. For example, traditional prevention programs in their promotion of abstinence and faithfulness, use and availability of condoms, and controlling of STIs have been problematic. Such approaches, which are directed to women and girls, don't take into account the reality and context of women's lives, including the lack of power they often have in negotiating condom use, in relying on their partner's faithfulness and in deciding when and where they will have sex. These approaches also simultaneously perpetuate men's irresponsibility and lack of engagement in matters of sexual and reproductive health. Key areas of concern in gender and HIV/AIDS programs and policies are: gender divisions of power, access and control of resources and benefits, and social, cultural, religious, economic, political and legal factors and trends (see Box 1). Indeed, gender norms greatly affect women's and men's access to information and services, their sexual behaviour and attitudes, and how they cope with illness once infected or affected.[3] It is widely recognized that HIV/AIDS programs that address gender as a central goal maximize overall effectiveness.[4] In fact, the World Health Organization (WHO) is committed to integrating gender into all HIV/AIDS programming to ensure:

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[1] UNAIDS and WHO. (December 2002). AIDS Epidemic Update. Geneva: UNAIDS. Available at: www.unaids.org.

[2] While 'sex' refers to biological and physiological attributes, 'gender' refers to the socially constructed roles, behaviours and expectations associated with men and women.

[3] Rao Gupta, Geeta, Whelan, Daniel and Allendorf, Keera. (2002). Integrating Gender into HIV/AIDS Programes: A Review Paper for Expert Consultation. Geneva: World Health Organization.

[4] UNAIDS. (1999). Gender and HIV/AIDS: Taking stock of research and programmes. Geneva: Author.

Increased coverage, effectiveness and efficiency of interventions;
The promotion of equity and equality between women and men, throughout the life course, and ensuring that interventions do not promote inequitable gender roles and relations;
The provision of qualitative and quantitative information on the influence of gender on health and health care, and
Supporting Member States in undertaking gender-responsible planning, implementation and evaluation of policies, programs, and projects.

Box 1: Summary of Gender-Based Determinants of HIV/AIDS

Gender roles and expectations restrict women's access to and use of economic resources as well as their sexual rights and autonomy while encouraging irresponsible and risky sexual behaviour in men. They also affect provision of and access to information and services.

Women
*Physiological factors*: the vulnerability of the reproductive tract and higher concentration of the HIV virus in semen means that women are 2-4 times more likely to contract HIV during unprotected vaginal intercourse; presence of STIs is a marker for unprotected sexual activity and provides an easy point of entrance for HIV.

*Sociocultural factors*: women are expected to be ignorant about sex and passive in sexual interactions; expectations of virginity in young women; sexual violence and coercion; cultural practices such as FGM, early marriage, wife inheritance and wife cleansing; role and expectations in bearing children and as caregivers.

*Economic factors*: lower access to education, limited opportunities for employment, lack of rights to own or inherit land or property, limited access to independent finance; increased likelihood of living in poverty; participation in prostitution and sex work.

Men
*Physiological factors*: presence of STIs is a marker for unprotected sexual activity and provides an easy point of entrance for HIV.

*Sociocultural factors*: men are expected to be sexually knowledgeable and experienced; pressure to have multiple sex partners; compulsory heterosexuality and ensuing homophobia; perpetrators of sexual violence; buyer of services of sex trade workers.

*Economic factors*: numbers of men who are migrant workers or in military service put them at risk for contracting and transmitting STIs, including HIV.

Effective HIV/AIDS care, treatment, prevention and support programs and policies must move beyond gender sensitivity and analysis and mainstream gender across sectors (see Box 2). Gender mainstreaming requires the *technical/substantive integration* of gender

(e.g. programs and policies that are transformative and empowering) and the *structural integration* of gender (e.g. gender responsive institutional systems, processes, and structures).

Box 2: Integrating Gender

*Gender sensitivity*: the ability to perceive existing gender differences, issues, inequalities, and to incorporate these into strategies and actions.

*Gender analysis*: systematic process and tool that uses sex and gender as an organizing principle or way of conceptualizing information.

*Gender mainstreaming*: considers women's and men's needs and ensures that women and men equally participate in every aspect of programs and projects. Required to implement a number of Commonwealth and international mandates.

*Gender management system (GMS)*: an integrated network of structures, mechanisms and processes put in place in an existing organizational framework in order to guide, plan, monitor and evaluate the process of mainstreaming gender into all areas of an organization's work (ACEWH, 2002). Requires gender analysis, gender training, management information system and performance appraisal system.

Mainstreaming gender will enable government departments to examine ways to influence and accelerate the adoption of a gender-based analysis into and across all national policies and programs that are impacted by HIV/AIDS. This process will also foster a more inclusive process for NGOs and people living with HIV/AIDS to participate in national planning and policy development. Objectives of a gender management system in the context of HIV/AIDS would include:

- To promote systematic and consistent gender mainstreaming into HIV/AIDS policies, plans, programs and activities at all levels.
- To assist state and non-state actors to acquire gender sensitization, analysis and planning skills necessary for development and implementation of national HIV/AIDS strategies, policies, plans and programs.
- To strengthen the capacity of National HIV/AIDS Coordinating Agencies to direct, advise and coordinate national gender mainstreaming efforts in the area of HIV/AIDS.
- To create an enabling gender-inclusive environment in the fight against HIV/AIDS and address the differential impact of the pandemic on women and men at all levels.

Human Rights

HIV/AIDS is a human rights issue because a lack of access to preventive methods, appropriate information and materials, treatment and care, leading to

vulnerability to HIV is linked to human rights violations such as poverty, inequality, racism and sexism.[5] It is also a human rights issue because PHAs and those affected by these epidemics are often unable to live a life of equality, dignity and freedom as their rights are often violated on the basis of their HIV status.[6] Indeed, there are several key legal and rights issues associated with HIV/AIDS, including, but not limited to: rights to personal autonomy and equality within relationships, cultural equality, social and economic equality, access to health care, access to nutrition, clean water, sanitation, access to social security, access to housing, access to education, access to resources through inheritance and reducing women's economic dependence on men.[7] Clearly, such rights and legal issues are also inextricably linked to other women's rights, including reproductive rights and equality rights.

In the context of HIV/AIDS, the promotion and protection of human rights, then, is necessary to reduce vulnerability to HIV infection since the incidence and spread of HIV/AIDS is disproportionately high among groups that already suffer from a lack of human rights protection and from discrimination, and among groups marginalized by their legal or economic status.[8] The promotion and protection of human rights is also necessary in order to lessen the adverse impact of HIV/AIDS on those affected. For example, care and prevention programs that contain coercive or punitive measures result in reduced participation and increased alienation of PHAs and people at risk because people will not seek counseling, testing, treatment and support if this means facing discrimination, lack of confidentiality or other negative consequences.[9] Lastly, the promotion and use of human rights tools and mandates (see Box 3) can empower individuals and communities to respond to HIV/AIDS.

Box 3: International Mandates and Conventions

Global Mandates

- The Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW)
- Programme of Action of the International Conference on Population and Development (ICPD)
- General Assembly Special Session on ICPD Programme of Action (ICPD +5)
- Beijing Declaration and Platform for Action, Fourth World Conference on Women
- General Assembly Special Session on Gender Equality, Development and Peace (Beijing +5)
- UN General Assembly Special Session on HIV/AIDS (UNGASS)

International Conventions

[5] Tallis, Vicci. (2003). Gender and HIV/AIDS: Overview Report. London: BRIDGE.
[6] Ibid.
[7] Albertyn, Cathi. (2000). Using Rights and Law to Reduce Women's Vulnerability to HIV/AIDS: A Discussion Paper. Montreal: Canadian HIV/AIDS Legal Network.
[8] International Council of AIDS Service Organizations. (1999). HIV/AIDS and Human Rights: Stories from the Frontlines. Available at: www.icaso.org.
[9] Ibid.

Universal Declaration of Human Rights
UN Guidelines on HIV-Related Human Rights

Development

In addition to recognizing and addressing the gendered and human rights dimensions of HIV/AIDS, it is also important to address HIV/AIDS as a development issue requiring a multi-sectoral response. This recognition of HIV/AIDS as a development issue requiring the coordinated response of all sectors was agreed to by governments in their Declaration of Commitment at the June 2001 UN General Assembly Special Session on HIV/AIDS. As such, all government ministries have a key role to play in HIV/AIDS care, treatment, prevention and support since no sector is immune or unaffected by the impacts of HIV/AIDS (see Box 4). Leadership in HIV/AIDS must be dynamic and responsive and needs to be exercised at all levels and by all sectors.

Box 4: Summary of Impacts of HIV/AIDS Across Sectors

*Agriculture*: labour shortage (sickness, death, care) and undermined transmission of knowledge and skills, loss of productive resources (irrigation, soil enhancement and other capital improvements), decline in crop production and concomitant food insecurity. HIV transmission can occur when workers, such as truck drivers, leave their communities and have sexual relations with the local population.

*Fisheries:* labour shortage (sickness, death, care) and undermined transmission of knowledge and skills, food insecurity. HIV transmission can occur when sailors have shore leave and have sexual relations with the local population.

*Education*: reduced supply and quality of education (absenteeism, deaths of teachers and administrators), decline in demand for education (due to absenteeism, death), failure to meet targets for gender equality in education.

*Health*: significant burden on health care system (shortage of hospital beds, supplies, medicines), high cost of treatments. Increased burden on women to provide out-of-hospital care.

*Labour*: adverse effects on economic growth and employment, reduced labour quality and supply (absenteeism, loss of skills and experience, lower productivity and profitability). HIV transmission can occur when workers are forced, out of economic necessity, to leave their communities to obtain employment where they subsequently have sexual relations with the local population.

*Law and justice*: discrimination (right to property, employment, housing, access to health care) and violation of human rights (women's access to property, employment, marital status and security), sex work (legality, vulnerability to STIs/HIV, abuse). HIV

transmission can occur through rape, including rape in conflict settings, and wife inheritance.

Key aspects of a multi-sectoral response:[10]

- Consider HIV/AIDS and its implications in all areas of policy-making;
- Involve all sectors in developing a framework to respond to the epidemic, at international, regional, national, district and community levels;
- Identify the comparative advantages and roles of each sector in implementing the response and where sectors need to take action together and individually;
- Encourage each sector to consider how it is affected by and affects the epidemic, and developing sectoral plans of action;
- Develop partnerships within government between ministries responsible for different sectors, and between the public sector, private sector and civil society.

A multi-sectoral response must also integrate gender. Gender mainstreaming in this area means:[11]

- Building capacity for training in gender sensitization and analysis for all key professionals and workers at national and local levels
- Establishing system-wide processes in each sector to oversee programme development, implementation, monitoring, and evaluation, taking into account women's and men's needs, interests and contributions;
- Enhancing capacities for the collection, analysis and use of sex-disaggregated data.

Part B. The International Institute on Gender and HIV/AIDS

*The International Institute on Gender and HIV/AIDS (IIGH/A) creates opportunities for leaders within organizations (public, NGO, and private sectors e.g. health, education, agriculture) as well as young leaders to understand the differential impact of HIV/AIDS on women and men, boys and girls around the globe. The IIGH/A intends to increase capacities to undertake gender-based analysis to transform HIV/AIDS policies, programs and practices across sectors in specific cultural contexts around the world. IIGH/A programs and initiatives are based on the principles of social justice, collaboration, commitment, capacity building, and accountability.*[12]

[10] Commonwealth Secretariat and Atlantic Centre of Excellence for Women's Health. (2002). Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach. London: Commonwealth Secretariat.
[11] Ibid.
[12] Draft Mission Statement, February 2003.

The goal of the ten-day International Institute on Gender and HIV/AIDS is to advance the gender and HIV international agenda through a transformative, catalytic, dynamic learning culture where faculty and participants interact to share best practices, analyze successes and failures and motivate and inspire each other.

Given the veritable wealth of available information and resources, this curriculum does not 'reinvent the wheel'; rather, approaches to gender, development, human rights and HIV/AIDS have been reorganized and restructured. This curriculum creates a framework for generating policy change in organizations and social change more generally.

Objectives of the curriculum:

1) To enhance understanding of a critical mass of change makers about the links between gender, HIV and human rights
2) To strengthen skills of a critical mass of change makers to mainstream gender and HIV across sectors
3) To catalyze responses that strengthen and expand HIV prevention and care networks

*A Transformative Framework*

In order to foster change, the curriculum is transformative. Simply put, this approach requires tools, techniques and resources that:

Increase knowledge gain;
Support skill development (e.g. to apply a gender lens, to support a mult-sectoral approach, to instigate organizational change); and
Raise critical consciousness and motivation (e.g. to become a 'change agent').

This curriculum moves beyond train-the-trainer approaches – in order to raise awareness and consciousness, it relies on participatory and action-based pedagogical approaches as well as practical and solution-focused tools for meaningful engagement that take into account gender and encourage multi-sectoral involvement. Because people remember 20% of what they hear, 40% of what they see and hear, and 80% of what they discover for themselves, this curriculum:

Involves reflection and action
Values the knowledge and experience of participants
Encourages an environment where everyone teaches and everyone learns
Asserts that education leads to action for social change

This approach is reflective of the spiral model of learning:[13]

[13] Arnold, Rick, Burke, Bev, James, Carl, Martin, D'Arcy, Thomas, Barb. (1991). Educating for a Change. Toronto: Between the Lines and Bishop, Anne. (1994). Becoming an Ally: Breaking the Cycle of Oppression. Halifax: Fernwood Publishing.

**Learning begins with the experience or knowledge of the participants (participants "place" themselves).** This approach values the knowledge and experience of participants in that everyone teaches and everyone learns. This approach will motivate participants to reflect on their own experiences and ideas to evaluate and question their everyday practices or beliefs.

**After participants have shared their experience, they analyze that experience (reflection)**. Participants identify surprises, insights, and patterns and link these to their experience (commonalities and/or differences).

**Collectively add or create new information or theory (analysis).** Present concepts and information that relate to the prior knowledge and experience of participants.

**Participants "try on" what they've learned (strategy).** Participants practice new skills and make strategies and plans for action in order to apply the new concepts, ideas and practices into their daily work and to address the obstacles and challenges that may impede such innovation.

**Afterwards, back in their organizations and daily work, participants apply in action what they've learned (action).** Education leads to social change.

*Role of the Facilitator*

Good facilitation is key to the success of any workshop. In order to foster meaningful engagement of participants, the facilitator must:

Watch the time and make sure that pacing is appropriate to the group.

Encourage the active participation of all group members.

Stimulate participants to think critically, identify problems and find new solutions.

Acknowledge and draw upon differences within the group. Ask about and draw on the range of knowledge and experience in the group.

Offer information, frameworks, and insights when appropriate.

Work democratically, with the space, resources, time and people in the room. Encourage mutual trust and respect for conflicting opinions while promoting consensus building.

Constructively address resistance, conflict and discomfort.

Summarize what's been accomplished at strategic points during the session.

Establishing ground rules can help foster an environment where people can feel confident, secure and safe. Ground rules also frame assumptions about and expectations for learning. Some sample ground rules (although participants should be encouraged to generate their own) are: good time keeping, confidentiality, all questions are acceptable, it is OK not to know, listen carefully, don't interrupt.

*Small Group Work*

In the spirit of interactive learning and an approach that values and draws on the knowledge and skills of all participants, several of the activities in this curriculum use

small group methodologies. Although self-guided, the facilitator should visit each group to ensure that they are working on the indicated theme, moving toward the stated objectives and working in a democratic fashion. When groups present their work, the facilitator must:[14]

- Allow groups to express the results of their efforts in their own way, respecting the diversity of opinions and ways of knowing and expressing knowledge.
- Observe carefully and later discuss the relationship between the indicated themes, directions and objectives, and the actual results of group efforts.
- Intervene to reorient discussions that get off track and do not enrich the topic at hand.
- Make a clear synthesis of the ideas and messages presented (often it is useful to discuss the main points and write them on a flipchart).

[14] FHI. (1999). Rethinking Differences and Rights in Sexual and Reproductive Health: A Training Manual for Health Care Providers. Available at: www.fhi.org.

## Pre-Institute to the International Institute on Gender and HIV/AIDS

The objectives of the Pre-Institute to the International Institute on Gender and HIV/AIDS are:

To select and invite participants;
To select a facilitator;
To prepare participants for the Institute by providing background reading material and by having participants prepare a situational analysis;
To select speakers for specific sections of the curriculum;
To gather baseline data for evaluation purposes;
To give participants an opportunity to introduce themselves to the group and share expectations about the Institute; and
To attend to all logistical and administrative duties (site preparation, etc.).

*Participant Selection*

Select participants with a diverse range of skills (e.g. with program, service and/or policy development, implementation, evaluation), from a range of sectors (research institutes, NGOs, media, government, private sectors) and lived realities (including HIV status).

Criteria:

Mandate/works in HIV/AIDS
Experience with/knowledge of gender, gender based analysis and/or gender mainstreaming
Has the support of his/her community/organization/institution to attend the Institute
Potential to facilitate change (some decision-making power, authority, leadership)
Time commitment to the Institute, including preparation and follow-up
Commitment to the goal of approaching HIV/AIDS as a gender, human rights and development issues requiring a multi-sectoral response

*Facilitator Selection*

Select a facilitator (or facilitators – it is not uncommon to have two facilitators) who has:

Knowledge of HIV/AIDS;
Knowledge of gender;
An ability to work with groups (including sensitivity re: culture, context, HIV status);
Commitment to participatory learning;
An ability to summarize, draw out themes.

*Participant Preparation*

Background reading

Provide participants with key documents for background reading. For example:

UNAIDS and WHO. (December 2002). AIDS Epidemic Update. Geneva: UNAIDS. Available at: www.unaids.org.

Regional/country profiles available at: http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/index_en.htm

UNAIDS. (2001). Resource Packet on Gender and AIDS. Available at: www.unaids.org

Refer to the Appendix 1: Resources for further ideas on obtaining up-to-date information.

2. Situational analysis

Send to all participants (hard copy or virtually) a copy of the "Situational Analysis" worksheet.

Participants will be expected to bring their situational analysis to the Institute.

3. Speakers/panels

Send to all participants (hard copy or virtually) a copy of the "Speaker Selection" worksheet.

Participants will submit this to the Institute well in advance to ensure the timely selection of speakers.

4. Baseline data

Send to all participants (hard copy or virtually) a copy of the "Questionnaire" that will assess the current state of knowledge and skill of participants.

Participants will submit this to the Institute well in advance.

5. Introductions and expectation setting

Refer to the "Introductions and Expectation Setting" resource sheet.

This activity should be done in advance of the Institute and ideally should be facilitated/moderated by the facilitator.

*Logistical and Administrative Duties*

Select location (city)
Book hotel rooms and travel for participants
Secure training space:
    Ensure it is large enough for the number of participants
    Flexibility for small group work
    Wall space for visual aids
    Quality: bathrooms, heating/cooling systems, ventilation
    Seating; suitable, moveable
    Outlets and curtains for A/V equipment
Secure A/V requirements (overhead, TV/VCR, video) and other materials (flipcharts, markers, tape, notebooks, pens, handouts, task sheets, etc.)
Select and book meals and snacks
Purchase travel insurance for participants
Secure per diems for participants
Arrange evening entertainment (optional but recommended particularly for the first few evenings)
Select participants to be speakers/panelists for specific sections of the curriculum:
    Ensure a diversity of views and experiences
    Ensure that participants have some expertise on the relevant issue(s)
Where there are gaps in participant expertise for the allotted speaker/panel slots, arrange for outside guest speakers

## Situational Analysis

*General Instructions:* Please complete these activities and bring them will you to the Institute.

### A. Historical Timeline[15]

Time it takes: About two hours

*Step 1:* Brainstorm the key events in the history of HIV/AIDS in either your organization/institute/agency or community/region/nation (whichever is most applicable).

*Step 2:* On a separate piece of paper (you may want to use flipchart paper) draw a timeline with periods representing years or months. Add events to the timeline.

*Step 3:* Add above the timelines the environmental events (economic, social, political) which had a positive impact on your history. Add below the timelines the environmental events which had a negative impact on your history. Feel free to use colour coding or images.

*Step 4:* Answer the following questions:

i) What is the critical event(s) in this timeline that distinguishes everything that came before and influenced everything that happened after?

ii) What happened at this time and why did it happen?

*Step 5:* On your timeline, consider how events connect with one another (e.g. one positive event may have lead to a negative event, etc.). Draw lines to connect the events.

*Step 6:* Answer the following questions:

What does this history tell you about the development of HIV/AIDS and/or your organization/community?

Are there any recurring themes?

Are there people or groups that seem to be central to the history?

[15] Adapted from: Lee, Bill and Balkwill, Mike. (1996). Participatory Planning for Action. Toronto: Commonact Press.

B. Partnerships

Time it takes: About 1 hour

*Step 1:* Write down all of the institutions, organizations, departments, etc. that you typically work with on HIV/AIDS issues (e.g. NGOs, government, academic institutions, CBOs, religious organizations, professional associations, private companies, etc.).

*Step 2:* On a separate piece of paper or flipchart paper, map out all of the departments, institutions, organizations that you have considered. Where possible, note and consider the structure, mandate, target population, funding and programs of the various organizations.

*Step 3:* Using colour, symbols or a variety of lines or arrows:

- Indicate any cooperative relationships between or among agencies or workers
- Indicate any conflicting or strained relationships between or among agencies
- Indicate a lack of relationship between or among agencies

*Step 4:* Answer the following questions:

Are there areas where two or more organizations are working in ignorance of each other?

Are there issues on which workers or organizations could be collaborating?

Are there areas of potential conflict (e.g. competition for funding) among the agencies and groups?

C. Where are you in your organization?[16]

Time it takes: About 15 minutes

| Organization Process | Description | Reaction |
|---|---|---|
| INFLUENCE | How much of a say do you have in determining the organization's actions and directions? | Enough<br>Not enough |
| STRUCTURE | How do you feel about the structure of the organization? | Too tight, rigid, controlling<br>Just right<br>Too loose |
| RESOURCES | How well do you feel your resources (skills, interests, abilities) are being used? | I'm over-used<br>Used just right<br>I'm under-used |
| EXPERIMENTATION | How creative, experimental, risk-taking is your organization? | Not enough<br>Just right<br>Too conservative |
| INTERGROUP COMMUNICATION | How much communication is there between you and other units in the organization? | Too much<br>Just enough<br>Not enough |
| GOALS | How challenging are the goals of the organization right now? | Too challenging & demanding<br>Just right<br>Too simple & undemanding |
| INVOLVEMENT | How involved and interested are you in the organization's activities? | Very involved<br>Just right<br>Uninvolved |
| TIME | How do you feel about the amount of time you have for the work? | Too much time<br>Just right<br>Not enough time |
| LEARNING | How good an experience is this for your learning about how organizations work? | Very good<br>Good<br>Fair<br>Poor<br>Very poor |

D. HIV/AIDS in your community/region/nation

[16] Adapted from: Hope, Anne and Timmel, Sally. (1995). Training for Transformation: A Handbook for Community Workers. London: ITDG Publishing.

Time it takes: About one hour

Answer the following questions:

What is the current status of the epidemic at the local, regional, national level? What is the projected status of the epidemic? Provide statistical information if possible.

What is the present local, regional, national policy on HIV/AIDS prevention and/or care?

What local, regional, national mechanisms are in place to implement the recommendations from the UN General Assembly Special Session on HIV/AIDS (UNGASS)? (Refer to http://www.un.org/ga/aids/coverage/)

What local, regional, national mechanisms are in place to support the HIV/AIDS and Human Rights International Guidelines? (Refer to http://www.unaids.org/publications/documents/human/law/hright2e.pdf)

What are some of the dominant culture, values and beliefs about HIV/AIDS?

What are some of the emotional responses to HIV/AIDS:
- What are people worried about?
- What are people happy about?
- What are people sad about?
- What are people angry about?
- What are people fearful about?
- What are people hopeful about?

## Speaker Selection

The International Institute on Gender and HIV/AIDS relies on participatory pedagogical approaches that value the knowledge and skills of all participants in the facilitation of a dynamic learning culture. As such, there are specific sections of the curriculum that require panels and guest speakers. Please indicate your ability and willingness to speak to the following topics:

1. HIV/AIDS programs and/or services and gender: can you provide a case study on a program or service that takes gender into account?
____ yes ____ no

2. Experience with gender-based analysis and/or gender mainstreaming: have you used gender-based analysis or gender mainstreaming? What have been the successes and challenges?
____ yes ____ no

3. Human rights and HIV/AIDS: can you provide a case study that takes a human rights approach to HIV/AIDS?
____ yes ____ no

4. Policy development: can you provide a generic overview on how to develop a policy?
____ yes ____ no

5. Development in HIV/AIDS: what is the role of development in HIV/AIDS? Why is HIV/AIDS a development issue?
____ yes ____ no

6. Research: can you provide a generic overview on how to develop a research protocol?
____ yes ____ no

7. Work plan development: can you provide a generic overview on how to develop a work plan?
____ yes ____ no

If you have answered "yes" to any of the above, please provide a short description of your experience in the area and/or a short summary of the intervention:

Questionnaire

[still in development]

## Introductions and Expectation Setting

### Procedure

1. Develop a complete email list of all participants.

2. In advance of the Institute, send a group email out to all participants. Inform participants that they will virtually introduce themselves and describe their expectations for the Institute. The purpose for this is to give participants an opportunity to "meet" each other in advance of the Institute, to describe their motivation for attending the Institute and to share their expectations of the Institute.

3. Ask participants to virtually:

   Introduce themselves to the group. For example:
   - Name
   - Country
   - Name of and role in organization, institution, agency, etc.
   - Experience in gender and/or HIV/AIDS

   Briefly describe their motivation for attending the Institute. For example:
   - A brief description of the HIV/AIDS epidemic in their community/region/country
   - A brief description of how their organization/institution responds to HIV/AIDS
   - A brief description of the gaps in knowledge and skills in their organization, institution, agency, etc.

   Provide two expectations – what participants are expecting to get out of the Institute (e.g. knowledge, skills, resources, tools, support, etc.)

4. Review all participant expectations to determine how well they "fit" with the curriculum. Activities can be adapted to participant expectations and/or participants can be informed in advance of the Institute which expectations will be met and which ones are beyond the scope of the Institute (and why).

The International Institute on Gender and HIV/AIDS
Day 1: Agenda
Foundations

Day 1

9:00 Welcome and Introductions

10:15 Break

10:30 River of Life

12:00 Lunch

1:00 Sectoral Role Play

2:30 Break

2:45 HIV/AIDS: the basics

3:30 Root Cause Analysis

4:45 Wrap-up (see Appendix 3)

## Welcome, introductions, overview and logistics

Objectives: to introduce participants to each other, to set the atmosphere, to build the group, to establish a process for the Institute with the participants

Time: 75 minutes

Materials: Flipchart, markers, tape.

### Procedure

1. Officials from the Atlantic Centre of Excellence for Women's Health and their international partner organizations welcome the participants.

2. Facilitate the activity "Buses or lifeboats: an introductory exercise."

3. Share with participants the objectives of the Institute:

4) To enhance understanding of a critical mass of change makers about the links between gender, HIV and human rights
5) To strengthen skills of a critical mass of change makers to mainstream gender and HIV across sectors
6) To catalyze responses that strengthen and expand HIV prevention and care networks

4. Describe how people learn: people remember 20% of what they hear, 40% of what they see and hear, and 80% of what they discover for themselves. As such, this Institute utilizes a participatory approach to learning. This means that activities will involve reflection and action and will value the knowledge and experience of participants. That way, everyone teaches and everyone learns. This approach is premised on the belief that education, the production of new ideas, approaches and practices, leads to action for social change.

5. Negotiate ground rules and document them on flipchart paper. Explain that the purpose of ground rules is to help establish an environment where people can feel confident, secure and safe. They also frame our assumptions about and expectations for the Institute. Sample ground rules (participants should be encouraged to generate their own): good time keeping, confidentiality, all questions are acceptable, it is OK not to know, listen carefully, don't interrupt.

6. Clear up any logistical details (washrooms, lunch and other breaks, designated smoking areas, concerns about accommodation, etc.).

## Buses or lifeboats: an introductory exercise[17]

Objective: To begin to get to know each other, to have fun and relax, to get a social X-ray of the group.

Time: 15-30 minutes

Materials: A large space, clear of furniture

### Procedure

1. Ask everyone to stand up and come to the space chosen for the exercise.

2. Explain the objective and how this activity is not intended to give people an in-depth introduction to each other

3. Give the directions, with a short introduction. For example, "There's a social evening on Saturday in the city, and we will all have to travel by bus. So we thought we'd begin with some practice getting into the same bus, given that we come from so many different sectors and regions."

4. Explain to participants that they'll be asked to form buses in different ways. For example, "The men in one bus and the women in another". Or, "Get into buses by the region you live in." Ask people to make sure they move close together in the bus so they don't falloff. No one can be in a bus by herself or himself, so if they have any trouble they should pick the most appropriate bus.

5. Name the buses according to important features of the particular group (asking participants to form buses by where they were born, where they live, sector, organization, decade they were born, gender, number of children), making the buses appropriate to the group and the theme of the workshop.

6. Ask people in one or more buses to tell each other their names, organizations.

7. To avoid the process dragging, try not to have too many buses and to minimize the time that people have to stay talking on their feet in each bus.

8. Summarize what was learned about the group from this activity and note any specific questions the activity has raised.

[17] Source: Arnold, Rick, Burke, Bev, James, Carl, Martin, D'Arcy, Thomas, Barb. (1991). Educating for a Change. Toronto: Between the Lines.

## River of Life[18]

Objective: To build trust in the group.

Time: 60 minutes

Materials: Paper and crayons

A river is a very meaningful symbol in many cultures, and most people find it quite natural and very stimulating to think of their own lives in terms *of* a river. Deepak Chopra writes that the river *of* our life always runs between two banks: one *of* pain and one *of* joy. We need both banks as we cannot know the joy without the sorrow. This exercise is very useful as a personal reflection, leading to greater self-knowledge, and also as the basis for a small group sharing, leading to greater trust in the group.

