



## DISCUSSION PAPER

### HIV & AIDS, GENDER AND DOMESTIC VIOLENCE:

Implications for policy and practice



## Table of Content

<b>Table of Content</b> .....	<b>1</b>
<b>List of Abbreviations</b> .....	<b>3</b>
<b>1. Introduction</b> .....	<b>4</b>
<b>1.1 Background</b> .....	<b>4</b>
1.2 Structure of the paper.....	4
1.3 Aim of the discussion paper .....	4
<b>2.1 Gender and HIV transmission</b> .....	<b>5</b>
2.1.1 Definition of Gender versus Sex.....	5
2.1.2 How do gender roles – expected male and female behaviour – relate to the risk of HIV transmission?.....	5
<i>Economic Dependence</i> .....	5
<i>Upbringing and Social Identity</i> .....	6
<i>Sexual Behaviour</i> .....	6
<i>Cultural Factors</i> .....	7
<b>2.2 Domestic violence and HIV and AIDS</b> .....	<b>9</b>
2.2.1 What socio-economic and political factors influence domestic violence? .....	11
2.2.2 Abuse of girls.....	12
<b>2.3 Gender roles, domestic violence and people living with the virus</b> .....	<b>13</b>
2.3.1 What impact do gender roles have on the effects of AIDS? .....	13
<b>3 Implications for policy and practice</b> .....	<b>16</b>
<b>3.1 Responses to HIV and AIDS, gender and domestic violence</b> .....	<b>16</b>
3.1.1 HIV and AIDS .....	16
3.1.2 Gender and domestic violence .....	16
<b>3.2 Meaning of mainstreaming HIV and AIDS, gender and prevention of domestic violence</b> .....	<b>16</b>
3.2.1 Definition of Mainstreaming .....	17
<b>3.3 Mainstreaming HIV and AIDS and gender – how to do it?</b> .....	<b>18</b>

3.3.1 How can HIV and AIDS, gender and the prevention of domestic violence be mainstreamed?.....	18
3.3.2 Mainstreaming HIV&AIDS and gender in projects.....	18
<i>Step 1: Situational analysis</i> .....	18
<i>Step 2: Project goal and objectives –deciding on a course of action</i> .....	19
<i>Step 3: Project strategies – gender matters!</i> .....	22
<i>Step 4: Monitoring and evaluation</i> .....	23
3.3.3 Mainstreaming HIV/AIDS and gender internally .....	24
<i>Organisational analysis – breaking the silence</i> .....	25
<i>How to develop and implement a workplace policy on HIV and AIDS and gender</i> .....	26
3.3.4 Flow chart: Steps in Mainstreaming .....	27
<b>References</b> .....	<b>28</b>
<b>Authors</b> .....	<b>32</b>

## List of Abbreviations

ARV	Antiretroviral
BfdW	Bread for the World
FGM	Female genital mutilation
IPV	Intimate partner violence
PLWH	People living with HIV

# 1. Introduction

## 1.1 Background

Bread for the World (BfdW) has been involved in the area of HIV and AIDS, gender and combating domestic violence for many years, and has not only supported work in these three fields but also encouraged partner organisations to address the three topics as cross-sectoral issues in their work. Several papers and publications have been written by BfdW on the close connection of HIV and AIDS, gender, and domestic violence in Africa (Berner-Rodoreda 2008), the connection between domestic violence and HIV and AIDS (Hombrecher 2007) and other internal documents have been developed on the cross-section of HIV, gender and domestic violence. Many of the documents, however, have been specific to one geographic area and few have taken into account all three dimensions in depth. This paper looks at the global situation in respect to all three issues.

## 1.2 Structure of the paper

This paper is divided into three chapters. Chapter One briefly describes the rationale and the aim of the paper. Chapter Two provides an overview of gender and domestic violence in HIV and AIDS discourse and in their interconnectedness. It analyses available literature regarding gender and HIV transmission, domestic violence and HIV and AIDS. It then moves on to discuss how gender roles impact the effects of AIDS. Chapter Three outlines implications for policy and practice. The chapter is sub-divided into two parts. Firstly, it provides a definition for mainstreaming and deals with mainstreaming HIV and AIDS and gender. Secondly, a detailed outline of specific implementation steps addresses the mainstreaming process of HIV and AIDS and gender, including domestic violence in both the project and the organisation (external and internal sphere).

## 1.3 Aim of the discussion paper

The aim of this discussion paper is to promote awareness and trigger discussion on the complex inter-connection of HIV and AIDS, gender and domestic violence, as well as provide specific steps for how these issues can be integrated into project design and implementation. The discussion paper is developed to serve:

- BfdW partner organisations
- Transfer of Function Consultants
- Project officers at BfdW.

## 2 Gender and domestic violence in the HIV and AIDS discourse

### 2.1 Gender and HIV transmission

HIV affects both women and men. There are, however, important differences between women and men in the underlying mechanisms of HIV infection, and in the social and economic consequences of HIV and AIDS. These stem from biological, social, cultural and economic factors that increase susceptibility of women for HIV infection and vulnerability to the impacts of AIDS (Berner-Rodoreda 2008; WHO 2003).

Worldwide 50% of all HIV positive people are women. In Africa, HIV positive women constitute about 60% of all HIV positive people. (UNAIDS 2008) Gender inequalities in society are recognized as playing a key role in driving the HIV epidemic, particularly in respect to women.

#### 2.1.1 Definition of Gender versus Sex

Sex refers to the biological characteristics that define humans as female or male. Gender and gender relations, 'masculinity' and 'femininity' are products of socially-constructed roles and relationships, attitudes, values, behaviour, relative power and influence that society ascribes to the two sexes on a different basis. While sex is determined by genetic and anatomical characteristics, gender is an acquired identity that is learned, changes over time and varies widely within and across societies, religions, class and ethnicity. Gender is relational and refers not simply to women and men but to the relationship between and among them. Masculinity and femininity are products of social and cultural processes (Silberschmidt 2001) and can therefore be altered or modified.

#### 2.1.2 How do gender roles – expected male and female behaviour – relate to the risk of HIV transmission?

##### *Economic Dependence*

In different societies women and men are assigned different gender roles. Traditionally, the gendered division of labour positions women as 'homemakers' and men as 'breadwinners' (Montgomery et al, 2006). Women take responsibility for the domestic affairs including household work and caring for children, elderly and the sick. Generally, the gender norms guiding women's behaviour include being respectful, obedient, submissive and loyal to the husband.

Female 'dependence' on men, in socio-economic terms, was expressed by several participants in a study in Myanmar: "What do I do for my living? Since marrying him, I've been depending on his earnings. All I can do is housework. No more. I'm not educated. So if he goes, whom shall I depend on? With whom shall I live?" (Griffiths, 2007).

Men frequently control the family income. This means that women are often in economically dependent positions that imply lower status and unequal power relations that limit

women's influence on decisions regarding themselves and the family. Although today in many societies the income patterns are changing, and often women are the 'breadwinners' and the men are unemployed, the underlying cultural implications seem to persist.

From an economic perspective, however, the income gap still persists. This is true for both Northern and Southern countries. In the United States of America a survey revealed that an

unmarried woman only earns about 56 cents of every dollar a married man earns, and married women earn less than two thirds of the income of a married man.

	Women		Men	
	Unmarried	Married	Unmarried	Married
Average	\$37,264	\$41,397	\$42,834	\$66,646
Comparative personal earnings	56¢	62¢	64¢	\$1.00

Source: American Community Survey (2006)

There is a general agreement that women are more affected by poverty than men. For many women, low income coupled with the culture of being economically dependent on men conversely fosters income generating initiatives that might put them at risk for HIV infection.

Nsanga, a very poor 26 year old widow lives with her 2 children in Kinshasa, DRC. Desperate for cash and without money to start a business, exchanging sex for subsistence appeared to be her only resource. The first year Nsanga thought she was lucky since she became the second, unrecognized wife of a government official who paid her rent and provided regular support. With a gift from her 'husband' she was able to start a small business, but soon after he left her. Then she began to take on more sexual partners. Most of Nsanga's clients were neighbourhood men, and as her friends or 'husbands', they did not label her as a prostitute. As a mother struggling to survive, she was admired for trying her best to meet family obligations. However, this survival strategy had become a death strategy (Schoepf 2004).

### **Upbringing and Social Identity**

Numerous studies highlighted that although there is a considerable onus on girls and young single women to contribute to the family income, it remains unclear whether similar duties are instilled in sons. This pattern seems to reflect a greater emphasis on duty and a stronger parental control over young women than in young men's socialisation, revealing greater personal privileges among men (Chant 1998).

