

VSO-RAISA

MEN, HIV & AIDS regional conference 2003 report back

MEN, HIV & AIDS CONFERENCE ORGANISERS:

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MEN, HIV & AIDS REPORT BACK:

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VSO is a registered UK charity No. 313757

The cover photo shows a message on the back of Regis Mtutu's t-shirt, a conference delegate.

Printed on recycled paper

Conference Objectives

To share experiences of each organisation highlighting their strategies for engaging men within the pandemic in regards to behaviour change, caring, and active community responsibility.

To explore the potential issues of both increased and decreased male involvement with regards to HIV & AIDS.

To highlight lessons learnt and share experiences of enlisting and maintaining involvement of the youth, specifically boys.

Explore opportunities and strategies for increasing the sharing of experiences and lessons learnt across the region.

Discuss how VSO, other international and national agencies can further commit to support and strengthen the response of current and potential partners both nationally and regionally to ensure that there is more involvement of men at appropriate levels in future.

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Acronyms

ADPP-TCE

Ajuda e Desenvolvimento do Povo para o Povo - The Total Control of the Epidemic

ASOs

AIDS Service Organisations

CBO

Community Based Organisation

CEDPA

The Centre for Development and Population Activities

DramAidE

Drama in AIDS Education

GIPA

Greater Involvement for People Living With and Affected by HIV/AIDS

HBC

Home Based Care

IEC

Information, Education and Communication

LGBT

Lesbian, Gay, Bisexual and Transgender

MANET+

Malawi Network of People Living with HIV/AIDS

MSM

Men who have Sex with Men

NAPHAM

National Association for People Living with HIV/AIDS in Malawi

NGO

Non Governmental Organisation

PLWA

People Living with AIDS

PLWHA

People Living with HIV/AIDS

PPASA

Planned Parenthood Association of South Africa

Pro-me-tra

Promotion of Traditional Medicine Association of South Africa

PSI

Population Services International

PWHA

People Living with HIV/AIDS

RAISA

Regional AIDS Initiative of Southern Africa

RH

Reproductive Health

SAMF

South African Men's Forum

SAfAIDS

Southern African AIDS Information and Dissemination Service

SAMNET

South African Men's Network

SRH

Sexual Reproductive Health

STD

Sexually Transmitted Disease

STI

Sexually Transmitted Infection

TKMOAMS

Tate Kalungu Mweneka Omukithi wo "AIDS"
Moshilongo Shetu
Translation: Our Mighty Father Protect Our Nation From The Deadly Disease "AIDS"

TRP

The Rainbow Project

UNAIDS

Joint United Nations Programme on HIV/AIDS

UNISA

University of South Africa

UZ-UCSF Programme

University Zimbabwe - University California,
San Francisco

VCT

Voluntary Counselling and Testing

VSO

Voluntary Service Overseas

YAO

Youth Activists Organisation

ZARAN

Zambia AIDS Law Research and Advocacy Network

Acknowledgements

VSO-RAISA would like to thank all the delegates who attended the conference and shared their experiences so openly and so passionately.

To quote one participant,

“the conference felt safe, people were risk taking in what they were saying and asking, there were changing of ideas and paradigms, we were seeing it happen day to day.”

Particular thanks goes to Pieter Dirk Uys for his inspirational humour and generosity with time and talent, to Lucky Mazibuko for opening the conference with such personal and inspiring words, to Mercedes Sayagués for her analysis of the conference and the swiftness of which she shared this with the wider community and to all the chairs and rapporteurs for taking on extra roles and for doing them so well.

Enormous thanks are also due to SAfAIDS for their incredibly generous donation of materials which made up the conference pack, the RAISA Country Co-ordinators for the pre conference co-ordination and post conference follow up, the staff who helped with the running of the conference over the three days and to Naseem Noormahomed for her astonishing organisation and administration skills that enabled the conference to happen.

Last and by no means least RAISA would like to extend special thanks to Peter Busse for all his advice, support, encouragement and participation which remained constant throughout.

Terina Stibbard & Lorna Robertson
VSO-RAISA Co-ordinators

Executive Summary

“Besides deep changes in society, what we need is a deeply spiritual transformation in the identity of men.”

This statement by a participant sums up the debates at a conference on **MEN, HIV & AIDS** organised in Pretoria by the **Regional AIDS Initiative of Southern Africa (RAISA)** of **Voluntary Service Overseas (VSO)** between 11-13 February 2003. Seventy-one participants, mostly from Southern African countries with a few from East and West Africa, examined how to engage men in the response to the HIV/AIDS pandemic.

In the region, national adult HIV prevalence has risen, says UNAIDS, *“higher than thought possible, exceeding 30% in Botswana (38.8%), Lesotho (31%) and Zimbabwe (33.7%).”* Namibia follows (22.5%), Zambia (21.5%) and Malawi (15%). South Africa’s estimated 13% prevalence translates into 4.5-4.7 million people infected.

Twenty years into the pandemic, the bulk of studies and interventions have centred on women and girls. There is greater understanding of the gender dimensions of HIV/AIDS but little funding and effort has gone into working with men, especially young men. Many interventions fail because they do not take into account the identity constructions of the men who interact with women and girls as partners, husbands, fathers, teachers and so forth.

The VSO-RAISA conference provided an unusual and very needed space for reflection and discussion among activists, researchers, and people involved in service delivery and/or advocacy around HIV/AIDS. The conference was structured around 10 parallel streams: Enlisting men as people living with HIV/AIDS; Men in prevention and advocacy; Marketing; Home based care; Man to man transmission; Male reproductive health; Boy child and construction of masculinity; Boy child and peer pressure; Men and cultural beliefs; Stigma and Violence.

A description of the main threads of analysis follows, weaving patterns of how men in Southern Africa relate to HIV/AIDS. A key issue is that deeply held notions of masculinity lead to high-risk behaviour for HIV infection among men and women. Research and surveys across the region show that men are socialised into a notion of masculinity as sexual prowess, risk taking behaviour and male dominance and superiority over women. At the same time, men perceive their privileged space in society to be under threat from socio-cultural changes taking place in the region. These include rural/urban migration, Western culture seeping through mass media and the entrenchment of women’s rights. *“Many men are feeling a bit hopeless, like there’s no place for them in the world.”* The sense of loss undermines men’s motivation for safe sex.

A study of how masculinity is constructed in schools in KwaZulu Natal found that the conflict between traditional and contemporary gender roles generates in boys and men a sense of displacement and irrelevance that cuts across race and class. White students and teachers feel threatened by the advancement of blacks and women. Black pupils and teachers fear women’s new status, poverty and unemployment.

Similar findings emerged in a survey by the University of Witwatersrand on risk taking behaviour among youth in Soweto, South Africa’s largest township, where nearly half of young men are unemployed. *“If you have no job and no future, life becomes cheap, and sex is a dangerous entertainment fuelled by boredom, alcohol and poverty.”*

From the other end of the social spectrum, a survey among traditional healers, chiefs and Zionist priests by the Promotion of Traditional Medicine Association of South Africa (Pro-me-tra) found that men feel socially disoriented through a loss of leadership position in family and community. *“Men have become spectators, irresponsible and indifferent.”* Traditional practices, however, make up male identity and to attack them is self-defeating, says Pro-me-tra. Better to tap into the traditional notion of men being responsible for their families. Male circumcision, wife inheritance, scarification and polygamy can be managed responsibly *“in safe and best practice”* if people are accurately informed about HIV infection risks.

Many, if not most men, do not engage in risk behaviour - i.e. promiscuity, irregular or no condom use, violence, alcohol and drug abuse - but they have little visibility in the predominant discourse of *“men as drivers of the epidemic.”*

According to the Centre for the Study of Aids at the University of Pretoria, which works with marginalised young men - unemployed, junkies, bodybuilders, drag queens and male sex workers, negative male images channelled by the media and by society are internalised by young men and turn into a self-fulfilling prophecy. *“There is more rejection than inclusion. As a result, young men feel blamed for all social evils and withdraw.”*

There was consensus that blaming and scapegoating are not productive or helpful and undermine male self-esteem. *“The men-drive-the-epidemic slogan has outlived its usefulness.”* *“We shouldn’t blame men, women or culture but take responsibility.”*

Another common thread is the pervasive silence surrounding male sexuality. Parents don't talk about sex with their children. Husbands don't talk with their wives. Men generally feel uncomfortable discussing intimacy. Their reproductive health needs remain invisible.

At the National Association for People Living with HIV/AIDS in Malawi (NAPHAM), nine out of ten male members would not disclose their HIV status to their spouses. Secrecy brought stress, risk of infection for the wife through unprotected sex, and inability to change lifestyle and live positively. But when NAPHAM started support groups for couples, 65% of men brought their wives. Male membership increased. *"The groups enabled men to talk."*

"Men need opportunities to explore and talk about their sexuality in non-threatening environments," concluded a regional survey by Southern African AIDS Information and Dissemination Service (SAfAIDS).

Zimbabwe's Men Forum Padare/Enkudleni reaches boys and men in schools, pubs, sports clubs and churches, where they can debate, in a non-threatening space, issues of sexuality, masculinity and power. So does South African Men's Forum (SAMF). *"We need to challenge this destructive concept of manhood that men make all decisions, men need many sex partners."*

The wall of silence is finally crumbling around the last taboo topics in Africa - male rape and male-to-male sex. Some political and religious leaders have denounced gay men and women as un-African although 19th century ethnographic research documents sex between men in Africa. Politically constructed homophobia has a negative impact on public health because it excludes homosexuals from prevention and awareness campaigns, making them vulnerable to HIV infection. A combination of research and activism is breaking the silence about men who have sex with men across race and class.

Researchers at UNISA in South Africa and the Population Council in Kenya reported on the sexual and reproductive health needs of men who have sex with men. A study of black, gay and bisexual men in Katutura township, Namibia, found they experience verbal, physical and sexual forms of assault and discrimination from hospital staff, police, army and church officials. Facing barriers in employment, they turn to (unsafe) commercial sex work.

That sex happens among male prisoners is now acknowledged even by correctional services. The Prison Fellowship of Zambia described its project to bring AIDS awareness, peer counselling and condoms into prisons. With HIV prevalence of 27-30% in its crowded prisons, Namibia offers counselling to prisoners but not condoms because it could be seen as encouraging sodomy, which is a criminal offence.

Male rape, possibly the last frontier in public debate, was brought into the conference by Men United, a South African group dedicated to breaking the silence about male rape, providing support and care for survivors and their families, and educating youth to speak out against all sexual abuse.

Some success was noted in men's involvement in home based care, reversing the tradition that nursing the sick is a female domain. Tovwirane in northern Malawi and Kara Counselling in southern Zambia have growing numbers of male care givers. Chiefs and church leaders help identify volunteers who are provided with training, bicycles and team support.

The conference showcased a number of male-centred AIDS awareness initiatives in the region, with migrant miners in Zimbabwe, through soccer games in Zambia, and with adolescents in Malawi. The Southern African Men's Network, formed in October 2002, seeks to amplify small local initiatives into visible and structured actions, and to mobilise national men's movements.

A vigorous debate centred on the role of African culture(s) in shaping masculinity. A consensus emerged that traditional culture is dynamic, it changes and adapts, and can accommodate and shape a different construction of masculinity.

After 20 years of rampant spread, AIDS is driving changes in male behaviour in Southern Africa. *"Men's perceptions of identities are changing."* These changes need to be followed-up and supported.

Participants agreed that the concept and practice of masculinity needs to be reconstructed in ways that fit new socio-economic realities, from rural-urban migration to women's advancement, AIDS and unemployment. A new way of perceiving manhood would empower men to live their sexuality differently and to take active community responsibility. Such efforts should be grounded in a culture of human rights that can bridge cultural differences and span the variety of situations men experience, i.e., rural and urban, old and young, heterosexual and gay, single and married, etc. The notions set out in the UN Declaration of Human Rights provide a common ground for the complex and conflictive task of renegotiating gender power relations.

