GENDER AND HIV/AIDS

A TRAINING MANUAL FOR SOUTHERN AFRICAN MEDIA AND COMMUNICATORS

GL/ALP training workshop in Swaziland

Acknowledgements

This manual is a joint project of Gender Links and the AIDS Law Project (ALP) at the Centre for Applied Legal Studies.

GL is a Southern African NGO, based in Johannesburg, South Africa, that promotes gender equality in and through the media.

The ALP has been at the cutting edge of research and litigation in the HIV/AIDS epidemic in South Africa and has recently been involved in litigation around providing access to anti-retrovirals to pregnant women with HIV to reduce the risk of vertical transmission. The ALP has a strong emphasis on helping to create informed public opinion on HIV/AIDS through better quality coverage by the mainstream media.

The development of the manual began with the establishment of a reference group (see **Annex A)** that developed the framework and chapter outline for the manual. Specialist authors (see **Annex B)** wrote the individual chapters. The manual was tested at three provincial workshops in South Africa (Gauteng, the Western Cape and KwaZulu Natal) and three regional workshops (in Namibia, Swaziland and Zambia) between September 2002 and May 2004. Media trainers from around the region commented on the final draft of the manual at a training of trainers workshop on Gender, HIV AIDS and the Media in Botswana in May 2004. Details of these workshops, and supplements produced as part of the training, can be found on the Gender Links website – www.genderlinks.org.za.

Pat Made, an independent media trainer, Liesl Gerntholtz, Head of the ALP Legal Department and GL Director Colleen Lowe Morna edited the manual. GL Senior Researcher Alice Kwaramba did the proof reading and Lindiwe Nkutha coordinated the project.

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List of boxes

GL trainer Nonqaba waka Msimang

Handouts

Foreword

By Lucy Oriang*

It is barely a year since we buried my friend. She was only 34. Hers was the classic scenario: Young woman meets man. He is significantly older but that is how it should be, according to conventional wisdom. He sweeps her off her feet and soon enough marriage is on the cards. And the disillusionment sets in. She heard through the grapevine that his longstanding mistress was constantly ailing, and neighbours started mentioning HIV/AIDS. She confronted him and got the beating of her life.

Being a good wife, she did as she was told. There is something seriously remiss with the kind of social conditioning that tells our daughters that it is heroic to stick with a bad relationship. There is something seriously wrong with social pressure that tells our daughters that they must submit to the sexual demands of husbands they know to be totally unfaithful. There must be something wrong with cultures and traditions that subject women and girls to rituals and power relations that expose them to HIV infection. It may have been a matter of family pride once, but these days it's tantamount to sending our daughters to the slaughter.

Without doubt, journalists have the power to shape and influence the way people think and make decisions. This agenda-setting role has never been more urgent, given the impact of HIV/AIDS on ordinary lives in eastern and southern Africa.

None of us in Africa today can claim not to have encountered the human face of this pandemic. It is the challenge of our times that, despite all the advances in communication, we should be faced with such limited success in the behaviour change necessary to stem the vicious tide. As a journalist whose life has been touched at a personal level by the devastation of HIV/AIDS, I firmly believe that efforts such as this manual will go a long way in helping change not just what we know, but how we behave.

The manual before you tackles the whole spectrum of gender issues that surround HIV/AIDS, from prevention to treatment and care, within the broader context of custom, culture, religion, as well as the political and economic environments in which HIV/AIDS is thriving. It addresses not just the concerns of women, but also of men. It sees HIV/AIDS not just as a catastrophe, but as an opportunity. For if, in fighting this pandemic, we also emerge with an understanding of the gender dynamics that underpin it, we would truly be on the road to victory.

As a board member of the African Woman and Child Feature Service, a partner with Gender Links in the African Gender and Media (GEM) initiative, I have been closely associated with the many practical media tools that these organisations have developed to promote gender equality in and through the media.

This manual lives up to GEM's proud tradition of professionalism and excellence. It belongs in every African newsroom, training institution and library. The time for journalists to be passive vehicles of information is long over. We are called upon not just to record, but also to prompt debate and to set agendas. Ending HIV/AIDS, as well as promoting gender equality, are two related agendas that we ignore at our peril.

**Lucy Oriang is the deputy managing editor of the Daily Nation, the flagship publication of the Nairobi-based Nation Media Group. She has worked in the print media for 20 years and specialises in gender and the media. Ms Oriang' has pioneered several women-in-the-media projects at the Nation, East Africa's largest media company. She is also the editor of Africa Woman, a virtual newspaper produced by women journalists in nine African countries. It is available at www.africawoman.net.*

Glossary of HIV/AIDS terms

Anti (retro) viral: Having the property of attacking (retro) viruses.

Cost of treatment: The direct cost of treatment for HIV/AIDS includes doctors' fees, test fees (for the HIV antibody test, X-rays, etc), hospital fees, fees for drugs and other forms of treatment and fees for home and hospice care.

CD4 cells: A type of blood cell, also known as T-helper cells or T-cells. When the immune system is functionally normally, CD4 cells protect the body by recognizing and destroying viruses and bacteria.

DNA: Deoxyribonucleic acid. The genetic material of most living organisms.

Home-based Care: The term is widely used, often in a positive light, but there is insufficient interrogation of who does the caring or whether there is any care at all for the patient. Home based care, in the face of stigma, lack of nursing skills and other financial and social priorities, sometimes becomes a form of neglect. "Care" is used as a euphemism to cover care and support, which can be done in the home under the right conditions, and for treatment, which properly belongs in hospitals or clinics.

Incidence/Prevalence: These do not mean the same thing. Incidence refers to the number of new infections within a defined period of time, while prevalence is a snapshot of the total number of people infected at a given point in time, usually expressed in terms of annual increase. An HIV incidence of 20 percent means that 20 percent more people will contract the virus in a given year than in the previous one. A prevalence among adults of over 30 percent means more than three in ten adults are living with HIV.

Palliative Care: This is treatment, which does not address the disease itself but improves the quality of life of the infected person, and it includes good nutrition.

Mother to Child Transmission: Transmission can occur before, during or after birth. This term places the onus of spreading the disease on a woman, ignoring that the woman is only the last link in a chain. A preferred term is parent to child transmission; perinatal transmission also is used because this shifts the emphasis to when the infection occurs and away from who is seen to have caused it.

Transmission: This word tends to be used to mask the fact that what is being talked about is sex because many people and journalists are uncomfortable talking about sex.

Treatment: The issue around this term is whether one is telling the full story or just a narrow story. In South Africa, for example, the discussion has become narrowly focused around a particular disease and particular treatment, ignoring the broader political issues around prevalence of disease and unavailability of treatment generally.

Syndrome/Disease: AIDS is, by definition, a syndrome, ie. it is a cluster of specific diseases, any of which the infected person might recover from.

Sero-status: Simply means whether an individual is HIV positive or HIV negative.

RNA: Ribonucleic acid. An organic compound storing genetic information.

Viral load: The quantity of the virus in the bloodstream, which is measured by sensitive tests. These tests are unavailable in most of Africa (this would be a good investigative story for journalists in African countries where the tests are unavailable).

Window period: It takes the immune system up to three months to produce antibodies to HIV that can be measured in the HIV antibody test. During this window period, an individual tests negative for the virus but is nevertheless capable of transmitting it to others.

CHAPTER ONE

Introduction

"If we agree that changing sexual behaviour is at the core of reducing HIV infection and that efforts to change sexual behaviour require changes in the social and economic power relations in society, then our ability to address the HIV/AIDS epidemic is inextricably linked with our ability to address gender inequality at all levels."

Dr Cathi Albertyn, Director, Centre for Applied Legal Studies.

Why this manual?

The Acquired Immune Deficiency Syndrome (AIDS) is one of the most devastating diseases the world has had to face. The virus that causes AIDS, the Human Immunodeficiency Virus (HIV), knows no boundaries, no class, no sex and no race.

By December 1 2001, according to UNAIDS, 40 million adults and children worldwide were living with HIV/AIDS, and 28.1 million of them were in Africa. Twenty percent of the world's new infections in 2001 occurred in Africa.

A large body of the knowledge, information and awareness that the general population has about HIV/AIDS comes from the mass media. Targeted HIV/AIDS information, education and communications campaigns by non-governmental organizations (NGOs) have also played a role in people's understanding of the pandemic. But it is the media, through its articles and broadcasts, which continues to reach a large audience, thereby having a great impact on people's attitudes, as well as on the national agenda set by countries to deal with HIV/AIDS.

It is undisputed, borne out by the numbers, that women and girls are more vulnerable to HIV/AIDS due to gender inequality and the power imbalances between women and men in every society. Women and girls also carry a heavier burden of care when HIV/AIDS enters households and communities, and they have more limited access to HIV/AIDS related information, prevention, treatment, care, support, commodities and services.

The human face of HIV/AIDS is portrayed as that of women and girls. The Declaration of Commitment of the June 2000 United Nations (UN) General Assembly Special Session on HIV/AIDS stresses that gender equality and the empowerment of women are fundamental elements in the reduction of women's and girls' vulnerability to HIV/AIDS.

Gender stereotypes and power relationships also increase the vulnerability of men to HIV infection. Men experience difficulty in accessing information about sex and HIV/AIDS. Society expects men to be knowledgeable about these matters. Many societies accept and indeed encourage men to have multiple partners. All of these factors have been associated with an increased risk of HIV/AIDS for men.

Understanding the link between gender, HIV/AIDS and rights is key to any strategies adopted and implemented to stem the spread of the infection. Strengthening knowledge of this link must be central to any HIV/AIDS information, education and communications strategy or campaign, as well as in the information on HIV/AIDS disseminated by the media.

Objectives of the manual

The manual's key objectives are to:

- Show and create an understanding of the link between gender and HIV/AIDS;
- Illustrate, through examples, how the gender dimension of the HIV/AIDS pandemic has been the missing story and/or misrepresented by the media and other communicators;
- Explore how the media and other communicators can contribute towards developing a human rights-based approach to covering HIV/AIDS, including the importance of gender equality to countering the pandemic; and
- Highlight the opportunity that HIV/AIDS presents in communicating more with men and women on the importance of building a more caring, compassionate society in which men and women enjoy equal rights and equal access to resources and opportunities.

Target audience

This manual is targeted at everyone who is involved in developing and disseminating messages on HIV/AIDS. Using a broad definition of communicators, this includes those working in the:

- Mainstream media;
- Community media;
- Government information units/departments at national, provincial and local level;
- Community-based organizations (CBOs) and Non-governmental organisations (NGOs); and
- Gender trainers.

Research suggests that journalists and information officers tend to have a superficial medical understanding of HIV/AIDS, as well as little knowledge of the gender dimensions and socio-cultural factors which fuel the spread of HIV/AIDS.

This lack of knowledge often leads to sensational or inaccurate reports; the use of facts and figures on HIV/AIDS without providing the context (i.e. without explaining the significance of these facts and figures in the wider scheme of things), and leads to the fostering of stereotypes and attitudes which cause stigma and discrimination.

Equipping those who disseminate information and communicate messages about HIV/AIDS with more knowledge and a greater understanding of the medical, public health, gender, rights and socio-cultural dimensions of the pandemic, can lead to the better crafting of information that brings to the fore the gender dynamics that contribute to the spread of the disease; create more spaces for frank discussions on sexual and reproductive rights, and on a human rights approach to stem the spread of HIV/AIDS.

Martin Foreman, the former director of the London-based Panos Institute's Global AIDS Programme, notes in *'An Ethical Guide to Reporting HIV/AIDS':*

"... Whether or not they actively seek to do so, the media either fuel the epidemic through sensationalism and poor or unethical reporting, or helps to restrain it by promoting information, understanding and behaviour change. The media shape attitudes, influence national agenda for good or for ill; it educates or misinforms; it investigates or ignores malpractice; and it raises or ignores questions of cultural values that lie behind the epidemic..."

How the manual is organised

Three foundational chapters provide the background to the manual, some of the key principles of training and introduce the key concepts in gender and HIV/AIDS.

The rest of the manual examines key gender and HIV/AIDS issues in topical chapters. They are structured in the following way:

- Objectives, at the beginning of each chapter, that assist the trainer to understand what information is provided and why;
- A discussion to introduce and define the topic area;
- Activities and exercises that assist the trainer to develop approaches for building gender and HIV/AIDS into training;
- Boxes within the text with statistics and key information;
- Handouts of terms and special information for general awareness and knowledge;
- Examples of articles from the media;
- A suggested list of stories for the media; and
- Key learning points.

The appendices at the end of the manual include:

- References of resources for further information;
- List of web resources on gender, HIV/AIDS and rights.

How to use this manual

The manual is intended to be a flexible training tool that can be used in many different ways, from an intensive one week training course, covering all aspects of gender and HIV/AIDS, to sessions on gender, HIV/AIDS and the media as part of other training programmes, to a modular course run during lunch times over the course of weeks or months.

Individuals can also use the manual for self-study, using the handouts and boxes on key information and statistics to build their own understanding and knowledge base as they continue to work in the area of information, education and communications on HIV/AIDS. This "shopping basket" approach should ensure that trainers are able to adapt the material in the manual to suit the specific needs of their participants.

Suggestions for developing the training programme

- Speakers invited to lead discussions on specific topic areas can include people living with HIV, health experts, gender specialists, journalists/editors from the local media. Inviting women and men living with HIV helps to reinforce the personal context for the learning process, while including information and communications officers, editors and journalists who have shown commitment and competency to the dissemination of HIV/AIDS and gender issues from a variety of angles would be a good way to address the media and information "fatigue" issue on HIV/AIDS with those in the field sharing their experiences and solutions. People living with HIV/AIDS also can provide critical input on areas of stigma, discrimination and information gathering techniques.

- Given enough prior preparatory work, a programme can be devised whereby the training ends with a production of a printed newsletter or small newspaper on gender, HIV/AIDS and rights. Participants can spend time in the field and can write stories that are edited and published (based on the agreement with the local daily for deadlines, etc). Radio programmes or any other form of media product also can be produced. This approach gives rise to a tangible product at the end of the training

- Keep a record of the training. It is important to identify a recorder during the training programme who can keep a daily record of the discussion, issues and questions raised, as well as observations on which topics sparked the most discussion, observations on the trainees' participation and of areas in the module which were easy to grasp and those which seemed most difficult.

Teboho Motebele of the ALP

CHAPTER TWO

The basics of training

By Patricia Ann Made

Patricia Made

What is training?

Training is a process which seeks to educate and inform those who participate. To do this effectively, communication is the key. Making the training inter-active, varied, fun but still businesslike helps to keep the participants alert, enthused, and alive to what is being taught and/or discussed.

Training is an interactive process of teaching, discussing and doing. All three aspects are central to effective training and in the context of training those who work in the media, the "doing" is critical to help journalists, editors, photographers and media managers translate new information and new worldviews into the day-to-day deadline and active pace of journalism.

Anyone or any organization involved in any form of training for the media must ensure that the training includes practical exercises. These should not only be exercises to gauge attitudes and measure understanding of key concepts, but exercises which can simulate in some fashion the actual work that journalists do – writing, reporting, editing, interviewing, designing and working with images.

Those who engage in training those in the media must have knowledge and skills on how the media works and a basic understanding of the principles of journalism.

Training tips

- ***Read widely*** and have a clear understanding of the area being taught – this is extremely important in areas like gender, HIV/AIDS and rights. A good understanding of all three areas and how they interlink is key to helping the target audience to grasp the concepts and issues, and to gain new insights that can be translated into their own work.

- ***Do not discount what you know, live, hear and see all around you each and every day*** – this grounds the training in a reality that cannot be dismissed as "lofty ideals", or "talk only". In addition to the secondary literature, the lived experience of people provides wonderful material for illustrating points and concepts during a training programme.

- ***Know your audience:*** It is important to have some understanding of the background of the people who will be trained. The techniques and material used for college students will not be the same used for adult learners with no media experience or for journalists/editors who work in the media.

- ***Be prepared:*** Before setting foot into the training room, the trainer/facilitator should prepare some basic outline of the course and the material and exercises to be covered in the training. This prior preparation helps one to approach the training competently and not give the impression of "talking off the top of your head."

- ***Be flexible:*** While it is good to be prepared and have a map of where the training will go during the time allotted, it is also important to be ready to switch gears and to concentrate on the material according to the trainees' needs. Listen attentively throughout the training to the various issues, concerns, knowledge gaps they share. In this way the trainer/facilitator can constantly add new information to meet these concerns as the training progresses.

- ***Have clear objectives (outcomes):*** During the preparatory process, set out clear objectives for the training. These objectives should be shared during the planning process with the audience (primary and secondary) and discussed again during the first day of the training when discussing the participants' expectations. It is important to set achievable objectives, especially within the time-span allowed for the training. Be realistic about not changing the world or making the participants experts right off the bat. Training is a process and within a set time period, there are some measurable goals that can be achieved.

- ***Building blocks:*** Think of the toys – building blocks or puzzles – and keep this image in mind when designing a training programme. You cannot send someone out on the first day to write a story until you've taught the basics of reporting. You cannot ask someone to solve a square root problem in Maths until you've taught basic arithmetic and algebra. The same applies to gender, HIV/AIDS and rights training – one must think of a course design whereby the areas link and fit together, building on each other until the end of the training is reached.

- ***Assessment and evaluation:*** This should always be built into training, even within formal institutions (other than just by way of exams), to measure the effectiveness of what you set out to do with the participants. Training is a learning experience not just for the participants, but for the facilitator and the evaluation helps you to identify areas of strengths, weaknesses, and will prompt ideas for future training.

Training methodology

The manual presents an array of topics and exercises to foster a participatory approach to the training sessions. A basic assumption of the manual's methodology is that the primary target audience, as listed earlier, will be adult learners – journalists and information and communications officers who are employed. The information imparted and the activities used throughout this manual are to help those in the training do the work of communicating HIV/AIDS better.

The participants will have varying degrees of knowledge and understanding of gender and HIV/AIDS, and some of this knowledge may be informed by personal experiences that should be drawn upon and discussed within the context of the training.

Box one: Adult learners

- The needs and interest of adult learners are the ideal starting-points and benchmarks for organising and delivering training.
- Adults view training in terms of its relation to their lives and work.
- Experience is the richest source of adult learning. So the most effective core methodology for adult learning programmes is participative: learners take part in a planned series of experiences, analyse them and relate them to their own life and work situations.
- Trainers/Facilitators need to be partners with their learners in a process of questioning, analysing and decision-making. Trainers of adults need to move away from transmitting knowledge to learners and then judging their conformity to it.
- Age and experience develop even apparently similar adult learners in very different ways. Adult learning programmes need to have sufficient flexibility to accommodate different learning styles.

Source: Malcolm Knowles, quoted in Chapter Two "Gender in Media Training – a Southern African Tool Kit" (2002) by Gwen Ansell, Executive Director of the Institute for the Advancement of Journalism.

Facilitator's role

The facilitator's primary role is to set up a context in which learning can take place.

The facilitator does not have to be a fountain of all knowledge. The handouts and the information throughout the chapters provide the facilitator with a good stock of key information needed to help guide the participatory learning process.

Given the subject area of this manual, the methodology used should include a strong emphasis on both the conceptual (understanding the key issues) and the personal contexts. HIV/AIDS affects us all. It is not an issue of the "infected" alone, because of the far-reaching impact of the pandemic on the entire social fabric of a society. The sharing of individual experiences and personal stories can greatly enrich the training process and help communicators to find ways to incorporate the training into their own work experience and into their lives.

When using this manual, the facilitator should keep the following key points on effective learning uppermost in his or her mind:

Learning is most effective when:
- It respects the participants;
- It starts from people's needs and existing knowledge;
- It is active and composed of varied activities;
- It has clear goals understood by both participants and trainers; and
- More time is spent on participant activity than on trainer talk.

(Gender in Media Training – A Southern African Tool Kit: 2002)

Getting started

On the first day of the training, the trainer/facilitator may use a number of ice-breakers/energizers he or she is familiar with to start the day.

Some musts that should be accomplished before the trainer/facilitator moves into topical areas are the following:
- Introduce yourself, the organization you represent and provide the participants with some background on "why this training?" (Pointers for this can be drawn from *"Why this manual"* in Chapter One.)
- Ask the participants to first introduce themselves by giving their names, name of organization they work for and their country of origin, if the group is comprised of people from several countries. Ask for this information only on "first" introductions.

Trainees expectations

Exercise one

Give each trainee a card and a marker and ask them to write one expectation they have of the training. Gather the expectations and place them on a wall, or a flip chart. Read aloud each expectation.

Tips for trainers: At the end of the exercise, the trainer should note first the expectations which will be met during the training, and then note those expectations which may not be met during the training, and indicate that perhaps these are issues that can be developed further in follow-up programmes. At the end of the training, the trainer should assess which expectations have been met.

Exercise two

Hand out the case study, "A House of Hope", in **Handout one** to the participants. In small groups, ask them to read the case study and then identify what they think are the key issues emerging from the case study. They should also be asked to think about how the issues that they identify have an impact on their work and on how HIV/AIDS messages are communicated.

Tips for trainers: This is a lengthy article and you must allocate enough time for the participants to read and discuss it. Some of the issues that should emerge will include:

- The age of women infected in Botswana – it represents the reproductive age group of women worldwide and raises issues of women's vulnerability to the infection and their reproductive health rights.
- The article emphasizes a multi-sectoral approach – this is significant for how information and communications campaigns on HIV/AIDS are constructed and implemented. Narrowly targeted campaigns have tended to have little impact on behaviour change. Media articles that do not report on HIV/AIDS in a context that analyses the gender, social and other factors that fuel the epidemic continue to misinform, build little awareness and sensationalize the issue.
- HIV/AIDS has no boundaries – this is illustrated by the quote by the United Nations Development Programme (UNDP) in the opening paragraph to this introduction.
- The involvement of men – this is a key and missing area in not only communications and information campaigns and messages, but also in media articles.
- The language and tone of the story is one of hope, people taking control; this is not the norm of HIV/AIDS reporting.
- The quote about "maintaining the momentum" is an ongoing challenge – this is a pointer for those who cry "media fatigue on HIV/AIDS coverage" as well as to those who cannot find new angles or insights.

handout one

Case study: A house of hope in Botswana

By Christina Stucky

Palapye, Botswana: The high-pitched sounds of toddlers singing the Botswana national anthem emanate from behind a closed door covered with children's drawings. These cheerful voices contrast with the sound of serious matters being discussed by the adults next door, but the discussion will affect their lives, their futures. The grown-ups are community leaders in Palapye, a small town a few hours' drive from the capital Gaborone. The topic is how the district is handling the HIV/AIDS pandemic.

The 50-odd children are orphans who spend their days at the House of Hope. Some have lost their parents to AIDS-related illnesses, some may even be HIV-positive, though none have been tested. Community leaders in Serowe/Palapye district are responding to the growing need to care for children orphaned by AIDS.

As part of an initiative of the Serowe/Palapye Multi-Sectoral AIDS Committee, the House of Hope was opened in November 1999, to deal with the after-effects of AIDS, according to Klass Motshidisi, the volunteer chairman of the House of Hope. This response is one of the many examples across Botswana of people addressing the HIV/AIDS pandemic in their own backyards – with the assistance of the Botswana Government and organisations like the United Nations Development Programme (UNDP).

Botswana's 36 percent HIV prevalence rate is the highest in the southern African region. According to UNDP's Human Development Report 2001, 150,000 women aged 15 to 49 are HIV positive. Given a population of only 1.6 million, these figures indicate that few families remain unaffected by HIV/AIDS in Botswana.

Many sectors – one aim

But with the assistance of UNDP, Botswana is proving that a "multi-sectoral approach" is perhaps the most effective answer to fighting the spread of AIDS and dealing with its consequences.

"AIDS affects all people, all genders, ages, ethnicities in all regions. In a sense, it's a comprehensive epidemic. To be able to respond effectively, one needs to mobilise effectively," says Macharia Kamau, UNDP Resident Representative in Botswana. "A multi-sectoral response just makes good sense. It's the right thing to do."

HIV/AIDS can no longer be dealt with simply as a disease under the auspices of a health ministry. Every sector, both private and public, is affected. "The spread of AIDS is also about what is going on in people's communities, homes and bedrooms," says Kamau.

The catalyst for Botswana's comprehensive response, and a key element in the government's successful approach to HIV/AIDS, came straight from the top, from President Festus G. Mogae. He chairs every meeting of the National AIDS Council, which includes all government departments and ministries, and the National AIDS Coordinating Agency (NACA), which monitors the government's HIV/AIDS programme.

UNDP supported the launch of NACA a year ago and helped to build its capacity to fulfill its role. Approximately 25 agencies and community groups report to NACA, including one designed to involve men in the effort.

In addition, UNDP has helped Botswana finance studies on the impact of HIV/AIDS, leading to more effective responses. The goal is to mainstream HIV/AIDS in all ministerial programmes, dealing with the impact of AIDS on their own staff, as well as on their clients.

While a national response is crucial, the involvement of local authorities, districts and chieftaincies is vital to maintaining the campaign's momentum.

The linchpin of the local response are multi-sectoral AIDS committees, which pull together key stakeholders at a district level – from mayors to school teachers, nurses to youth leaders, local chiefs to businesswomen.

In districts like Serowe/Palapye, two United Nations Volunteers, Jean-Pierre Tshamala, a Congolese, and David Saliadie, from Botswana, are working with district managers.

Local HIV/AIDS committees are the conduit by which national directives reach the grassroots, Kamau notes. UNDP supports the process vigorously and works to strengthen the response of non-governmental sectors.

Still, such efforts mean little unless individuals become involved. Tshamala says that many Batswana are still in denial about AIDS. Saliadie adds that people living with AIDS are now being encouraged to speak openly in the community about their status.

Motshidisi and his colleagues at the House of Hope are acquiring an entirely new vocabulary. Sitting in a slightly cramped room at the House of Hope, elderly men like Motshidisi speak of "anti-retrovirals" as if talking about the weather.

A school teacher, paid by the House of Hope, is busy next door teaching the children songs and expanding their vocabulary. A nurse, seconded from the government, conducts regular check-ups of the children and assists with a fledgling home-based care programme. A social worker regularly assesses children at the House of Hope on a volunteer basis.

More volunteers come in and out of the House of Hope, depending on its needs. For example, when the garden or its poultry are in need of assistance, the home draws help from the district's agricultural department.

"The biggest success by far has been getting the Botswana Government to adopt in an effective, committed and political way the multi-sectoral response," says Kamau.

Though maintaining momentum is an ongoing challenge, the volunteers at the House of Hope are doing a great deal to ensure that the "multi-sectoral approach to HIV/AIDS" is translated into reality for thousands of people living with AIDS in Botswana.

('"CHOICES", December 2001, published by the Communications Office, UNDP New York)

CHAPTER THREE

Key concepts

By Colleen Lowe Morna

"AIDS affects all of us. But it affects women and girls in very specific ways. It brings together factors of poverty and unemployment, women's and men's biological make up, violence, gender inequality and the famous double standard (the man who sleeps around is a real man, the woman who does the same is a "slut"...) This epidemic forces us to examine the most difficult issues – the ones closest to home. We are challenged to refuse to play by the patriarchs' rules in the bedroom and in the boardroom."

(Pregs Govender, former Member of Parliament and Chair of the Committee on the Quality of Life and Status of Women, South Africa)

Objectives

The objectives of this chapter are to:

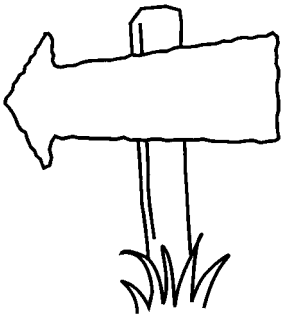
- Convey the difference between sex and gender;
- Examine the key elements of HIV/AIDS; and
- Examine the critical links between gender and HIV/AIDS.

Introduction

Of the approximately 36 million people infected with HIV/AIDS globally, 69 percent live in Sub Saharan Africa, and approximately 55 percent of these are women (compared to the global average of 46 percent women infected by the virus).

There are biological reasons why women, and especially young women, are more vulnerable to the disease. However, these are compounded by a host of other factors relating to the social and economic status of women. Because of the unequal power relations between women and men, women are not able to negotiate safer sex especially where the only known method for reducing the spread of the disease (short of abstinence) is the condom – a device almost exclusively controlled by men.

The power imbalance between men and women is exacerbated by various traditional practices that contribute to the spread of the disease. Among the scariest of these is the myth, highly prevalent in the region, that having sex with a virgin can cure the disease. HIV/AIDS is also being spread through large numbers of sexual offenses. Few, if any, government facilities provide access to post-exposure prophylaxis to rape survivors and survivors of sexual violence, leaving many women with a death sentence hanging over them.



See Chapter Six on Gender violence and HIV/AIDS and
Chapter Seven on Gender, culture, religion and HIV/AIDS.

Contrary to the view in many opinion surveys that women are responsible for spreading the virus through sex work and through promiscuous behaviour, many women unwittingly contract the virus in their own homes through unfaithful husbands and partners. Indeed some studies show that among sex workers who receive education and access to resources, the spread of HIV/AIDS is better controlled than in other relationships and the incidence of HIV/AIDS in these populations is lower than in the general populace.

Despite this, AIDS has been dubbed a “prostitutes’ disease” and a “woman’s disease”. The naming of vertical transmission as mother to child transmission, rather than parent to child transmission has continued to emphasize the role of women as vectors of the infection and contributes to the notion that women bear sole responsibility for children. Practices such as having sex with virgins to “cleanse” older men of the disease, or banning young women from having sex, have gone without critical comment, debate, or provision of information to help dispel the myths that surround them.