Drug dependence and excessive alcohol consumption seem to have prominent places in the lives of many adult men and boys as part of their masculine social identity. In contrast, moral considerations and pressure to be sexually virtuous are placed on young single women.

### **Sexual Behaviour**

Traditional gender role training promotes different values and views about sex for men and women (Campbell 1995). In many societies 'manliness' and 'masculinity' are often closely associated with having

In a qualitative study in Myanmar a member of the Women's Association explained: "The main thing is having sex. Do you think my husband is honest? All men are not honest. According to a Chinese saying, if men don't like eating and drinking, they have to have sex or play cards. No man can stay without these 3 facts. My husband avoided having sex with others before but I don't believe that he could resist persuasion. He could refuse the first time. But he couldn't resist when persuaded the second time. My husband used opium before. During that time he did not indulge in women. As he was using opium, he didn't like to go out. So he was freed of women. If he didn't like eating and drinking, he wouldn't be freed of women" (Theuss, Schuele 2007).

multiple sexual partners and negative attitudes towards condom-use, which seems to hold true for both heterosexual men and men who have sex with men (MSM) (Wood and Jewkes 2001, Halkitis et al 2004).

Generally, the fact that men are far more likely to initiate, dominate and control sexual interactions and reproductive decision-making, creates a tremendous barrier to women being able

A qualitative study in Ghana describes the context of HIV transmission, that for most women the use of condoms has a negative association with prostitution, and women have limited ability to influence decision-making. As Karen explains; “As for him he is my husband with whom I live, so I can’t tell him to use a condom when he wants to sleep with me. If a man and woman are married, it is because of children that they have come together” (Mill, Anarfi 2002).

to adopt HIV risk reducing-behaviour (Commonwealth Secretariat 2002). Furthermore, within unequal gender power relations women often are forced to join men in sexual relationships that do not meet their interest and need. This includes sexual relationships that prioritize male pleasure over female pleasure, or forced sex in

which women cannot generally demand condom use, even if they know their husband/partner is involved in multi-partner sexual relations or may be HIV infected. Another factor which puts women at a higher risk of infection and makes it difficult for them to negotiate safer sex practices is the fact that many women – particularly in Africa - marry or enter sexual relationships with much older men who have been sexually active for many years (UNAIDS 2004). This is often seen as a good match, as older men can provide economic security.

Traditional marriage arrangements provide an anchorage for basic trust, but an individual must be both trusting and trustworthy (Giddens 1991). The quest for intimacy as the heart of sexual relationships, coupled with gender asymmetries, sets the background for womens’ vulnerability to HIV infection

In a qualitative research, a young Chinese woman revealed her love story with a much older married man whom she completely trusted. She followed his advice to undergo an abortion when she was pregnant. Following the abortion, they were both tested for HIV and the results were negative. She described him as a real gentleman, a good man who loved her, so she felt a sense of safety; thus he was a man who could be trusted (Schüle 2008).

in marital and extramarital relationships. The notion of trust built through sexual relations creates difficulties in discussing the implications. Insisting on condom use in this context would violate the trust relationship.

### **Cultural Factors**

A number of cultural practices (polygamy, levirate, widow cleansing, female genital mutilation and bride-price and its consequences on the rights of women) make women vulnerable to an HIV infection. Modifying cultural practices needs courageous chiefs and traditional leaders, as well as men and women who are prepared to go against the expectations society has towards them.

70 year old Chief Mbonifor of Bafut is the only chief in his area who lives a monogamous life-style. Other chiefs have recommended that he take on more wives, but he sees the risks of contracting HIV in the polygamous life-style of his fellow-chiefs. Mbonifor was not born into a chief's family. In 1982 he was made 'chief' over 'Nsem'. His wife has always been one of his closest advisors. He has ensured that 50% of his advisors are female. He has also made sure that young people are represented as his advisors. Other chiefs have also increased the number of women as advisors so that women can bring their issues directly to the attention of the chief. Chief Mbonifor also wants to change the rights of inheritance. In order to ensure that women are not left penniless when their husbands die and that property is not taken away from them, he wants to enable them to inherit land so that they have a solid basis for the future (Berner-Rodoreda, 2008).

Female genital mutilation (FGM) affects between 100 and 140 million girls and women worldwide and is practiced mainly in West and East Africa, as well as in some countries in Asia and the Middle East and among some immigrant communities in the north. It is estimated that 3 million girls undergo the procedure every year (WHO 2008). FGM has disastrous consequences on initiates and their sex-life— these have been documented and lobbied against by one of the most out-spoken critics - Waris Dirie (Dirie 1999) and is a manifestation of gender inequality deeply entrenched in socio-cultural, political and economic structures (WHO 2008). FGM also increases the risk of HIV infection in that it may cause tearing and bleeding to occur during sexual intercourse. Often women who have undergone FGM have an increased risk of bacterial vaginosis and a higher prevalence of herpes simplex virus 2 (HSV2), which in turn facilitates HIV infection (Morison et al 2001). It also has harmful effects on childbirth. As well, of course, if same surgical instruments are used without sterilization the procedure of removing the external part of the female genitalia can already be a source of infection. A number of BfdW's partner organisations have already started the fight against practices such as female genital mutilation.

The BfdW partner organisation 'Community Organisation for Relief and Development' (CORD) in Somalia educates trainers on female genital mutilation (FGM) and HIV and AIDS. Topics include: The cultural background of female circumcision, health aspects of FGM, how to eradicate FGM, the Islamic perspective of the practice, as well as risks and basic information on HIV prevention. The trainers then work in the community and hold workshops for traditional birth attendants, midwives, women and youth groups, community elders, religious leaders and journalists. The organisation has found that after only a few months of carrying out these workshops, many parents have come to the understanding that FGM is not advisable for the girls - neither on religious nor health grounds. Yet, the fact that the rite is deep-rooted in the culture of the communities and that the livelihood of the FGM practitioners depends on this practice makes it difficult to eradicate. The organisation works towards a reduction in the number of girls being circumcised through education and media campaigns and by fostering dialogue between religious leaders, medical professionals and the community at large to discuss the dangers of FGM (Berner-Rodoreda, 2008).

The lower status of women and culturally accepted unequal gender power relations makes it possible for men to demand, buy, or enforce sexual favours from girls and women. This may result in outcomes ranging from sexual violence against women, to women trading sexual favours

for material support or aspirations of a particular life style (transactional sex) and prostitution (Du Guerny & Slöberg 1993).

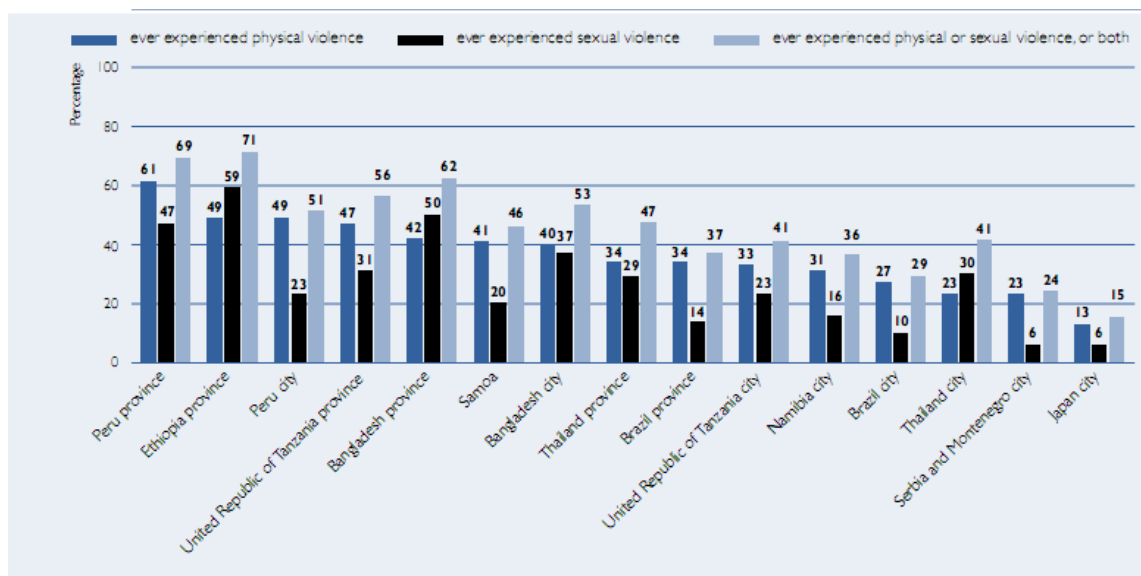
Against this background there are severe limitations on the ability of women to negotiate the boundaries of sexual encounters and ensure their safety, thus contributing to the risk of HIV transmission. In addition, while gender inequalities put men and women at risk of HIV infection, women often are blamed to have departed from socially perceived behaviour that characterizes a 'good' woman and are judged as causing society's problem, - the problem of HIV and AIDS. On the other hand, cultural expectations justify commercial sex, premarital and extramarital relations, to ensure that men's sexual needs are satisfied. This in turn contributes to large-scale 'unsafe' sexual networking as a fertile ground for HIV transmission (Chantavanich et al. 2000).

