HIV & AIDS, Gender, and Domestic Violence

Implications for policy and practice

Difäm
Gesundheit in der Einen Welt

Brot für die Welt
www.brot-fuer-die-welt.de

Imprint

Published by:
Diakonisches Werk der EKD e.V.
for "Brot für die Welt"
Stafflenbergstraße 76
D-70184 Stuttgart
Germany
Phone: ++49 711/2159-568
E-Mail: info@brot-fuer-die-welt.de
www.brot-fuer-die-welt.de

Authors: Dr Elisabeth Schuele, Astrid Berner-Rodoreda
Editorial Staff: Thorsten Göbel, Lydia Kissel
Layout: Jörg Jenrich, Renate Zimmermann
Responsible: Thomas Sandner
Cover Photo: Tarik Tinazay

Art.Nr.: 129 600 370

Stuttgart, November 2010

HIV & AIDS, Gender, and Domestic Violence

Implications for policy and practice

Table of Contents

Table of Contents

Figures

Tables

Abbrevations

ARV	Antiretroviral
FGM	Female genital mutilation
IPV	Intimate partner violence
M&E	Monitoring and evaluation
PLWH	People living with HIV

Preface

"Brot für die Welt" (Bread for the World) and the Deutsches Institut für ärztliche Mission (German Institute for Medical Mission/Difäm) have been involved in the area of HIV and AIDS, gender, and combating domestic violence for many years. They have not only supported work in these fields, but also encouraged partner organisations to address these topics as cross-sectoral issues in their work. Several papers and publications have been written by "Brot für die Welt" and Difäm on the close connection of HIV and AIDS, gender, and domestic violence in Africa (Berner-Rodoreda 2008; Hombrecher 2007). Many of these 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.

The paper is divided into two parts. The first chapter provides an overview of gender and domestic violence in the HIV and AIDS discourse and their interconnectedness. It analyses literature regarding gender and HIV transmission, domestic violence, and HIV and AIDS. It then discusses how gender roles impact the effects of AIDS.

The second chapter outlines implications of these findings for policy and practice. This section provides a definition for mainstreaming and deals with various aspects of mainstreaming HIV, AIDS and gender. Then, a detailed outline of specific steps of implementation addresses the mainstreaming process of HIV and AIDS and gender, including domestic violence in both the project and the organisation (external and internal sphere).

The aim of this paper is to promote awareness and encourage discussion on the complex inter-connection of HIV, AIDS, gender, and domestic violence, as well as providing specific steps for integration into project design and implementation. The paper should serve our partner organisations, transfer of function consultants and project officers at "Brot für die Welt" and Difäm as a framework for HIV & AIDS and gender mainstreaming. Especially the second part of the paper will be a helpful tool for the dialogue with our partner organisations. The implications for policy and practice will form the basis for recommendations to improve the situation of target groups

The discussion paper was prepared by Dr Elisabeth Schuele, Public Health Consultant at Difäm and Astrid Berner-Rodoreda, Advisor on HIV & AIDS at "Brot für die Welt". We are very grateful for their work, which will greatly contribute to the discussions on HIV & AIDS, gender, and domestic violence and will assist partner organisations in addressing these issues in their daily work as well as in their own organisations.

Dr Gisela Schneider,
Director
Difäm

Dr Klaus Seitz
Head of Policy Department
Brot für die Welt

1 Gender and domestic violence in the HIV and AIDS discourse

1.1 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 impact 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 inequities in society are recognized as playing a key role in driving the HIV epidemic, particularly in respect to women.

1.1.1 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.

> 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).

1.1.2 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. 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.

Even though today in many societies the income patterns are changing, and often women are the "bread-

Table 1: Average income of men and women in the United States of America

	Women		**Men**	
	Unmarried	Married	Unmarried	Married
Average	$ 37.264	$ 41.397	$ 42.834	$ 66.646
Comparative personal earnings	$ 0,56	$ 0,62	$ 0,64	$ 1,00

Source: American Community Survey (2006)

winners" 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 (see Table 1).

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.

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 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/Jewkes 2001, Halkitis/Green/Wilton 2004).

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)

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 to adopt HIV risk reducing-behaviour (Commonwealth Secretariat/Maritime Centre of Excellence for Women's Health 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.

Women are often not in a position to 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 women's vulnerability to HIV infection 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.

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).

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.

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 "Brot für die Welt" partner organisations have already started the fight against practices such as female genital mutilation.

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).

Considering these implications of gender roles, cultural norms and status 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/Beesey/Paul 2000).

1.2 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

The "Brot für die Welt" 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).

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 % (UNAIDS Interagency Task Team on Gender and HIV/AIDS).

Domestic violence is a phenomenon found in all societies and among all social classes. 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.