### Procedure

1. Give each person a sheet of plain paper and make plenty of crayons of different colours available.

2. Ask each to draw the river of their own life, going right back to the source (the early years in their families), the different periods of their lives, such as quiet peaceful times, and wild stormy times (of rapids and waterfalls). Major influences which contributed to the growth of your river can be shown as tributaries and labelled. And small drawings, showing the important people, events, and experiences, can be drawn beside the river.

c. Encourage the group to use colours to express different moods at different periods of their lives.

d. Ask people to form groups of 3 -5 to share the experience illustrated by the river.

e. It is not advisable to share in a large group, but if people wish they can put the drawings on the wall and explain them informally to each other.

[18] Source: Hope, Anne and Timmel, Sally. (1995). Training for Transformation: A Handbook for Community Workers. London: ITDG Publishing.

# Sectoral Role Play

Objective: To establish a basis of shared experience, to critically think about the roles and responsibilities of various actors in HIV/AIDS prevention and care, to provide baseline data for participatory evaluation (participants will be encouraged to reflect on this activity in the post-Institute).

Time: 90 minutes

Materials: Paper, pens.

## Procedure

1. Ask participants to form groups of 3-5 people. Ensure that each small group is as representative of a variety of sectors as possible (e.g. health, education, research, government, NGO, etc.).

2. Within each small group, participants summarize the role of his/her sector in HIV/AIDS prevention and care. Encourage participants to think about roles and responsibilities, power relations, decision-making power, resources, understanding and knowledge.

3. After all participants have shared their stories, the group should develop a short role play to illustrate to the larger group the various responses and roles.

4. Ask each small group to perform their role play. At the end of each roles play, encourage participants to share their observations and reactions.

5. Wrap-up by discussing the common themes running through the role plays. Give each participant paper and pen. Ask participants to take 5-10 minutes to summarize and document their role play – the key interactions, scripts, reactions, etc. used by their particular sectors. Inform participants that they will need these notes to refer to in the Post-Institute.

# HIV/AIDS: the basics

Objective: To solidify an accurate understanding of HIV/AIDS.

Time: 45 minutes

Materials: "HIV/AIDS: the basics" resource sheet, flipchart paper, markers, tape.

## Procedure

1. Introduce the objective for the activity.

2. Participants form small groups. Each small group gets flipchart paper and a marker.

3. Assign 1-2 of the following questions to each small group:

- What is HIV?
- What is AIDS?
- How is HIV transmitted?
- How is HIV not transmitted?
- What are some symptoms of HIV?
- What are some symptoms of AIDS?
- How can HIV be prevented?
- How is HIV/AIDS treated?

4. Instruct participants to generate a response to their question and document it on flipchart paper.

5. In the large group, ask each group to present their question(s) and answer(s). Quantify the response or clear up any misunderstanding with the "HIV/AIDS: the basics" resource sheet. This is also an opportunity to address the myths and misinformation surrounding HIV/AIDS.

Resource Sheet

# HIV/AIDS: The Basics

What is HIV?

- HIV is a retrovirus. It is the virus that causes AIDS.
- It attacks the immune system. The body is then unable to defend itself against opportunistic infection (illnesses or cancers that are rare in healthy people).

What is AIDS?

- AIDS is usually diagnosed when a person living with HIV has one or more opportunistic infections (illnesses or cancers that are rare in healthy people).

How is HIV transmitted?

- HIV lives in blood, semen (cum) or pre-cum, vaginal fluids (including menstrual fluids) and breast milk
- HIV is transmitted through:
    - Unprotected sexual intercourse (vaginal or anal intercourse without a condom)
    - Pregnancy-related vertical transmission
    - Blood transfusion
    - Sharing of infected needles used to inject drug intravenously, used in health care settings

How is HIV not transmitted?

- Saliva, sweat, urine, nasal secretions, stool
- Air (e.g. coughing or sneezing)
- Casual contact
- Donating blood
- Using common swimming pools, toilets, etc.
- Sharing bed linen, eating utensils, food, etc.
- Animals, mosquitoes and other insects

What are some symptoms of HIV?

- There can be no symptoms
- You can't tell by looking at someone whether they have HIV or not
- Some people experience flu-like symptoms: swollen lymph glands (in the neck, underarms or groin area), recurrent fever, "night sweats", sudden weight loss, extreme fatigue, white spots or sores in mouth, chronic diarrhea
- Women-specific symptoms: persistent yeast and vaginal infections, menstrual irregularities, severe herpes simplex virus, chronic Pelvic Inflammatory Disease (PID), Human Papillomavirus (HPV)

What are some symptoms of AIDS?

- You can't tell by looking at someone whether they have AIDS or not
- Low T-cell count
- High viral load
- Opportunistic infections (illnesses or cancers that are rare in healthy people) such as: Kaposi's Sarcoma (KS), Pneumocystis carinii pneumonia (PCP), cervical cancer, cytomegalovirus (CMV)

How can HIV be prevented?

- Use protection for intercourse (e.g. male or female condoms)
- Take care of overall sexual and reproductive health (regular examinations, STI testing, etc.)
- In the case of sexual assault or rape, post-exposure prophylaxis can reduce the risk of HIV infection.
- Properly clean or use new needles for injection drug use and in health care settings

How is HIV/AIDS treated?

- There is no cure for HIV or AIDS
- HIV can be managed with anti-retroviral medications (nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, protease inhibitors) and prophylactic medications (to help prevent opportunistic infections)

## Root Cause Analysis[19]

Objective: To develop a holistic analysis of the causes of HIV/AIDS.

Time: 75 minutes

Materials: Flipchart paper, coloured markers, tape.

Procedure:

1. Ask participants to brainstorm all of the causes – social, economic, cultural, etc. – of HIV/AIDS. Document every suggestion on the flip chart paper, making sure to get the wording and meaning correctly.

2. Explain the rest of the exercise:

(a) Offer the group the metaphor of ecology, using the imagery of a plant. A plant contains three parts: blooms or flowers, a stem and leaves, and roots.

*Blooms or Flowers:*
Presenting problems - the things we most easily see and which in the short run are most easily gotten rid of. Of course, the plant is still alive and will probably replace the bloom fairly easily; sometimes two blooms replace the one that was lopped off. In this case, the bloom/flower is HIV.

*Stems and Leaves:*
Supporting or systemic problems - things that support (or feed) the problems we see. While not as obvious as the blooms, they can be seen and gotten rid of with a bit more effort than the bloom. Only rarely does this destroy the plant (problem system) as well.

*Roots, or a Root:*
The basic problem(s) or cause(s) - although they are out of sight and perhaps out of mind, they provide the presenting and supporting problems with most of their energy for life.

(b) Ask participants to form into small groups in which they are to:

- Decide on the metaphor they wish to use to "order" their problems. It can be anything they want it to be. It doesn't have to be a plant. Groups have used weather systems, sea creatures, whole gardens or forests, spider webs, etc.-as long

[19] Methodology adapted from: Lee, Bill and Balkwill, Mike. (1996). Participatory Planning for Action. Toronto: Commonact Press.

as it helps them explain the ecology (the way things fit together) of their problem situation.

- Assign the problems to the various parts of the picture. They can draw as they go, order first and draw second or do the reverse. It doesn't matter as long as they are doing it in a way that fits for them.

(c) Reconvene the large group and ask the groups to present their pictures and analyses. After each analysis, anyone can ask for clarification of the picture or suggest some insight that the picture/analysis has stimulated in him/her. Make sure that people link their metaphors.

*Sample "stems" and "leaves":* lack of safer sex education, lack of condoms, lack of HIV/AIDS treatment, marginalization, homophobia, injection drug use, sex-phobia.

*Sample "roots":* poverty, heterosexism, homophobia, sexism, globalization.

(3) The facilitator assists the group to examine the picture for similarities (themes) and differences. The facilitator may wish to add her/his own observations to add to the overall analysis.

(4) Wrap-up the activity by describing how HIV/AIDS is a complex problem requiring a holistic response.

The International Institute on Gender and HIV/AIDS
Day 2 & 3: Agendas
Gender

Day 2

9:00 Panel/speaker: programs/services that take into account gender

9:45 The Power Flower: Reflection on our Social Identities

11:00 Break

11:15 To be a Man or Woman: What Defines Us?

11:45 Differences in Health

12:30 Lunch

1:30 Exploring Gender Issues in HIV/AIDS

2:30 Break

2:45 The Brick Wall: Gender, Culture, Sexuality and HIV Vulnerability

3:45 Wrap-up (see Appendix 3)

Day 3

9:00 Panel/speaker: successes and failures of GBA/GMS

9:45 What is a Gender Lens?

10:15 Break

10:30 Gender Mainstreaming

12:30 Lunch

1:30 Force Field Analysis

2:45 Break

3:00 Pulling it All Together: Developing Gender Sensitive Programs

5:00 Wrap-up (see Appendix 3)

## The Power Flower: Reflection on our Social Identities[20]

Objectives: To identify who we are (and who we aren't) as individuals and as a group in relation to those who wield power in our society, to establish discrimination as a process for maintaining dominant identities.

Time: 75 minutes

Materials: "Flower Power" handouts, flower power reproduced on flipchart paper, a variety of coloured markers

### Procedure

1. Introduce the activity by describing how, prior to discussing gender, culture, sexuality, human rights and HIV, it is helpful to reflect on and understand our own social identity in relation to those who wield power in society in order to understand the role of discrimination in maintaining dominant identities.

2. Introduce the power flower, which has been drawn on large paper and placed on the wall. As a group, fill in the dominant social identity of the group on the outside circle.

3. Ask people to work with the person next to them and hand out individual flowers to each pair. Ask participants to locate themselves on the inner blank circle.

4. The groups of two post their identities on the inner circle of the large flower as soon as they are ready to do so.

5. Review the composite as a group and reflect on:
   - Personal location: how many factors you have as an individual that are different from the dominant identity; what factors can't be shifted, changed?
   - Representation: who we are/ are not as a group - and how that might influence the task/discussion at hand.
   - The relationship between and among different forms of oppression.
   - The process at work to establish dominance of a particular identity and, at the same time, to subordinate other identities.

[20] Methodology adapted from: Arnold, Rick, Burke, Bev, James, Carl, Martin, D'Arcy, Thomas, Barb. (1991). Educating for a Change. Toronto: Between the Lines.

Handout

Flower Power

(insert graphic)

## To Be a Man or a Woman: What Defines Us?[21]

Objective: To understand the basic concepts underlying the definitions of sex and gender and examine the characteristics of the concept of gender.

Time: 30 minutes

Materials: Flipchart, markers, overhead projector, overheads: "Definitions of Sex and Gender", "Social Construction of Gender", "Social/Biological", "Gender and Health"

### Procedure

1. Draw a vertical line down the middle of the flipchart and head the one side "Women", the other "Men," and pose the question: "What are the characteristics of women and men?" to be answered in sequence. Encourage participants to randomly call out their answers without reflection, for a fast and dynamic interaction. Fill in the flipchart, until it is full, without comment—unless childbirth and lactation are omitted, in which case, pose a question to ensure the inclusion of these biological functions.

2. After contributions have concluded, cross out the headings, and replace "men" with women, and "women" with men, (in order to reverse the assumptions) and pose the question: "Which characteristics could not be possible in any society?" Underline "childbearing" and "breast-feeding" (or equivalent terms). These are the only characteristics which are biologically determined. All the rest are socially constructed.

3. Ask: "What do these characteristics that you have identified as socially constructed have in common?" (If participants ask "In what society?" or "Should we say what is real or ideal?," respond that the characteristics can be from any society, during any historical period, and can be either real or ideal.) Look for: change over time; differences between cultures; differences within cultures; learned behavior; historical. Point out that these are the key characteristics of gender.

4. Display the overhead "Definitions of Sex and Gender" and discuss.

5. Display the overhead "Social Construction of Gender" and discuss how the analytical category of gender has the following characteristics:

**RELATIONAL:** It is relational because it refers not to women or men in isolation, but to the relationships between them and how these relationships are socially constructed.

**HIERARCHICAL:** It is hierarchical because the differences established between women and men, far from being neutral, tend to attribute greater importance and value to

[21] Adapted from: Pan American Health Organization. (1997). Workshop on Gender, Health and Development. Facilitator's Guide. Washington: Author.

the characteristics and activities associated with what is masculine and to produce unequal power relationships.

**CHANGES OVER TIME:** Even though gender is historical, the roles and relations do change over time and, therefore, have definite potential for modification through development interventions.

**CONTEXT SPECIFIC:** There are variations in gender roles and gender relations depending on the context: ethnic group, socio-economic group, culture etc., underlining the need to incorporate a perspective of diversity in gender analysis.

**INSTITUTIONAL:** It is institutionally structured because it refers not only to the relations between women and men at the personal and private level, but to a social system that is supported by values, legislation, religion, etc.

NOTE: In presenting these gender characteristics, ask participants to contribute their own examples.

6. Display the overhead "Social/Biological" and points out how the emphasis on social factors within the gender approach does not imply the exclusion of the profound influence of the biological element. On the contrary, this perspective provides for the examination of interactions between biological factors and factors in the social environment that lead to situations of relative disadvantage or advantage for one of the two sexes.

7. Display the overhead "Gender and Health" and discuss.

Overhead

# Definitions: Sex and Gender

"**Sex**" refers to the biological differences between men and women

"**Gender**" refers to roles that men and women play and the relations that arise out of these roles. They are socially constructed, not physically determined.

Overhead

# Social Construction of Gender

Relational: Socially Constructed

Hierarchical: Power Relations

Changes: Changes over time

Context: Varies with ethnicity, class, culture, etc.

Institutional: Systemic

Overhead

# Social/ Biological

Emphasizing the social, does not exclude the role of biology

Recognition of social factors is crucial to an analysis of this interrelationship in order to identify the differential disadvantages and/or advantages for men and women's health

Overhead

# Gender and Health

In HEALTH, advantage and disadvantage can be measured by:

1. Probability of maintaining health, or becoming ill or dying from preventable causes

2. Equity of access to and control of resources, responsibilities and rewards in health work

## Differences in Health/Illness Profiles of Women and Men[22]

Objective: To understand how the interrelationship between biological, psychological and social factors generates specific health needs for women and men.

Time: 40 minutes

Materials: Flipchart, markers, overhead projector. Overheads: "Circles: Biology of Women and Men", "Circles: Gender Constructions", "Circles: Needs", "Equity and Need", "Origin of male and female differences in health". Handouts: "Circles: Needs in Health", "Origin of Male/Female Differences in Health/Illness".

### Procedure

1. Introduce the activity by describing how we all know that there are differences between men and women with regard to their physical and mental health. However, traditionally, the health sciences, particularly the medical profession, have focused on what they considered to be strictly biological differences between the sexes.

2. Present the overhead "Circles: Biology of Men and Women". Place the "Circles: Gender Constructions" overhead directly over it. Discuss how men and women also play different roles in different societies, and because of that they develop different skills and abilities. These roles, skills and abilities are valued differently, and it is usually those associated with masculine spheres that receive greater social recognition and are valued more highly than those associated with feminine spheres. This differential value has direct implications for the degree to which men and women have access to and control of resources. Collectively, these sexually assigned roles and responsibilities and the abilities, values and access to and control of resources that arise from them, give rise to gender inequities.

3. On the overhead, point to labels on the outside of the circle (culture/race/class) and state that it is important to note that these gender constructions are strongly influenced by culture, by socioeconomic level and by age, and these all must be taken collectively into account when examining how gender influences health and health work.

4. Place the "Circles: Needs" overhead directly over the other two. Discuss how if men and women are biologically different and, in different cultures, socioeconomic groups and generations, are shaped by different gender constructions, then we can also assume that men and women have different needs in health which must be understood so as to respond in an equitable and efficient manner to them.

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[22] Adapted from: Pan American Health Organization. (1997). Workshop on Gender, Health and Development. Facilitator's Guide. Washington: Author.

5. Distribute copies of the “Circles: Needs in Health” handout. Point out that to attain equity in health it is necessary to identify and respond to different health situations, conditions and problems pertaining to each sex. To define equity and need, show the “Equity and Need” overhead.

6. Show the overhead: “Origin of Male and Female Differences in Health/Illness”, and describe how we can further understand the interaction of biological and social factors on health by examining specific health situations or problems. This overhead demonstrates the origin of the differences in health/ disease patterns between men and women.

7. Point out that the differences in health profiles between the sexes are based on an interaction between biological determinants and gender constructions.

8. Ask participants for examples of health situations/conditions/problems, and write their contributions on a flipchart.

9. Point out that the last category (generate different response) is clearly gender based, i.e., important structural barriers to access to the resources and benefits of the health system derive from the roles that men and women play in society and the relations that arise from the value assigned to these roles. For example:

- Domestic violence toward woman is judged differently from public violence against strangers and there is a greater degree of social tolerance for violence towards women from their male partners than there is for other types of social violence. This tolerance is reflected in legislation on family violence in almost every country.
- The exclusion of women from clinical studies of pathologies affecting both sexes; consequently, therapies based on these studies may not be reliable for application to women, and may be hazardous for the female population. The consideration of the male body as the standard for clinical studies acts to limit the number of studies that focus on women's reproductive and non-reproductive health, and obfuscates the impact of certain medications or treatment at different stages of their life cycle.
- There has been low priority assigned to research of pathologies and treatments exclusively or primarily affecting women.
- Focus of family planning services on women have excluded men, with the result that men have limited access to such services. In addition, given the gender relations within a family, decisions about contraception need to include men, otherwise women can be prevented from using them by their partners/husbands.
- Differences by sex in the quality of care in health services: research in the United States of America, Canada, Australia, Sweden and some countries in Latin America shows that the quality of care received differs between men and women, and that this difference is inequitable for women (waiting time, over-medication, humiliating treatment).

10. Emphasize the following:

- Differences and disadvantages in the field of the health are manifested not only in the way health and disease are distributed in a population but also in the way health is promoted, disease is prevented and controlled, patients are cared for, and in the models adopted for structuring health and social security systems.
- Without fully appreciating the implications and impact of gender roles and relations, health practitioners will fail in their treatment of certain groups and individuals, and health planners will inadequately serve the total population.
- The facilitator emphasizes the fact that bio-psycho-social differences in health profiles for men and women naturally lead to differences in their respective response needs to particular conditions, situations, or problems.

11. Using HIV/AIDS as a case study, describe how attention to gender can provide us with guidelines for designing interventions that respond adequately to the needs that are specific to men and women. Ask: "What are the gender-specific risk factors and needs?" There are:

- different risk factors for the sexes
- different degrees of severity of consequences
- different responses from women and men, the health sector in particular or society in general

12. Using the overhead "HIV/AIDS Biological Characteristics", describe how women are more vulnerable than men to HIV infection through heterosexual relations; studies show that women are two to four times more likely than men to be infected in this way. There are several explanations for this, including:

- Semen Highly Infectious: HIV needs live cells in order to be transmitted. The body fluids richest in cells are the most infectious. As a result, semen is more infectious because it has greater cellular content than vaginal fluids;
- Vaginal Mucous Membrane More Vulnerable: The epithelial quality of the vaginal mucous membrane is more vulnerable to infections than the penis;
- Semen Remains in Vaginal Tract: Semen remains in the vaginal or rectal tract for a longer period than do vaginal fluids on the penis; as a result, women's exposure time to the virus is greater in heterosexual relations;
- Age Factor: under 18; After Menopause: Age is an independent factor that increases susceptibility to HIV of women under 18 years and in the post-menopausal stage. This is because the vaginal mucous membrane in young women does not acquire a cellular density that acts as an effective barrier until after 18 years of age; after menopause, the vaginal mucous membrane becomes thinner and weaker and is more vulnerable to HIV.
- STD - HIV/AIDS link: Incidence for Women: Women suffer more than men from sexually transmitted diseases which increases the risk of HIV infection through heterosexual relations. In many cases STDs are asymptomatic in women, which impedes early detection and timely treatment.

**Gender Perspective:** However, biology alone does not explain rapid rise in women. Although there are important biological differences between women and men with

respect to susceptibility to HIV, these biological differences do not explain the fact that women now constitute 75% of the new cases of infection. We have to consider the interaction between psychosocial and biological factors: a gender perspective allows us to understand how women, in addition to their biological risk for HIV, are psychosocially at greater risk than men because of those gender constructions characteristic to many societies.

13. Divide participants into four groups and ask the groups to:
    1) Identify situations in which social gender constructs increase the risk of contracting HIV for one sex or the other.
    2) Include concrete experiences/observations of own societies/cultures/lives that provide evidence for 1).

Possible responses:

- Social tolerance of male promiscuity: the deep-seated idea that men have more urgent sexual needs by "nature," means that women as a group, and society in general, find it "forgivable" for these needs to be fulfilled indiscriminately;
- Social assignment of greater value to what is masculine and the positive social support for female passivity and self-denial: women internalize from the time they are very young the idea that it is "natural" for the man to be "worth more" and thus women, less. In many cultures, the qualities of the ideal woman include resignation, passivity and dependence. The psychological construct of feminine sexuality inhibits many women from questioning men in any area and particularly in the area of sexuality;
- Lack of open communication on sexuality among partners: a problem for many women is that, inhibited from inquiring about the sexual habits of their partners, they assume that they are faithful and, as a result, are not aware that they are at risk of contracting HIV and other STDs. In other cases, psychological denial mechanisms are also involved;
- Male rejection of the condom: rejection occurs more frequently in sexual relations of the man with his stable partner (use of the condom is associated with relations with prostitutes). In addition, the definition of masculinity is built around the idea of "taking risks" which implies that a "real man," will take a risk rather than take precautions. Also, women often reject condom use among their partners, because they associate its use with promiscuous sexual relations or prostitutes;
- Female psychic construct based on economic and social subordination: women may be aware of their vulnerability but may tend, because of gender constructions, to lack an internal locus of control that would enable them to reduce or eliminate the risk of their sexual relations. Men who do not want to use condoms generally will not do so, and women will not risk their relationship or male economic support, nor will they face the violence of a confrontation that this type of situation can cause. National AIDS Control Programs often assume that the strategies of prevention are equal for men and women, an assumption that is not reflected in reality, for example, in the control over the use of condoms;
- Women have not been taken into account by the scientific community when carrying out clinical research on HIV/AIDS: with the exception of prostitutes,

women have been ignored for many years in efforts to prevent transmission of HIV and in research on AIDS. This is probably due to the fact that there was a much greater proportion of men than women affected in the countries that led international biomedical research. Accordingly, for years the natural history of HIV was defined and studied in men, without taking into account the fact that women are at greater risk for HIV/AIDS for the reasons we have seen here;

- Prohibitions on access to sex education and contraceptives, including condoms: among the multiple obstacles to the condom, there are religious prohibitions imposed by churches and the most conservative sectors of society; the male argument is based on the loss of sensitivity to sexual pleasure and the association of condom use with STDs and casual relations; in addition, there is a lack of adequate sex education and a lack of access to contraceptives and condoms, often justified with the argument that sex education promotes promiscuity in youth;
- Age of Sexual Partners: men have sexual relations with younger and younger women, particularly virgins, because of the belief that younger women are less likely to have contracted the virus. This is spreading the virus among increasingly younger women and girls.
- Lack of health services for women with STDs or HIV which take into account gender-based needs: generally, the health sector has not developed a satisfactory response for women suffering from STDs; this is one of the factors that significantly increases their biological susceptibility to HIV. Although women suspect that they may have STDs, they do not seek care because of the social stigma that the situation entails;
- Sexual violence: sexual violence against women, both public and domestic, increases the risk that women will contract STDs and HIV;
- Fidelity and virginity: both characteristics are considered culturally very valuable for women. In this context, women do not easily share their sexual history with their sexual partners, putting the couple at risk.

14. Groups report back, one group at a time, with responses to Task No. 1 and one response to Task No. 2.

Overhead

# Circles: Biology of Men and Women

[insert graphic]

Overhead

# Circles: Gender Constructions

[insert graphic]

Overhead

# Circles: Needs

[insert graphic]

Handout

# Circles: Needs in Health

[insert graphic]

Overhead

# EQUITY AND NEED

To attain equity in health, it is important to recognize that different groups have different needs that must be identified so as to adequately address them.

The gender perspective enables greater equity in interventions in health and increases the effectiveness of these actions.

Overhead/Handout

# ORIGIN OF MALE AND FEMALE DIFFERENCES IN HEALTH/ILLNESS

[insert graphic]

Overhead

# HIV/AIDS Biological Characteristics

Women more vulnerable because:

- Semen Highly Infectious
- Vaginal Mucous Membrane More Vulnerable
- Semen Remains in Vaginal Tract
- Age Factor: under 18; after menopause
- STD - HIV/AIDS link: Incidence for Women

## Exploring Gender Issues in HIV/AIDS[23]

Objective: To explore how HIV/AIDS is experienced differently by women, men, boys and girls.

Time: 60 minutes

Materials: Flipchart, markers, pens, participant notebooks, handout "Gender and HIV/AIDS: Case Study"

### Procedure

1. Introduce the objectives of the activity.

2. Divide the participants into small groups.

3. Distribute one handout to each group.

4. Allow 30 minutes for group discussion.

5. Facilitate a report back session and allow other participants to ask questions and make comments.

6. During the group reports, record the key emerging issues on flip chart to facilitate an overall summary.

[23] Adapted from: Commonwealth Secretariat. (Draft). Gender and HIV/AIDS Training Manual. London: Author.

Handout

## Gender and HIV/AIDS: CASE STUDY

Upon the death of both her mother and father, twenty year-old Nnini decided to leave her home village and go to the city, to look for work. Shortly after, she was recruited as a cleaner at a government institution but hired on very poor pay. She met a fairly rich man, Henry, who was willing to take care of her – housing, food, clothing, and all other needs. Nnini could not resist the temptation of living in a big, well-furnished house with a boyfriend. He was her first partner. She moved out of the little room in her uncle's house to stay with him.

One day she began to notice sores on her body. She concluded that it was just some kind of skin rash. After a few days she discovered more sores. She started worrying and thought endlessly about going to the doctor. She got weaker and weaker until she was advised by her friend to go to the doctor once and for all. After three months, she picked up courage and went to the doctor. She was diagnosed HIV positive. Her days were darkened when she learned about the results. She was not able to afford the drugs on her own. The possibility of a future for her was remote and her life changed drastically. She no longer enjoyed the company of friends. She spent days and nights thinking of her orphanhood, and especially of her mother. She decided to break the news to Henry who was furious and accused her of promiscuity. He evicted her from his luxurious house.

There was nowhere for her to go except to her uncle, the only close relative she had. She decided to break the news to him as well hoping that he would sympathize with her situation, but he was furious. He accused her of irresponsibility, carelessness, and being everyman's girl. He told her to rent a house somewhere far from where he lived. He ordered her to stop using his surname, as she had been a disgrace to the family. She was devastated. She felt miserable and rejected.

After some time Henry got married to one of Nnini's best friends. They had two children, both of them diagnosed HIV positive. The last Nnini heard was that both Henry and his wife had left employment because of ill health and were on antiretroviral drugs.

Consider both HIV/AIDS prevention and care to answer the following questions:

What are some of the pertinent issues surrounding Nnini's experience with HIV/AIDS?
What are the underlying causes of Nnini's responses and reactions?
What are some of the pertinent issues surrounding Henry's experience?
What are the underlying causes of Henry's responses and reactions?
What are some of the issues that are reflected in the uncle's response and reaction to Nnini's situation?
What programmes do you know of that could have helped Nnini solve her problem?
How are all these issues likely to impact on Henry's wife and children?
What programmes could be used to further strengthen support for Nnini, Henry and his family?

## The Brick Wall: Gender, Culture, Sexuality and HIV Vulnerability

Objective: To examine beliefs, values, social norms and practices that influence the vulnerability of women, men, girls and boys to HIV/AIDS.

Time: 60 minutes

Materials: Pad of paper, markers, tape, wall space, "The Brick Wall: Gender, Culture, Sexuality and HIV Vulnerability" resource sheet.

### Procedure

1. Introduce the objective of the activity. Specifically, this activity will examine how our beliefs, values, norms and practices around gender, culture and sexuality all intersect and inform HIV/AIDS vulnerability.

2. Ask participants to define sexuality. Sample definition:

> "It is the social construction of biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behaviour; it is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, influence an individual's sexuality."[24]

3. Ask participants to identify, discuss and describe the social, cultural and economic norms, beliefs, practices and values that make women and girls, boys and men, vulnerable to HIV/AIDS. As they are generated, have participants summarize their response(s) onto a piece of paper (each piece of paper represents a brick), indicate if it is relevant for women, men, boys and/or girls and tape them onto the wall.

4. Once there is a "brick wall" of responses, ask the following questions:
   - Which of these norms, beliefs, practices and values keep people apathetic?
   - What institutions or groups are expressing, reproducing or disseminating these norms, beliefs, practice, values?

5. Encourage the group to consider one brick at a time:
   - What is the implication of each norm, belief, value?
   - How can it be challenged? For example, what might be the role of programs and services?
   - How might these responses be different from current/traditional responses?

[24] Rao Gupta, Geeta. (2000).

5. As participants generate solution(s) for each norm, belief and value, remove the relevant brick(s).

6. Wrap-up the activity by discussing how the beliefs, values, norms and practices around gender, culture and sexuality clearly impact on HIV-related vulnerability. However, they are not static – because of their fluidity and changeability, programs and services are advantageously positioned to challenge and address these beliefs in the contextual realities of women, men, boys and girls.