## **2.2 Domestic violence and HIV and AIDS**

Violence against women is a universal problem and one of the most widespread violations of human rights. More women die through domestic violence than through wars and civil wars. Domestic violence includes physical, psychological, sexual and economic violence (Hombrecher 2007).

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) adopted in 1979 by the UN General Assembly has been ratified by 185 countries. The Convention is the only human rights treaty that affirms the reproductive rights of women and targets culture and tradition as influential forces shaping gender roles and family relations (UN Division for the Advancement of Women). Yet despite its widespread ratification, reality on the ground is different with many women still experiencing discrimination and abuse.

Globally, at least one of every three women will suffer some form of violence that includes physical and sexual attacks in her lifetime. It is estimated that one in five women around the world will become a victim of rape or attempted rape in her lifetime (UNIFEM). However, women are more at risk of experiencing violence from their intimate partners than from other persons. Although the full extent of violence against women is not known, current research indicates that intimate partner violence ranges from 10 to 69 percent (UNAIDS Interagency Task Team on Gender and HIV/AIDS). Domestic violence is a phenomenon found in all societies and among all social classes.



Source: Prevalence of lifetime physical violence and sexual violence by an intimate partner, among ever-partnered women by site, WHO 2005

Women who have experienced violent and forced-sex situations are at higher risk of acquiring sexually transmitted infections including HIV infection due to the increased risk of injuries and tearing during sexual intercourse.

The mere suggestion of condom use can also spark off violence and in Africa, is often closely linked to the tradition of the husband's family paying the bride-price to the wife's family. This makes it extremely difficult for women to protect themselves against HIV.

Some women have suffered rape and severe beatings at the hands of their husbands when they have suggested the use of condoms and such men justify their actions by saying: I paid *lobola* in full and no cow was deducted to compensate for the use of condoms (Women and Law in Southern Africa Research Trust 2000).

Sexual violence against women is not only a cause but also a consequence of HIV infection. Women may be afraid of disclosing their HIV-positive test result to their husbands/partners because of fear of violence. The HIV status of women, therefore, can contribute towards higher degrees of domestic violence:

A study on intimate partner violence (IPV) among pregnant women in Rwanda showed that “of the 600 respondents, 35.1% reported IPV in the last 12 months. HIV + pregnant women had higher rates of all forms of IVP violence than HIV - pregnant women: pulling hair (44.3% vs. 20.3%), slapping (32.0% vs. 15.3%), hitting with fists (36.3% vs. 19.7%), throwing to the ground and kicking with feet (23.3% vs. 12.7%), and burning with hot liquid (4.1% vs. 3.5%). HIV positive participants were more than twice likely to report physical IPV than those who were HIV negative”. Other factors associated with physical IPV included sexual abuse before the age of 14 years, having an alcohol drinking male partner, and having a male partner with other sexual partners (Ntaganira et al. 2008).

In addition, a 2003 report by the US Centres for Disease Control and Prevention (CDC) revealed considerable economic costs of intimate partner violence that exceed US\$ 5.8 billion per year in the United States. This indicates that violence against women impoverishes individuals, families and communities, thus reducing the economic development of nations (UNIFEM).

Domestic violence is based on the model of abuse of a violent, controlling man and a passive woman as a manifestation of gender inequality, growing out of patriarchy (VanNatta 2005). Masculinity is often associated with aggressiveness, control, dominance, courage and strength as a result of a combination of biological, cultural and social influences and relates to the understanding of power in society (UNIFEM).

## 2.2.1 What socio-economic and political factors influence domestic violence?

There is an assumption that the patriarchal system resides in the fact that male authority requires

In a study in Myanmar, women explained that the major reason for friction between couples is matters of money. The inability of fathers to fulfil real family needs and their consumptions on various indulges is expressed as: “Their husbands drink and use drugs. After they get drunk they beat their wives. So the wives get disappointed and go out of home” (Schuele 2008).

a material base, while male responsibility is culturally and normatively constructed. In many countries, socioeconomic change has brought increasing hardship and changing

norms and values. These in turn have weakened the material base of male authority. This situation has a disempowering effect that challenges men’s self-esteem and social value resulting in violence and sexual aggressiveness (Silverschmidt 2001).

The relationship between masculinity and domestic violence, however, suggests a more general crisis of masculinity in men’s identity (Campbell 1992). Violence and masculinity are closely intertwined in the history of armed conflicts and war. Men’s readiness to fight seems to be engendered both in the military camp and at home (New 2001). Frustrations and unfulfilled expectations of significant political and economical changes in post-conflict situations coupled with some men’s inability to live up to socially defined roles, seems to result in men’s loss of their masculine identity. Studies revealed that, although ceasefire agreements have resulted in the end of armed conflict, due to increased economic pressures, gender inequalities play a crucial role in perpetuating violence against women (Schuele 2008, Zwanck 2008).

In 1997, after the genocide in Rwanda, HIV prevalence was 11% in rural and urban areas. This contrasts with the low pre-war HIV prevalence in rural areas (estimated at 1%), where approximately 95% of the population resided. In addition, of the women raped during the war, 17% were HIV-positive (Mc Ginn 2000).

In addition, the context of gender violence in patriarchal cultures, especially in Asia and Eastern Europe, is often linked to masculine identities and their repertoire of desires of various consumption patterns including

In Russia excessive alcohol and narcotic drug consumption coupled with domestic violence is often the reason for divorce. However, as a social worker in Jekaterinburg explained, in the case the former husband has been sentenced, the wife might visit him in prison to provide both material support and sexual services as a sign for love and compassion (personal communication 2008).

excessive alcohol and narcotic drug consumption. In Africa and Latin America excessive alcohol consumption often exacerbates gender violence and can be seen as a primary source of conflict which becomes closely linked to gender violence.

### 2.2.2 Abuse of girls

A UNAIDS survey revealed that HIV prevalence rates of girls in the age group 15-24 year-olds is 2-3 times higher than that of boys the same age in many countries (UNAIDS 2008).

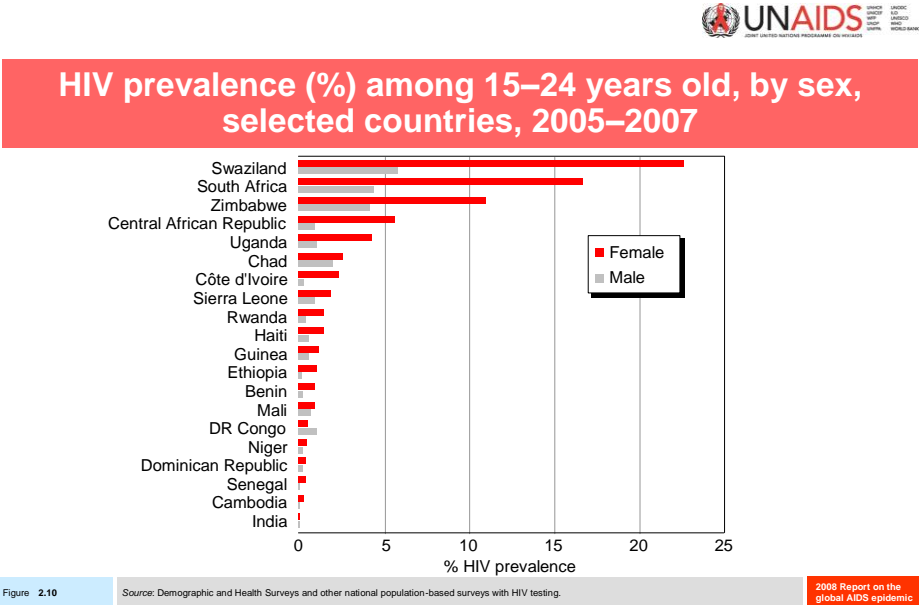


Figure 2.10 Source: Demographic and Health Surveys and other national population-based surveys with HIV testing. 2008 Report on the global AIDS epidemic

UNAIDS (2008) Report on the global AIDS epidemic

In Zambia, widespread sexual abuses of girls significantly contribute to the spread of HIV according to a Human Rights Watch report (2003). Orphaned girls are often sexually assaulted by family members, by their male guardians or by others meant to assist or look after them, including teachers. Also child-headed households are at risk as they often face poverty and have few options apart from trading sex for their own and their siblings’ survival, making use of ‘sugar daddies’ and are mostly not in a position to demand safe sex. The myth, which still circulates in wide parts of Africa, that having sex with a virgin will cure people from HIV infection, has contributed to the widespread sexual abuse of young children (Bernier-Rodoreda 2008).