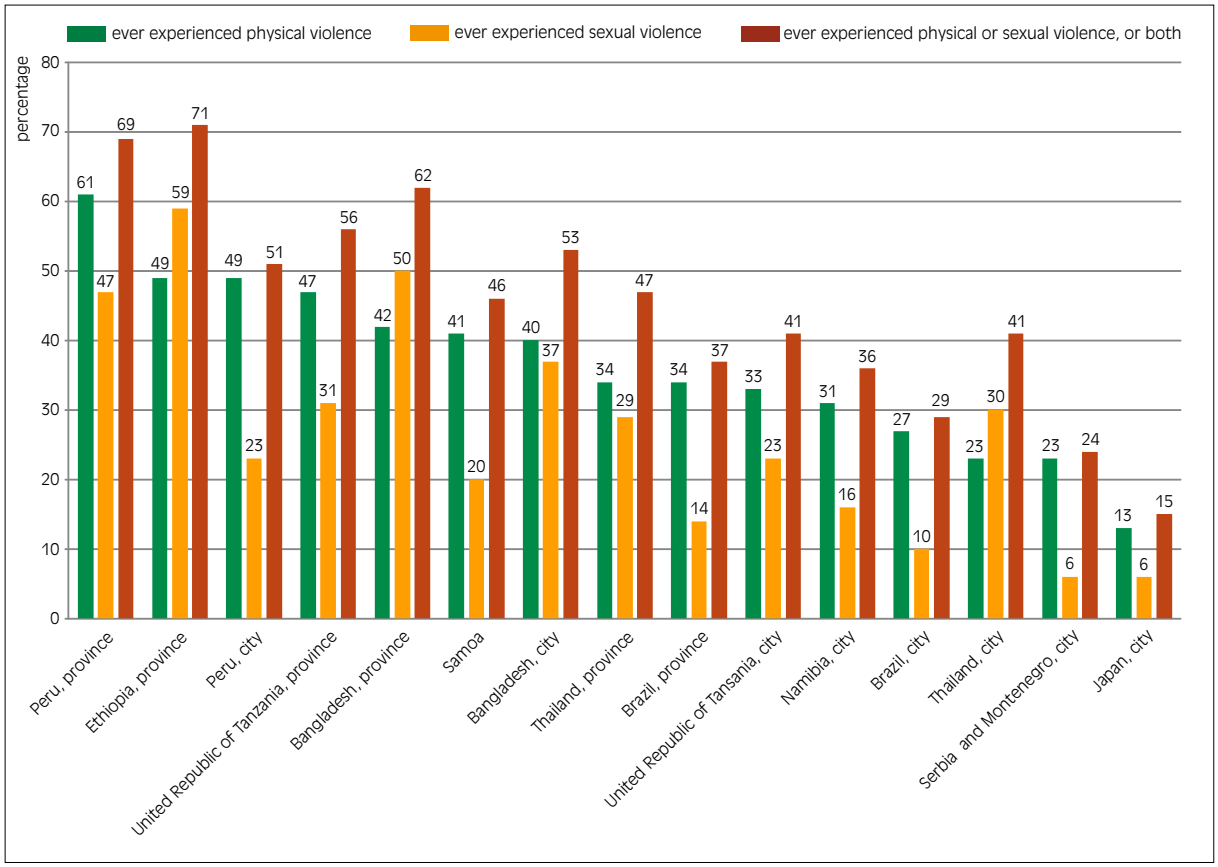
The mere suggestion of condom use can also spark off violence and in Africa, is often closely linked to the tradition of the husband's family paying the bride-price to the wife's family. This makes it extremely difficult for women to protect themselves against HIV.

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.

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 Unites States. This indicates that violence against women impoverishes individuals, families and communities, thus reducing the economic development of nations (UNIFEM).

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 2002).

Figure 1: Physical and sexual violence



Based on: World Health Organisation 2005

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).

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).

1.2.1 Which socio-economic and political factors influence domestic violence?

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

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 as 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).

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).