As much as HIV/AIDS is a devastating threat to the region, it also presents enormous opportunities for better understanding the gender dynamics that are contributing to the spread of the disease, for frank discussions on sexual and reproductive rights, and for a human rights approach to dealing with the pandemic. This can only be achieved if those who communicate about the disease are well equipped to understand and convey these issues.

Many communicators and media practitioners, male and female, have never been exposed to gender training of any kind. Even if some have, it is important that all participants begin from a common understanding. As in any learning, these concepts are best understood when they are applied to the experience of individuals, and their work.

Exercises from this chapter can be used as a package or in various combinations for introducing gender and its significance to reporting in the more specific chapters that follow.

Exercise one

Six volunteers are requested to give one-minute impromptu speeches on the subjects below. The speakers may either agree or disagree with the statement, but should give reasons why they do so:

- If my partner insisted that we use a condom, I would be suspicious.
- If I found out that my domestic worker had HIV/AIDS, I would dismiss him or her.
- If I heard that someone in my workplace had a family member living with HIV/AIDS, I would avoid them.
- Women should not enjoy sex.
- Once a man is sexually aroused, he needs to have sex, otherwise he will be in a lot of physical pain.
- If I had a choice between the male and female condom, I would use the female condom.

Tips for trainers: Impromptu speeches are a useful way of surfacing stereotypes, assumptions and in this case, the complexities of gender issues as well as their significance to public policy. Indeed, the above questions should be adapted to your particular situation and pick up on any recent, newsworthy events. Impromptu speeches are also fun and a good way of breaking the ice. Use this exercise mainly for this purpose and for surfacing the issues that will then be unravelled gradually through the remainder of the training. It would be useful to write up some of the key issues that arise on a flip chart so that you can refer back to them as you go through the training.

Another format for this exercise that is more active and participatory, but also more time consuming, is to have all participants stand up in an open space. The facilitator reads out the statement. Those who agree go to one side of the room and those against go to another side of the room. Each has to give one reason why they are for, or why they are against. Rather than pose all the statements at one go, this exercise could be repeated at several different junctures throughout the workshop as a kind of reality check; a way of constantly linking the training to the real world, testing how gender analysis skills are developing, as well as relieving boredom and fatigue.

Sex and gender

Understanding the difference between sex, the biological difference between women and men, and gender; the roles assigned to men and women, is a critical starting point in any gender training. These terms are frequently confused. For example, arrival and departure forms in South Africa ask travelers what their gender is. This is, of course, incorrect. The question should be, what is your sex. Open the discussion on the difference between sex and gender through a quick quiz such as the one below.

Exercise two

In pairs or buzz groups, participants should tick whether the following functions are associated with sex or gender.

How would you define the difference between gender and sex?

FUNCTION	SEX	GENDER
Breastfeeding		
Cooking		
Menstruation		
Managing		
Growing a beard		
Boxing		
Voice breaking		
Knitting		

Tips for trainers: The above exercise is intended to test whether participants understand the difference between sex and gender. Breastfeeding, menstruation, growing a beard, and the breaking of the voice are biological processes associated with sex. Cooking, managing, boxing and knitting are activities traditionally associated with men or women that have no biological basis – they are therefore a function of gender, or a social construct. The list is not exhaustive – participants can be invited to add more examples. Another approach is to distribute cards and ask participants to list functions of men and women, and then pin these up on separate walls under the headings sex, or gender.

Definitions

Sex describes the biological difference between men and women; men produce sperm, women become pregnant, bear and breastfeed children.

Gender describes the socially constructed difference between men and women, which can change over time and which vary within a given society and from one society to another. Our gender identity determines how we are perceived and how we are expected to behave as men and women.

Gender relations describe the social relationships between women and men. These are socially constituted and do not derive from biology. Biological differences are permanent, with the rare exceptions of those who undergo sex changes. Gender relations are dynamic. They may also be impacted on by other factors, such as race, class, ethnicity and disability.

Sex and gender roles

Now that you have established the difference between sex and gender, build on this knowledge to help participants understand how this leads to women occupying secondary positions – socially, politically and economically in every country of the world.

Exercise three

In plenary or in small groups, fill out the table in **Handout two** of the biologically and socially determined roles of men and women.

Ask participants to answer the following questions, after they have completed the table:

- Is this not just a natural division of labour?
- What are the economic differences between the roles assigned to men and those assigned to women?
- What is the political difference in the roles assigned to men and women?
- What is the social difference in the roles assigned to women and men?
- What is meant by a stereotype? How do stereotypes lead to discrimination?

Tips for trainers: The reproductive role is the only one that is biologically determined. The roles in the home, community and work place are "grafted" onto these biological roles. Thus, it is assumed that because women give birth to children, they must care for them and for the home and offer voluntary "care" services in the community. Gender stereotypes are carried into the work place, where women predominate in the "care" professions like being secretaries, nurses, domestic workers etc. Men are assumed to provide and protect. They take on "control" work in the community and work place – as politicians, managers and decision-makers; working in industry, business etc.

Through interactive questions and answers, draw out what is amiss with these "socially constructed roles". For example:

1. They lead to stereotyping. No individual exists in a little box. Its possible for men to raise children, and for women to lead nations. It's also possible to be caring and to be ambitious; to be emotional and to be strong.
2. The effect of the roles that women are assigned to is to make them inferior to men in almost every way, in almost every country:
   - Economically, the work that women do in the home is unpaid, and most women's work in the community is voluntary. When women do enter the "formal economy" they earn, on average, almost half what men earn because "care work" is not as valued in our society as work that involves "control".
   - Politically, whether in the home, community or in the nation, women are glaringly absent from decision-making. This makes a mockery of concepts of equal participation, citizenship, democracy, responsive governance etc.

handout two

Sex and gender roles

ROLES AND ASSUMED ROLES	WOMAN	MAN
REPRODUCTIVE WORK = BIOLOGICALLY DETERMINED		
PRODUCTIVE WORK = SOCIALLY DETERMINED		
HOME		
COMMUNITY		
WORK PLACE		
PERSONALITY TRAITS = SOCIALLY DETERMINED		

- Socially, women are often minors their whole lives, answerable first to their fathers, then to their husbands, and later in life even to their sons, and their brothers-in-law.
- Gender violence – the ultimate expression of any difference in power relations is violence. This kind of violence is even more frightening than others because it is often socially condoned. The man is expected to be strong and assertive and in control – to the point of being violent. The woman is expected to suffer in silence. She is frequently blamed and blames herself for any breakdown in relationships.

Definitions

Reproductive work comprises the child bearing/rearing responsibilities and domestic tasks undertaken by women, required to guarantee the maintenance and reproduction of the labour force. It includes not only biological reproduction but also the maintenance of the work force (husband and working children) and the future workforce (infants and school going children).

Productive work comprises work done by both women and men for payment in cash or kind. It includes both marketplace production with an exchange value, and subsistence/home production with an actual use value, but also a potential exchange value. For women in agricultural production this includes work as independent farmers, peasant's wives and wageworkers.

("Gender Planning and Development: Theory Practice and Training." Caroline O.N Moser)

What is HIV/AIDS?

It is important to test participants understanding of HIV/AIDS before establishing the links between the pandemic and gender equality.

Exercise four

A good way to do this is through the true/false quiz in **Handout three.** Follow the quiz with a mini-lecture and the basic facts on HIV/AIDS in **Handout four.**

Tips for trainers: The answers to the quiz are as follows:
1= F; 2= F; 3=F; 4=T; 5=F; 6=T; 7=T; 8=F; 9=F; 10=T; 11=F; 12=T; 13=F; 14=T; 15= T; 16=F; 17=F; 18=F; 19=T; 20=T.

handout three

What do you know about HIV/AIDS?

		T	F
1.	You can get HIV/AIDS drinking from the same glass that a person with HIV/AIDS has just used.		
2.	AIDS can be cured if you are given medicines early enough		
3.	It is safe to have sex without a condom, once you know the person really well.		
4.	Once you have HIV/AIDS, you cannot do anything to rid yourself of the virus.		
5.	People living with HIV/AIDS are always skinny and look very sick.		
6.	You can test negative for HIV/AIDS and still be HIV positive.		
7.	It is easier for a girl to get infected by HIV/AIDS than a boy.		
8.	Mosquitoes carry HIV/AIDS and can pass it on to people.		
9.	If you test HIV positive it means you will soon die.		
10.	A person who has a sexually transmitted disease is at greater risk of getting HIV/AIDS than someone who does not.		
11.	There is no difference between HIV and AIDS.		
12.	Babies can get HIV/AIDS from their mothers through breast-feeding.		
13.	Condoms do not protect against HIV/AIDS.		
14.	AIDS weakens your body so that it cannot fight off other diseases such as tuberculosis and meningitis.		
15.	HIV positive women can give birth to an HIV negative baby.		
16.	Caring for people with HIV/AIDS is risky.		
17.	We can control HIV if we test the whole population of a country and isolate those who are HIV positive.		
18.	The highest rate of new HIV infections is among young men.		
19.	Gender violence increases the possibility of HIV infection because any form of coercive sex increases the chance of skin tearing.		
20.	Some three quarters of HIV transmission takes place through sexual intercourse.		

(Source: "Gender, HIV and Human Rights, a Training Manual", UNIFEM and ACT Now! A Resource Guide for Young Women on HIV/AIDS, UNIFEM)

handout four

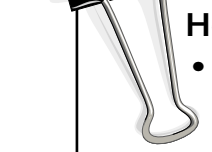
Fact sheet on HIV/AIDS

What is HIV/AIDS?

- AIDS, the Acquired Immune Deficiency Syndrome is a disease caused by the Human Immunodeficiency Virus (HIV).
- A virus is a tiny piece of biological material that attaches itself to the cells of a creature and uses them to make copies of itself. These cells make copies of HIV and then die, releasing those copies to attach to other cells.
- When the body makes anti-bodies to fight HIV/AIDS, this is called "sero-conversion"
- When enough of these cells are dead, the immune system is weakened and can no longer fight off the disease as well as it could before. At this point, many diseases that would not normally be a problem become very dangerous.

How is it transmitted? How can this be prevented?

MODE OF TRANSMISSION	PREVENTION STRATEGIES
Sexual: Having unprotected sexual intercourse with an infected person. Some 75 percent of HIV infections are caused by sexual intercourse. Three quarters of these are caused by heterosexual intercourse. HIV enters the body through tiny cuts and scrapes. Sexually transmitted infections (STI's) – especially those that cause open sores or lesions – increase the possibilities of transmission.	**Biological** • Control STI's. • Vaccines and micro bides. **Behavioural** • Formal education. • Mass media. • Social marketing.
Injections: Sharing syringes or other drug-injecting equipment with an infected person.	• Provision of sterile drug equipment. • Outreach and peer education. • Access to health care, testing and treatment.
Blood transfusion: Receiving a blood transfusion that contains HIV-infected blood.	• Screening of blood donors. • Screening of blood supply.
Parent to Child Transmission: Being exposed to HIV while still a baby in the uterus of a mother with HIV, during birth or through breastfeeding.	• Prevention of HIV infection in parents. • Use of antiretroviral drugs by the mother before giving birth. • Provision of health alternatives to breastfeeding.



How is HIV/AIDS not transmitted?

- HIV/AIDS cannot be transmitted by everyday contact for example shaking hands, kissing, coughing, sneezing, and using common swimming pools and public toilet seats.

How is HIV/AIDS diagnosed?

- HIV antibodies can be detected through the HIV antibody test about three to six months after infection.
- The period during which the antibodies are not yet detected is called the window period. Transmission of infection can take place during this period.

How does HIV become AIDS?

The progression from HIV to AIDS takes place in three phases:

- *Acute infection:* a person who has just been infected may demonstrate flu-like symptoms. This normally goes away in 1-3 weeks.
- *Asymptomatic infection:* During this phase, that can last up between eight to 10 years, the person does not appear ill, even though HIV is destroying the cells in the immune system faster than the body can replace them.
- *Clinical AIDS:* the immune system becomes very weak, the infected person catches diseases and eventually dies.

What kind of treatment is available?

There are five main types of treatment:

- *Post exposure prophylaxis (PEP):* If someone has recently been exposed to HIV, anti-retrovirals can be taken to reduce the risk of sero-conversion. These drugs must be taken within three days. There are mounting campaigns around the region for governments to make these drugs readily accessible to survivors of rape.
- *Anti-retrovirals to reduce parent to child transmission:* Drugs such as AZT and nevirapine can be used to reduce the risk of babies being infected by mothers with HIV/AIDS.
- *Combination therapy:* Certain medicines can be used together to help fight other infections that move in when the body is weak. They can slow down the change from HIV to AIDS, but they are not a cure for HIV/AIDS
- *Treatment and prevention on opportunistic infections (OIS)* – diseases that people living with HIV/AIDS get because their immune system is weakened are called “opportunistic infections”, e.g. TB. These are treated with drugs called “prophylactics” that are cheaper than drugs used to fight HIV/AIDS.
- *Palliative care:* At the stage of AIDS, the only care that can be offered is to make the patient as comfortable as possible and manage the pain. This is known as “palliative care”.

(Sources: “Gender and AIDS Almanac”, UNAIDS; “Gender, HIV and Human Rights: A Training Manual’; “HIV/AIDS, Current Law and Policy” ALP).

Gender and HIV/AIDS – making the link

Because of the unequal power relations between women and men in our society, women are frequently unable to ensure that they practice safer sex. Our social structures often put women in a position where they cannot say no to having unsafe sexual relations. Problematic areas include the whole range of negotiating sexual relations, from rape and gender violence to marital sex and committed loving relationships.

Exercise five

Start with a role – play of a woman trying to buy condoms in a small cafè. Now role-play what happens when women ask for safer sex in each of these situations:

- Sex within sanctioned structures such as marriage;
- Women who earn a living from sex work;
- Women (particularly young women) who are expected to establish social status through relationships with men; and
- Rape.

Tips for trainers: Short of abstinence, the condom is the only means of preventing the transmission of HIV/AIDS, and it is the one contraceptive that men by and large have control over. Participants should consider the following issues:

- Young women are often defenseless against demands for sex;
- A request to use a condom within the marriage setup is often seen as an admission of infidelity or a lack of trust;
- Clients of sex workers often demand unsafe sex and are willing to pay extra for sex without a condom.

Ask participants how many are familiar with the female condom, and whether or not this is available in your country. What are the advantages and disadvantages of this device?

Why is HIV/AIDS a gender issue?

Exercise six

Ask each participant to write on separate cards four events that show that HIV/AIDS is a gender issue. The facilitator should collect the cards, and arrange them into a "map" on the wall, arranging the cards to fit roughly in the following categories:

- The difference in power relations between women and men;
- Coerced sex; and its impact on HIV/AIDS – including rape, marital rape etc;
- Negotiating safer sex;
- Access to information and education;
- Higher levels of poverty among women;
- Stigma and discrimination around gender (male and female);
- Transmission from mother to child;
- The higher burden of care shouldered by women;
- Harmful traditional or cultural practices that compound the spread of HIV/AIDS; and
- Special vulnerabilities of women imposed by war and conflict.

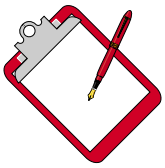
When the participants' cards have been placed on the "area map", ask participants if any of the categories above have not been raised in their cards. Should these issues be added to the map? Can members of the class find links between the different categories identified on the map and events of the epidemic in their country?

Tips for trainers: This exercise is a good barometer of participants' understanding of the issues around gender and HIV/AIDS. Do participants, as a SA public opinion poll recently showed, associate HIV/AIDS with sex workers and promiscuity, or do they see beyond these stereotypes? Follow this exercise with a mini-lecture on the links between gender and HIV/AIDS, and by giving out the following handout.

Exercise seven

Ask participants to read the article in **Handout five** from a GL training workshop in Lesotho on the links between gender and HIV AIDS. What are some of the key points that emerge from this article? Are participants aware of similar articles or coverage in their country? Is this an important angle for the media to be examining?

Tips for trainers: This article, and especially the graphic showing that "housewives" are the largest category of reported AIDS cases in Lesotho, followed by miners and former miners should spark an interesting discussion. Use it to draw out the links between gender and HIV/AIDS, using information provided in **Handout six**. The story should also be used to spark other story ideas.



Story ideas from this chapter

- Exploring the gender dimensions of HIV/AIDS statistics, as the Lesotho participants did.

Key learning points

- Gender refers to the socially constructed roles of women and men.
- Differing power relations between men and women encourage the spread of the HIV pandemic, and become instrumental in its effects on our communities.
- Gender equality is key to stemming this alarming tide.

Gender inequalities at the heart of HIV/ AIDS

By Teboho Senthebane-Shale

Women constitute 54.9 percent of those infected with the HIV virus, according to statistics from the Lesotho Ministry of Health and Social Welfare. And, according to these same statistics, out of 29 percent of the total, "housewifes" are the largest occupational category of those afflicted by the virus, followed by miners at 18 percent.

These statistics are a reminder that women are more vulnerable to HIV AIDS than men, and that it is often women going about their business in their homes that are the hapless victims of the pandemic. Why is this so? There are both biological reasons and gender related reasons for this.

Biologically, women are more vulnerable to HIV infection than men. During sex between a woman and a man, a woman is the receptive sex partner. Semen, which may be infected, stays for some time after sex and has more opportunity to enter the blood stream.

This is compounded by the gender-related or "constructed" roles of men and women in our society. Basotho believe that men are heads of the households and decision-makers. In sexual relations, men are expected to be the initiators and women the receivers of sex.

"Manhood" is often equated with qualities such as virility, strength and dominance. "Proof" of "manhood" often requires a man to have multiple sexual partners and condoms are often seen as undermining manhood.

In addition there is a pervasive belief that men's natural sex drive is far stronger than women's, so men need more than one sexual partner. Where women do request the use of a condom, they are labeled as bad and are accused of sleeping around.

While HIV is the cause of AIDS, poverty creates a social and economic environment conducive to the spread of the virus. There are strong gender dimensions to poverty.

HIV/AIDS
HIV/AIDS is everyone's responsibility. The Law, you and me can make a difference.

For example, in communities where there is little or no work, particularly in the rural areas, men are often forced to leave their wives, family and communities to seek employment. A migrant worker who is away from his wife for long periods may engage in casual sex, with sex workers or multiple partners, which puts him at risk of HIV infection.

Poverty forces women to enter into unequal relationships with men, on whom they are dependant for their economic survival. This dependence makes negotiations for safer sex very difficult.

As Nthati Moorosi, Mass Communications lecturer at the Institute of Extramural Studies (IEMS) puts it, "what kind of power do women have in the bedroom when they have no power in decision making institutes?" Women comprise 11 members of parliament in Lesotho, compared to 120 male members of parliament.

Poverty may also force a girl or woman to exchange sex for money or goods. A recent report of the Southern African Development Community (SADC) on the prevention of violence against women in March 1998 showed that 16% of sexually experienced girls between 12 and 17 had sex for money, drinks, food or other gifts.

One in five boys had given a girlfriend pocket money or bought her drinks or food in return for sex.

When women are infected with HIV, this rapidly deteriorates into full-blown AIDS because they cannot afford to eat a healthy diet and take drugs needed to control the virus.

Pregnant women can also transfer the virus to their babies because they cannot afford anti-retroviral drugs to prevent transmission of the virus.

Gender- based violence now literally carries the death threat, when women are coerced into sex by perpetrators carrying the HIV/AIDS virus. Due to ignorance and lack and of access to facilities for testing, it may take a long time before women who have been raped know their status and it may be too late.

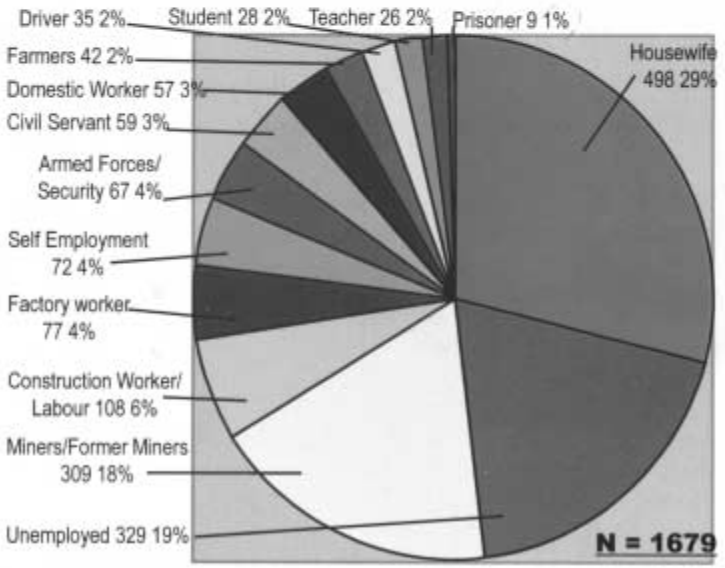
As seen from the statistics of "housewifes" constituting the largest category of those living with HIV AIDS, marital rape is exacerbating the magnitude of the pandemic. The Sexual Offences Bill will hopefully empower a woman to go straight to the police station, bypassing known customary structures to lay a rape charge against her husband.

Cultural practices such as early marriages and initiation ceremonies oppress women and teach girls to be submissive to their future husbands. The practice of older men having sex with virgins to "purify" themselves of the virus make women even more vulnerable to HIV AIDS.

Gender inequalities also surface in care and treatment as women bear the major additional burden of caring for those living with HIV/AIDS. Women also form the majority of nurses, which also exposes them to infection. In hospitals where basic necessities, such as gloves cannot be afforded, they have very little protection. Some women also face violence when they reveal their HIV/AIDS status to their partners.

HIV AIDS is both a threat and a challenge. If we could use this pandemic to raise awareness on the importance of gender equality, there would be a silver lining to the dark cloud that we are confronted with.

OCCUPATION OF REPORTED AIDS CASES 2000



DISEASE CONTROL: STD/AIDS UNIT; Ministry of Health; LESOTHO.

handout six

The links between sex, gender and HIV/AIDS

It is a biological fact that women, and especially younger women, are more vulnerable to HIV/AIDS than men. These biological factors are exacerbated by the gender roles and expectations that society places on women and men – and the economic, social and political factors that create an "enabling environment" for the pandemic.

Biological facts

- Women are far more likely to become infected through heterosexual intercourse than they are through any other means of transmission.
- The vagina and anus have larger areas of exposed, sensitive skin.
- The virus has an easier time surviving in the vagina and anus than it does on the surface of the penis.
- There is a higher presence of the virus in a man's semen than in the fluids of the vagina or anus.
- More cuts and scrapes occur during vaginal or anal intercourse. Cuts and scrapes are especially likely during violent or coerced sex or when a woman is very young, since her cervix is not fully developed.

Gender roles

- Women are often not able to negotiate safer sex with their partners, especially in marriage.
- Traditional practices such as "dry sex" and Female Genital Mutilation (FGM), aimed in the one instance at maximising men's sexual pleasure and in the other minimising women's sexual pleasure, add to women's vulnerability.
- Women bear the brunt of caring for the sick as one of the many forms of unwaged work that they perform.

Gender expectations

- In many countries, women are under great pressure to demonstrate their fertility and become mothers. Women who seek to become pregnant may have no real options to protect themselves against HIV/AIDS.
- Poor men may be unable to provide for their families, an important gender role that they feel obliged to fill. This may lead to alcoholism, violence, or seeking to exert sexual control over those whom they perceive to be weaker.

Gender dimensions of the enabling environment

Economic

- Poor women often lack knowledge, the power or indeed the time to be worried about safer sex.
- Poverty often leads to men migrating to cities to work where they have multiple sex with sex workers and multiple partners.

Political

- Women are poorly represented in decision-making structures at all levels. Their voices are not heard where policies regarding HIV/AIDS are being made.
- War and social upheaval can result in the disintegration of the family, the loss of local social systems and mass migration, creating an enabling environment for the transmission of HIV. Rape and atrocities often accompany the violence of war.

Legal

Many laws contribute wittingly or unwittingly to the "enabling" environment. These include:

- Prevention and suppression of commercial sex work.
- Homosexuality, categorised under sodomy, that is punishable by law.
- Laws that reduce women's access to property and economic security.
- Policies regulating sex education in schools.

Men should be a primary focus

The promotion of behaviour change is an important element in preventing the spread of the epidemic as well as minimising impact. The tacit and explicit acceptance in many societies that men should have multiple sexual partners contributes to the spread of HIV/AIDS to women.

(Sources: "Gender and AIDS Almanac"; UNAIDS; "Gender, HIV and Human Rights: A Training Manual", UNIFEM; "The HIV/AIDS Epidemic: An Inherent Gender Issue", Commonwealth Secretariat).

CHAPTER FOUR

Communicating HIV/AIDS

By Colleen Lowe Morna and David Lush

Objectives

The objectives of this chapter are to:

- Analyse the shortcomings of HIV/AIDS campaigns from a gender perspective;
- Explore how reporting has helped to perpetuate prejudice, discrimination and blatant myths about HIV/AIDS and in particular to lay the blame and many of the burdens of the epidemic on women; and
- Develop new approaches to training media workers and communicators on integrating gender into advocacy and coverage on HIV/AIDS.

Participant in a GL workshop on gender violence in South Africa's Northwest province.

Introduction

Why is it that despite all the information now available on HIV/AIDS, behaviour has been so slow to change? The traditional theory of communication is that if sufficient information is provided, this will eventually be turned into knowledge; that if knowledge is applied, this will eventually affect attitudes and that if attitudes change, these will ultimately alter behaviour.

The aim of any social campaign is to change attitudes and behaviour. In the case of HIV/AIDS, where we have precise information on the way the virus is transmitted, and its devastating consequences, you would imagine that behaviour change would be quick to follow. The reality, as we know, has been different. In many countries in Southern Africa, one of the worst affected regions, the levels of unsafe sex and multiple partners continue to be extremely high. Why is this so?

There are several possible explanations. The kind of message being sent out from the highest political level about the pandemic is a critical factor. HIV/AIDS is, in the end, about the two things that in Africa we find most difficult to talk about: sex and death. It is no coincidence that the countries that are succeeding in rolling back the tide are those that have openly confronted these most sensitive of life's realities. That calls for unprecedented leadership.

Leadership in all our countries has strong gender dimensions. All the heads of state and the vast majority of decision-makers are men. The typical response of men to a disease that threatens their lifestyle and their notions of masculinity has been to deny its existence and gravity, and to try to shift blame elsewhere.

Many countries in the region have lost years and thousands of lives in the fight against the pandemic through long periods of denial or of sending out confusing messages.

South Africa is an example of a country that is relatively well endowed with human and financial resources that could be used to address the pandemic. The controversial stance taken by President Thabo Mbeki however, has caused incalculable damage. While his theorizing on the matter may be warranted in academic circles, his stance is a good example of how, in communication terms, simple, clear messages, rather than academic theorizing, are needed in a crisis.

This, indeed, is what President Yoweri Museveni of Uganda, and President Festus Mogae of Botswana have grasped. Museveni took the line in Uganda that when a snake is in your home, you do not wait to ask where it has come from. You get rid of it and then worry about its origins. Museveni has also taken a strong and consistent position on promoting gender equality. Uganda succeeded in lowering HIV prevalence from 21 percent in 1991 to six percent in 2001.

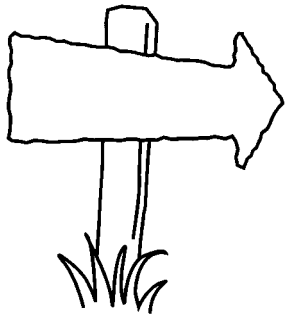
Researchers delving into the reasons for this success point out that in fact condoms have had very little to do with it, and that the success lay much more in real behaviour change. A recent Harvard study in Uganda revealed a drastic reduction in multiple sexual partnering, from a reported rate of 18 percent in 1989, to eight percent in 1995 and descending to two percent in 2002 (Mail and Guardian, 4-10 October 2002). It is fair to assume that most of this change has come from men.

Many campaigns in the region continue to give the impression that women are to blame for the spread of HIV/AIDS or that they need to take action, when in fact the reality is that many women are faithful but get infected by male partners having multiple relationships. These women often do not have the power to negotiate safer sex. Many women in poor countries do not have access to information about safer sex in the first place.

The media has often contributed to the hype and hysteria, as well as sexist stereotypes surrounding HIV/AIDS, rather than promoting a holistic, human rights-based approach. It has encouraged the view that HIV/AIDS is a disease of sinners and prostitutes; that women are to blame for contracting the virus, that they are responsible for the growing misery of AIDS orphans.

The media representation of men in relation to the epidemic has been similarly biased and prejudiced, but often the male gender issues have been subsumed under aspects of race, class, and cultural prejudice. For men, blatant gender discriminations around the AIDS epidemic are commonly seen as aspects of these other biases.

See Chapter Nine: The Role of Men.



Because of the gravity of HIV/AIDS in our region, many media training institutions are offering courses on the pandemic and/or seeking to "mainstream" it in their regular course offerings. Communicators more broadly – in government, NGOs and at community level – are also seeking to understand how best to structure and convey messages on HIV/AIDS that will lead to the desired behaviour change. The massive campaigns that are being conducted around HIV/AIDS across the region offer an opportunity not just to arrest the pandemic, but to talk about what underpins it. Gender equality needs to be at the heart of that discussion.

Opening the debate

Exercise one

A good way to start this session is through asking participants in pairs or in small groups to draw from their own experience of HIV/AIDS campaigns, and then to look at the Knowledge Attitude Practices Behaviour (KAPB) model in **Handout seven** and ask how effective the campaigns have been. **Handout eight** is a case study of the loveLife campaign that is rooted in South Africa, but has been influential in the region and can be used as source material for this session. Some questions might include:

- When you hear the words HIV/AIDS, what campaigns in your country or in the region come to mind? Why?
- How successful have these campaigns been? Why?
- Analyse these campaigns in terms of the KAPB model in the handout. How successful have they been? To what extent has knowledge about HIV/AIDS in your country translated into behaviour change?