In addition, children affected by HIV and AIDS who are orphaned often experience poverty. As they become the breadwinner they are forced into exploitive labour, including sexual exploitation which significantly increases their risk to HIV transmission (ECPAT International 2007).

## 2.3 Gender roles, domestic violence and people living with the virus

### 2.3.1 What impact do gender roles have on the effects of AIDS?

Stigma and discrimination associated with HIV and AIDS are major factors in preventing many, both men and women from accessing health services. Women might be more affected by stigma and discrimination than men because of social norms in relation to acceptable sexual behaviour of a 'good woman'.

#### Blame

"In case – after I get married and we are found to be HIV-positive, then I might be suspected, although my husband also might have done something stupid in his youth life. But in case we have HIV then I would be suspected".

#### Shame

"...the parents will be ashamed in front of other people because of their daughter. For the parents to be ashamed would be the worst thing that can happen" (Schuele, 2008).

"In most cases, women carry the burden of breaking the news and they will be blamed for bringing HIV. Men have the means to escape stigmatization by buying friends and buying sex. Also, women stay away from each other if one is HIV positive." (BfdW/ Weinreich, Mokwena 2004, unpublished).

A study in India found that discrimination against daughters-in-law is blatant and women were stigmatized as being "of loose character" and a potential source of infection to their husbands. At the same time they were expected to provide good care for their husbands. This is expressed in the quote as follows: "My in-laws do not have a good opinion about me. They say that my husband got this disease from me. I sometimes feel "Why should I live with this insult? It is better to die." But I am living for the sake of my children". In many cases, after the death of the son, the daughter-in-law was asked to leave to either return to her family or was forced to support herself (Bharat, Aggleton & Tyrer 2001, p 41).

Yet men may be reluctant to go to a health clinic as the clinics are perceived to be for women rather than for men and going to a doctor, nurse or health centre means acknowledging the fact of being unwell which may run counter to the gender expectation of being a strong man who does not need a doctor. This seems one of the reasons why many men present extremely late for receiving ARV treatment. A recent Venezuelan study showed that women were half as likely to present late as men, while homosexual men were less likely to present late than heterosexuals (Bonjour 2008).

"...His answer was "no", he added in case he had HIV, he would commit suicide. Whenever I asked my husband to do the blood test, he used to deny and said he would commit suicide if he is infected" (Schuele 2008).

Violence or fear of violence has been an underlying factor in terms of women seeking HIV testing and treatment. Women may hesitate to be tested for HIV or fail to return for the test result. There is a real fear for many women that disclosure of their HIV status may result in violence, expulsion from their homes or social ostracism.

In 1998, I.M. from Rwanda knew that she was HIV positive. She was raped during the genocide. She suffered from various illnesses and had to go to hospital frequently. Eventually she underwent an HIV test and was given ARVs in 2002. She kept her HIV status to herself and would not talk about it with her children. When she fell seriously ill, she confided in her brother, who took her to the hospital in Kigali. Today she is full of hope and takes her medicines regularly.

Another woman, M.M., also tried to keep her HIV status a secret within her family. One day her child found a bag with medicines and asked what medicines they are. She told her the truth. The child was under shock and ran away from home. Tears running down her cheeks, M.M. told how she lost her only child. Her daughter did not go to school anymore. The family which previously supported the mother dropped her when they found out that she is HIV positive. She still sees her daughter from time to time but the daughter is hostile towards her. (BfdW/Berner-Rodoreda, 2007b unpublished).

Moreover, for women, the effects of AIDS go beyond the severe suffering and death of an infected person. It is likely that women have to carry the economic responsibilities, while, at the same time, care for their husband and sick children, even when being infected themselves. Although, women of all strata of society may be affected, poor women have to carry the heaviest burden.

There is an increased recognition to not only focusing on girls and women but to include men and boys in all project interventions. BfdW partner organisations, therefore, adopted the concept 'Men as Partners' in their project design.

In 2006, the Bread for the World Partner organisation Padare/Enkundleni initiated the Men as Partners Programme, an Advocacy Campaign to work with men and young boys in order to prevent gender based violence and the spread of HIV and AIDS in Zimbabwe. The organisation has mobilised and formed male networks in schools, tertiary institutions, workplaces and communities with the aim of building a gender-just society and facilitates an internal transformation process. [www.padare.org.zw](http://www.padare.org.zw).

In Latin America a number of partner organisations started working with men, as well as focusing on men having sex with men, sex workers and other high risk groups to promoting transformation of behaviour.

Centro de Mujeres de Masaya (CMM) in Nicaragua works with men and women to talk about sexuality, violence in the family and the access to medical services. As a result of the work done by CMM men have gone to urologists to be treated for fungal and sexually transmitted diseases. 80% of sex-workers now insist on condom use and 70% of them have undergone an HIV test, and they are backed by their employers when they are threatened by clients (BfdW/Erdelt-Herzel 2009 unpublished).

This highlights the important role men and boys have in meaningfully changing gender based power relationships, addressing the issue of domestic violence and reducing susceptibility of HIV infection. However, it is not our intention to portray an image of men and boys as perpetrators of violence or of passing on the HIV virus, and girls and women only as victims. This implies that a clear distinction can be made between perpetrators and victims. In social research male vulnerability is largely neglected. While a feminist standpoint seeks to highlight the gendered nature of sexual assault as a social phenomenon, the existence of male victims challenges dominant understanding of victimization that problematize men's sexuality (Graham 2006).

The plight of men and boys is often neglected in projects that address gender-based violence. Since men and boys find it difficult to talk about these issues, specific projects need to be designed to deal with sexual violence directed at boys and men.

It is imperative to work with gender groups in the prevention of domestic violence and the reduction of susceptibility to HIV infection. The realisation that both men and women are equal and responsible partners in their relationship and in the community they live in, contributes to health and wellbeing as well as the harmonisation of gender relations.

### **3 Implications for policy and practice**

For several years now, considerable focus has been placed on the risk that women face from heterosexual contacts, and prevention strategies aimed at reducing women's risk. These prevention strategies, however, often miss acknowledging gender power relations and treat women's risk behaviour separate from the behaviour from men (Campbell 1995). Therefore, there is a need to assess interventions in terms of different levels and to ensure that men are included at each level.

#### **3.1 Responses to HIV and AIDS, gender and domestic violence**

A comprehensive response to HIV and AIDS, gender and domestic violence is involving all actors, and is central to current strategies combating not only the HIV epidemic but addressing gender inequity including domestic violence. Since HIV and AIDS, gender and domestic violence are development issues that have an impact on every aspect of life, all sectors in society, government, civil society and the private sector, need to be included in the response.

##### **3.1.1 HIV and AIDS**

In relation to HIV and AIDS, UNAIDS formulated three interrelated approaches to expand and improve the response to HIV and AIDS as follows:

1. Integration of HIV prevention, care and support into existing health and development projects/programmes
2. Mainstreaming of HIV and AIDS into planning and implementing development projects/programmes
3. Scaling up effective initiatives to cover a wider area or a larger number of people (Collins, J, Rau, B. 2000)

##### **3.1.2 Gender and domestic violence**

Gender mainstreaming aims to reframe the way in which development processes are conducted to achieving gender equity. Moreover, there is increasing recognition that unequal gender power relations and the prevailing notion of masculinity and femininity facilitate HIV transmission and the negative impact of AIDS. Therefore, mainstreaming gender into HIV and AIDS projects by ensuring that gender related factors are taken into account in planning, monitoring and evaluation is central for an effective approach.

The critical element of both HIV and AIDS and gender mainstreaming is re-conceptualising the core work of development and health organisation to pursue strategies aiming to reduce vulnerability to, and impact of HIV and AIDS and promote gender equity (Elsej et al 2005).

#### **3.2 Meaning of mainstreaming HIV and AIDS, gender and prevention of domestic violence**

Generally, the concept of mainstreaming relates to the way organizations and projects have modified operational practices to address cross-cutting issues. The complex inter-connection between HIV and AIDS, gender inequity including domestic violence and development has led to the mainstreaming approach, in which all development actors adopt their core activities to address both the root causes and effects of HIV and AIDS, as well as unequal gender based

power relations. While root causes contribute to individuals (particularly women and girls) and communities' increased susceptibility to the virus, the effects of AIDS deprive households and communities of their assets, thus increasing vulnerability to the effects of the virus. These can also lead to increased incidence of domestic violence.