Summing up the conference, one participant said: ***"Men should think not about what we stand to lose but what we stand to gain."***

Mercedes Sayagués

Timetable

Day & Time, Title of Session, Names of Presenters, Organisation & Country

Day 1 Tuesday 11 February Enlisting Men

9.00-9.15 Welcome Address

Terina Stibbard, VSO-RAISA, Regional

9.15-9.30 Introductions, Conference Objectives, Housekeeping

Terina Stibbard & Lorna Robertson
VSO-RAISA Regional & UK

9.30-10.30 Opening Address

Lucky Mazibuko, Sowetan Newspaper, South Africa & Nkululeko Nxesi, SAMNET, South Africa

10.30-11.00 Tea Break

11.00-12.30

Enlisting Men A - PLWA

Chair: Carine Munting

Rapporteur: Ian Swartz

1 Meaningful Participation of People Living With and Affected by HIV/AIDS

Brett Anderson, GIPA, United Nations, South Africa

2 Disclosure and Positive Living

Mark Kumbukani Black, NAPHAM, Malawi

3 I am Thine Brothers Keeper

Believe Dhlwayo, The Centre, Zimbabwe

11.00-12.30

Enlisting Men B - Prevention & Advocacy

Chair: Sam Connor

Rapporteur: Miranda Lewis

4 The Role of the HIV Co-ordinator in Addressing Men's Issues

R V Kavendjii, Omaheke Regional Council, Namibia

5 Challenging Men to be Responsible

Priscilla Mataure, SAfAIDS, Zimbabwe/Regional

6 Risk Taking Behaviour of Migrant Workers

Phineas Murapa, PriceWaterHouseCoopers, Zimbabwe

12.30-2.00 Lunch

2.00-3.30

Enlisting Men C - Marketing

Chair: Kate Iorpenda

Rapporteur: Barry Farkas

7 Men, Sex and HIV/AIDS

Regis Mtutu, Padare/Enkudleni/Men's Forum on Gender, Zimbabwe

8 Fat Thighs Make for Record Condom Sales

Sam Connor, PSI, Malawi

9 South African Men's Forum

Mbuyiselo Botha, SAMF, South Africa

2.00-3.30

Enlisting Men D - ASOs/Home Based Care

Chair: Chad Kalobwe

Rapporteur: Stephen Armstrong

10 Less Participation of Men in Home Based Care Activities - a Case of Choma District

Ian Milimo, Kara Counselling and Training Trust, Zambia

11 The Challenge of Incorporating Men in HIV/AIDS Related Activities within the Tovwirane Organisation

Stephen Gichuki, Tovwirane HIV & AIDS Organisation, Malawi

3.30-4.00 Tea Break

4.00-5.00 Chair: Alan Smith

Rapporteur: Peter Busse

Round up Rapporteurs report back (5 mins each), and debate continues.

Day 2 Wednesday 12 February Sexuality & Boy Child

9.00-9.15 Welcome, Housekeeping

George Kampango, MANET+, Malawi

9.15-10.30

1 Challenges of a Gay Man in African Society

Ian Swartz, TRP, Namibia

2 HIV & AIDS, Implications for Male Sex Work

Prof Michael Herbst, UNISA, South Africa

10.30-11.00 Tea Break

11.00-12.30

Sexuality A - Sexual Practices

Chair: Stephen Armstrong

Rapporteur: Mercedes Sayagués

3 Men to Men Transmission

Pride Simana, Prison and Correctional Services, Namibia

4 Same-Sex Sexuality, HIV/AIDS and Public Health in Namibia

Robert Lorway, TRP, Namibia

5 The Influence of Sexual Practices on the Spread of HIV/AIDS among Youth in Soweto

Barbara Fisher PhD, University of Witwatersrand, Perinatal HIV Research Unit (PHRU), South Africa

11.00-12.30

Sexuality B - Reproductive Health

Chair: Miranda Lewis

Rapporteur: Carine Munting

6 Using Sports: Community Sexual

Reproductive Health and Football Camps

Clement M Bwalya, YAO, Zambia

7 Men's Call

Pheya Alinah Mabote, CEDPA, South Africa

8 Understanding the Sexual and Reproductive Health Needs of Men who have Sex with Men
Harriet Birungi, Population Council, Kenya
12.30-2.00 Lunch

2.00-3.30

Boy Child A - Behaviour Change

Chair: Peter Busse

Rapporteur: Kate Iorpenda

9 Masculinity, Boys and HIV Risk Behaviour
Prof Graham Lindegger, School of Psychology Natal University, South Africa

10 Behaviour Change for Adolescent and Secondary School Boys

Sam Connor, PSI, Malawi

2.00-3.30

Boy Child B - Peer Education/Pressure

Chair: Englebert Mwanyangapo

Rapporteur: George Kampango

11 Peer Pressure/Role Modelling

Thulani Ngubane, Youth for Christ, ACTIVE Youth, South Africa

12 Towards Defining a Methodology for Peer Support Facilitation

Samuel Kawiila, Prison Fellowship, Zambia

13 Young Men & Boys & HIV/AIDS: the Strategic Group

Tom Mzumara, ZARAN, Zambia

3.30-4.00 Tea Break

4.00-5.00

Round up

Chair: Robert Lorway

Rapporteur: Chad Kalobwe

Rapporteurs report back, 5 mins ea and debate on sexuality and boy child continues in separate rooms.

Day 3 Thursday 13 February Culture, Stigma & Violence

9.00-9.15 Welcome, Housekeeping
Priscilla Mataure, SAfAIDS, Zimbabwe/Regional

9.15-10.00

1 Love, Hope and Courage

Peter Busse, RAISA Advisory Board Member, South Africa

2 Stigma, Culture & Violence

Ivan Louw, Men United, South Africa

10.00-10.30 Tea Break

10.30-12.00

Culture

Chair: Kate Iorpenda

Rapporteur: Stephen Armstrong

3 Men, the Displaced Component of Society

Douglas Kabanda, Pro-me-tra, South Africa

4 The Role of Cultural Beliefs and Practices in Entrenching Gender Based Human Rights Abuses Against Women in the Context of HIV & AIDS

Malala Sakufiwa, ZARAN, Zambia

5 Shades of Masculinity: Junkies, Body Builders and Drag Queens

Sebastian Matroos, Youth Skills Development, South Africa

10.30-12.00

Stigma & Violence

Chair: Richard Delate & Susan Fox

Rapporteur: Harriet Birungi

6 Sex, Drugs, Abuse & Kids

Newton Zulu & Carl Edmonds, Prison Fellowship, Zambia

7 Men, Culture, HIV & AIDS in Mozambique

Lutz Mocker & Cristina Marques, ADPP-TCE, Mozambique

8 Rights Based Approaches to HIV & AIDS Summoning and Empowering Affected Communities

Kaumbu Mwondela, ZARAN Zambia

12.00-1.00 Entertainment

Pieter Dirk Uys, Entertainer & HIV/AIDS activist, South Africa

1.00-2.00 Lunch

2.00-3.30

Debate

9 Do Cultural Practices Contribute to the HIV & AIDS Epidemic?

Chair: Peter Busse

Rapporteur: Priscilla Mataure

For

George Kampango, MANET+, Malawi &

Jedidah Nyongesa, African Population Advisory Council, Kenya

Against

Paul Botha, DramAidE, South Africa &

Moeti Lesuthu, DramAidE, South Africa

3.30-4.00 Tea Break

4.00-5.00

Wrapping up

Super Chair: Alan Smith

Rapporteur: Lorna Robertson

Rapporteurs report back on Tues and Wed afternoon debates, as well as this morning. Questions on any aspect will be welcomed.

5.00-5.30 Evaluation & closing remarks

Day One, Tuesday 11 February, Enlisting Men

Enlisting Men A - PLWA

1. Meaningful Participation of People Living With and Affected by HIV/AIDS

By Brett Anderson, GIPA, United Nations, South Africa

South Africa has one of the highest HIV/AIDS prevalence rates in the world yet still the number of people who know and are open about their status is relatively small. One contributing factor is the fear of stigmatisation and discrimination. GIPA is widely recognised as an effective and ethical intervention that is critical in addressing these fundamental barriers to behavioural change.

Description and results of the project

The GIPA Project has been in operation since 1997/8 and serves to advocate for the GIPA Principle through the GIPA Work Place Model. The model recruits, trains and places people living openly with HIV/AIDS in partner organisations so as to enrich and support that organisation's HIV/AIDS policy and programme by creating an enabling, non-discriminatory environment. Since its inception the project has trained over 20 GIPA Fieldworkers - 50% of whom have been men. The role of the GIPA Fieldworker will vary according to the needs of the organisation and the skills of the individual. The role of male GIPA Fieldworkers within the work place environment has been found to be an effective tool to addressing some of the different gender related problems. By being able to share their own experiences many male employees have been better able to identify with the GIPA Fieldworker and to consider their own risk taking behaviour.

Summary of experiences/lessons learnt and implications for the future

- ⌘ Meaningful involvement of male PLWHA must be based on skills not just status.
- ⌘ Effectiveness of work place settings as an entry point.
- ⌘ Number of male PLWHA willing to participate is lower than female PLWHA.

2. Disclosure and Positive Living

By Mark Kumbukani Black, NAPHAM, Malawi

NAPHAM was formed in 1993 and is involved in care and support services. It operates in all three regions of Malawi.

Description of the problem

Men living with HIV/AIDS were not able to disclose their HIV status to their partners. 90% of HIV+ men did not allow their wives to accompany them to a support group. It was therefore difficult for men to introduce positive living measures at home because their partners were not aware of their HIV status. Women, who joined the association after informing their husbands of their HIV status, were forced to continue having unprotected sex. After refusing their husbands' requests, they were beaten and banned from attending the support group.

Description of the project

NAPHAM organised positive living training session targeting spouses. Partners were told to bring their husbands/ wives. This project was started in 2000 with support from USAID. Group work was used to encourage active participation. The issue of nutrition, medication and more importantly having peace of mind and acceptance in positive living was emphasised. Positive living sessions were done in small groups of men, women and youth in order for them to bring real issues without shame. After group session's plenary presentations were done capturing positive living guidelines, problems and other pressing issues like common opportunistic infections, stigma and discrimination in the society. As a group they could seek solutions and apply them individually. A separate training session was organised targeting single members living with HIV/AIDS.

After the training, NAPHAM members intensified positive living awareness and the benefits of disclosing HIV status to a partner. Regular supportive counselling targeted positive members and was expanded to their partner (non-members). Positive living materials were produced and distributed to members and their partners.

Training was also organised to equip leaders from the 6 branches of NAPHAM. The training focused on group therapy facilitation. Group therapy sessions take place every Saturday where people living with HIV/AIDS have a chance of sharing concerns and coping mechanisms and as a group they seek solutions to problems that come due to their HIV status.

Results

65% of male members introduced their partners to NAPHAM for continued psychological support. Men were able to allow their partners to participate in positive living sessions. There has been a reduction in complaints from

female members on the issue of husband not willing to follow positive living measures especially condom use. There has been an increase in male membership - after understanding the importance of belonging to a support group. Membership of NAPHAM increased and people are able to disclose their status wherever necessary. Members have reached a point of educating others on benefits of knowing HIV status and disclosure. NAPHAM assessment revealed that members are able to cope with HIV after accepting the situation of being infected and have hope to live.

Conclusion

Acceptance, hope and information on care and support are key factors leading to positive living. Disclosure of HIV status to relevant people especially family members is important. Support groups of people living with HIV/AIDS are conducive places for infected people to share concerns and find comfort from one another. These support groups should be formed in all levels to facilitate positive living among the people i.e. in companies and communities.

3. I am Thine Brothers Keeper

By Believe Dhliwayo, The Centre, Zimbabwe

Five reasons why we should focus on the boy child in our quest to be truly thine brother's keeper

1. Boys' health is important but receives inadequate attention. The boy child copes less effectively in stressful situations, such as living with AIDS, than the girl child.
2. Boys behaviour puts them at risk of contracting HIV. Boys are more likely to engage in risky activities, they compete in doing the most wildest things not even recorded in the Bible or anywhere else in our African culture.
3. The boy child's behaviour puts the girl child at risk. On average, young men have more sex partners than young women. HIV is more easily transmitted sexually from men to women than vice versa. A young HIV+ man is likely to infect more people in his life time than a young HIV+ woman.
4. Unprotected sex between men endangers both men and women. Most sex between young men is hidden, but its happening. Note sex between men is safe as long as protection is used, and it is very natural for one to have feelings for men not for women.
5. Young men need to give greater consideration to HIV/AIDS as it affects their future and family too. Future fathers should be encouraged to consider the potential impact of their sexual behaviour on their partners and children - including leaving orphans and introducing HIV into the family.

Genuine efforts of thine brother's keeper should aim to focus on six areas of action

1. Mobilise community leaders and NGOs to bring HIV/AIDS campaigns to all social and cultural events where the audience is mostly men such as sports events and recreation halls.
2. Lobby for policies and programmes to increase access to high quality VCT for young men and provision of other psycho social services to compliment VCT initiatives.
3. Promote programmes and client friendly services that respond to the special health and reproductive needs of the boy child.
4. Lead efforts to raise awareness of the higher risk of HIV Infection facing young men in special settings.
5. Support efforts to change attitudes and practices that link boy child's masculine identity to practices that undermine HIV/AIDS prevention measures such as using condoms.
6. Promote programmes that raise awareness of the boy child regarding the consequences of their sexual behaviours and on the danger of leaving behind orphans and destitute families.

Conclusion

- ✂ It should be a collective responsibility to focus on the boy child's' needs.
- ✂ Let's invest in their wellness and avoid unnecessary costs.
- ✂ Remember they are the fathers and leaders of tomorrow.
- ✂ Lets strive to have an HIV/AIDS free generation of tomorrow.
- ✂ Keep asking yourself: Am I thine brothers keeper? Start being one now if you were not.

Enlisting Men B - Prevention & Advocacy

4. The Role of the HIV Co-ordinator in Addressing Men's Issues

By R V Kavendjii, Omaheke Regional Council, Namibia

In March 1999, the president of Namibia Dr Sam Nujoma launched the national strategic plan on HIV/AIDS. The medium term plan 2 (MTP2) is a five-year action plan for a multi-sectoral approach - everybody should get involved with the implementation.

The role of the HIV Co-ordinator is

- ✂ Co-ordinate regional structures to ensure implementation of regional HIV/AIDS action plans.
- ✂ Develop a sound transparent mechanism for resource mobilisation, allocation and utilisation.