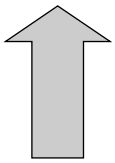
Tips for trainers – the KAPB model is often criticized for its linear approach and assumptions. This is particularly relevant when dealing with a complex subject like HIV/AIDS where experience has shown that the simple knowledge that AIDS is sexually transmitted and that it kills, does not necessarily lead to attitude or behaviour change. Models like this fail to take account of the socio-economic, cultural and social circumstances in which the pandemic is flourishing. Gender cuts across all of these factors. Most of our countries have adopted the Abstain-Be Faithful-Condomise (ABC) approach. Explore in the plenary session the gender dimensions of each of these. To what extent is abstaining an option and what are the different pressures on young men and women? Is the "be faithful" message being targeted at women or men and with what success? Who is the condom message being targeted at, and with what success? Is there any discussion in your country on the female condom?

The loveLife case study raises interesting issues about how best to target young men and women, and whether to emphasize safe sex, or mutual respect, and responsible sexual behaviour. loveLife would probably argue that it tries to do all these things. Critics are not so sure. The bottom line is that behaviour change in South Africa, where there have been huge multi-media campaigns on HIV/AIDS, has been dangerously slow in taking place.

handout seven

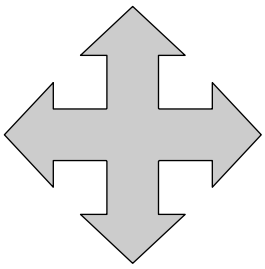
The KAPB model

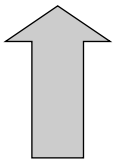
BEHAVIOUR CHANGE ---------- THE MOST DIFFICULT GOAL TO ACHIEVE!!!



ATTITUDES START TO LEAD TO CHANGES IN PRACTICES

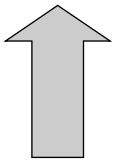
PRACTICES

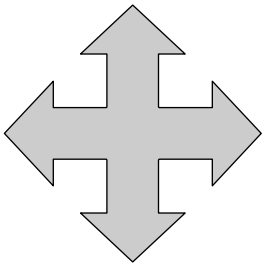




ATTITUDE

MORE ANALYTICAL INFORMATION INCREASES KNOWLEDGE; MAYBE SOME ATTITUDE CHANGE





KNOWLEDGE

CLEAR MESSAGES RAISE AWARENESS

handout eight

The loveLife campaign

loveLife claims to be, “one of the largest and most ambitious HIV prevention efforts in the world today”. Launched by a consortium of four South African non-government organizations in 1999, its primary aim is to positively influence adolescent sexual behaviour on a national scale. It targets youth between 12-17 years of age and draws upon a wealth of international and local experience. loveLife aims to reduce the rate of HIV infection amongst 15-20 year-olds by 50 percent over a five-year period. loveLife is both capturing and sustaining the attention of the youth through their simple message: “talk about it”. But critics say that the straight talk campaign, which they see as having a heavy bias towards urban and middle class youth, places too much emphasis on safer sex rather than on mutual respect and real behaviour change.

Research indicates that despite the 98 percent awareness rate of HIV/AIDS in South Africa, previous campaigns have had little effect in changing behaviour. The loveLife approach encourages open discussion and better, more direct communication about sex. In it’s initial year of operation, loveLife endeavored to create a lifestyle brand that capitalized on popular youth culture. A series of highly visual multi-media campaigns have been used to provoke discussion. loveLife has a billboard holding of approximately 2060 and each component of the images is carefully thought out and researched. The evocative, “Everyone he’s slept with is sleeping with you” or “One roll on all women want’” strike several viewers as being too bold and overt. However each image carries strong messages of mutual male and female empowerment, responsible decision-making, protected sex as well as delaying the first sexual experience.

loveLife Billboard Campaign: November 2002 – May 2003

Along with a number of outdoor, media, television and print campaigns, loveLife offers outreach and support programs as well as adolescent-friendly services in public clinics. Their toll free line, the thetha junction, receives over 30 thousand calls a month and is testament to the success of their campaign. loveLife continues to broaden its base though innovative projects such as 'loveLife games' where their involvement in school sport has provided exposure to four million students. Steps have also been taken to increase their impact at a local level. Several smaller organisations participate in the loveLife initiative and through them the loveLife campaign is being turned into community action. This, "franchise concept", has provided a base for peer educators to work and has allowed loveLife to accommodate the range of cultural diversity.

As a result of these initiatives, loveLife hopes their message will filter down into individual lives and be internalised. Behaviour change will be encouraged when the youth become a source of educators and when condom use is integrated into youth culture.

In November 2001 a national survey indicated that 62 percent of the South African youth were aware of loveLife and that of that group, 76 percent had become more aware of the risks of unprotected sex. Sixty-five percent of the group stated that the campaigns had delayed or caused them to abstain from sex and 64 percent felt it had created an opportunity for them to talk to their parents about HIV/AIDS. In general, the youth provide a positive assessment of the impact of loveLife and are receptive to their open communication strategy.

Others are more skeptical. A recent letter to the *Citizen* newspaper quoted a number of excerpts from the LoveFacts publication of loveLife including:

- "Why let others decide how we should behave and how far we will go?"
- "Friend, TEACHER, lover or partner? It makes no difference. When it comes to a relationship that involves sex – have safe sex!"
- "Bonking, jika-jika, screwing, have a ball but keep it safe"
- "Who with, how, where and when we want to do it. Its in our hands"

The letter points out that according to loveLife, 50 percent of South Africans have had full penetrative sex by age 16. They also point out that 55 percent of sexually experienced girls have been forced to have sex, mostly by their boyfriends. The letter points out that sexual intercourse with a minor under the age of 16 constitutes statutory rape, and forced sex is rape.

The letter argues: "to say that we know young people are doing things that are wrong, and then encourage them to continue, makes us accessories before the fact…tell children what they need to know, but also instill in them a sense of pride, self respect and respect for others."

Professor Suzanne Leclerk-Madlala, head of anthropology at the University of Natal comments (Mail and Guardian 4-10 October 2002): "the youth are portrayed as middle class, sophisticated and seem likely to spend their weekends enjoying multiracial camaraderie in sub-urban rave clubs. Wittingly or unwittingly, the thrust of our national HIV/AIDS prevention efforts speaks primarily to a narrow band of privileged youth."

Using the Uganda experience, where studies have shown that promotion of abstinence before marriage and faithfulness in relationships – rather than promotion of safe sex – may be key to halting the spread of HIV/AIDS, she notes that when it comes to reducing HIV infection, South Africa has "nothing at all to teach the rest of Africa."

But she adds that promoting abstinence and mutual faithfulness in South Africa is highly unpopular: "who would be willing to produce glossy media materials to convey such killjoy messages?" On the other hand, she argues, "in the raging epidemic such as we have here, messages that promote real sexual behaviour change are far more than moral choices. They are about sensible health choices and basic survival tactics."

(The organizations involved are the Advocacy Initiative, Health Systems Trust, Planned Parenthood Association of South Africa and the Reproductive Health Research Unit. Case study compiled by Janine Morna).

What gender messages are sent out in HIV/AIDS campaigns?

Exercise two

Ask participants to bring with them examples of posters from HIV/AIDS campaigns and to analyse them in groups. What messages do these posters convey? Here is one example from Zambia that you could write up on a flip chart:

KARA COUNSELLING TRUST POSTER

"Respect yourself to decide for yourself
HIV/AIDS is a threat and the end of the world if you do not know the facts

Abstinence is better than AIDS

Stay away from pre-marital sex and extra-marital sex

Women make a difference in deciding on matters concerning your health".

Tips for trainers: The loveLife campaign poster- "Everyone he's slept with is sleeping with you" – see loveLife campaign – can also be used to spark off a lively discussion. The campaign has been quite controversial in South Africa.

The one thing that these two posters have in common is that they target women ("women make a difference" and "everyone he's slept with") and give the impression that a) it is women's sole responsibility ("respect yourself to decide for yourself") and b) that women have the power to change things ""women make a difference". They also use scare tactics ("HIV/AIDS is the end of the world"; "Everyone he's slept with, is sleeping with you"). The loveLife poster conveys the message that men have free license to sleep around and that other women are passive victims of this fact. You may wish to pose the question why the messages in these two posters – what they convey to women and to men, and what impact they are likely to have on behaviour. Critique as many different posters as possible and draw some conclusions on the way in which gender issues are conveyed in HIV/AIDS campaigns.

Role of the media in HIV/AIDS campaigns

Exercise three

Invite a panel of editors to come and speak on what they see as the role of the media in HIV/AIDS campaigns and whether they have ever thought of the gender dynamics of the pandemic. Use this panel to draw out a discussion on the role of the media: is it just to provide the facts, or to help change behaviour?

Tips for trainers: The following are some comments from the media quoted in a study by the Centre for AIDS Development, Research and Evaluation (CADRE) in South Africa called "What's News: Perspectives on HIV/AIDS in the South African Media" that provide some hints of the different perspectives on this issue:

- "If its news, it will end up in the paper...
- If my work were partisan, I would not have the good relationship that I have with all role players".
- "I think its hypocritical to say – and I'm thinking here of the AIDS dissident argument – that we have to give both sides of the story when one side is being presented by a lunatic."
- "The idea that it is the moral responsibility for a newspaper in the public domain to play an advocacy role is such a dangerous territory. A paper's moral imperative is to make money. That's the reason it exists.... The media are riding the consensus, not creating it, because that is how they make money."
- " My personal view is that newspapers ought to reflect society in general, but ought to lead society in particular in those areas such as AIDS.... Don't ask me to set the limits because I don't know where they are."

The research also raised a number of constraints to coverage including:

- The imperatives of news values;
- HIV/AIDS is not amusing and engaging;
- HIV/AIDS is not new;
- HIV/AIDS is not dramatic enough;
- Attempts to influence journalistic coverage towards an educational agenda are based on a misunderstanding of the journalist's role and news values;
- Lack of commitment to the story;
- Economic and resource constraints; and
- Inadequate in-house journalistic expertise.

Media coverage of gender and HIV/AIDS

Exercise four

Look through a sample of media coverage on HIV/AIDS. What messages are conveyed on gender and HIV/AIDS? You may also want to refer to the attached case study by a South African researcher on gender and HIV/AIDS in the South African media or to relevant research from your country. What do the articles and research reveal? Give participants a copy of the article, "Have you had sex with this woman?" in **Handout nine.** They should answer the following questions:

- What are the gender, HIV/AIDS and violence issues raised in the article?
- What messages does the article convey?
- Identify the gender stereotypes that emerge from the article.
- What impact is the article likely to have on the public?

Follow this through with the excerpts of research on the portrayal of women in **Handout ten.**

Tips for trainers: Encourage the participants to discuss the difference between the messages sent out by the headline and the contents of the article itself. The article in many respects is a thoughtful piece, while the headline is sensational and stereotypes women, blaming them for the spread of the infection. Qakisa's research adds useful information on gender biases in coverage of HIV/AIDS.

Media under the spotlight: Training workshop in the Western Cape.

HAVE YOU HAD SEX WITH THIS LADY?

- Caught the disease through sexual contact
- Became too sick to look after her daughter
- Every breath came with a pain in her lungs
- Brave Sally was finally consumed by AIDS
- No need for whispered grave-side gossip

HEY DAYS: Sally pictured in '94 when she was sexually active

Sally Modise wanted everyone to know that she had AIDS. Her life was her message. She died last week aged 32.

BY STAFF REPORTER

Sally's death came exactly a year after she gave an interview to *The Voice* following her decision to publicly reveal her condition. She was the first fully blown AIDS patient in Botswana to take this brave step.

She wanted people to know that the disease was real. She was the living proof of its existence, its human face. She was not afraid to tell people of her condition and how she became infected.

Sally wanted people to see how the disease was destroying her.

Her aim was to educate and warn.

Sally did not get AIDS by accident. She was sexually active. She caught the disease from sexual contact with an infected person. She in turn infected others before she became aware of her condition. You may not have slept with Sally but the chain of infection is long. She was only one tiny link in a network of mass destruction.

Brave Sally was finally consumed by the fatal disease at her home in Mahalapye. Her death was as much a relief to her as it was to family and friends who had watched helplessly as Sally suffered through the long and painful end to her life.

Announced

At the grave-side her sister announced that Sally had died of AIDS. Probably this was the first AIDS funeral where the cause of death did not remain an unspoken secret.

Sally had spent the last year of her life repeating her message. "AIDS is real. I am its human face." There was no need for whispered grave-side gossip or speculation.

For the last month she had had to be nursed by her mother and two sisters as she was too weak to leave her bed. Every breath she took was accompanied by a sharp pain that pierced her lungs and reminded her that death was near.

She confided to a friend a few days before the end," I'm beginning to be afraid of death. I don't have enough time left to live. The pain is too much for my lungs to work."

Pedzisani Motlhabani, the AIDS project coordinator at the University of Botswana, who Sally worked with and had come to regard as a mother figure, paid tribute to her courage.

"Sally was an outstanding woman whose bravery as the first fully

■ TURN TO PG 2

handout ten

The portrayal of HIV-positive women in the South African media

Excerpt from research by Mpine Qakisa

The media's message about AIDS has been skewed right from the beginning. AIDS was looked at as a disease of "sinners " such as prostitutes, homosexuals and people with multiple partners. Popular media continued to carry reports of people who may be infected knowingly by sufferers who are seeking revenge.

Media scare stories, negative images, the nature of AIDS stories, and the reporting of AIDS related stories have all helped frame how people understand and react to the epidemic. In South Africa, this is even more pronounced because of the political and economical history of racism and sexism.

In an effort to identify the way women are portrayed with regards to HIV/AIDS as people who are infected and affected, I visited the newsroom library of the Independent Newspapers. I first looked at all AIDS articles published between 29 June 2000, a week before the World AIDS Conference in South Africa, and 9 February 2001 in The Star, the Saturday Star, The Sunday Independent, The Weekly Mail & Guardian and The Sowetan.

To identify relevant articles, a keyword search was conducted using The Independent Newspapers library database. The search yielded 805 articles on AIDS between 29 June 2000 and 9 February 2001. This means that there was an average of 3.6 articles on the subject of HIV/AIDS in these selected newspapers. There is no doubt that AIDS as a subject is covered extensively in the South African media. After looking at AIDS articles, I then screened out articles that did not focus on women.

Of the 805 articles on AIDS, 107 of them focused on women. About 13.2 percent of all AIDS articles dealt with women and HIV/AIDS. I then divided the articles into three categories. The first category looked at women in their reproductive role, that is, HIV positive pregnant women, infected infants and drugs to stop the transmission of HIV to unborn children. The second category of articles focused on violence/abuse on HIV positive women. The third category of articles dealt with general issues.

Of the 107 articles, 56 articles focused on the issue surrounding the availability of drugs to stop the transmission of HIV from mother to child. In these articles, it was clear that pregnant women with HIV are perceived as transmitters of HIV to innocent unborn babies, not as individuals with a life threatening illness.

What the media messages are not saying is that although HIV can be transmitted from mother to child, transmission does not occur to a majority of babies born to HIV positive mothers. According to the World Health Organisation, two-thirds of babies born to HIV positive mothers are not infected at all. Of the remaining one third that is infected, two thirds are infected in the womb or during childbirth and the remaining one-third is infected through breastfeeding (loveLife, 2000). If this type of information is available in the news media, then HIV positive mothers will be in a better position to make informed choices about their lives.

The underlying factor is that "women with HIV are perceived as incubators of sick babies who are destined to become a burden to society, not as individuals with a life-threatening illness, nor as a mother in struggle and in pain" (Cline and Mackenzie 1996:388) hence the headlines "Saving the Innocents" (*Sowetan,* 31 January 2001), "SA AIDS babies tragedy grows" (*Citizen,* 10 January 2001), "Drugs could save babies" (*Citizen,* 12 July 2000), "Study promises life to babies" (*Business Day,* 12 July 2000).

In almost all the articles that focused on babies there is no mention of women's health except the fact that they are carrying the babies and may infect their babies with the deadly virus. These babies, according to the articles, should be saved from their "irresponsible mothers" who basically got what they wanted. In fact, the largest single issue of the mother to child transmission relates directly to the government's policy of not providing anti-retroviral drugs to HIV-pregnant mothers. Even the screaming "Free treatment for HIV positive mums" headline failed to address the issue of HIV positive women.

Of the remaining 56 articles, 28 of them focused on women abuse and violence. These articles dealt with destitute HIV positive women who were abandoned by their families when they heard that they are HIV positive or dying of AIDS. Most of these women lived on the streets with their children until some "Good Samaritan" picked them up and that's how they end up in the media.

What these articles are saying is that if you reveal your HIV status you may end up like a 29-year-old HIV positive woman who have been kicked out of her home by her husband after she told him that she had AIDS. Her husband told her that she is useless because she could no longer cook, wash his clothes or clean the house. He also did not want her to die in his house. He threw her out at night and she just managed to sleep under a nearby tree soiled and dirty. A neighbour picked her up and a week later she died in her shack (Sowetan, 8 February 2001). Although this article is trying to bring the human face and suffering of this woman to the public, it also discourages disclosure. People may interpret this story as warning not to tell or talk about your HIV status with your partner. If you reveal that you are HIV positive, you may end up like this abandoned woman.

Media messages are failing to tell people that people who are living with HIV can live a full and productive life for many years. Almost all the articles analysed used expert opinion or government official as the source of information and in the process sidelined the people with first hand information. Right from the beginning of the epidemic, the AIDS story was never told by a sufferer.

The personal can be professional

The first step journalists can take towards understanding HIV/AIDS is to look at how the topic affects their own lives. Many journalists fall into the millions throughout Southern Africa who have never taken an HIV test. Yet this one step could help journalists develop not only empathy, but help them to cover the issue from an informed perspective.

Exercise five

Find out during the training how many people have had an HIV/AIDS test. Ask if there are any volunteers willing to undergo a test and write about their experience. An example of how this might work is given in **Handout eleven** – the story written by a student at the Polytechnic of Namibia during the workshop there to test this training manual.

Tips for trainers: Although this may be a sensitive exercise, when handled with care it can be educational. As the story in the handout illustrates, a visit to a testing centre can be most revealing. It helps those in the communications business to challenge their own fears and prejudices before they presume to communicate on this subject to others. Note that in the Namibia exercise the outcome of the test remained confidential.

Counselling in session at the New Start Centre in Windhoek, Namibia.

handout eleven

Time for a "new start"?

By Immanuel Kooper

Windhoek: Just the idea of being tested sent shivers down my spine. But what else could I do, because I had already decided to go through the process to get a first hand feel for voluntary testing and counselling before presuming to write about it. I calmed myself down and decided to go ahead.

On arrival I went for registration with a friendly receptionist who opened a file. A secret code was attached to the file. She asked me to give a fictitious name, which would be used with the code.

I asked myself what difference this code and names would make, because it would not change the outcome of my results. People might find out at any stage anyway, I reasoned, and the test is really not that confidential since the centre would be the first to know.

If the result is positive, I mused, might they stare at me when I came to collect it? Will I be able to handle all this? What if I test positive? What will happen to my family and how will I break the news to them? These were the questions that went through my mind.

Then came the next stage in which the counsellor called me in after a few minutes in the waiting room. Again, I asked myself, what type of questions is she going to ask? Will she not dig too deep into my sexual life and find out my deepest secrets, and how will my life change after all this?

But every thing went well. I came out with a bright smile on my face. I felt like staying a bit longer, but did not have time.

As I write, the result is still to come, but this does not bother me at all because I am ready to accept any outcome, thanks to the professional counselling session I had at "New Start" – a brand name under which centres such as Catholic AIDS Action, Council of Churches in Namibia (CCN), Red Cross and Life Line Child Line are providing voluntary testing and counselling.

"HIV spreads very fast because of people not knowing their status", notes Mike Haidula at the Council of Churches in Namibia (CCN) in Katutura says. The centre, he adds, "is easily accessible, cheap, fast and confidential."

Counselling is important, he noted, since people often do not know how to handle the situation after being diagnosed HIV positive.

"When the centre started officially in February this year, around eight hundred people visited the centre," Haidula says. Of the 239 people who visited the centre in March this year, 94 (39.3 percent) were male and 145 (60.7 percent) female, with 57 percent between the ages of 20 – 29. He attributes the high level of young female clients to the fact that this is the segment of the population most affected by the pandemic.

Counsellor Esmelda Peterson adds: "There should be a way for people to overcome the stigma and discrimination by sharing their status and being counselled to accept their conditions and to live positively with the disease."

First person accounts

Once someone is willing to speak openly about living with HIV/AIDS, there is a tendency for the media and AIDS organisations alike to latch onto them and to set them up as some kind of representative of people with HIV/AIDS. This too can be counter productive, as different people respond to HIV/AIDS in different ways, and no one person can possibly represent the views of all people.

There is no single representative "face of AIDS". (as an additional resource on this point, the trainer can refer to an interview that David Lush had with Sue Valentine of Health-e News (www.health-e.org.za/view.php3-id=20011022.)

To enable people to tell their own stories, the way they want to, requires journalists to drop the professional instinct to control the media production process and to tell the stories the way they see them.

Rather, journalists should put their professional communication skills at the disposal of others. In doing so, journalists and other media workers will be facilitators rather than mediators. This too requires, time, effort and the need to address ethical issues.

Self-expression and self-representation through the media can be incredibly empowering for anyone who has been stigmatised and denied a voice in the way that people with HIV/AIDS have been.

But it is important to emphasize that the media on its own does not change behaviour. People alone change their behaviour. What the media can do is to provide the public with the kind of information needed to make informed decisions.

Exercise six

Share with participants the first person story written by one of the participants at the Gauteng workshop to test this manual in **Handout twelve.** Why do such stories make for powerful media? What relationships need to be built between People Living with AIDS and the media for such stories to be told?

Tips for trainers: The story illustrates the "who feels it knows it" principle. It is always best for people to be able to speak in their own words. See also the personal accounts of men in Chapter Nine, The Role of Men.

handout twelve

From despair to hope: my personal story

By Hazel Tau Mlangeni*

I was diagnosed as HIV positive in November 1991, seven years after being married. I told my husband. On 2 November 1993 I found a divorce decree between the base and mattress of my bed.

I had never received a summons. My male counsellor advised me to go and see the Aids Law Project. As the case was being investigated, I came home from counseling one day to find my house empty. My husband had taken every thing in the house and the house had been sold, even though we were married in community of property.

My friend took me to her house to rest, cry and express my anger. The next day I found out that my husband, a prison warder, had been transferred to Durban Westville.

My life started to change. I hated men. I did not have any income. Staying in the back room of the home of my friend, who has a caring husband and two sons, I felt so alone.

In 1994/95, I decided to lodge a case against my husband. Although I had support from the AIDS Law Project, in court, I found myself pitted against powerful male lawyers hired by my husband. I felt powerless before the legal system. I could not live with the stress. I decided to withdraw the case.

Through the help of my male counselor and my friend, I slowly regained my confidence. I decided to speak out and become involved in the campaign against HIV/AIDS. I got a job as a counselor at ACCT. I went on to work at the AIDS Help Line, where I am now a senior counselor.

Last year, I fell very ill. After appearing on a TV show, an anonymous donor offered to pay for anti-retroviral drugs for me. My health has improved considerably.

It has not been easy to deal with the pain I have felt over the past years. But now I have learned as a woman that I was robbed of my legal rights.

As a counsellor, I tell my story to other women to give them courage and strength. My message to them is: Keep fighting. Be positive. There is hope, even in the depths of despair.

**Hazel Tau Mlangeni wrote this story during the Gauteng workshop to test the manual.*

Practical tips for media practitioners

The media needs to work closely with everyone involved in the HIV/AIDS struggle to make sure that the information it disseminates compliments efforts to help people to cope with the disease.

The media should not be unquestioning conduits for AIDS propaganda. On the contrary, the failure of HIV/AIDS communication to date has been partly a result of media workers' failure to criticize and question experts and officials, who often propagate a very narrow and sterile perspective of the epidemic.

Journalists should always abide by one of the basic rules of journalism: there are two sides to every story. This is as true about the coverage of men and HIV/AIDS as it is about any other story.

Exercise seven

Ask the group to brainstorm on some of the practical measures that media practitioners can take to be more professional in their reporting of HIV/AIDS. Then share with them some of the pointers in **Handout thirteen** on "What the Media Can Do."

Tips for trainers: It is important for media practitioners to recognise that there is no conflict between a human rights approach to reporting and the principles of good journalism. They are not being asked to practice advocacy journalism. They are merely being asked to be fair and balanced reporters.

Language

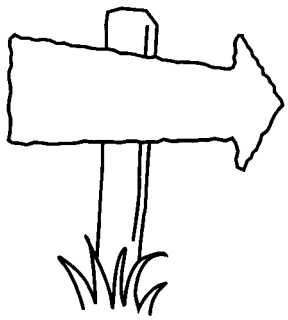
Our thoughts, ideas and prejudices are transmitted through language. Thus language is often unwittingly the transmitter of biases. As in any sensitive area of reporting, it is important for reporters to think carefully about the words they use in communicating about HIV/AIDS.

Exercise eight

Brainstorm with participants on some of the language that is commonly associated with HIV/AIDS, especially by the media. What does this language convey? What alternatives might be used? The handout contains some examples that can be built on.

Tips for trainers: Because language is a powerful conveyor of stereotypes, this discussion is a good way of drawing out deeply ingrained prejudices. Thinking of alternatives is also a good way of challenging these stereotypes. Examples are given in **Handout fourteen.**

See also "English as Medium of Discrimination" page 116 and 117,
"Gender in Media Training, A Southern African Tool Kit: GL and IAJ, 2002"



handout thirteen

What the media can do

The following pointers, although targeted at journalists, are guidelines for anyone working in the area of information, education and communications on HIV/AIDS.

- **Good contacts:** Journalists must invest the time and effort to build good contacts among people living positively with HIV and with people working for HIV/AIDS organisations. Taking the time to get to know people living positively with HIV/AIDS, helps to increase the journalist's understanding of the issues that are important to them, and builds their confidence and trust in the journalist.

- **Confidentiality:** Journalists should always respect confidentiality. This is fundamental to professional and ethical reporting (see also ethics section later in this chapter).

- **Empathy is not sympathy:** Journalists should approach those being interviewed, and write their stories, with understanding, compassion and empathy. Journalists should beware of expressing sympathy, and of viewing people living with HIV/AIDS as powerless, without hope, and unable to make choices.

- **The personal can be professional:** To write from an "informed" position journalists need to take stock of how HIV/AIDS affects their own lives. Journalists must remove the layer of aloofness and check their own biases and prejudices that often lead to one-dimensional, stereotypical and misleading reporting on HIV/AIDS.

- **Look within one's own house:** Media institutions must begin to address the impact of HIV/AIDS within their own organisations.

- **Do not create "tokens":** There is no single representative "face of HIV/AIDS". The media should tell as many stories as possible about how men, women, boys and girls are responding to HIV/AIDS.

- **Do not silence people's voices:** Journalists should drop the professional instinct to control the media production process and to tell the stories as they see them. Journalists should put their professional communication skills at others' disposal enabling them to tell their own stories in the way they want.

- **Know the limits:** The media on its own does not change behaviour. People alone change their behaviour. The media should strive to provide the public with the kind of information it needs to make informed decisions.

- **Multi-sector approach:** It is not only institutions and governments that should take a multi-sector approach to cope with HIV/AIDS. The media too needs to work closely with everyone involved in the HIV/AIDS struggle to ensure that the information disseminated through the media compliments efforts to help people cope with the disease.

- **Balanced reporting:** The media should not be an unquestioning conduit for AIDS propaganda. Reporters must remember the basic rule of the profession: There is more than one side, one perspective, to every story.

handout fourteen

The language of HIV/AIDS

LANGUAGE TO AVOID	WHY	RECOMMENDED LANGUAGE
AIDS scourge/ plague	Suggests HIV cannot be controlled. Sensational.	HIV epidemic, HIV pandemic.
AIDS test	Does not exist. Only tests to determine if HIV exists.	HIV test.
To catch AIDS	Cannot be caught or transmitted People become infected with HIV Transmission of HIV is correct.	To become infected with HIV To contract HIV.
AIDS sufferer	Many people with HIV/AIDS can have relatively good health for years.	Person living with HIV/AIDS.
AIDS victim	Gives the impression the person is powerless.	Person living with HIV/AIDS.
Safe sex	No sex is completely risk free.	Safer sex
Promiscuous	This is accusatory and derogatory.	Having multiple partners.
Prostitute	A derogatory, insulting, value laden word.	Sex worker.
Drug abuser, drug addict.	It is the act of injecting with a contaminated needle, not drug use itself, that can transmit HIV.	Intravenous drug user.
To die of AIDS	AIDS is not a disease but a syndrome, a group of illnesses. HIV causes the weaknesses that lead to opportunistic infections.	To die of an AIDS-related illness.

("Reporting on HIV/AIDS in Africa: A Manual", The African Women's Media Centre).

Ethical issues in covering gender and HIV/AIDS

Communicating and writing on HIV/AIDS for media articles and public awareness campaigns presents both ethical and legal challenges to journalists and communicators.

The prejudice and stigma attached to being identified as an individual living with HIV/AIDS is often in conflict with the need to end the silence around the epidemic.