Mainstreaming HIV and AIDS and gender including prevention of domestic violence proposes an alternative approach to addressing the challenges of HIV&AIDS and unequal gender based power relations within organizations and projects.

### 3.2.1 Definition of Mainstreaming

The term mainstreaming is often used interchangeably with integrating HIV and AIDS related interventions into a project/programme using a multi-sectoral approach to HIV and AIDS. Integration should, however, be separated from mainstreaming as the two concepts denote two entirely different approaches. Integration refers to interventions, which directly focus on prevention, care, treatment, or support in conjunction with or in addition to other projects or within wider programmes (Holden 2004). Integration therefore means adding on components, which could be HIV and AIDS, gender or domestic violence based to a development project.

Mainstreaming, therefore, does not refer to implementing HIV and AIDS and gender activities along with, or as part of other projects/programmes. It is an approach that looks at one's usual work through a gender and/or HIV and AIDS lens. The main question refers to how the organisation and the work could be altered in both gender relations so that women and men benefit from changed gender power relations, lower incidence of domestic violence and reduced susceptibility to HIV infection, as well as mitigating the effects of AIDS in the organisation and community.

There are a number of definitions for mainstreaming. UNAIDS proposes the working definition of mainstreaming HIV and AIDS as follows:

*“Mainstreaming HIV & AIDS is a process that enables development actors to address the causes and consequences of HIV & AIDS in an effective and sustained manner, both through their usual work and within their workplace practices” (UNAIDS).*

Mainstreaming gender is defined as a comprehensive strategy by including a gender perspective into all programmatic areas and existing mainstream institutions. The UN defines gender mainstreaming as follows:

*“... the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres as that women and men benefit equally and inequality is not perpetuated” (UNDP RBEC 2007).*

The prevention of domestic violence follows a gender mainstreaming approach, but focuses on the question of violence experienced and perpetrated by women and men in their domestic and community context.

### 3.3 Mainstreaming HIV and AIDS and gender – how to do it?

#### 3.3.1 How can HIV and AIDS, gender and the prevention of domestic violence be mainstreamed?

The concept of mainstreaming HIV and AIDS and gender consists of an internal and external domain. Internal mainstreaming refers to processes within an organisation or in other words, this process puts the house in order and effectively strengthens the organisation. The external sphere refers to the ways project work is adopted in the communities; it addresses susceptibility factors to the virus, reduces the vulnerability of the impact to AIDS and reflects a gender perspective.

Firstly, the process is explained at the project level, the external sphere. The final part addresses the mainstreaming process at the organisational level or internal sphere.

#### 3.3.2 Mainstreaming HIV&AIDS and gender in projects

##### *Step 1: Situational analysis*

<p><b>Analysis of the context of the project:</b></p> <p><b>What information do we need?</b></p>	
<p><b>General Conditions in the Country</b></p> <ul style="list-style-type: none"> <li>• What is the general situation of HIV and AIDS in the country/ in the project area?</li> <li>• What is the general situation of women and men in the country? (economic situation, socio-political rights including domestic rights, socio-cultural situation)</li> <li>• What are the rights of women, what are the rights of PLWH? Do specific laws exist which uphold the rights of PLWH and of women? Does the country have legislation on domestic violence? If any of these laws exist, how are they enforced?</li> <li>• What are the main issues/ problems concerning HIV and AIDS and gender equality in the country/in the project area?</li> <li>• Who does what about these issues?</li> </ul>	<p><b>Gender analysis</b></p> <ul style="list-style-type: none"> <li>• How can you include data broken down by sex taking into account other factors such as age, disability, ethnic groups, PLWH, mobility, etc.</li> <li>• How are gender roles constructed and maintained by our culture?</li> <li>• How do men and women differ in their perception of the issues/ problems the project is planning to address?</li> <li>• Given the present gender roles, what interventions will have the most immediate effect on the epidemic in the short run?</li> <li>• Which gender roles need to be strengthened or modified for women and men respectively to combat the spread of the epidemic effectively in the long run?</li> <li>• How can violence against women including domestic violence be combated?</li> <li>• How can women be empowered to deal with HIV and AIDS related consequences for the family?</li> <li>• How can gender roles linked to caring of the sick be balanced for women and men?</li> </ul>

### Stakeholder analysis

- Who should be involved in the risk and gender analysis?

Identification and participation of stakeholders, men, women, vulnerable groups who can provide the information required as follows:

- Who are the most vulnerable in our communities and why?
- How will they be affected by our work?
- Who might be excluded?
- How can we increase the benefit for the most vulnerable?

Perception of risk to HIV transmission and domestic violence:

- How do gender power relations affect HIV transmission of both women and men?
- How do men differ from women in their perception of risk to HIV transmission and their ability to protect themselves?
- How do men differ from women in their perception of risk to perpetration or exposure to domestic violence?
- What are the risk factors/ risk situation of both men and women in relation to HIV transmission and domestic violence?

Transformation of gender roles:

- Who is responsible for constructing and maintaining 'gender roles' in our society?
- How can we reconstruct and transform gender inequities to empower ourselves as women and men within our socio-cultural context to reduce the risk of HIV transmission, mitigate the impact of AIDS and reduce the incidence of domestic violence?

This first step should result in an analysis that clearly identifies: issues/needs, strength, weaknesses, opportunities and risks/threats/hazards according to sex, age and vulnerabilities of the various stakeholders.

### **Step 2: Project goal and objectives –deciding on a course of action**

The second step addresses how HIV and AIDS, unequal gender power relations including domestic violence affect our work. Three key questions can guide the process of mainstreaming HIV and AIDS and gender, which addresses the external mainstreaming process into existing projects:

1. How does HIV and AIDS and gender inequity including domestic violence affect our work? This concerns the beneficiaries, the sector, as well as the project objectives, indicators and activities.
2. How does our project do no harm? Could the intervention have potential negative implications with regard to HIV and AIDS, further gender inequalities and contribute to a greater incidence of domestic violence? How could this be avoided?

3. How can the project contribute to fight HIV and AIDS and transform gender power relations? Where does our work have a comparative advantage in:
- limiting the spread of HIV by reducing risk situations and vulnerability of both women and men,
  - reducing domestic violence and other forms of imbalanced gender power relations and
  - mitigating the impact of the epidemic on both women and men?

The following table provides a format for a framework for organisations to think through the issues to be considered in mainstreaming HIV externally (adopted from Elsey and Kutengule 2003):

**Example: Residential Training**

How might the work of the project:		How might HIV and AIDS impact on the work of the project?	What should the project do to respond to these issues?	How should progress in this area be measured?
increase susceptibility to HIV infection?	reduce the capacity of households/communities to deal with the impacts of HIV and AIDS?			
Trainers are in a position of power – can take advantage of girls/women	Unwanted pregnancies, sexually transmitted infections including HIV	Trainers may take advantage and sexually harass students	Develop a code of conduct Disciplinary committee to reduce sexual harassment	Number of cases reported and investigated
Girls/women might have to resort to transactional sex to participate in the course due to high costs	Direct and indirect costs of the course by the household	Participants might harass each other	No residential courses Training in communities Single sex training	
Residential courses might lead to sexual activity at night – girls/women might be forced by male participants or trainers to have sex				

It is equally important to identify a gender-related goals, objectives, activities and indicators in the implementation process of a mainstreaming approach asking questions as follows:

Goal and objectives:

- Does the goal and objectives of the proposed interventions reflect the needs of both women and men?
- Does the goal and objectives include a broader commitment to changing attitudes or other factors that hamper gender equity?

Activities:

- Do planned activities involve both women and men?
- Have particular attention been paid to specific issues of adolescents and young people?
- Has particular attention been paid to vulnerable and disadvantaged groups, such as those living in poverty, PLWH, disabled, mobile people, sex workers, drug users, child-headed households, etc?
- Have above mentioned groups participated in the project design?
- Have the needs of care givers been taken into account?
- Are any additional activities needed to ensure that the gender perspective is made explicit (e.g. gender training, etc)

Indicators:

- Have indicators been developed to measure the gender aspect of each objective?
- Are indicators gender disaggregated?
- Are targets set to ensure a sufficient level of activities for male and female participation?
- Do indicators go beyond numbers to reflect issues such as stigma and discrimination and gendered power relations?

Implementation

- Who will implement the planned intervention?
- Will men and women, including people living with the virus, participate equally in the implementation?
- Have staff/stakeholders received gender mainstreaming training to ensure a gender perspective throughout the implementation (UNDP RBEC 2007)?