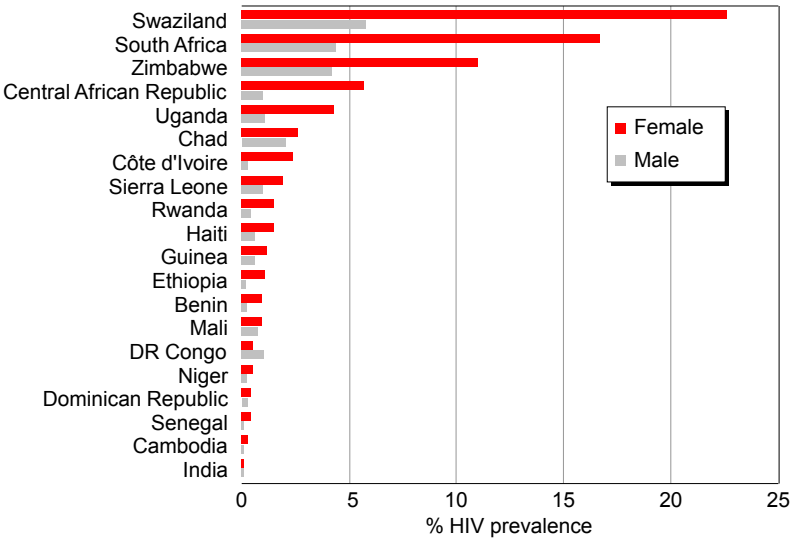
In addition, the context of gender violence in patriarchal cultures, especially in Asia and Eastern Europe, is often linked to masculine identities and their repertoire of desires of various consumption patterns, including excessive alcohol and narcotic drug consumption. In Africa and Latin America excessive alcohol consumption often exacerbates gender violence and can be seen as a primary source of conflict which becomes closely linked to gender violence.

1.2.2 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).

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

Figure 2: HIV prevalence (%) among 15-24 years old, by sex, selected countries, 2005-2007



Source: UNAIDS 2008

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 (Berner-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).

1.3 Gender roles, domestic violence and people living with the virus – Which 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".

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 show up extremely late for receiving ARV treatment. A recent Venezuelan study showed that women were half as likely to seek medical advice late as men, while homosexual men were less likely to seek medical advice late like heterosexuals (Bonjour et al. 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.

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." (Brot für die Welt/Weinreich/Mokwena 2004, 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 focus on girls and women but to include men and boys in all project interventions. "Brot für die Welt" partner organisations, therefore, adopted the concept "Men as Partners" in their project design.

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.

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 (Brot für die Welt/Berner-Rodoreda, 2007b 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 high light the gendered nature of sexual assault as a social phenomenon, the existence of male victims challenges dominant understanding of victimization that problematizes 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.

In 2006, the "Brot für die Welt" 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).

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.

2 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.

2.1 Responses to HIV and AIDS, gender and domestic violence

A comprehensive response to HIV and AIDS, gender, and domestic violence is one 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.

2.1.1 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:

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 (Brot für die Welt/Erdelt-Herzel 2009 unpublished).

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

2.1.2 Gender and domestic violence

Gender mainstreaming aims to reframe the way in which development processes are conducted to achieve 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 at organisational and programmatic level to pursue strategies aiming to reduce vulnerability to, and impact of HIV and AIDS and promote gender equity (Elsey/Tolhurst/Theobald 2005).

2.2 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, calls for 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 an increase of domestic violence.

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

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 address HIV and AIDS, gender or domestic violence.

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 project activities could be altered with regard to 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 adress 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.

2.3 Mainstreaming HIV and AIDS and gender – how to do it?

2.3.1 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 adapted in the communities; it addresses risk and vulnerability factors to the virus, reduces the vulnerability of the impact to AIDS and reflects a gender perspective. There are three key questions that can guide the process of mainstreaming HIV and AIDS and gender in both spheres as follows (adopted from SDC, 2004):

1. How do HIV and AIDS and unequal gender-based power relations affect our work and our organisation?

2. How to 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 fighting HIV and AIDS and transforming 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 unequal gender-based power relations and
- mitigating the impact of the epidemic on both women and men?

We will first explain this process at the organisational level, – the internal sphere. The final part will address the mainstreaming process at the project level or external sphere. However, mainstreaming activities in the internal and external sphere are interlinked.

2.3.2 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 has 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 absenteeism due to HIV and AIDS?
- How can a HIV and AIDS and gender policy be developed?
- How can stigma and discrimination be addressed?
- How can the organisation take care of staff and volunteers infected and affected by HIV and AIDS?

Step 1:
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 an understanding of 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 general feelings; understanding what employees in the organisation think about HIV and AIDS and gender roles, and the impact that 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 will 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.

Step 2:
How do HIV and AIDS and gender inequality affect our organisation?

It is important to reflect on the impact of HIV and AIDS and gender inequalities on human resources and the workplace. This assessment addresses issues such as how staff and their families are affected, sexual harassment in the workplace and to what extent the planned outputs and outcomes can be achieved given the impact of HIV and AIDS on staff and the workplace.

Step 3:
Analysis of potential negative implications on what we do regarding HIV and AIDS

"Do no harm" is not only an essential principle in relation to project interventions but also to the workplace practices. Therefore, it should be examined how the potential risk of HIV transmission faced by staff and volunteers can be minimized; for example, ensuring that women do not travel alone when going out into the field.

Other issues include potential interactions and power dynamic between project staff, volunteers, and beneficiaries that might increase risk of HIV transmission for any of these parties.