Ethical reporting of the HIV epidemic requires that journalists and communicators understand and acknowledge the unequal power relations between women and men, and the link between these unequal relations, human rights and women's vulnerability to HIV infection.

Reporting on HIV/AIDS requires that journalists and communicators also are mindful of the individual's human rights. This requires care in the treatment of information gathered and places a responsibility on the journalist and communicator to be accurate, fair, and to use language that reduces stigma and discrimination.

Exercise nine

Give participants a copy of the case study, "Sensitive Reporting on Gender and HIV/AIDS" **(Handout fifteen).** Break participants into two groups and ask the groups to read the case study provided and then answer the following questions:

- What are the gender, HIV/AIDS and rights issues raised within the case study?
- What issues on ethical and sensitive reporting emerge?
- What messages on stigma and discrimination are conveyed by the case study?
- What steps should journalists and communicators working on HIV/AIDS information take to ensure ethical reporting on gender and HIV/AIDS?

Tips for trainers: Other media articles or information case studies on gender and HIV/AIDS can be selected from material available within your country to illustrate the issues of gender, HIV/AIDS and ethical reporting. Some key issues to consider are:

- Privacy and confidentiality;
- Avoiding blame and harmful stereotypes;
- Empowering versus victimizing;
- Compassion and support; and
- Handling the bereaved.

Using the case study, you can also ask participants to draw up a set of guidelines on reporting HIV/AIDS. An example of this is given in Handout sixteen.

handout fifteen

Sensitive reporting on HIV/AIDS and gender

By Ruth Ansah Ayisi*

Arranging for journalists to cover a story as part of the training is the best way to sensitise them to the difficulties and ethics of good reporting on HIV/AIDS and gender. It was as part of the fieldwork during the Gender Links (GL) gender violence workshop in Maputo that I personally learnt important lessons about this sensitive area of work.

I accompanied a group of six journalists to Kindlimuka, a centre for people living with HIV/AIDS. Already, we encountered our first challenge: finding women who were prepared to talk to journalists about their HIV status and their experience of domestic violence; two subjects which are taboo in most countries. But after some convincing, we managed this, especially when we assured them that if they wished, their anonymity would be guaranteed.

The journalists had been briefed about the ethics of confidentiality. They were told to brief the interviewee fully about the purpose of the interview and why it was important that her story be told. They were also to make it clear that the article would be published, so if she wished, a pseudonym could be used. The photographer discussed different techniques, such as shooting from behind or a silhouette shot to make sure the interviewee could not be recognised.

But even these precautions proved insufficient.

The journalist and I interviewed a 32-year-old mother of two children who told of how her husband beat her and raped her when she requested he used a condom. This was despite the fact that he was having a relationship outside the marriage and had a syphilis sore on his penis. The husband, who has since left her, is now also sick with what she suspects are AIDS-related illnesses. The woman said she fears she is HIV positive, but has not yet had a test.

The first problem was over the confidentiality issue. The woman had indicated that she was happy to have her real name used. But on hearing her story, it became clear that neither her children nor her family admit that her husband is living with HIV/AIDS. We realised it was our duty to explain again the implications of the women's story coming out in the newspaper, at which point she decided to give a pseudonym.

In class we discussed how due to lack of education and exposure, women often need more advice about anonymity. It is, we agreed, the journalists' responsibility to make sure the interviewee fully understands what is at stake.

Besides changing the name, we made sure that the information included in the article would not give away her identity. We also checked the photo to make sure it had been shot from behind with only my face and that of the journalist showing.

However, the following week, the local Savanna newspaper, which carried the workshop' supplement, had confused me with the interviewee. Fortunately the interviewee had her back to the camera, but my face had an ineffective, small white strip across my eyes. Two mistakes had been made. In the production, not only had they portrayed me as the interviewee, but also even more serious they had not even hidden my face properly.

For the first time in my life I realized how it must feel, not only to be misrepresented in the press, but also to fear reactions of people who would mistakenly think I am HIV positive, and had been raped and beaten up by my partner. The following afternoon after the paper had come out, I had to attend a school function for my eight-year-old son. Every time somebody looked at me, I was convinced that it was because they had recognised my picture in the newspaper and I had become the centre of gossip amongst our friends.
I wondered whether I was just being paranoid, but then my heart sunk when close friends actually came up to me for an explanation.

I can only hope that fellow trainers don't have to go through the same experience to realize how important it is not just to be ethical, but follow through on all the technical processes of production, in making sure we access the voices we need, without adding to their suffering.

**Ruth Ansah Ayisi is a communication consultant, specialising in the effect of conflict and HIV/AIDS on women and children in Africa. She has written brochures and articles on these issues in Mozambique, Sierra Leone, Uganda, Botswana, Lesotho and Angola, regularly undertakes assignments for UNICEF, and served as the Africa editor of the New Delhi-based Women's Feature Service.*

handout sixteen

Useful guidelines for reporting on gender and HIV/AIDS

Confidentiality

The rule is clear – do not publish the name of anyone living with HIV/AIDS without their permission. Human rights law recognises the rights of individuals to maintain their privacy, and there are few exceptions to this rule in the context of the HIV/AIDS pandemic.

Reducing stigma

Stigma can be reduced by avoiding words that compare the pandemic to the plague, and by identifying people living with the virus as carriers of the infection. Words such as promiscuous and evil also should not be used.

Reporting on treatment and cures

Reports should be accurate and journalists and communicators must be familiar with the scientific and medical issues. Journalists and communicators should not give credibility to false cures and/or to individuals who claim to have found cures that often have a negative influence on those who are ill or marginalised. However, it is equally important that journalists and communicators report on new scientific and medical developments in a way that is accessible and informative.

Misconceptions

A number of factors can lead to inaccurate and misleading reports on HIV/AIDS. Martin Foreman, the former global director of the HIV/AIDS programme for the London-based PANOS Institute has identified the following:

- Carelessly used, misunderstood or misused language;
- Scientific or pseudo-scientific information that is reported indiscriminately;
- Sensationalised information;
- Reports that are influenced by the personal attitudes of writers or editors;
- Sub-editors' headlines;
- Repetition of information that is out of date or distorted; and
- Inappropriately used quotes.

Journalists and communicators should be aware of the consequences of repeating and reinforcing commonly held myths about the epidemic.

Sources of information

There are many different sources available and journalists and communicators should be aware of as many of them as possible. Information obtained should be independently verified as far as possible, and it should be accurate and relevant. Ethical reporting requires that journalists and communicators take the time to distinguish the facts from the source presenting them.

Minorities and vulnerable groups

These include sex workers and prisoners, among others who are often subjected to prejudice and discrimination. These groups often are blamed for spreading the virus. Journalists and communicators should be careful not to perpetuate stereotypes about vulnerable groups and to ensure that in their reporting, the rights of these groups are respected.

Story ideas from this chapter

- What communication campaigns are being run in your country on HIV/AIDS? What impact have they had? Why is behaviour slow to change?
- Has there been any research into/ analysis of media coverage of HIV/AIDS? What does this point to?
- How do editors and media practitioners feel about their role with regard to the HIV/AIDS pandemic?

Key learning points

- Despite the huge amount of information now available on HIV/AIDS, this has often not been accompanied by behaviour change.
- Traditional KAPB models used for designing campaigns have often failed to take sufficient account of the socio-economic conditions, and underlying gender dynamics that fuel the spread of HIV/AIDS.
- The mass media has found itself caught in a dilemma over whether its role is simply to "convey the facts" or play an advocacy role over HIV/AIDS. This links to a broader debate over the role of the media in development and indeed in society. Is it the role of the media just to convey what is, or what could be?
- Media practitioners are often ill equipped to cover the pandemic, and especially the gender dynamics that underpin it. Media coverage is often event, rather than issue driven. HIV/AIDS is a complex issue, deeply rooted in social, cultural, political and economic realities. It is not just, as many media houses often treat it, a health issue.
- The natural propensity in the media to focus on the bizarre, the unusual and the sensational, and the deeply entrenched gender biases that permeate most newsrooms, have often led the media to be part of the problem, rather than of the solution, where HIV/AIDS is concerned.
- The media has often contributed to stigmatisation and discrimination around HIV/AIDS. It has revived old prejudices and stereotypes, giving these renewed life in an HIV context.
- Specifically, the media has ignored, downplayed, misrepresented and distorted the gender dimensions of the epidemic.
- The media could play a potentially critical role in providing accurate information and education on HIV/AIDS, including of the role of gender. Accurate media on HIV/AIDS could allow us to deal with the pandemic not only as a threat, but also an opportunity to bring about a more just and equal society.

CHAPTER FIVE

Gender, human rights and HIV/AIDS

By Liesl Gerntholtz

"Human rights are inalienable ... they apply to all human beings, because they ARE human beings. These rights are founded on principles that describe how we want to be treated as human beings and how we believe all human beings should be treated. We understand these rights as minimum standards for the enjoyment of all human life. As societies we create laws to protect and promote these principles"

(Women's Net, Women and Human Rights Reference Group, 12 August 1999.)

Objectives

- Define human rights with a specific focus on sexual and reproductive rights, and their relevance to gender and HIV/AIDS;
- Show the links between gender inequality, human rights violations and vulnerability to HIV/AIDS;
- Identify how human rights violations of women living with HIV/AIDS cause and reinforce stigma and discrimination; and
- Explain why a human rights perspective is critical to effective reporting on HIV/AIDS and gender.

Introduction

The concept of human rights was first introduced in the aftermath of the Second World War, and it forms part of the system of international law, when the world was shocked by the knowledge of the systematic torture and extermination of millions of men, women and children on the grounds of their religion.

In 1948, the Universal Declaration of Human Rights (UDHR) was signed by a number of countries. The central idea in the UDHR is that all people are equal and must be treated with equal dignity and concern. Although the UDHR is not a legally binding document, it marked the start of an on-going international concern for human rights, that has manifested in numerous binding international human rights treaties ranging from those on torture to gender equality.

Although many of the international treaties, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) are enforceable, it is in fact difficult to enforce these treaties, and many countries that have signed these agreements, continue to violate the human rights of their citizens. The enforcement of human rights therefore still remains a challenge.

Unlike the national laws of a country, which are enforced through the courts and other national systems, international human rights can only be enforced when the countries that have entered into the agreements ensure that these provisions are respected at national level. Once the provisions of international agreements have been incorporated into national and domestic laws, then these rights can be enforced through various mechanisms including the judiciary.

Definitions

Signing – when a country signs an agreement, it commits itself to the aim and purpose of the agreement. But by signing the country does not yet bind itself to the agreement.

Ratify – when a country ratifies an agreement after signing it, it becomes a "party" to the agreement. The rights and duties in the agreement are then binding on the country under international law. Ratification is the process by which a legislature confirms a government's action in signing a treaty; formal procedure by which a state becomes bound to a treaty.

Protocol – a supplementary addition to a treaty; when state parties can still agree to the main treaty without signing on to the protocol, this is known as an Optional Protocol.

State Parties – governments that have ratified a treaty.

Recommendations – documents explaining how a particular treaty should be interpreted and applied. The Committee on the Elimination of All Forms of Discrimination Against Women has issued several influential recommendations.

Treaty – formal agreement between states that defines and modifies their mutual duties and obligations, used synonymously with convention.

("HIV/AIDS and the Law: A Resource Manual", 2nd Edition, published by the ALP and the AIDS Legal Network; "Local Action, Global Change", Mertus, Flowers and Dutt, published by UNIFEM and the Centre for Women's Global Leadership, 1999.)

Women's human rights

Although every major human rights treaty contains an anti-discrimination provision that affirms the right of women to be treated equally, the notion that women's rights are human rights is a relatively recent one. It was first discussed in 1993 at the International Human Rights Conference that took place in Vienna.

Despite the international recognition of the equality of women, women all over the world are still subject to many human rights violations.

Women as a group have less access to the world's resources, including education, land and food; they are disproportionately affected by violence and poverty and many women have yet to realize their rights as citizens of the countries they live in. African women and women living in developing countries are particularly vulnerable to human rights violations. For these reasons, it is critical that women's rights be seen as human rights and be promoted and protected by international human rights laws and by local and national laws.

The most important human rights treaty for women is CEDAW. It is often called the Bill of Rights for Women and the handout below identifies some of the key provisions in CEDAW and how they can be used to protect women's human rights in the context of the HIV/AIDS epidemic.

Exercise one

A 30-year-old Nigerian woman, Amina Lawal was sentenced to death by stoning by a religious court in the province of Katsina, northern Nigeria. Her crime? Having a child out of wedlock. The child's father was acquitted, because in order to convict a man of adultery, he must either confess to the crime or, there must be four eye witnesses, all men.

Ask the participants to answer the following questions:

- Why is this a rights issue?
- Which rights of Amina Lawal's are being violated? Explain your answer.
- Who is at the forefront in violating her rights? What is the justification for this?
- Why is there a difference in the treatment of Amina and the father of the child?
- This case has appeared frequently in the media. What are some of your reflections on the media's handling of the case? What has been positive in the media's coverage? What has been negative?

Tips for trainers: This case study, or any other that is relevant, can be used to illustrate this exercise. Participants, in answering the questions, should begin to examine how Lawal's human rights are being violated. They should begin to discuss how Lawal has been treated differently to the father of her child, even though they have both committed the same "crime". The reasons that participants give for this will be built on in the discussion about sexual and reproductive rights.

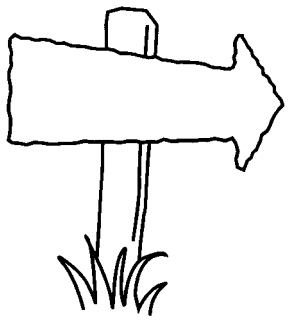
Sexual and reproductive rights

In 1994 at the Cairo Conference on Population and Development, reproductive rights were first identified at an international level as a key human rights issue for women. The Cairo Programme of Action, the document that encapsulated the discussions at the conference and its outcomes, stated that for women to realize their full potential, they "must be guaranteed the exercise of their reproductive rights and must be able to manage their reproductive roles."

This discussion on women's rights as human rights continued during the 1995 Beijing World Conference on Women. The Beijing Platform for Action includes a section on women and health (as a Critical Area of Concern), recognising the limited power and control that women have over their bodies. It also states that this lack of power over their sexual and reproductive lives is a major cause of ill health among women.

Many of the human rights violations committed against women stem from society's desire to control women's bodies and their sexuality. Often religious and cultural institutions emphasize the need for women and especially young women, to be chaste and a high value is placed on virginity in many communities.

see Chapter seven, Gender, culture, religion and HIV/AIDS.



handout seventeen

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and HIV/AIDS

Access to health care: Women living with HIV/AIDS often receive inferior treatment. They experience many barriers in accessing services, especially in terms of reproductive health care.

- Article 12 requires all states to "take appropriate measures to eliminate discrimination against women in health care".
- Article 14 ensures that the needs of women living in rural areas receive special attention.

The Committee's General Recommendation on HIV/AIDS is that programmes developed to combat HIV/AIDS give special attention to the "factors relating to women's reproductive role and their subordinate social position which makes them especially vulnerable to HIV infection".

Inequality within the family: Women's inequality within the family has created an environment in which women are unable to negotiate safer sex practices. If they do, they "may risk impoverishment or assault, may be legally unable to divorce their husbands, or may be certain of losing their children in the process."

- Article 16 requires states to eliminate discrimination in the context of marriage and the family. Men and women should have the same rights to enter into marriage, to freely choose a spouse, and to enter into marriage with free and full consent; women should have the same rights and responsibilities during marriage and the same rights to property during and after the dissolution of the marriage.
- Article 16.2 refers to young women and early marriage, a factor that increases vulnerability to HIV infection.

Discrimination against women and access to information: In many countries, women do not receive the information and education they need to protect themselves from HIV/AIDS.

- Article 10 provides that states must take measures to eliminate discrimination against women in education, and "specifically in relation to their access to educational information that will ensure the health and well-being of families, including advice on family planning".

In its General Recommendations on HIV/AIDS, the CEDAW Committee has directed states to increase public awareness of the risk of HIV infection and AIDS, especially in women and children.

Gender-based violence: Women's exposure to violence can increase their risk of HIV/AIDS. CEDAW does not deal directly with violence against women, but it contains certain provisions that address the underlying issues.

- Article 6 requires all states to take measures to suppress all forms of trafficking in women and the exploitation of women. In its General Recommendation on Violence against Women, the Committee recognised the special vulnerability of sex workers to HIV infection.

("Turning the Tide: CEDAW and the Gender Dimensions of the HIV/AIDS Pandemic," UNIFEM 2001.)

Reproductive rights are integral to a woman's health. About half of the world's female population is in the reproductive age (15-49), and the control over reproductive and sexual life is central to women's existence.

Reproductive and sexual rights assume that individuals have the capacity to make decisions about their lives. Yet, women's choices are often imposed or limited by direct or indirect social, economic and cultural factors. Studies however have shown that everyone benefits from equality for women in their reproductive and sexual lives – the conditions of men and children improve as well, and when these human rights are more respected in society, the standard of living is higher, birth rates lower and health care better.

Box two: Reproductive rights

The right to make reproductive decisions includes:

- The right to choose whether or not to have children, which means being able to choose whether or not to have sex, and whether to use contraception;
- How many children to have and the time in between pregnancies;
- Access to information regarding reproduction, including contraceptive methods;
- Access to information about reproductive health issues (impact of multiple births on women's health status)
- Access to information regarding sexually transmitted infections (STIs) and preventative measures.

Women's reproductive health care varies from society to society depending on social, cultural and economic factors. But without education, access to information, health care and financial resources, women and girls cannot fully make their own decisions regarding reproduction and sexuality.

Definitions

Reproductive rights: Include the rights of couples and individuals to decide freely and responsibly on the number, spacing and timing of their children, and to have access to information, education and the means to do so; to attain the highest standard of sexual and reproductive health and to make decisions about reproduction free of discrimination, coercion and violence.

Sexual rights: Include the right of all people to decide freely and responsibly on all aspects of their sexuality, including promoting and protecting their sexual and reproductive health; to be free of discrimination, coercion or violence in their sexual lives and in all sexual decisions and to expect and demand equality, full consent, mutual respect and shared responsibility in sexual relationships.
("Gender in Media Training: A Southern African Tool Kit, GL and IAJ 2003").

Making the links: gender, HIV/AIDS and human rights

Women who are not able to make decisions about sex and reproduction are particularly vulnerable to HIV/AIDS eg. a woman who cannot say no to sex with her husband, when she knows that he is unfaithful to her, and cannot ask him to use a condom, will be at a high risk of HIV infection.

Exercise two

Break the participants into two groups and give each group a different scenario. Ask each group to read and answer the following questions.

Scenario One

A married woman who is pregnant, discovers that she has HIV/AIDS during the course of her ante-natal exams.

- Does she have the right to terminate the pregnancy?
- Does she have the right to terminate the pregnancy without consulting her partner?

- What gender issues are raised by this scenario?
- What are the rights issues at stake here?
- What are the links here between gender and HIV/AIDS?

Scenario Two
A woman, not in formal employment, in an abusive relationship discovers that she has HIV/AIDS. She knows that if she discloses this to her partner, he will assault her and then evict her and her children from their home. She also knows that he will continue to demand unprotected sex. What should she do?

- What are the human rights issues raised by Scenario Two?
- What are the links between gender and HIV/AIDS?
- What have been some of the messages communicated to women in Scenario One and Two through the media and HIV/AIDS information campaigns? How would the group craft new messages?

Tips for trainers: This exercise should illustrate how important reproductive and sexual rights are to women's equality and they form a fundamental part of women's human rights. Participants should discuss what choices the women in the two case studies are faced with and how these relate to sexual and reproductive rights. In the second case study, participants should identify how the woman's lack of reproductive choice (not to have sex; to have sex with a condom) and her lack of equality (she is unemployed and as a woman, is less likely to find employment) have made her vulnerable to HIV infection, but also increases the spread of the infection (she may not tell her partner that she has HIV/AIDS for fear of violence and will continue to have unprotected sex.)

Stigma and discrimination

The need to protect the human rights of people living with HIV/AIDS has arisen because of the intense stigma and discrimination that disclosure of HIV status can bring about. Women are especially susceptible to victimization as a result of their HIV status, and their unequal position in society will often be reinforced once they are identified as living with HIV/AIDS.

Exercise three

Give out the case study in **Handout eighteen** and ask participants to read it. Divide participants in smaller groups and give them time to discuss the human rights violations described in the case study. Ask them whether they think the situation would have been different if Jabu has discovered his HIV status first.

Tips for trainers: This exercise should firstly help participants to examine issues of stigma and why it is so important to protect human rights – the right to confidentiality is very important in this exercise and participants should identify that the violation of Mary's right to privacy gave rise to other human rights violations against her. The exercise is also useful because it should reinforce the discussion about sexual and reproductive rights – Mary is unable to negotiate safer sex with her husband, even though she is aware of her own HIV status and she may suspect Jabu of being unfaithful.

Exercise four

Give participants a copy of the article, "HIV man jailed for knowingly infecting lover" in **Handout nineteen**
Break participants in two groups and ask them to read the article and answer the following questions:
- What are the rights issues raised in the article?
- Does the article raise issues about stigma and discrimination? What are they?
- According to the article, both the woman's and the man's rights have been violated? Do you agree? Give your reasons.
- What are several key gender issues raised by the article?
- What do you think of the way that the article has dealt with these issues?

Tips for trainers: The initial response from many participants in this exercise may be to sympathize with the woman in the article. It is however important for you, as the trainer, to make sure that participants also address the stigmatization of the man with HIV/AIDS. Participants must think about the fact that the parties were in a consensual relationship, that the woman could have asked the man to use a condom and that in the context of HIV/AIDS, every person must take responsibility for their own safety.

handout eighteen

Case study: Stigma and discrimination

Mary (a domestic worker and barely literate) and Jabu have been married for five years. Jabu is a mineworker who is at home only four times in a year. Because Jabu does not trust Mary, she and their children have been forced to stay with his parents so that they can "keep an eye on her." Jabu is very abusive towards Mary and has on occasion during a drunken stupor not only physically and sexually abused Mary, but has also thrown her out of the family home.

Mary is six weeks pregnant. During an antenatal examination, she discovered that she has HIV. At the clinic, a nurse in front of other patients informed her that she would have to terminate her pregnancy, as she will transmit the virus to her baby (if has not done so already). She is also told that she will have to be sterilised to prevent future pregnancies. The doctor also proceeds to telephone Mary's employer to inform her of Mary's HIV status. When Mary returns to work the following day, her employer informs her that her services are no longer needed. She is told that her being in the home places the children at risk of infection and that her employer is not comfortable with her employer's children being looked after by a woman with "loose morals".

When she gets home, she telephones the mine and leaves a message for her husband to call her urgently. In the evening, her husband calls and she immediately tells him that she has tested positive for HIV and will have to terminate her pregnancy and be sterilised. Her husband immediately hurls abuse at her and accuses her of sleeping around. He also demands that she packs her bags and leave the family home immediately. He demands to speak to his parents and informs them of Mary's news. They in turn react in the same manner. They accuse her of being a prostitute and wanting to kill their son. They also call her "a baby killer" for wanting to terminate her pregnancy on the advice of the doctor at the clinic. They also demand that she leave the home and take her children with her.

Mary realises that she could have kept her mouth shut but also recognises that if she had, Jabu would have continued to demand unprotected sex. Not knowing his status, she assumed that he would be negative and that she would infect him.

As Mary leaves the house with her bags, she is confronted by a mob consisting mainly of her neighbours. They start calling her names "slut" "whore" "prostitute" "baby killer" and accuse her of bringing shame to the community. She is even assaulted and it is clear that but for the AIDS activists who rescued her, she could have been killed by the mob.

handout nineteen

HIV man jailed for knowingly infecting lover

By Kirsty Scott

A man found guilty of infecting his girlfriend with the virus that leads to AIDS was jailed for five years last week in a case that has made British legal history and caused an outcry by HIV and human rights campaigners.

Stephen Kelly, 33, of Provanmill in Glasgow, was found guilty last month of endangering Anne Craig, a mother of three, by repeatedly having sex with her despite knowing he carried the virus. At the high court in Edinburgh he was jailed for five years for culpable and reckless conduct.

It is the first time in Britain that anyone has been convicted of deliberately infecting another person with HIV, and the sentence has been condemned by campaigners who say it will only criminalise the disease and further stigmatise sufferers. There are also concerns that police investigating the case were able to seize evidence of blood samples from a confidential clinical trial to use in the prosecution.

Kelly, who denied the charge, had met Ms Craig in 1994, six months after he had been diagnosed with HIV while serving a prison sentence.

Ms Craig, 34, told the court during Kelly's trial that she had asked him if there was any reason other than the risk of pregnancy why they should not have unprotected sex. He said no. Kelly had argued that he had been honest about his heroin use and HIV infection during their relationship.

Sentencing him, the judge, Lord Mackay of Drumadoon, said Kelly had shown total disregard for Ms Craig, and the jail terms reflected the gravity of the charge and the severe consequences of his actions. The judge said it was for the prison authorities and Scottish ministers to decide whether a deterioration in Kelly's medical condition warranted early release from prison.

In a statement released afterwards, Ms Craig said the sentence itself was irrelevant. All I wanted was for the jury to hold Mr Kelly responsible for what has happened to me and I was delighted by its decision" she said. Her lawyer, Cameron Fyfe, said the sentence reflected the "life of misery" to which Kelly had subjected his former girlfriend. "This case contains a warning that we should be cautious about our sexual health," he said. "It should also be a deterrent to others not to act in the way Mr Kelly has done."

HIV support groups, however, said the sentence could have a devastating effect on efforts to destigmatise the disease. "We don't believe that criminalizing the virus is going to make things any better," said Lisa Power of the Terrence Higgins Trust. "It will discourage people from testing and it will create a false complacency because people may see the trial and think in future people will tell me. It is really going to help restigmatise HIV in a way that is hugely unhelpful. We have been working towards a situation where people with HIV are able to talk about their status and don't feel afraid or feel they need to conceal it".

Lawyers for Kelly had told the judge that he had believed Ms Craig had known of his HIV status. Defence counsel Petra Collins said the couple had embarked on a relationship shortly after Kelly had lost his long-term partner and had been diagnosed with HIV. She said he had not shown any symptoms for some time but had recently started taking combination therapy drugs.

Clare Dyer adds: The Kelly case has alarmed research scientists because police, armed with a warrant, were able to sweep aside guarantees of confidentiality to link blood samples provided separately by Kelly and Craig to two research studies on HIV.

Kelly was serving a sentence at Glenochil prison when he agreed to give a sample as part of a study to find out the extent of an HIV outbreak through needle-sharing among drug addicts. The prisoners were assured that the findings would be held in the strictest confidence.

The virus takes different forms and the samples from the prisoners at Glenochil, who had passed it on to each other, were strikingly similar.

When Craig felt unwell, she gave a blood sample which was sent to a research project funded by the Medical Research Council (MRC) on genetic diversity of HIV in Scotland. Professor Andrew Leigh Brown, head of the center for HIV research at Edinburgh University, who led the study, said: "This transmission was of a virus very similar to the Glenochil cluster and distinct from other viruses we see in Scotland." He was appalled when this confidential information was produced as part of the investigation.

("The Guardian Weekly", March 22-28, 2001.)

Story ideas from this chapter

- Who protects the rights of people with HIV/AIDS? A story that interrogates national laws and policies exposing weaknesses and strengths;
- HIV/AIDS legislation – a story that examines what laws are, or are not, in place in your country.

Key learning points

- Reproductive and sexual rights are fundamental human rights, especially for women.
- The violations of these rights, and other human rights, have resulted in women living with HIV/AIDS being subject to discrimination and prejudice.
- Women are particularly vulnerable to human rights violations as a result of their HIV/AIDS status.
- HIV/AIDS discrimination and fears of being discriminated against have an impact on the spread of the epidemic – people living with HIV are afraid to disclose their status and do not seek counseling, testing and treatment.

CHAPTER SIX

Gender violence and HIV/AIDS

By Liesl Gerntholtz

Objectives

The objectives of this chapter are to:

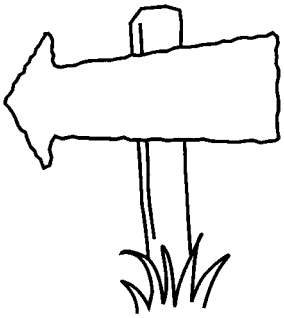
- Define the various forms of gender-based violence and how they contribute to the spread of HIV/AIDS;
- Explore and illustrate the link between gender-based violence and HIV/AIDS, as both a cause and an effect of the epidemic;
- Identify the role of the media and communicators in publicizing and raising awareness on the links between HIV/AIDS and gender-based violence.

Counselling on gender violence and HIV/AIDS in Marondera, Zimbabwe.
Photo: Trevor Davies

Introduction

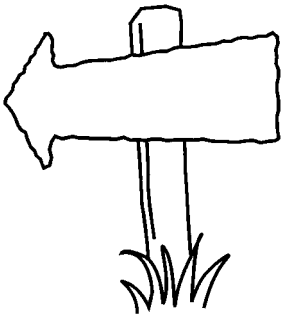
Women and girls are vulnerable to violence throughout their lifetimes. They experience violence in different forms, from abuse within a relationship, to rape committed by strangers, to state sponsored violence against refugee and migrant women. Women experience different forms of violence throughout their life cycle, and they will experience violence differently, according to their class, occupation, race, religion or other status.

Many traditional and cultural practices constitute violence against women and many cultures condone or ignore these acts.



See Chapter seven: Gender, culture religion and HIV/AIDS.

The conditions of poverty – lack of food, nutrition, no access to basic health care or to means to earn a decent wage – perpetuate an oppressive system and make women more vulnerable to violence. Women as the majority of the poor worldwide are therefore more likely to be the victims of violence.