- ⌘ Ensure support to the infected and affected people in the region.
- ⌘ Improve access to affordable condoms within the region.
- ⌘ Collaborate with all sectors to ensure a multi-sectoral response to the HIV/AIDS epidemic at regional and local levels.
- ⌘ Address the cultural and traditional set up.

It is well known that men should be involved in articulating and addressing HIV/AIDS problems within their respective communities. However, getting men involved is not an easy task. A considerable effort was needed and our approach was to establish constituency HIV/AIDS committees.

After the formation of the committees, we noticed that men represented the majority members of the committees. So, we initiated programmes aimed at involving men. For example, men facilitating workshops, men leading social mobilization campaigns, letting men demonstrate both male and female condoms.

Our target is as follows

All line ministries • NGOs, CBOs • schools • truck drivers • old people/youth • churches and their congregations. It is not easy to have a committee consisting only of men as men per se are not supportive enough to run a committee alone. I think that there is a need to also consider women when setting up committees. My final recommendation is to come up with workable strategies that will enable us to get men involved in the fight against HIV/AIDS.

5. Challenging Men to be Responsible

By Priscilla Mataure, SFAIDS, Zimbabwe/Regional

What/who is a man?

Powerful • Protector • Provider • Leader • Risk taker

Where were such men found?

South Africa • Swaziland • Zambia • Zimbabwe • Namibia • Lesotho • Botswana

How were they found out?

- ⌘ Men have a big role to play in HIV/AIDS prevention.
- ⌘ SFAIDS began to catalyse Southern Africa partner organisations to meet in workshops to discuss how to incorporate this focus on men into their programmes.
- ⌘ Explored the dynamics of male sexuality and behaviour as well as interventions to target men.

Issues

- ⌘ Many men and women think that it is “natural” for men to have more sexual partners or that a man’s sexual drive is so strong that it cannot be controlled.
- ⌘ Attitudes towards risk taking lead many men to reject condoms and consider STIs as no more than an inconvenience. They do not recognise that their partner/s may be HIV+.
- ⌘ Men hold very strong internalised and self centred sexual beliefs and gender stereotypes that they use to justify their behaviour.
- ⌘ Their power is misdirected.
- ⌘ Although viewed as protectors, they perpetrate violence against their loved ones.
- ⌘ As protectors, they fail to protect women and children against HIV infection.
- ⌘ Many men believe that control of women’s lives is an essential element of masculinity. When they feel they are losing this control - particularly when they abuse alcohol and other drugs - some men resort to violence towards their partners.
- ⌘ Men’s lack of understanding of women’s sexuality is one factor, which prevents them from understanding the best way to protect themselves and their partners from HIV.
- ⌘ As leaders and fathers, they are not role models to children and do not provide guidance and overlook planning the future of their families even when their HIV+ status is known.

Issues Around Gender Roles and Care

- ⌘ Men do not adequately share domestic chores or household tasks. These are designated “unmasculine”.
- ⌘ This excludes their involvement in home care for people dying from AIDS, even for members of their own families.
- ⌘ Men consider “nursing work” to be women’s work; it is low status and menial.
- ⌘ On the other hand, women also feel threatened when men step into their “domain”.

What are the challenges?

- ⌘ How do we go about changing men’s behaviour when his stereotypes are supported by women themselves?
- ⌘ Men’s behaviour is a result of many factors which are influenced by situations at that point in time, e.g. intoxication, peer pressure, etc.
- ⌘ Behaviour change choices in most African countries are limited by many factors which have a colonial legacy such as racism, sexism, poverty and therefore gender equality.

Therefore...

- ✘ Address policy makers, raise awareness and advocate for their support for male involvement in HIV/AIDS prevention, care and mitigation.
- ✘ Lobby for the support and development of appropriate policies and mechanisms (at community level) that support gender equalities.
- ✘ Appreciate differences between men and women.
- ✘ Boys can be taught through example, to respect women and not see them as sex objects.
- ✘ Men need non-threatening environments to explore and talk about their sexuality, to increase their participation in the discourse around HIV prevention.
- ✘ Mode of presentation of messages has a lot to do with how information is assimilated, believed and used.
- ✘ They should be engaged in dialogues on gender inequality and its costs to men, women and society at large.
- It is acceptable for men to feel masculine, but the definition of masculinity should change.
- ✘ Change norms and all the difficult issues we are not currently addressing.

6. Risk Taking Behaviour of Migrant Workers

By Phineas Murapa, PriceWaterHouseCoopers, Zimbabwe

Special reference is made to the Murowa Diamonds mine (still under development) in Zimbabwe. The argument put forward is that prevention must be at the forefront both for the employees and the hosting community.

Brief description of the problem

Traditionally health and safety policies at mine houses, due to the machinery used, have been associated with the prevention of injuries. Diseases such as STIs, Acute Respiratory Infections (ARIs), TB and HIV/AIDS although recorded in the policy frameworks were not given prominence in the Environmental Health Support (EHS) actions the mine would take towards their prevention or treatment.

A new mining concept, the commute system, where professional and skilled staff will stay in the mine village for 14 days after which they will be given 7 days off to go home before they come back in again for another 14 days, is being introduced in Zimbabwe. Unskilled workers will be recruited from the neighbouring community. By nature of mine operations, the majority of all staff will be male.

The problem and hypothesis to the presentation is that mining houses are poorly equipped to effectively deal with issues related to the pandemic, and that the introduction of the commute option will compound the high levels of infection and new infections, posing a health risk to the host community and the mine's own personnel.

Description and results of the project

The health risks were examined within the contexts of community vulnerability, environmental receptivity and the capacity and preparedness of the mine and the community at large to respond to the health risks.

- ✘ Staff at the local health centre where the mine is located have reported an increase in the number of STD's among contract staff.
- ✘ Contract staff avail themselves more for treatment than locals who fear stigmatisation.
- ✘ Increase in cases of STIs reported in the first two months at the start of the project.

The impact of the project with regards to community vulnerability goes beyond the project boundaries as infected partners are likely to infect their spouses during the 7 day period that they visit their homes. Most mines terminate services of employees with serious conditions (TB, HIV/AIDS). Such employees vacate mine premises after award of terminal benefits and end up in the care of public health service providers, or relatives in rural communities. There is little or no after employment care and little or no psycho-social assistance.

Lessons learnt and implications for the future

New mine developments pose a health risk to communities. Mine houses are not adequately prepared to deal with the spread of HIV/AIDS to its staff, their families and the community.

What to do: Smart 1999c Core elements of HIV/AIDS work place programme

- ✘ Develop programme document
- ✘ Awareness activities
- ✘ Peer education
- ✘ Training of trainers
- ✘ Condom promotion
- ✘ Condom distribution
- ✘ Voluntary counselling and testing
- ✘ STI management
- ✘ Infection control for occupational risk
- ✘ Wellness programme
- ✘ Programme monitoring

Enlisting Men C - Marketing

7. Men, Sex and HIV/AIDS

By Regis Mtutu, Padare/Enkudleni/Men's Forum on Gender, Zimbabwe

Padare is an anti sexist group started by Zimbabwean men in 1995. Padare is committed to developing a men's movement that contributes to the elimination of discrimination against women and to promote ideas and actions that enable the participation of men in the struggle for a gender just society. The organisation takes its name from the Zimbabwe tradition whereby men gather around a fire or under a tree in order to discuss local issues and make decisions about the community.

The goal of Padare/Enkudleni is to subvert this exclusively male tradition and bring men together to discuss cultural and social issues related to gender justice and equality inclusive of all members of the community.

At Padare we believe that any policies and programmes on HIV/AIDS should aim at eliminating power imbalances between gender roles. Zimbabwean men have been brought up in a society that promotes a culture and attitudes based on the domination of women by men. Gender roles do play a significant role in the spread of HIV so Padare has taken a gender perspective, and this should contribute to the design of policies and programmes ideas and actions for combating the HIV/AIDS epidemic more effectively.

Padare seeks to challenge the destructive traditional and false perceptions of manhood. Some of these notions are the belief that having multiple sex partners is a sign of strength, that as men we have a right to be the only decision makers in matters of sex, contraception and so on. This inequality between men and women fuels the spread of HIV/AIDS.

Padare has created platforms where men critically reflect on our own gender roles and how these can contribute to the arrest of the AIDS pandemic. Men are best confronted with the devastating results of our assumptions and behaviour, not by women, not by the media, not by the press which often ignores us, but by other men.

How has Padare done this?

We have come together as men and we talk, talk and talk, and talk: about our assumptions on sex, women that have made us oppressive and unhelpful in creating a meaningful response to HIV/AIDS.

Discussions have centred on how to bring out specifically male related aspects of the pandemic such as the macho identity, masculinity, the "sugar daddy" syndrome, domestic violence and traditional beliefs. We have opened debate among men and how we can change men's sexual behaviour and attitudes towards sex.

Basically by being in a group of men, in a non-threatening environment - always in pubs - Padare members became confident to talk about issues. We opened debate and provided strong support where we attempted to divorce masculinity from sexual prowess.

We have formed our own "boozers team" soccer team where we challenge other men's teams at social soccer. While we play the game some members run around the pitch with messages such as "Real Men care do you", and "Men of quality score a goal for equality" and "Men can make a difference". We also hand out leaflets and after the game - if we are the hosts - we have our beers and start discussing men's sexuality, responses to HIV/AIDS and so on.

Conclusions

We have seen that it is possible that men can have a deeper understanding of the connections between gender inequality and HIV/AIDS. It is also possible for men to take practical steps that can lead to attitude and behaviour change particularly around risky sexual practices.

The Future

- ⌘ We need as Padare to learn what men want and need.
- ⌘ We need to present men as caring partners and not adversaries, encourage men to talk about sex to our partners and make joint decisions on matters of sex.
- ⌘ We need to publicise and promote services such as Padare, and make these more visible.
- ⌘ We need to work with opinion leaders, young men and above all continue to learn.

In Padare we believe

Men Ought To Change, Men Can Change, Men Must Change

8. Fat Thighs Make for Record Condom Sales

By Sam Connor, PSI, Malawi

Brief description of the problem

Unprotected sex is rampant in Malawi. While ever-use of condoms is reasonable, consistent every-time use is very low. HIV continues to spread through unprotected sexual acts. The problem to be solved is to convince men to want to use condoms and thereby increase the number of protected sex acts, reducing the rate of infection.

PSI Malawi introduced the first condom into Malawi in 1994. It was branded Chishango - meaning "shield" in

Chichewa. This condom sold over 36 million units in the ensuing 7 years. When launched the brand was marketed to all sexually active people, and the imagery for the packet itself was very staid, showing a couple in silhouette, holding hands in a very impersonal manner.

While brand recognition of the Chishango condom was already incredibly high (98% brand awareness by the government DHS 2002) and people preferred it to any of the unbranded government condoms, focus group work by PSI demonstrated that this brand was not pulling in new users. In fact it became clear that the young men felt that this condom was “for our dads” and did not appeal to young men in the least.

Description and results of the project

The challenge was to reposition the brand and create a lifestyle positioning. After extensive creative development using various cross-sections of male society to inform the process, a new design for the package, size and shape of the box, new dispenser, instruction leaflet inside and massive advertising campaign were all launched in May 2003. The resultant scandal in Malawian society clearly showed the hypocritical tendencies of the guardians of culture - the outcries about the “fat thigh” on the cover are from the very same crowd that is no stranger to illicit behaviour.

In addition to breaking all previous sales records (up 600 000 units to 1.4 million in the first month) the New Look Chishango has broken the silence in the media and in the living rooms on the topic of HIV and sex. Various aspects of this rich debate can be explored further within a participatory workshop session.

9. South African Men's Forum

By Mbuyiselo Botha, SAMF, South Africa

The SAMF is a movement of men which aims to achieve and promote human dignity. The SAMF is establishing remorse centres to counsel men who are emotionally abused by their partners. The centres will be countrywide. Male social workers and psychologists will be providing counselling services. The forum will use community buildings such as churches for counselling.

Men in our society are invited to take part and make a difference in their respective communities. The SAMF visits prisons to counsel the inmates. Once inmates are integrated into the larger society, the forum intends using them as agents to spread the message of morality and the benefits of a violence and crime free society.

The SAMF has established a shebeen project as a strategy to communicate to men about the plight of women and children in our society. Renowned South African actors Sello Maake Ncube and Patric Shai are instrumental in this project. As most men spend their time in pubs, shebeens and taverns, the forum visits these places and talks to them.

The SAMF also attends religious gatherings. The objective is to work together in sensitising men about problems of crime and abuse. The organisation has already met Bishop Mvume Dandala of the Methodist church and Ray McCauley of Rhema Ministries.

The SAMF is perceived as a reactive organisation. This is not true. The organisation has joint marches with women's organisation such as People Opposing Women Abuse (POWA) and Agisanang Domestic Abuse Prevention and Training.

Violence and crime have become one the greatest threats to South Africa's new democracy. Although it is a problem facing everyone in society, the vulnerability of women, children, elderly people, and people with disabilities makes them a cause for special concern. This is why the SAMF was established on the 4 December 1997.

The SAMF is committed to working vigorously against crime, violence, rape, spouse abuse, sexual harassment, child molestation, discrimination on basis of gender and other forms of brutality, subjugation and dehumanisation of women and children. As well as seeking to initiate and support programmes and interventions aimed at affirming, securing and promoting the dignity and integrity of our women folk as well as boy children and girl children.