Step 4:
How to develop and implement a workplace policy on HIV and AIDS and gender and programme

Organisational vision and values, together with the results of the analytical process of Step 1 to 3, should inform the development of a policy on HIV and AIDS, gender and programme.

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 people living with HIV (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 also that HIV testing is neither a requirement nor pre-requisite 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 ways of overcoming them. There is a need to review and harmonise implications of the HIV policy with other organisational policies.

In addition, findings of the analysis (Step 1 to 3) can be used to plan discussions and awareness raising activities through workshops and training for all employees, which not only involves 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, particularly 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 equality 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.

Step 5:
Monitoring and evaluation

Clear promotion and implementation strategies of the HIV policy and programme are necessary for effective monitoring of the implementation process.

A monitoring and evaluation system should be designed in such a way that it is able to develop reflective and analytical capacities of those involved in the implementation process of the policy and workplace programme.

This will enhance a continuous learning experience in the internal mainstreaming process and, at the same time, will be living out the organisational values.

Experience has shown that it is recommendable to establish a team who monitors the implementation of the workplace policy and programme.

2.3.3 Mainstreaming HIV&AIDS and gender in projects

Step 1:
Situational analysis

Table 2: Analysis of the context of the project: What information do we need?

General Conditions in the Country
■ What is the general situation of HIV and AIDS in the country/in the project area?
■ How are women, men and children affected by HIV and AIDS?
■ What is the general situation of women and men in the country? (economic situation, socio-political rights including domestic rights, socio-cultural situation)
■ 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?
■ What is the situation regarding domestic violence? Does the country have legislation on domestic violence? If any laws exist, how are they enforced?
■ What are the main issues/problems concerning HIV and AIDS and gender equity in the country/in the project area?
■ Who does what about these issues?
Gender analysis at the project level
■ How can you include data broken down by sex and age, as well as taking into account other factors such as disability, ethnic groups, PLWH, mobility, etc?
■ How are gender roles constructed and maintained by social and cultural practices?
■ What factors lead to violence against women, including domestic violence, in the project area?
■ How do men and women differ in their perception of the issues/problems the project is planning to address?
Stakeholder analysis at project level
Identification and participation of stakeholders, men, women, and 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 of 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 situations of both men and women in relation to HIV transmission and domestic violence?
- What are vulnerability factors that increase susceptibility to HIV transmission for both men and woman?

Transformation of gender roles:

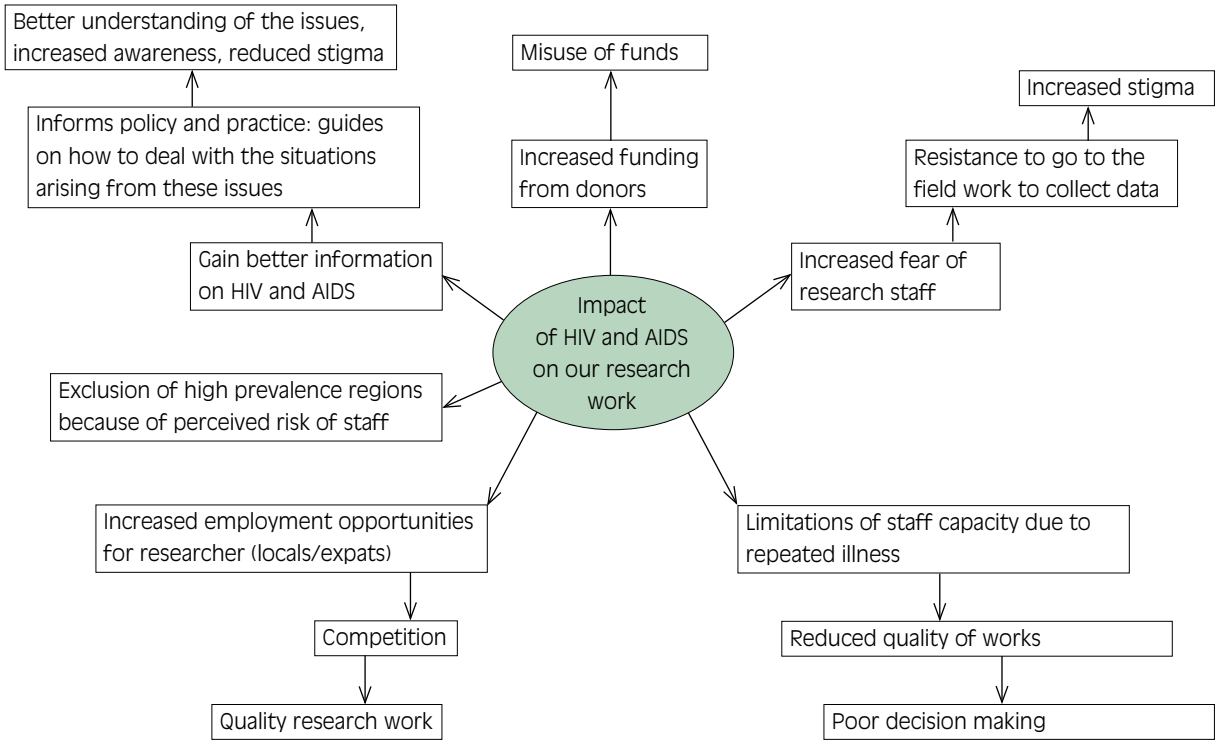
- Who is responsible for constructing and maintaining 'gender roles' in our society?
- How can we reconstruct and transform gender inequities to empower ourselves as women and men within our socio-cultural context to reduce the risk of HIV transmission, mitigate the impact of AIDS and reduce the incidence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