Resource Sheet

## The Brick Wall: Gender, Culture, Sexuality and HIV Vulnerability

### Women and girls

| Norms, beliefs, practices, values | Implication |
|---|---|
| Culture of silence: good women are expected to be ignorant about sex, passive in sexual interactions | Difficult for women to be informed about risk reduction or if informed be proactive in negotiating safer sex |
| Traditional norm of virginity for unmarried girls | Restricts ability to ask for information. Risk of rape in high prevalence countries (sex with virgin will cleanse man of infection). Practice alternative sexual behaviours (anal sex). |
| Motherhood as feminine ideal. | Barrier methods or non-penetrative sex as safer sex difficult to negotiate. Barriers to HIV positive mothers using formula. |
| Economic dependency. | Less likely to succeed in negotiating safer sex. Less likely to leave a relationship that they perceive as risky. |
| Violence against women | Women abused more likely to engage in unprotective sex, have multiple partners, trade sex for money or drugs. Physical violence, threat of physical violence and fear of abandonment are barriers for women who have to negotiate condom use, discuss fidelity, or leave perceived risky relationship. Myth that sex with virgins will cure HIV can result in rape. Prevalent in conflict situations (HIV rates often higher among military personnel, rape common in refugee camps, increased survival sex re: loss of income, home, family). |
| Poverty | Sexual trafficking, exploitation. Young women engage in relationships with sugar daddies. Exchange sex for necessities and goods. |
| Marriage | Promote respect of men's authority in sexual matters and contraceptive use. Sex as duty. Women powerless to negotiate condom use or husbands' extramarital behaviour. |
| Early marriage | Consequences re: young women's education, health |

| | |
|---|---|
| | consequences of early childbearing, diminished access to productive resources, economic dependency on male partner. |
| Older women are asexual. Young women aren't supposed to have sex. | Lack of information, education and services. |
| Cultural norms lead to unsafe practices. | FGM, vaginal cleansing, anal sex, wife inheritance all increase vulnerability to HIV. |

Men and Boys

| Norms, beliefs, practices, values | Outcome |
|---|---|
| Men are supposed to be more knowledgeable and experienced about sex. | Prevents men from seeking information, admitting lack of knowledge about sex or procreation and coerce them into experimenting with sex in unsafe ways and young age to prove manhood. |
| Men are supposed to have a variety of sexual partners | Mutual monogamy conflicts with definition of masculinity. |
| Dominance over women | Physical, sexual, economic abuse. |
| Compulsory heterosexuality | Contributes to homophobia and stigma toward MSM. Forces MSM to keep sexual behaviour a secret, deny sexual risk. Inability to reach MSM with information and services. Increases risk of other partners (male or female). |
| Fatherhood | Accumulation of resource networks in number of children they father |
| Self-reliant, not show emotions, not seek assistance | Runs counter to expectation that men protect themselves from potential infection. Encourages denial of risk. |
| All traditional notions of masculinity strongly associated with risk-taking behaviour | Substance use, violence, delinquency, unsafe sexual practices. |

Considerations of Program and Services

Overcoming inequality and changing cultural norms means:

- Recognizing, understanding and publicly discussing ways in which the power imbalance in gender and sexuality fuels the epidemic
- Breaking the silence around sex – talk about it. Talk about sexual health, pleasure and rights.
- Discussing not just the what and why, but also how to address gender, sexuality and HIV/AIDS in a way that has impact on epidemic
- Not reinforcing damaging gender and sexual stereotypes.
- Encouraging male involvement – in both program/service design and implementation and in engaging men and boys as program/service target populations.
- Taking into account and addressing economic realities and barriers.

Divergence from Traditional/Current Responses

Challenges efficacy of prevention messages that call for fidelity, condom use, reduction in number of sexual partners, monogamy.

Challenges the fact that programs and services, indeed the responsibility for protection, lies with women. Because of dominant ideologies of femininity, accessing treatment services can be highly stigmatizing for adolescent and adult women. Also, because clinics and services are geared to women, men are less likely to benefit from services.

## What is a Gender Lens?

Objective: To develop understanding of the tools and methods of considering gender in programs, policies, services and organizations.

Time: 30 minutes

Materials: Flipchart, markers, overhead projector, overheads: "What is a Gender Lens" and "Mistaken Beliefs".

### Procedure

1. Introduce the activity by pointing out how a focus on gender is necessary to ensure effective programs, services, policies, etc. "Approaches that do no harm" or gender-neutral programming fail to respond to the gender-specific needs of individuals. On the other hand, care must be taken in addressing gender – for example, approaches that focus on gender stereotypes entrenches HIV related stigma (e.g. men as predators, women as powerless victims; women sex workers as sources of infection).

2. Divide participants into six groups.

3. Assign each group one of the following concepts:
   - Gender analysis
   - Gender planning
   - Gender monitoring and evaluation
   - Gender sensitivity
   - Gender integration
   - Gender mainstreaming

4. Give the groups sufficient time to generate a definition for their assigned concept.

5. In the large group, small groups report back on their definitions of gender analysis, gender planning, gender training and gender monitoring and evaluation. Point out that these are tools essential to gender-based approaches. Then ask the remaining three groups to provide their definitions for gender sensitivity, gender integration and gender mainstreaming. Use the overhead "What is a Gender Lens" to confirm and clear up any misconceptions.

6. Wrap-up the activity by emphasizing the importance of a gender in ensuring efficient and effective policies, programs and services and by sharing the "Mistaken Beliefs" overhead.

Overhead

# What is a Gender Lens? Tools

**Gender analysis**
The collection and analysis of quantitative information by sex (sex disaggregated data), which identifies the gender differences and inequalities in roles, responsibilities, access to resources and opportunities. Qualitative gender analysis seeks to examine the causes of these differences and inequalities between women and men.

**Gender planning**
A process of applying the results of gender analysis to bridge the gaps/inequalities identified between women and men, through the planning process at various levels. Gender planning includes taking appropriate action to bring marginalized groups up to an equal standing with others.

**Gender monitoring and evaluation**
Involves developing gender specific indicators to observe and measure the efficacy of an intervention for both men and women.

**Gender sensitivity**
Recognizes the differences, inequalities, and specific needs of women and men and acts on this awareness to promote equal/equitable opportunities and outcomes for women and men.

**Gender integration**
Incorporates sensitivity to gender differences/inequalities in policy making, planning, budgeting, program implementation and/or activities.

**Gender mainstreaming**
Similar to gender integration but changes occur on a wider, structural scale – it occurs at all levels and in all sectors and organizations. It has the potential to transform the existing policy agenda and service delivery into one which bridges gender, race/ethnicity, class/caste, age, language, religion and other inequalities in access to resources, opportunities and power. Once awareness is achieved, gender issues will become a functional component of an organization's work.

Overhead

# Mistaken beliefs

**1. Empowering men will disempower women.**

Power is not a finite concept. More power to one means more power to all. Empowering women empowers households, communities, nations.

**2. Fear that changing gender roles to equalize gender power balance conflicts with value of multiculturalism and diversity.**

What is being altered is not a society's culture but its customs and practices which are typically based on interpretations of culture. Customs and practices that seek to subordinate women and trap men in damaging patterns of sexual behaviour are based on biased interpretation of culture that serves narrow interests.

**3. The gender approach will be at the expense of a feminist agenda which gives high priority to help women change or transform power dynamics.**

The gender approach does not automatically remove the need for women-specific programs or projects targeting women. Moreover, in the gender approach, gender isn't merely descriptive, focusing on different roles and responsibilities of women and men. It must challenge and aim to transform power imbalances.

## Gender Mainstreaming

Objectives: To understand the principles and process of gender mainstreaming, to apply the concepts of gender mainstreaming.

Time: 2 hours

Materials: Flipchart, markers, overhead projector, overheads: "Gender-Based Approaches", "The Gender Management System", "GMS: Illustrated"

### Procedure

1. Use the overhead "Gender-Based Approaches" to review the benefits of interventions that take into account gender.

2. Use the overhead "The Gender Management System" to both define and provide objectives for the Gender Management System. Use "GMS: Illustrated" to demonstrate how the enabling environment, structures, processes and mechanisms are all interrelated[25]:

#### The enabling environment

There are a number of interrelated factors that determine the degree to which the environment in which the GMS is being set up does, or does not, enable effective gender mainstreaming. The enabling environment includes the following:

political and administrative will and commitment at the highest level to gender equality and equity;
willingness of those stakeholders and implementers who have never been exposed to issues related to gender to acquire knowledge and skills in gender awareness, and gender analysis and planning;
a legislative and constitutional framework that is conducive to advancing gender equality;
a 'critical mass' of women in decision-making bodies;
adequate human and financial resources; and .an active civil society.

#### Structures

Enabling all the key stakeholders to participate effectively in the mainstreaming of gender into governments' policy and programming requires the establishment and/or strengthening of formal institutional arrangements within and outside government. These arrangements can be summarised as follows:

- a Lead Agency (possibly a National HIV/AIDS Coordinating Committee) which initiates and strengthens the GMS institutional arrangements, provides

[25] The following on enabling environment, structures and mechanisms is from Commonwealth Secretariat and Atlantic Centre of Excellence for Women's Health. (2002). Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach. London: Commonwealth Secretariat.

overall coordination and monitoring and carries out advocacy, communications, media relations and reporting;

- a Gender Management Team (consisting of representatives from the Lead Agency, key government ministries and civil society) which provides leadership for the implementation of the GMS; defines broad operational policies, indicators of effectiveness and timeframes for implementation; and coordinates and monitors the system's performance;
- an Inter-Ministerial Steering Committee whose members are representatives of the Lead Agency and the Gender Focal Points (see below) of all government ministries, and which ensures that gender mainstreaming in government policy, planning and programs in all sectors is effected and that strong linkages are established between ministries;
- Gender Focal Points (senior administrative and technical staff in all government ministries), who identify gender concerns, co-ordinate gender activities (e.g., training); promote gender mainstreaming in the planning, implementation and evaluation of all activities in their respective sectors; and sit on the Inter-Ministerial Steering Committee;
- Parliamentary Gender Caucus (consisting of gender- aware, cross-party female and male parliamentarians) which carries out awareness raising, lobbying and promoting the equal participation of women and men in politics and all aspects of national life and brings a gender perspective to bear on parliamentary structures and procedures, legislation and other matters under debate; and
- representatives of civil society (a National Gender Equality Commission/Council, academic institutions, NGOs, professional associations, media and other stakeholders), who represent and advocate the interests and perspectives of autonomous associations in government policy- making and implementation processes.

Mechanisms

There are four principal mechanisms for effecting change in an organization using a GMS:

Gender analysis: This clarifies the status, opportunities, etc. of men and women. It involves the collection and analysis of sex-disaggregated data which reveals how development activities impact differently on women and men and the effect gender roles and responsibilities have on development efforts.

Gender training: Many of the stakeholders in a GMS will require training in such areas as basic gender awareness and sensitisation, gender analysis, gender planning, the use of gender-sensitive indicators, monitoring and evaluation. Training should also include segments on overcoming hostility to gender mainstreaming and may also need to include conflict prevention and resolution and the management of change.

Management Information System: This is the mechanism for gathering the data necessary for gender analysis and sharing and communicating the findings of that analysis, using sex-disaggregated data and gender sensitive indicators. More than just a library or resource centre, it is the central repository of

gender information and the means by which such information is generated by and disseminated to the key stakeholders in the GMS.

Performance Appraisal System: Based on the results of gender analysis, the OMS should establish realisable targets in specific areas. For example, one target might be to reduce vulnerability to HIV / AIDS by ensuring that at least 90 per cent of young men and women have access to prevention methods by 2005. On achievement, further targets should be set. The achievement of these targets should be evaluated both at the individual and departmental level through a gender, aware Performance Appraisal System. This should not be separate from whatever system is already in place for appraising the performance of employees; rather the present system should be reviewed to ensure that it is gender, sensitive. The Performance Appraisal System should also take into account the level of gender sensitivity and skills of individuals (for example, as acquired through gender training or field experience).

3. Ask participants to form small groups comprised of individuals from similar organizational/institutional settings.

4. Ask small groups to consider what would be important to include in gender mainstreaming guidelines for an organization/ institute like their own and to begin to think what some of their guidelines might look like. Give each participant a copy of the "Gender Sensitivity Checklist" handout. The checklist can be used as a guide to provide ideas regarding program/policy development and implementation as well as organizational structure.

5. Give participants sufficient time to draft their framework/guidelines.

6. Small groups report back to the large group by describing what was included in their guidelines (e.g. key content areas). Ask participants to consider the similarities and differences across groups and what is critical to include in guidelines that mainstream gender into programs and services.

Overhead

# Gender-Based Approaches

**Gender sensitive interventions**

- Recognizes needs of men and women are often different because of physiology and context.

**Transformative interventions**

- Seek to change the underlying conditions that cause gender equities
- Reach both men and women: both seen as critical players
- Facilitate an examination of gender and sexuality and its impact on male and female sexual health and relationships
- Encourages examination of culturally prescribed expectations and norms
    - E.g. the dominant form of masculinity can be changed and replaced with more gender equitable models of manhood)

**Empowering interventions**

- Free women and men from impact of destructive gender and sexual norms
- Equalize balance of power between women and men
    - E.g. decrease gender gap in education, improve women's access to economic resources, increase women's civic and political participation, protect women from violence
- Deconstruct sources of power: individuals require access to information, education, skills
- Address the systems, mechanisms, policies and practices needed to support such genuine change

Overhead

## The Gender Management System[26]

Gender management system (GMS): an integrated network of structures, mechanisms and processes put in place in an existing organizational framework in order to guide, plan, monitor and evaluate the process of mainstreaming gender into all areas of an organization's work. Requires gender analysis, gender training, management information system and performance appraisal system.

Objectives of a gender management system in the context of HIV/AIDS would include:

- To promote systematic and consistent gender mainstreaming into HIV/AIDS policies, plans, programs and activities at all levels.
- To assist state and non-state actors to acquire gender sensitization, analysis and planning skills necessary for development and implementation of national HIV/AIDS strategies, policies, plans and programs.
- To strengthen the capacity of National HIV/AIDS Coordinating Agencies to direct, advise and coordinate national gender mainstreaming efforts in the area of HIV/AIDS.
- To create an enabling gender-inclusive environment in the fight against HIV/AIDS and address the differential impact of the pandemic on women and men at all levels.

[26] Source: Commonwealth Secretariat and Atlantic Centre of Excellence for Women's Health. (2002). Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach. London: Commonwealth Secretariat.

Overhead

GMS Illustrated[27]

[insert graphic]

[27] Source: Commonwealth Secretariat and Atlantic Centre of Excellence for Women's Health. (2002). Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach. London: Commonwealth Secretariat.

Handout

## Gender Sensitivity Checklist[28]

### Program/policy development

Does your program policy:

- Encourage community members, especially women and girls, to participate in the development planning process?
- Use innovative and non-traditional means to solicit the participation of community members, especially women and girls, in the development planning process? (For example, hold planning sessions where women usually gather, provide services to women so they can forgo their daily tasks in order to participate, etc.)
- Encourage community groups, especially women's groups, to participate in the development planning process?
- Encourage people living with HIV/AIDS (PLHA), especially women and girls, to participate in the development planning process?
- Include all participants, especially women and girls, in the development of program/policy goals and objectives?
- Provide gender training for program facilitators?
- Include facilitators who are members of the program's target population?
- Include facilitators who are comfortable with discussing gender-sensitive issues?
- Tailor activities to the particular economic, political and cultural realities of participants?
- Tailor activities to address the power imbalances between women and men and between girls and boys?
- Include participatory activities (group activities, role playing, brainstorming, mapping, story telling, etc.)?
- Produce educational materials that promote positive representations of women, men, girls and boys, as well as PLHA?
- Occur at a time and place that is convenient to all participants, especially women and girls?
- Provide transportation for participants in an effort encourage attendance?
- Provide childcare for participants during program activities?

### Program/policy implementation

Does your program/policy:

Encourage community members, especially women and girls, to participate in peer education? (For example, leading segments of the workshop/discussions, demonstrating condom use, etc.)

Encourage PLHA, especially women and girls, to participate in program implementation?

[28] Source: UNAIDS. (2001). Resource Packet on Gender and AIDS. Available at: www.unaids.org

Provide access to information and knowledge about HIV / AIDS to all participants equally?

Encourage discussion about socially assigned gender roles affecting women, men, adolescents and the elderly?

Enable women and men, and girls and boys, to understand one another's needs?

Attempt to ensure that women and men, and girls and boys, are listening to the needs of one another? (For example, have participants represent one another in role play, have participants summarize and repeat the issues raised in discussion, etc.)

Encourage discussion of the various social factors, such as economics, politics and social structures, that put women or men more at risk for HIV/AIDS?

Encourage discussion of the biological factors that put women or men more at risk for HIV/AIDS?

Encourage discussion of how gender inequality affects HIV/AIDS prevention, transmission, treatment and care?

Address the financial difficulties brought on by HIV/AIDS, which often disproportionately affect women and girls?

(For example, laws which do not allow women to inherit land from their husbands, the need for widows to seek out new forms of income to support their families, the burden of health care costs which often become the responsibility of women, etc.)

Encourage discussion of the power imbalance between women and men, girls and boys, and how these imbalances affect the transmission and prevention of HIV / AIDS? (For example, the difficulties women face in insisting that their partners use condoms, the ability to choose when and with whom to have sex, etc.)

Encourage discussion of how empowerment of women and girls could help lessen their vulnerability to HIV/AIDS? (It is crucial to include men and boys in this discussion so they can participate and support their wives, sisters and mothers as opposed to becoming threatened by their empowerment.)

Work to eliminate the power imbalance between women and men and between girls and boys?

Address the issue of violence against women and girls?

Provide opportunities for women and girls to become empowered through HIV/AIDS education? (For example, enhance the self-confidence of women and girls by encouraging them to attain new skills, take on more responsibilities as desired, become local leaders in health promotion, etc.)

Encourage and acknowledge the support that women and girls can provide to one another.

Encourage equal communication among participants about sexuality, sexual health and sex practices (dry sex, anal sex, sex with commercial sex workers, etc.)?

Address the double standard that exists between men and women in relation to sexual activity? (For example, men being allowed to engage in sex outside of marriage while women are not, men being expected to have sexual experience before marriage while women are not, etc.)

Address the issue of sexual abuse (rape, incest, etc.)?

Address adolescent sexuality and the affect it may have on HIV/AIDS?

Address the importance of equal access to education for both girls and boys?

Address the sexual and reproductive health needs of children and adolescents?
Facilitate awareness in adults of the sexual and reproductive health needs of children and adolescents?
Encourage adults to address the sexual and reproductive health needs of children and adolescents?
Provide demonstrations to all participants on how to use both the male and the female condoms and encourage all participants to practice their use?
Encourage discussion about the possible difficulties associated with condom use experienced by both women and men?
Address how HIV/AIDS affects how women and men make reproductive choices?
Encourage the involvement of both women and men in family planning?
Address how to avoid HIV transmission from mother to child (both before and during birth)?
Address the need to improve the quality of health services for women and girls?
Address the need to improve access to health services for women and girls (transportation, financial, etc.)?
Address the various health care changes that occur over a lifetime and how these changes affect HIV/AIDS treatment and prevention? (For example, a women's health needs and HIV/AIDS susceptibility may change significantly as her body changes through adolescence, child~ bearing years and menopause.)
Encourage men and boys to participate equally in HIV/AIDS prevention efforts?
Encourage men and boys to help with domestic tasks as women's lives are impacted by HIV? (Greater assistance with domestic tasks may be needed if a mother, sister or wife becomes ill, if she has to care for infected loved ones, if she has to begin to generate the family income, etc.)
Encourage men to become more involved in the care of their families?

Organizational structure

Does your organization:

- Have stated policies that affirm a commitment to gender awareness (goals and objectives, mission statement, etc.)?
- Encourage and support participation among women and men in practices and activities? (For example, do both women and men have an opportunity to participate in discuss ions, to manage and develop programs/projects, to hold advisory positions, to participate equally in planning and implementation of services, etc.)
- Monitor internal practices in an effort to identify areas that are not currently gender sensitive?
- Continually adapt internal practices in an effort to remain gender sensitive?
- Support gender awareness among staff? (For example, provide gender sensitivity training to staff members at all levels.)
- Have ideas of gender sensitivity formalized at all levels? (For example, include gender sensitive practices from entry level positions through top management level.)

- Employ both women and men?
- Provide women with access to a variety of positions at all employment levels?
- Pay women and men the same for equal work?
- Support the needs of employees, both women and men, with families? (For example, provide childcare facilities, allow employees to work flexible schedules, provide leave to care for loved ones, etc.)
- Provide both women and men with access to training activities and extension services to facilitate professional development?

## Force Field Analysis[29]

Objective: To identify both the resources and forces that push, or can be mobilized to push, for gender mainstreaming, as well as forces that tend toward the status quo, or even toward some sort of negative situation.

Time: 75 minutes

Materials: Flipchart, markers, tape, overhead projector, "Force Field Analysis" overhead.

### Procedure

1. Introduce the objective of the activity by stating how it is important to take into account organizational/institutional willingness and capacity to adopt a gender mainstreaming approach to HIV/AIDS.

2. Offer the group the analogy of a force field as shown in the diagram. The arrows pushing down are barriers from within the organization, institution, etc., which are preventing the goal (in this case, gender mainstreaming). The arrows pushing up are any resources or forces which are available to further the achievement of this goal.

3. Break the large groups into small groups (this activity works best when the small groups are comprised of people who work in the same situation – organization, institution, etc.).

4. Ask them to construct a force field, as in the overhead. Name the particular forces – lack or possession of a particular resource, support or opposition from a significant individual or group – and indicate how strong the forces are and whether they are pushing towards the achievement of gender mainstreaming or against it.

5. Explain that movement towards the goal of gender mainstreaming can occur through either increasing the helper forces or by weakening the hindering force. Ask the small groups to choose either one of the helping forces which they could strengthen or one of the hindering forces which they could reduce or weaken (a sub-goal).

6. Once selected, ask small groups to draw a new diagram listing the helping or hindering forces related to this new sub-goal. This process can be done 2 or 3 times.

7. In the large group, ask the small groups to summarize their discussion. Encourage questions and comments.

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[29] Methodology adapted from: Lee, Bill and Balkwill, Mike. (1996). Participatory Planning for Action. Toronto: CommonAct Press and Hope, Anne and Timmel, Sally. (1995). Training for Transformation: A Handbook for Community Worker. London: ITDG Publishing.

Overhead

Force Field Analysis

[insert graphic]

## Pulling it All Together: Developing Gender Sensitive Programs

Objectives: To apply gender mainstreaming to program development

Time: 2 hours

Materials: Flipchart, marker, participant notebooks, pens. Handouts: "Developing Gender Sensitive Programs", "Information, Education and Communication Programs", "Home-Based Care Programs", and "Counselling Programs".

### Procedure

1. Ask participants to form six groups comprised of individuals from similar geographic regions.

2. Give each participant a copy of the "Developing Gender Sensitive Programs" handout. Give two groups the "Information, Education and Communication Programs (IEC)" handout, two groups the "Home-Based Care Programs" handout and two groups the "Counselling Programs" handout.

3. Each group is to go through the steps of designing a program, relevant to their geographic context, using the handout as a guide. Give the groups sufficient time to design their programs.

4. Afterwards, ask the two groups who designed the IEC program to get together, the two groups who designed the Home-Based Care program to get together and the two groups who designed the Counselling Programs to get together to share and discuss their program design, paying particular attention to the similarities and differences, strengths and challenges.

5. In the large group, ask the three groups to highlight the key components of their program design. Probe for similarities and differences, strengths and challenges, key insights, critical factors for success.

Handout

## Developing Gender Sensitive Programs

Program:

1. Situation analysis and problem identification

2. Design and formulation

3. Implementation and management

4. Monitoring and evaluation

Handout

## Information, Education and Communication (IEC) Programs[30]

*Situation analysis and problem identification*

- Collect information on key gender issues in the country relevant to IEC programming by linking with advocacy and gender groups. This can help in the development of IEC messages aimed to reach disadvantaged populations, including women, on issues related to their rights and their ability to protect themselves from HIV. Messages on HIV prevention can be combined with messages on women's rights, property rights, family law, domestic violence, sexual harassment, inheritance, etc.
- Examine the reasons why behaviour change has been difficult to achieve for men and women, despite growing awareness about AIDS. IEC programs need to be able to address the complexity of gender relations that contribute to the spread of sexually transmitted infections.
- Analyze innovative IEC activities (inside and outside the country) on gender issues related to sexual and reproductive health. This can help influence organizations to adopt more innovative and gender-responsive approaches to IEC programming.
- Assess the level of government and NGO promotion of gender equality objectives in the country. This will help reveal how conducive or constraining the environment is for the implementation of empowering IEC strategies on reproductive and sexual health issues.
- Collect gender-disaggregated data (data that separate out men and women) on the groups to be reached by the IEC messages. If you aim to reach young people, for example, you might want to look at where girls and boys go for health information.
- Avoid concentrating only on the community level. While the community level is where gender inequalities reveal themselves, other levels (such as the institutional/organizational and policy level) play an important role in perpetuating discrimination and gender stereotypes.

*Design and formulation*

- Assess the gender needs of the different stakeholders of planned IEC activities. In this process, identify the main group for whom the messages are intended: women, men, youth, etc. A participatory and gender-sensitive approach should be used to help the recipients identify their own issues to be addressed in IEC messages. This will help reveal perceptions and attitudes related to AIDS. For example, messages that encourage people to abstain from sex or to use condoms without highlighting other related sexuality issues might not be appropriate or effective.

[30] Source: Southern African AIDS Training Programme. (2001). Mainstreaming Gender in the Response to AIDS in Southern Africa. Zimbabwe: Author.

- The collected information should be built into a project plan that reflects gender-specific concerns. The plan should be assessed to ensure that the messages reach and involve different social groups (women, men, adolescent girls and boys).
- Consider who should be delivering IEC messages. Peer education programs, for example, have often used women to deliver HIV prevention messages to men in bars, at work, or at truck stops. Test whether programs are more effective if messages are delivered by men or by women.
- Efforts should be made to develop IEC messages that promote public discussion on cultural issues and on gender and sexual inequality.
- Develop a gender-focused budget for IEC activities. Gender mainstreaming in budgeting for IEC includes allocating budgets explicitly for activities that reach women and activities that reach men. For example, budgets might include funds for specific messages to encourage male involvement in counselling or to challenge gender stereotypes.
- Develop a monitoring plan that includes gender as an important variable when assessing the IEC program's effectiveness, efficiency, reach, and impact.

*Implementation and management*

- Decide which type of implementation strategy to adopt -women-specific or mainstreaming gender components throughout all program activities - and why. A women-specific IEC activity focuses messages towards girls or women. A gender mainstreaming approach uses I EC messages geared towards addressing specific needs and issues of both men and women. Both approaches can be utilized, depending on the situation and context. A woman-specific approach can help to close certain information gaps that have been identified. For example, widows may benefit from information on inheritance rights that can be delivered in an IEC program.
- Public awareness messages for HIV prevention should use empowering approaches that are gender-sensitive and participatory. Vulnerable groups are reached more effectively if they are actively involved in designing and delivering the program. What messages on AIDS are being delivered to sex workers? To people with disabilities? From whose perspective? Do the messages focus on general sexual behaviour or do they take issues like women's sexual satisfaction into consideration?
- Gender-oriented approaches to IEC need to be flexible, supportive, and committed. All material should be reviewed to identify and remove possible gender bias and stereotyping.
- Look for innovative IEC materials with empowering messages that challenge conventional norms. For example, show a husband and wife attending a clinic together, or communities engaging in discussions on sexuality and AIDS.
- IEC materials and messages need to avoid gender stereotyping and projecting gender insensitive messages to the public. Too often such materials have drawn upon prevailing ideas of male sexuality. Women are often portrayed as one of two stereotypes: weak and innocent victims, or sex workers and adulteresses. In the process of developing IEC materials, an organization or a program can either strengthen stereotypes or transform them to promote gender equality objectives.

*Monitoring and evaluation*

The monitoring and evaluation framework will have been developed during the program design phase. Everybody in the organization who implements IEC activities should use the framework to ensure that these activities achieve the expected impacts. Questions on gender issues in IEC activities to be monitored include:

- What messages are we conveying about male and female gender roles?
- What progress, impact, or benefit is being measured?
- From whose perspective?
- How are changes being documented?
- How are we using the information from the records?
- Do the monitoring tools capture the different perceptions of various groups, including disadvantaged or stigmatized groups?

The following criteria are important when developing qualitative indicators for monitoring IEC materials and processes:

- perceptions on women's control over resources and decision-making;
- changes in attitudes of men and women at household and community levels;
- male participation in activities such as counselling and home-based care;
- women's and men's attendance at health care facilities;
- women's participation in sexual decision-making.

Monitoring and evaluation teams should be gender sensitive and gender balanced. Gender monitoring and reporting should be part of their terms of reference.

## Case Study/Example: *SIDA dans la Cité*

High levels of HIV infection in Côte d'Ivoire have created an urgent need for effective HIV prevention programmes. Although HIV prevention programmes that rely on mass media, such as radio and television, generally cannot restrict their broadcasts to high-risk groups, they have the advantage of reaching both that audience and the rest of the population at no additional cost. So if such programmes are proved effective in promoting safer sexual behaviour, they are a valuable tool in the fight against the spread of the HIV virus.

*SIDA dans la Cité* is a weekly TV soap opera on AIDS, describing the life of a family touched by HIV/AIDS and aiming to inform and educate the public about the disease. Two series were produced and the paper focuses exclusively on the second series which was broadcast on Thursday evenings, immediately following the eight o'clock news, from October 1996 to February 1997. Both series were produced as part of the condom social marketing programme implemented by Population Services International (PSI)/Côte d'Ivoire and its local partner, Ecoform Development (ECODEV). This programme, which started in 1991, distributes *Prudence* brand condoms at subsidized prices in pharmaceutical and other commercial outlets, and promotes the brand through an ongoing advertising and information campaign.

This study is based on a cross-sectional survey containing information on exposure to the TV series, sexual behaviour and condom use among a random sample of 2,150 respondents aged 15 to 49 living in three different regions. The series had high exposure, with 65% of the sample having seen at least one episode.