The SAMF believes that it has to achieve a major shifting of attitudes and massive fundamental change in behaviour among men in our communities.

Good men of our nation are being asked to use their power, influence and the resources legitimately at their disposal to support the SAMF mission of restoring the soul of the nation.

The SAMF is one demonstration that men are willing to comfort their shortcomings and strive towards a better future for themselves and society.

Men's Summit

The Men's Summit was held in April 2001. The purpose was to mobilise men with the view to engage them in problems facing the country. The major problem South African society faces is moral decay - the Summit aimed to challenge this situation.

Topics included

- ✂ What is a South African man?
- ✂ What are the challenges facing men?
- ✂ The myths that undermine manhood.
- ✂ Cultural issues facing men in the world today.
- ✂ The role of socialisation and its impact.

At the end of the summit, projects were identified. These projects were aimed at focusing on education of men around domestic violence, rape, women and children abuse and job creation.

Enlisting Men D -ASOs/Home Based Care

10. Less Participation of Men in Home Based Care Activities - a Case of Choma District

By Ian Milimo, Kara Counselling and Training Trust, Zambia

In 1997 Kara Counselling and Training Trust opened a branch in the Choma District (Southern Province of Zambia) to address the HIV/AIDS pandemic in the District and to eventually extend the services to the whole Southern Province.

Home Based Care (HBC) services had been previously offered by the staff at the General Hospital, but this care had discontinued. As a result, terminally ill patients were being discharged and sent home to relatives who did not have the skills or the expertise to care for them. People looked to Kara staff for provision of the necessary continuation of care. Having assessed the situation and discussed with all the stake holders, it was decided that volunteers from the community would be the best way forward.

A training course was designed with the following topics

- ✕ How to care for the terminally ill.
- ✕ How to control pain.
- ✕ When to refer to the hospital or clinic.
- ✕ Basic counselling skills in helping the client to open up.
- ✕ Basic skills to help the client plan for the future and draw up a will.
- ✕ Basic skills to help the client prepare for death.
- ✕ Basic skills to help the family cope with sickness, death and bereavement.
- ✕ Knowledge of HIV/AIDS.

Reasons men do not participate in HBC

Men do not participate due to cultural reasons and socio-economic factors. Generally, African people have a specific socialisation regarding the different roles and responsibilities of each family member. Women have always been carers both within the family systems and in society. For this reason they continue to take an active role in HBC. It has been observed that there are some men who would like to get involved in HBC activities, but are afraid of what other males would say. This is why there has been very few Zambian males joining the nursing profession. However, the trend is changing.

As the head of the family, most men would prefer to engage themselves in activities that enable them to have money to support the family. As HBC operates on a voluntary basis, men would rather leave this to their female counterparts. In Zambia, 80% of people live below the poverty datum line as the majority of the adult population is out of work. This puts most men in a very difficult predicament.

Strategies used by Kara Counselling to encourage male participation in HBC

As Kara is a community-based project we could not work in isolation. Therefore, we approached existing institutions with letters of invitation to identify suitable individuals to be trained. This is one of the best ways of involving men in HBC training and work. After training, these men are encouraged to work hand in hand with Kara and the institutions that sent them.

Open days

Another strategy that has brought positive results is convening open days/workshops. During open days, the public is given an opportunity to ask questions with regards to HIV/AIDS, HBC and other services that Kara offers. Most people have a lot of misconceptions and until they are told details, they do not get actively involved. After such an event a lot of men come to register while others come to test for HIV/AIDS.

Enhanced outreach programmes

Outreaches have been conducted in different sections of society. The Post Test Club - composed of boys and young men between 19 to 30 years of age - members who educate the public using drama and songs always accompany the outreach officer. We usually have a lot of inquiries about our programmes after a performance.

Provision of bicycles to facilitate transport

After a group has graduated from our HBC course, we provide them with bicycles. In addition to the official use, care givers are also allowed to use the bicycles for their personal ventures. This is one way we have managed to attract and motivate male care givers.

Subsidising the training costs

Each participant only pays a \$4 commitment fee to be trained (the actual cost is about \$25 per person). In some special cases, even the commitment fee is not charged (especially to those who come through churches). We also organise training exclusively for men and exempt them from paying fees because we want to get them involved. This has also proved effective in attracting male involvement.

Distribution of HBC brochures and flyers

We distribute brochures and flyers advertising the various services we offer. This enables us to reach many people in the district. Our aim is to start producing newsletters and other materials in local languages. We also use the local radio station to advertise our services.

The way forward

There is great need to change our cultural beliefs and practices, especially those that reflect ignorance, stigma and denial about HIV/AIDS. Without the active participation of men in both preventive and care programmes we are bound to lose the battle against HIV/AIDS. All men need to be actively involved in these programmes just the way they are actively involved in spreading the pandemic. Let us not leave our wives, sisters, nieces and daughters to fight the battle alone. Let us, as men take a leading role in this fight.

Conclusion

Strong negative traditional values can hinder progress in this fight. For us to win the fight and start to see more men get involved in caring for the sick, we need everyone to participate. Our traditional leaders need to be involved in the education of their subjects. We need to come up with deliberate strategies to sensitise the public on the dangers of continuing our cultural orientation of children. It is hoped that if cultural orientation does not segregate roles in a family according to gender, then we would have men getting involved in the so called "roles for women".

11. The Challenge of Incorporating Men in HIV/AIDS Related Activities Within the Tovwirane Organisation

By Stephen Gichuki, Tovwirane HIV & AIDS Organisation, Malawi

Tovwirane is a community based organisation that was established in 1993 and is run by volunteers. Its objectives are to mitigate the social impact of HIV/AIDS by strengthening the ability of the local people to provide awareness, care and support among those infected or affected by HIV/AIDS.

There are 5 programmes

- ✂ Home based care programme
- ✂ Orphan care programme
- ✂ Counselling programme
- ✂ Income generating activities programme
- ✂ IEC programme

Activities

- ✂ Increasing awareness on HIV/AIDS and VCT.
- ✂ Establishing a workable home based care system in the villages.
- ✂ Identifying and supporting orphans with vocational skills.
- ✂ Identifying and supporting baby orphan guardians with nutritional support.
- ✂ Reducing village level poverty by provision of Income Generating Activities (IGAs) loans to volunteers.
- ✂ Support to the community with counselling services.
- ✂ Support to PLWA.

Incorporating men in HBC and PLWA activities

The main challenge was to recruit men in care giving activities in a situation where cultural beliefs regarding the role of men in society are very strong. Roles such as home based care are seen as a woman's job.

Approaches used

- ✂ Incorporating men in village's HBC committees so as to play a greater role in care giving.
- ✂ Emphasise the role of men as fathers.
- ✂ Raising awareness between men's behaviour and HIV through PLWA outreach activities.
- ✂ Emphasis on masculine attributes as protectors.
- ✂ Use of condoms.
- ✂ Encouraging HIV+ men in the PLWA group to make provision for their children when they die.

Challenges

- ✂ Traditional expectations, e.g. men should take risks.
- ✂ Cultural practices, e.g. wife inheritance.
- ✂ Stigma
- ✂ To get HIV+ men to come out in the open for proper targeting.

Achievements

- ⌘ Among 520 care givers 208 are men.
- ⌘ Among 90 PLWA 18 are men.
- ⌘ Greater involvement of men in home based care.
- ⌘ Improved membership of men in PLWA group.
- ⌘ Increased number of young men who join the care givers committees.

Lessons learnt

- ⌘ When incorporating men, select those who have flexibility in time availability.
- ⌘ Focus on men who are respected in the community.
- ⌘ Work closely with community leadership especially when selecting men for HBC.
- ⌘ Make utilisation of men who are motivated by compassion.

Rapporteur Report, Day 1

PLWA

GIPA is widely recognised as an effective and ethical intervention. It adds credibility to HIV/AIDS programmes by giving a face to HIV and personalising it.

GIPA Fieldworkers

- ⌘ Help create an enabling, non-discriminatory environment.
- ⌘ Set up, review or enrich work place policies and programmes.
- ⌘ Act as role models to de-stigmatise the disease.
- ⌘ Communicate policies to employees.
- ⌘ Assist in the implementation of programmes (peer education, counselling).

Outcomes of the model

- ⌘ Use the experience of PLWA to give a face to HIV and to normalise HIV infection.
- ⌘ Contribute towards a less stressed and more productive workforce.
- ⌘ Create a supportive work environment for PLWA within workforces.
- ⌘ Contribute towards reducing health care costs.
- ⌘ Utilise the special skills and experience of the GIPA Fieldworker.

Training needed

- ⌘ Computer skills
- ⌘ Setting up sector-specific work place programmes
- ⌘ Office management
- ⌘ Running support groups
- ⌘ The HIV/AIDS disease profile
- ⌘ Caring issues
- ⌘ Succession planning for children

NAPHAM is a positive living programme targeting HIV+ men and their spouses in Malawi. 90% of HIV+ men do not disclose, therefore wives/partners have no support. NAPHAM has had success - 65% introduced partners to NAPHAM for continued psychological support. NAPHAM positive living training includes nutrition, medication, peace of mind, common opportunistic infections, stigma, discrimination, etc.

- ⌘ Older men must act as role models for the boy child, teaching not to engage in risk taking behaviour.
- ⌘ Boys less likely (than girls) to seek help.
- ⌘ Boys more "active" thus greater chance of infection, in turn endangering the girl that they are involved with.
- ⌘ Sex between boys takes place, but not spoken about or dealt with.
- ⌘ Future fathers must consider the impact of their sexual behaviour on their families.

Efforts of Thine Brother's Keeper (and others) should aim to focus on

- ⌘ Mobilise community leaders, NGOs and ASOs to bring HIV/AIDS IEC campaigns to all social and cultural events where the audience is mostly men such as sports events, recreation halls, etc.
- ⌘ Lobby for policies and programmes to increase access to high quality VCT for young men and provision of other psycho social services to compliment VCT initiatives.
- ⌘ Promote programmes and client friendly services that respond to the special health and reproductive needs of the boy child.
- ⌘ Lead efforts to raise awareness of the higher risk of HIV infection in young men in special settings.
- ⌘ Support efforts to change attitudes and practices that link the boy child's masculine identity to practices that undermine HIV/AIDS prevention measures such as using condoms.
- ⌘ Promote programmes that raise awareness of the boy child on the consequences of their sexual behaviours and

on the danger of leaving behind orphans and destitute families.

Prevention and Advocacy

The key message was that everyone should get involved in the fight against HIV/AIDS. A multi-sectoral approach was needed and men should be in the mainstream of the movement. Societal and cultural norms - such as it is "natural" for men to have more sexual partners than women and that if men take on domestic roles they are "unmasculine" - are deeply entrenched and believed by both men and women. To change men's behaviour these stereotypes need to be challenged by empowering both men and women. We need to look at changing the definition of masculinity and we need to focus on educating boys. All of us need to start at home with this, empower our boys and girls alike.

The colonial legacy was touched upon with a presentation on migrant labour. The new commute option increases levels of infection and the mining industry is poorly equipped to deal with the problem.

Marketing

This section dealt with engaging men to talk about sex/sexuality. Platforms are needed to encourage men to talk. Gender issues need to be discussed and new perspectives created that challenge the norms. Men need a forum where they feel comfortable expressing themselves and can talk about sexuality and sexual behaviour.

The PSI condom marketing in Malawi discussion revolved around the controversial packaging and marketing using an image of "fat thighs" to sell condoms. PSI has encouraging statistics of increased condom sales as a result of the new branding but there were questions around monitoring usage and education on correct usage. The branding may also perpetuate gender stereotypes as it is in contradiction with the need for men to change their orientation and not see woman as sexual objects. It was suggested that branded condoms would sell just as well.

ASOs/HBC

This session looked at the challenges of involving men in HBC and the strategies to overcome these challenges. Malawi, Namibia and Zimbabwe all experienced similar issues. Involving men not only reduced the burden on women, but also had specific advantages as men often found it easier to discuss certain issues with other men.

The main challenges are

Cultural - women are socialised to be carers, while men are expected to provide for their families. Even if men want to be carers, it may be difficult for them due to cultural pressure. Some HBC activities may be very difficult for men to undertake.

Socio-economic - there is an expectation that men will earn money rather than undertake volunteer work. This is even more difficult in situations where there is high unemployment or food shortages.

Strategies to overcome these issues

- ✂ Involve men through existing institutions, e.g. churches.
- ✂ Involve respected male members of the community such as head men/elders.
- ✂ Involve respected medical professionals.
- ✂ Provide incentives such as bicycles and subsidised training.
- ✂ Hold open days and music workshops to ensure the public understands the importance of HBC.

Day Two, Wednesday 12 February, Sexuality & Boy Child

1. Challenges of a Gay Man in African Society

By Ian Swartz, TRP, Namibia

Gay Men and the Challenges they Face in Namibia:

The African Continent is in no way friendly to lesbian, gay, bisexual and transgender (LGBT) communities. This presentation focuses on gay men and their access to, or rather lack thereof, health services and how this affects the way in which they deal with HIV/AIDS.