Step 2:
How do HIV and AIDS and gender inequities affect our work?

The second step addresses the question of how HIV and AIDS, unequal gender power relations, including domestic violence, affect our work. This step is linked to both the first and third step, as it is part of an analytical analysis that will provide the necessary input to formulate the response according to the comparative advantage within the program work.

The following example was presented at the "Mainstreaming HIV and AIDS and Gender" workshop in Madang, Papua New Guinea on July 18, 2009. A mindmap was developed to demonstrate how HIV and AIDS affect the work of a research institute both positively and negatively as follows:

Figure 3: Impact of HIV and AIDS on the work of a research institute



Step 3:
Project strategies: Analysis of potential negative implications of what we do regarding HIV and AIDS and gender

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 risk behaviour and vulnerability to HIV infection of beneficiaries and whether interventions 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 exclude people living with HIV or people affected by HIV and AIDS?

Will project activities:

- increase risk situations for domestic violence and sex work?
- result in increased mobility of specific groups?
- increase gender inequity?
- increase the risk of HIV infection?

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 in which basic information about prevention of perinatal transmission of HIV is provided only to women. This has harmful outcomes as it undermines any efforts in 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 their 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, as well as 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:
Project goal and objectives – deciding on a course of action

This step explores possible contributions to reducing risk and vulnerability, and mitigating the impact of the epidemic according to the comparative advantage of the project. The following table provides a format as a summary of the analytical steps and how the project could respond to the issues (adapted from Elsey/Kutengule 2003).

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

Goal and objectives*:*

■ Do the goal and objectives of the proposed interventions reflect the needs of both women and men?

■ Do 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?

■ Has particular attention been paid to specific issues of adolescents and young people?

Table 3: Example: Residential Training

How might the work of the project increase susceptibility to HIV infection?	How might the work of the project reduce the capacity of households/ communities to deal with the impacts of HIV and AIDS?	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?
■ Residential courses might lead to sexual activity at night – girls/women might be forced by male participants or trainers to have sex or do it voluntarily	■ Direct and indirect costs of training borne by the household ■ Participants spending extended time away from home – may have less time to assist sick family members	■ Increased susceptibility to HIV transmission of target group ■ Girls/ women may face violence at home when they become pregnant ■ Care-givers are excluded from training	■ Develop a code of conduct ■ Disciplinary committee to reduce sexual harassment ■ Double up trainers (Male and female) ■ No residential courses ■ Training in communities ■ Single sex training	■ Number of cases of forced sex reported and investigated

■ 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 the 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 as well as participation by PLWH?

■ 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 5:
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 needs 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 will 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 deal with 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 have experienced domestic violence as well as PLWH – in the whole monitoring and evaluation process.

- What indicators are critical to the 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, questions 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.

As part of planning the evaluation, a few key questions should be answered as follows:

- What is the purpose of the evaluation?
- What are the evaluation objectives?
- How is the evaluation to be carried out?
- Who should be responsible for the evaluation?
- When should the evaluation be carried out?
- How much resources will be needed?

When these questions are answered, Terms of Reference can be formalised. This is the actual contract for the evaluation, with headings covering the most important areas as follows:

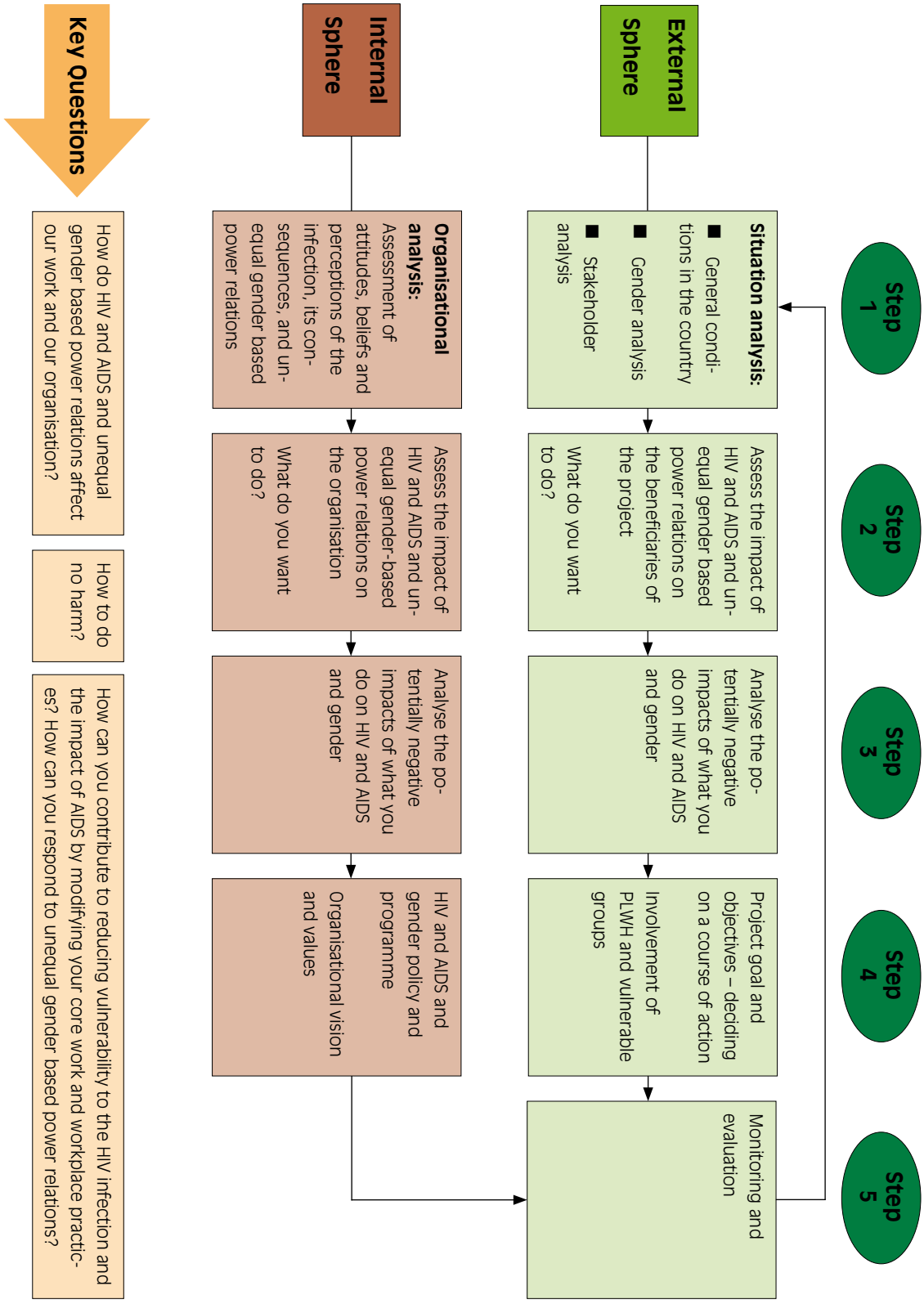
1. Background: A short description of the history and current status of the project, including goal, objectives, indicators and activities.

2. Purpose of the evaluation: A clear definition of the purpose of the evaluation. Why should it be evaluated at this time?

3. Evaluation objectives: The key questions that the evaluation should answer. What is the focus?

4. Evaluation process and methods: What is the evaluation process? Which methods should be used?

Figure 4: Flow chart: Steps in Mainstreaming



What are relevant indicators? What information should be collected and how? Who are the people to be interviewed? How is the analysis carried out? What should be the scope?

5. The evaluation team: Who should be responsible for the evaluation? The composition of the team with respect to experience, language skills, sex, etc.

6. Timeframe: Time frame for the evaluation: preparation, field work, feed-back and report writing.

7. The evaluation report: Who should write the report? The extent of the report, translations? Should there be different versions for different audiences? How will recommendations be followed up?

8. Budget and logistics: The budget of the evaluation.

Conclusions and recommendations of the evaluation serve as the foundation for changes and future direction.

Evaluation, 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.