Allocation of resources

- Are financial and human resources allocated for mainstreaming HIV&AIDS and gender within the project and organisation?

### **Step 3: Project strategies – gender matters!**

Project strategies should be based on best practices. However, in designing appropriate project strategies it is crucial to firstly analyse potential negative implications of what you already do, or plan, on HIV and AIDS and gender. Therefore the question should be asked: “Does our project do no harm?” This means looking at whether the planned or ongoing activities increase vulnerability or risk behaviour of beneficiaries and whether they might aggravate the immediate and long-term consequences of HIV and AIDS. A number of questions can help to identify such potential harmful effects:

- Will the project activities result in increased mobility of specific groups?
- Will the project interventions increase gender inequity?
- Will the project exclude people living with HIV or people affected by HIV and AIDS?
- Will project activities increase risk situations for domestic violence and sex work?

After analysing potential negative implications, strategic issues based on best practices can be addressed as follows:

- Who should be involved in designing the project interventions? Which stakeholders are involved in the planning, implementation, monitoring and evaluation of the project?
- Is the project gender sensitive? Does the project offer different services for women as compared to men when their needs differ? Does the project ensure that services do not treat women and men differently when their needs are the same?
- Does the project strategy avoid providing different interventions or information based on stereotypes of women’s and men’s roles when their needs and responsibilities are the same? (An example for this is a health project when basic information about prevention of perinatal transmission of HIV is provided only to women. This has harmful outcomes and undermines any efforts encouraging parenting as a responsibility of both parents and reinforces the stereotype of women as the ‘vector of the virus’).
- Are men involved as partners in the project? Are women and men considered as equal partners in promoting reproductive and sexual health?
- What strategies are adapted to transforming gender roles and creating more gender-equitable relationships? Are men and women, girls and boys involved in examining gender roles and sexuality and its impact on male and female relationships and sexual health?
- Does the strategy proactively address gender stereotypes such as violent, predatory and irresponsible images of male sexuality, while portraying women as powerless and passive ‘victims’ of male power and domination? Is the strategy based on promoting responsible, respectful, and mutually satisfying sexual partnerships?
- Do the strategies employed prevent exploitation of child headed households?
- Are project strategies designed to empower women and girls and seek to equalize power relations between women and men and to reduce vulnerability to HIV transmission and the impact of the epidemic? Are elements considered for empowering individuals in society such as access to education, information and skills as well as access to economic resources and assets – including a change in inheritance laws for women? Does empowering women go

hand in hand with empowering men to critically look at their roles, responsibilities and the prevention of domestic violence?

- Does the project address socio-cultural, economic and political structures and acknowledge that gender, class, race, age and sexuality oppress women and men – although in different ways with different consequences and outcomes?

#### **Step 4: Monitoring and evaluation**

##### Keeping an eye on things

Workshops provide an opportunity to develop a practical monitoring and evaluation (M&E) plan from the logical framework. Teams then review and refine the indicators of the objective hierarchy, define roles, responsibilities and time lines for data collection, analysis and reporting. Simple reporting formats might be developed. The M&E system need to be in harmony with principles of stakeholder involvement. The M&E plan should include regular (e.g quarterly) review and planning meetings to review activity progress and plans for a systematic annual performance review.

There is a need to develop a gender-sensitive monitoring system, which include the systematic collection of gender disaggregated data.

Furthermore, questions should be considered as follows:

- Are women and men, as well as women and men living with HIV, participating equally in project decision-making?
- Is it possible to pro-actively involve people perpetrating and experiencing domestic violence?
- Are men and women living with or without HIV and other affected groups treated with equal respect as decision-makers, implementers, and/or participants?
- Are all people involved in the implementation process continually motivated to keep a gender perspective (UNDP RBEC 2007)?

When deciding what information to monitor and evaluate, issues needs to be kept in mind as follows:

- How do we seek the information needs of different stakeholders – with them – and not only considering project management information needs?
  - This means building in a feedback loop from stakeholders – female and male, women and men who experienced domestic violence and PLWH - in the whole monitoring and evaluation process.
- What indicators are critical to project?
  - Qualitative and quantitative indicators need to be specific in relation to the topic of interest, type of change you are trying to understand, including the unit of analysis such as changes in a household, village or region; the timeframe over which it will be monitored and the location in which the indicator will be applied. Monitor indicators and adjust activities to address risk and vulnerability to HIV and AIDS and domestic violence in relation to men and women.

- How can we explain progress - monitor the quality of the implementation process - and not only measure how much of something occurred?
  - Use qualitative methods that ask people about their opinions on the process; keep up-to-date on the operating environment.
- How can we look for the unintended through regular reflections? In addition to tracking information related to the objectives, what mechanisms can we employ to seek out unintended positive and negative impacts so that we can take any corrective action that might be necessary?

During annual review and planning meetings question can be asked as follows:

- What happened since we last met that was unexpected? How was it different from what we expected?
- What are the implications of the unexpected for our work (e.g. for a specific activity, project output, relationship between women and men that might increase or reduce vulnerability to HIV infection, domestic violence)?
- How can we decide on which of the proposed indicators to monitor?
  - The less-is-more principle refers to screening all proposed indicators before agreeing to monitor them. Ask yourself: “Who needs to use the information, when and to do what exactly?” so that you include only what you need to know (IFAD 2002).

#### Evaluation - How did we do?

An evaluation is crucial for providing an evidence base of the complex impact of HIV and AIDS and gender on the work of different sectors. This stage, therefore, is crucial for establishing best practices and lessons learned in mainstreaming HIV and AIDS and gender as well as the prevention of domestic violence in development projects.

### **3.3.3 Mainstreaming HIV/AIDS and gender internally**

Mainstreaming HIV and AIDS and gender internally focuses on the organisation itself by asking what effect organisational policy and practice have on HIV and gender and how HIV and gender affect the organisation. In addition, it also addresses gender balance in the institution at every level.

Internally, organisations should address questions as follows:

- What do employees know about HIV and AIDS and violence against women?
- How do employees talk about HIV and AIDS and violence against women?
- How can gender roles be identified within the organisation?
- How is the organisation affected by absentees?
- How can a HIV and AIDS and gender policy be developed?
- How can shame, stigma and discrimination be addressed?
- How can the organisation take care of people infected and affected by HIV among staff and volunteers?

## ***Organisational analysis – breaking the silence***

Generally, HIV and AIDS as well as violence against women is surrounded by misconceptions that lead to stigma. This is perceived as a major obstacle to HIV prevention. Therefore, it is important for organisations to discuss and address issues surrounding HIV and AIDS, gender and domestic violence openly.

Mainstreaming HIV and AIDS and gender internally is a learning process – not an event, or series of events, which requires the participation of the employees at every stage of the process.

The mainstreaming process works best when the starting point is understanding HIV and AIDS as well as the effects of gender based violence at a personal level. Developing and modifying policies as well as educating staff about the theory and purpose of mainstreaming will not in itself make the process successful. Success will require changing the attitudes and behaviour of employees so that HIV and AIDS and gender issues can be discussed and addressed in an open and non-stigmatising way.

Mainstreaming HIV and AIDS and gender internally first requires the organisation to explore more on general feelings and understanding about what employees in the organisation think about HIV and AIDS and gender roles and the impact stigma and discrimination may have for the organisation.

Therefore, it will be important to undertake a qualitative assessment with the aim to understand the complex nature of shame, stigma and discrimination against HIV and AIDS and unequal gender based power relations within the organisation. This assessment needs to include a gender perspective by:

- exploring attitudes, beliefs, meaning, and understanding of the infection and its consequences for women and men
- gaining an insight into the socio-cultural and religious beliefs, and fears surrounding HIV and AIDS among employees
- exploring attitudes and beliefs of gender roles in decision-making and leadership.

The findings of the assessment form a basis for the organisation to facilitate and speed up the internal mainstreaming process and contribute to the setting up of a supportive environment within the organisation for those who are infected and affected by the virus.

Findings can be used to plan discussions and awareness raising activities through workshops and trainings for all employees that involves not only knowledge transfer about HIV and AIDS, but engagement at a personal level for employees to acknowledge HIV as an issue that concerns everyone. Employees reflect upon their own attitudes, in particular through discussing issues of shame, stigma and discrimination and practical concerns in relation to care and support of women and men with HIV.

Furthermore, capacity building of staff and volunteers to adequately address HIV and AIDS and gender equity is a means of mainstreaming HIV and AIDS. Capacity building can be done through training; for example in counselling skills, pastoral care, home based care, positive living and other areas. Organisations do not necessarily need highly trained AIDS and gender experts but can make use of already existing resources within other organisations, networks of PLWH, or other support groups. However, not having enough skilled personnel should not prevent organisations from starting a process of mainstreaming HIV and AIDS and gender.