- ✂ Two years ago Egypt made it into the International news when 52 men were arrested on the suspicion of being gay. There was no evidence, none of these men admitted to being gay; none of them were caught in the act yet police were able to detain them for some time. In the court case that followed some were fined and others imprisoned.
- ✂ In the Ivory Coast, a few brave gay men have been trying to draw the International World's attention to the fact that transvestites are regularly arrested and detained just for wearing female clothing.
- ✂ In Uganda, a professional woman recently "disappeared" after giving an anonymous and exclusive interview to a supposedly credible newspaper to try and explain the situation of LGBT people in the country. After a journalist outed her to her family and the wider public, she not only lost her job, but really disappeared and has to this day not been found.
- ✂ Zimbabwe has become famous for its President's homophobic stance and the infamous "worse than pigs and dogs" speech. The LGBT community still suffers great discrimination, but has disappeared in the marsh of human rights abuses.
- ✂ The Namibian President runs a close second to Robert Mugabe. His "arrest them, detain them and deport them" speech is well known, but not as well as Jerry Ekandjo, Minister of Home Affairs', speech in which he told 700 police cadets that "gays should be eliminated from the face of Namibia".

Even though organisations such as The Rainbow Project (TRP) in Namibia and Gays and Lesbians of Zimbabwe (GALZ) are seriously advocating for legal reform, in which progressive laws will protect all minorities, the South African situation clearly shows that the change of laws does not mean a change in attitudes. LGBT people all over South Africa, in rural and urban settings report various forms of discrimination and abuse. It is clear that with the change of laws must come a serious campaign in which people are educated as to why these laws are needed.

Sexuality, sexual identity and sexual orientation are not clear-cut issues. We often forget that sexual orientation does not necessarily determine sexual behaviour. Most gay men are not effeminate and cannot be identified as gay by just looking at them. Many heterosexual men do at times behave as what is seen as an effeminate manner and can wrongly be identified as being gay. Many gay men are married often with children, which makes it very difficult to detect them. Clothing styles and wearing of jewellery, particularly earrings, is not an indicator of a person's sexual orientation. Many men who have sex with other men do not identify as gay. We must also not forget that in settings such as prisons and mining camps, many heterosexual men engage in homosexual acts. The perceived distinctions between homosexual and heterosexual people are not as clear as most people believe.

What does this all have to do with the HIV/AIDS pandemic? We are all aware of the stigma and discrimination people living with HIV/AIDS face or experience in their day to day lives. Being HIV+ and gay translates into double the stigma and discrimination. As gay people we are often pushed to the edge of society. Being positive as well seems to push us over the edge. Gay men, even in spaces where they are supposed to be safe, are forced to be silent. Even in LGBT communities, positive gay men are being ostracised, cutting them off from what often is their only source of support.

For out positive gay men, access to public health services in Namibia, is a challenge. In Namibia at present, the treatment of HIV/AIDS does not go further than providing vitamins and painkillers. The majority of gay men are not able to obtain even this meagre treatment. They are turned away from clinics and hospitals with derogatory remarks such as "your types the President does not allow here". In most cases these men are turned away before even seeing the doctor on call, often after spending most of the day in a queue. When they do get attention, it is often embarrassing. Nurses call other health workers to see that the male has the STI "at the wrong end" or "look who has AIDS". Because the community is small and people often know each other, this information is shared with family and friends of the gay person thereby disclosing the person's HIV status. Similar scenarios present themselves in other African countries. On the odd occasion when gay men do have access to services, they often don't use it.

This problem will prevail unless HIV/AIDS organisations do away with what is perceived as acceptable sexual practices/behaviour and LGBT people and other minorities are included their work. Only then will we successfully fight this pandemic.

2. HIV & AIDS, Implications for Male Sex Work

By Prof Michael Herbst, UNISA, South Africa

Background

Evidence of male sex work has a history as long as female sex work. However, male sex workers have not received the same attention from researchers as their female counterparts. This is despite the large numbers of male sex workers in cities all over the world who potentially contribute to sexually transmitted infection rates including HIV.

It is known that wherever indiscriminate sexual activities take place, the risk of transmission of infection is greater. The activities between male sex worker and his client/s determine the health problems they are exposed to.

Purpose of the Research

- ✂ What transpires between male sex workers and their client/s.
- ✂ What health risks they and their client/s were exposed to.
- ✂ What could be done to empower male sex workers to protect their own health as well as the health of their client/s.

Research Methodology

The study followed a qualitative research design. The following strategies were employed: description; ethnography; phenomenology, and the biographic method of qualitative research.

Data collection was done by means of phenomenological semi-structured in-depth interviews with informants. A total of 58 informants were interviewed. Only information that could be corroborated was included in the research. Additional data was collected by means of participant observation in places where male sex work occurred.

Main Findings of the Research

Categories of Male Sex Workers: The following categories were identified: Streetwalkers, Male-to-Male Masseurs, Call Boys, and Super Call Boys.

Procurement of Clients by Male Sex Workers

Places where clients were solicited included: street corners, public parks, gay bars, gay baths, men's toilets, movie houses, pornographic bookstores, bus station, train station.

Reasons for Entering Into Sex Work

Most of the sex workers entered into sex work for the financial reward. Other reasons were preference for having sex with men and difficulty in finding other employment.

Sexual Orientation of Male Sex Workers

A large number of the sex workers perceived themselves as being gay, although some saw themselves as being bisexual or not gay.

Life Traits Common to the Male Sex Workers in the Study

- ✂ The majority were white young men from Afrikaans speaking homes.
- ✂ Most were between the ages of 19 and 25 years (Age of consent in South Africa is 19 and so the researcher could not interview those young men who were under the age of 19).
- ✂ Most of them completed at least 10 years of schooling.
- ✂ Most could not find other employment.
- ✂ Most had good family relationships.
- ✂ Most were either the youngest or oldest of the siblings.
- ✂ Most entered sex work between the ages of 14 to 18.
- ✂ Most of them were introduced to gay sex by close family members - uncles, cousins, brothers, fathers and a grandfather.
- ✂ Most had a history of multiple sexually transmitted infections.
- ✂ A considerable number of them were using hard drugs.
- ✂ Condom usage was generally very poor.
- ✂ Most did not know their HIV status and for a variety of reasons were not interested in knowing their HIV status.
- ✂ Most of them were prepared to have unprotected sex for as little as ZAR10 (± US\$1).

Activities which exposed sex workers to HIV included

Anilingus; Anal Sex; Fellatio (with swallowing of semen); Insertion of objects, fingers, hands, and arms up someone's rectum; contact with urine; contact with faeces; sharing of sex toys; sex and master (S&M) activities with broken skin; bondage and discipline (B&D) activities with broken skin.

The researcher identified a total of 49 sexually transmitted infections to which male sex workers and their clients were exposed. Many male sex workers were either recipients of violence or perpetrators of violence.

Recommendations

- ✂ Regarding factors which hinder delivery of programmes of safer sex to men who have sex with men.
- ✂ Regarding effective responses to programmes of safer sex for men who have sex with men.
- ✂ Regarding structuring, organising and regulating male sex work.

Sexuality A - Sexual Practices

3. Men to Men Transmission

By Pride Simana, Prison and Correctional Services, Namibia

Objectives

- ✂ Mention various methods in which HIV/AIDS is transmitted from men to men.
- ✂ Identify various alternatives of preventing men to men transmission and suggest suitable measures of preventing future men to men transmission.
- ✂ Provide guidance on how to care and support people with HIV/AIDS.

Introduction

HIV/AIDS is a global problem that needs an urgent solution. I believe the main aim of this Conference is to find answers to questions such as; what causes HIV/AIDS, how will we solve it and when? My task is to tackle the problem of HIV/AIDS transmission from men to men.

Methods of HIV/AIDS Transmission (Men to Men)

- ✂ Sharing of razor blades, hair cutting machines and instruments used for tattooing. The virus can be transmitted through infected blood left on the instruments. Prison inmates are forced to share because only a few of them have access to these instruments. Government can not afford to provide each inmate with his own cutting machine. Razor blades are only supplied once per month, therefore inmates end up sharing.
- ✂ Sodomy (men having sex with men). Inmates engage in homosexual activities thus helping to spread the disease. Homosexuality is regarded as a criminal offence in Namibia and therefore condoms are not provided to inmates. It is believed that should condoms be provided it might promote sodomy. Those inmates already living with the virus cannot be separated from other persons in prison on the grounds of their HIV/AIDS status as this is unjustified and is therefore not permitted.

Prevention Methods

- ✂ Encourage individual hair cutting machines and razor blades.
- ✂ Discourage tattooing. (This can be done by teaching inmates how the HIV virus is transmitted; e.g. through infected blood contact. Also by telling inmates to cover all cuts and wounds with waterproof plasters. If no plasters are available, a piece of clean cloth can be used.)
- ✂ Workshops with inmates and formation of HIV/AIDS committees in prison. (This can be done by involving inmates in providing skills and information to others in order to prevent them from becoming infected with HIV/AIDS.)
- ✂ Establishment of resource centres within the prison, where men can have access to HIV/AIDS booklets in the language they can read and understand.
- ✂ Conduct demonstration session on proper use of condoms to men in prison and supply each one of them with a condom on completion of sentence.

Through proper counselling, testing and recommendation from doctors, those inmates becoming symptomatically sick should be released from prison in order to have proper support and care from their families.

Counsellors and HIV/AIDS prison committees should organise home visits to any inmate released on his HIV/AIDS status in order to provide physical, medical, social, spiritual and material support to the infected and affected people. Counselling of client, family and care givers at home level should be done. Health education on nutrition and positive living should also be given. Accurate record keeping, e.g. number of visits made and type of services rendered and follow-up on the HIV infected person/PLWA.

Regular annual National and International conferences for inmates should be organised and sponsored by concerned organisations.

4. Same-Sex Sexuality, HIV/AIDS and Public Health in Namibia

By Robert Lorway, TRP, Namibia

Namibian AIDS awareness campaigns, as in many African countries, target persons who are assumed to engage exclusively in different-sex sexual behaviour. As a consequence of this 'heterosexual' assumption, persons involved in same-sex sexual relationships in Namibia are particularly vulnerable to HIV infection since prevention/education initiatives ignore this group. Ironically, while same-sex sexuality is elided beneath prevention/education initiatives that target 'the heterosexual', 'homosexuality' is highly visible in legislative debates where notions of Namibian authenticity are contested. On March 19, 2001, President Sam Nujoma called for the arrest, imprisonment and deportation of all gays and lesbians in Namibia during his address to students at the University of Namibia. Although no official enforcement, arrests, or deportations have yet been made, the effects of publicly expressed homophobia have made particular impact on men who have sex with men (MSM) in the area of public health. For example, persons who are incarcerated in Namibia and involved in same-sex sexual behaviour are prohibited from receiving condoms despite the growing HIV prevalence within the country's 13 overcrowded prisons. Furthermore, national research and public

health efforts in Namibia have left unexplored the areas of male prostitution, sex between occupants of same-sex mining hostels and military bases. In short, there have been no national or regional HIV/AIDS prevention-education campaigns in Namibia that have included any suggestion of same-sex sexuality in their messages.

HIV vulnerability is produced not only through individual decision making but is also greatly facilitated by larger political economic influences. Drawing on ethnographic fieldwork, I discuss some of the daily-lived experiences of black gay and bisexual men and transgender persons living in the Namibian township of Katutura. During interviews these persons stated that they experienced regular verbal, physical and sexual forms of assault by and discrimination from hospital staff, police and National Defence Force officers, church officials and other members of their community. As a result of such systemic homophobia (and racism) in Namibia, black LGBTs encounter specific barriers to employment and access to health care services. Moreover, although LGBT men and women verified for me that they possessed basic knowledge of HIV transmission, their high frequency of involvement in commercial sex work as the only possible source of employment undermined individual safer-sex negotiating power.

5. The Influence of Sexual Practices on the Spread of HIV/AIDS among Youth in Soweto

By Barbara Fisher PhD, University of Witwatersrand, Perinatal HIV Research Unit (PHRU), South Africa

Introduction

South Africa has the fastest rate of HIV/AIDS infection in the world. It is estimated that currently about 5,000,000 adults and children in South Africa are infected with HIV/AIDS. The increasing rates suggest that prevention methods that focus on educating adolescents and youth - initiated by governmental and non-governmental organisations - have increased awareness. Unfortunately, it does not seem to have had an equivalent impact on changing the behaviours of individuals. Some critics maintain that this is because biomedical approaches are employed and that these approaches tend to over-focus on educational strategies and neglect the influence of wider social, cultural and political influences effecting individual behaviour change.

Therefore, it seems necessary to study what motivates individuals to engage in unsafe sexual practices even when they know that they may get infected or that they will spread HIV. It is assumed that men need to be considered in reproductive health and HIV/AIDS issues because they "exercise preponderant power" in nearly every sphere of life, ranging from personal decision regarding the size of families to the policy and programme decisions taken at all levels of government.

The study, conducted in 2001, focused on male sexual practices and their influence on the spread of HIV. The aim is to explore masculine practices that may act as impediments to the practice of unsafe sex and hence expose males to HIV infection.