References

Berner-Rodoreda, Astrid (2008): HIV and AIDS in Africa – a female epidemic requiring only a female response? Brot für die Welt, Stuttgart

Bharat, Shalini/Peter Aggleton/Paul Tyrer (2001): India: HIV and AIDS-related Discrimination, Stigmatization and Denial. UNAIDS, Geneva

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, 5 (6)

Campbell, Catharine (1992): Learning to Kill? Masculinity, the Family and Violence in Natal. In: Journal of Southern African Studies, 18 (3), pp. 614-628

Campbell, Carole A. (1995): Male Gender Roles and Sexuality: Implications for women's AIDS Risk and Prevention. In: Social Science & Medicine, 41 (2), pp. 197-210

Chant, Sylvia (1998): Households, gender and rural-urban migration: reflections on linkages and considerations for policy. In: Environment and Urbanization, 10 (1), pp. 5-22

Chantavanich, Supang/Allan Beesey/Shakti Paul (2000): Mobility and HIV/AIDS in the Greater Mekong Subregion. Bangkok

Collins, Joseph/Bill Rau (2000): AIDS in the Context of Development. Paper Number 4. UNRISD programme on social Policy and Development. Geneva

Commonwealth Secretariat/Maritime Centre of Excellence for Women's Health (2002): Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach. New Gender Mainstreaming Series on Gender Issues. London

Dirie, Waris (1999): Desert Flower – The Extraordinary Life of a Desert Nomad. New York

Du Guerny, Jacques/Elisabeth Slöberg (1993): Inter-relationship between gender relations and HIV/AIDS epidemic: some possible considerations for policies and programmes. In: AIDS, 7 (8), pp. 1027-1034

ECPAT International (2007): Linkages between HIV/AIDS and the Commercial Sexual Exploitation of Children in Africa. Bangkok

Elsey, Helen/Prisca Kutengule (2003): HIV/AIDS Mainstreaming: 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

Elsey, Helen/Rachel Tolhurst/Sally Theobald (2005): Mainstreaming HIV/AIDS in development sectors: have we learnt the lessons from gender mainstreaming? In: AIDS Care, 17(8), pp: 988-998

Gammeltroft, Tine (2002): Seeking trust and transcendence: sexual risk-taking among Vietnamese youth. In: Social Science and Medicine, 55 (3), pp. 483-496

Giddens, Anthony (1991): The Trajectory of the Self. In: Giddens, Anthony (Ed.): Modernity and Self-Identity: Self and Society in the Late Modern Age. Cambridge Polity Press, pp. 70-108

Graham, Ruth (2006): Male Rape and the Careful Construction of the Male Victim. In: Social & Legal Studies, 15 (2), pp. 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

Halkitis, Perry N./Kelly A. Green/Leo Wilton (2004): Masculinity, Body Image, and Sexual Behavior in HIV-Seropositive Gay Men: A Two-Phase Formative Behavioral Investigation Using the Internet. In: International Journal of Men's Health, 3 (1), pp. 27-42

Holden, Sue (2004): Mainstreaming HIV/AIDS in Development and Humanitarian programmes. Oxford

Hombrecher, Una (2007): Overcoming Domestic Violence. Brot für die Welt, Stuttgart

Human Rights Watch (2003): Suffering in Silence. The Links between Human Rights Abuses and HIV Transmission to Girls in Zambia. New York/Washington/London/Brussels

International Fund for Agricultural Development (2002): Deciding what to monitor and evaluate. In: International Fund for Agricultural Development: Managing for Impact in Rural Development: A Guide for Project M & E. Rome

International Labour Organisation (2001): An ILO Code of Practice on HIV/AIDS and the world of work ILO. Geneva

Mc Ginn, Therese (2000): Reproductive Health of War-Affected Populations: What Do We Know? In: International Family Planning Perspectives, 26 (4), pp. 174-180

Mill, Judy E./John K. Anarfi (2002): HIV risk environment for Ghanaian women: challenges to prevention, in: Social Science & Medicine, 54 (3), pp. 325-337

Montgomery, Catherine M. et al. (2006): Men's involvement in the South African family: Engendering change in the AIDS era. In: Social Science & Medicine, 62 (10), pp. 2411-2419

New, Caroline (2001): Oppressed and Oppressors? The Systematic Mistreatment of Men. In: Sociology, 35 (3), pp. 729-748

Ntangira, Joseph et al. (2008): Intimate Partner Violence among Pregnant Women in Rwanda. In: BioMedCentral Women's Health, 8 (17)

Schuele, Elisabeth (2008): Internal mobility and vulnerability to HIV in Myanmar, Kachin State: Implications for HIV and AIDS Policy and Practice. DrPH Dissertation, unpublished, Flinders University, Adelaide

Swiss Agency for Development and Cooperation (SDC) (2004): Mainstreaming HIV/AIDS in practice. A toolkit with a collection of resources, checklists and examples on CD Rom for SDC and its partners. Bern

SIDA (2007): Aids and Gender Relations. Men Matter! Aids, Gender and Masculinities. Stockholm

Silberschmidt, Margrethe (2001): Disempowerment of Men in Rural and urban East Africa. Implications for Male Identity and Sexual Behavior. In: Social Science & Medicine, 29 (4), pp. 657-671