See Chapter eight: Gender, poverty and HIV/AIDS

Violence against women has been recognised as a key human rights issue and has become an integral part of international human rights campaigns. The eradication of violence against women is seen as critical to the achievement of full equality for women.

The impact of violence on women's lives ranges from women leaving employment to serious health consequence, such as sexually transmitted infections (STIs). Violence against women limits their ability to participate in society and must be viewed as a serious barrier to development. The impact on both the girl child and the boy child is also receiving attention, and research has suggested that children who grow up in households where violence is the norm, tend to replicate similar patterns in their own adult lives.

It is important to recognize that men are also subject to violence, by women and by other men. Men in prison are particularly vulnerable to sexual violence and assault. It is important for journalists and communicators to understand that although men and boys are subject to violence, women, because of their unequal position in society socially – economically and politically – bear the brunt of violence. This chapter focuses on violence against women.

The different types of gender-based violence

Exercise one

Ask participants to each come up with one type of gender- based violence and list these on cards. Pin the cards up on a wall, cluster these, and discuss the links between them.

Tips for trainers: Below is a list of useful definitions. It is important for reporters and communicators to understand the different forms that violence may take, and also to appreciate that the law now defines many of these terms. Many are used indiscriminately when reporting on violence, and often inaccurately.

Definitions

Violence against women: Refers only to women. It is frequently confused with gender violence because over 90 percent of gender violence is violence against women.

Domestic violence: Domestic violence occurs between people who live together, are married, are in a relationship and used to be in a relationship. It is not limited to spouses, but can occur between family members, for example an uncle may assault his niece who lives in his house.

Sexual offences: Many cases of gender violence, violence against women, domestic violence and child abuse are, or have an element of, sexual violation.

Sexual harassment: Is viewed as an unfair labour practice. It is broadly defined as any unwanted conduct of a sexual nature, which can include touching, written and verbal communication and even rape.

Intimate femicide: The killing of women by their husbands, boyfriends or intimate partners.

Rape: is defined in many countries as the "intentional, unlawful penetration of the vagina by the penis". This is a very narrow definition and means that many acts, including forced anal sex between men and between men and women, would not be considered as rape by the law. This can be a problem because most countries consider rape to be a serious crime that carries a severe sentence.

Sodomy: Is the penetration of the anus. It is not considered a crime in South Africa, although many other African countries do consider it unlawful, even if it is between consenting adults

Indecent assault: Is a broad term that is often used to describe different forms of sexual assault that do not fall within the narrow definition of rape. This could include penetration by any object, other than a penis.

Statutory rape: Many countries have laws that protect young women from rape, even if they have consented to sex. In South Africa (and other countries) for example, a young woman under the age of 16 cannot consent to sex, so even if it can be shown that she agreed to have sex, the perpetrator can still be prosecuted for rape.
("Gender in Media Training: A Southern African Tool Kit, GL and IAJ 2003").

Gender violence and the life cycle

Exercise two

This exercise can be conducted in a plenary session or participants can be divided into smaller groups, depending on the time available.

Ask participants to write down the four stages of a woman's life: childhood, adolescence, adulthood, old age, and identify what kinds of violence the woman may be vulnerable to during those periods. Then ask them to identify why the violence places the woman at risk of HIV/AIDS.

Tips for trainers: Handout twenty can be given to the participants after they have completed this exercise to help them begin to think through some of the links between violence and HIV/AIDS.

handout twenty

Violence and HIV/AIDS risk throughout a woman's life

Childhood	The immature genital tract and lack of power against adult sexual aggressors place children at risk of HIV infection from sexual abuse and child prostitution.
Adolescence	The immature genital tract and lack of power against adult or peer sexual aggressors place adolescent females at risk of HIV infection from rape and coerced sex, economically-motivated sex, forced prostitution, and courtship or date rape.
Adult reproductive years	Violence from the following contributes to the HIV risk of women in their adult reproductive years: intimate partner violence; marital rape; violent retaliation of husbands or partners at the suggestion of condom use; and forced prostitution.
Older age	Women later in life may be particularly vulnerable to violence as a result of economic insecurity and (in some societies) diminished social status. Violence against older women can include rape and violence between intimates, both of which pose a risk of HIV transmission.

Adapted from Heise, L., Ellsberg, M. and Gottemoelle, M., "Ending Violence Against Women", Population Reports, December 1999, Series L(11.)

Gender violence and HIV/AIDS – reinforcing gender inequality?

Violence and HIV/AIDS interact in complex ways to reinforce gender inequality: violence increases women's vulnerability to HIV/AIDS, and HIV/AIDS in turn may lead to violence against women who disclose their HIV status.

Box three: Gender violence and HIV/AIDS

There are four main reasons why violence against women and HIV/AIDS overlap;

- Coercive sex can cause injuries and bleeding that can lead directly to a higher risk of HIV infection for women; typically this type of sex, including rape, takes place without the use of condoms, and women are unable to negotiate condom usage in these encounters;
- Abusive relationships represent an on-going threat to women – again it is difficult for women to negotiate condom usage and safer sex practices within violent relationships;
- Research indicates that women who have been abused as children are more likely to engage in high-risk sex practices e.g. multiple partners;
- Women who know their HIV status or who are perceived to be living with HIV may be at risk of violence from partners and their community.

Violence against women with HIV/AIDS

Exercise three

Gugu Dlamini lived in KwaZulu-Natal, a province of South Africa. On International AIDS Day, 10 December 1998, she publicly revealed that she was living with HIV/AIDS at a rally to mark the day. Shortly afterwards she was murdered near her home by several youths. It has been suggested that these young men had heard about her HIV status and were angry that she had chosen to reveal it publicly.
Ask participants to discuss reasons why Gugu's HIV status could have given rise to her murder. Then ask them to discuss whether things would have been different if Gugu had been a man who had chosen to disclose his status. Participants must give reasons for their answers.

Tips for trainers: Participants should think about the fears that people have about HIV/AIDS and the way that the disease has been stigmatized.

Exercise four

Give participants a copy of the article, "Raping to Live" in **Handout twenty-one**. Ask them to read it and discuss the gender and violence issues and how these are linked to HIV/AIDS that are raised in the article. They should be asked to comment on the journalistic strengths and weaknesses of the article. Participants should answer the following questions during their discussions:

- Why are some groups of women are particularly vulnerable to violence.
- What are the links between gender violence and HIV/AIDS in the article?

Participants can be divided into smaller groups to facilitate discussion on the article.

Tips for trainers: The article illustrates how women and girls are vulnerable to violence – young women who cannot say no to sex, girl children without parents, children who are being abused. Participants, after they have identified these vulnerable groups, should try to list the factors that increase their vulnerability to HIV infection – violence during the assault; having to have sexual intercourse without a condom and with men who have multiple partners etc. The article also deals with the controversial issue of virgin rapes. Participants should be asked how they felt the article dealt with the issue – in particular, they should be asked to comment on the headline of the story. What evidence does the journalist put up to support her view? You should also ask participants what the situation is in their country – have there been any reported cases of rape to "cleanse" the rapist of HIV/AIDS? The groups should consider how these myths, and their perpetuation by media reports, contributes to the stigmatization of people living with HIV/AIDS.

handout twenty-one

Raping to live

By Penny Dale, (BBC Focus on Africa, April-June 2003.)

One of the first things that struck me when I visited nineteen-year-old Misuzi Mtonga at the Canaan Orphanage in Lusaka was her willingness to talk so openly about the pain she went through while being sexually abused by her father.

The subject is still taboo in Zambia, but for Misuzi, being open is the way forward. This calm and bright young woman is determined to shed her unhappy past, not just to make a difference to her own life but also to that of others.

She has been helped by the kindness, love and counseling offered by her new home in Chelston, one of Lusaka's busier suburbs.

Thanks to the Anglican Children Project which runs the home, Misuzi, and another 50 or so boys and girls, sleep easily in their beds, are back in school, and are learning practical skills such as raising chickens and sewing.

But Misuzi is aiming much higher. She has set her heart on becoming a doctor: a profession through which she hopes to give the love and care denied to her in her own home.

Misuzi's sexual abuse at the hands of her father began when she was 10 years old and lasted for five years.
"My father would abuse me, sometimes every day. If I refused him, he would beat men and he would warn that if I told anyone he would kill me," Misuzi recalls.

The psychological and physical affects were horrendous.
"Sometimes I felt sick, usually I felt very lonely. I wondered why this was happening to me, and why my own father did this to me," she says. "At school, I lost my concentration. I thought everyone was talking about me; that they knew what I was going through. But they didn't."

In desperation, Misuzi would run away to her aunt, confiding to her about the abuse. But her aunt would return her to her family home and the abuse continued.

Misuzi eventually found the strength to leave home, to break free from the clutches of her father by taking refuge in the orphanage. She is amongst the lucky ones. Others have not been able to escape the fate that often awaits the victims of sexual abuse: infection with HIV.

According to a recent report by Human Rights Watch, entitled "Suffering in Silence", sexual abuse is a major reason why five times as many Zambian girls as boys under the age of 18 are HIV positive.

The report says that Zambia is in the grip of a social crisis which is wrecking the lives and spreading HIV among vulnerable young girls to such an extent that, if left unchecked, it could derail attempts to control the AIDS pandemic.

Sexual assaults on girls have reached shocking proportions. Girls mostly fall victim not to strangers but to members of their own family. Families often close ranks, leaving girls to suffer in silence.

Very few cases are reported to the police who – in any case – are not trained to deal with abuse cases in a sensitive or efficient way.

Because abuse and rape are still not talked about openly in Zambia, it is hard to get accurate statistics. But one clinic in Lusaka, the YWCA, recorded 23 cases in 1998, 77 in 1999, 88 in 2000, 110 in 2001, and 152 in the first 10 months of last year (2002).

Even more difficult is pinpointing the number of girls who have been infected as a result of abuse, partly because most Zambians do not know their HIV status.

However, the country's National AIDS Council estimates that about 1.75 million girls are vulnerable to HIV infection, and one of the main reasons is the growing incidence of sexual assaults.

All too common is the abuse of orphans by guardians, the very people who are supposed to protect vulnerable children from harm.

This kind of abuse has spiraled out of control in the past few years. Experts working in the field of child protection say this has happened precisely because of very high rates of HIV infection in the country.

There is a common but mistaken and dreadful belief that sleeping with a virgin – and the younger the better – is a cure for AIDS. This belief is one of the reasons why more and more cases of rape are now being reported.

The belief that raping a child or a virgin will cure a man of AIDS appears to stem in many cases from a custom that has been practised in the country for a long time, according to Felix Mwale of the Anglican Children's Project.

"Sexual cleansing" involves a widow having sex with a relative of her husband in order to purge the widow of her husband's spirit, a high-risk practice given that one in five people in Zambia are living with HIV.

According to Mwale, that belief is now being given a new interpretation, with people seeing it as a way of 'cleansing' themselves of AIDS.

The myth is being perpetuated by some traditional healers, and it is also tied into a culture that is dominated by men and has little respect for the rights of women and children.

Moreover, there is no access to the anti-retroviral drugs that do prolong lives in other countries, and without which HIV infection usually means a death sentence.

The result? The rape of young girls, including babies.
Few politicians have spoken out against the 'cleansing crime' but Kenneth Kaunda – the founding father of Zambia – has broken the taboo.

"It would appear to me that some people believe that a man who is suffering from HIV/AIDS can rape a child, six months old, one year old, whatever, and he'll be cured," Kaunda said recently. "What a stupid belief. It brings shame to Africa. You rape a child believing you'll be healed by this, what madness is this?"

Marital rape

UNAIDS research suggests that married women are particularly vulnerable to HIV infection. Many cultures and communities condone multiple sex partners for men, a practice that increases the risk of infection for women; married women who request the use of condoms are often subjected to violence, as it is believed that they must be committing adultery.

Many men do not believe that it is possible to rape their wives – they believe that marriage entitles them, legally and morally, to have sex with their wives whenever they wish.

Exercise five

Divide participants into pairs and ask them to interview one another on the issue of marital rape, using the following questions:

- Should rape within marriage be a crime? Give reasons for your answer.
- Do you think that marital rape is linked to the spread of HIV/AIDS in your country? Give reasons.

Tips for trainers: This exercise tests the underlying views of the participants on the issue of marital rape. This exercise however will only work successfully if your groups contain men. If not, send participants out to interview members of the public at random, using the same question. Remind them to interview equal numbers of men and women to get a sense of the gender dimensions of the issue.

Post exposure prophylaxis (PEP)

Reporting on PEP for rape survivors is an important aspect of the media's role. PEP, drugs that can reduce the risk of contracting HIV/AIDS after a rape, is not available in many African countries and is therefore a key issue for women, especially in those countries that have high levels of violence against women and girls.

Exercise six

Give participants copies of the article, "AIDS drugs do protect rape survivors" in **Handout twenty-two.** Participants should read the articles and answer the following questions:

- oes the article provide useful information about PEP?
- What other information could be provided?

Tips for trainers: The article can also provide a useful starting point for a discussion about the use of statistics. There have been many questions raised about the figures that are provided on the numbers of women who are raped. Ask participants to examine where the statistics used came from, whether they are accurate and how the author used them. **Handout twenty-three** is a useful fact sheet about PEP that can be given to participants after the session.

Violence against women, HIV/AIDS and the media

There has been a growing debate about the role that the media has played and the role that it should play, in reporting on violence against women.

These problems are exacerbated in stories where HIV/AIDS and violence against women
Overlap. Where they are reported, women are stigmatized and HIV/AIDS is portrayed as the "disease of sinners and prostitutes" and one that thrives on immorality and promiscuity.

Journalists and communicators pay little attention to the impact of violence on women's ability to keep themselves safe, and rarely explore the links between violence and HIV infection.

handout twenty-two

AIDS drugs do protect rape survivors

New local research challenges President Thabo Mbeki's stance on treating the pandemic

A groundbreaking study by a Johannesburg clinic has provided incontrovertible evidence that anti-retroviral drugs stave off HIV infection in raped women if taken soon after the attack.

The findings of the study, conducted on hundreds of rape survivors at the Sunninghill Clinic in Sandton, Johannesburg, over the past two years, contrast starkly with the government's controversial contention that the efficacy of such treatment remains unproven – in particular the stance of President Thabo Mbeki and Minister of Health Manto Tshabalala-Msimang.

The government has objected to administering anti-retroviral in state hospitals. The ban has been slated as particularly bizarre in the cases of raped women – at the risk of getting the disease from their attackers – or HIV positive pregnant women – for whom the drugs can be highly effective in preventing transmission to the unborn child.

South Africa's position is becoming increasingly out of synch with the rest of the world. The World Health Organisation reported this week that two-thirds of HIV positive women in Rwanda became infected as a result of rape – which debunks Mbeki's questioning of women's vulnerability to HIV in cases of rape.

The new Sunninghill study coincides with the latest embarrassment to hit the government over its anti-retroviral policies. Last week the Mail & Guardian reported that the Northern Cape Health MEC had blasted Kimberley hospital for administering anti-retrovirals to "Tshepang", the nine-month-old baby who was allegedly rapec and sodomised by six men last November.

The saga at Kimberely hospital exposed how officials across the country have fallen under the spell of Mbeki's controversial beliefs about the connection between HIV and AIDS and the efficacy of anti-retroviral drugs drugs. The governments' position on anti retrovirals has not been codified, but instead disseminated through statements from the President and debate in the media.

The M&G was alerted to the clash between the government and the Kimberley hospital by a German doctor who was suspended by the hospital for, among other things, criticising Mbeki in a report to her foreign funders. This week the South African Medical Association reacted to the saga by saying that doctors should do as they wish with regard to anti-retrovirals, and should not allow their ethics to be affected by government thinking.

The Sunninghill study, by Dr Adrienne Wulfsohn, has proved the efficacy of the treatment if anti-retrovirals are given to raped women within in 72 hours of the attack, confirming similar studies elsewhere that have so far been ignored by the government. Wulfsohn's study – the largest of its type yet in the world – confirms that no rape survivor becomes HIV positive if she receives anti-retrovirals within in 72 hours.

Wulfsohn has monitored more than 1000 rape survivors – of whom more than 600 have come through Sunninghill. Her findings form part of the world's first guidelines for post-exposure prophylaxis after sexual assault to be issued soon by the influential Centres for Disease Control (CDC) in the United States.

In preliminary notes the CDC says: "Post-exposure anti-retroviral therapy after sexual exposure to HIV should be considered where the risk of HIV exposure in the assault appear significant."

Apart from proving the drugs' efficacy, the study also contains observations about their toxicity, one of Mbeki's main bugbears. The CDC says: "Post-exposure prophylaxis appears to be well tolerated in adults and children, and significant adverse effects are rare in the short periods of time during which prophylaxis is taken."
In South Africa, researchers estimate that the risk of HIV after rape is 40 percent, given the prevalence of HIV in young men – those most often involved in rape – and given the fact that most rape in South Africa is gang rape.

Wulfsohn's research began almost three years ago when she set up the first Netcare rape clinic at Sunninghill. "I couldn't find any research data and so began monitoring my patients," she says. Although Sunninghill is wealthy area, 95 percent of rape patients come from poor areas such as Thembisa, Diepsloot and Alexandra.

"We have a big enough research study to show that post-exposure prophylaxis after rape works," Wulfsohn says. However, her approaches to the government have met with no response. Wulfsohn says it will cost the state much more to treat HIV-infected women than to administer the drugs. What makes the government's stance even more puzzling is that the price of the drugs has dropped almost 300 percent over the past two years.

Post-exposure prophylaxis to rape survivors is being administered widely in 20 European countries, Botswana, Thailand, several US states and Canada.

According to a South African Law Commission report in 1999, South Africa has about 1,6-million rape attacks a year.

Jo-Anne Collinge, spokesperson for the national Department of Health, said of the Sunninghill study: "The department would be open to looking at any research that exists because one of the great problems is the lack of research." She added that the study will be of "great interest" to the department.

The South African Law Commission this week launched its revised discussion paper on sexual offences – radically proposing that the state should assume responsibility for "providing the financial means to cover the cost of prescribed medication for victims of rape", including anti-retroviral drugs, writes Khadija Magardie.

The treatment to be covered by the government also includes trauma and pre and post-HIV test counseling.

The document's proposals, which were released for public comment in late December, would mean that if a doctor regards the drugs as necessary and prescribes them, the state should foot the bill. The impetus behind the suggestion would be to help indigent people who cannot afford the drug cocktail, which costs nearly R2000.

The purpose of the latest discussion document, commissioned last year, was to reform the laws relating to sexual offences – and includes recommendations relating to, among other things, reporting and investigating of sexual offences, the procedures for disclosure, court hearings, rules of evidence and sentencing of sexual offenders.

The discussion paper also suggests that failure by a person to disclose that he or she is infected with a sexually transmitted disease, including HIV, prior to having sexual relations with another person, consenting or otherwise, should be a criminal offence.

The law commission says in the document that such behaviour constitutes "criminal sexual activity", adding that it "provisionally endorses the view that a separate offence should be created which specifically criminalizes harmful HIV-related behaviour in the context of committing a sexual offence". In effect, rapists could face an additional sentence to that received for their crime.

(Source: Mail and Guardian January 18-24 2002).

handout twenty-three

PEP and rape survivors

Q: What is PEP?

A: PEP (post exposure prophylaxis) is a course of anti-retroviral medication that may stop you from getting HIV after a rape.

Q: Who should take PEP?

A: Anyone who has been raped or who has been penetrated through the anus.

Q: When should I take these drugs?

A: These drugs must be taken within 72 hours (about three days) after the rape. It is very important to take them as soon as possible.

Q: Can children who have been raped take these drugs?

A: Yes they can, but the dosage is different to that taken by adults. A doctor will work out how much the child needs to take.

Q: How long do I have to take the drugs for?

A: 28 days.

Q: When will I know if the drugs have worked?

A: When you first report the rape or assault, you will be asked to undergo an HIV test (this must be done with your informed consent and with pre- and post-test counseling). If the result is negative, you will be given a course of PEP. You will have to have another test three months after the rape, and another one six months after the rape. If you are still HIV negative, it means that you have not contracted HIV from the rape. If you test positive immediately after the rape, it means that you were living with HIV before the rape and you will not be able to take PEP.

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Q: Where can I get PEP?

A: On April 17, 2002, the South African Cabinet announced that PEP would be available to rape survivors at public hospitals in South Africa. PEP is however still not available through the public health system to women in other SADC countries.

("PEP for rape survivors", prepared by the ALP and the Center for the Study of Violence and Reconciliation.)

Story ideas from this chapter

- PEP – a story that investigates whether PEP is available in your country and if not, what options are available to rape survivors to protect themselves.

- Seek out organizations in your country that are conducting research on the links between violence against women and HIV/AIDS. Stories on the research could be linked to the need for more effective legislation, policies and practices.

Key learning points

- Violence against women reinforces gender inequalities.

- Gender violence limits women's ability to negotiate safer sex and increases their vulnerability to HIV infection. HIV/AIDS in turn may be a cause of violence.

- Journalists and communicators rarely make the links between violence against women and vulnerability to HIV/AIDS, preferring instead to sensationalise stories and identify women as either victims or vectors of the infection.

CHAPTER SEVEN

Gender, culture, religion and HIV/AIDS

By Lindiwe Nkutha and Thenjiwe Mtintso

Objectives

The objectives of this chapter are to:

- Provide a broad understanding of culture and religion, as well as an appreciation of the inherent difficulties in the definition of both;
- Explore the impact of culture and religion on gendered social relations and on the management of HIV/AIDS.
- To illustrate ways in which cultural and religious practices can be used effectively in the management of HIV/AIDS.
- To explore new ways of disseminating information on HIV/AIDS from a cultural and religious point of view.

Culture can be a powerful force for change: AIDS awareness day at the Polytechnic of Namibia, May 2003.

Introduction

Culture and religion play a key role in defining and shaping gender relations. Culture is one of the fundamental bases from which "female" and "male" identities are formed and entrenched in different societies.

The survival of culture is largely dependent on the role played by various social institutions in the maintenance, encouragement and passing from generation to generation certain behaviour patterns. Over time, these patterns become unquestionable and acceptable norms.

Religion also underpins identity formation. It is a major institution in all societies, and almost every human civilisation has produced a system of religious beliefs. Religions may or may not include a belief in a supreme being, but all are concerned with the transcendent, the spiritual, and with aspects of life beyond the physical world.

Often societies turn to religion as a means of connecting with a supernatural force, which they believe is more powerful than themselves, and which they also believe to be in control of their destiny and fate.

The initial foundations of patriarchy can in many instances be traced back to culture and religion. While not all cultural and religious practices seek to reinforce gender inequality, there are many practices that have been endorsed by citing culture or religion as their basis.

The HIV/AIDS epidemic has forced societies to reckon with issues of sexuality and sexual conduct. It also has simultaneously stirred within various cultures and religious institutions vigorous discussions on issues of morality and immorality. Cultural and religious views have again found themselves in the eyes and ears of the public: influencing mindsets, casting blame, as well as battling to gain a position from which solutions to the epidemic can be found.

Communicators who carry within them their own cultural and religious belief systems are tasked with communicating on HIV/AIDS in a manner that does not pass judgment, foster existent stereotypes or stigma and discrimination.

Exercise one

Ask the participants to identify and list cultural and religious beliefs that they have personally internalised as part of their belief system. (This can be done anonymously.)

Put up the cards or list for all to analyse together. Ask the following questions:

- Are there any beliefs among the list that are not oppressive to any group of people?
- Are there any beliefs among the list that determine how we expect women and men to behave?
- Are there any beliefs among the list that have implications on how as communicators we may view people infected with HIV/AIDS?

Tips for trainers: This exercise helps the group to begin from the personal to illustrate how the belief system carried by individuals has an impact on how they view their own role in society and the role of "others". These beliefs lead to the development of prejudices or biases that can often influence the perspective journalists and communicators take in writing on issues of gender and HIV/AIDS. The facilitator, using examples that emerge on the list from the group should illustrate how the beliefs listed translate into several of the evaluative messages prevalent in the mass media and information campaigns on gender equality and on HIV/AIDS.

Definitions

Culture is the learned behaviour of a given human society, which acts like a template, in that it has a predictable form and content that shapes behaviour and consciousness within that human society, and it is passed on from generation to generation.

The common strands in understanding what culture is and what it does are:

- It is socially constructed;
- It shapes one's identity and consciousness;
- It is passed on from generation to generation through institutions of socialisation, such as the family, the church, schools, the community; and
- It is not static. Culture is dynamic and therefore is capable of being influenced and changed.

Religion is a system of faith and worship, which provides adherents with meaning and purpose in their lives. It is one of the major institutions in society, with almost every human civilization producing a system of religious belief. Religions may or may not include a belief in a supreme being, but all are concerned with the transcendent, the spiritual and with aspects of life beyond the physical. Theology refers to religious study, or an academic discourse on religion.

Box four: Culture and religion

Similarities

- Gives meaning to an individual's existence;
- Prescribes and/or proscribes behaviour;
- Provides a sense of belonging and a sense of community and support;
- Marks life events through the use of rites of passage; and
- Provides a sense of continuity – connects the past and the future.

Differences

- Faith in a supernatural being is not a requirement for culture – adherence is sufficient;
- Culture is not perceived as having been revealed in scripture and it can evolve organically to reveal the changing context of the group and is not constrained by the divine word of a supernatural being;
- Religion views itself as the principle custodian of the soul; and
- Culture focuses primarily on the here and now, while religion is concerned with the hereafter.

The family

The first point of cultural formation is the family, which also represents a microcosm of society. The family reflects the values, customs and norms of the bigger community.

Different family members express themselves within the family largely in ways they would express themselves within the community. The most evident form of this is gender roles within the family, which largely follow societal patterns of power relations between men and women.

Families are also capable of influencing gender role changes within society, making them prime sites for change. One example of this is when a girl is socialized by her parents to excel in non-traditional roles for women – becoming an airline pilot, astronaut, political leader, among others. While society may accept this role change in the public, it still puts pressure on women to revert back to traditional roles when they are within the domain of the private/domestic.

The community

The community mirrors what happens in families. The role of the community at a macro level is to maintain and enforce a shared consciousness within members of that community of who it is, what it does and how it does it.

Culture and exclusion

Exercise two

Ask the group to identify groups within their community or nation who are marginalised and denied their basic human rights. Write the list on the board or flipchart and ask the group the following questions:

- What reasons are given for the marginalisation of the groups listed?
- Who ensures the continued marginalisation of the groups listed?
- Why do you think the marginalisation of the groups listed continues in societies?
- How many of the participants fall into any of the groups listed on the flip chart or board? (Ask the participants to raise their hands without necessarily volunteering into which group they fall. If a member of the group feels free to identify the group they fall into, ask him or her how they reconcile the conflict between culture and universal human rights).

Tips for trainers: The group should identify culture and religion as two of the factors that contribute to marginalization; when they begin to understand who is responsible for continuing that marginalization, they may also begin to see the links between gender, religion and culture. **Handouts twenty-four and twenty-five** provides more information on culture and human rights.

Gender, culture and HIV/AIDS

Culturally – entrenched gender roles and norms about sexuality help to fuel the spread of HIV/AIDS, and women and girls are particularly vulnerable to infection because of the cultural practices and norms which continue to keep women in a position of inequality.

In many societies, cultural norms dictate that women must play a passive role in sexual interactions, and there are strong social pressures for women and girls to remain ignorant about sexual matters. When young girls remain uninformed about how to protect their sexual health, they may engage in high-risk behaviour – such as unprotected anal sex to avoid pregnancy – placing themselves at greater risk to HIV infection.

Boys and men also are disadvantaged by the culturally-accepted expectations that they are knowledgeable about sex – and therefore need no information or guidance – or that they will learn from their peers. Norms of masculine strength and self-reliance also encourage the denial of risk in men.

The power imbalances and inequalities between men and women, which are rooted in and justified by culture, hinder women's and girls' abilities to negotiate safer sexual practices with their partners.

There also are several cultural practices and beliefs that hinder providing information on sex that could empower women, girls and young boys to better protect themselves from HIV infection. Some of these practices and beliefs are:

- Fathers cannot talk to their sons about sex, it is the duty of the uncle.
- Mothers cannot talk about sex to their daughters, it is the duty of the aunt.
- When a girl falls pregnant, she should not let her parents know.
- Anything related to sex and reproductive organs is taboo, so child abuse cannot be reported to the authorities.
- Culture does not allow children to be too close to their parents; parents wield too much power for the children to be able to open up.
- Women should learn in silence.
- Women should not question men on anything.
- Children cannot go directly to their fathers if there is anything they want. They should first go through the mother, who in turn will take the matter up with the father.

handout twenty-four

Culture and human rights

In theory, there should be no conflict between culture and human rights.

The concept of universality establishes a legal and moral standard of minimum protection for maintaining human dignity. Therefore universal human rights should not be understood as the imposition of one cultural standard.

Human rights are based on the principle of respect for cultural diversity and integrity while ensuring that the assertion of cultural rights does not lead to the denial of the rights of anyone or any communities. In other words, no human right can be exercised in a way that undermines the human rights of others.

The right to cultural or religious expression is often used for the denial of the fundamental human rights of women. Those who argue that culture should have precedence over human rights often attack the concept of universality as "Western".

It is important for the media and communicators to clearly distinguish between the notion of "universal" and "Western", and to identify discrimination based on culture.

For women, and many other marginalised and vulnerable groups within any society, the challenge of this century continues to be how to maintain the integrity and distinctiveness of one's culture while at the same time, challenging and changing those aspects of culture that treat women or any vulnerable group as less than human.