The results indicate that viewers of *SIDA dans la Cité* are more likely than non-viewers to have engaged in risky sexual behaviour. Since the series was most popular among those people who engage in risky sexual behaviour, it effectively reached a large share of those segments of the population most likely to contract and transmit the HIV virus. The results also show that viewers of the series, particularly the men, were significantly more likely to engage in protected sex, and that this propensity to use condoms increases with the individual's level of exposure to the series. This finding is partially explained by the fact that viewers have socio-economic characteristics that are associated with higher condom use; for example, levels of education and occupation. However, women who have seen 10 or more episodes of the soap opera *SIDA dans la cité* (about one quarter of all sexually active women), and men who have seen five or more, are significantly more likely than others to have used condoms in their last sex act, even after controlling for various socio-economic characteristics.

This analysis shows that television soap operas on AIDS, such as this popular series in Côte d'Ivoire, can be an important tool for promoting condom use. Even though TV programmes can only be used in regions with electricity, they tend to reach a large fraction of the population in those areas. Moreover, such programmes are most appealing to viewers who tend to engage in risky behaviour, which implies that they have good reach among those individuals who are likely to have the largest impact on HIV transmission. The finding that it takes at least five episodes of the series before there is a net effect on condom use implies that repeated exposure to HIV/AIDS information is needed. So HIV prevention programmes that provide continuous information through multiple media channels –which may include producing multiple soap opera series and/or repeating the broadcasts – are likely to have the greatest impact on condom use.

Handout

## Home-based Care Programs[31]

*Situation analysis and problem identification*
The situation analysis should identify the gender issues that are relevant to the proposed home-based care initiatives. These might include:

Access to health services, trends in health financing, changes in health care policies, and the gender implications of these;
Participation of women in planning health services or allocation of health care resources;
Gender inequalities in access to housing, water, and sanitation.

Review the health care options available for people living with AIDS (e.g. hospital care, hospice care, home care) asking these questions:

What do we know about the gap between hospital beds or home-care spaces needed and beds or spaces provided for men and for women?
What is the gender breakdown of people with AIDS currently being served by home-based care programs? Is it consistent with AIDS prevalence rates by gender? If not, why not?
Do women have the same level of access health services as men? If not, why not? (e.g. attitudes of staff, poverty, lack of transport)?

Examine the gender roles and stereotypes that affect home-based care programs:

- Who is responsible for caring for the sick and the dependent (at home and professionally)?

What happens to women who need home care? What happens to men who need home care?

Review research on the household impact of AIDS. How do families cope with sickness or death in the family? Consider the gender dimensions of this research (e.g. access to education for girls, orphan support for girls and boys, issues of poverty and inheritance, etc.). If there is no research available that applies to the community of your program, consider organizing focus groups to discuss these issues. Be sure to report and distribute the results of these discussions.

Identify other individuals and organizations in the community that have an interest in the delivery of health and social services that may be useful resources for the home-based care program and its clients.

*Design and formulation*
One of the gender issues that a home-based care program should address is the fact that in most communities the burden of home care is carried predominantly by women. Strategies to address this issue may include:

[31] Source: Southern African AIDS Training Programme. (2001). Mainstreaming Gender in the Response to AIDS in Southern Africa. Zimbabwe: Author.

increasing the involvement of men in home care;
reducing expectations of women;
providing respite care for caregivers;
providing alternatives to home care in the program.

Integrate the home-based care program in a comprehensive offer of services to meet the social, psychological, health, spiritual, economic, information, and practical needs of families affected by AIDS.

Providing home-based counselling offers an opportunity for the home-based care program staff to engage families and the broader community in a discussion of gender issues related to sexuality, gender roles, domestic violence, etc. This will require relevant gender skills and support.

Identify the gender needs of:

- **Home care clients:** Do men and women have different needs and concerns? Areas to be explored include access to medication; emotional, physical, sexual or economic abuse; reproductive health concerns; assistance with planning for family members.
- **Home care providers:** (family members) Gender needs may be related to information, supplies, community support, respite (a break when someone else can do the care-giving), assistance with other responsibilities in the home, assistance with long-term planning, the option to not provide care or to share care responsibilities between men and women, protection from abuse.
- **Home care facilitators:** (usually volunteers recruited by the program) The needs among volunteers may be related to issues of promoting the involvement of men, training and skills development (e.g. monitoring for abuse), transportation, recognition, burn-out.
- Remember to consider longer-term strategic needs that can contribute to *empowerment* (e.g. more appropriate health care services, changes in the law, support groups for care providers, etc.) as well more immediate or practical needs (e.g. supplies, transportation, etc.).

Use participatory planning approaches to help ensure that the needs of the participants in the program are identified and reflected in the program design. There should also be a mechanism that allows clients, care providers, facilitators, and other stakeholders in the program to provide regular feedback to the program management.

*Implementation and Management*

- The way home-based care is delivered can re-enforce gender stereotypes and inequalities. Home care facilitators should therefore be trained to recognize these stereotypes and to avoid them.
- One of the main gender issues in home-based care is the lack of involvement of men as care providers and facilitators. Hold a discussion in your community to see how this situation might be changed. Try and enlist support from influential

men in the community, raise this issue in IEC activities, or offer additional training and support to men moving into this unfamiliar role.

- Home care facilitators should be familiar with the range of resources and support available in the community. This includes being familiar with the services and procedures of groups and organizations against gender violence, involvement in gender advocacy, or providing legal support on issues such as estate planning or inheritance. Home care facilitators should also be trained to detect gender violence and to respond appropriately and effectively when they suspect that a family member is subject to abuse.

*Monitoring and Evaluation*

All data collected on the clients of the home-based care program, the care providers, and the care facilitators should be disaggregated by gender. These data frequently show that women are under-represented as clients or men are under-represented as care providers. The program design and implementation should address these imbalances. Monitoring should tell you how successful your program is in this regard.

The choice of monitoring and evaluation indicators is guided by the objectives of the program and should include indicators to monitor and evaluate the gender impact of the home care program. Monitoring may answer the following questions:

- What impact does the program have on the workload of women and men?
- What impact does the program have on the economic situation of women and men?
- Is there evidence of an increase in the number of families that have wills or have made provisions for their children in the event of the death of one or both parents?
- Is there evidence that women are becoming empowered through their involvement in the program and the support it offers?
- Is there evidence that men are becoming more involved in home care activities?
- Has there been advocacy to raise public awareness of some of the gender issues of home care?
- Does the program address the practical and strategic gender needs of men and women?

## Case Study/Example: Mobilizing Men as Home-Based Care Volunteers

*The Issues*

Community Home Based Care (HBC) is a proven cost effective way of caring for people with chronic illness. HBC projects depend on local volunteers to provide the care and support needed by the sick and their families. Most HBC volunteers are women — often because caring is seen as a traditionally female role. Female volunteers cannot always provide the full range of services required by clients, especially men, for social and cultural reasons. In addition, female volunteers alone cannot meet the needs of the growing number of community members needing help — it is necessary to mobilize men.

*Case Study: Word Alive Ministries International*

*Word Alive Ministries International* is a church-based community organization in Blantyre, Malawi. In 1992, it began providing counselling for people being tested for HIV at the city's main government hospital. By 1996, it was clear that clients needed support beyond post-test counselling. As a result, the Intervention Counselling and Care Project was started — with the aim of reducing HIV transmission and mitigating the impact of HIV and AIDS by providing *Home Based Car*e. HBC work is carried out by volunteers who perform many roles, including counselling, basic nursing care, spiritual support, training and supporting caregivers and supervising TB treatment. They also help with household tasks, promotion of HBC in the community, distribution of condoms, referrals for treatment and liaison with local community leaders. As their work developed, the project found a major gender imbalance was emerging (40% of home care clients were men, but all HBC volunteers were women); cultural barriers limited the ability of female volunteers to meet the needs of male home care clients; and demand for home care kept increasing.

*The Community's Response*

World Alive Ministries decided to mobilize male HBC volunteers – both to reach more people and to improve their breadth and quality of HBC services for men.

In practice, they found that this was not a question of doing one thing. Instead, it involved combining several different strategies, including:

- Making a conscious, organisational decision to recruit and train men.
- Conducting a baseline knowledge, attitudes and practices (KAP) survey, including questions about men's attitudes and behaviours.
- Involving community members and leaders in identifying male volunteers who are respected and influential in the community.
- Breaking down myths and stigma about care work and HIV/AIDS by giving local men the chance to see male volunteers "in action".
- Encouraging community leaders to challenge any teasing that care work is "unmanly".
- Targeting men with flexible working hours, such as those who run their own business or those who are not formally employed.
- Targeting men motivated by compassion, love and faith rather than money.
- Involving a range of ages — young as well as older men.
- Having a written agreement with each volunteer that outlines what is and is not expected of them, and what the project can/cannot provide.
- Giving male volunteers — alongside female volunteers — training in relevant personal and technical skills, such as counselling and bathing clients.
- Providing support and supervision to volunteers.
- Carrying out follow-up surveys to assess the project's impact.

*Key Lessons*

- It can be done! But mobilizing men does not happen by chance. Community groups and organizations need to make a strong and deliberate decision to do it.

- Involving male HBC volunteers can improve basic nursing services for men. For example, a male volunteer can bathe a male client, rather than have to leave it to the female relatives.
- Man-to-man counselling is particularly effective in relation to sensitive issues such as sexually transmitted infections and condom use.
- The involvement of community leaders is vital. Local leaders have an important role in identifying appropriate male volunteers and breaking down stigma around HIV and AIDS and around home care work. Male community leaders can also become HBC volunteers themselves.
- Mobilizing male volunteers has positive "knock on" effects in the broader community. It helps to tackle unhelpful gender stereotypes and can encourage a more comprehensive community response to HIV and AIDS.
- Male HBC volunteers increase the acceptance of condoms among men — they can more easily promote condoms to their peers.
- Male volunteers are important advocates for encouraging other men to become involved in care and support. Enabling male community members to accompany their peers during care activities can be a powerful advocacy tool.
- Written agreements help to clarify the work and the relationship of the volunteer to the project and the community. They can also reduce unrealistic expectations, for example about financial payment for the work.
- Group discussions and training sessions for HBC volunteers become more interesting and useful when there is a better gender mix.
- Providing regular support and supervision to volunteers ensures provision of quality care. Male volunteers may need additional support to help them counteract gender stereotypes.
- "Before" and "after" studies provide data to demonstrate success. They will show whether by mobilizing more male volunteers there is any impact on the quality or coverage of HBC, and show evidence of any broader influence on the community.

Handout

## Counselling Programs[32]

*Situation analysis and problem identification*
Information on the gender issues in AIDS counselling, particularly in relation to culture-laden beliefs and issues, might include:

Sexuality, especially attitudes and beliefs related to homosexuality;
Norms of virginity, sexual initiation, and female and male genital cutting;
Women's rights (e.g. inheritance, decision-making);
Norms about masculinity, femininity, and marriage;
Stigmatization (e.g. female sex workers, men who have sex with men);
Coercion and violence;
Ideas about illness and death (e.g. the role of traditional healing);
Unequal power relations.

This information will be relevant during the formulation of a gender-sensitive counselling program. Other questions to ask are:

What counselling services are available in the community?
What form of counselling do men and women prefer (individual counselling, couple counselling, peer counselling, group counselling)?
Are HIV testing services accessible for men and women? T What prompts men and women to go for counselling? T What are their needs and concerns?
Are there gender differences in need and access to counselling?

Gather information on gender-related risks that may arise from counselling: e.g. women may risk violence from the partner when testing positive for HIV when disclosing their HIV status, when initiating safe-sex discussions, etc.

*Design and formulation*

- Counselling should provide opportunities for women and men to explore their situation, to discuss their feelings and needs openly, to find an empathetic and non-judgmental listener, and to explore ways of meeting their needs.
- Counselling facilities should support gender-friendly approaches and provide an environment that can protect the confidentiality of women and men. Counsellors should be equipped to explore issues of gender inequality and work towards women's empowerment.
- Develop counselling approaches that consider the different roles and needs of men and women, in terms of information, support, and involvement. For example, a woman who has tested positive for HIV and has been counselled may face violence when disclosing her HIV status to her partner. This means that in some cases it is better to provide pre- and post-test counselling to both partners together.

[32] Source: Southern African AIDS Training Programme. (2001). Mainstreaming Gender in the Response to AIDS in Southern Africa. Zimbabwe: Author.

- Ensure that the counselling staff is gender balanced and that there are sufficient male and female counsellors to adequately meet the needs of clients. The gender focus of the counselling program should be reflected in its budget. Funds for gender training of counselling staff need to be identified, as well as budgets for women-specific and for gender-focused counselling activities.

*Implementation and Management*

- A gender-sensitive approach to counselling takes women's social and economic vulnerability into consideration and explores associated factors. For example, a woman with children whose husband has died of AIDS may need support on issues such as inheritance and ownership. The counsellor should be able to link her with an organization that can help her address these issues.
- Counselling programs need to establish links to other initiatives that address the needs of affected men and women. Income-generating or micro-credit programs may offer a point of entry for empowering men and women living with HIV
- Issues of sexuality can be addressed effectively in group counselling sessions and age- and gender-specific discussion groups. These groups can provide a space for women, men and youth to raise issues in safety. Group debates encourage healthy discussions that challenge social norms contributing to vulnerability to HIV.
- Counselling primarily serves women's practical needs, but it can also promote the realization of women's and men's strategic needs. Without compromising the task of providing emotional support and practical advice, counsellors should strive to promote gender equality and to deconstruct gender stereotypes.

*Monitoring and evaluation*

- The monitoring framework should use qualitative indicators that measure changes in attitudes, levels of participation, and trends in the social environment related to issues of sexuality and sexual relations. Gender aspects of counselling that can be monitored are the degree of confidence-building among women and changes in men's openness to discuss issues of sexuality.
- The achievements and constraints of different counselling approaches, such as group counselling or couple counselling should also be documented. Tools and skills should be developed to trace how women and other disempowered groups benefit from counselling services.

## Case Study/Example: Confidential Approach to AIDS Prevention

Confidential Approach to AIDS Prevention (CAAP) is a Hotline Education Centre, based in Dhaka, Bangladesh, providing HIV/AIDS information and carrying out counselling and action research.

The overall goal of the project is to prevent and control the spread of HIV/AIDS in Bangladesh, through awareness creation and social mobilization. It aims to promote safer sex behaviours and to provide care and support for people with HIV and their families. Its target beneficiaries are: young people between 16 and 30, mainly high school, college

and university students; garment workers in factories; slum dwellers; pregnant women attending antenatal classes, and community leaders.

HIV/AIDS in Bangladesh is at the beginning of a fast-growing epidemic which will become a major cause of morbidity and mortality for the adult population and children within the next few years. In Bangladesh, sexual behaviour is a domain of privacy and confidentiality. The initial reaction of rigid Bangladesh society to an open discussion of reproductive health education or education on sex and HIV/AIDS is influenced by myths, misconceptions, taboos and discrimination leading to social rejection. Sex is a forbidden subject for students and teenagers; teachers totally skip the chapter on reproductive health. There is no welcoming place where they can discuss the issue in a free and friendly atmosphere.

Realizing the dangers, some concerned women, with expertise in different disciplines, felt the moral responsibility to save young people from the clutch of the deadly disease and formed an organization to provide a culturally accepted means of providing information, education and skills to prevent it. So CAAP was formed in 1996.

***Services***

In the centre, the services include providing information and/or counselling anonymously over the telephone, and by post; individual and group education and counselling; crisis counselling and emotional support; anonymous HIV testing and pre/post counselling; capacity building, and clinical services. Callers from all over the country can call the Centre between 9am and 5pm, five days a week (Sunday through Thursday) and can receive information, education, counselling and problem-solving advice. Toll free services cannot be provided by the Telephone and Telegraphic Board in Bangladesh. Letter counselling is also provided in order to offer a cheaper alternative to the telephone and reach a wider population. There is a computerized system of recording and analyzing queries.

There is also a mobile unit. A team of communicators trained in the field of HIV/AIDS conduct education/advocacy sessions and disseminate information and counselling to students, garment workers, pregnant women at antenatal clinics, and others. Once a month there are education sessions for students and garment workers and different teaching materials are provided for different levels of literacy. There are demonstrations of condoms and disposable syringes. The effectiveness of such sessions is evaluated by using pre- and post-session questionnaires. There are similar sessions held every week in the city's slums where poverty-stricken, illiterate people are vulnerable to adopting risky behaviours leading to HIV infection.

Health Shop is a family health care initiative; clinical services for any ailments are provided to whoever wants or needs them, for a minimum charge. It includes a Mini Lab which offers free anonymous HIV testing for people with high risk behaviour. It also aims to promote the use of condoms, to encourage behaviour change through counselling and to detect people with positive HIV status and provide them with a supportive environment. The health Shop is open from 9 to 4 during the day, and 6 to 9 in the

evenings, five days a week Sunday through Thursday. So far 500 individuals have been tested, and five of them were found to be HIV positive.
Other activities include capacity building programs for staff, networking with other NGOs, action research and media linkage.

The International Institute on Gender and HIV/AIDS
Day 4 & 5: Agendas
Human Rights

Day 4

9:00 Panel/speaker: human approaches to HIV/AIDS

9:45 Human rights from a personal perspective

10:45 Break

11:00 He has HIV/She has HIV

12:00 Lunch

1:00 Critical Imperatives Facing Men and Women

2:45 Break

3:00 The Long Walk/Plague of the Century

4:30 Wrap-up (see Appendix 3)

Day 5

9:00 Newspaper Analysis: Human Rights and the Media

10:30 Break

10:45 UN Guidelines and Declarations on HIV/AIDS in Your Country

12:00 Lunch

1:00 Energizer (see Appendix 2)

1:15 Speaker: policy development

2:15 Break

2:30 Pulling it All Together: A Workplace policy

4:30 Wrap-up (see Appendix 3)

## Human Rights From a Personal Perspective[33]

Objectives: To increase awareness that the promotion or violation of rights is easily identifiable and relevant to everyone's life, to understand that the realization of rights is necessary for HIV/AIDS.

Time: 60 minutes

Materials: Flipchart, markers, handouts: "Personal Accounts of Rights Being Violated" and "Universal Declaration of Human Rights"

### Procedure

1. Divide participants into groups of five. Give each participant a copy of the "Personal Accounts of Rights Being Violated" handout. Give small groups sufficient time to work through the handout.

2. In the large group, ask each small group to report on the rights they considered relevant to their group. Ask: Why did they see these as important? Note the rights mentioned on the flipchart. Each group should add to the list the rights that have not been mentioned yet. At this point, do not go into the stories behind the rights. Some possible rights that may emerge include:

- right to health
- right to security
- right to be treated equally
- right to respect
- right to emotional fulfillment
- right to information
- right to choice
- right to dignity
- right to earn an income and support a family
- right to make decisions concerning one's life
- right to education.

3. Ask participants to volunteer to share stories about what they consider to be violations of rights which impacted on sexual and reproductive health and rights, including HIV/AIDS. Some possible examples may be:

- female genital mutilation
- the right to be informed when one's partner tests positive for HIV
- the right to health workers to be protected from HIV infection

[33] Source: WHO. (2001). Transforming Health Systems: Gender and Rights in Reproductive Health. Geneva: Author.

- the right to choose one's marriage partner
- the right to use a contraceptive method of one's own choice without overt or covert coercion from the health system
- the right not to be discriminated against in the labour market because of having children

4. Hand out copes of the "Universal Declaration of Human Rights". Give participants a few minutes to read it individually. Ask them to skip over the preamble and begin with Article 1.

5. Go over each of the rights on the flipchart and ask participants to identify which article in the UDHR most closely addresses it. One point which is often raised, is whether something can be considered a violation of rights even when it is legal within a country's framework. Make it clear that the answer can be yes.

6. Wrap-up the activity by pointing out that human rights standards are relevant to laws, policies and practices. Governments have the primary obligation to promote and protect rights, and they also draft the international standards. Governments have an obligation to amend national laws to be in line with international human rights standards and to ensure that their laws are not in violation of their international human rights obligations. Those advocating for change in legislation or procedures can use international human rights norms to call attention to the gap between the national law and the international standard, and thus hold governments responsible for appropriately amending their laws.

Handout

## Personal Accounts of Rights Being Violated

1. Thinking back on your own life
Spend two minutes alone recalling one incident when you felt a right was violated.

2. Sharing
Share your story with the group if you feel comfortable.

3. Name the rights
At the end of each story, the person sharing should try to name which rights s/he thinks were relevant to the story and in what ways. Write these down. Group members are then free to suggest other rights which they feel were relevant.

4. Develop a list
Start a list of rights from these contributions. Each person shares a story until everyone who wants to speak has had a turn. As the list of rights grows, each time a right is relevant to more than one person's story put an X next to it. If the group is large, try to restrict stories to avoid repetition.

5. Look for systematic differences
Are there systematic differences in the violation of rights that different members of your group have reported on? For example, by race, class and sex? In other words, are women more at risk of experiencing a rights violation and more likely to report violation of the right to non-discrimination, compared to others?

6. Generalizing to uncover further relevant rights
As a final step before returning to the large group, revisit the stories that related to sexual and reproductive health and HIV/AIDS. Go beyond the story to consider the additional rights you could add to the list if the group considered the issue in general terms. In human rights terms, these are some of the issues likely to be relevant:

- the right not to be discriminated against
- the right of access to health services
- the right to information.

Handout

## Universal Declaration of Human Rights[34]

### Preamble

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore,
The General Assembly,
Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

[34] OHCHR. (1948). Universal Declaration of Human Rights. Geneva: Author.

Article 1: All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2: Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3: Everyone has the right to life, liberty and security of person.

Article 4: No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6: Everyone has the right to recognition everywhere as a person before the law.

Article 7: All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8: Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9: No one shall be subjected to arbitrary arrest, detention or exile.

Article 10: Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11: Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.

No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12: No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13: Everyone has the right to freedom of movement and residence within the borders of each State.

Everyone has the right to leave any country, including his own, and to return to his country.

Article 14: Everyone has the right to seek and to enjoy in other countries asylum from persecution.

This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15: Everyone has the right to a nationality.

No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16: Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

Marriage shall be entered into only with the free and full consent of the intending spouses.

The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17: Everyone has the right to own property alone as well as in association with others.

No one shall be arbitrarily deprived of his property.

Article 18: Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice,

worship and observance.

Article 19: Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20: Everyone has the right to freedom of peaceful assembly and association.

No one may be compelled to belong to an association.

Article 21: Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

Everyone has the right to equal access to public service in his country.

The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22: Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23: Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

Everyone, without any discrimination, has the right to equal pay for equal work.
Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24: Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26: Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory.
Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27: Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28: Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29: Everyone has duties to the community in which alone the free and full development of his personality is possible.

In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.
These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30: Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

## He has HIV/She has HIV[35]

Objective: To highlight the gender based discrimination affecting people living with HIV / AIDS.

Time: 60 minutes

Materials: "He has HIV and She has HIV" handout, overhead projector, "Human Rights Abuses – He Has HIV/She has HIV" overhead.

Procedure

1. Divide the participants into small groups and distribute the handout: "He has HIV / She has HIV."

2. Ask participants to read the handout and enact a role-play depicting the scenario presented. Inform participants that this handout was adapted from discussions with poverty stricken women in India some of them living HIV/AIDS. As such, participants should be encouraged to use the given scenarios as a guide, and use their own experiences/imaginations in developing the role-plays. They are given 20 minutes to plan their performance.

3. Invite each group to perform their role-play, allocating five minutes to each group.

4. Sum up areas of gender based discrimination in the lives of people living with HIV / AIDS linking up the role-play to the information in the "Human Rights Abuses – He Has HIV/She has HIV" overhead.

5. To wrap-up, ask participants what reactions and feelings emerged during the role-plays.

[35] Adapted from: UNIFEM. (2000). Gender, HIV and Human Rights: A Training Manual. New York: Author.

Handout

He has HIV/She has HIV

| | He has HIV | She has HIV |
|---|---|---|
| The Doctor breaks the news | You have tested positive for HIV. This is a terminal illness. Be careful about your health. | You have tested positive for HIV. This is a terminal illness. Make sure that you do not conceive as it will transmit to your child and you will be the one to blame for the misery which the child will suffer. If you are pregnant, it is imperative that you abort the child as soon as possible. |
| Notifying their respective spouses | You should not fall sick. I will be by your side. Your service is my honour. | You woman with a large vagina. You must be sleeping with someone else. You're a curse to my life. You need not stay here at all. Find a place for yourself. |
| The family learns of their HIV positive status | You have brought us shame. It is better that we keep the family's honour by dissociating ourselves from you. Please leave the house. Take your wife and children with you. | We did not know that we were sheltering a whore in this household. Leave the children here and before the sun rises tomorrow we do not want to see you here. Even your shadow is doomed for us. She leaves alone. |
| The community learns about their HIV positive status | It is unfortunate that this has happened to him. After all, men will be men. They do go around sometimes but such misfortune does not strike everybody. It is his destiny. In any case a bull is not a bull without scars. | The kind of activities she has indulged in, she has got away lightly by just being thrown out. In our times she would have been branded so as to be a lesson for other girls to keep away from base activities. |
| The employer learns about their employees' HIV positive status | None of those interviewed had revealed their husbands' sero-status to their employers. | Prior to receiving their HIV status, none of the women had held jobs. Upon learning of their status and being kicked out of their homes the women have |

| | | |
|---|---|---|
| | | looked for work with little success. There is a deep fear of rejection. |
| The individuals begin getting opportunistic infections | His wife has provided the medical staff with extra money and favours in order for her husband to be seen by the doctor. The doctor refuses knowledge of patients' HIV status. | The woman is made to wait by the clerical staff, the nurses, and the doctor. |
| The need for medical treatment arises | The family uses all of their savings and his wife seeks additional work to pay for the medications. She eats less and cuts down the nutrition of her children in order to be able to provide medicines for her husband.<br>OR<br>If they are living in an agricultural subsistence economy in rural India the burden of care for the husband leaves very little time for the wife to work in the fields. She grows tuber instead of wheat or rice which is less labour intensive and the produce is inadequate to nourish either her or the children. | The need for medicine remains unfulfilled. The issue of survival looms large – food and shelter are more critical than medical care.<br>OR<br>If she lives in an agricultural subsistence economy, her marginal land is lying fallow and she is waiting for a show of sympathy by the members of the community to save herself and her children from death. |
| The inevitable happens – death | The woman is left alone hearing the inevitable from all quarters – "she will also die soon." The burden of childcare and their survival lingers on… There is a very bleak change that she will ever remarry – perhaps another man with HIV. The question that arises is will she want to go through it all again. | The children wail. More orphans join the children of the street. |

Overhead

# HUMAN RIGHTS ABUSES – HE HAS HIV / SHE HAS HIV

| **HUMAN RIGHTS** | **MANIFESTATIONS OF ABUSE** |
|---|---|
| Right to information | No information provided on:<br>~ Abortion<br>~ Parent/Mother to Child Transmission |
| Right to dignity | Abusive language |
| Right to equality | Attitude of community |
| Right to employment | Loss of paid work on disclosure of disease |
| Right to property | No access to housing if thrown out by the husband |
| Right to marriage and family | Isolated by the family life |

## Critical Imperatives Facing Men and Women

Objective: To create awareness about the legal and ethical issues that affect the lives of people living with HIV / AIDS.

Time: 2 hours 45 minutes

Materials: Questionnaires for each of the five critical imperatives, five sheets of paper with one statement on each of them, overhead projector, overheads: "Mother to child Transmission", "Breast Feeding", "Abortion", "Partner Notification", "Discrimination".

### Procedure

1. Divide participants into five groups and give each group a statement to discuss, keeping the contextual realities of their geographical locations in mind. The statements are:

- Group I: A pregnant woman who realizes that she is HIV positive should begin to take AZT in the 14th week of her pregnancy as this reduces the chances of mother to child transmission by 66 percent. The costs for this treatment amount to $800.
- Group II: Women living with HIV/AIDS should not breast-feed their babies as this carries with it a 15 percent chance of transmission of the virus from the mother to the child.
- Group III: Women living with HIV/AIDS should immediately seek abortion the moment they learn that they are pregnant.
- Group IV: A doctor should notify the husband of his patient about her serostatus without essentially informing the woman.
- Group V: People living with HIV/AIDS should be isolated/quarantined because collective survival is more important than the exercise of the individual's human rights.

2. Ask each group to choose a group leader to facilitate the discussion and make a presentation at plenary. The presentation can only be made if a consensus is reached in the group. The exercise therefore also builds the capacity of the participants in consensus building.

3. Report back and group discussion takes place in stages:

- Group I reports back on its response to the critical imperative it was given to consider (Mother to Child Transmission (MTCT).
- Before opening the discussion to the group, the facilitator hands out a short quiz on the critical imperative topic being considered and asks the participants to fill it out individually and score themselves. (5-10 minutes per quiz)
- The facilitator provides the answers to the plenary, using these as an entry point for group discussion. The discussion is closed after 15 minutes. The facilitator

synthesizes the issues raised using the relevant transparency (e.g. overhead "MTCT").

The process is repeated for each of the remaining critical imperatives: breastfeeding, abortion, partner notification, and discrimination and stigma.

Note: Since many of these issues remain controversial and information from field level research is still inadequate, the facilitator should present the ethical debate in a non-partisan manner. It should be left to the participants to adopt any approach that is appropriate within their contextual realities.

# Statement One

A pregnant woman who realized that she is HIV positive should begin to take AZT in the $14^{th}$ week of her pregnancy as this reduced the chances of mother to child transmission by 66%. The cost for this treatment amounts to $800.

***QUESTIONNAIRE ON CRITICAL IMPERATIVE I***
***Mother to Child Transmission***

1. Approximately _____ of the one million children under 15 living with HIV around the world acquired the disease from their mothers during pregnancy at birth or from breast-feeding.