Methods

The study is anthropological and uses a variety of qualitative research strategies as a means of data collection. These methods were designed to find the meaning of the individuals studied rather than merely describing their action. The method used to determine this included focus group discussions, informal conversations, in-depth interviews and participant observations. Interviews took place with thirty-five high school males, ages 18 to 22 in focus group discussions and twenty-seven unemployed males between 18 and 32 in shebeens and on the street. Focus group discussions were held with Matric students in three different schools in Soweto. Participants, who belonged to three youth clubs, participated in either both focus group discussions and in-depth interviews or in only focus group discussions. Data from personal observations and informal conversations were also used.

Conclusion

The reasons that young males in Soweto engage in unsafe sexual activities requires a more complete understanding of the social context in which they live and how it shapes their perception of themselves and their futures. Clearly having a low degree of self-efficacy results in young men exerting their coercive power in their sexual relations and displaying behaviours associated with hyper-masculinity. It also results in engaging in sexual health compromising behaviours.

This study serves as a pilot for exploring in greater depth issues related to male sexual practices in Soweto. These themes will be used to inform the next phase of the study. Based upon the findings of this pilot study, we have begun to collect additional data from in-depth interviews, conducted with a broader cross-section of men of different ages, socio-economic strata, as well as men who are employed. In-depth interviews are also being conducted with a cross section of women to obtain data on their sexual practices as well as their perceptions of male sexual practices.

Sexuality B - Reproductive Health

6. Using Sports: Community Sexual Reproductive Health and Football Camps

By Clement M Bwalya, YAO, Zambia

Background

✂ Among 15 - 19 year olds, 44% of boys and 56% of girls say they have had sex.

✂ Condom use is extremely low among youth - only 6% of young women and 13% of young men used a condom

- during their last sexual encounter with a non-regular partner.
- ✘ Among sexually active, never married youth, 24% of boys and 13% of girls reported that they had more than one sexual partner in the past year.
- ✘ Sexual activity is high and risk perception is very low among Zambian youth. 64% of 15 - 19 year old girls and 70% of boys think they are not at risk of contracting HIV/AIDS.

Why involve Men in RH?

- ✘ Men are more likely to infect their partners with STI/HIV/AIDS than women. 19% of male respondents believed that a man cannot be satisfied with one wife and only 35% thought being faithful to one sexual partner reduces one's risk of contracting the HIV virus.
- ✘ Knowledge about HIV/AIDS is high among men in Zambia. 90% of male respondents have heard about AIDS and 86% of both rural and urban male respondents thought HIV can be avoided.
- ✘ The common ways reported were: Abstinence (87%), No casual sex (74%), One faithful partner (85%) and Consistent condom use (67%). Of these only 30% reported to have used a condom during their last sexual contact (non-marital relationship).
- ✘ Men usually view matters concerning sex education, family planning and child health in the family as a woman's responsibility.
- ✘ Men play important, often dominant roles in decisions which are crucial to women's and adolescents reproductive health.
- ✘ Men have the potential to be key role models for their children.

Male Involvement and Women Empowerment

- ✘ Inequities in power often make women vulnerable to men's risky sexual behaviour and irresponsible decisions thus the need for their empowerment.
- ✘ If women are to be empowered with negotiation/decision making skills and if we were to increase their self-esteem, then it is imperative that men understand and appreciate this.
- ✘ Ignoring men would only perpetuate the problems being faced by the women at the moment (increase in sexual violence, wife battering, multiple relationships, etc.).
- ✘ Women empowerment cannot be achieved without the involvement of men in the process

Project Goal

To increase men's participation in sexual and reproductive health, HIV/AIDS prevention, family planning and child health issues in their families/communities through sports.

Objectives

- ✘ To increase young men's knowledge on SRH, STI/HIV/AIDS, prevention and family planning.
- ✘ To promote safer sex and improve young men's skills in using condoms.
- ✘ To equip young men with life skills such as decision-making, goal setting and self esteem.
- ✘ To promote parent to child communication on issues concerning SRH.
- ✘ To promote youth friendly health services for young men to access.
- ✘ To promote voluntary counselling and testing, and encourage communities to mitigate stigma.

Target audience

- ✘ Primarily boys aged 14 - 24, both in and out of school.
- ✘ Girls, parents of the boys, Neighbourhood Health Committees (NHCs), CBOs, traditional leaders and healers, men and women, and the community at large.

Project activities

- ✘ RH/HIV/AIDS/FP sessions - YAO.
- ✘ RH/HIV/AIDS/FP sessions - John Hopkins Univ (JHU)/Society for Family Health (SFH).
- ✘ Linking RH/HIV/AIDS to the game of life (soccer) - Zambia Football Coaches Association (ZAFCA).
- ✘ Mobile Video Shows - SFH/JHU/YAO.
- ✘ Local resource mobilisation - US Peace Corps Volunteers and community leaders.

Results

- ✘ Awareness of reproductive health knowledge and contraceptive methods increased in campaign areas.
- ✘ Greater youth participation in community affairs.
- ✘ An increase in VCT especially among engaged couples.
- ✘ Parent to child communication on issues concerning SRH increased.
- ✘ Heightened awareness among the community regarding the transmission and prevention of HIV.
- ✘ Increase in the number of young people accessing condoms from the health centre.
- ✘ Formation of anti-AIDS clubs and other community groups.
- ✘ Increased numbers of people reporting for STI cases to the health centre.

Lessons Learnt

- ✂ Youth involvement in the fight against HIV/AIDS increases the reach and impact of reproductive health interventions directed to young men in the rural areas where there is a lack of reproductive health information.
- ✂ Community involvement facilitates collaboration of local institutions in networking during planning and implementation of community based programmes.
- ✂ Community involvement is a key to success of the soccer camps as ownership of the programme is the cornerstone of the community getting involvement in planning, implementation and management of the programme.
- ✂ Community partnerships promote cost and resource sharing.

Conclusion

The Programme is implemented in three provinces of Zambia (the Eastern, Luapula and Northern Provinces). YAO has implemented this programme in 21 villages reaching over 150,000 people with consistent messages on RH.

7. Men's Call

By Pheya Alinah Mabote, CEDPA, South Africa

CEDPA is an international development organisation headquartered in Washington, DC. CEDPA aims to empower women to be full partners with men. Our values are emphasised through four programme areas that define our approach: Capacity Building, Youth Development, Reproductive Health, Women's Rights and Advocacy.

This presentation focuses on the relatively understudied issue of men and reproductive health matters. The findings reflect the complexity and ambivalence of reproductive innovations and of gender dynamics in our society that play an important role in the formation of men's attitudes towards reproduction in general which in turn greatly affects reproductive health decisions and practices.

The findings of this study are based on data collected in South Africa. The fieldwork included three focus group discussions on a wide range of issues with men between the ages 26-38. The motive of this study is to assess if progress has been made as well as to provide key future actions for the realisation of the International Conference on Population and Development Conference (ICPD) goals adopted by many countries - including South Africa - in 1994.

Findings

Knowledge of male sexual and reproductive health: None of the participants could think further than sexually transmitted infections. However, when probed, most of the men admitted to having heard of other problems such as erectile dysfunction/impotence, infertility, herpes etc. Participants indicated that they have never experienced any sex related problem.

One participant said that learning basic information about men's reproductive health through interaction with other men was relatively rare unless at the bar or shebeen. When asked about who do they choose to talk to when they have sexual health problems, participants responded that men are most likely to manifest their concerns or curiosity with those whom they trust most but they will still get slightly drunk to talk about a sexual issue.

Culture

Culture was an issue that hinders communication amongst men. Men are brought up to see themselves as strong, both physically and emotionally. Participants indicated that men think of themselves as independent, not needing to be nurtured by others. Men are unlikely to ask others for help. Men talk about anything but feel uneasy discussing sexual problems.

Most participants still value culture, tradition, beliefs and values. They indicated that culture changes over time. Sensitive approaches are required that promote discussion and involvement, not top-down instructions from outside the culture. Instead of change being threatening to them, men need to share in the benefit of change and help promote it.

Age

Age differences are another barrier to men's communication because of the traditional age-based social hierarchy and partly due to generational differences in education and aspirations. Older men rarely interact on reproductive health issues.

Actual and preferred sources of knowledge about reproductive health

Most men report learning about reproductive health issues from their social networks, friends and colleagues and from the mass media such as magazines. Media messages do not necessarily cultivate an interest in sexual and reproductive health issues. They indicated that they would like to get information from the health sector.

Utilisation of clinics

There appeared to be considerable dissatisfaction with health services and several of the problems revolve around the attitudes of health workers. The men felt that in-depth discussions between men and health workers needed to take place.

Many felt that clinics have been designed to provide services to women and that the nurses lack good communication skills. The men indicated that the nurses approach patients harshly. Confidentiality and trust are the two main issues that are lacking in a clinic.

Recommendations

Assess needs: Some programmes have demonstrated that a clinic can be successful in reaching males. It is necessary to change the clinic environment so that men feel at home. Other barriers such as the service provider's lack of knowledge and biases regarding men's reproductive health should be identified. Service providers require special training, particularly in counselling, to successfully serve a male clientele.

Close the knowledge-practice gap: There is a gap between what people know and what they actually do. Condom social marketing has not lead to increased condom usage. Although these strategies have generated high levels of awareness, acceptance rates have remained relatively low. Addressing this gap should be the next step in future programmes.

Develop appropriate service delivery strategies: It is important to design programmes that give men accurate information about reproductive health as well as enable men to communicate with their partners about these issues. Male services should integrate male reproductive health care services as a broader definition of male health would make it easier for men to walk into a clinic.

Include evaluation in programme design: It is important to measure the targets and outputs of the programme, monitor the quality of services provided, measure the impact achieved and to use the lessons learnt for adjusting or changing future programmes.

Learn about the male audience: Information on male attitudes, needs and preferences are essential for developing programmes.

Target messages to men: Reproductive health messages that portray responsible men who discuss contraception with their partners should be designed for male audience. Campaigns should emphasise the need for the husband and wife to share decisions.

Develop education and services for young people: Introducing reproductive health knowledge into secondary schools and university prepares young people for future responsible parenthood. Programmes should view sexuality education as a life-long process. Such programmes will ensure ongoing dialogue and meaningful behavioural change.

Advocate for men's reproductive health services: Programme managers, service providers, teachers and male opinion leaders need strong advocacy training to enable them to advocate for and propagate reproductive health issues in their own communities.

8. Understanding the Sexual and Reproductive Health Needs of Men who have Sex with Men

By Harriet Birungi, Population Council, Kenya

Brief description of the problem

In Kenya, despite the denials of some that MSM does not exist, the media has made this an increasingly visible issue. Population Council researchers in Nairobi have made contact with two MSM associations - Galebitra and Ishtar. Galebitra, founded in 2000 with a membership of over 50, aims to protect and fight for the rights of gay, lesbian, bisexual and transgender members of Kenyan society. Ishtar, with a membership of 300, is a non-profit self-help group established in 1997 with a mission to educate its members and others about HIV/AIDS. Such organisations are not limited to Nairobi - such as the Forum for Positive Generations on AIDS Prevention (FPGAP), a group formed by homosexual men from Kisumu, which was disbanded for allegedly recruiting homosexuals. There are also recognised gay bars and meeting points in Nairobi. These locations and networks are indicative of same sex relationships in Kenya, however social and religious hostility, legal persecution, epidemiological invisibility and funding gaps have combined to exclude MSM from preventative interventions.

MSM in Kenya have reported limited access to information and health services and limited input in policy and intervention efforts aimed at health improvement. Also, MSM have been virtually absent in general population surveys such as the Demographic Health Surveys which provide policy makers and programme managers with information on specific segments of the population. The lack of targeted research into the very different practices of MSM renders national level interventions ineffective. Our study is the first of its kind in Kenya to focus on MSM, identifying the challenges and moving from a position of blame towards a constructive position.

Description of the project

The presentation highlights possible research methodology for understanding sexual and reproductive health needs of MSM and discusses the link between research and intervention for MSM. The presentation will look at possible ways of negotiating the gap between HIV/AIDS and reproductive health and actual sexual diversity.

It suggests how researchers can use data to make policy makers and programme managers aware that while MSM is illegal, it is a reality that has to be addressed. MSM groups could use the data to influence policy and negotiate for equitable access to health services and information.

The solidarity strategy for supporting MSM to work together for the promotion of safer sex behaviour is discussed.

The presentation discusses possible ways of making sexual and reproductive health services more accessible and appropriate to MSM using the privacy and confidentiality model. Findings from the surveys have to be discussed with MSM groups as they are generated and interventions developed together.

Boy Child A - Behaviour Change

9. Masculinity, Boys and HIV Risk Behaviour

By Prof Graham Lindegger, School of Psychology, Natal University, South Africa

Background

Much work has been done in the area of HIV/AIDS and women, demonstrating that women carry the bulk of the burden and responsibility for HIV/AIDS. More recently, there has been the realisation that men do make a difference. In particular, that the construction of masculinity impacts substantially on risks for HIV/AIDS. This study focused on the socialisation of boys into manhood at school, the way in which teachers construct masculinity, how they think boys construct masculinity, and the potential impact of these constructions on HIV risk.

The project interviewed teachers across a range of schools from historically different sites in KwaZulu Natal in order to assess commonalities in constructions of masculinity, as well as the intersections of race, class and culture in the construction of masculinity.

Conclusion

A number of common, essentialist notions of masculinity emerge, for example displacement of men in society, masculinity as risk taking or sexual conquest. But there are also important differences across sites. Teachers speak of masculinity and HIV with multiple voices, reflecting different discourses around masculinity in society.