Universality is often questioned in the following three contexts:

- By oppressed communities to assert their own identity against the domination of a more powerful group;
- By governments to justify political and/or economic repression against the general population or particular groups of people;
- By governments and other authorities to justify acts of discrimination and violence against women.

("Local Action, Global Change – Learning About the Human Rights of Women and Girls").

handout twenty-five

Cultural practices that make women vulnerable to HIV/AIDS

Practice	Definition	Gender Issue	Justification for practice	HIV/AID
Lobola	Paying of bride price – groom pays to the family of the bride in livestock and/or a determined sum of cash.	Woman becomes man's "property"; she is subject to the will of her husband and of his family.	Culture – seen as a necessary token to solidify ancestral bonds between two families.	Bride pr negotiat husband him the from his
Female genital mutilation (FGM)	Clitoridectomy: partial or total removal of the clitoris. Excision: removal of the clitoris and labia minora (vaginal lips). Infibulation: removal of all external genitals and the stitching together of the lips leaving a small opening; the stitches are removed when the girl is married.	The practice is done to ensure female chastity and ensure that women do not experience sexual pleasure.	The practice is sanctioned by culture and some religions.	The incr vaginal contract tissue a mutilate hymen suscept infection
Death cleansing	Elder of the family, usually the maternal uncle of the deceased, has sex with the widow to cleanse her of her husband's spirit.	Women have no say or choice in the act.	Culture	A woma whose knowled
Widow inheritance	Following a man's death, the widow is inherited by a younger brother or close relative of the deceased.	The woman is denied the right to choose what she wants for her life after her husband's death.	Culture	A woma already other wo

Exercise four

Break the participants into two groups and give each group a copy of the article, "Morality list at altar of money – Outdated cultural practices are spreading AIDS" in **Handout twenty-six.** Ask the groups to consider the following:

- What reasons are given by the religious leader for the spread of HIV/AIDS?
- How would you sum up the religious leader's views on the role of culture?
- How does the article link gender, culture and the spread of HIV/AIDS?
- What are the religious messages communicated through the article?

Reconvene and discuss the group's answers and other points raised from the article.

Tips for trainers: The interview is an interesting combination of back-to-roots but also being critical of certain aspects of culture. It conveys the sense that culture is dynamic. How possible is to keep sifting out the good from the bad? From a media point of view how could this article have been strengthened through other points of view? How could it have been cast as a more analytical piece?

Culture, HIV/AIDS in the media

The media tends to write and produce stories on cultural practices in a sensational and unbalanced way often perpetuating stereotypes, norms and myths. Such unbalanced reporting further entrenches norms and beliefs rather than challenging practices which perpetuate gender inequality and which lay a basis for the spread of HIV/AIDS.

The media often appears to regard tradition and culture as untouchable. Rather than raising the public's consciousness about the inherent dangers of harmful cultural practices, the media has, in some cases, created myths. For example in South Africa, the "myth of sleeping with virgins", reported on as a cultural practice, as a means of cleansing men of their HIV infection, is said to be one of the contributing factors to the high level of child rape cases in the country. Yet research has not linked this practice to any ethnic group in the country.

The media can play a constructive role by providing a forum for debate and analysis of the cultural practices in a society. Many communities also have started to adapt rituals, like widow inheritance, in light of the HIV/AIDS pandemic, and it is critical that the media also reflects the dynamic changes in culture that are taking place.

handout twenty-six

Morality lost at the altar of money: Outdated cultural practices are spreading AIDS

The world leader of the YMCA movement has lashed out at the decadence caused by materialism writes Keith Ross

South Africans should rediscover their morals, said theologian and television personality, Mr Caesar Molebatsi in Durban over the weekend.

He said South Africans of all races were in need of moral regeneration and that too many South Africans of all races were obsessed with their economic goals and had lost touch with their souls.

"They equate a better life for all with economic prosperity and this brings a sterility that excludes the soul," he said.

Molebatsi said an obsession with material values had led to social and moral decay, and caused communities to become decadent.

"Many people now have the money to do things they could not afford before, but morals have lapsed, and this has led to corruption, lawlessness and the spread of HIV/AIDS".

He said it was also obvious that many black people were slowly losing their culture and traditions. Some young people from affluent black families were even losing their language.

"In my house I have had to rule that nobody speaks English after six in the evening. My children were not speaking their own language at all."

Molebatsi said black people should therefore look to their past, and save that which was best from their culture and traditions before it was too late.

"I would like to see a spiritual reaching out by our people. I would like to see a revival in this country of the spirit of ubuntu in its most basic form."

He said the time had come for them to discard the things that were "bad" and unsuited to modern-day circumstances.

Molebatsi, who is also a community leader and company director was recently elected president of the World Alliance of Young Men's Christian Associations.

"Economic ambition without good ethical and social constraints impoverishes people and destroys the value of relationships."

But he also felt that South Africans should stop blindly following traditions without assessing their modern-day relevance. "Some things in African culture are retrogressive. There is a kind of cyclical thinking that does not promote progress. People should stop doing things in a certain way just because their grandfathers did them."

Molebatsi said the traditional African view of women would also have to change. The traditional view put men in a protective but dominating role.

"Women in the African tradition stayed at home while the men went to war. In this tradition the focus of wisdom was based on the person who was the strongest.

"But wisdom is no longer the preserve of the strongest – of men. There is now a great equalizer; education. Wisdom is now the preserve of the experienced and the educated."

He said the old tradition of male domination was contributing to the spread of AIDS. "Because of the old conditioning, many women feel they cannot say no. They know they will not be taken seriously.

"This is one of several factors that have caused AIDS to spread more quickly in our country than would normally have been expected."

(Daily News Durban, South Africa, October 28, 2002.)

Culture as a tool in HIV/AIDS prevention

Culture is dynamic and there are positive ways in which practices and ceremonies can be used to become the channels for communicating information and education on sex and how to prevent the spread of HIV.

Exercise five

Ask participants to read the article in **Handout twenty-seven.** "Tradition takes center stage in HIV/AIDS Prevention" written during the Zambia training workshop on HIV/AIDS and discuss. Find out if participants know of similar uses of culture and traditional practices in their own country to stem the spread of the virus.

Tips for trainers: Encourage participants to think about how established cultural practices and traditions can be used positively to reduce the spread of the epidemic.
Some of the cultural practices and rites that can be used are:

- **Initiation ceremonies for women and men:** Initiation rites of passage have been historically used as "schools" where cultural concepts of femininity and masculinity are passed on from generation to generation. These platforms could be used instead to feed through new messages on gender roles and HIV prevention.
- **Abstinence and virginity:** Virginity testing ceremonies, which most Southern African cultures practice, could focus on virginity as a way to stay safe from contracting the virus, not necessarily as way to check the chastity of girls. Also, boys too should be tested to highlight the responsibility of both sexes in preventing the spread of HIV/AIDS. Abstinence, however difficult it is to encourage, remains one of the safest means to avoid contracting the virus.

Gender, religion and sexuality

Power relations within religions follow patterns of power relations within given societies. Patriarchy is entrenched in religion, affording men power over women, which is justified as "the will of God".
Religion also remains one of the most powerful tools for shaping and defining moral values in societies. Within all religions, there is a strong focus on sexual morality. Religion also impacts on the shaping of sexual identities of its observers. In Christianity, for example, women are presented with the image of the virtuous virgin (Mary mother of Jesus) and of the vilified prostitute (Mary Magdalene). There are however, no opposing roles for men, apart from their role as the "head of the family" or "head of the woman".

Heterosexuality is the acceptable sexual orientation of religious doctrines. People whose sexual orientation is other than heterosexual are seen as "sinners" or "defilers" of the divine law. For example, when HIV/AIDS first appeared more than 20 years ago, it was tagged as the "gay disease" and seen as divine punishment for homosexuality.

In addition to the emphasis on the sexual values propagated by most religions of faithfulness to one partner, abstinence before marriage and heterosexual behaviour, religion also has been used to justify women's subordinate position in society. In all the world's major religions, religious texts have been interpreted to reinforce the power of men in society.

Throughout the world conservative or fundamentalist movements, often associated with conservative nationalism or right-wing politics, pose a major challenge to gender and sexual equality. Religion is the foundation on which these movements build their doctrines. Their attitude towards gender and rights issues may include a belief that women's proper place is in the home; opposition to reproductive and sexual rights; blaming women for the "decline in moral values"; vilifying women who step outside traditional roles; and active homophobia.

Religious texts are often interpreted and used as justification for gender discrimination, as well as for discrimination against homosexuals. Because religious texts are considered sacred and hold divine authority for believers, people often accept gender discrimination and homophobia as the way the world's order should be.

But almost all religious texts have been subject to numerous interpretations, translations and have been influenced by the views of those religious scholars (usually male) who interpret the texts. These scholars' views are informed by the norms and values of their societies.

handout twenty-seven

Tradition takes centre stage in HIV prevention

By Julius Silupumbwe

On a hot Saturday night in a packed hall with drums beating led by Mtendere's best known drummer, Kenny Tabula, one by one, young women walk onto the stage.

Dressed in traditional regalia, beads, reeds, etc one young woman says: "My name is Patience Tembo and I'm 18 years of age. A Nsenga girl wears the traditional outfit I am wearing when she becomes of age. She is put in a house for a month, and traditional counselor or "Bana Chimbusa" teach her good manners, hygiene and to stay away from boys."

"The traditional teaching I am giving is coming from the Bemba.; *Umwana ashumfwa amenene umwefu kwikoshi,* which means "if you can't hear what people are saying to you, something bad may befall you..."

The "Miss Tradition" Pageantry is not your average beauty contest. In fact, the event is not about beauty at all. It is an initiative of youth who belong to the Society for Women and AIDS in Zambia (SWAAZ) started at their Mtendere Family Support Home to teach their peers about traditional practices that can reduce the spread of HIV/AIDS, and those which contribute to the spread of the virus.

The youth identified traditional initiation ceremonies and traditional weddings as cultural practices that should be strengthened and promoted, while practices such as sexual cleansing, circumcision and polygamy were among the practices identified as promoting the spread of HIV/AIDS. Ways to improve the harmful practices included, but were not limited to, the use of non-sexual methods of cleansing, the use of one razor for each child circumcised, and encouraging monogamy in marriage.

Following the National Consultative Meeting on Traditional Rituals and HIV/AIDS organized by SWAAZ in 2001, the youth decided to develop a strategy that would catch the attention of their peers. They decided on a modeling contest, the first of which was held this year on Jan 25 at the Alliance Francaise.

Fifteen girls were chosen from the 60 who were trained for three months by various organizations in traditional rituals, beliefs, customs, HIV/AIDS, sexually-transmitted diseases, family planning, adolescent sexual and reproductive health, condom use and assertiveness.

Zambia's Integrated Health Programme (ZIHP), the Society for Family Health, the Youth Activist Organization, the Lusaka Museum and individuals like advice columnist Auntie Josephine, among others, trained the young women.

The pageant had three categories. In the first one, the young women had to explain a traditional attire and a traditional teaching. The second category required them to present and explain another attire and the nutritional value of a traditional food. The young women answered

questions on traditional rituals and HIV/AIDS in the third category, and also explained another traditional outfit.

"The Miss Tradition idea has started to move among the youth and should not be left to slacken or stop," said Bernadette Nkaka Sikanyika, the SWAAZ Project Coordinator. "It needs to be supported technically, materially and financially to enable these youth who participated in this to go out there and teach their peers in their communities, schools, churches and other institutions".

(*Our Right/Write,* The Newspaper of the Zambia Media Training Workshop on Gender and HIV/AIDS, 1 February 2003.)

Gender, religion and HIV/AIDS

When the HIV/AIDS pandemic first unfolded, many people sought answers to "why" the virus and the subsequent long and debilitating illnesses leading to death arose, not in medical science only, but in religious doctrine.

While medical science and research could provide the facts about how the syndrome came to be, how it is transmitted and its effects on the body's immune system, religion provided for many people, the "moral justification" for HIV/AIDS.

As noted earlier, the epidemic was first seen as a punishment for gays who had deviated from the "natural order" of sexuality as "divined" by religious law. Later, as it became increasingly clear to societies that HIV is also transmitted through heterosexual relations, people again sought answers in religion with a focus on issues of sexual morality – abstinence before marriage; monogamy in relationships and marriage; sex once again being placed within the context of marriage and procreation as prescribed in religious texts.

Religious leaders, especially in Christianity, became vociferous in messages that warned people of the breakdown in morality, which had led communities away from the traditional, strong family structures. Religious leaders also began to strongly advocate against sex education for youth.

The HIV/AIDS pandemic gave many religious leaders the excuse to raise patriarchal arguments such as:

- Women should leave the workplace and return to the home to nurture and give moral guidance to their children;
- Sex education should not be offered in the schools or offered to youth by any institution;
- Women's rights activists had contributed to the breakdown of the moral fabric of societies by advocating for the change in gender roles;
- Advocates of reproductive rights (abortion, contraceptives) have promoted sex outside of the institution of marriage, which leads to immorality and sin; and
- Sex work, promiscuity, homosexuality are all forms of the immorality that have gripped modern society.

These messages also formed the basis of earlier information, education and communication campaigns on HIV/AIDS, which were primarily targeted at women. Also, because these messages were grounded in religious doctrines, the stigma of "an immoral person" was attached to those who were infected with HIV/AIDS. "Loose or immoral women ("prostitutes"), promiscuous men and women, and gay men, were stigmatised as the ones most likely to pay for their sins by being infected with HIV/AIDS.

So strong have been these earlier religious messages on "who is most vulnerable" to HIV/AIDS, that a wall of silence emerged and people continue to hide their status for fear that their "moral" character will be judged.

Both the media, and information and communications experts working in the area of HIV/AIDS have been locked in the "moral conflict of right and wrong". Many of the "religious messages" on the pandemic as outlined earlier, found their way into media reports, as well as in HIV/AIDS prevention campaigns. In earlier media reporting, for example, stories focused on sex workers and homosexuals. This form of reporting reflected the "religious" message and fuelled an attitude of self-righteousness.

To break away from this form of "blame" reporting or the construction of self-righteous messages grounded in religious doctrine, journalists and communicators should remember the following tips:

Exercise six

Break the participants into groups and ask each group to do the following:

- Identify HIV/AIDS campaigns or media articles member in the groups have come across which had identifiable gender, cultural and/or religious messages for the target audience.
- Choose one or two from the examples cited by members of the group and prepare a summary of the campaign or article to share with the plenary in the report back.

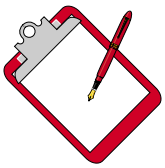
- In addition to the summary, list the gender, cultural or religious messages that were transmitted by the campaign and/or media article.
- In the light of the chapter's discussion on gender, culture, religion and HIV/AIDS, how would the group re-write the messages of the campaign and/or articles identified?

Tips for trainers: This exercise is designed to allow the group to reflect on the kinds of religious and cultural messages that the media transmit on HIV/AIDS. Some useful tips are provided in Box six.

Box five: Avoiding self-righteous messages on HIV/AIDS

- Identify the behaviours that put one at risk, rather than the type of person that may be at higher risk. High risk behaviours include unprotected sexual intercourse, sharing needles for injections, sex with multiple partners.
- Messages should reveal how HIV/AIDS can be transmitted to people who are not necessarily engaging in high-risk behaviour – someone who is raped is at risk of HIV/AIDS; a person who gets a blood transfusion where screening mechanisms for blood banks are not fully in place may also be at risk; married and monogamous women are at risk, because their husbands or partners may secretly engage in unprotected sex with other partners.
- People with or otherwise affected by HIV/AIDS should not be portrayed as irresponsible, which shows bias and judgment.
- When profiling a person living with HIV/AIDS in a story or information campaign, focus less on how the person became infected and more on other aspects of the person's experience.

(Adapted from "Reporting on HIV/AIDS in Africa: A Manual" by Julia Beamish, African Women's Media Centre, Dakar Senegal.)



Story ideas from this chapter

- Stories that expose the cultural practices that continue to place girls and boys at risk of HIV/AIDS.
- Stories on how communities are adapting cultural practices in the light of the HIV/AIDS epidemic.

Key learning points

- How the interface between culture, religion and gender oppression contribute to the spread of HIV/AIDS.
- Culture and religion have an impact on gendered social relations, and there are many examples of practices that exacerbate power imbalances between the sexes, adding to the disempowerment of women and the increased spread of HIV/AIDS.

CHAPTER EIGHT

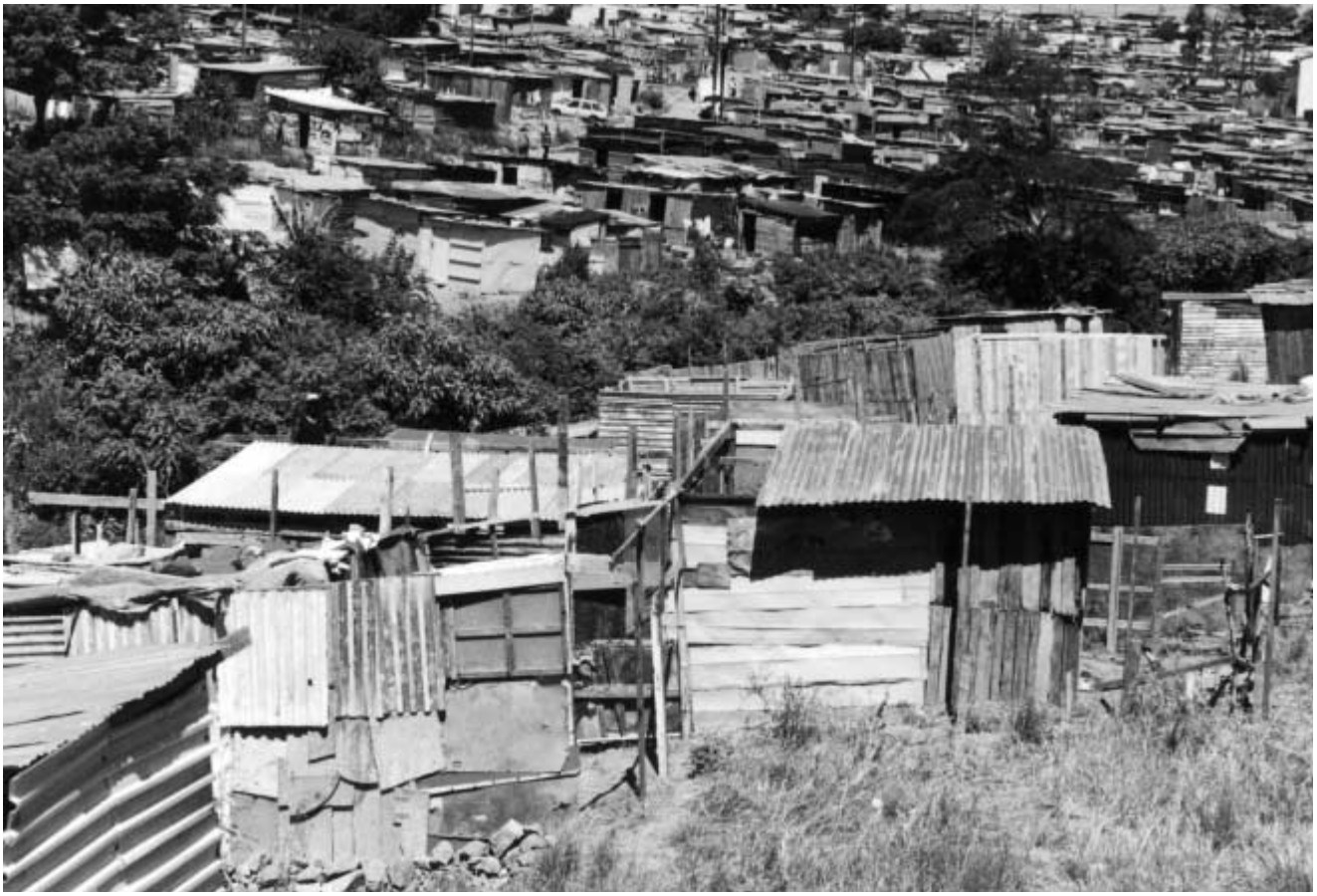
Gender, poverty and HIV/AIDS

By Judy Seidman

Objectives

The objectives of this chapter are to:

- Illustrate the cyclical link between gender, poverty and the HIV/AIDS pandemic.
- Highlight the increased vulnerability of women and girls to HIV due to economic inequality.



Introduction

Poverty fuels the HIV/AIDS pandemic. The poorer regions of the world bear the brunt of the pandemic. Despite the facts and figures that clearly establish a link between poverty and HIV/AIDS, much of the information disseminated on the pandemic does not explore the social and economic factors which fuel the spread of the virus.

Eleven percent of the world's population lives in Sub-Saharan Africa, where the per- capita Gross National Product (GNP) is only ten percent of the world's average. This region has 70 percent of the world's HIV/AIDS infection.

According to global data projections, countries with an AIDS prevalence of 20 percent or more, (several countries in Southern Africa fall into this grouping) can expect Gross Domestic Product (GDP) to fall up to two percent a year, and even a 22 percent reduction in the work force.

Behind the statistics are people – those who bear the brunt of HIV/AIDS in their daily lives. When the data is disaggregated by sex, the face of HIV/AIDS is female, young and poor. Seventy percent of the more than 1.2 billion people living in poverty worldwide are female. Gender inequality and poverty go hand in hand, and the two feed HIV/AIDS.

HIV/AIDS deepens the poverty of households and nations. With few financial assets, the poor are often politically and socially marginalised and often have limited access to health care information and services.

Women living in poverty may adopt behaviour that expose them to HIV infection, including the exchange of sex for food, shelter or money to support themselves and their families.

"Breaking this cycle will require not only greatly increased investments in more effective HIV prevention and care, but also more effective measures to combat poverty," said Robert Hecht, the UNAIDS Associate Director for Policy, Strategy and Research at the International AIDS Conference held in Durban, South Africa in July 2000. *("Conveying Concerns: Media Coverage of Women and HIV/AIDS", Population Reference Bureau, 2000.)*

Definitions

- **Gross Domestic Product (GDP)** is the measure of all goods and services produced in a country.
- **Gross National Product (GNP)** differs from GDP by including the income of nationals from foreign activity and subtracts the income of foreigners.
- **The unwaged work of women:** Traditionally neither the GDP nor the GNP include women's unwaged labour such as housework, nor the contributions of the informal sector, which is where many women in the developing countries work.
- **The informal sector** comprises of a wide range of unregulated economic and "extra-legal" activities in an economy, generally involving work for pay that does not come in the form of wages and employment conditions regulated by local, state or national governments.

How poverty fuels the epidemic

Exercise one

Discuss the following questions with the group:

- Which group comprises the majority of the poor in your community?
- What makes these people poor?
- How does poverty affect the group?
- What factors help people escape from poverty?

(*Adapted from "Local Action, Global Change".)*

Tips for trainers: This exercise should show participants that in general women are found within the poorest groups. Some additional information is provided in **Handout twenty-eight.**

handout twenty-eight

The links between poverty and HIV/AIDS

The poor often do not have access to information:
Most AIDS activists agree that preventing the spread of HIV/AIDS requires education and information for behavioural change. Yet many of the health and HIV/AIDS education and information campaigns appear in mediums and forms that are not accessible to the poor and the communities in which they live.

The poorest of the poor often live in remote areas and have no access to even the mass media, including radio. There also tends to be a correlation between high illiteracy and poverty, creating more of a challenge for the crafting of messages and information on basic health and HIV/AIDS for the poor.

When poor women are further burdened by the demands of care-giving, they have no time to access information they need about prevention, treatment and care. Even where prevention messages physically reach people, they may not be accepted or acted upon – especially where these messages are not related to people's experiences. In the late 1980s, Batswana commonly referred to AIDS as 'the radio disease'. This was because of 60-second long radio adverts which touted the "danger" of HIV/AIDS. But most people at that time did not relate to the ads because the "danger of AIDS" appeared distant from their own experience, and the advert did not tell people where to get the condom advertised as the means of protection.

Poverty leads to behaviours that expose people to the risk of HIV infection:
Many HIV/AIDS information and communications campaigns emphasize "safer sex" as a means of protection. When women and young girls or boys are engaged in sex work to earn money for basic needs, "safer sex" becomes an option that is hard for them to negotiate due to their impoverished status.

Marriage for poor women in patriarchal societies, also is seen as the most reliable way for women to survive. According to some studies, about half of the women in Africa are married by the age of 18, and of these, one out of three is in a polygamous marriage.

Women within these marriages are economically dependent on their husbands, and because of this dependency, they often silently risk unfaithfulness and do not dare to discuss the issue of safer sex for fear of violence and of being thrown out of the "economic security" provided by the marriage. The fact that women cannot practice safer sex within marriage has become a central – but often hidden – feature of the spread of HIV/AIDS.

If a woman is forced to leave the home, because she has married young, often without basic education and skills, she may resort to sex work to survive, thus continuing the vicious cycle of inequality, social disempowerment and poverty.

The same cycle is prevalent among young boys and girls who throng the streets of cities worldwide, and who enter into sex work. These youth, who drop out of school to support their families, or who have no place to go because they have joined the growing number of children orphaned by HIV/AIDS, place a higher priority on hunger and safety from violence, than on long-term safety from HIV/AIDS.

Labour migration, which becomes the route through which women and youth seek to escape poverty, puts young women particularly at risk of sexual exploitation. It also creates unequal ratios of men and women, increasing the possibility of HIV transmission through shared partners or sex work.

Often prevention messages that advocate the use of condoms and safer sex, do not consider the situation of the poor. Also condoms, if not distributed for free by public health and other structures, may be unaffordable for the poor, and, distribution may not reach remote areas.

Living conditions of the poor weaken their resistance to illness:
Poor people often live in unhealthy situations. In South Africa, one in seven people does not have access to clean water in their home, and one in four does not have electricity. Very poor people are not able to get enough food, or enough good food. Many people live in informal settlements, hostels and inner city slums, where sanitation and refuse removal are poor.

Diseases like TB, pneumonia and diarrhea – to mention a few – spread rapidly when people live under these kinds of conditions. Poor people living with HIV/AIDS are more likely to become ill sooner from opportunistic infections.

Because the poor often go without food, and when food is available it tends not be nutritious, they are constantly in a state of malnutrition which weakens resistance. Coupled with the lack of clean and safe drinking water, and the lack of decent housing, all of these factors compromise the health of the poor.

Once infected with HIV/AIDS, the body of the poor in such a weakened state is unable to fight the opportunistic diseases that take their toll faster.

Treatment and medical care are often beyond the economic reach of the poor:
In Africa, 290 million people live on less than 30 U.S. dollars a month (or one U.S. dollar per day). Yet the cost of medications for HIV/AIDS would require them to have access to 400 U.S. dollars per month.

A Food and Agriculture Organisation (FAO) study in one African country showed that caring for a family member with HIV/AIDS and meeting funeral expenses, costs more than the average farm income for a year. As a result, already poor rural households sell their tools, their livestock, and their land, to care for the sick or pay the funeral expenses. ("Poverty Briefing", No 2.)

The cost, as well as access to treatment and care, determines who survives with HIV/AIDS. People's access to treatment and care is dictated by poverty. People who can afford the anti-retroviral drugs are able to prolong their lives, while the poor – the majority of whom are women – die in large numbers.

In the urban areas, treatment and medical care programmes are provided through large companies and often apply to men as the recognised heads of households. The mining companies for example, argue that they cannot afford HIV-wellness maintenance or treatment (especially anti-retrovirals) for "dependents". Medical care is not available or affordable for the poor.

Gender, poverty and HIV/AIDS

One of the most dramatic impacts of HIV/AIDS on many women has been the effective loss of existing possessions and property when the male head-of-household dies. The man's relatives claim "his" possessions – the household and all within it, leaving a widow and her children in total destitution.

Also, women who are found to have HIV/AIDS (sometimes with their children) have been expelled from their own homes, even before the man dies, by the husband himself or another male relative of her spouse. Unable to return to her own family and often shunned by the community in which she has lived with her husband, these women too find themselves in a poorer situation with no access to any means of survival.

As noted earlier, where cash is in short supply, women are less likely to have access to medicine and treatment than are men in the same household. This situation is even more acute for women who are past their full reproductive years.

Missing in the studies and stories on the impact of the HIV/AIDS epidemic on women is the effect on women over the age of 40. These women are not covered in the antenatal clinic surveys, and their illness is often perceived only as an added burden to the household.

Women in this age-group are likely to make up a large number of women who are poor because there are virtually no avenues left open to them to earn an income. Often they are left to take care of their orphaned grandchildren without any means or support structures at their disposal.

Girl children are often the first and are among the majority of children taken out of schools to help with household tasks, when the mother needs extra help, while she cares for her husband, or when the mother herself is no longer well enough to care for the remaining family or herself.

With their education cut short, these girls, once the mother dies, are left to a fate of early marriage or fall into sex work to survive, repeating the cycle of gender inequality and poverty, which makes them vulnerable to HIV/AIDS.

Box six: Gender and poverty

- Women make up almost two-thirds of the world's illiterate.
- Women are denied property rights and access to credit.
- Women earn 30-40 percent less than men for the same work, and most of those who are working, are employed outside the formal sector in jobs characterised by income insecurity and poor working conditions.
- Poverty and gender are inextricably intertwined. Seventy percent of the world's poor are women. The number of women living in poverty throughout the world has been growing disproportionately compared with the number of impoverished men.
- Gender inequalities, built into economic structures, lead to women having less control and access to economic resources than men. This is called the "feminisation of poverty".
- Women carry the burdens of unpaid domestic and subsistence work.
- Women have unequal – and less – access to education and skills training.
- All of these factors leave women impoverished and unable to challenge their poverty, and in turn, this worsens the impact of the AIDS epidemic on women.
- Poverty violates the human rights of women and girls, denying them participation in political and public life; education; food and freedom from hunger; health; freedom from violence; housing; life iitself.