## ***How to develop and implement a workplace policy on HIV and AIDS and gender***

The establishment of a workplace policy is a key part of the internal HIV and AIDS and gender mainstreaming process. This may be a policy for HIV and AIDS and gender specifically, or a policy on chronic and terminal diseases including HIV and AIDS, which might be a fairer and more acceptable approach, and less likely to cause stigma.

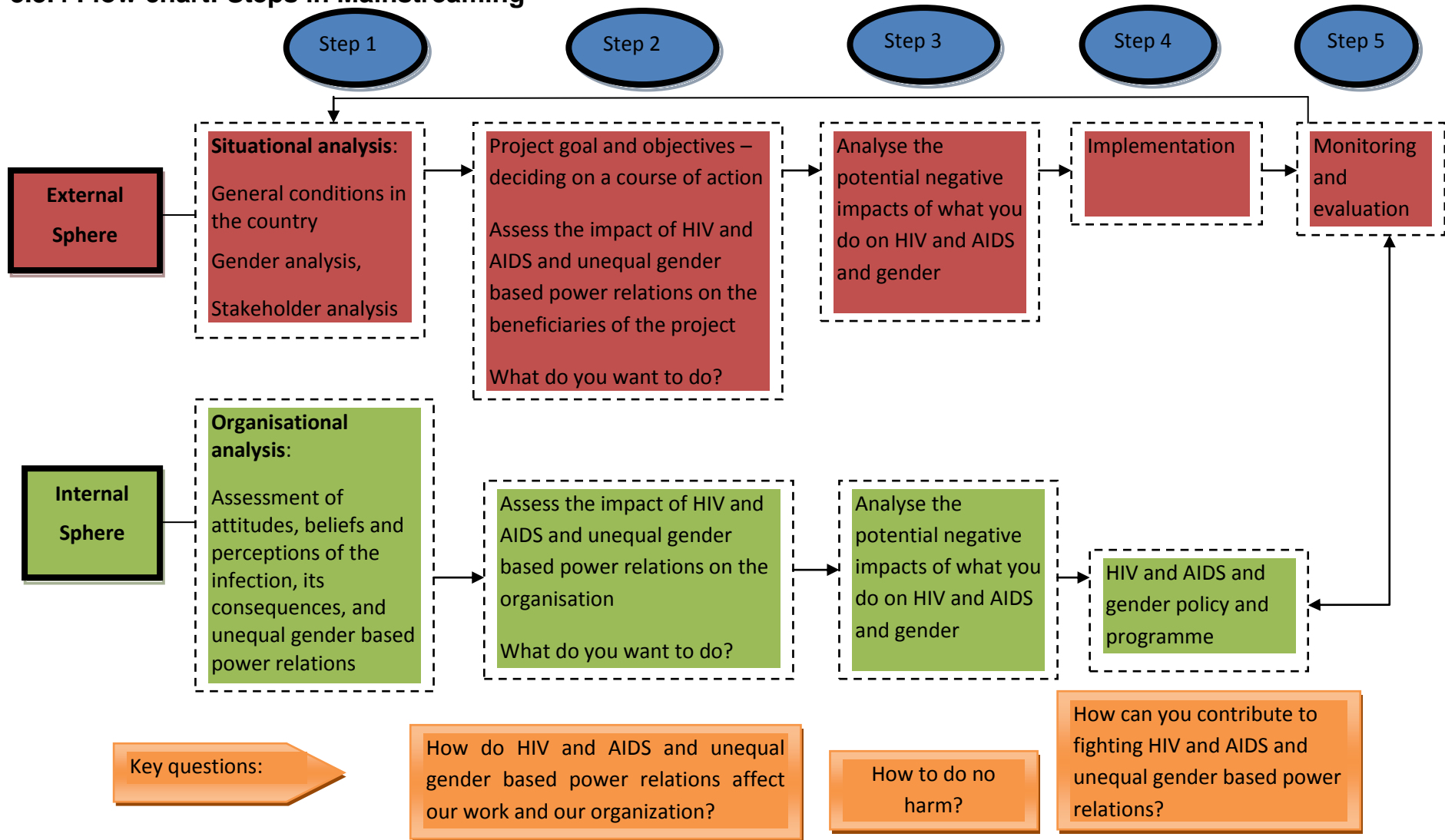
The main components of a Work Place Policy on HIV and Gender are the following (ILO 2001):

- Recognition of HIV as a workplace issue
- Non-discrimination
- Gender equality
- Healthy work environment
- Social Dialogue
- Confidentiality
- Continuation of employment relationship
- Prevention, Care and Support

All HIV interventions should aim at reducing stigma and discrimination. The workplace policy needs to reflect this principle. A workplace policy therefore, formalises the responsibilities of the organisation to its employees, provides the core values and basic concepts of an organisation, includes employment criteria, grievance procedures and upholds “equal treatment” for all, irrespective of gender and HIV status. It ensures that women and PLWH have the same right to being promoted as men and HIV negative employees, that disciplinary action is taken against any form of discrimination and stigmatization as well as against any form of sexual harassment, and that HIV testing is neither a condition for hiring and/or continuation of employment.

The process of developing, revising and implementation of the workplace policy requires consultation with employees. Organisations need to ensure that staff and managers are aware of its contents. However, having a policy in place does not necessarily result in a supportive workplace environment. Therefore, careful follow-up is needed to identify needs and barriers and to find ways to overcoming them.

### 3.3.4 Flow chart: Steps in Mainstreaming



## References

- Berner-Rodoreda (2008) *HIV and AIDS in Africa – a female epidemic requiring only a female response?* Bread for the World, Stuttgart, Germany
- Bharat, S., Aggleton, P. & Tyrer, P (2001) India: HIV and AIDS-related Discrimination, Stigmatization and Denial. UNAIDS, Geneva, Switzerland.
- Bonjour et al (2008) Determinants of late disease-stage presentation at diagnosis of HIV infection in Venezuela: A case-case comparison *AIDS Research and Therapy* 2008, **5**:6
- Campbell, C.A. (1995) Male Gender Roles and Sexuality: Implications for women's AIDS Risk and Prevention. *Social Science & Medicine*, 41 (2): 197-210.
- Campbell, C. (1992) Learning to Kill? Masculinity, the Family and Violence in Natal. *Journal of Southern African Studies*, 18, 614-628.
- Chant, S. (1998) Households, gender and rural-urban migration: reflections on linkages and considerations for policy. *Environment and Urbanization*, 10, 5-22.
- Chantavanich, S., Beesey, A. & Shakti, P. (2000). Mobility and HIV/AIDS in the Greater Mekong Subregion. Bangkok, Thailand, Asian Research Center for Migration, Institute of Asian Studies, Chulalongkorn University.  
[http://www.adb.org/documents/books/hiv\\_aids/mobility/default.asp](http://www.adb.org/documents/books/hiv_aids/mobility/default.asp). 03/10/2006.
- Collins, J., Rau, B. (2000) AIDS in the Context of Development. Paper Number 4; UNRISD programme on social Policy and Development; UNRISD & UNAIDS.
- Commonwealth Secretariat (2002) *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach*. New Gender Mainstreaming Series on Gender Issues. Commonwealth Secretariat and Maritime Centre of Excellence for Women's Health, London, UK.
- Dirie, W. (1999) *Desert Flower – The Extraordinary Life of a Desert Nomad*, New York: Virago Press
- Du Guerny, J., Slöberg, E. (1993) Inter-relationship between gender relations and HIV/AIDS epidemic: some possible considerations for policies and programmes. *AIDS*, **7**: 1027-1034.
- ECPAT International (2007) Linkages between HIV/AIDS and the Commercial Sexual Exploitation of Children in Africa. ECPAT International, Bangkok, Thailand.  
<http://www.ecpat.net>.
- Elsely, H. and Kutengule, P. (2003) A Definition, Some Experiences and Strategies; A resource developed by HIV/AIDS focal points from government sectors and those that have been working with HIV/AIDS mainstreaming. Health Economics & HIV/AIDS Research Division, University of Natal.  
[http://www.sarpn.org.za/documents/d0000271/p263\\_HIV\\_Reports.pdf](http://www.sarpn.org.za/documents/d0000271/p263_HIV_Reports.pdf).
- Elsely, H., Tolhurst, R., Theobald, S. (2005) Mainstreaming HIV/AIDS in development sectors: have we learnt the lessons from gender mainstreaming? *AIDS Care*, 17(8): 988-998.
- Gammeltoft, T. (2002) seeking trust and transcendence: sexual risk-taking among Vietnamese youth. *Social Science and Medicine*, 55: 483-496.
- Giddens, A. (1991) The Trajectory of the Self. In Giddens, A. (Ed.) *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Cambridge Polity Press: 70-108.