50%
10%
**90%**
(Source: Prevention Strategies and Dilemmas – Marcel Bianco)

2. In 1994, Protocol 076 proved that mother to child transmission could be effectively prevented by administering AZT to HIV positive women beginning in the 14th week of pregnancy, then intravenously during child birth and finally to the baby in the first six weeks of life. The success in the prevention rate of transmission was recorded as being _____.

16%
**66%**
6%
(Source: Women's Vulnerability and AIDS – Adriana Gomez and Deborah Meacham)

3. Although the World Health Organisation (WHO) has claimed that there is _____ valid public health rationale for forced HIV testing many countries still impose this practice on specific groups of people, including prisoners, sex workers, resident aliens, migrant workers, and pregnant women.

Some
A strong
**No**
As far back as 1987, WHO declared that HIV testing in order to identify specific individuals should be voluntary, should entail free and informed consent, should be confidential and should be followed with counselling.
(Source: AIDS in the World – Mann, Tarantola, Netter; v.1, pag.561)

4. As of 1991, _____ countries allowed excessive restrictions on HIV-infected citizens, including forced hospitalization, isolation, and quarantine for HIV infected people.

No
Two
**Seventeen**
(Source: AIDS in the World – Mann, Tarantola, Netter; v.1, pg.561)

5. In 1988, in the former Soviet Union, four million pregnant women were the target of a compulsory screening program. Of the women tested, _____ HIV+ women were identified.

60,000
6,000
**6**
(Source: AIDS in the World – Mann, Tarantola, Netter; v.1, pg. 561)

6. UNAIDS states that the cost effectiveness of a short course of the anti-retroviral regime (SCARVE) for pregnant women varies according to the HIV prevalence levels.

a) In Tanzania, SCARVE could cost less than _____ per averted HIV infection (1/2 the cost of providing supplementation to avoid malnourishment in pre-school children.)

**$600**
$6000

b) In Thailand where prevalence is high, the cost per avoided infection would be _____ (just over twice the cost per year of caring for a child with AIDS.)

$280
**$2800**
(Source – HIV and Infant feeding: Guidelines for Decision-making, UNICEF, UNAIDS, WHO)

Overhead

# ETHICAL DILEMAS: Mother to Child Transmission

Who decides? The State? The couple? or more specifically the Woman?

Will the massive application of protocol 076 ensure that the reproductive rights of women are guaranteed e.g. information and services?

If not, will the pilot studies in a few developing countries be used only to demonstrate and reinforce to others in wealthier countries that the treatment actually works and AZT must be sold?

# Statement Two

Women living with HIV/AIDS should not breastfeed their babies as this carries with it a 15% chance of transmission of the virus from mother to child.

***QUESTIONNAIRE ON CRITICAL IMPERATIVE II***
***Breast Feeding***

1. In 1992, analysis of six studies including one from Africa indicated that the contribution of breastfeeding to perinatal transmission is _____.

40%
**14%**
4%
(Source: Review of Current Research on Breast Milk & MTCT of HIV – UK NGO-AIDS Consortium 1998.)

2. In February 1998, a study in Thailand indicated that the risk of perinatal transmission was reduced by _____ if a short-term doze of AZT was given to women in their 34 th week of pregnancy and if no breastfeeding was allowed once the child was born.

5%
**50%**
15%
(Source: Synopsis of Bangkok Short Course Perinatal ZDV Trial – Mastro T – PROCARE Email list 27, Februrary 1998)

3. The Chief of Obstetrics and Gynaecology at Makere University School in Uganda recently stated that about 30 percent of babies born to infected mothers become infected from breastfeeding. In rural areas _____ of all babies will die from dirty water used in formula.

50%
**85%**
20%
(Source: Prevention of Perinatal HIV Transmission, Maria de Bruyn)

4. UNICEF has noted that approximately _____ hours a month could be spent on cleaning and preparations of food in the first three months of child rearing.

15
**50**
100
(Source: WHO/UNAIDS/UNICEF Technical Consultation on HIV & Breastfeeding: Report of Meeting – Geneva, April 1998)

5. In Zambia, the average family income is less than $100 a month. The costs of providing the least expensive formula of powdered milk to an infant amount to _____ a month.

$16
**$36**
$66
(Source: HIV and Breastfeeding, and Old Controversy, Z. Gelow)

6. The cost of formula for one child in Uganda averages _____ times the rural family's average annual earnings.

1/2
1/3
**1 ½**
(Source: Breastfeeding and HIV- Weighing Health Risks- M Specter – New York Times, 19 August 1998)

7. Baby food manufacturers suggested in July 1997 that they were giving mothers free supplies in Thailand as part of a government project for infants of PLWHAS. Twenty five percent of the mothers received free samples while only _____ were positive.

10%
**2%**
50%
(Source: Rundall P. – Implications for Commercial Exploitation U.K. NGOs AIDS Consortium 1998)

Overhead

# ETHICAL DILEMAS: Breast Feeding

Edward Mbidde, chief of Uganda's Cancer Institute has commented, "What is worse? – To let a baby die of AIDS when you can save it, or to let the baby into the world just to become an orphan in a society that has been overwhelmed by death?"

Frerichs has posited that it is a question of the mother's rights versus the child's rights – the child's right to life or the mother's right to keep her HIV status confidential i.e. her right to dignity.

# Statement Three

Women living with HIV/AIDS should seek an abortion upon learning that they are pregnant.

## *QUESTIONNAIRE ON CRITICAL IMPERATIVE III*
## *Abortion*

1a) Of the 50 million induced abortions worldwide every year, _____ are illegal.

1/2
**1/3**
2/5

b) Nearly _____ of all abortions are performed outside the health care system.

**50%**
75%
25%
(Source: Unwanted Pregnancy, HIV/AIDS and Unsafe Abortion, by Radhakrishna, Gringle and Greenslade – Women's Health Journal, February 1997)

2. Abortion under any circumstances is illegal in Mauritius, even in cases of rape and incest. In 1992, ___ of maternal deaths were related to complications from illegal abortions.

14%
24%
**44%**
(Source: Women in Law & Development (WILDAF) Info Practice for the 43 rd Session of the Commission on the Status of Women, March 1999)

3. In developing countries, only _____ of women live in states where abortion is legally available to save a woman's life.

60%
10%
**30%**
(Source- Unwanted Pregnancy, HIV/AIDS and Unsafe Abortion-Radhakisha, Gringle and Greenslade)

4. If a woman has advanced HIV, pregnancy carries the risk of hastening her own progression to full blown AIDS. In a study undertaken amongst tribal women in India living with HIV/AIDS,
a) _____ of the women who had an uneventful legal and safe first trimester abortion, died.

**16%**
60%
96%

b) _____ died undelivered between 30-34 weeks of gestation.

14%
**41%**
4%

c) Twenty seven percent of women living with HIV/AIDS but who were not pregnant died during the time frame of the study compared to _____ of pregnant women with HIV/AIDS.

17%
**56%**
83%

d) The study reported a negative outcome for the pregnancies that resulted in live deliveries with _____ of the infants who died within 6 weeks of birth diagnosed with an AIDS defining illness.

28%
**82%**
58%
(Source-AIDS in Pregnancy among Indian Tribal Women-Kumar, RD Rizvi and A. Khurana)

Overhead

# ETHICAL DILEMAS: Abortion

Should abortion laws be reviewed and made less restrictive especially in the context of the HIV/AIDS epidemic?

Should the right to terminate pregnancy on the grounds of HIV infection be expressly stated through amendment to the current legislation?

Should our health care system be more responsive to adolescents who are unrelentingly faced with the triple jeopardy of HIV infection, unwanted pregnancy and unsafe abortion?

Should the ethical code of conduct of the health care providers be reviewed to ensure more sensitivity to women with HIV seeking abortion?

# Statement Four

A doctor should notify the husband or parents about the serostatus of a woman living with HIV/AIDS without informing the women first.

## *QUESTIONNAIRE ON CRITICAL IMPERATIVE IV*
## *Partner Notification*

1a) In Cote d'Ivoire, under a UNAIDS pilot project, _____ of women refused to be tested for HIV.

50%
**20%**
5%

b) _____ of those tested did not return for the test results.

50%
5%
**20%**

c) _____ of those who tested positive did not inform their partners of the result.

25%
**50%**
5%
(Source –Relevance of Current Trials to Breastfeeding Policy and Practice – Vande Pierre)

2. _____ of the STD clinics in Delhi have a contact card or referral slip for partner notification.

**0%**
50%
80%
(Source- NACO-Study to Map Patterns of Risk Behaviour in the State of Delhi)

3. A 1993–94 survey in South Africa of more than 700 HIV-infected clients who had been in counselling sessions at an AIDS service group found that more than _____ had not told their spouse or regular partner of their positive HIV status.

6%
**60%**
20%
(Source- New York Times-December 4, 1998)

Overhead

# ETHICAL DILEMAS: Partner Notification

Should the woman/man have the right to know about her/his partner's HIV status, particularly given the data on discordance among couple's?

Should this confidential information be shared and how should this be undertaken?

Who should undertake it?

Will it necessarily violate counsellor client relationship?

What about the right to confidentiality?

# Statement Five

People living with HIV/AIDS should be isolated/quarantined because collective survival is more important than the exercise of the individual's human rights.

***QUESTIONNAIRE ON CRITICAL IMPERATIVE V***
***Discrimination***

1. Women in Asia and the Pacific Region are considered to have a _____ times greater risk of contracting HIV/AIDS than men due to their greater social and biological vulnerability.

Two
**Five**
Ten
(Source: World Bank 1993)

2. After a positive diagnosis, women generally experience AIDS related illnesses _____ than men do.

**Sooner**
Later
(Source: Women's Vulnerability and AIDS – Gomez and Meacham)

3. The ratio of AIDS cases of men to women dropped from 31:1 to _____ in 1995 in Chile.

25:5
15:5
**10:5**
(Source: CONSIDA 1997)

4. In one survey on KAP (Knowledge, Aptitude, Perception) done in Colombia, _____ of those consulted said they were unsure of how to protect themselves from STD's and AIDS.

91%
**61%**
21%
(Source: Sexual Conduct in the Adult Population, Profa Milia – Bogota Seguro Social Vol. 3, 1994)

5. In the same survey, the reported use of condoms among women with their partners was _____.

14%
**4.1%**
41%
(Source: PROFAMILIA (1994))

6. As shown clearly by studies of discordance among heterosexual couples in both Zimbabwe and Zambia, up to _____ of couples studied were discordant (far more commonly the man positive and the wife negative).

**1/3**
1/5
1/4
(Source: Key Problems Facing Women in the Concept of HIV/AIDS in South Africa – Helen Jackson)

7. An IPS Survey at the 1997 Adolescent Reproductive Health forum found that _____ of professionals stated that the majority of health providers would refuse to provide abortions related care if the adolescent had HIV/AIDS.

17%
**47%**
7%
(Source: Unwanted Pregnancy: HIV/AIDS and Unsafe Abortion – Radhakrisha, Gringle and Greenslade)

8. A recent survey undertaken by YRG Centre on PLWHAS observed that of the respondents, who had been victims of violence, _____ had experienced that violence at home and 21.4% had experienced it in the community.

**12.3%**
80.1%
50.5%
(Source: Challenges Facing People Living with HIV/AIDS – Soloman and Sathiamoorthy)

9. In the same survey when they disclosed their positive serostatus to health care providers, _____ of the respondents claimed to have experienced discrimination from those providers.

**37%**
80%
5%
(Source: Challenges Facing People Living with HIV/AIDS – Soloman and Sathiamoorthy)

10. The study on high-risk behaviour conducted by NACO in the state of Kerala, India states that IVD users when spotted by police in Trivandrum are _____.

Taken to drug addiction centres
Counselled by the police and restored to their families
**Beaten up**

11. A recent finding of a study conducted by the University of California notes that _____ of medical professionals throughout the world have refused care to at least one HIV infected person.

**39%**
12%
7%
(Source: Challenges Facing PLWHAS – Solomon and Sathiamoorthy)

12. FGM is a socially sanctioned practice in many parts of Africa. In some countries _____ out of 10 women have had at least some part of their external genitalia removed.

4
7
**9**
(Source: WILDAF: Information Packet prepared for the 43rd Session of the Commission on the Status of Women, March 1999)

13. A 1997 study in Zimbabwe found that _____ out of 10 people caring for someone with AIDS was/were willing to admit that they were nursing someone with the disease.

1
5
**8**
(Source: New York Times – December 4, 1998)

**ACCESS**
1. Despite the high degree of government involvement in health care, most African states continue to suffer from circumstances related to insufficient infrastructure. In Ethiopia, there are only _____ health centres (including hospitals) to serve 55 million people.

**2,200**
22,000
220,000
(Source: A Snapshot of the Current Status of Women's Health in Africa – WILDAF, March 1999)

2. Women are hardest hit by cutbacks in health services and fee impositions. In West Africa, where SAP's caused rates of inflation to soar to 300 percent in the 1990's and underemployment to soar as high as 80 percent, the per capita income has plummeted from an average of $1000 in 1970 to _____ in 1995.

$500
$700
**$300**

(Source: A Snapshot of the Current Status of Women's Health in Africa – WILDAF, March 1999)

3. In countries like Zimbabwe where 86 percent of the women live in rural areas, women must frequently walk _____ or more to a clinic.

30 minutes
One hour
Three hours
(Source: A Snapshot of the Current Status of Women's Health in Africa – WILDAF, March 1999)

4. In South Africa, there are about _____ people per doctor in the former homelands.

3,000
13,000
**30,000**
(Source: A Snapshot of the Current Status of Women's Health in Africa – WILDAF, March 1999)

5. Cost recovery programs in which people are asked to contribute to the cost of condoms they buy and use have in fact discouraged the use of condoms. In Zimbabwe, where cost recovery for condoms was introduced in 1993, the number of condoms distributed at the survey site health centres fell by _____.

25%
**50%**
75%
(Source: A Snapshot of the Current Status of Women's Health in Africa – WILDAF, March 1999)

Overhead

# ETHICAL DILEMAS: Discrimination

Should we adopt the public health approach of saving health at the cost of elimination of the sick?

Is collective survival more important than the exercise of individual rights and freedom?

# The Long Walk/Plague of the Century

Objectives: To consider the inter-relatedness of gender, culture, human rights and HIV/AIDS, to examine the impact of HIV/AIDS.

Time: 90 minutes

Material: One of two videos (see below), TV and VCR.

Procedure:

1. Obtain one of the following two videos:

a) The Long Walk
1998, 48 minutes, National Film Board (www.nfb.ca)

Abstract: Ken Ward was the first Native Canadian to go public with his HIV diagnosis. Seven years later, he has developed AIDS and remains a passionate advocate for HIV prevention and treatment. Filmmaker Alan Bibby provides a moving account of the man and his work in *The Long Walk*. Ward works primarily with First Nations populations, where the epidemic is often compounded by isolation and poverty. He also takes his message into prisons, where the infection rate among Native inmates is 17 times the national average. Bibby accompanies Ward as he travels the back roads of the Canadian West, nurturing tolerance and understanding within fearful communities, and bringing hope and guidance to people living with HIV or AIDS.

b) AIDS: The Plague of the Century – The Global Impact of AIDS
1999, 50 minutes, Films for the Humanities and Sciences (www.film.com)

Abstract: In America, many AIDS patients receive as much as $25,000 per year in medical assistance, while patients in poorer nations receive virtually none. In this program, doctors, members of advocacy organizations, patients, and others assess the current state of AIDS in the U.S., Europe, South Africa, Uganda, Zimbabwe, India, Thailand, Cambodia and Hong Kong; underscores the value of education and prevention; and study the impact of AIDS on society. In places where medical treatment is simply not an option, compassion is viewed as a key therapy – a therapy still being learned in medically advanced America.

Note: If you cannot obtain one of these two videos, be sure to preview the movie you plan to share with the group to ensure it is appropriate. It is also important to develop discussion questions that facilitate both a critical analysis and emotional response.

2. After the film, as a large group, discuss some of the following questions:

a) The Long Walk

- "Shunning, running and acceptance": what are the impacts of HIV/AIDS on the individual, family, community? Consider reactions to HIV, how HIV is and is not dealt with, who is infected/affected, how and where HIV is transmitted, stigma and discrimination, role of spirituality, role of human rights.
- What did you learn from this film?
- What are some of your personal/emotional reactions to the film?

b) AIDS: The Plague of the Century – The Global Impact of AIDS

- How the impact is similar and how it differs from country to country? Consider who is affected/infected, how HIV is and is not dealt with, national and community impacts and responses, political contexts, stigma and discrimination, disparities of wealth, role of human rights.
- What did you learn from this film?
- What are some of your personal/emotional reactions to the film?

## Newspaper Analysis: Human Rights and the Media

Objectives: To examine the stigma, discrimination and human rights violations associated with HIV/AIDS, to examine the role of the media in addressing and perpetuating stigma, discrimination and human rights violations.

Time: 75 minutes

Material: Newspaper articles, "Newspaper Analysis" handout, pens, flipchart, markers.

### Procedure

1. Ask participants to divide into give small groups. Give small group a copy of the "Newspaper Analysis" handout and one of the newspaper articles.

2. Give groups sufficient time to read the article and to answer the questions on the handout.

3. Reconvene the group. Ask each small group to provide a summary of both the article and their analysis.

4. As the groups report back, document the rights issues inherent to each article on flipchart.

5. Wrap-up the activity by reviewing the multitude of rights abuses that can and do occur in the case of HIV/AIDS. Discuss the gendered elements of these abuses. On the one hand, the media is simply reporting events, policies and laws. On the other hand, the media also has a role to play in the way the accounts are written (language, values, etc.), in providing a critical analysis and in advocating for solutions.

Handout

## Newspaper Analysis

1. What does the headline signify?

2. What are the main messages in the article?

3. What kind of language is used throughout the article?

4. What values are espoused in the article?

5. Who are the heros? Who are the villains?

6. What are the human rights and gender issues in the article?

7. From this article, what do you think the role of media and/or law is in perpetuating and/or addressing human rights violations?

**8.** If you were to write a letter to the editor, to critique and/or support the article, what would your main points be?

**Kerala schools shun HIV positive pupils**
By Akhel Mathew
Gulf News Online Edition
February 16, 2003

Kerala, known for several internationally hailed social indices including highest literacy rate in India, still treats even hapless children AIDS/HIV patients as outcast.

The latest victims of social ostracism in the state are seven-and-a-half-year-old Bency Chandy and her five-and-a-half-year-old brother Benson, children of a couple from Chathannur in Kollam district who died of the dreaded disease.

The HIV-positive children had to be to be shifted from one school to another six times in the last one-and-a-half-years following objections from parents' associations and teachers. Now they are on the lookout for a school where they can continue their studies without interruption.

Their plight came to the public attention on Thursday when they staged a one-day fast in front of the state secretariat and Chief Minister A.K. Antony promptly ordered the district collector to tackle their problem. However, their problem still seems to be far from solved.

Though medical and AIDS control experts certify that their presence in school would not pose any danger to other students, school authorities still shun them.

The experts say that only in case of injuries the disease could spread through blood. Their presence in the classroom would pose no threat to others. Nor could the disease spread through saliva.

Not only school authorities and parents but also Pratapavarma Thampan, MLA from Chathannur, feels that they deserve no compassion. "AIDS patients should be avoided. They deserve no mercy. I do not want to waste my precious time going after two AIDS patients," says he.

The millions spent on AIDS awareness campaign in the state in the recent past have not had any positive impact even on a well known people's representative like Thampan.

Referring to the statement of the grandfather of the children, Geevarghese Chandy, that the children had now got admitted in yet another government school and that he feared they would be turned away from there too, Thampan says: "Wait for two days. Government schools are suffering from a dearth of students.

"When other students come to know that these children have joined their school they would quit. Four or five teachers in the school would be rendered jobless (for want of the fixed minimum number of pupils)".

The grandfather says that the MLA objected to even the children entering his office.

Chandy said the MLA threatened to call the police if he did not leave his office with the children.

When Thampan's intervention was sought to secure school admission for the children he shot back: "Are they going to become officers after their studies? Is it not enough for them to spend their time playing at home? Why do they study, are not they AIDS patients?"

Chandy said Thampan asked him why he did not dispose of his properties in Kerala and migrate to the neighbouring state of Tamil Nadu. "Whey are you so adamant that they should live here?" the MLA was quoted as saying.

Human Rights Commission chairman Justice Pareed Pillai says that in case of a complaint about school admission being denied to the children he would initiate suitable steps. The commission's full bench would consider the complaint, he says.

Meanwhile, according to an AFP report, M.N. Gunavardhan, a project controller of Kerala's AIDS Control Society, said the government had taken serious note of the plight of these children.

"The government will ensure that both Bency and Benson are granted admission to a local school and we will also ensure that they are properly rehabilitated," he said.

**Defence forces start HIV/AIDS screening**
By Times Reporter
Times of Zambia
Tuesday, March 4, 2003

The defence forces in Zambia have said they will, from now on, only recruit officers who are HIV/AIDS negative.

The announcement was made at a joint function between the defence forces medical services and Project Concern International at Mulungushi International Conference centre in Lusaka.

Defence forces medical services director- general James Simpungwe said the force would go ahead with the screening of fresh entrants even with out the approval of the human rights commission.

He said serving members who were found to be positive would not be disposed of but would be placed in lower categories and offered available medical attention

The measures are designed to prevent the spread of HIV/AIDS by influencing behavioural change and teaching officers on safer sex.

"The advent of ARV drugs has in fact brought about a new outlook. Some of the members who could otherwise been downgraded have had their employment standards categorised upwards," he said.

He noted with sadness that the HIV/AIDS had claimed many skilled personnel in whom the force had invested a lot.

The high morbidity and mortality rate had consequently reduced productivity in the defence forces.

And Health Minister Brian Chituwo who officially launched the programme commended the defence force for the initiative they had taken to combat HIV/AIDS transmission.

Dr Chituwo said the military personnel were more at risk of contracting HIV/AIDS than civilians because that they spent more time away from home.

He stated that the officers did not only defend the country, but were now involved in UN peacekeeping missions away from home adding that military personnel were expected to be away tours of duty for at least six months.

The minister said that he was happy with the proposed programme as it was in line with the national HIV\AIDS programme. The international human rights convention was against any form of discrimination at work places on account of HIV/AIDS.
The activists maintained everyone was entitled to equal employment opportunities regardless whether one was HIV/AIDS positive.

**HIV test used to bar potential immigrants**
Lisa Priest
The Globe and Mail
Monday, February, 24, 2003

The federal government has rejected 75 prospective immigrants and others with the AIDS virus under a new compulsory-testing program that excludes some whose disease has been deemed as being too costly to the health-care system.

Another 207 others who tested positive for HIV from Jan. 15 to Dec. 31, 2002, were allowed into Canada, according to Access to Information Act documents.

The mandatory testing program allows Canada to bar potential immigrants with HIV and those seeking a temporary permit to work or study, should they be expected to place an excessive demand on medicare.

Excessive demand is defined as needing more than $15,016 worth of publicly funded health care over five years, according to Citizenship and Immigration Canada's operational processing instruction manual, also provided to The Globe and Mail after an Access to Information Act request.

Those exempt from the so-called excessive demand category -- no matter how severe and costly their disease to medicare -- include refugees, sponsored spouses, dependent children, and common-law and conjugal partners, Immigration spokeswoman Susan Scarlett said.

"Someone who is a skilled worker, someone who is coming into the labour market, someone whom we're selecting based on their background, profession and work experience" would be exempt, she said in a telephone interview from Ottawa.

"We test for two reasons: one is to protect the health and safety of Canadians and the other reason is to prevent excessive demand on the Canadian health and social services," Ms. Scarlett said.

Philip Berger, a Toronto-based family physician who has treated AIDS patients for more than two decades, said there is no justification for the test and it further stigmatizes those with the AIDS virus.

"It is going to have the disproportionately punitive effect on the highest prevalence of HIV, which are in sub-Saharan Africa," said Dr. Berger, who is also an associate professor at University of Toronto's faculty of medicine. "There are racial underpinnings of this policy -- it's discriminatory."

But immigration lawyer Richard Kurland defended the policy, saying it is really just pinning a dollar figure to a medical condition that could place a burden on society's social programs.

AIDS activists and others have condemned the policy, saying it is unjustified and punishes productive members of society.

According to Citizenship and Immigration Canada documents, HIV-infected adults expected to require a minimum of eight months of antiretroviral therapy over the ensuing five years are ineligible for admission under the excess demand criteria. Antiretroviral therapy helps prevent HIV, the retrovirus that causes AIDS, from reproducing and infecting cells in the body and slows the progression of the disease.

As well, any HIV-infected adult expected to require a minimum of 18 months of antiretroviral therapy over the ensuing 10 years at an estimated cost of $30,240 is also deemed ineligible.

Canada is not alone in its new policy. Some 60 countries, including the United States and Australia, have mandatory HIV testing requirements for those seeking to immigrate and for some temporary visitors, according to the latest figures from the U.S. Department of State.

And in Britain, the government is considering the compulsory screening of immigrants for HIV, after studies showed that more than 2,000 people with the AIDS virus settled there in 2001.

**South Africa heeds calls for free anti-AIDS drugs**
Mbeki backs off bitter debate over HIV link as pharmaceutical giant agrees to slash its prices

Liz McGregor
Sunday February 2, 2003
The Guardian

In a dramatic turnaround, the South African government is to announce next month a programme that will eventually provide anti-AIDS drugs free to all those who need them.

South Africa's Finance Minister, Trevor Manuel, is expected to make the commitment in his budget speech. It will give, on average, an extra eight years of life to the country's five million people living with AIDS and HIV - the highest infection rate in the world.

At first, the anti-retroviral drugs will be given in pilot schemes to new mothers. These will be expanded over the next few years and the government is still considering how they will be financed and the drugs distributed.

This is the culmination of a long, bitter war in which much of civil society, including activists, unions and churches, was pitted against the government. Although President Thabo Mbeki, who infamously declared that HIV does not cause AIDS, has withdrawn from the debate, Health Minister Manto Tshabalala-Msimang dismayed doctors last month by inviting a notorious AIDS dissident, Dr Roberto Giraldo, to a government-sponsored meeting where he reiterated his view that HIV is not infectious and is not spread through sex.

The health department tried to block a $70 million grant from the Global AIDS Fund to the rebel province KwaZulu Natal, on the grounds that the correct administrative procedures had not been followed.

Now the government has given the grant the go-ahead on condition that the programme does not begin until March, ensuring the govern ment's announcement of its own initiative is not upstaged.

The other powerful interest group to take a hammering in the AIDS war is the pharmaceutical industry. Its attempt to take the government to court to protect its patents - and prices - ended in capitulation, in the face of worldwide revulsion.

British-American giant GlaxoSmithKline has given a licence to a KwaZulu drugs manufacturer, Aspen, to make Combivir, the pill that combines AZT and 3TC, two-thirds of the most common anti-AIDS regimen. Stephen Saad, head of Aspen, is waiting for the Medical Control Council's approval before he can release the boxes piling up in his warehouse.

What GlaxoSmithKline calls its 'preferential pricing at cost price' for state and non-governmental organizations will cost £33 per person per month. Saad will sell it for £19 per person for month - but he is restricted to supplying the NGO/state sector. AIDS and HIV are primarily the affliction of the poor, so by far the largest market will be the state. In KwaZulu, Dr Patrick McNeil, of the Port Shepstone hospital, said the health system was overwhelmed by the epidemic: 'Every second patient has HIV. Some days you walk through the wards and all you see is telltale gaunt faces.'

Patients are resented by staff, he said, because 'they have constant diarrhoea, they won't eat, they have sores and hate being moved. We can only make them comfortable and give them analgesics for the pain.'

McNeil is skeptical about success for a universal anti-retroviral drugs campaign; once a patient starts on a program of anti-retrovirals, he or she has to take them every day at the same time throughout life, otherwise new, drug-resistant strains will emerge.
'If you stop taking anti-retroviral drugs, it's only weeks till resistance develops and then there is no treatment,' he said.

The hospital's paediatrician, Dr Irina Andre, says her dreams are haunted by dying babies. Some 100,000 are born with HIV every year, many because their mothers refuse to be tested for HIV while pregnant because a positive diagnosis can lead to family rejection. Seventy per cent die before the age of two.

'This means the mothers don't get the nevirapine which could have protected their babies,' she said. 'They come from families affected by malnutrition. If you feed them properly, they can fight off the virus for longer.

'The other 30 per cent are "slow progressors". At six or seven, they develop continuous diarrhoea and their bodies begin to waste away. One child born with HIV lived to 13, but he was adopted by a white family who could give him good food,' said Andre.

And that is the other difficulty with anti-retroviral drugs: they must be taken with food. Nzimakhwe Nonjabulo, 22, lies curled up on a filthy mattress in one of the poverty-stricken hillside villages where most black people live. Diarrhoea has reduced her body to a skin-covered skeleton. In acute pain, she has the rasping cough of pneumonia, one of the diseases that kills many AIDS patients. Her mother has given up her job to care for her; both of them live on an HIV sufferer's grant of £45 a month. There is no food, no electricity, no running water.

On the other side of the hill, in a larger house with electricity and a fridge, Sindisiwe Ngidi cares for her identical twin, Philisiwe. They are 27. They live with their children and mother and a third sister sends home enough for them to live on.

Philisiwe is emaciated and a large bandage covers an abscess on her chest; she is an eerie shadow of her strong, lithe twin who bustles in and out with basins and ointments.

Philisiwe is an intelligent, spirited woman who worked as an AIDS counsellor until the abscess confined her to her home. She is angry with the government for not providing drugs that could have allowed her to see her son grow up. 'I want to fight,' she said. It may be too late for her.

**Bush cripples his AIDS initiative**
By Frances Kissling
March 4, 2003
Boston Globe
WASHINGTON

I WAS STUNNED and delighted when President George W. Bush announced in his State of the Union address that he planned a major commitment to fighting AIDS. A five-year, $15 billion program of treatment and care for those infected and even some modest support for condom education and distribution -- it sounded like something that I, a fairly reliable critic of this administration, might have proposed myself. Could it be that I would be able to halt my barrage of letters to the president and to Secretary of State Colin Powell attacking their assault on family planning, their reneging on support for the UN Population Fund, and their "faith-based initiative," which would force-feed the poor with religious propaganda? Would I be able to stop worrying about all the women who could die from the administration's sellout to right-wing radicals who see abortions in any reference to women's health? Could I now write a letter praising my president for a well-intentioned humanitarian aid program?