Because women have been the main food producers in the rural areas, the HIV/AIDS pandemic is having a grave impact on food security for the rural poor. AIDS widows in the southern African nation of Zimbabwe, for example, are growing less food because they lack money to hire a tractor, a plough or casual labour.

Exercise two

Ask participants to read the article, "Waking up to find everything gone" in **Handout twenty-nine**, and identify the following:

- What are the gender issues raised by the story?
- What are the rights issues?

Tips to trainers: Use this story to draw out the link between the denial of women's rights and poverty. Some additional information is provided in Box seven and in **Handout thirty** on unpacking the household.

handout twenty-nine

Waking up to find everything gone

By Moeti Thelejane, Sharon Motena Makoae, Maphats'oane Molefi, and A. Afex Sekhamane

Mamokete T (not her real name) is an angry woman. Her anger stems from the impotence, frustration, and humiliation she endured after seven in-laws sauntered into her home unannounced and "took all that mattered".

Mamokete, a bank teller at one of the commercial banks plying their trade in the capital, jointly built the eight-roomed house with Arthur (not his real name), a taxi owner who was gunned down in March.

The 24 year-old mother of two young boys had barely overcome her grief when she had, with the help of her mother and older brother, to deal with a police force that seemed to shrink under the influence of a high-profile lawyer who happens to be an uncle of her late husband.

The humiliation began on Sunday April 14, the day after the customary shedding of the mourning clothes she wore for a month after her husband was buried on March 9. Ironically, she suffered at the hands of a group that consisted mostly of women.

"His mother, his two sisters, one sister-in-law, his two brothers and (male) cousin walked in and said they had come to collect some of the deceased's belongings," the youthful Mamokete said.

She said she asked them to explain what they really meant. "His cousin replied by demanding the keys to his two taxis," she explained, her eyes watering slightly. She said his Toyota bakkie was already in one of his brothers' possession. But she had not given it a thought as the bakkie was used during the preparations for the funeral.

During the mourning period she was in no position, emotionally and customarily, to stake an immediate claim on the car. "Besides, I did not harbor any suspicions that what eventually transpired was coming," she said.

After they had taken the two taxis, they loaded her lounge suite, cupboard, electric stove, television set and music system. "All the while, as they took all that mattered, my two boys solemnly watched, listening to their grandmother saying she had always disapproved of her sons marrying "these Maseru whores", she said.

Upon reporting the matter at Ha Thamae charge office, the desk sergeant said they would investigate. For a whole month she was told that investigation were underway. She said it even got to a point where they lost patience with her, saying the case is not supposed to be treated as a criminal offence, but a private family matter.

"It was only after my brother, who works in Johannesburg, helped me secure the services of a lawyer and contacted a police officer friend of his who works at headquarters that I heard that his brothers have been questioned. My husband's two taxis, which were carrying fares while investigations were supposed to be underway, were returned to me and my young sons," Mamokete said.

However, she has yet to recover her lounge suite, cupboard and electric stove, which are reportedly in her mother-in-law's possession in Mohale's Hoek.

The Ha Thamae police confirmed that the taxis and Toyota bakkie have been recovered. "But as for the rest of the property, we have already sent word to Mohale's Hoek police to investigate," he said. No one has yet been charged.

Mampuru Litabe is a 28 year-old Mosotho woman, whose husband Seboto (50) collapsed and died on his way to work, along the main North 1 Highway near Ha Matobe. At the time of his death, his wife was in Berkersdaal trying to earn a living.

Litabe's in-laws phoned to notify her about her husband's death. She arrived a week later.

Seboto's family had sold their flat and had grabbed all the property in the house.

Her neighbour called her to notify her of what her in-laws had done. This is the time when she showed up. When I asked her why she did not come, she said she and no money for transport.

When she finally arrived, Litabe went to the magistrate court to ask for a court order which she was granted. Seboto's family had already made arrangements for the funeral when Litabe arrived. A cow and sheep had already been slaughtered. Since Litabe had the court order, the deceased was not buried.

There was a nasty exchange of words between Litabe and Seboto's family. The family maintain that they thought Litabe would never come back to Lesotho.

Litabe fought with her in-laws for over a month over the rights to bury Seboto. Litabe's lawyer pointed out that she had full rights to bury her husband. Litabe is now trying to get her property back through the court of law.

Ntaoleng (not her real name) is an unemployed woman and tormented woman in the outskirts of Maseru. Ntaoleng, whose original home is in Mohale's Hoek some 120 km away from the capital town Maseru, came to live with her elder sister in Maseru. She fell in love and moved in with a lecturer at the National University of Lesotho.

Despite his heavy drinking habits, Ntaoleng did everything a woman could do to please her man. This includes making their flat the most homely place, filling the house with the most beautiful and expensive furniture. Soon after, her husband became ill and died. Ntaoleng was denied all rights to property at one of the most painful moments in her life.

One organisation that offers help is "Selibeng", 'M'e 'Mathuso, a volunteer at the centre, says economic violence affects women emotionally, psychologically and physically because it compounds the loss she feels on bereavement. Women and Law in Southern Africa offers practical legal advice and is also urging women to stand up for their rights.

(Source: Gender violence supplement, Public Eye, Friday 20 September 2002)

handout thirty

Unpacking the "household"

Words and concepts often disguise the structures of inequality, especially those inherent in the "feminisation of poverty".

"Household" in the rural areas, where peasant and subsistence farming are the main activities, is considered as the basic unit. Cash income, property and labour power are aligned to the male head of household.

Dependent refers to women, children, and sometimes the elderly, all of whom are not recognised as contributing property or income, even though they may engage in income-generating and household maintenance activities which have a cash value if purchased on the market.

While men may control more resources and earn higher incomes, this does not translate into improved family or household welfare.

Women's incomes and spending patterns are better indicators of the welfare of household members, since women spend more of their increased earnings on food, medicine and education for their children and other dependents. Improving women's incomes leads to better welfare for the entire family.

The HIV/AIDS pandemic has had a significant impact on the understanding of "household". Often the concept disappears when the man dies – widows, orphans and the elderly may join other households.

And, where the household does not disappear altogether, it may change its nature dramatically (for instance, becoming a child-headed, single-parent, or grand-parent-headed unit). A study of 771 HIV/AIDS-affected households in South Africa found that most of the households were female-headed, and one in five was headed by a pensioner.

('Women in Africa's Development, Overcoming Obstacles, Pushing for Progress', Takyiwaa Manuh, and 'AIDS in the 21st Century: Disease and Globalisation, Tony Barnett and Alan Whiteside 2002.)

Alexandra township, Johannesburg

What journalists and communicators can do?

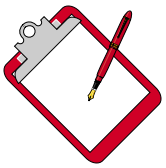
- When reporting on poverty, the media has often fallen into many of the same traps of creating stereotypes and stigma as when it reports on gender and HIV/AIDS.
- The poor are often portrayed as victims, rather than as survivors, and the tone of the stories is one of hopelessness and disempowerment. Stories about the poor are written as "doom and gloom" pieces, and often the context of what causes poverty and how it should be tackled at all levels is missing.
- Poverty also is written about as an unending, unchanging status, without an analysis of the inequalities, structural deficiencies, poor policies and other factors that make people poor. Instead, stories often reflect the poor as being "responsible" for their own status.
- Portrayals of the poor, especially of poor women, tend never to capture their personal survival and coping skills and their determination to move forward. The language used often elicits pity.
- Journalists and communicators must equip themselves with a firm understanding of poverty and its impact on all aspects of a nation's development. Current approaches to poverty reduction emphasize that the empowerment of women is key. Therefore, no article on poverty would be complete without explaining the links between gender inequality and poverty.

Exercise three

Ask participants to put together an information campaign for a rural community on HIV/AIDS. Sketch out the basics of this campaign and address the following aspects in the campaign:

- Target audience(s);
- What are the central messages of the campaign?
- How do you plan to disseminate the information?
- What form of communications will be used to get the information to the community?
- What are some of the key issues you would raise through the information chosen to build your campaign?
- Would you involve others in designing the campaign? If so, who?

Tips for trainers: Participants should feel free to provide other information in addition to the questions asked above to give the facilitator a good overview of their campaign. At the end of the time allocated to this exercise, randomly choose members from the group to share their campaign structures – this can be done orally or the participant can write up his or her campaign sketch on flipchart or the board. Discuss and analyse as a group.



Story ideas from this chapter

- The feminization of HIV/AIDS and its impact on a country's development;
- Poverty eradication – a story that analyses whether the national poverty eradication policies in your country are informed by HIV/AIDS and gender; and
- Develop stories that examine the impact of HIV/AIDS on food security, labour, education, agriculture and highlight the gender dimension.

Key learning points

- Poverty affects the impact of the AIDS epidemic, and people's responses to the epidemic.
- Gender inequalities lead to higher levels of poverty among women compared to men, within households, communities and within society.
- The impact of the AIDS epidemic worsens gender inequalities, especially under conditions of poverty.
- The AIDS epidemic accelerates impoverishment, leading to a destructive downward spiral for individuals and communities.
- The media has consistently down-played, ignored and distorted the importance of poverty and gender inequality and how these factors affect individuals, communities and society.
- Addressing this vicious cycle of poverty/gender/HIV/AIDS has major implications for developing effective responses to the epidemic.

CHAPTER ELEVEN

Gender, prevention, treatment and care

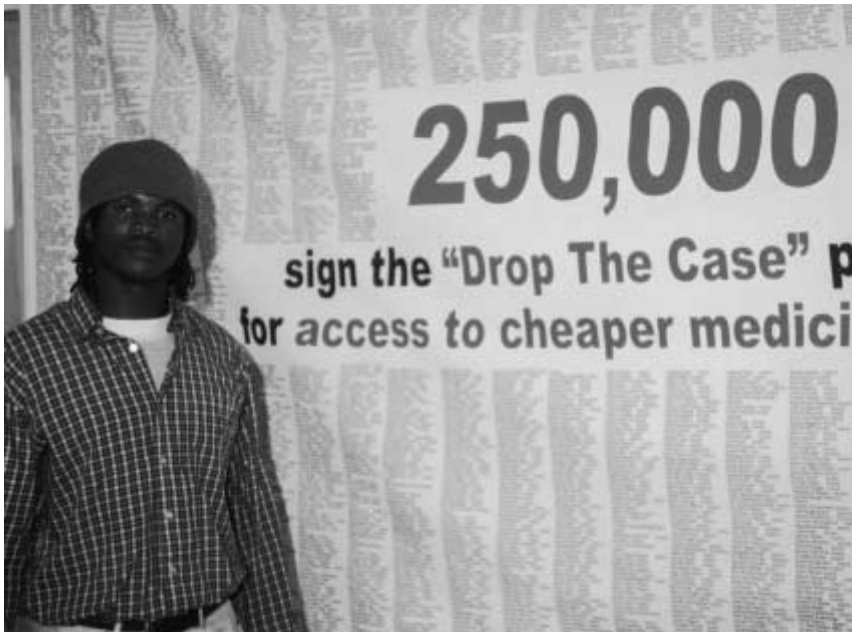
By Belinda Beresford

"Amidst the poverty of Africa, I stand before you because I am able to purchase health and vigour. I am here because I can afford to pay for life itself... Given the epidemic's two most signal changes, in demographics and in medical science, it must surely be that the most urgent challenge it offers us is to find constructive ways of bringing these life-saving drugs to the millions of people whose lives and well-being can be secured by them. Instead of continuing to accept what has become a palpable untruth (that AIDS is of necessity a disease of debility and death), our overriding and immediate commitment should be to find ways to make accessible for the poor what is within reach of the affluent."

(Women's Net, Women and Human Rights Reference Group, 12 August 1999.)

Objectives

- To provide an in-depth understanding of HIV/AIDS and treatment options currently available to people with HIV/AIDS.
- To examine the gender dimensions of HIV/AIDS prevention, treatment and care.
- To illustrate how treatment and care programmes often put the burden of guilt and greater responsibility on women.



Introduction

Treatment and care have become highly controversial issues. While anti-retroviral drugs are now available to help prolong the life of those with HIV/AIDS, their accessibility and affordability still put them well out of the reach of poor women and men.

The gender dimension of the global AIDS pandemic has become more prominent, especially when the features of the pandemic in highly affected areas are considered. Alongside the gender dimension of the pandemic has emerged a gender dimension to treatment and care.

Women, in particular, have few options open to them when it comes to their own treatment and care once they are infected with HIV/AIDS. They are often the caregivers and have little time or resources to seek treatment and care for themselves.

In her book, "AIDS Africa", Helen Jackson uses World Bank data to estimate that for every 1,000 cases of unprotected sex with a man with HIV/AIDS, one or two women will be infected with the virus. Women are more likely to get infected from a man than vice versa, because the infected seminal fluid stays inside the woman's body. This increases the chances that the virus will make its way past the body's defence systems. In contrast, infected vaginal fluid mainly stays outside the man's body, unless he has an open sore or injury.

Treatment for HIV/AIDS is often taken automatically to mean antiretroviral therapy (ART) using antiretroviral drugs, often abbreviated to ARVs. These usually work by preventing HIV from reproducing. This reduces the strain on the immune system, which is better able to mop up virus in the body. ARVs cannot cure HIV/AIDS, but they can buy time. How much time, is variable – it can range from a few months to many years.

These drugs, unless heavily subsidised or provided for free through the public health system, are not accessible to a large majority of women – especially to the swelling population of poor women, who are among those with the highest rate of HIV infection.

The assumption that the poor will not be able to take their anti-retrovirals – if made easily available to them – is not borne out by many researches and pilot studies. A hospital in Cape Town has reported that its indigent patients – black and from some of the worst townships in South Africa – have compliance rates on a par with patients in the United States.

Women in the United States and Western Europe have tended to be less compliant in taking their medicines than men. The same is not true in South Africa, where women appear to be at least as good as men at sticking to the treatment regime. Doctors suggest that this is because in Western Europe for example, high levels of women with HIV/AIDS are also intravenous drug users – not a group that is likely to be good at taking medicine. In South Africa with its heterosexually transmitted epidemic, women with HIV/AIDS are much more representative of women as a whole.

handout thirty-eight

A profile of HIV/AIDS

Researchers discovered what is now called HIV-1 in 1984, three years after it became clear that a previously unknown disease was loose in the world. A French team of scientists first identified HIV, but international politics led to an American team being given joint recognition for the discovery of the virus.

Viruses related to HIV appear to have been living in relatives of humans such as monkeys and apes for a long time. No-one knows when the virus later identified as HIV first colonised human beings, but we do suspect that it has happened more than once. There are at least two different kinds of HIV, labelled HIV-1 and HIV-2. HIV-2 was isolated from patients in West Africa in 1986. This strain is less virulent, it kills more slowly and appears to be less infectious than HIV-1. At one time scientists hoped that having HIV-2 would "vaccinate" people against the more dangerous HIV-1, but this does not appear to be true. People have been identified carrying both HIV-1 and HIV-2 simultaneously.

HIV has many related viruses, which infect other animals such as SIV (simian immunodeficiency virus in monkeys) and FIV (feline immunodeficiency virus in cats). Some of these related viruses do not appear to harm or kill their hosts – this is a sign that the virus and the host have lived together for a long time, and have fought each other to a form of truce. The fact that monkeys live with their form of SIV, which is very similar to HIV, without getting sick, suggests that the human virus developed from the simian one, rather than the other way around.

It is possible that HIV has made the transition to humans from monkeys many times, but that the infected person or people died without transmitting the virus on in large enough numbers to create an epidemic. HIV is a sensitive virus. It dies rapidly outside the body and it is very vulnerable to disinfectants.

HIV itself does not kill

It is not the virus itself that kills people; rather the virus destroys the human immune system, opening the door for lots of other infections, which are the ones that eventually kill.

Human beings are under constant attack by different bacteria, fungi, moulds and viruses, most of which the immune system fights off before we get sick. But when the immune system is trying to combat a growing number of HIV particles, and is itself being destroyed by HIV, it starts to fail against other disease-causing agents. This is when a person starts to move from being infected with HIV, to living with AIDS.

Weakened by the loss of some of its defence mechanisms and trying to control this flood of virus, the body ceases to be able to defend itself effectively against day-to-day infections. This results in the person being affected by opportunistic infections, which may either be common illnesses which can normally be fought off, like thrush, or rare diseases like Kaposi Sarcoma.

An epidemic is not just the result of an infection agent, it is also the social and cultural setting in which the disease is spreading. What makes HIV so effective is that it has a long incubation period, which gives plenty of opportunity for infected but healthy people to unwittingly pass the virus on. It is also transmitted through some of the most basic human activities, sex and breastfeeding. Gender inequalities, poverty and ignorance – which are all linked – help create an environment where HIV can spread successfully.

How long can you live with HIV?

It is hard to know how long people live with HIV before becoming AIDS sick, because it is so difficult to know when a person actually became infected. There are no obvious and immediate signs of having HIV – either at the point of infection or for years afterwards, this is why HIV is sometimes referred to as a silent epidemic.

In developed countries such as the US and the UK, it is estimated that on average eight years elapse between initial infection, and the person becoming AIDS sick. Without treatment, particularly anti-retroviral treatment, the average person lives with AIDS for an average of three before dying.

However, it is uncertain whether people living in less affluent or developed areas such as Sub Saharan Africa would live on average for the same amount of time with the virus. It was thought that people in less developed countries would be likely to sicken and die faster, because their immune systems would be under greater assault as a result of unclean water, lack of sanitation, and the prevalence of microbes such as malaria.

Whether this is true or not is still unclear. Several studies have suggested that people in developing countries live for the same amount of time on average with HIV/AIDS as those in developed countries. But doctors working on the ground are wary of these findings. One research team for example, points out that South Africans infected with HIV/AIDS tend to die quickly because of tuberculosis. There is still a lot that is unknown about HIV.

Preventing sexual transmission

In sub-Saharan Africa, the main form of transmission is through sexual intercourse. Any sexual activity that brings the bodily fluids of one person into contact with those of another can also spread HIV/AIDS. Oral sex, anal sex and vaginal sex are all potential ways of transmission. Conversely, anything that prevents fluid-to-fluid contact will reduce, or remove, the chances of HIV infection. At the moment this primarily means condoms, whether male or female. If a man or woman is giving oral sex to a woman, they can use a dental dam – piece of latex – to prevent contact with her vaginal fluids.

It is the male condom, which is regarded as the basic way to curb the spread of HIV/AIDS. However, while the male condom has the advantage of being cheap, use of it is totally controlled by the man. A woman can almost certainly never force a man to unknowingly use a male condom.

The female condom gives more control to the woman, and there have been reports of women using them without their sexual partners being so aware of it. Female condoms however are slightly harder to use, and are much more expensive than male condoms.

Exercise one

Ask participants to conduct *vox pop* interviews with members of the public about the female condom. It might be advisable for female participants interview women interviewees, and for men to interview fellow men. First off, each interviewee could be asked if they have heard of the female condom. Those who have then could be asked whether or not they and their partners have ever tried using one during sex. Those who have could be asked what they think of the female condom. Those who have not used one could be asked if they would consider doing so. If possible, the journalists could have a female condom with them to show the interviewees. The findings of the interviews could then be presented to the group.

Tips for trainers: Campaigns promoting the use of female condoms in Southern Africa are few and far between, so it is likely that awareness of the female condom may be low among interviewees and journalists alike. Problems raised by the interviewees should be noted down for future reference. For example, perhaps the majority of the interviewees had not heard of, or had not tried using the female condom. Or perhaps those who had used one did not like it because it was too noisy. Participants could then discuss how media might be used to address the problems highlighted by the interviewees.

Preventing parent to child transmission

Another way HIV is transmitted is through mother to child transmission, now known as parent to child transmission.

For every 1,000 pregnant women with HIV/AIDS, between 130-480 are likely to pass the virus on to their child, although this can be reduced dramatically by using preventative drug treatment. As a rule of thumb, it is usually said that up to a third of newborns will contract HIV/AIDS from their mother in one or another way. Conservative estimates are that up to half of these new infections could be prevented with the use of antiretroviral drugs like AZT or nevirapine.

HIV infection of newborn infants has been cut to less than one percent in some developed countries, thanks to the use of anti-retroviral drugs, caesarean deliveries and artificial feeding of the infant. In many less affluent countries, women cannot get access to any of these facilities, let alone the full armoury.

Babies become infected in the womb before labour, during labour and after birth, through breastfeeding. The chances of infection are reduced if the amount of virus the child is exposed to is reduced, for example if the mother is taking on-going anti-retroviral therapy. But this is not a possibility for most women in developing countries, which is why scientists have come up with two shorter, and cheaper alternatives. Just giving one pill of the anti-retroviral drug, nevirapine, to a pregnant woman in labour, and then another dose to the child after birth, will cut by about 50 percent its chances of contracting HIV/AIDS. Giving AZT over a period of weeks before and after birth achieves similar results.

Caesarean births reduce the risk of infections because the child is not forced through the birth canal, risking breaks in its skin and close exposure to infected maternal blood. But even if a caesarean birth is not possible, other measures eg. not breaking the waters until as late as possible, can also protect the child.

Discussions about programmes to prevent transmission of HIV from pregnant women to their babies often focus on the infant. This is compounded by use of words like ‘innocent’ to describe the baby, which in turn implies that the mother may be ‘guilty’ or at least ‘not innocent’, and therefore less deserving of care and attention.

The crucial point about PTCT programmes is that they focus on preventing the child from being infected with HIV/AIDS. They are not holistic treatment programmes and do not provide treatment for the mother. There sometimes seems to be an implicit assumption that by providing MTCT the women are also being helped. They are, but in a very limited way. Giving a woman advice, counselling, and a few pills to help save her baby during labour, will not necessarily help her physically several weeks down the line. Nor will such an intervention help a baby with HIV/AIDS, or children with a sick or dead mother.

Underlying debates and media coverage about vertical transmission of HIV from parent to child is based on the assumption that all the mother cares about is saving her unborn child from the virus. What is often forgotten is that the odds are that a pregnant woman with HIV/AIDS may already have children to whom she may have a greater emotional attachment than to the unborn child. That alters the real choices that women face, and the decisions they make.

Consider a woman advised to bottle feed her newborn to prevent it becoming infected with HIV/AIDS during breastfeeding. She may understand the need to bottle feed, but choose not to if doing so diverts scarce resources from her older children.

To be really effective, PTCT programmes should aim to help the mother as well as the child. Giving vitamins, ongoing support and advice, artificial baby food, food supplements for the rest of the family, are all issues that can help the mother longer term. So too can taking proper care of her physical state – ensuring that she has recovered from any trauma during childbirth, checking that she is being treated for opportunistic infections, giving her counselling and emotional support.

In the longer term neither the short courses of AZT, nor nevirapine will protect the child from catching HIV/AIDS through its mother's breast milk.

Exercise two

Hand out the article, "The Need for Nevirapine" in **Handout thirty-nine** to participants and ask them to read it and identify the gender issues raised by the article.

Tips for trainers: Use the article to examine the media's coverage of the options available to a pregnant woman with HIV/AIDS. Participants should think about how the article portrays women, as mothers and as individuals, and what options are available to them in both capacities.

Breastfeeding

Breastfeeding is best for children, but it also risks giving them HIV/AIDS. Bottle feeding reduces the chances of HIV transmission, but drastically increases their chances of dying from intestinal infections or malnutrition. Artificial feeding is costly, both financially and in terms of time. It requires the artificial food, clean water, facilities to sterilise the bottles and keep them sterile and time to do the cleaning, sterilising, mixing and feeding.

One World Health Organisation doctor recounted his unease at having to recommend that women bottlefeed their babies. He had spent a large part of his professional life promoting the concept that "breast is best" to save infants from illness and death due to intestinal infections and malnutrition, and now had to accept that in ideal circumstances breast may not be best.

Whether to recommend breastfeeding or bottlefeeding depends on the mother's circumstances. A woman with access to all the necessary resources would probably be encouraged to bottlefeed. A woman with none of the resources needed may have no choice but to breastfeed.

Preliminary research has indicated that exclusive breastfeeding – which means nothing else is given to the child, not even water – can be as safe as being bottlefed for the child. The problem is exclusive breastfeeding means that the mother must be able to feed the child continually day and night – difficult if she is working and cannot take the baby with her. Exclusive breastfeeding also puts a strain on the mother's body, and some researchers say is likely to accelerate the death of malnourished women.

Many media reports on breastfeeding are either explicitly or implicitly critical of women. They ignore the fact that women as the traditional nurturers of the family are often faced with the most heartrending decisions. And then there is the issue of the formula food itself. Too expensive for many women, even giving it out for free doesn't always help. There are reports of families using formula food intended for a newborn to feed older children, and even adults. This is sometimes represented as foolish or selfish of the woman and her family, when really their actions need to be put in context.

Exercise three

Break participants into groups and ask the groups to discuss the following questions for a report back.

- What is the message being given to women, and to men about feeding babies?
- Should this differ now, in the age of HIV/AIDS, compared to two decades ago when the campaign first really got underway?
- What is the real impact of the campaign on women and their choices, particularly in the light of the HIV/AIDS epidemic?
- Does the campaign provide enough information? If not, what more information should be given and how?
- Should the "breast is best" slogan still be used?

Tips for trainers: The exercise aims to discuss the "Breast is best" campaign, which has formed an integral part of the messaging sent to pregnant women over the last three decades. The gender dimensions of the campaign should be discussed – women are made solely responsible for feeding babies; if they cannot breastfeed, they are assumed not to care about their children.

handout thirty-nine

The need for nevirapine

By Lynne Gidish

HIV positive pregnant women don't have to pass the virus on to their babies. Early testing, bottle-feeding and a single dose of Nevirapine means new-borns have a nearly 90 percent chance of starting their lives HIV-free. **Lynne Gidish** investigates.

Today is a great day for Sarah*, 26, and her 16-month old boy, Sipho*. She's beaming from ear to ear because she's just been informed that Sipho has tested HIV negative. Everything she's been through – all the hardships she's endured – have finally paid off.

Sarah only discovered she was HIV positive when she fell pregnant with her son. She admits she's been lucky. "I was given Nevirapine," she says, " and now that my child is negative, I no longer have to feel guilty. I'm positive, it's only my problem to deal with. What would I do if Sipho had been positive too?"

Realising in retrospect that she'd been infected by her previous boyfriend, who has since died, Sarah never disclosed her status to Sipho's father. "I was too scared to tell him when we were together," she says. "And now that we've broken up because of his womanising, we have no contact whatsoever. He hurt me so much in the past that I really don't care whether he has the virus or not, and if he's infected and is passing it on to his other women, it's of no concern to me."

Explains Manko Ngakane, a counsellor who runs the follow-up clinic of the Perinatal HIV Research Unit (PHRU) at the Chris Hani-Baragwanath Hospital in Soweto: "Sarah's attitude is very common among our women and it's mainly because they're angry. At the clinic, we try, firstly, to help them through their anger about men and, secondly, to explain that they have a responsibility to reveal their status. But it takes time."

Sarah is still in the first stages of anger and has only revealed the fact that she's HIV positive – and took Nevirapine – to her mother. The stigma and pressure attached to her status are far too high for her to risk telling anyone else. But so is the stigma of not breast-feeding her child (HIV can be transmitted through breast milk).

"The trouble is the community," Sarah says. "What woman doesn't breast-feed her child? I felt really guilty that I couldn't. Everyone kept asking me why I was giving Sipho a bottle. I had to lie and say my milk was no good. Then there was the worry of finding money to pay for formula. My mother works so she was able to help, but it hasn't been easy."

Having spent so much time living in secrecy, clouded by anxiety and guilt, Sarah admits the results of Sipho's HIV test are "the best news ever".

"Everything's been worth it. We've both been blessed. Sipho has been given a clean bill of health – and a future."

It's stories like Sipho's that warm Manko's heart and reinforce her belief that every pregnant mother who is HIV positive should be given Nevirapine. "It's hard to describe the looks on the faces of mothers who are told their babies are negative," she says. "They have a long wait; the babies can only be tested one year after birth. But thanks to the drug, there are fewer and fewer of them who do test positive."

Without anti-retroviral drugs and with prolonged breast-feeding, 42 out of every 100 babies born to HIVpositive mothers contract the virus. Research has shown that when Nevirapine is administered and the babies aren't breast-fed, this figure drops to 13 out of 100 babies.

One child who hasn't been as lucky as Sipho is four-year-old Mbali*, whose mother Nonhlanhla* discovered she was HIV positive two years ago. "I thought I'd been infected by the man I was involved with at the time," Nonhlanhla explains. "It was only later, when I heard Mbali's father had died of AIDS, that I had her tested and discovered she was positive too. When I heard my results, I was angry. When I received hers, I felt it was the end of the world."

Nonhlanhla only now realises the importance of knowing your HIV status during pregnancy. "You always think: "It can never happen to me," but it can – and it does," she says. "I really feel bad that because of my ignorance, I wasn't given a chance to take Nevirapine to prevent Mbali becoming infected too."

Manko believes the importance of anti-retroviral drug awareness campaigns can't be over-emphasised. She'd like to see more of them in churches, community centres and other public places. "It all starts with being tested – regardless of whether you're pregnant or not," she explains. "The problem is our men. They just don't care."

Says Nonhlanhla: "Our men refuse to wear condoms so even if I try to be responsible, it doesn't work. When I meet a man and tell him I'm HIV positive, he looks at me and laughs. He says I'm too fat and healthy-looking to have the virus, and thinks I'm lying – so we have unprotected sex."