The findings reveal that it is the historically least changed sites, namely, black township schools and private, single sex schools, that are the real bastions of traditional masculine supremacy. By comparison the urban (especially co-ed) schools with rapidly changing demography show the greatest evidence of changing notions of masculinity.

10. Behaviour Change for Adolescent and Secondary School Boys

By Sam Connor, PSI, Malawi

Brief description of the project

Adolescent in-school boys and girls represent the highest risk group for new HIV infections. Yet, they also represent the best chance of reversing the trends of the pandemic among youth. Their age affords them a chance to imagine a better future. However, while their knowledge of HIV is high, the hard part for them is to internalise the personal risk to themselves even in the presence of hard data proving transmissions etc. Other factors to overcome are their understanding of condom effectiveness and the trusted partner myth.

PSI Malawi's comprehensive baseline study of secondary schools before Youth Alert! began yielded the following

- ✂ The national HIV infection rate is approximately 14% among 15-49 year olds.
- ✂ An estimated 300 000 young people in Malawi are living with HIV/AIDS - end of 2001.
- ✂ 46% of all new adult infections in 1998 occurs in youth aged 15-24.
- ✂ Of new infections, 60% occur among young women.
- ✂ HIV knowledge is very high among secondary school students (98%).
- ✂ Risk perception is very low. 47% of girls and 42.7% of boys expressed no concern over their chances of getting HIV/AIDS.
- ✂ Young girls and virgins were less likely to be able to talk about sexual matters with their partners.
- ✂ Over 90% of respondents agree with abstaining.
- ✂ Although ever condom use was quite high, self-efficacy and trust in condoms was low.

Description and results of the project

Youth Alert! is a secondary school programme in Malawi to help people reach their goals in life. The multimedia approach uses edutainment - dramatic presentations from young communications officers who work with PA systems, music, and question and answer formats. Youth Alert! reached 350 schools in the first year, has printed 42 000 calendars and distributed them and held regional events - serving 20 000 children - for music and dance festivals and girls football. Youth Alert! will be launching a national weekly radio show addressing young peoples' concerns on a variety of topics including HIV/AIDS.

Further areas for research

- ✂ What is a trusted partner and is this term relevant for young people?
- ✂ Youth's perception of myths and misconceptions surrounding condom use and effectiveness.
- ✂ Increased communication of consistent condom use as ever-use.
- ✂ Examine barriers to purchase and discussion of condom use, particularly among girls.
- ✂ In-depth analysis of the contextual factors surrounding risk-perception in relation to HIV/AIDS.
- ✂ Further investigation of knowledge levels about STIs.

Summary

Overall knowledge level among young people is quite high. They are trying out the appropriate life saving behaviours such as condom use and abstinence, but lack the self-confidence to adopt these behaviours permanently.

Boy Child B - Peer Education/Pressure

11. Peer Pressure/Role Modelling

By Thulani Ngubane, Youth for Christ, ACTIVE Youth, South Africa

Generally, men are projected to be physically strong, emotionally tough, daring and virile. These perceptions translate into attitudes and behaviours that have become unhelpful or lethal with the advent of HIV and AIDS. While being a boy child and then a man generally brings privileges, it also carries high health costs. Peer pressure and role models are very powerful forces that can influence growing personalities.

The culture of multi-sexual partners or of casual sex has become standardised into norms. Norms are a standard of expected behaviour, if violated a person pays a social penalty. Peers penalise peer group members who do not conform to their values. Because of this pressure to conform, a boy often ends up yielding to the expectations of his peers, and this has disastrous effects in most cases.

ACTIVE Youth is a peer education programme, focusing on rural high schools in Sweetwaters, KwaZulu Natal. Sweetwaters has one of the lowest average per capita incomes in Pietermaritzburg and among the highest incidences of HIV/AIDS - 35-40% of the adult population is infected.

It is important for us to engage men because they impart a sense of self to boys. Youth For Christ has critically visited the problem of peer pressure and the developing culture around the upbringing of a boy child. A powerful tool that needs to be considered in altering behaviour is Peer Education, as behaviour change is most likely to occur if peers educate and support each other.

Youth programmes that are run by the youth for the youth are all extremely effective in promoting practices and behaviour leading to reduction of HIV transmission. A successful peer education programme transfers the control of knowledge from the hands of experts to lay members of the group, thereby making the educational process more accessible and less intimidating.

Reasons for use of peer education

- ✂ It is more cost effective than the use of other mentors.
- ✂ Peers are a credible source of information.
- ✂ Peer education empowers those involved.
- ✂ It utilises an already established means of sharing information and advice.
- ✂ Peers are more successful than professionals in passing on information because people identify with their peers.
- ✂ Peer educators act as good role models.
- ✂ Peer education is beneficial for those involved.
- ✂ Education presented by peers may be acceptable when other education is not.
- ✂ Peer education can be used to educate those who are hard to reach through conventional methods.
- ✂ Peers can reinforce learning through ongoing contact.

Our aim is to equip young people with the skills to start an ACTIVE Youth group in their school to educate their peers. Their focus is to address the rampant HIV and AIDS epidemic and to enlist fellow peers to join the ACTIVE Youth group by making a pledge to play a pro-active role in being a catalyst to bring about attitude/ values shifts through change of behaviour.

12. Towards Defining a Methodology for Peer Support Facilitation

By Samuel Kawilila, Prison Fellowship, Zambia

Brief description of the problem

Peer practice has emerged as a major strategy in support and prevention of HIV and AIDS in sub-Saharan Africa. Although the peer movement has articulated important issues and problems faced by people living with HIV/AIDS, we are still not clear as to what the practice of peer support constitutes. At present many peer workers and projects act on the assumption that simply being a peer is enough to provide professional support to other peers.

Description and results of the project

This paper seeks to integrate distinct practices and philosophies of support into a model, which can be used for HIV peer support, facilitation, training and supervision. The results are based on personal experience as a Peer Counsellor and Peer Support worker with the AIDS Alliance of Chingola and AIDS Task-force.

Lessons Learnt: Effect of our interventions

The proliferation of peer-based workers and projects in the HIV community sector has led to some clear and effective ways to access, educate and support people living with HIV/AIDS. Research conducted in many countries

has highlighted the vulnerability of men who have sex with men to HIV and other STIs. Yet in Africa they receive little attention in HIV/AIDS programming and service delivery because of widespread denial and stigmatisation of homosexual behaviour. Unprotected sex between men endangers both men and women. Most sex between men is hidden. Many men who have sex with other men often also have sex with women.

At the Chingola Local prison and Ipafu Open-Air Prison, we conducted a peer health education of 500 new prisoners on awareness and prevention: After extensive questioners and focus group discussions it became apparent that 83% of the in-mates considered themselves at little or no risk of infection.

Many men who suspect that they may be HIV+ embrace a flawed logic, "If I am already infected, I can sleep around because I can't get it again." Ignorance and an irresponsible attitude towards AIDS and STD's also contribute to the spread of HIV/AIDS. Another area of ignorance is that AIDS is caused by witchcraft. Only concerted peer education can destroy these beliefs.

Summary of experiences/lessons learnt and implications for the future

Creation of self-esteem as an essential foundation that enables men to put life skills into practice. Breaking of silence, e.g. by testimonies and role models. Counselling and caring, many HIV/AIDS sufferers have serious misconceptions.

Sexually transmitted diseases, if left untreated, are a major source of HIV transmission. Men do not openly talk about STDs and most find it embarrassing to go to a doctor. To adopt such a posture these days is to put one's head in the sand. Going beyond societal, religious, cultural practices and taboos, e.g. polygamy, sexual cleansing, extra-marital activities etc. Old taboos and lewd rites and practices, which may have been part of a traditional culture, must be exposed and rejected.

Men can make a difference to the HIV epidemic

Men's behaviour puts women at risk of HIV. They tend to have more sexual partners than women and they often do not use the condoms consistently. HIV is more easily transmitted sexually from men to women than vice versa. A man with HIV is therefore more likely to infect more people over a lifetime than an HIV+ woman. It is usually men who decide whether to have sex with whom and whether to use a condom. Men's violence has an impact on many women's lives and can increase women's vulnerability to HIV/AIDS. Men make themselves vulnerable by taking sexual risks in order to prove themselves as "real men" e.g. having lots of partners or refusing to use condoms.

What will make a difference?

- ✂ Increased education campaigns on the harmful, often fatal, effects of unequal gender relations, and also on condom use.
- ✂ Communication between men and women about sexuality and reproductive health.
- ✂ Making men be more responsible.
- ✂ Raising awareness of the relationship between men's behaviour and HIV/AIDS.
- ✂ Emphasising the role of men as fathers and care givers by encouraging them to consider the impact of their sexual behaviour on their partners and children. This includes being good role models to their children in particular boys.
- ✂ Teaching boys through example, to respect women and not to see them as sex objects.
- ✂ Encouraging HIV+ men to take responsibility and to make provision and plans for their children who will be left behind when they die.
- ✂ Promoting the need for men to take a greater role in home care activities when family members are sick or dying of AIDS.
- ✂ Encouraging men to actively participate in making an effort to protect women.

13. Young Men & Boys & HIV/AIDS: the Strategic Group

By Tom Mzumara, ZARAN, Zambia

Introduction

This paper seeks to affirm the conviction that young people are themselves a force for change. Special attention has been given to young men and boys as a strategic group in the fight against HIV/AIDS. It is conceded that the future course of the pandemic depends on the efforts mounted today to prevent HIV infection among young people.

Young people make up about 63% of the African population and it is estimated that this segment of the continent's population will increase by 27% by the year 2005. The majority of the Zambian population is between 15-25 years. Globally, statistics show that almost a third of persons living with HIV or AIDS are in same age bracket. The sad fact is that these young men and boys do not realise that they are at risk. No one knows for certain why the epidemic is so serious in Zambia. Several factors seem to have contributed to the high prevalence in the country.

Some of the factors

- ✂ Early sexual activity
- ✂ Traditional/customary law practices
- ✂ Knowledge, Attitude and Behaviour

Early sexual activity

The Zambia Sexual Behaviour Survey 1998 reports that the average age of first sex is 16.4 years for males and 16.3 years for females. Boys start experimenting with sex when they are about 11 years old. This early exposure to sex, which in most cases is unprotected, makes young people more vulnerable to STIs and HIV.

Traditional/customary law practices

The question of masculinity: Men have more sexual partners than women and do not often use condoms consistently. Men behave the way they do because society tells them that is how they should behave. The question of masculinity is closely related with sex in many young peoples' minds. Men should feel masculine, but the definition of masculinity should change. Men should take responsibility for their own lives and share responsibility with their partners for each other and their children. Negative aspects of masculinity such as violence should be replaced with positive aspects such as care. Sportsmen, musicians and other male role models should make strong statements about positive aspects of masculinity.

Knowledge, Attitude and Behaviour

Knowledge about HIV/AIDS is virtually universal among Zambian adults, most of whom understand that it is a fatal disease and that no cure is available. Many also know that positive actions can be taken to avoid transmission of the virus. Similarly, more than 80% of adults know that an otherwise healthy looking person can be infected. About 70% of adults know someone who died of AIDS. However, misconceptions about HIV transmissions still persist. (About 30% of the population believe that mosquitoes or witchcraft can transmit HIV. The 15-19 years group is the least informed about AIDS making them particularly vulnerable. Youth's vulnerability to HIV infection is also related to unclear perception about risky behaviour, insufficient knowledge and incorrect information about sex, sexuality and health.)

Why is this age group strategic?

The typical pattern of transmission depicts young men as particularly vulnerable. Older men are infecting the young women that the younger men would experiment with. Thus, if the younger men are imparted with the necessary knowledge, attitudes and skills to prevent them from becoming infected as they grow older, the resulting older men will be responsible citizens. In this way, society will have men who will play a key role in modelling young people. Working in partnership with young people is the best hope of containing the pandemic. As well as being a resource to tap into for idealism and energy, young people's ideas and values are not always set, and they are more willing to question and change social norms and behaviour than adults.

What can be done?

Lack of knowledge among young people is a critical issue that needs to be addressed. Young men and boys need to know that they are at risk and that there is no known cure for HIV/AIDS. Society can not continue to assume that young people will learn from experience.

In Zambia, the following initiatives are yielding results

School curriculum: The Ministry of Education has adopted HIV/AIDS/STI and reproductive health teaching materials in the mainstream school curriculum at national level. This is within the context of Life Skills education from primary school to tertiary levels.

Strengthening of Health Services: Initiatives have been started to train health workers and to make health centres and other facilities youth-friendly.

Youths and peer educators: The current response related to the general problems faced by the youth is found in a framework defined by the National Programme of Action for Youth in the Ministry of Sport, Youth and Child Development (MSYCD). The importance of positive youth is recognised as a national priority, and is well expressed in the National Youth Policy.

Information, Education and Communication (IEC): The main thrust of the IEC programmes was the use of mass media to inform the general public about HIV/AIDS. The channels used included television, radio, billboards and use of pamphlets. IEC also included introduction of applicable materials in school curricula. Several NGOs and Churches have implemented IEC activities. While these programmes tend to cover smaller and less accessible groups of individuals, the overall quality of such activities is variable.