I did write that letter, and now I'm sorry I did. As it turns out, the president's AIDS initiative is likely to attach antiabortion paranoia to every single dollar and to force-feed religion to the poor on a global scale. It also ignores this basic truth about AIDS: The pandemic has a woman's face, as UN Secretary General Kofi Annan has put it, and meeting women's needs is key to stopping it.

The State Department recently floated a proposal to apply the infamous "Mexico City policy" to all organizations that get the new AIDS initiative funding. That policy, a global gag rule imposed by President Reagan, lifted by President Clinton, and reinstated by President Bush on his first day in office, bars funding to family planning groups that provide abortion counseling, referrals, or services or that lobby on abortion rights, even if they do it with their own money.

The gag rule has never applied to HIV/AIDS assistance. Yet the administration tried to portray this move as somehow a "compromise" that merely requires family planning groups to separate their work fighting HIV/AIDS from everything else they do. But the two are inseparable, and every responsible international family planning program has been integrating them for years.

Family planning is not just handing out contraceptives, and neither is fighting HIV/AIDS. Central elements in both are education on reproductive health care, safe sexual practices, and pre- and postnatal care for mothers and their babies. Effective programs in both promote a woman's right to decide the number and spacing of her children, because AIDS is spreading most rapidly where young girls have no power to negotiate the terms of sex with older men or where women cannot insist on condoms or fidelity from their partners for fear of violence.

Women are also the chief caretakers of other AIDS victims and their orphans. Often they are forced out of work and school and into poverty. Bush's initiative promises medicines, condoms, and care for the sick, but it makes no reference to addressing women's needs.

On the contrary, the initiative would expect women to visit separate facilities for family planning and for HIV/AIDS education and services.

Where AIDS victims are stigmatized, many who are now treated quietly at family planning clinics would be forced either to go public or go without assistance. The initiative would force perennially short-funded nongovernmental groups with proven track records of success against AIDS to set up separate buildings and bookkeeping systems and perhaps double their staffs and equipment in order to continue. In many poor countries where US-funded family planning clinics are the only health care providers within miles, this simply will not happen.

Meanwhile, given the president's belief that religious groups are the best providers of social services, we can expect they will be favored recipients of the funds. Will evangelical Christian groups who still believe that homosexuality is a sin that can be cured by prayer proliferate? Will Catholic groups that abhor family planning offer anything that prevents AIDS other than abstinence?

The administration's agenda seems clear: to defund secular, tolerant providers of health care and family planning worldwide in favor of religious groups that will likely choose whom to treat and how to treat them based more on ideology than medicine. Dear President Bush: I write you yet again to urge you to reconsider this latest assault on women. You can and must do better.

*Frances Kissling is president of Catholics for a Free Choice.*

## UN Guidelines and Declarations on HIV/AIDS in Your Country

Objective: To increase knowledge of relevant UN guidelines on HIV/AIDS, to get participants to think critically regarding the implementation of these guidelines in their own countries.

Time: 75 minutes

Materials: Flipchart, markers, handouts: "UN Guidelines on HIV-related Human Rights", "UNGASS Declaration of Commitment", "HIV/AIDS and Human Rights: Lessons Learned". Overhead: "UN Guidelines and Declaration of Commitment in Your Country".

### Procedure

1. Give each participant a copy of both handouts: "UN Guidelines on HIV-related Human Rights" and "UNGASS Declaration of Commitment".

3. Share the "UN Guidelines and Declarations in Your Country" overhead.

4. Give participants sufficient time to read the handouts and answer the questions.

5. As a large group, go through each of the questions to discuss the successes and challenges.

6. Discuss the following questions:

- What are the strengths of the UN Guidelines and Declaration of Commitment?
- What are some of the challenges that are likely to be encountered in the implementation of the Guidelines and Declaration of Commitment?
- How can these challenges be addressed?
- What conditions are necessary for the successful implementation of a human rights approach to HIV/AIDS?

7. Wrap-up by disseminating the "HIV/AIDS and Human Rights: Lessons Learned" handout.

Overhead

# UN Guidelines and Declaration of Commitment in Your Country[36]

1. Has information about the UN Guidelines and Declaration of Commitment been disseminated in your country? Who are the actors involved in this process? What kinds of information are being disseminated by each of them, to whom and in what ways?

2. Has the government or any other actor put into place an institution, mechanism or process for review if and how the provisions of the UN are being implemented?

3. Have there been any changes in laws, policies, or resource allocation concerning HIV/AIDS since the development of the Guidelines and Declaration of Commitment? Who has been involved in making this happen?

[36] Adapted from: WHO. (2001). Transforming Health Systems: Gender and Rights in Reproductive Health. Geneva: Author.

Handout

## UN Guidelines on HIV-related Human Rights[37]

*Guideline* 1: States should establish an effective national framework for their response to HIV/AIDS which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and program responsibilities across all branches of government.

*Guideline* 2: States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, program implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.

*Guideline* 3: States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.

*Guideline* 4: States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.

*Guideline* 5: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation.

*Guideline* 6: States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price.

*Guideline* 7: States should implement and support legal support services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

*Guideline* 8: States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and sup port to community groups.

[37] Source: OHCHR and UNAIDS, 1996

*Guideline* 9: States should promote the wide and ongoing distribution of creative education, training and media programs explicitly designed to change attitudes of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance.

*Guideline* 10: States should ensure that government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

*Guideline* 11: States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV / AIDS, their families and communities.

*Guideline* 12: States should cooperate through all relevant programs and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV/AIDS at international level.

Handout

Declaration of Commitment on HIV/ AIDS, 'Global Crisis -Global Action', Special Session of the UN General Assembly on the Problem of HIV/ AIDS in All its Aspects[38]

A Special Session of the UN General Assembly was held in June 2001 in order to intensify international action to fight the HIV *I* AIDS epidemic and to mobilize the resources needed. Governments unanimously agreed on a Declaration of Commitment to reduce infection rates by 25 per cent by 2005, end discrimination by challenging 'gender stereotypes and attitudes' and inequalities between men and women worldwide, and provide AIDS education to 90 per cent of young people by 2005. Poverty, women's rights and funding issues were also addressed as a part of the solution to combat HIV/AIDS.

In the Declaration, governments emphasize that the vulnerable must be given priority in the response to the HIV/AIDS crisis, and that empowering women is essential for reducing vulnerability. They agree to take action in eleven key areas:

- Leadership
- Prevention
- Care, support and treatment
- HIV / AIDS and human rights
- Reducing vulnerability
- Children orphaned and made vulnerable by HIV/AIDS
- Alleviating social and economic impact
- Research and development
- HIV/AIDS in conflict and disaster affected regions
- Resources
- Follow up

All countries are called on to take the necessary steps to implement, in "strengthened partnership and co-operation with other multilateral and bilateral partners and with civil society", a number of time-bound targets, including to:

**By *2003***

Ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that:

address the epidemic in forthright terms;
confront stigma, silence and denial;
address gender and age-based dimensions of the epidemic
eliminate discrimination and marginalisation;
involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people;

[38] Source: Commonwealth Secretariat and Atlantic Centre of Excellence for Women's Health. (2002). Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach. London: Commonwealth Secretariat.

are resourced to the extent possible from national budgets;
fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health;
integrate a gender perspective;
address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity (para. 37).

- Establish time-bound national targets to achieve the internationally agreed goal of reducing HIV prevalence among young men and women aged 15-24 by 25 per cent in the most affected countries by 2005 and globally by 2010. Intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes and gender inequalities in relation to HIV *I* AIDS, encouraging the active involvement of men and boys (para. 47).

- Have in place in all countries strategies, policies and programs that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including:
    - underdevelopment
    - economic insecurity .poverty
    - lack of empowerment of women
    - lack of education
    - social exclusion
    - illiteracy
    - discrimination
    - lack of information and/or commodities for self-protection
    - all types of sexual exploitation of women, girls and boys, including for commercial reasons.

Such strategies, policies and programs should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement (para. 62).

- Develop and/or strengthen strategies, policies and programs to reduce the vulnerability of children and young people by ensuring their access to primary and secondary education; including HIV/AIDS in curricula for adolescents; and ensuring safe and secure environments, especially for young girls (para. 63).

- Evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to:
    - address the impact at the individual, family, community and national levels;
    - develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods, and access to basic social services, with a special focus on

individuals, families and communities severely affected by the epidemic; and
    - review the social and economic impact of HIV / AIDS at all levels of society especially on women and the elderly, particularly in their role as caregivers and in families affected by HIV / AIDS and address their special needs (para. 68).

- Develop and begin to implement national strategies that incorporate HIV / AIDS awareness, prevention, care and treatment elements into programs or actions that respond to emergency situations. Populations destabilized by armed conflict, humanitarian emergencies and natural disasters, particularly women and children, are at increased risk of exposure to HIV infection (para. 75).

***By 2005***

- Ensure that a wide range of prevention programs is avail- able in all countries, including:
    - information, education and communication aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity;
    - expanded access to essential commodities, including male and female condoms; and
    - early and effective treatment of sexually transmittable infections (para. 52).

- Ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15-24 have access to the information and education necessary to develop the life skills required to reduce their vulnerability to HIV infection (para. 53).

- Reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by:
    - ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them;
    - increasing the availability of effective treatment to reduce mother-to-child transmission of HIV;
    - providing effective interventions for HIV-infected women (para. 54).

- Implement national strategies that:
    - promote the advancement of women and women's full enjoyment of all human rights;
    - promote shared responsibility of men and women to ensure safe sex;
    - empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection (para. 59).

- Implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection through:
    - the provision of health care and health services, including sexual and reproductive health;
    - prevention education that promotes gender equality within a culturally and gender sensitive framework (para. 60).

- Ensure development and accelerated implementation of national strategies for women's empowerment; promotion and protection of women's full enjoyment of all human rights; and reduction of their vulnerability to HIV/AIDS. This should include the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls (para. 61).

***Periodically***

Conduct national reviews involving the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, of progress achieved in realizing these commitments and identify problems and obstacles to achieving progress and ensure wide dissemination of the results of these reviews (para. 94).

Handout

## HIV/AIDS and Human Rights: Lessons Learned[39]

The International Council of AIDS Service Organizations (ICASO) collected a series of articles on HIV/AIDS and human rights, including access to treatment issues, immigration, housing, employment, the law, confidentiality, marriage, prisons, violence and access to care. These articles describe how non-governmental organizations (NGOs) have responded to human rights violations, the campaigns organized by NGOs to promote and protect human rights in the context of HIV/AIDS and some recent examples of human rights abuses.

Several lessons learned emerged from these articles:

- Know your country's constitution and, in particular, what rights are guaranteed by the constitution.
- Be aware of what international conventions have been signed by your country and what rights are protected by these conventions.
- Make use of the UN Guidelines on HIV-Related Human Rights. The Guidelines are an excellent tool for advocacy, education and awareness raising.
- Be familiar with your national AIDS policy, law or program. It is important to monitor what activities have been planned and implemented. It is also useful to make recommendations for new activities, particularly in response to emerging issues.
- Form partnerships and alliances. They greatly enhance the chances of success.
- Use the media. The media is key to the success of advocacy campaigns.
- Obtain key documents that may assist you in your efforts to better understand HIV/AIDS and human rights issues.

[39] Adapted from: International Council of AIDS Service Organizations. (1999). HIV/AIDS and Human Rights: Stories from the Frontlines. Available at: www.icaso.org.

## Pulling it All Together: An HIV/AIDS Workplace Policy

Objectives: To apply human rights and gender to HIV.

Time: 2 hours

Materials: Flipchart, marker, participant notebooks, pens, handouts: "The ILO Code of Practice on HIV/AIDS – Key Principles", "HIV/AIDS Workplace Policy Checklist", "Example: Congress of South African Trade Unions (COSATU), Draft Workplace Policy on HIV/AIDS."

### Procedure

1. Give each participant a copy of the handouts: "The ILO Code of Practice on HIV/AIDS – Key Principles", "HIV/AIDS Workplace Policy Checklist", "Example: Congress of South African Trade Unions (COSATU), Draft Workplace Policy on HIV/AIDS."

2. Ask participants to design an HIV/AIDS workplace policy for their organization/institution. Give participants sufficient time to draft their policies.

3. Ask participants to form small groups comprised of individuals from similar organizations/institutions. Participants should present and share their policies with one another.

4. Ask the small groups to consider the similarities and differences and key insights of all participant policies. Each small group should consider: how do the policies address gender and rights? What might be the successes of such a policy? What might be the challenges? How can these challenges be addressed?

4. In the large group, each small group can describe the similarities and differences and key insights of all participant policies. Document the answers to the questions: how do the policies address gender and rights? What might be the successes of such a policy? What might be the challenges? How can these challenges be addressed? on flipchart paper. Discuss.

Handout

## The ILO Code of Practice on HIV/AIDS – Key Principles[40]

1 **Recognition of HIV/AIDS as a workplace issue**
HIV/AIDS is a workplace issue, not only because it affects the workforce, but also because the workplace can play a vital role in limiting the spread and effects of the epidemic.

2 **Non-discrimination**
There should be no discrimination or stigmatization of workers on the basis of real or perceived HIV status.

3 **Gender equality**
More equal gender relations and the empowerment of women are vital to successfully preventing the spread of HIV infection and enabling women to cope with HIV/AIDS.

4 **Healthy work environment**
The work environment should be healthy and safe, and adapted to the state of health and capabilities of workers.

5 **Social dialogue**
A successful HIV/AIDS policy and program requires cooperation and trust between employers, workers, and governments.

6 **Screening for purposes of employment**
HIV/AIDS screening should not be required of job applicants or persons in employment and testing for HIV should not be carried out at the workplace except as specified in this code.

7 **Confidentiality**
Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with existing ILO codes of practice.

8 **Continuing the employment relationship**
HIV infection is not a cause for termination of employment. Persons with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.

9 **Prevention**
The social partners are in a unique position to promote prevention efforts through information and education, and support changes in attitudes and behaviour.

10 **Care and support**
Solidarity, care and support should guide the response to AIDS at the workplace. All workers are entitled to affordable health services and to benefits from statutory and occupational schemes.

[40] Source: ILO. (2002). Implementing the ILO Code of Practice on HIV/AIDS and the world of work: an education and training manual. Available at: www.ilo.org.

Handout

## HIV/AIDS Workplace Policy Checklist[41]

An HIV/AIDS policy defines an organization's position and practices for preventing HIV transmission and for handling HIV infection among employees. The policy provides guidance to supervisors who deal with the day-to-day issues and problems that arise in the workplace. Also, the policy informs employees about their responsibilities, rights and expected behavior on the job.

An HIV/AIDS policy:

- Sets a foundation for HIV/AIDS prevention and care programs;
- Offers a framework for consistency of practices within a business;
- Expresses the standards of behavior expected of all employees;
- Informs all employees what assistance is available and where to get it;
- Guides supervisors and managers on how to manage HIV/AIDS in their work groups;
- Assures consistency with relevant local and national laws and statutes.

The following checklist can be used as a guide in preparing a company HIV/AIDS policy. The points in the checklist can be considered paragraphs or provisions in the policy.

**Introduction**

Reason(s)why the company has an HIV/AIDS policy;
Persons covered by the policy (some or all employees or different provisions for different
categories of employees);
Policy compliance with national and local laws and trade agreements;
How the policy will be applied.

**General Considerations**

- Statement regarding the intent of the company to have an HIV/AIDS policy for application to company operations;
- Statement whether the policy is specific to HIV/AIDS or whether it incorporates HIV/AIDS into existing sections on life-threatening illnesses.

**Elements Relating to Employment Criteria**

- Statement that applicants and employees will not be screened for HIV as a condition of continued employment or promotion;
- Provision on circumstances where an employee would be asked to be tested for HIV, including:

[41] Source: Family Health International. (2002). Workplace HIV/AIDS Programs: An Action Guide for Managers. Available at: www.fhi.org.

- Explanation of the reasons why a request would be made for an HIV test;
- Statement of whether the employer or employee would be responsible for paying for an HIV test;
- Statement that pre-and post-test counseling would be provided for any employee who is asked (or asks) to take an HIV test;
- Statement of the company response if an employee refuses to be tested;
- Statement of the company ’s intention to keep all medical information, including results of HIV tests, confidential;
- Statement of company intentions toward employees who, if required to be tested, are found to be HIV-positive;
- Statement of the appeal, arbitration and resolution options for employees who refuse to be tested or who, if tested, are found to be HIV-positive;
- Statement of the company ’s position toward insurance companies that may require an HIV test for various forms of coverage.
- Statement that the company is willing to make accommodations (such as less rigorous work or a different work environment) for employees who request such accommodations because of HIV infection;
- Provision that the company will maintain and enforce legal, acceptable and recognized occupational safety precautions to minimize risk of workplace exposure to HIV;
- Provision relating to the privacy of employee personnel records, including medical records;
- Statement prohibiting stigmatization of and discrimination against employees who are (or who are suspected of being) HIV-positive.

**Elements Relating to Benefits and Treatment for HIV-infected and HIV-affected Employees**

- Provision of benefits related to HIV infection is likely to be an extension of existing benefit provisions. As part of an overall prevention program, an HIV policy can explicitly refer to assistance in the treatment of STIs. As implied in the previous section of this checklist, workers with HIV/AIDS should receive the same type, level and form of benefits as other employees with serious illnesses.

***Provisions include:***

- Statement about company and employee contributions to health and medical care, life and disability insurance, workers ’ compensation, social security and other retirement benefits, compassionate leave (for caregiving, funerals), death benefits for beneficiaries, treatment for opportunistic infections related to HIV and treatment for HIV;
- Coverage for dependents;
- Statement about company provision of or support for assistance in gaining access to life-saving treatments and drugs for HIV and opportunistic infections;
- Provision of or support for counseling and related social and psychological support services for HIV-infected and HIV-affected employees (and dependents);

- Statement that the company recognizes the importance of peer-support groups and permits such groups to be formed and to meet on company property (during or outside of work hours);
- Legal support services. Although companies may worry about legal challenges, company support for employees (in-house or contracted out) to access legal advice can assist in safe-guarding dependents through preparation of wills, transfer of property and leveraging of public services.

**Elements Relating to Workplace Prevention**

Statement that HIV/AIDS prevention is the responsibility of all employees, including senior management and supervisors;

Statement about the leadership role of managers and worker representatives, both in the company and in the wider community, in addressing HIV/AIDS;

Statement emphasizing the importance of (and company expectations of) employees avoiding risky sexual behavior;

Statement referring to company and union responsibilities for maintaining an environment that reinforces safe sexual behaviors;

Statement of company and union responsibilities for providing all employees with timely, accurate, clear and adequate information about HIV prevention, community support services, treatment options and changes in company prevention activities;

Description of the HIV prevention components that will be available to employees. Recommended components include easy and regular access to male and female condoms, access to diagnosis and treatment of STIs, training of peer educators who will be accessible to employees and information about prevention and care services that exist in the community.

Handout

Example: CONGRESS OF SOUTH AFRICAN TRADE UNIONS (COSATU), "DRAFT WORKPLACE POLICY ON HIV/AIDS."[42]

**Preamble**

HIV and AIDS in South Africa are a major health problem, with employment, human rights and economic implications. This policy is intended to cover all employees and employers in the Republic of South Africa. The policy is necessary for the workplace because: HIV infection takes place mostly among the economically active age group. Women are additionally at risk of HIV infection. The policy recognizes that workplace-based programs that promote HIV/AIDS awareness, prevention and care are an important part of a national HIV/AIDS strategy.

The main objective of this policy is to reduce the number of new infections among employees and their families and to ensure that the rights of employees with HIV are fully respected. This policy conforms to the Southern African Development Community Code on HIV in Employment, which was endorsed at the SADC summit in September 1997.It is also in compliance with the protections against arbitrary discrimination that are embodied in existing labor legislation.

**Non-discrimination**

Employees with HIV/AIDS should be treated the same as all other employees.

Employees with HIV-related illnesses, including AIDS, should be treated in the same way as any other employee with a life-threatening illness.

An employee with HIV/AIDS should not face unfair discrimination in access to employment, training, promotion or employee benefits.

Employees infected with HIV should be protected from stigmatization and discrimination by co-workers. Where there has been adequate information, education and provisions for safe work, then disciplinary procedures should apply to people who victimize other employees with HIV.

**Confidentiality and Testing**

It is the law that HIV testing should only take place after appropriate counseling and with informed consent.

There should be no direct or indirect pre-employment testing for HIV. There should also be no HIV testing for training or promotion purposes.

The HIV status of an individual employee is of no relevance to an employer. People with HIV have equal rights to privacy and confidentiality. If an employee discloses his or her HIV status to colleagues and management, this information should be treated as confidential.

**Managing Illness and Job Security**

[42] Source: Family Health International. (2002). Workplace HIV/AIDS Programs: An Action Guide for Managers. Available at: www.fhi.org.

No employee should be dismissed merely on the basis of HIV status; nor shall HIV status influence retrenchment procedures.

When, due to medical reasons, an employee can no longer continue with his or her normal employment duties, efforts should be made to offer alternative employment (reasonable accommodation). When the employee becomes too ill to perform his or her job, standard procedure for termination of employment due to incapacity should apply, without discrimination.

**Education, Counseling and Training**

A fund should be established at the industry level, jointly managed by the union and employers, for the purpose of HIV/AIDS education and training in the industry.

HIV/AIDS education and counseling should take place in every workplace during working hours.

The objectives of education, counseling and training should be:

1. To create awareness of the HIV/AIDS epidemic;
2. To remove the stigma against those infected;
3. To promote safe sex through condom distribution;
4. To equip union leadership with counseling skills;
5. To provide care and support for people with HIV/AIDS.

To ensure effective education, the industry should build partnerships with local, provincial and national government, as well as with NGOs, CBOs [community-based organizations] and organizations of people living with HIV/AIDS. Strategies should be devised to monitor the impact of training on an ongoing basis.

**Health and Safety**

- All workplaces must ensure that they are equipped with proper universal precautions (infection control equipment and procedures) that can be used in cases where there are accidents that lead to blood spills.
- Workplace health and safety committees should receive special training in HIV and AIDS and on how to take universal precautions.

**Healthcare Funds**

Efforts should be made to standardize health care services throughout the industry, and primary protocols for the care and management of HIV should urgently be developed.

No healthcare fund should be allowed to discriminate by refusing cost-effective treatment and/or reasonable benefits for the treatment of sexually transmitted diseases (STDs), including HIV.

Additional funds should be made available in order for the healthcare funds to offer quality services for HIV/AIDS infection.

**Provident Fund and Other Benefits**

While it is recognized that HIV/AIDS may make it necessary to restructure or revisit employee benefits, this should be done in a way that allows the funds to remain economic but does not exclude or limit benefits to employees with HIV/AIDS.

Employers and unions should commission research into the impact of HIV/AIDS on existing employee benefits.

**Implementation**

The union should establish necessary structures at all levels, including joint union and management teams, for the successful implementation of this policy.

**Review, Monitoring and Evaluation**

A baseline study to establish the present impact of HIV in the workplace, including knowledge of HIV by workers and employers, should be conducted as soon as possible. Pilot programs to test AIDS prevention strategies should be devised and run jointly by the union and employers. In addition, there should be ongoing evaluation and monitoring of activities that are required by this policy.

The policy should be reviewed periodically in the light of changes in medicine and science concerning the HIV/AIDS epidemic.

**Notes:** If we oppose discrimination against PLAs, then the phrase *unfair discrimination* should be avoided; *discrimination* should assume its rightful place. In other words, we should talk of "discrimination," rather than of "unfair discrimination."

The International Institute on Gender and HIV/AIDS
Day 6 & 7: Agenda
Development

Day 6

9:00 Panel/speaker: The role of development in HIV/AIDS

9:45 Demographic Silhouettes

11:15 Break

11:30 Development and Adoption of Strategies

12:30 Lunch

1:30 Gender Sensitive Responses to the Multi-Sectoral Approach to HIV/AIDS

3:30 Wrap-up (see Appendix 3)

Day 7

9:00 Panel/speaker: success and failures of a multi-sectoral approach to HIV/AIDS

10:00 Break

10:15 Helps/Hinders: resistance and motivators

12:00 Lunch

1:00 Energizer (see Appendix 2)

1:15 Speaker: how to conduct a research project

2:15 Break

2:30 Pulling it all together: A research protocol to measure impact

4:30 Wrap-up (see Appendix 3)

## Demographic Silhouettes[43]

Objective: To create awareness of the social and economic causes and consequences of the epidemic at the level of the family and by extension at the community level.

Time: 90 minutes

Materials: Silhouette cut-outs representing persons of different ages and sexes (they should have a yellow dot on the top and some should have a blue dot on the back), "Demographic Silhouettes" resource sheet.

Procedure:

1. Place piles of silhouettes of men, women, children, old men, and old women on a table with the yellow dot facing up.

2. Participants should form small groups. Each group is asked to select silhouettes that represent members of an imaginary family of their choice.

3. When all have comprised their imaginary families, ask each small group to develop a story of their family, indicating the roles the members play in terms of meeting the economic, social, health and other needs of the family. This should result in a lively sharing of ideas about how members contribute to a family's quality of life.

4. After the stories are shared, ask the groups to flip over the cards to expose the other side where some of the cards are marked with a blue dot.

5. Inform the group that these members have HIV/AIDS.

6. Ask participants to develop the story further by reflecting on and discussing how this new information will affect the family roles established, and the well being of the family as a whole.

7. Ask what issues emerge from the stories, e.g. burden on women, denial, impact on the economy. Supplement the discussion by referring to the "Demographic Silhouettes" resource sheet.

8. Discuss how an impact at the household level can be transformed into an impact at the national and macro economic level.

[43] Adapted from: UNIFEM. (2000). Gender, HIV and Human Rights: A Training Manual. New York: Author.

Cut-Outs

Demographic Silhouettes

## Development and Adoption of Strategies[44]

Objective: To identify critical stakeholders and develop gender responsive strategies for the prevention, treatment and care of HIV/AIDS.

Time: 60 minutes

Materials: Flipchart, markers, tape, handouts: "Development and Adoption of Strategies: Case Studies" and "Development and Adoption of Strategies: Guiding Questions", "Development and Adoption of Strategies: Summary Notes" resource sheet.

### Procedure

1. Divide participants into 4 groups. Assign each group a case study or testimony from the "Development and Adoption of Strategies: Case Studies" handout and give each group a copy of the "Development and Adoption of Strategies: Guiding Questions" handout.

2. Allow 30 minutes for discussion. Remind participants to tease out the gender dimensions in the case studies and questions.

3. Facilitate a report back session and allow the larger group to ask questions and make comments to refine the strategies. Refer to the "Development and Adoption of Strategies: Summary Notes" resource sheet.

4. Record the key emerging strategies and conclude the activity by reaching a consensus on them.

[44] Adapted from: Commonwealth Secretariat. (Draft). Gender and HIV/AIDS Training Manual. London: Author.

Handout

## Development and Adoption of Strategies: Case Studies

### Case study 1: Patty's experience

Patty is married and has nine children. The seven older children live with her mother. In 1999 Patty was diagnosed HIV positive. Her husband threw her out with their two youngest children. When Patty was thrown out of the marital home, which was characterised by extreme violence, she went to live with her mother. Her father had died of HIV/AIDS in the year 1995. In the year 2000 her mother also died of HIV/AIDS. Patty now has to care for the nine children all by herself. None of the children are in school and some are malnourished. They live in one room, a corner of which is partitioned off and used to generate income by selling small household commodities. This meagre income and what the older girls can earn from selling sex keeps the family alive. No help has been forthcoming from Patty's husband or from her in-laws and other extended family relatives. Patty is becoming weaker and weaker, and is in and out of hospital. She is extremely depressed and keeps indoors, avoiding contact with the community.

### Case study 2: Ayanda's Story

Ayanda is 26 years old. When her partner died of HIV/AIDS he left her with two children aged three and five. Immediately following the death of her partner, Ayanda was also diagnosed HIV positive. She lives in a shack near a dumping site in Maritime City. Ignorant of her HIV/AIDS status her aunt invited Ayanda to stay with her. Soon the information that she was HIV positive spread like wild fire. The neighbours started talking. Some of the aunt's close friends advised her to evict Ayanda from the house. People in the community would stare at Ayanda as she walked the streets. They would avoid communicating with her, including those who used to be her friends. Finally, Ayanda's aunt advised her that the mourning period was over and that she should go back to her "home". She also promised to provide Ayanda with basic necessities.

In desperation Ayanda sought help and support from a charitable organisation for vulnerable children, as she got weaker and weaker. A year has passed and the organisation has not made a decision on how they intend supporting her inspite of Ayanda's frequent visits. They keep postponing their decision and turning her away. She then approached the local social worker, who has been promising to visit Ayanda to assess her case.

Ayanda is back in the shack and the City Council is threatening to evict her. She is unemployed and destitute and the children have nothing to eat. Her aunt has not provided her with the basic necessities as promised. Ayanda becomes increasingly depressed.

Case study 3: Something to share from Zwinila

When the HIV/AIDS epidemic hit Zwinila country in 1985, numerous activities emerged, undertaken by different sectors in the economy. Information dissemination messages such as "AIDS kills", "abstain", "be faithful", "condomise", "live positively to live long" emerged. Different messages from different sectors flooded the market. The church, NGO's, health, education and the private sectors had their share in the development of messages. Years later, assessment through various studies indicated that there was no significant progress in reducing the impact of the disease. The Government of Zwinila became very concerned and decided to declare HIV/AIDS a national crisis. The National Policy on HIV/AIDS was formulated in 1998. Programmes and projects were put in place to address the crisis. A number of structures were established to implement HIV/AIDS specific programmes and projects.