Dr Glenda Gray, the recipient (together with Professor James McIntyre) of the 2002 Nelson Mandela Health and Human Rights Award, and who heads up the PHRU comments: "Generally, people in South Africa don't talk about sex, so trying to talk about sex and HIV and death all at once is almost too much to handle. Furthermore, black South African women usually have a subordinate status in relationships and their men neither believe them nor take them seriously. Mbali's situation highlights the very definite need for something to be done to empower women with the skills to communicate effectively with their partners, as well as change men's attitudes about listening to them. It also highlights the importance for all pregnant women to be offered HIV testing during pregnancy, especially given the high rates of HIV in South Africa, where more than one in four pregnant women are HIV infected.

"Knowing your HIV status empowers you. It can help you access treatment if you're infected, and you can get treatment to help prevent your baby getting HIV from you.

"Yet, despite pregnant women wanting the best for their babies, there's still a stigma attached to being HIV-positive in the community," Glenda continues. "As a result, women struggle to disclose their status because of the fear of rejection and shame about being infected. This is complicated by the fact that they're also often ostracised because they're not breast-feeding their babies."

Adds Manko: "Not being able to breast-feed their babies is a huge issue for many women. Besides being scared of abandonment and of physical abuse should their partners ever discover their HIV status – and this fear is far worse if the woman is unemployed – many infected women have to deal with both their maternal instinct and the cultural pressure to breast-feed their babies.

"When women are given Nevirapine, we stress the importance of feeding their children formula. And because they're terrified to reveal their status, like Sarah, they often resort to lies. They tell family and friends they have breast cancer, that their doctors have told them they have no milk – anything, in fact, to give their babies a chance."

There's been huge controversy recently surrounding the use of Nevirapine in South Africa. According to Glenda, the government has a pilot programme using the drug to prevent mother-to-child transmission. "This is thanks to the Treatment Action Campaign winning a court case in the Constitutional Court against the government," she says.

"It forces the government to roll out this programme so that all HIV infected pregnant women can get access to Nevirapine, the drug that the World Health Organisation, UNAIDS and UNICEF organisations have all endorsed for the prevention of mother-to-child transmission of HIV. Nevirapine is widely used in the world in mother-to-child transmission programmes.

"Yet despite the fact that we need to eradicate paediatric HIV in this country, we're stymied by the unavailability of the drug in the public sector and the slowness of the government in implementing its programme nationally," Glenda continues.

"To date the introduction of free healthcare and good immunisation programmes have done a lot to control infant mortality in South Africa, but HIV is now threatening these programmes."

Zackie Achmat, chairperson of the Treatment Action Campaign (TAC) agrees: "HIV is a threat to South Africa's development," he says. "However, we can overcome this threat by ensuring that mother-to-child transmission prevention is implemented in clinics throughout the country and by introducing anti-retroviral treatment programmes in the public sector for people with HIV who have developed AIDS.

"The situation in Gauteng, Western Cape and KwaZulu-Natal is improving with a steady roll-out of mother-to-child transmission prevention. We believe the North-West Province is also making an effort. However, the TAC is unhappy with the roll-out in a number of other provinces, particularly Mpumalanga, where nothing seems to have been done.

"On the positive side," Zackie adds, " the national director-general of health has assured us that efforts are being made to implement the judgement of the Constitutional Court. This is the first step in the government's moral obligation to develop and implement a comprehensive treatment plan that will save hundreds of thousands – even millions – of lives."

Adds Glenda: "More than half the children admitted to the Chris Hani-Baragwanath Hospital are HIV infected, and two-thirds of all deaths among children in our hospital are HIV-related. This occurs because mothers didn't receive any interventions during pregnancy, which I find totally unacceptable.

"HIV infection in children is preventable by using simple interventions during pregnancy and labour, and I believe we all have a moral and ethical obligation to make sure the children in our country are born uninfected. These are our future leaders and without programmes like this – without the free availability of Nevirapine to every pregnant infected mother – we face their decimation."

*(*Not their real names.)*

(Source: True Love, November 2002.)

Blood transfusion

Blood transfusions, occupational injuries and needle stick injuries, when a healthcare worker is pricked by needle previously used on a patient with HIV/AIDS, are the other main ways of getting HIV/AIDS. Untreated HIV infected blood will almost certainly result in the recipient becoming infected with the virus, as will organ transplants. Occupational injuries, including needle stick injuries, carry varying amounts of risk. The chances of being infected can be lowered if the person potentially exposed to the virus is given anti-retroviral therapy.

Testing for HIV

Most tests do not actually measure the presence of HIV in bodily fluids; rather they look for the anti-bodies – the signals that the immune system is fighting HIV. Some tests do look for the virus itself, but they tend to be expensive and not as widely used. The usual anti-body tests are regarded as extremely accurate.

Usually it is the blood of a person, which is tested for HIV, but there are also tests for saliva and urine. Saliva and urine tests are regarded as slightly less accurate and so should not be used for diagnosing HIV infection without a confirmation from a different kind of test.

Rather saliva and urine tests are widely used for anonymous surveys to find out the level of HIV infection in a particular group. They are particularly used by employers to get some idea of what proportion of the workforce may be HIV positive.

There is a window period when someone is newly infected with HIV, and their body will not yet have manufactured the antibodies to the virus. This period, prior to seroconversion (from a negative test response to a positive one) is also a time when the person is highly infectious.

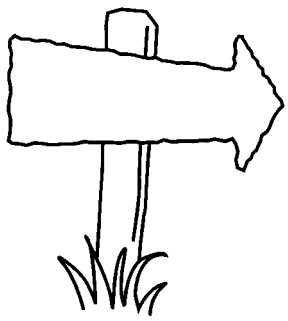
Like all other medical tests, HIV tests are not infallible, but they are highly unlikely to give the wrong result. HIV tests have to be accurate and sensitive. Accurate means they identify which samples are infected with HIV. Sensitive means they identify which samples are not infected. So an accurate and sensitive test will reduce the chances of getting the wrong result.

But, people do get misdiagnosed. This can be because of shoddy work in the laboratory; it can be because they have not yet seroconverted; or it could be because some other infection is confusing the test. This is why ideally people are not diagnosed as being HIV positive on just one test result.

In practice in poorer countries, doctors often make a clinical diagnosis of HIV/AIDS. They look at the physical state of the patient, consider the illnesses he or she has and decide whether they have HIV/AIDS. The odds are that a very thin and wasted woman with Kaposi's sarcoma, oral and vaginal thrush, and constant diarrhoea has HIV/AIDS.

Unless having a definite diagnosis will change the treatment or prognosis for the patient, doctors sometimes do not do the blood test. Without access to anti-retroviral treatment, and with the stigma surrounding HIV/AIDS in many communities, an individual may be better off just being treated for their symptoms. Especially if doing an HIV test is going to use scarce resources of either the patient or the medical facility.

See also exercise five, Chapter three (Communicating HIV/AIDS) on sending reporters out to get tested during training; as well as the article in **Handout eleven –** "Time for A New Start"



Drug Treatment for HIV/AIDS

The first ARV identified and used was AZT. It was used as mono-therapy – i.e. only AZT was given to patients. Although it had a miraculous effect initially, the impact of the drug rapidly wore off as it took just one mutation of the virus to make it immune to AZT.

Box ten: What are anti-retroviral drugs

Anti-retroviral drugs are chemical compounds that either kill retroviruses, or prevent them from replicating so that when the existing virus particles die, they are not replaced. Sometimes anti-retrovirals are known by the more general name of antivirals – drugs that work against viruses – and are often referred to as AIDS drugs.

Reverse transcriptease inhibitors interfere with reverse transcriptease, the enzyme used by HIV to hijack the DNA of human cells and make them produce more HIV.

Protease inhibitors work by interfering with the creation of the protein coat around HIV, again preventing the creation and release from human cells of fully functional virus.

For further information on antiretroviral therapy, drugs, and different forms of therapy, a good starting point on the Internet is the HIV InSite website. www.hivinsite.com or alternatively www.thebody.com

The next step in anti-retroviral therapy was duo-therapy, when two drugs were given together. This means that if the virus is immune to one drug, it should still be vulnerable to the other. Some drug combinations also reinforce the effectiveness of each other – AZT/3TC for example.

The discovery of protease inhibitors, which really came onto the market in the West in 1996, heralded Highly Active Antiretroviral Therapy or HAART.

This is the so-called “gold standard” of antiretroviral therapy today. Usually three different drugs are given, each killing or preventing reproduction of HIV in a different way. Even if a person has a virus population, which is immune to one kind of drug, it will succumb to one or both of the others.

Effective though triple therapy is, it is not infallible. Some people cannot handle the side effects of three highly toxic and powerful drugs at once. Sometimes the drugs damage the patient so much that he or she has to stop taking them. Doctors in the US report more patients dying as a side effect of the drugs, than as a result of HIV/AIDS. But, they balance this against the fact that the patients would probably have died years earlier if they had not taken the ARVS.

The trend seems to be that the longer you take drugs the less effective they get, because HIV eventually mutates to such an extent, that it can cope with all three drugs. This drug resistance is probably the biggest problem in treating HIV, if you exclude access to resources.

Box eleven: Drug resistance

There will be many differences between virus particles in any given person. These differences may be slight, the result of different mutations as virus particles replicate. Among those mutations will be some that confer immunity to one or another anti-retroviral drug.

As a person takes the drug, the virus particles, which are immune to it, manage to dupplicate while the particles, which are not immune, do not replicate as successfully, if at all. The results is that after a while the drug resistant from of the virus will become most common. When this occurs the side effects and health risks of taking that drug outweigh any potantial benefits, and the patient must stop taking it.

Multi-drug treatment, using two or more drugs together, attempts to get around this problem. A virus population that is resistant to one drug should not also be resistant to another, and so the second compound will kill it

But for this to work the patient must be taking the treatment properly – and that means taking their medicines exactly as prescribed. If this adherence to treatment falls below about 95 percent, then the patient will almost certainly become resistant to the drug. Unfortunately, this also tends to mean that it is resistant, to varying degrees, to all other drugs in the same class. And since there are only four classes of drugs, someone who doesn't take their treatment properly will fairly quickly become at least partially resistant to all the available anti-retrovirals. This is one reason why some people are taking four or even five drugs together as they try to exploit any vulnerability on behalf of the virus.

Drug resistance does occur even when patients fully comply with their treatment regimes. The ideal is for patients to stay on one particular drug combination for as long as possible before having to move onto the next. Hopefully this way new drugs will be discovered before the patient becomes resistant to all the existing ones.

Who gets treated?

For most low and middle-income countries, anti-retroviral treatment is available to those who can afford it. This may mean travelling to another country with doctors who are experts in treating the disease – South African doctors say they have many patients who fly down from other African countries for anti-retroviral therapy.

The most obvious problem in getting anti-retroviral therapy is the cost of the medicines. Pressure by local and international activists has seen a dramatic fall in the price of anti-retroviral drugs from thousands of dollars to hundreds in some cases. And the prices in South Africa at least look set to fall further under ongoing legal pressure from the Treatment Action Campaign and others. For more information on this complicated and long running debate start with the websites of the Treatment Action Campaign, www.tac.org.za and the Consumer Project on Technology www.cptech.org.

The publicity about the treatment means that more people are aware of, and want access to anti-retrovirals. But, lowering drug prices is having some unexpected hazards. In particular people are being treated by doctors who do not understand the complexities of anti-retrovirals and may inadvertently kill or fail to help their patients. Alternatively, they may only be able to afford one or two anti-retrovirals with consequent risks of drug resistance, or perhaps be unable to afford proper monitoring tests.

There are also growing anecdotal reports of people buying anti-retrovirals on the black or grey market and not knowing whether they are indeed getting the proper drug, or a fake. Blood tests should pick up if someone is not being given the proper drugs – but they have to be able to afford the tests.

Probably the most common way of accessing such treatment is through employers or private medical schemes.

Employment-related treatment

Increasingly, employers are recognising the benefits of giving proper care, including anti-retroviral therapy to employees. Largely this is due to self-interest, in a continent that suffers a shortage of skilled labour, it can be cheaper and easier to keep the workers you have alive, rather than let them die and have to search for new employees.

Box twelve: Case study of Debswana

The Debswana diamond company is half owned by De Beers and the Botswana government. It is estimated that one in three adult Batswana is infected with HIV/AIDS. Debswana has announced that it will give anti-retroviral drugs to all employees who needed it, and one dependent. In South Africa, a growing number of employees have had access to anti-retroviral therapy through their prrivate or employer medical schemes. However these individuals tend to be of higher socio-economic status, and have lower prevalence rates. To some extent therefore, Debswana's move is regarded as a test of just how well mass anti-retroviral therapy can be given.

Media reports on employee access to antiretroviral drugs rarely look at the gender implications surrounding the issue. If men are more likely to be formally employed than women, and especially if they tend to be in higher level jobs, then they are more likely to get access to anti-retroviral treatment.

Similarly, the kind of employment matters since companies may be willing to give antiretroviral therapy to permanent employees, but not to contract workers. This has resulted in a spate of outstanding of perceived high-risk job categories as companies try to limit the effects of HIV/AIDS they face.

The issue of giving antiretroviral therapy to a dependent or dependents is a minefield, particularly in environments of migrant labour.

Exercise three

Break participants into groups and ask each group to answer the following questions and to give feedback on their discussion in plenary.

- What are the practical and emotional difficulties when a family faces limited access to anti-retroviral drugs?
- How easy would you find it to take a life saving drug, while watching your children and/or spouse die of the same disease?
- Would you want to/try to share the drugs? If so, what would be the likely result?
- Some companies put a financial limit on the amount of medical care a family can receive in one year. Do you think women would be expected to put the health of their husband above their own?
- Is a woman who is able to get anti-retroviral drugs likely to face more pressure to not take or share her drugs with her husband than if the situation was reversed?

Tips for trainers: This exercise attempts to unpack the gender dimensions of treatment and the particularly difficult choices that poor women may face in accessing life-saving drugs.

Human guinea pigs

Clinical trials are, often quite rightly, controversial. They are often regarded as the poor becoming human guinea pigs and testing drugs they are unlikely to be able to afford. So the poor put their health at risk for the benefit of the rich.

In Africa this view has the added weight of race – poor black people in Africa are testing drugs for rich white Europeans. This viewpoint has been exacerbated by the undoubted abuses that have occurred during clinical trials, which after all represent a lot of money to the drug company and usually to the

people running the trial. Ethics have a tendency to get slightly obscured where money is involved, which is why there is a need for international clinical trial guidelines.

But, clinical trials often represent the only chance that people have of getting proper medical care. This is particularly true in the case of anti-retroviral therapy, where the drugs are very expensive and need trained doctors to dispense and monitor. Incorrect use of anti-retroviral drugs can kill a person faster than the virus alone will do.

Exercise four

Devise practical exercises for participants to find out what trials are going on, and for what companies, using what products. Some important questions include:

- Why are these medicines being tested in your country rather than in the country that the sponsoring company comes from?
- Obey the fundamental rule of journalism – follow the money. How much money do clinical trials bring both your country, the organisation running the trial and the doctors and nurses involved?
- Focus on one or two trials and look at the terms and conditions facing people taking part in them. What protections are there? What happens for example, if someone on a trial for anti-retrovirals gets a different illness, say a sexually transmitted infection, would the doctors running the trial treat them, and if so who pays? Are there any national guidelines on clinical trials? And if not, why not?
- Who is running the trial? Is it a private for profit company, a not for profit company, a research unit, or part of the public health sector?
- Who bears the real cost of the trial, the drug company or the public health sector? Consider – if someone on the trial gets sick as a result of the drugs is he or she treated in a state hospital or private one?
- In particular what happens when the trial ends? Do people who have been taking part continue to get the drugs? What are the short and long term implications for the health of the people concerned?
- How do the terms and conditions surrounding a clinical trial in your country differ from those that would surround a similar trial in the drug company's home country?

Tips for trainers: Almost certainly, the sponsored drug company is going to be from Europe or America. In addition, almost as certainly, a lot more trials will be underway than you expect. Try and assess if there are gender dimensions to these trials.

Other forms of treatment

One of the key factors to living successfully with HIV/AIDS is to reduce stress on the immune system. If the body has to use resources to fight many other infections, it will have less resilience at holding back a chronic HIV infection.

Helping the immune system can be done in a number of ways, from alleged immune system boosters, to improved nutrition. Similarly, treating or preventing opportunistic infections removes an added burden from a person's body. In some cases people are given a broad spectrum and cheap antibiotic, Bactrim, to take to prevent bacterial infections developing.

Public health measures such as improving access to sanitation and potable water also reduce the chances of other diseases that will strain the immune system. Relieving psychological stress is also important, which is where counselling and support groups can play an important role.

Monitoring and testing

The two main HIV/AIDS related tests are for viral load and CD4 count.

The viral load is the number of copies of HIV in a cubic millimetre of blood. The higher the viral load, the sicker the person is likely to be, and the more infectious they are. A person who is on successful anti-retroviral therapy, or whose immune system is still holding its own against HIV, will have an undetectable

viral load. This means that there are less than 50 copies of the virus in each ml3 of blood; it does not mean that they are no longer carrying the virus.

CD4 cells are part of the human immune system. HIV destroys them, and so the number of CD4 cells is used as an indicator of how strong a person's immune system is. One of the definitions of AIDS is if a person's CD4 count drops below 200/mm3. Internationally it is now recommended that people start anti-retroviral therapy when their CD4 drops under 350. At a certain level, the CD4 count becomes less meaningful. Whether a person has a CD4 count of 12 or 32, is somewhat irrelevant. Without anti-retroviral treatment, and possibly even with it, they are dying.

Anti-retrovirals are very powerful drugs and work by affecting the basic biochemistry of HIV. But, that means they can also affect the biochemistry of the person on the therapy, resulting in a number of potentially fatal side effects such as kidney failure. To prevent this, patients must have liver function tests and blood tests at regular intervals.

Unfortunately, these also tend to be a significant expense because while the cost of drugs may be coming down, the price of tests is not dropping as quickly. Increasingly activists are turning their attention away from pushing companies on the prices of anti-retroviral drugs, to demanding cheaper monitoring tests.

At the moment treatment protocols – the standard way of giving the treatment – is based on giving treatment in the US or Europe. Such protocols may not be the best for developing or middle-income countries. For example, the litigation conscious doctors in the US may be over-monitoring their patients in an attempt to prevent being sued by unhappy clients.

In Africa the main problem of treatment is scarcity of resources – doctors may rather choose to increase the intervals between monitoring because their patients or the state medical services cannot pay for more.

Gender, prevention, treatment and care

Exercise five

Divide the group into buzz groups to discuss whether there are gender dimensions to this holistic approach to treatment.

Tips to trainers: Women tend to be less likely to help themselves in these basic ways. The female role as nurturer can mean the woman of the household eats last, or least, if there is a shortage of food. Women are also more likely to be faced with caring for people who are sick, and their bodies are subjected to great strain by pregnancy.

handout forty

Gender, prevention, treatment and care

- Women are more likely than men to become infected with HIV through heterosexual transmission, yet women have few options open to them when it comes to treatment and care.
- Drug therapy is often out of reach for the large majority of poor women who comprise the highest numbers of those infected with HIV.
- The female condom, the only preventative method which gives women more control is slightly harder to use and is more expensive than male condoms.
- HIV-infected women often report discriminatory treatment during maternal and antenatal care.
- Preventative drug treatment, when available can cut parent to child transmission dramatically. But, PTCT programmes are not holistic and do not provide treatment for the mother.
- Men make up the ranks of those in formal employment, and are therefore more likely to gain access to antiretroviral treatment through employment-related treatment programmes. Dependents are often not included in such schemes.
- The HIV/AIDS pandemic has led to an increase in female-headed households.
- These households are poor and where care is required, it is provided by the women whose own care, if they have HIV/AIDS, is neglected.
- Families quickly fall into destitution when the male dies and his income, often the only one, is lost. Family resources often go towards the care of men, and when they die, the women left behind have little independent access to resources.
- In rural areas, where women are responsible for subsistence farming, their care burden reduces productive time in the fields, threatening the family's food security. Children are withdrawn from school to provide extra labour.
- Payment for drugs, in these situations, cannot be considered. The most pressing needs become food and money.
- When faced with little resources, the choice of who will be provided with treatment and care in an HIV-infected household, often favours men.
- Women are less likely to benefit from the effects of holistic treatment due to the burden of care they carry which puts stress on their immune system. The female role as nurturer can also mean that women eat last, or least, if there is a shortage of food, which means women are more likely to be malnourished than men.
- The HIV/AIDS pandemic has made apparent how false the savings are when the state cuts back on public expenditures for welfare and health care. These costs do not disappear; they fall to women.

("Turning the Tide, CEDAW and the Gender Dimensions of the HIV/AIDS Pandemic".)

Story ideas from this chapter

- Re-examining campaigns like “Breast is best” in light of the HIV/AIDS epidemic – an investigative piece on counselling and options provided to mothers in your country;
- Hard Choices – are women with HIV/AIDS the last to be treated? A story that explored this issue in the context of poor communities and community-based care.
- An investigative story on clinical trials of new HIV/AIDS drugs in your country.
- An investigative piece on the black market for anti-retrovirals.

Key learning points

- Women are more vulnerable to HIV infection during heterosexual transmission than men and have increasingly become the human face of HIV/AIDS, yet they have less access to treatment and care.
- The female condom is the only form of preventive method available to women, which gives them a measure of control for safer sex, but it is more expensive and less available than the male condom.
- Parent to child transmission puts more emphasis on the child over the mother. PTCT programmes are not holistic and do not provide treatment for the mothers.
- Employee access to anti-retroviral drugs is more likely to benefit men, since more men are formally employed than women.
- Campaigns such as the “Breast is Best” highlight many of the conflicting issues of treatment and care that have arisen for women and children in light of the HIV/AIDS pandemic.

HIV/AIDS Awareness Day at the Polytechnic of Namibia.

ANNEX A

Reference group for the manual

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Pat Made (centre) at the workshop to test this manual in South Africa's KwaZulu Natal province.

ANNEX B: CHAPTER AUTHORS

Belinda Beresford is presently writing a book on Aids in South Africa, which is due to be published later this year. The decision to write a book came out of her reporting on HIV/Aids for the Mail & Guardian newspaper. She has been a journalist for more than seven years, mainly at the Mail & Guardian where she held a number of specialist editorial positions, ending up as Assistant Editor. She won an award for her Aids coverage, specifically on her work debunking Aids dissident theories, and this year was one of the three finalists for the Nieman fellowship. Belinda has two children, and freelances for local and overseas organisations to support her book writing habit.

Colleen Lowe Morna began her career as a journalist specialising in gender and development. Among positions she held were co-ordinator of the Africa office of Inter Press Service in Harare; correspondent for South Magazine and Africa Editor of the New Delhi- based Women's Feature Service. She worked for the Commonwealth Secretariat as a senior researcher on the Africa desk in 1991, and later served as Chief Programme Officer of the Commonwealth Observer Mission to South Africa. She subsequently served as founding CEO of the South African Commission on Gender Equality. She holds an MA in Communications from Columbia University; BA in International Affairs from the Woodrow Wilson School of International Relations, Princeton University; and a certificate in executive management from the London Business School.

Liesl Gerntholtz is the former head of the legal department of the Commission for Gender Equality and the current head of the legal unit of the AIDS Law Project. She has worked extensively on issues of gender – based violence and is a past Deputy Chairperson of POWA (People Opposing Women Abuse).

David Lush is a media consultant specialising in HIV/AIDS communication and media development. He is also a founding member and current Chair of Lironga Eparu, the Namibian network of people living with HIV/AIDS. Based in Namibia, David has worked in and with media in southern Africa for the past 15 years. He was a journalist with The Namibian newspaper and the Namibian Broadcasting Corporation, before heading the Media Institute of Southern Africa's (MISA) information department. David ran the media programme of the Open Society Initiative for Southern Africa (OSISA) from 2000 – 2002, and holds a Masters degree in Political Communication.

Thenjiwe Mtintso, a veteran freedom fighter and gender activist is Chair of GL, South Africa's ambassador to Cuba, former Deputy Secretary General of the African National Congress and former Chair of the Commission on Gender Equality. She recently completed her master's dissertation on the impact of, and constraints faced by women parliamentarians in the new South Africa. Highly regarded in gender circles, Thenjiwe writes and speaks regularly on gender issues. Her framework for analysing women in decision-making, found in the book "Redefining Politics" has become a frame of reference in gender training in Southern Africa.

Patricia Ann Made is a Zimbabwean-based journalist, and independent editor and media trainer and board member of GL. She has worked in the media in Zimbabwe, regionally and for international media for more than 15 years. Pat has published several articles on the media, and gender issues and co-authored two publications: Women in Industry in Zimbabwe (Zimbabwe Publishing House, 1985) and Beyond Beijing: Strategies and Visions Towards Women's Equality (published by SADC Press Trust in 1996). She was instrumental in the development of a gender editorial policy and a pioneering Gender and Media Programme of work for Inter Press Service (IPS) international news agency, which is based in Rome, and served as its first female Director General (May 2000-May 2002).

Lindiwe Nkutha has a formal academic back ground in accounting and auditing, and is the process of completing her Honors Degree in Gender Studies, with a view of grounding her passion for gender and feminist activism in theories of development as they affect gender and activism respectively. As one who loves reading contemporary women's literature, Lindiwe herself has a penchant for writing that has included in the past, a few journalistic pieces, some poetry and prose.

Petronilla Samuriwo is a 35-year-old trained journalist with some 13 years experience in print journalism, church media and developmental reporting in gender, health and HIV/AIDS issues. She started her career in 1988 as the first rural reporter for the Zimbabwe Mass Media Trust's Rural Newspapers' Project. In 1991 she joined Munn Publishing as production editor. In 1994 she joined the Zimbabwe Catholic Bishops Conference as editor for the national Catholic Church News, which dealt with issues of health, religion, social change and development. In 2001 Petronilla moved on to developmental media as publications/media officer for the Southern Africa AIDS Information Dissemination Service. She is currently pursuing a Masters Degree in Gender Studies at the University of Newcastle upon Tyne in the United Kingdom.

Judy Siedman was born in the USA in 1951, educated at Achimota School in Ghana, then at University of Wisconsin (BA sociology, MFA Fine Arts). She has lived and worked in Zambia, Swaziland, Botswana, Zimbabwe and South Africa (where she has lived since 1990). She currently works as a graphic artist, writer and educator on issues ranging from arts and culture to gender and HIV.

ANNEX C

Additional reading and websites

1. AEGIS (biggest website on HIV/AIDS) – www.aegis.org
2. African Counselling Network – www.geocities.com/kim1122a
3. AIDS Consortium, South Africa – www.aidsconsortium.org.za
4. AIDS Law project, South Africa – www.alp.org.za
5. Amnesty International – www.amnesty.org
6. Centre for AIDS Development, Research and Evaluation (CADRE) – www.cadre.org.za
7. Centre for Health Policy, South Africa – www.halthlink.org.za/chp/
8. Commission on Gender Equality, South Africa – www.cge.org.za
9. Community Law Centre, University of the Western Cape, South Africa – www.communitylawcentre.org.za
10. Eldis Gateway to Development Information – www.eldis.com
11. Gay Men's Health Crisis – www.gmhc.org
12. Health Gap – www.healthgap.org
13. Health Link International – www.healthlink.org.uk
14. Health Systems Trust, South Africa – www.hst.org.za
15. Human Rights Watch – www.hrw.org
16. Inter-Africa Network for Human Rights and Development, Zambia – www.afronet.org
17. International Lesbian and Gay Association (ILGA) – www.ilga.org
18. International Labour Organization (ILO) – www.ilo.org
19. loveLife, South Africa – www.lovelife.org.za
20. Media Institute of Southern Africa – www.misanet.org
21. Medicins Sans Frontiers (Doctors without Borders) – www.msf.org
22. Naledi (National Labour and Economic Development Institute), South Africa – www.naledi.org.za
23. Project Inform – www.projinf.org
24. Rape Crisis, South Africa – www.rapecrisis.org.za
25. Regional AIDS Training Network – www.ratn.org
26. Rural AIDS Development Action Research Programme, South Africa – www.wits.ac.za/radar
27. SADC – www.sadc.int
28. SADC Gender monitor – www.sadc.net/widsaa/sgn
29. SAfAIDS, Zimbabwe – www.safaids.org.zw
30. Secure the Future – www.securethefuture.com
31. Society of Women and AIDS in Africa, Uganda – www.maxpages.com/swaauganda
32. Soul City, Institute for Health and Development, South Africa – www.soulcity.org.za
33. The Body – www.thebody.com
34. The Equality project, South Africa – www.equality.org.za
35. The Triangle Project (gay and lesbian issues), South Africa – www.triangle.org.za
36. Treatment Action Campaign, South Africa – www.tac.org.za
37. United National High Commission on Human Rights – www.unhchr.ch
38. UNICEF – www.unicef.org
39. UNDP – www.undp.org
40. UNAIDS – www.unaids.org
41. UNIFEM web portal on gender and AIDS – www.genderandaids.org
42. World Health Organization – www.who.org
43. Women Alive – www.women-alive.org
44. Women's Health Project, South Africa – www.wits.ac.za/whp
45. Women's Health website, with a list of useful links – www.research.umbc.edu
46. Women's Human Rights Net – www.whrnet.org
47. Women's Legal Center, South Africa – www.wlce.org.za
48. Women's Net, South Africa – www.womensnet.org.za
49. Women Watch – the UN gateway on the advancement and empowerment of women – www.un.org/womenwatch/
50. World Bank – www.worldbank.org