Theuss, Marc/Elisabeth Schuele (2007): The "Moderns Disease": Drug use, HIV and AIDS in the Context of Mobility. World Concern, Yangon, Myanmar

UNAIDS (2003): Support to Mainstreaming AIDS in Development. UNAIDS Secretariat Strategy Note and Action Framework 2004-2005. Geneva

UNAIDS (2004): Aids Epidemic Update. Geneva

UNAIDS (2008): Report on the Global AIDS Epidemic. Geneva

UNAIDS Inter-Agency Task Team on Education (2008): Girls' Education and HIV Prevention. Paris

UNDP RBEC (2007): Gender mainstreaming in practice: a toolkit. United Nations Development Programme's Regional Bureau for Europe and the CIS. Bratislava

UNICEF (2004): Girls, HIV/AIDS and Education. New York

UNIFEM http://www.unifem.org/gender_issues/

VanNatta, Michelle (2005): Constructing the Battered Woman. In: Feminist Studies, 31 (2), 416-542

Women and Law in Southern Africa Research Trust (2002): Lobola – its implications for women's reproductive rights in Botswana, Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe. Harare

Wood, Katherine/Rachel Jewkes (2001): "Dangerous" love: reflections on violence among Xhosa township youth. In: Morrell, Robert (Ed.): Changing men in southern Africa. Pietermaritzburg, pp. 317 – 336

World Health Organisation, Department of Gender and Women´s Health, Family and Community Health (2003): Gender and HIV/AIDS. Geneva

World Health Organisation, Department of Gender and Women´s Health, Family and Community Health (2003): Integrating Gender into HIV/AIDS Programmes. A review paper. Geneva

World Health Organisation (2005): Prevalence of lifetime physical violence and sexual violence by an intimate partner, among ever-partnered women, by site. Geneva

World Health Organisation, Inter-Agency (2008): Eliminating Female Genital Mutilation. An interagency statement. Geneva

References

Zwanck, Desirée (2008) On the Road to Empowerment? The Microcredit program of Guéris mon Peuple Maniema. Research paper for Guéris mon Peuple Maniema/HEAL Africa. Berlin

Unpublished material

Brot für die Welt (2003): Cross-Sectoral Project Study on HIV/AIDS and Gender in South Africa; research by Sonja Weinreich and Kebogile Mokwena

Brot für die Welt (2005): Important Questions for the Assessment of Proposals Regarding HIV/AIDS and Gender in Africa

Brot für die Welt (2007a): Neue strategische Überlegungen im Bereich Lateinamerika & Karibik zur Verknüpfung von Gender Mainstreaming mit den weiteren Querschnittsthemen HIV/Aids Mainstreaming und Verhinderung häuslicher Gewalt

Brot für die Welt (2007b): Travel Report Rwanda-Kenya by Astrid Berner-Rodoreda

Brot für die Welt (2009): Abschlussbericht Centro de Mujeres de Masaya (2005-2007) by Karin Erdelt-Herzel

Recommended readings on mainstreaming HIV&AIDS and gender

Onipede, Iris D./Sabine Dorlöchter-Sulser (2005): Responding to HIV/AIDS: A Practitioner's Guide to Mainstreaming in Rural Development Projects. Published by Misereor, Aachen

Holden, Sue (2004): Mainstreaming HIV/AIDS in development and humanitarian programmes. Published by Oxfam, Oxford

Elsey, Helen/Prisca Kutengule (2003): HIV/AIDS Mainstreaming: 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

Swiss Agency for Development and Cooperation (SDC) (2004): Mainstreaming HIV/AIDS in practice. A toolkit with a collection of resources, checklists and examples on CD Rom for SDC and its partners. Bern

Commonwealth Secretariat/Maritime Centre of Excellence for Women's Health (2002): Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach. New Gender Mainstreaming Series on Gender Issues. London

UNDP RBEC (2007): Gender mainstreaming in practice: a toolkit. United Nations Development Programme's Regional Bureau for Europe and the CIS. Bratislava

Dr Elisabeth Schuele (DrPH, Flinders University, Adelaide)
works for the Deutsches Institut für ärztliche Mission (German Institute for Medical Mission/Difäm) in Tübingen, 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)
is Advisor on HIV and AIDS at "Brot für die Welt". She has lived and worked in several countries. Since 2004 she has worked with partner organisations of "Brot für die Welt" 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.

Special thanks go to **Alexandra C. Henry** for proofreading this document.

Diakonisches Werk der Evangelischen Kirche
in Deutschland e.V.
for Brot für die Welt
PO Box 10 11 42
D-70010 Stuttgart
Stafflenbergstraße 76
D-70184 Stuttgart
Germany

Phone: ++49 711/2159-568
E-Mail: info@brot-fuer-die-welt.de
www.brot-fuer-die-welt.de