Case study 4: Testimonial

"My husband passed away due to HIV/AIDS when he was 35; he was ill for six months. He used to work as a general labourer on a big farm and only came home at weekends. We have eight children, but the last two both died of HIV/AIDS. This leaves me with six children to feed. It is very difficult. The two eldest have had to leave school to try and earn money, but I am trying to keep the youngest four in school.

In the early stages of my husband's illness we could cope. It became difficult when he lost his job. We had to spend a lot of his savings on special food for him, and he lost his medical aid cover. I grow maize and try to make money selling crochet work, but it is not sufficient. I cannot get a well paying job – These days it is even more difficult as a woman.

My husband's employers helped with the funeral expenses and will pay me a small pension for four years. As he had not worked there for long, the amount is insufficient. However my husband's brother is supposed to take care of us. Although he knows our problems he did not help at all during my husband's illness or after his death. Now he wants to marry me, but I suspect his aim is to inherit my husband's estate, as is commonly practised in this community. I am lucky because my husband left a letter instructing that his property was to remain with the children and me and that I should not marry his brother in the traditional way. My husband had realised that marrying his brother would automatically transfer ownership of the family estate to him. My children would loose out on their inheritance and general well being. Fortunately, the headman and the other village elders support this decision because they know that this brother did not help us when my husband was alive. Otherwise it would have been very hard for me to refuse. I have to think of my children. But by refusing to marry him I lose any hope of help from him.

If I die the older children will have to take care of the young ones. I cannot trust my husband's brother, and I do not think his first wife would treat them well. My own two sisters cannot take the children because their husbands will not allow it. It is not traditional and they have their own families. The women take care of the children, but it is the husbands who must make the decision about this."

Questions

- Who are the critical stakeholders in your case study or testimony? Identify and list them.
- What challenges does each stakeholder face, stated or implied?
- What are the roles and responsibilities of each stakeholder in HIV/AIDS prevention, treatment and care? What additional roles and responsibilities would you expect of each critical stakeholder?
- What strategies can each stakeholder adopt to achieve HIV/AIDS prevention and treatment measures including provision of care?

Use the following reporting format to assist you in your group work:

| Critical stakeholder | Problems faced | Roles and responsibilities | Strategic action |
|---|---|---|---|
| | | | |

Resource Sheet

## Development and Adoption of Strategies: Summary Notes

The following key issues emerge from the exercise in this session – these should be highlighted as a summary:

Socio-economic

Sex work – restricted opportunities for girls due to poverty
Economic deprivation, poverty and women's dependency on men
Imbalances in the sharing of responsibilities between women and men
Violence: physical, emotional and psychological suffered by women and children
Inadequate shelter, food and clothing.

Negative cultural practices

Stigma, negative attitudes and cultural practices,
Male and female vulnerability due to harmful traditional practices.

Community based support

- Lack of family support,
- HIV/AIDS responsive community leaders,
- Inadequate support services such as counseling, testing and general public education that should facilitate informed decision-making in HIV/AIDS,
- Lack of coordination of efforts in service delivery.

Legislation

- Women's rights to property ownership,
- Need to protect the lives and privileges of people living with HIV/AIDS as well as those affected by the epidemic.

National level interventions

- Policies and programmes do not filter down to local communities

Gender analysis in HIV/AIDS

Research has demonstrated that HIV/AIDS impacts differently on the lives of females and males. It is therefore imperative that any response to the epidemic should begin by recognising that females and males are likely to have different strategic needs and therefore different interventions. This recognition calls for a gender analysis, to identify the different impacts of HIV/AIDS on females and males. The gender analysis will serve as an organizational tool, encompassing principles that will bring out the nature of social relationships, between females and males in a conceptual manner. The analysis will reveal social realities, life expectations and economic circumstances. It will further provide the information on the following aspects:

- a framework to analyse and develop policies, programmes, projects and legislation

- research and collecting data that recognizes that women and men are not the same in terms of for instance race, ethnicity, and sexual orientation. This should lead to a realization that the assumption that individuals and especially women and men are affected differently by the HIV/AIDS epidemic.

The analysis identifies how the conditions and experiences of women and men make them susceptible to infections. The collection and use of sex aggregated data revealing the roles of females and males is critical. The data needs to be more qualitative rather than quantitative in order to make visible socially constructed experiences, which increases the risk of infection. The data is then fed into policies, programmes, projects and activities indicate the differences.

## THE STRATEGIES

Both women and men need to be empowered to protect themselves against HIV/AIDS.

*Women* need information and education, skills, access to services and technologies, access to economic resources, social capital and the opportunity to have a voice in decision-making at all levels.

*Men* need to become partners in prevention and education, and to be encouraged to adopt healthier sexual behaviour. This means that in addition to health information, education, counseling and services, they should be provided with information about the gender dimensions of HIV/AIDS and the implications of their behaviour for women, families and communities.

*Young persons* need programmes and projects specifically targeting young women and men based on the following principles:

- Participation in programme planning, implementation, monitoring and evaluation,
- Provision of youth friendly services and centers,
- Parental involvement, guidance and supportive communication,
- Sensitisation and education of boys and men about their sexuality and behaviour
- Establishment of networks for young people including those living with HIV/AIDS, for the protection of human rights and promotion of acceptance by society,
- More commitment and more decision-making by young people themselves about their sexual behaviour and influence on peers.

### National response

Policy makers should recognize the importance of the involvement and enrolment of stakeholders particularly at community level, from planning through to implementation, monitoring and evaluation of programmes.

## Gender Sensitive Responses to the Multi-sectoral Approach to HIV/AIDS[45]

Objectives: To define the multi-sectoral response to HIV/AIDS, to identify the strengths and weaknesses of a multi-sectoral response to HIV/AIDS, and determine conditions conducive to its successful implementation.

Time: 2 hours

Materials: Flipchart, markers, tape, "Gender Sensitive Responses to the Multi-sectoral Approach to HIV/AIDS" resource sheet, overheads: "Commonwealth Framework for a Multi-Sectoral Response at National Level", "Commonwealth Framework for a Multi-Sectoral Response at Community Level", and "Objectives and key aspects of a multisectoral approach to HIV/AIDS"; "Analysis of a Multi-Sectoral Response to HIV/AIDS" handout

### Procedure

1. Conduct a short discussion on the multi-sectoral response to HIV/AIDS. Guiding questions can include the following:

- What do you understand the multi-sectoral approach to mean?
- What are some of the sectors that should be involved?
- How can it be applied to HIV/AIDS?
- Who are the key actors in HIV/AIDS?
- What resources would be needed in a multi-sectoral approach to HIV/AIDS?
- What are the essential success factors for a multi-sectoral approach to HIV/AIDS?

Use the resource sheet to guide the discussion.

Record all key points from the responses on a flip chart.

2. Use the overheads "Commonwealth Framework for a Multi-Sectoral Response at National Level", "Commonwealth Framework for a Multi-Sectoral Response at Community Level" to generate a discussion using the following questions:

- What are the missing components, elements or key players? (Record them on a flipchart)
- What might be the positions of women, men and young persons?

[45] Adapted from: Commonwealth Secretariat. (Draft). Gender and HIV/AIDS Training Manual. London: Author.

- What implications does this have on a decision-making, policy development and implementation?
- How might we enhance equitable participation in decision-making within the multi-sectoral response context for HIV/AIDS?

3. Divide participants into small groups. Give each small group a copy of the handout "Analysis of a Multi-Sectoral Response to HIV/AIDS". Give groups sufficient time to complete the handout and consider the questions.

4. In the large group, ask each small group to provide a summary of their discussion.

5. Wrap-up the activity by sharing the overhead "Objectives and key aspects of a multisectoral approach to HIV/AIDS".

Resource Sheet

## Gender Sensitive Responses to the Multi-sectoral Approach to HIV/AIDS

What is a multi-sectoral approach to HIV/AIDS?

"A multi-sectoral response means involving all sectors of society – governments, business, civil society organisations, communities and people living with HIV/AIDS – at all levels – pan-Commonwealth, national and community – in addressing the causes and impact of the HIV/AIDS epidemic. Such a response requires action to engender political will, leadership and co-ordination, to develop and sustain new partnerships and ways of working, and to strengthen the capacity of all sectors to make an effective contribution."

(Commonwealth Secretariat, 2001)

| | **GOVERNMENT** | BUSINESS | CIVIL SOCIETY ORGANISATIONS |
|---|---|---|---|
| **ACTORS** | Heads of state<br>Government Ministers and MPs<br>Political leaders at central and local government levels<br>Civil servants at central and local government levels | Chief Executives<br>Managing Directors<br>Boards of Directors<br>Managers | University and educational leaders<br>Religious and community leaders including traditional and spiritual healers<br>NGOs<br>Trade union leaders<br>Leaders of professional associations<br><br>Traditional political leaders<br>PLHA, people affected, orphans |
| **SECTORS** | Health<br>Education<br>Social Welfare<br>Water and Sanitation, Finance<br><br>Labour<br>Transport<br>Industry, Commerce, Agriculture,<br>Defense<br>Culture and National Heritage<br><br>Home Affairs<br>Public Service<br>Information and Broadcasting | Insurance<br>Banking<br>Beverages<br>Human Resource Development<br>Construction<br>Tourism,<br>Pharmaceuticals<br>Mining<br>MFI, medium and small enterprises | NGOs and charitable organizations<br><br>Professional associations<br>Religious organisations<br>Traditional, community and cultural leaders<br>PLHA<br>Media<br>Traditional healers |
| **RESOURCES** | Human resources<br>Physical infrastructure<br>Funds | Human resources<br>Physical infrastructure<br>Funds | Human resources, immediate families and extended families. |

Overhead

Commonwealth Framework for a Multi-Sectoral Response at National Level

| | GOVERNMENT | BUSINESS | CIVIL SOCIETY ORGANISATIONS |
|---|---|---|---|
| **ACTORS** | Heads of state<br>Government Ministers and MPs<br>Political leaders at central and local government levels<br>Civil servants at central and local government levels | Chief Executives<br>Managing Directors<br>Boards of Directors<br>Managers | University and educational leaders<br>Religious and community leaders including traditional and spiritual healers<br>NGOs<br>Trade union leaders<br>Leaders of professional associations<br>Women's and youth leaders<br>Traditional political leaders<br>PLHA, people affected, orphans |
| **SECTORS** | Health<br>Education<br>Social Welfare<br>Water and Sanitation, Finance<br>Gender/Women's Organizations<br>Labour<br>Transport<br>Industry, Commerce, Agriculture,<br>Defense<br>Culture and National Heritage<br>Youth<br>Home Affairs<br>Public Service<br>Information and Broadcasting | Insurance<br>Banking<br>Beverages<br>Human Resource Development<br>Construction<br>Tourism,<br>Pharmaceuticals<br>Mining<br>MFI, medium and small enterprises | NGOs and charitable organizations<br>Women's organizations and groups<br>Professional associations<br>Religious organizations<br>Traditional, community and cultural leaders<br>PLHA<br>Media<br>Traditional healers |
| **RESOURCES** | Human resources<br>Physical infrastructure<br>Funds | Human resources<br>Physical infrastructure<br>Funds | Human resources, immediate families and extended families. |

Overhead

Commonwealth Framework for a Multi-Sectoral Response at Community Level

| | GOVERNMENT | BUSINESS | CIVIL SOCIETY ORGANISATIONS |
|---|---|---|---|
| **ACTORS** | Local government officers and chiefs<br>Bureaucrats<br>Local chiefs and community leaders<br>Social welfare officers<br>Politicians<br>Health workers<br>Agricultural, forestry and veterinary extension workers<br>Other development workers | Commercial farmers<br>Traders<br>Retailers and food sellers<br>Pharmacies<br>Manufacturers<br>Media | PLHA<br>Traditional, religious, political and community leaders<br>Teachers<br>Parents and grandparents<br>NGOs, CBOs and ASOs<br>Women's organizations and groups<br>Trade unions<br>Vulnerable groups<br>Community media<br>Associations e.g. women, youth, poverty action,<br>Subsistence farmers<br>Formal and informal sector workers<br>Community volunteers<br>Traditional and faith healers |
| **SECTORS** | Transport<br>Industry, trade and mining<br>Education<br>Health<br>Legal and justice<br>Community Development<br>Culture<br>Youth<br>Agriculture<br>Information<br>Traditional, political, community leaders' associations | Transport<br>Industry, trade, commerce and mining<br>Retailing | Prominent individuals e.g. sportspersons, musicians<br>Professional associations<br>Cultural organizations<br>Religious organizations |
| **RESOURCES** | Primary health centres, Schools and other government facilities<br>Funds | Volunteers and mentors<br>Funds<br>Skills<br>AIDS aware workforce<br>Commodities e.g. condoms, drugs | People<br>Trained professionals<br>Aware media<br>Community groups e.g. handicraft, income generation<br>Human spirit, inner strength<br>Families |

Handout

## Analysis of a Multi-Sectoral Response to HIV/AIDS

What current sector-based HIV/AIDS activities do you know of? Record these on the table below:

| SECTORS BY GROUP | ACTIVITIES | LEVELS (e.g. national, regional or community) |
|---|---|---|
| Government<br>Education<br>Agriculture<br>Defence<br>Finance | | |
| **Business/Private**<br>Banking<br>Construction<br>Tourism<br>Enterprises | | |
| **Civil Society**<br>NGOs<br>CBOs<br>Care providers<br>PLWA<br>Tradition healers<br>Faith healers<br>Sex workers<br>Religious organizations<br>Professional associations<br>Traditional and community leaders | | |

Questions:

1. Are there activities that are implemented by more than one sector, within or across groups? (For example, within the government group – Education and Health, or across groups – Health and NGOs).

2. What are some of these common activities.

3. What deliberate measures are being taken to recognize these commonalities in program initiatives?

4. What steps are being taken to address duplication of programs across sectors?

5. Are there activities that are exclusively implemented by sectors? Give examples.

6. What should institutions and organizations do to strengthen support for and improve service provision to people living with AIDS and affected persons?

7. How can networking and collaboration be made more strategic in order to enhance efficiency in the provision of services?

Overhead

Objectives and Key Aspects of a Multi-Sectoral Approach to HIV/AIDS

- To link HIV/AIDS to all poverty reduction strategies and other actions aimed at improving quality of life.
- To recognise that people living with HIV/AIDS (PLHA) must be central to responses and that their participation and empowerment to enable them to take effective action themselves and with others is essential to success.
- To promote political will and mobilise action to break the silence about HIV/AIDS, reduce discrimination and stigma, protect the human rights of PLHA, provide effective programmes to prevent, treat, care for and mitigate the impact of HIV/AIDS, and mobilise and make available resources for civil society organisations engaged in prevention and care.
- To pay particular attention to the specific needs of adolescents and young people, especially girls, in order to prevent them from becoming infected.
- To address the needs of vulnerable and disadvantaged groups, such as the majority of women and girls in developing countries, those living in poverty, street children, the disabled, migrants, refugees, sex workers, people in detention, those living in conflict zones, injecting drug users, and men who have sex with men.
- To ensure that the needs of those caring for PLHA are taken into account.
- To promote policies that enable communities to take effective action themselves and with others to prevent HIV infection and to improve the quality of life of PLHA.
- To facilitate partnerships among all agencies at local, national and international levels, recognising the important roles that civil society and the private sector can play.
- To expand efforts and improve methods for prevention, treatment and care. This includes providing access to affordable drugs that alleviate the symptoms and opportunistic infections associated with HIV and reduce parent-to-child transmission, and vigorously pursuing innovative measures including vaccines, microbicides and traditional and complementary therapies that are appropriate and affordable for those living in developing countries.

Key aspects of a multisectoral approach to HIV/AIDS are to:

- Consider HIV/AIDS and its implications in all areas of policy-making;
- Involve all sectors in developing a framework to respond to the epidemic;
- Identify the comparative advantages and roles of each sector in implementing, activities;
- Encourage each sector to consider how it is affected by HIV/AIDS and how its actions impact on the disease;
- Develop partnerships within government and between the public sector, private sector and civil society.

## Helps/Hinders[46]

Objective: to identify key forces, allies and elements, success and failures, in adopting a multi-sectoral response to HIV/AIDS prevention and care.

Time: 90 minutes

Materials: Cards or small pieces of paper, markers, large headings – "Helps", "Hinders", "Both", "Not Sure" – placed on the wall

### Procedure

1. Introduce the objective of the activity.

2. Ask participants to get into groups of two. Instruct the groups to discuss the key forces and elements and major supports and allies in developing a multi-sectoral response to HIV/AIDS prevention and care. Ask them to choose four of the most important (two strengths and two challenges) and note them on the cards in headline form.

2. Give each pair four cards and some markers.

3. After twenty minutes, explain how to post the cards in the four columns on the wall: "Helps, Hinders, Both, Not Sure." Ask the first group to post their cards and to explain how each force or element is helping or hindering their struggles. If it is both helping and hindering, place it under "both". Subsequent groups should place their cards in relation to what is already there.

4. When all the cards are posted, reflect on the "Hinders" column. Ask, "What's missing?" and "What are the common threads?" Ask the group to summarize the dominant agenda (what we're up against).

5. We look at the other columns to pinpoint key elements for a discussion of strategy:
- In "Helps", who are our allies? What are some stories of resistance or of how we've already worked together?
- How can we turn the "Both" and "Not Sure" forces into "Helps"?
- How can we find the "cracks" in the dominant agenda to turn them into "Helps"?

6. Wrap-up the activity by summarizing the conditions that are necessary for the successful implementation of a multi-sectoral response to HIV/AIDS.

[46] Methodology adapted from: Arnold, Rick, Burke, Bev, James, Carl, Martin, D'Arcy, Thomas, Barb. (1991). Educating for a Change. Toronto: Between the Lines.

## Pulling it all Together: A Research Protocol to Measure Impact

Objectives: To apply a gender mainstreaming and development approach to HIV.

Time: 2 hours

Materials: Flipchart, marker, participant notebooks, pens, handouts: "A Research Protocol to Measure Impact", "An Agenda for Further Social Science Research".

### Procedure

1. Give each participant a copy of the "A Research Protocol to Measure Impact" handout.

2. Ask participants to form pairs – preferably two people from similar regions/communities. Instruct the pairs that they will design a research protocol to determine the impact of HIV/AIDS on families in their community. Give participants sufficient time to draft their protocols.

3. Ask participants to form small groups of two pairs. Participants should present and share their protocols with one another.

4. Ask the small groups to consider the similarities and differences and key insights of all participant protocols. Each small group should consider: how is gender an integral consideration for the protocol? How can this research be used to consider the impact on the community, region, or nation? Who and what sectors would be interested in the research results?

4. In the large group, each small group can describe the similarities and differences and key insights of all participant protocols. Document the answers to the questions: how is gender an integral consideration for the protocol? How can this research be used to consider the impact on the community, region, or nation? Who and what sectors would be interested in the research results? on flipchart paper.

Handout

## A Research Protocol to Measure Impact

### Steps for Research

1. Problem identification

2. Literature review

3. Specify the research question and objectives

4. Research study design and methodology

5. Review of existing evidence/data

6. Data collection

7. Data processing

8. Data analysis

9. Report writing

10. Using research findings: dissemination/feedback to respondents, application to policy and/or intervention

### About Research Problems

Consider:

- What is/are the research questions?
- What existing evidence would answer these?
- What type of new evidence do you need?
- What kind of research methodology is needed?
- Who/what would the study population be?
- How will gender and/or rights be addressed in this study?

Study Designs[47]

The type of study design chosen depends on:

- The type of problem,
- The knowledge already available about the problem, and
- The resources available for the study.

| State of knowledge of the problem | Type of research question | Type of study design |
|---|---|---|
| Knowing that a problem exists, but knowing little about its characteristics or possible causes | What is the nature/magnitude of the problem?<br><br>Who is affected?<br>How do the affected people behave?<br>What do they know, believe, think about the problem? | Exploratory studies or descriptive studies:<br><br>Descriptive case studies<br>Cross-sectional surveys |
| Suspecting that certain factors contribute to the problem | Are certain factors indeed associated with the problem? | Analytical (comparative) studies:<br>Cross-sectional comparative studies<br>Case-control studies<br>Cohort studies |
| Having established that certain factors are associated with the problem; desiring to establish the extent to which a particular factor causes or contributes to the problem | What is the cause of the problem?<br>Will the removal of a particular factor prevent or reduce the problem? | Cohort studies<br>Experimental or quasiexperimental study designs |
| Having sufficient knowledge about cause to develop and assess an intervention that would prevent, control, or solve the problem | What is the effect of a particular intervention/ strategy?<br>Which of two alternative strategies gives better results?<br>Are the results in proportion to time/money spent? | Experimental or quasiexperimental study designs |

**Exploratory study**: is a small-scale study of relatively short duration which is carried out when little is known about a situation or problem and/or if the problem and it's contributing factors are not well defined. When doing exploratory studies, we describe the needs of the population studied, the causes of problems and possibilities for action. Exploratory studies gain in explanatory values if we approach the problem from different angles at the same time. Method:

**Descriptive study**: involves the systematic collection and presentation of data to give a clear picture of a particular situation. They can be done on a small or large scale.

[47] Adapted from: World Health Organization. (2001). Transforming Health Systems: Gender and Rights in Reproductive Health. Geneva: Author.

Descriptive studies describe in-depth the characteristics of one or a limited number of "cases" (patient, health center, village, etc.). Method: interviews, focus groups.

**Cross-sectional surveys**: aim at quantifying the distribution of certain variables in a study population at one point of time (e.g. physical characteristics, socioeconomic characteristics, behaviour, knowledge, attitudes, beliefs, opinions, events). Cross-sectional surveys cover a sample of the population and may be repeated to measure changes over time. Method: survey.

**Analytical study**: attempts to establish causes or risk factors for certain problems. This is done by comparing two or more groups some of which have or develop the problem and some of which have not. The common types of analytical studies are:

- **Cross-sectional comparative studies**: Many cross-sectional surveys focus on comparing as well as describing groups (e.g. percentage of population with the problem you are studying; the socioeconomic, physical, political variables; knowledge, beliefs, opinions).
- **Case-control studies**: compares one group among whom a problem is present with another group, called a control or comparison group, where the problem is absent to find out what factors they have contributed to the problem.
- **Cohort studies**: where a group of individuals that is exposed to a risk factor (study group) is compared with a group of individuals not exposed to the risk factor (control group). The researcher follows both groups over time and compares the occurrence of the problem that he or she expects to be related to the risk factors in the two groups to determine whether a greater proportion of those with the risk factors are indeed affected.

**Intervention studies**: the researcher manipulated a situation and measures the effects of this manipulation. Usually (but not always) two groups are compared, one in which the intervention takes place and another groups that remains "untouched". There are two categories of intervention studies:

- Experimental studies: individuals are randomly allocated to at least two groups. One group is subject to an intervention, or experiment, while the other group(s) is not. The outcome of the intervention (effect of the intervention on the dependent variable/problem) is obtained by comparing the two groups. The classical experimental study design has three characteristics:
  - Manipulation – the researcher does something to one groups of subjects in the study.
  - Control – the researcher introduces one or more control group(s) to compare with the experimental group.
  - Randomization – the researcher takes care to randomly assign subjects to the control and experimental groups. (Each subject is given an equal chance of being assigned to either group).
- Quasi-experimental studies: is where at least one characteristic of a true experiment is missing, either randomization or the use of a separate control group.

A quasi-experimental study, however, always includes manipulation of an independent variable that serves as the intervention. One of the most common quasi-experimental designs uses two (or more) groups, one of which serves as a control group in which no intervention takes place. Both groups are observed before as well as after the intervention, to test if the intervention has made any difference. The subjects in the two groups (study and control groups) have not been randomly assigned.

Data Collection Methods

1. **Surveys or questionnaires**

*When to use it:* for standardized responses from a large number of people, for measurable information, to compare changes in responses before or after an intervention, to get a lot of information from people in a non-threatening way.

*When not to use it:* if you need detailed information from a small number of people, if you want to emphasize richness rather than numbers, if you want to tell a story.

*Advantages:* anonymous, inexpensive, easy to compare and analyze, can get a lot of information for a lot of people, can collect qualitative data to enrich/compare

*Challenges:* may not get careful feedback, wording bias can affect participant responses, may not get "the full story", surveys are impersonal.

2. **Focus groups**

*When to use it:* to learn about consensus or disagreement on a topic, if you have a small and homogeneous group of people that you want to interview together, if you want a range of ideas on a complex topic, if you want to tell a story.

*When not to use it:* if you don't have someone with appropriate skills to conduct the focus group, if participants are not comfortable with each other, if participants have had too little involvement/interest in the topic.

*Advantages:* can quickly and reliably get common impressions, can be an efficient way to get a range and depth of information in short time.

*Challenges:* can be hard to analyze responses, need a good facilitators, can be difficult to schedule people to come together.

3. **Telephone interviews**

*When to use it:* for long-term follow-up, when it is difficult to get an entire group of people together at the same time, when your target population has telephones.

*When not to use it:* if you need detailed information, if anonymity is important, if your target population doesn't have telephones.

*Advantages:* can get full range and depth of information, can develop relationship with participants, can be flexible, can get a better response rate than surveys.

*Challenges:* can take a lot of time, can be hard to analyze and compare, can be costly, can bias participant responses, requires trained interviewers, provides less anonymity.

4. **In-person Interviews**

*When to use it:* to collect data from people with key information, to have open-ended discussion on a range of issues, to obtain in-depth information on an individual basis about perceptions and concerns.

*When not to use it:* when anonymity is important, when you need quantitative information.

*Advantages:* can be used to discuss sensitive issues that interviewees may be reluctant to discuss in a group, can probe individual experience in depth.

*Challenges:* can be time consuming, can bias participant responses, can be hard to compare and analyze, requires trained interviewers, provides no anonymity, can be costly.

5. **Document Review**

*When to use it:* when you want to know about implementation of a project, when you want data from outside your project to compare.

*When not to use it:* when you are not sure if the data or information is reliable and/or valid.

*Advantages:* can get comprehensive and historical information, does not interrupt project, information already exists, fewer biases.

*Challenges:* can take time to document, information might be incomplete, requires good and consistent recording skills, data restricted to what already exists.

6. **Observation**

*When to use it:* to see a situation/activity first hand.

*When not to use it:* when your presence would be disruptive to the participants.

*Advantages:* provides firsthand knowledge of a situation, can discover problems that parties are unaware of, can produce information from people who have difficulty verbalizing their points of view, more objective.

*Challenges:* can affect the activity being observed, can be time consuming, can be labour intensive, not always easy to analyze observational data.

7. **Case Studies**

*When to use it:* to fully understand or depict participant's experience.

*When not to use it:* if you have a large number of participants.

*Advantages:* can fully depict client's experience with project input, process and results and is a powerful means to portray a situation to outsiders.

*Challenges:* can be time consuming to collect, organize, and describe.

Ethics

Always consult and adhere to your institution's guidelines on the ethical treatment of human subjects in research projects.

Essentially, such guidelines are concerned with:

- Ensuring participants have given informed consent (in writing) to participate in the project.
- Preserving the confidentiality of participants.
- Protecting your participants from harm (physical, mental, emotional). There are usually special considerations for children and for marginalized populations (e.g. PHAs, Aboriginal peoples, etc.).

Handout

## An Agenda for Further Social Science Research[48]

There is no shortage of issues for research by social scientists seeking to improve understanding of, and response to, the HIV/AIDS pandemic. The following list grows out of our own work for this paper, and it is also shaped by our discussions with social scientists already actively involved in research and its application in this field.

Two overarching concerns are reflected in the list. The first is the need for greater differentiation in the analysis of *who* is affected by the epidemic (distinguishing by gender, age, social position, education, occupation, rural or urban setting, and so forth), greater ability to distinguish the *reasons* for any distribution and trends that appear to be occurring, and a more concrete understanding of *how* HIV/AIDS affects households and societies as a whole. Second, there is a need to appreciate the socioeconomic, cultural and political factors that both strengthen and inhibit the capacity of particular societies to deal with the epidemic.

The list is then divided into three broad categories: (i) *contextual issue*s, research about which can help policy makers, program planners and managers, social scientists and activists understand and respond better to the numerous factors that are driving the pandemic; (ii) *impact issues* that remain critical to understanding effective approaches to mitigation, support for affected households and communities, and realistic international responses; and (iii) *programming issue*s, where research can aid in the design and implementation of prevention, care and mitigation efforts.

Findings from too many of the research projects undertaken to date have not been relevant for program design or policy development. Thus, beginning at the conceptualization and design stage of any social science research activity that deals with HIV/AIDS, researchers must work closely with program planners, policy makers and advocates to ensure that findings are relevant to their needs.

### Contextual issues

#### The global context for HIV/AIDS

1. It is obvious that rapid and equitable economic growth is an essential element in slowing the AIDS epidemic. What changes in global trade, debt relief and commodity price policies would be required to ensure that fairly distributed economic growth can be achieved in developing countries? And what global socioeconomic conditions and policies are heightening the susceptibility of people - especially of people in developing countries - to the HIV epidemic? To answer these questions requires integrating HIV/AIDS thinking into international debates on major development issues. Research on specific country cases can highlight the role played by various international policies and

[48] From: Collins, Joseph and Rau, Bill. (2000). AIDS in the Context of Development. Available at www.unrisd.org.

institutions (including multinational corporations) in affecting the capacity of governments and NGOs to conduct effective prevention, mitigation and care programs.

2. It is also extremely important to evaluate global development goals, including those agreed by the OECD Development Assistance Committee and others set at international summits, in light of the worsening pandemic. It is likely that HIV/AIDS will be the biggest obstacle to achieving these goals - and in fact that it will not be possible to meet them at all unless there is a much more effective response to AIDS.