- Graham, R. (2006) Male Rape and the Careful Construction of the Male Victim. *Social & Legal Studies*, 15, (2): 187-208.
- Griffiths, M.P. (2007) Liminality and Risk: Beliefs about HIV/AIDS in Myanmar: Implications for HIV Prevention. MSc PHC thesis, Flinders University, Adelaide, Australia.
- Halkitis, P., Green, K., Wilton, L., (2004) Masculinity, Body Image, and Sexual Behavior in HIV-Seropositive Gay Men: A Two-Phase Formative Behavioral Investigation Using the Internet, *International Journal of Men's Health*, 3 (1): 27-42
- Holden, S. (2004) Mainstreaming HIV/AIDS in Development and Humanitarian programmes. Oxfam Publishing, Oxford.
- Hombrecher, U. (2007) Overcoming Domestic Violence. Bread for the World, Stuttgart, Germany.
- Human Rights Watch (2003) suffering in Silence. <http://www.hrw.org/en/node/12368/section/1>
- International Fund for Agricultural Development (2002) Deciding what to monitor and evaluate. In: Managing for Impact in Rural Development: A Guide for Project M & E. International Fund for Agricultural Development (IFAD), Rome, Italy.
- International Labour Organisation (2001) An ILO Code of Practice on HIV/AIDS and the world of work ILO: Geneva
- Mc Ginn, T. (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 26 (4): 174-180
- Montgomery, C. M., Hosegood, V., Busza, J., Timaus, I.A. (2006) Men's involvement in the South African family: Engendering change in the AIDS era. *Social Science & Medicine*, 62: 2411-2419.
- New, C. (2001) Oppressed and Oppressors? The Systematic Mistreatment of Men. *Sociology*, 35: 729-748.
- Ntangira, J., Muula, A. S., Masaisa, F., Dusabyez, F., Siziya S. and Rudatsirika, E. (2008) Intimate Partner Violence among Pregnant Women in Rwanda. *BioMedCentral Women's Health*, 8: 17
- Schuele, E. (2008) Internal mobility and vulnerability to HIV in Myanmar, Kachin State: Implications for HIV and AIDS Policy and Practice. DrPH Dissertation, Flinders University, Adelaide, Australia.
- SIDA (2007) Men Matter! Aids, Gender and Masculinities *Aids and Gender Relations*, Sida: Stockholm
- Silberschmidt, M. (2001) Disempowerment of Men in Rural and urban East Africa. Implications for Male Identity and Sexual Behavior. *Social Science & Medicine*, 29 (4): 657-671.
- Theuss, M., Schuele, E. (2007) The 'Moderns Disease': Drug use, HIV and AIDS in the Context of Mobility. World Concern, Yangon, Myanmar.
- UNAIDS (2004) *Aids Epidemic Update* UNAIDS, Geneva.
- UNAIDS Support to Mainstreaming AIDS in Development. UNAIDS Secretariat Strategy Note and Action Framework 2004-2005. [http://unaidsrsta.org/Documents/knowledgedesk/thematic\\_areas/Mainstreaming/UNAIDS\\_SupportToMainstreaming\\_2004.pdf](http://unaidsrsta.org/Documents/knowledgedesk/thematic_areas/Mainstreaming/UNAIDS_SupportToMainstreaming_2004.pdf)
- UNAIDS (2008) *Report on the Global AIDS Epidemic* UNAIDS, Geneva:35

- UNDP (2007) Gender mainstreaming in practice: a toolkit. United Nations Development Programme's Regional Bureau for Europe and the CIS; Bratislava, Slovak Republic.
- UNESCO (2008) IAAT on Education: Girls' Education and HIV Prevention UNESCO: Paris
- UNICEF (2004) Girls, HIV/AIDS and Education UNICEF: New York
- UNIFEM [http://www.unifem.org/gender\\_issues/](http://www.unifem.org/gender_issues/)
- VanNatta, M (2005) Constructing the Battered Woman. *Feminist Studies*, 31:416-542.
- Women and Law in Southern Africa Research Trust (2002) *Lobola – its implications for women's reproductive rights* WLSA, Harare
- Wood, K., Jewkes, R. (2001) 'Dangerous' love: reflections on violence among Xhosa township youth in Morrell, R.: *Changing men in southern Africa*, Pietermaritzburg: University of Natal Press
- World Health Organisation (2003) *Gender and HIV/AIDS*. Department of Gender and Women's Health, Family and Community Health. WHO, Geneva.
- World Health Organisation (2003) Integrating Gender into HIV/AIDS Programmes: A review paper. Department of Gender and Women's Health, Family and Community Health, WHO, Geneva.
- World Health Organisation (2008) Eliminating Female Genital Mutilation – An interagency statement, Geneva
- Zwanck, D. (2008) On the Road to Empowerment? The Microcredit program of Guéris mon Peuple Maniema. Research paper for Guéris mon Peuple Maniema/HEAL Africa.

### **Unpublished material**

- BfdW (2003) Cross-Sectoral Project Study on HIV/AIDS and Gender in South Africa; research by Sonja Weinreich and Kebogile Mokwena
- BfdW (2005) Important Questions for the Assessment of Proposals Regarding HIV/AIDS and Gender in Africa
- BfdW (2007a) Neue strategische Überlegungen im Bereich Lateinamerika & Karibik zur Verknüpfung von Gender Mainstreaming mit den weiteren Querschnittsthemen HIV/Aids Mainstreaming und Verhinderung häuslicher Gewalt
- BfdW (2007b) Travel Report Kenya by Astrid Berner-Rodoreda
- BfdW (2009) Abschlussbericht Centro de Mujeres de Masaya (2005-2007) by Karin Erdelt-Herzel

### **Recommended readings on mainstreaming HIV&AIDS and gender**

- Onipede, I.D. und Dorlöchter-Sulser, S. (2005) *Responding to HIV/AIDS: A Practitioner's Guide to Mainstreaming in Rural Development Projects*. Misereor, Aachen, Germany.
- Holden, S. (2004) *Mainstreaming HIV/AIDS in development and humanitarian programmes*. Oxfam, UK.
- Elsley, H. and Kutengule, P. (2003) *A Definition, Some Experiences and Strategies; A resource developed by HIV/AIDS focal points from government sectors and those that have been working with HIV/AIDS mainstreaming*. Health Economics & HIV/AIDS Research Division, University of Natal. [http://www.sarpn.org.za/documents/d0000271/p263\\_HIV\\_Reports.pdf](http://www.sarpn.org.za/documents/d0000271/p263_HIV_Reports.pdf).

Swiss Agency for Development and Cooperation (2004) *Mainstreaming HIV/AIDS in Practice*. SDC. <http://www.eldis.org/go/topics/resource-guides/hiv-and-aids&id=17740&type=Document>

Commonwealth Secretariat (2002) *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach*. New Gender Mainstreaming Series on Gender Issues. Commonwealth Secretariat and Maritime Centre of Excellence for Women's Health, London, UK. <http://www.thecommonwealth.org/gender>

UNDP RBEC (2007) *Gender Mainstreaming in Practice: A Toolkit*. Regional Programme of the United Nations Development Programme's Regional Bureau for Europe and the CIS.

## Authors

Dr Elisabeth Schuele (DrPH, Finders University, Adelaide)

Elisabeth Schuele works for the German Institute for Medical Mission (DIFAEM) in Tuebingen, Germany, as a consultant in health services since 2008. One of her focus of work is HIV and AIDS including mainstreaming HIV and AIDS. She has lived and worked in Kenya, Somalia, Ethiopia and Myanmar in primary health care programmes, famine relief and as technical advisor in public health for the Somali National Regional Health Bureau and World Concern Myanmar. Her academic interest is in the relationship between mobility, gender, poverty, drug use and HIV and AIDS.

Astrid Berner-Rodoreda (MA, University of London, School of Oriental and African Studies)

Astrid Berner-Rodoreda is Advisor on HIV and AIDS at Bread for the World. She has lived and worked in several countries. Since 2004 she has worked with partner organisations of Bread for the World in 18 African countries focusing on the close link of gender and HIV, the need to involve more men, mainstreaming HIV and gender as well as doing lobby and advocacy work for the scale-up of anti-retroviral treatment. She currently also holds the position of Speaker for the Protestant Organisations in the German lobby and advocacy network 'Action against AIDS' and Chairperson of the International Reference Group of the Ecumenical HIV Initiative in Africa.