Country and local context

1. To gain a clearer picture of the socioeconomic, cultural and political factors affecting the course of the epidemic, case studies of the development of HIV/AIDS in similar kinds of environments - say commercial farming areas - in three or four different countries could be very useful. Work like this should trace the profile of the epidemic in each case and document, for each stage, how different groups were affected, how society responded and what social changes have occurred. If a study of this kind is well done, it might be possible to distil lessons of use in other contexts.

2. Specific public policy approaches in countries like Uganda or Thailand, which have been relatively successful in containing the epidemic, could also be compared with those of countries where little has been accomplished. A similar exercise could focus on regions within a single country (comparing, say, the situation in Kerala with that in another Indian state). The challenge in this kind of work is to explain the social, political and institutional factors that make for more or less effective responses to HIV/AIDS.

3. At the same time, it would be useful to assess the implications of HIV/AIDS for national poverty reduction strategies, carrying further the work that is already in progress. Many countries are setting time-bound targets for poverty reduction and for progress in such fields of human development as literacy, life expectancy, child mortality and gender equality. The epidemic must be factored into these plans, so that there will not be a bias in projections or a limitation to actions in Heavily Indebted Poor Countries (HIPCs) that are preparing Poverty Reduction Strategy Papers.

4. It is urgently necessary to improve debate on issues of health sector reform by relating them clearly to the challenge of HIV/AIDS. What are the essential elements of public and private health systems that can successfully confront a rapidly expanding pandemic? Here the holistic nature of health care must be highlighted through case studies. What kinds of counselling and testing services, for example, would have to be in place before sharp reductions in the cost of AIDS drugs could really benefit most people who must live with the disease in developing countries? How can needed laboratory systems and staff training services be provided?

5. In most countries, civic organizations have taken a lead in promoting prevention and care. How have responses to the epidemic strengthened or weakened civil society in

different countries and regions? What are the practical implications for governance of different approaches to HIV/AIDS? Here the experiences of the Philippines and Myanmar might usefully be compared.

6. There is a broad scope for new research on AIDS and the workplace. For example, the organizational cultures of different kinds of companies affect HIV prevention programs. Unions and workers groups also play an important role in determining whether HIV/AIDS is a workplace issue and how the epidemic is negotiated with management. In turn, the dynamics of labour/management relations affect the likelihood that people living with HIV/AIDS will be able to participate more broadly in the kinds of mobilization that can assert and protect their rights.

7. Labour migration is an essential element in the social and economic context of HIV/AIDS. It could be very useful to identify sites of labour migration where living conditions (privacy, the right for workers to be accompanied by their families, recreational facilities and opportunities, health services and so forth) are reasonable, and to analyze the costs and benefits of such situations from the perspective of AIDS prevention - as well as from the broader perspective of sustainable human development.

8. In a similar vein, case studies of the relation between construction projects and HIV/AIDS - and the way this symbiosis affects both workers and host communities - have immediate policy relevance. What factors seem to reduce susceptibility to HIV/AIDS? Projects that supposedly have taken steps to reduce susceptibility of workers and host communities - if there are such - should be included in the research.

The International Institute on Gender and HIV/AIDS
Day 8, 9 & 10: Agenda
Work plans and Evaluation

Day 8

9:00 Speaker/panel: how to develop a work plan

10:00 Break

10:15 Dreams, Nightmares and Realities

12:00 Lunch

1:00 Work plan development

4:00 Wrap-up (see Appendix 3)

Day 9

9:00 Work plan development (continued)

12:00 Lunch

1:00 Work plan presentation and discussion

4:30 Wrap-up (see Appendix 3)

Day 10

9:00 Sabotage List

10:00 Break

10:15 Post-Institute: Directions & commitments

10:45 Evaluation of Institute

11:45 A Closing Activity: Warm Fuzzies

12:15 Lunch

## Dreams, Nightmares, & Realities[49]

Purpose: To assist participants to name their positive and negative fantasies and then nail down the reality with which they are confronted. This puts them in a more realistic position to act, to build a strategy around the resources they possess and those that they might need to acquire.

Time: 90 minutes

Materials: Flipchart, markers, and tape.

### Procedure

1. Introduce the activity by informing participants that they will consider the dreams, nightmares and realities which they are faced in order to be in a more realistic position to act. This will give participants a context for which to develop their work plans.

2. Ask participants to break into three groups. Give each group flipchart paper and markers. Ask one group to brainstorm their most cherished dream for their community (or organization or themselves) and document them on flipchart paper. Then, pick one dream to draw into a picture to capture how they are feeling about the situation. Ask the second group to repeat the process for nightmares. Ask the third group to repeat the process for realities.

3. In the large group, ask each small group to share their lists and pictures.

4. Next, encourage people to talk about what actions must be taken, or what things must be prevented from occurring, to keep the situation from descending into their nightmare. Conversely, they also talk about what they must do to move their situation toward the dream.

[49] Methodology adapted from: Lee, Bill and Balkwill, Mike. Participatory Planning for Action. Toronto: Commonact Press.

# Work Plans

Objective: to develop a work plan that will mainstream gender, incorporate human rights and foster a multi-sectoral response to HIV/AIDS.

Time: 6 hours (development), 3.5 hours (presentation and discussion)

Materials: Paper, pens, handouts: "Situational Analysis: Revisited", "Transformative Projects". "Program/Project Worksheets". Participant Situational Analysis (conducted during the Pre-Institute).

## Procedure

1. Give each participant a copy of each of the handouts and worksheets.

2. Inform participants that over the next several hours, they will develop a work plan/action plan. This is an individual activity unless there are two or more people from the same organization in which case they can work together. Participants are encouraged to:

   Refer to their Situational Analysis
   Refer to their notes and handouts from the Institute
   Reflect on the acquired knowledge and skills regarding gender, human rights, development, multi-sectorality and HIV/AIDS

3. In the report back session, participants can either:
   - Present their work plan to the large group
   - Form small groups of participants comprised from the same region/country

4. Participants should discuss each work plan by:
   - Considering the strengths, challenges
   - Sharing ideas and strategies
   - Providing motivation and support

Handout

## Situational Analysis: Revisited

Refer to your situational analysis to consider the following:

1. Historical Timeline
    - What forces in your timeline will support an approach to HIV/AIDS that mainstreams gender, incorporate human rights and foster a multi-sectoral response to HIV/AIDS? Can you predict a best case, worse case or middle case scenario?
    - What forces might hinder this? Can you predict a best case, worse case or middle case scenario?

2. Partnerships
    - What institutions, organizations, departments, etc. have you not typically worked with, but now might consider?
    - How can you foster collaboration between agencies?
    - How can you resolve or avoid conflict?

3. Where are you in your organization?
    - Do you feel differently about any of your answers?
    - Do you feel that you have the knowledge, skills and tools to address the areas you are dissatisfied with?

4. HIV/AIDS in your community/region/nation
    - How can you build on the successes/strengths of your community/region/nation?
    - How can you address the challenges of you community/region/nation?

Handout

## Transformative Projects[50]

Practical projects can serve the process of transformation.

- Projects should be the result of a process where people have seen the need for them. This will require a clear-cut vision of a just society. Projects can be undertaken as instruments for social transformation.
- Projects must be translated into useful tools to hasten the establishment of a just society.
- Projects operated on a collective basis can build the solidarity of a community.
- Projects can be used specifically to do survey and research, which is necessary to lead to critical awareness and education work. The ultimate goal is organizing people for power. Again, this will, even in the initial stages of planning projects, need a clear-cut vision of the goal to be achieved.

Practical projects are detrimental to the process of transformation when:

- they fail to analyze power relations and/or continue/maintain paternalism.
- they are seen as the functional end, and not as a means of the entire social transformation process. This prevents projects from being temporary instruments for social transformation, and ways to develop a people's movements.
- they kill all self-reliance and make people parasites.
- by channelling resources, they make the churches (or other agencies) temporal powers, separating and alienating the group or a religious person from the rest of society.
- instead of organizing people for power to bargain with the government, they support unjust government plans and projects and divert people's attention from the basic problems.
- they create tense competition or resentment among people and obstruct the process of social transformation (e.g. when projects encourage competitive profit-seeking).
- they serve the middle class in society.
- they are managed by people outside the project community, and so can never take root in it.

To ensure that projects are to serve the social transformation of society:

- Projects should have the vision of the transformed society.
- People should participate in deciding, planning and implementing projects according to their needs.
- Projects must be small enough to build awareness and organization among people, and to keep people aware that it is their own struggle.

[50] Adapted from: Hope, Anne and Timmel, Sally. (1995). Training for Transformation: A Handbook for Community Workers. London: ITDG Publishing.

Handout

## Project/Program Worksheets

1. Writing Program Goals and Objectives

Goals: general statements about what you are broadly trying to accomplish, over a longer time frame, through the implementation of the program/project.

Objectives: specific, measurable statements of what you want to accomplish by a given point in time by implementing the program/project.

| Goal: | | |
|---|---|---|
| | Question | Answer |
| Specific | Who is expected to change? | |
| | What do you want to change? (e.g. knowledge, skills, attitudes, behaviours) | |
| | Where do you expect the change to occur? (e.g. schools, community, city) | |
| Measurable | How would you measure the objective? | |
| Action-oriented | How many or how much change is expected? | |
| Realistic | What makes you think the goal is doable? | |
| Time-limited | When do you expect the change to occur? (e.g. end of program, in the next 6 months) | |
| Objective: | | |

2. List of Goals and Objectives

List the objectives for each goal. Ensure that each objective contributes to the goal and that no objective is repetitive/redundant. Repeat this for each goal. The number of goals will vary depending on the project/programs and the number of objectives for each goal will also vary.

| |
|---|
| Goal: |
| Objective 1: |
| Objective 2: |
| Objective 3: |
| Objective 4: |

3. Identifying Activities, Outputs and Outcomes

Use the following template to identify your target group(s), activities and outputs associated with each of your project goals. Repeat for each goal.

| |
|---|
| Project Goal (Intended Long-Term or Final Outcome): What are you ultimately trying to accomplish or change with your project? What benefits are you ultimately trying to achieve? |
| Target Group(s): To whom is this program/project targeted? In which target group(s) do you intend to make the desired changes? |
| Activities: What key activities are done in your program/project which are focused on achieving this goal? |
| Outputs: What products, tools, resources, or services are produced by each project activity? |

4. Logic Model

A logic model is a visual depiction or flow-chart of the activities, outputs and outcomes of the program/project and how these components are related. It is useful for clarifying how your program/project is supposed to work and for confirming that it "makes sense".

5. Developing Indicators of Your Outputs and Outcomes

Use this template to identify the indicators of your program/project's outputs and immediate outcomes. Repeat the template to identify indicators for all of your outputs and outcomes.

| Indicators of Outputs: What pieces of information could you collect in order to determine if each output has been produced? | |
|---|---|
| OUTPUT 1 | INDICATORS |
| OUTPUT 2 | INDICATORS |
| Indicators of Immediate Outcomes: What pieces of information could you collect in order to determine if each immediate outcome has been achieved? | |
| OUTCOME 1 | INDICATORS |
| OUTCOME 2 | INDICATORS |

6. Evaluation: Developing a Plan

Use this template to adapt one of your immediate project outcomes into an evaluation question. Then specify the associated indicator(s), possible data sources and data collection methods to answer the question. Also indicated who would be responsible for collecting data and the timing or frequency of data collection. Repeat this for each of your evaluation questions.

| |
|---|
| Evaluation Question/Immediate Outcome (e.g. To what extent has the program/project increased participants' knowledge…): |
| Indicators (e.g. level of participants' knowledge and awareness before AND after the program/project activities): |
| Data Sources (e.g. participants)/Data Collection Methods (e.g. questionnaire): |
| Responsibility for Collection (personnel): |
| Timing/Frequency of Data Collection (will depend on timelines, budgets, human resources, travel restrictions, etc.): |

## Sabotage List[51]

Objective: to create a list of behaviours that may harm the work plans that participants have developed.

Time: 60 minutes

Materials: Flipchart, markers, tape, pens, paper.

### Procedure

1. Introduce the concept of unintentional sabotage:

"Almost every group that undertakes action will find that things don't always go according to plan. At some point, the strategy apparently breaks down. In many instances, this will occur because of an unforeseen circumstance – the resources weren't there or information was not as accurate as we would have liked.

Sometimes, however, part of the failure can be traced to our own behaviour, to things we could have done that we did not do, or something that we did do that we should not have done. These "sabotage behaviours" are not necessarily deliberately malevolent acts aimed at blocking positive change. They are often subtle, daily acts or omissions that can disrupts a generally solid strategy."

2. Ask participants to form small groups. Give each group paper and pen. In each group, ask participants to think about, describe and document the behaviours that will damage their strategy/work plan. One way of stimulating thinking is to ask: "What could we do or refuse to do that could really endanger our work plan?"

3. Next, ask the small groups to examine the list and check it for:

- overlapping ideas;
- missed ideas;
- ambiguous language;
- anything they are uncomfortable with.

Encourage the group to be as clear as possible with the list. This is the list that participants will use to keep themselves on track as they pursue the work plan that they have worked so hard to create.

4. When the groups have completed their work, ask each one in turn to make one contribution and document it on flipchart. Keep going around until all ideas are up on the flipchart.

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[51] Lee, Bill and Balkwill, Mike. (1996). Participatory Planning for Action. Toronto: Commonact Press.

## The Post-Institute: Directions and Commitments

Objectives: to plan the follow-up to the Institute, to foster the commitment of participants beyond the Institute.

Time: 30 minutes

Materials: Flipchart, markers, tape, wall space.

### Procedure

1. Tape up X pieces of flipchart paper on the wall.

2. Inform participants that the goal of the Post-Institute is to extend the learning and sense of community beyond the Institute and to measure the impact of the Institute – e.g. did it create 'change agents'? Make a difference to organizations, communities, etc.?

3. On the first piece of flipchart paper, ask participants to brainstorm the role of the Post-Institute, what would be useful and helpful to participants back home. Document their responses. Possible responses could include:

- To report on and garner support for the implementation of work plans
- To develop and support an alumni, a learning community.
- To share tools and resources in order to carry out action research
- To share tools and resources on gender, human rights, development and HIV/AIDS
- To share challenges and successes
- To mentor, coach, support each other
- To report on and monitor dissemination and uptake

4. On the next piece of flipchart paper, discuss and document the mechanism by which to facilitate the Post-Institute and who will take the lead. Possible responses could include:

- A members-only list serv (virtual community) – two participants could volunteer to moderate, take the lead
- Follow-up meeting (e.g. in one year) – ACEWH staff could agree to look into possibility of funding and other logistics

5. Inform participants that they will be expected to complete a follow-up questionnaire to measure the impact and uptake of the Institute (e.g. in six months and/or in one year). Ask participants if there are other ways that they think the impact and uptake could and should be measured.

## Evaluation of the Institute

Objective: to measure the efficiency and effectiveness of the Institute in terms of process and content.

Time: 60 minutes

Materials: "Evaluation of the International Institute on Gender and HIV/AIDS" questionnaire, pens.

### Procedure

1. Give each participant a copy of the questionnaire and a pen. Give participants sufficient time to complete the questionnaire.

2. Collect the questionnaires.

3. Facilitate a round robin session by asking participants to consider the following:

- One thing about the Institute that worked.
- One thing about the Institute that could be improved.
- One word to describe your overall impression of the Institute.

International Institute on Gender and HIV/AIDS
Evaluation[52]

1. What were your expectations for the Institute?

2. Were these expectations met?
- Yes
- No
- Partially

Comments:

3. Are you satisfied with the overall balance of topics and materials in the course?
- Yes
- No
- Partially

Comments:

4. Was the course long enough?
Yes, in fact too long
Yes, just right
No, partly
Not at all

Comments:

5. How did you feel about the daily schedule?
Just right
Too short
Too long

Comments:

[52] Adapted from: WHO. (2001). Transforming Health Systems: Gender and Rights in Reproductive Health. Geneva: Author.

6. Were you satisfied with the logistical arrangements (accommodation, meals, meeting room, etc.)?

Yes, mostly
No, partly
Not at all

Comments:

7. Day 1

| Foundations | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Usefulness of content | | | | | |
| Effectiveness of methods | | | | | |
| Level of detail | | | | | |
| Stimulation of thinking | | | | | |
| Impact on professional skills | | | | | |
| Impact on personal skills | | | | | |

Comments:

8. Day 2-3

| Gender | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Usefulness of content | | | | | |
| Effectiveness of methods | | | | | |
| Level of detail | | | | | |
| Stimulation of thinking | | | | | |
| Impact on professional skills | | | | | |
| Impact on personal skills | | | | | |

Comments:

9. Day 4-5

| Human Rights | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Usefulness of content | | | | | |
| Effectiveness of methods | | | | | |
| Level of detail | | | | | |
| Stimulation of thinking | | | | | |
| Impact on professional skills | | | | | |
| Impact on personal skills | | | | | |

Comments:

10. Day 6-7

| Development | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Usefulness of content | | | | | |
| Effectiveness of methods | | | | | |
| Level of detail | | | | | |
| Stimulation of thinking | | | | | |
| Impact on professional skills | | | | | |
| Impact on personal skills | | | | | |

Comments:

11. Day 8-10

| Work plans | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Usefulness of content | | | | | |
| Effectiveness of methods | | | | | |
| Level of detail | | | | | |
| Stimulation of thinking | | | | | |
| Impact on professional skills | | | | | |
| Impact on personal skills | | | | | |

Comments:

12. What was most useful/valuable about the Institute?

13. What could be improved about the Institute?

14. Was there a key learning moment for you during the workshop? If so, what was it and when did it happen?

15. Some courses make a personal impact and some don't. Reflecting on this Institute, do you think there are any ways in which it has changed you?

# Warm Fuzzies

Objective: for participants to show appreciation to and for one another.

Time: 30 minutes

Materials: Paper, tape, markers.

## Procedure

1. Give each participant a piece of paper and a marker.

2. Ask participants to tape the piece of paper on their backs.

3. Participants should then move around the room and write something on each other's backs to show appreciation for the energy, commitment, knowledge, skill, etc.

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Appendix 1

## Resources

### Advocacy, Communications and Media

Advocacy Guide for HIV/AIDS
http://www.ippf.org/hivaids/advocacyguide/index.htm

Advocacy Guide to the Declaration of Commitment on HIV/AIDS
http://www.icaso.org/ungass/advocacyeng.pdf

Community Mobilization Kit - Microbicides: A Female-Controlled Method of Preventing HIV and other Sexually Transmitted Diseases
http://www.cdnaids.ca

Gender Equity and Health Advocacy Kits
http://www.paho.org/english/hdp/hdw/advocacykits.htm

HIV/AIDS and Human Rights: Young People in Action
http://www.unesco.org/human_rights/index.htm

Monitoring HIV/AIDS Reporting Through a Gender Lens
http://www.womensmediawatch.org.za/archives/products/hivaidsreporting.html

Multi-Media Advocacy Materials: Fact Sheets; Speeches and Presentations; Videos, Films and Photo Exhibits; CD-ROMs; Posters
http://www.genderandaids.org/modules.php?name=Type

Positive Development: setting up self-help groups and advocating for change. A manual for people living with HIV
http://www.gnpplus.net/programs.html

The Wise Guide
http://www.hc-sc.gc.ca/hppb/hiv_aids/can_strat/community/wiseguide.html

### International HIV/AIDS Commitments

ACPD. The Application of Human Rights to Reproductive and Sexual Health: A Compilation of the Work of International Human Rights Treaty Bodies
http://www.acpd.ca/compilation/

Turning the Tide: CEDAW and the Gender Dimensions of the HIV/AIDS Pandemic

http://www.undp.org/unifem/resources/turningtide/

UNAIDS and UN High Commissioner for Human Rights. HIV/AIDS and Human Rights: International Guidelines
http://www.unaids.org/publications/documents/human/law/hright2e.pdf

UNFPA. HIV/AIDS Language from Treaties and International Consensus Documents
http://www.unfpa.org/aids/consensus.htm

UN General Assembly Special Session on HIV/AIDS (UNGASS)
http://www.un.org/ga/aids/coverage/

International HIV/AIDS Organizational Web Sites

Action Canada for Population and Development (ACPD)
http://www.acpd.ca/

BRIDGE: Development, Gender
http://www.ids.ac.uk/bridge/

Canada International Development Agency (CIDA) – Global Health – HIV/AIDS
http://www.acdi-cida.gc.ca/aids.htm

The Commonwealth Secretariat
http://www.thecommonwealth.org/index.asp

Family Health International (FHI): HIV/AIDS
http://www.fhi.org/en/aids/naids.html

The Henry J. Kaiser Family Foundation: Issue Spotlight – The HIV/AIDS Epidemic
http://www.kaisernetwork.org/static/spotlight_hivaids_index.cfm

International Council of AIDS Service Organizations (ICASO)
http://www.icaso.org/

International Centre for Research on Women (ICRW): HIV/AIDS and Development
http://www.icrw.org/strategicareas/hivaids/hivaids.htm

Interagency Coalition on AIDS and Development (ICAD)
http://www.icad-cisd.com/

International HIV Treatment Access Coalition
http://www.itacoalition.org/

International Planned Parenthood Federation (IPPF)
http://www.ippf.org

International Planned Parenthood Federation (IPPF) Western Hemisphere Region: Program Area – HIV/STI Prevention
http://www.ippfwhr.org/programs/program_hiv_e.asp

Pan American Health Organization (PAHO)
http://www.paho.org

Stephen Lewis Foundation
http://stephenlewisfoundation.org/index.html

UNAIDS
http://www.unaids.org/

UNAIDS: HIV/AIDS and Gender
http://www.unaids.org/gender/index.html

United Nations Development Programme (UNDP): HIV/AIDS
http://www.undp.org/hiv/

UNIECF: HIV/AIDS
http://www.unicef.org/aids/

UNIFEM: Web Portal: Gender and HIV/AIDS
http://www.genderandaids.org/index.php

UNRISD
http://www.unrisd.org

World Bank: HIV/AIDS
http://www1.worldbank.org/hiv_aids/

World Health Organization (WHO): Department of HIV/AIDS
http://www.who.int/hiv/en/

Monitoring and Evaluation

FHI: Evaluation and Surveillance
http://www.fhi.org/en/aids/wwdo/wwd12.html

Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision-Makers
http://www.fhi.org/en/aids/impact/impactpdfs/evaluationhandbook.pdf

Guide to Project Evaluation: A Participatory Approach
http://www.hc-sc.gc.ca/hppb/phdd/resources/guide/index.htm

UNAIDS: Monitoring and Evaluation
http://elink.unaids.org/menew/default.asp

Policy

African Priorities for HIV/AIDS: A Summary Document from the National AIDS Plans of Several Sub-Saharan Countries
http://www.aids.harvard.edu/africanow/pdfs/summary.pdf

Workplace HIV/AIDS Policies: An Action Guide for Managers
http://www.fhi.org/en/aids/impact/impactpdfs/workplacehivprograms.pdf

Implementing the ILO Code of Practice on HIV/AIDS and the world of work: an education and training manual
http://www.ilo.org/public/english/protection/trav/aids/code/manualen/index.htm

Appendix 2: Energizers

## The People Say[53]

Objective: to deal with sluggishness during a workshop/meeting/event.
Time: 5 minutes
Materials: None

Procedure

1. Explain to participants whatever has prompted the introduction of the exercise (glazed eyes, fatigue, post-lunch, etc.). Explain that there is a physiological reason for the exercise: to get oxygen to the brain.

2. Explain the game. "I will be asking you to take an action. Because we are concerned about democratic social change here, we want the people involved in our decisions. So, respond to my request only if l preface it with 'the people say'. For example, if l say 'the people say, stand up', you stand up. If I only say 'stand up', you pay no attention."

3. Do the exercise. We don't have people drop out if they miss the trick because the idea is to get some exercise.

## Post Office[54]

Objective: to deal with sluggishness during a workshop/meeting/event.
Time: 5-10 minutes
Materials: chairs in a circle, one for each participant with the facilitator's chair removed, a piece of paper.

Procedure

1. Explain the purpose of the exercise.

2. Outline the rules. The facilitator is a letter carrier with a letter (the piece of paper). The facilitator says, "I have a letter here for everyone with hair on their heads - and the amount of hair doesn't matter." Everyone fitting this description changes chairs across the circle (and not just shifts sideways). Explain that the facilitator will also be looking for a chair. The person without a chair becomes the new letter carrier. Continue until everyone looks more or less awake.

A caution: This activity is not appropriate for groups with participants who are unable to move quickly and easily from chair to chair.

[53] Source: Arnold, Rick, Burke, Bev, James, Carl, Martin, D'Arcy, Thomas, Barb. (1991). Educating for a Change. Toronto: Between the Lines.
[54] Ibid.

## Person to Person[55]

Objective: to deal with sluggishness during a session.
Time it takes: 10 minutes
Materials: an odd number of people

Procedure

1. Ask participants to choose a partner and stand in a large circle.

2. Borrowing a partner, explain the rules and demonstrate how it's done. When two parts of the body (for instance, hand to head) are called out, one person puts her hand on the head of her partner. Continue to call out different combinations until people are tangled up. At that point, shout "person to person" and everyone changes partners. The person without a partner becomes the new caller.

3. Begin the exercise, calling, for instance, "knee to hip, toe to toe, shoulder to ankle" - until everyone is tangled. Then call "person to person" and find a partner yourself. A participant becomes the new caller.

4. Continue as long as time is available or until it threatens to become boring.

## Amoeba[56]

Objective: to deal with sluggishness during a session.
Time it takes: 10 minutes
Materials: none.

Procedure

1. One person starts as the amoeba and tries to catch others. The person caught links arms with the first amoeba to become a two-person amoeba on the prowl.

2. When they catch a third person, all three link hands and are an almost mature amoeba. When they catch a fourth person, all four link hands, and are now a fully grown amoeba.

3. And what happens to the amoeba? It splits down the middle into two amoebas each prowling around.

4.The multiplying and dividing happens again and again, until everyone in the group has been totally “amobeafied”: everyone in the room is an amoeba of two or three persons linked together.

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[55] Ibid.
[56] Weinstein, M. and Goodman, J. (1980). Playfair. San Luis Obispo: Impact Publishers.

## Elbow fruit hop[57]

Objective: to deal with sluggishness during a session.
Time it takes: 5 minutes
Materials: A whistle.

Procedure

1. Call upon any participant to come up and blow a whistle, naming three things. The first is a part of the body and the second is a category from which each participant can choose a member, and the third is a way to move around. So, "elbow, fruit, hop" would mean each person hops around touching her/his elbow and calling out the name of any fruit.

2. Participants continue until someone else comes up and calls out another sequence, say "nose, animal, shuffle".

3. The way to end the game is to come up, blow the whistle and call out "elbow, fruit, hop" again.

[57] Ibid.

Appendix 3: Wrap-Up Activities

## Basic Wrap-up[58]

Objective: To summarize and reflect on the key learnings of the day, to discuss next steps.
Time: 15 minutes
Materials: None

1. Ask a volunteer to summarize some of the key learnings of the day. Encourage other participants to add to the summary.

2. Obtain feedback on the day by asking some of the following questions:
- How are you feeling?
- How is the content useful?
- Who has participated? Who hasn't? Why?
- How is the pacing? Too fast or too slow?
- How is the balance between new and familiar content?
- How is the language level? What has been clear/unclear?

3. Inform the participants of the topic area/objectives for the following day.

## Fly on the Ceiling[59]

Objective: to determine to what extent the process and content of an event are meeting the needs of participants
Time: 10-30 minutes.
Materials: "Fly on the ceiling"

1. Give each participant a copy of the handout and explain the purpose of the exercise. Note that the sheet is for their own reference and will not be collected.

2. Ask for volunteers or ask all participants to comment on what happened for them during the day; what worked or didn't work. Stress that this information will help us redesign the program for the next day.

Variations:
Focus on a particular problem that emerged during the day.
Participants can be asked to say what they want the program to stop, start, keep doing the next day.

[58] Source: Arnold, Rick, Burke, Bev, James, Carl, Martin, D'Arcy, Thomas, Barb. (1991). Educating for a Change. Toronto: Between the Lines.
[59] Ibid.

## Head, heart, feet[60]

Objective: to evaluate a session at its conclusion.
Time: 30 minutes
Materials: Evaluation sheet for each participant, flipchart, markers, tape.

1. Hand out the evaluation sheet, explaining its objective and how the information will be used.

2. Invite participants to draw their head, heart, feet on the paper, using the markers.

3. Ask participants to fill in the form (individually or with someone else).

4. If there is time, ask them to share something they learned or to give final comments.

Variations:
Draw a large head, heart, feet on flipchart paper and post it. Distribute small slips of paper and ask participants to write down the major things they learned or got out of the event. Post these points in the appropriate position on the flipchart and discuss them.

## One Word or Feelings[61]

Objective: to take the "temperature" of the group and get in touch with any dissatisfactions.
Time: 30 minutes
Materials: Paper, pens.

1. Ask each person to write down one or two words expressing how s/he feels about the program so far.

2. Go around the circle asking each person to say only the one or two words they wrote. Do not start discussion until all have given their words.

3. Ask some, especially those who have expressed dissatisfaction or whose comments are puzzling, to explain why they said what they did.

[60] Ibid.
[61] Hope, Anne and Timmel, Sally. (1995). Training for Transformation: A Handbook for Community Workers. London: ITDG Publishing.

## Listing the Main Parts of the Program[62]

Objective: to evaluate the day.

Time: 45 minutes

Materials: Agenda of the day listed on flipchart, paper, pens.

1. Give each participant paper and pen.

2. Consulting the flipchart with the agenda listed on it, ask participants to write whether each part of the agenda was: very helpful, fairly helpful or not helpful. They are also asked to write a remark about each part. If an opportunity is provided to discuss with participants why they rated each item as they did, one often gets a much fuller understanding of people's needs, and good ideas for the future.

[62] Ibid.

Handout

## Fly on the Ceiling

1. What did we do today? Why?

2. What happened for you – summarize what you learned or how you felt.

3. What could you use? How could you change it to meet your own situation? What alternatives can you think of?