Peer education: Peer educators speak the same language, share the same values and are effective in reaching young people. In 2000, 52 young people in Lusaka were trained as peer counsellors within primary health care clinics to provide services, and link staff with young clients. The programme has enhanced mutual respect in the community, and helped break down the taboo on discussing sex.

Overall evaluation

It is most encouraging that several programmes targeting youths exist. There is also a general practice of involving young people in the design and implementation of these programmes. However, more work needs to be done to ensure complete coverage of the country as the emphasis is currently placed on urban areas.

Recommendations

✕ It is recommended that special programmes aimed at improving service delivery in the context of HIV/AIDS education by teachers be designed.

- ✘ Early education on HIV/AIDS facts is strongly recommended as sexual experimentation starts quite early amongst young men.
- ✘ Church organisations must continue to promote abstinence. However, due regard must be given to those who are not part of the church. Abstinence will only make sense to them after their conversion to Christ.
- ✘ Deliberate programmes targeted at older men must be encouraged. This recommendation is made in view of widespread assumptions that older men know all about HIV/AIDS.

Conclusion

In order to ensure that the entire population is covered, the approach must be holistic. No one single method of prevention is suitable for the whole population. Special attention must be given to young men and boys. Older men must take responsibility for their sexual behaviour and set good examples for young people.

Rapporteur Report, Day 2

Sexuality A - Sexual Practices

Pride Simana from Prison Correctional Services in Namibia described methods of HIV/AIDS transmission in prisons and methods of prevention, and ways of care and support. However, sodomy is a criminal offence in Namibia, so prison services cannot provide condoms to prisoners.

Robert Lorway from The Rainbow Project (TRP), showed that male homosexuality exists in Namibia.

The following risk factors of HIV transmission were identified

- ✘ Poverty which leads to sex for money and gifts
- ✘ Alcohol, drug use and abuse
- ✘ Unstable condom use; lack of lubricants for anal sex
- ✘ Homophobic government discourse which leads to fear, isolation, harassment and poor self esteem
- ✘ Discriminatory attitudes of health staff and lack of confidentiality
- ✘ Serial partnerships with men and women
- ✘ The “foreigner” fetish
- ✘ Sex with older men

Many of these risk factors are the same for young black heterosexual men in Soweto as Barbara Fisher PhD described with data from a pilot study by University of Witwatersrand, Perinatal HIV Research Unit (PHRU). Young men who do not have a job, education or future use coercive power in their relationships with women. We need to change the concept of masculinity anchored in coercive power as well as attitudes and economic status.

Sexuality B - Reproductive Health

YAO chose sports to communicate and educate men/boys (14-24 years). The goal of the project is to increase men's participation in sexual and reproductive health. Reaching men/boys is done by organising football camps. Parents are also invited to these camps to bridge the gap between child and parent. Football language is used to educate life skills/reproductive health skills.

Results of the project

- ✘ Increased knowledge of sexual and reproductive health.
- ✘ Increased number of women going to the health centre for information.
- ✘ Increased number of young people accessing condoms from the health centre.
- ✘ YAO has reached 150 000 people in 3 provinces, in 21 villages.

CEDPA focuses on reproductive health; capacity building; youth development and women's rights/advocacy. In order to achieve these, CEDPA realised it also has to work with men. Focus group discussions were held to get more information on men's knowledge of sexual and RH issues, men's preferred sources of knowledge and advice and men's utilisation of health services.

Findings

- ✘ There is a big need for information as men/boys do not talk about RH issues due to reasons of communication, culture and age differences.
- ✘ Sources of information used are the mass media and friends.
- ✘ Utilisation of services is poor as clinics are male unfriendly and there are issues of confidentiality, privacy and judgment.

The needs of men must be assessed and specific messages and information for men produced. There is a gap in HIV/AIDS programmes as most programmes focus on hetero sex. MSM is illegal in Kenya. The Population Council has made contact with MSM organisations and proposes to research how MSM affects HIV/AIDS and the social context of MSM.

Goal of the research

To see MSM as a group of individuals and research their sexual behaviour in a non-judgmental manner. After data collection, discussion will be held with MSM - who could use the data to influence policy making. Other dissemination presents an ethical dilemma.

Boy Child A - Behaviour Change

Professor Lindegger from South Africa spoke about the links between masculinity and behaviour change and the difficulties of behaviour change.

Findings

- ⌘ There are striking intersections between race and class as reflected in the commonalities in black and white schools.
- ⌘ Gender roles are changing albeit slowly.
- ⌘ The construction of a new masculinity is reflected in "confusion" i.e. boys feel they have no role any more and are not sure of their place in society.
- ⌘ The construction of a new masculinity has enabled more open discussions on sexuality and issues such as HIV/AIDS.

Sam Connor from PSI Malawi spoke about behaviour change for young people in a conservative traditional setting. PSI recently launched Youth Alert!.

Youth Alert! aims to

- ⌘ Develop new living messages.
- ⌘ Create platforms for young people.
- ⌘ Encourage parents to be supportive and see the need for their children to get accurate information.
- ⌘ BUT young people do not see themselves at risk, so messages have to be developed that will encourage the youth to delay sexual debut, set their goals and make the correct choices.

Boy Child B - Peer Education/Pressure

All three presentations illustrate that young people are a very powerful force in changing the trend of HIV/AIDS in our region.

Peer education

- ⌘ An effective empowerment and education tool.
- ⌘ A credible source of information.
- ⌘ Utilising already existing means of information sharing and advice.
- ⌘ Peer educators are role models.
- ⌘ Is readily acceptable.

The Prison Fellowship in Zambia has found peer education to be a successful tool in accessing, educating and providing support to vulnerable groups in society and PLWHAs.

Findings

- ⌘ MSM are vulnerable to STIs.
- ⌘ Unprotected sex between men endangers both men and women.
- ⌘ Training is a motivating factor for peer educators, nurses are recruited to work alongside the peer educators to build a sense of confidence.
- ⌘ Ignorance, misconception such as "If I do it once I can't be at risk"; "sex with a virgin will cure me"; AIDS is caused by witchcraft and AIDS is an urban disease.

Conclusion

- ⌘ Approach must be holistic (condom use to abstinence).
- ⌘ Pandemic is real.
- ⌘ Special attention to youth programmes.
- ⌘ Youth are a door of hope in containing the epidemic.
- ⌘ Youth must learn to respect older men and women.

Day 3, Thursday 13 February, Culture, Stigma & Violence

1. Love, Hope and Courage

By Peter Busse, RAISA Advisory Board Member, South Africa

I have been asked to speak to you today on Stigma, Culture and Violence. However, as somebody who has been living with HIV for eighteen years, and has been involved in the unfolding of the epidemic in this country, I would like to share some of my personal feelings and experiences with you as well.

I would like to highlight the link between violence against women and HIV/AIDS. South Africa can be seen to be experiencing two epidemics, an epidemic of violence against women and of HIV/AIDS. These two epidemics are converging in new and lethal ways. However, our current responses are split, and are parallel rather than complimentary.

We know that rape increases the risk of HIV infection. Abusive relationships limit women's ability to negotiate safer sex. Women with a history of childhood sexual abuse may engage in riskier sexual behaviour as adults. Women receiving testing and counselling may be at risk of partner violence if they disclose their status. Violence against women can be seen as a continuum, with a range of abuses, intimidation, threats and force. These acts are not isolated and many overlap.

Research in South Africa shows that physical abuse against women is common. In South Africa in 1998 a total of 49,280 rapes were reported. These figures are conservative, as only 25 – 50% of all rapes are reported. The figures for women attending ante-natal clinics show that one in four women is HIV+.

We know that women are biologically and physiologically more vulnerable to HIV infection. This is due to the larger surface area of the vagina, susceptible mucosal surfaces, the high incidence of sexually transmitted infections, the practice of dry sex and the undeveloped genital tract in young women. A girl's risk of contracting HIV increases as her age at first intercourse decreases. We know that poverty and desperate economic circumstances lead to commercial sex work, survival sex and transactional sex. Young girls are at risk due to the growing phenomenon of Sugar Daddies, who provide financial and other incentives for a sexual relationship.

Traditional and cultural practices also increase risk. The practice of lobola or bride price, polygamy and female genital mutilation make women and girls more susceptible.

Migrancy and refugee movements fuel the spread of HIV. Conditions of war and armed conflict also fuel the epidemic. The growing humanitarian and food crisis in Southern Africa will also exacerbate risk and vulnerability.

We know that the pattern of AIDS increases under conditions of poverty, migration and conflict. AIDS is now increasingly seen as a development issue, which will impact on all levels of society and erode or reverse many of our developmental gains. We need to plan AIDS activities that include sexuality and sexual behaviour and recognise the vulnerability of women and girls. Sexuality can no longer be treated in silence.

Men have greater power and control over sexual relations and dominate decision making about sex. It is crucial that men respond to the pandemic. However, it is still necessary to promote the empowerment of women and the development of women controlled prevention methods. The interplay between sexuality, gender, poverty and AIDS is key to our understanding and response to the pandemic.

HIV has brought into sharp relief two of the most insidious forms of human oppression, gender and sexuality, in a way that has exacerbated human rights violations and made the pandemic more difficult to address effectively. We need to base our response on a strong rights based approach.

We need to understand that social norms and beliefs are embedded in cultural and religious values. Peoples' decisions regarding their sex lives are based on social norms and peer influences, and are often culturally determined. In most cultures men are expected to be assertive and women passive in their sexual relationships. Culture is not static but dynamic. To understand and change people's sexual behaviour it is necessary to understand the culture in which sexuality and sexual practices are imbedded. Culture can be a reservoir for behavioural change or for its refusal.

The denial of the existence of homosexuality and bisexuality has led to widespread discrimination and stigma against homosexuals and bisexuals. Issues of stigma, discrimination and denial remain dilemmas facing the development of public health and education programmes. My experience as a HIV+ gay man has taught me that there are marked similarities between being gay and being HIV+ in South Africa. The first and most obvious area of similarity is in the area of disclosure.

The process of disclosure is interesting, as it takes a long time of preparation and coming to terms with issues yourself before you are ready to share them with others. Talking to people I trusted about being gay and positive was a great help, as it allowed me to explore my own feelings and responses.

The words used to describe and talk about gay men are very damaging and stigmatising. Pansy, fairy, faggot, moffie, homo, queer and sissy all undermine and demean who and what we are. The words used to describe people living with HIV and AIDS are also stigmatising (victim, patient, sufferer, afflicted, guilty and dirty) and damaging.

The visual representation of people with HIV and AIDS is also one-dimensional - emaciated and skeletal figures, looking helpless and terrified, without hope or dignity. Where is the portrayal of the many years lived with hope and courage? Where are the role models? How can we identify with and aspire to be the images used? I do not deny the pain and suffering, the reality and horror of death, but there is also life, and love, and this is rarely shown.

Social attitudes towards gay and positive people are often similar. In the public's mind, there is a strong association between AIDS and being gay. Sex is seen as something dirty, shameful and unnatural, gay people and people with HIV and AIDS are seen in the same way.

We do exist. We are real. We have lives that are positive, courageous and brave. We have had to confront and overcome huge challenges, enormous prejudice and untold discrimination and stigma. Sex is important; it is tender, fun, affirming and life giving. It connects us and can express love and intimacy. It is what made us positive. We need to reclaim our sexuality and sexual lives. We need to remember that in the midst of all the death and dying, fear and loneliness that there is love, that there is hope and that we do have courage. That in what is often seen as an ending there can be new beginnings.

2. Stigma, Culture and Violence

By Ivan Louw, Men United, South Africa

I'm a 27 year old, happily married South African male. Life as I knew it ceased to exist on the 28th of September 2001. I was in Pretoria for a business trip, and it was the night before I would return to George, my hometown. As I stopped at an intersection, a tall slender man approached my car and asked for directions. As I replied, he produced a pistol. I was taken to a deserted road off the N1, North of Pretoria. There he ordered me to remove my clothing. It made sense to me. I won't go running off for help too quickly without any clothes on, would you? So I was sort of relieved at that stage, believing he will now take my car and leave. As I was undressing, a second vehicle stopped behind us. It was a white Isuzu 4x4. There were two men in the 4x4, one of them got out. I was pushed to the ground, my hands tied behind my back, and a noose placed around my neck. This was no hijacking.

In the back of the truck, which had a canopy, I was raped by two of the men. They then forced me to have oral sex with both of them. That was the worst.

With my hands still tied, I drove to the nearest hospital. Statements were taken by a police officer and I was escorted to a provincial hospital where the District Surgeon went about the task of collecting evidence. I was raped all over again, or so it felt. Today I must say that I firmly believe that this part of the exercise is of vital importance. The evidence the Doctor collects will help to put the perpetrators in jail, although not pleasant, it is a necessity. I also received my dose of AZT. As with the district surgeon's examination, taking AZT is not pleasant at all, but it prevents HIV and is worthwhile. I have proven negative in both my HIV blood tests so I am very hopeful for a clean bill of health.

My wife was the one person that I could confide in. I told her exactly what had happened to me and although she could not always understand what I was going through, she never judged me.

The word that I was hijacked spread like fire in my small hometown, no one knew that I was raped. My company was quickly going down the drain. The AZT kept me from working for the first month. I had no ambition left and decided to close the company. I had some money saved up and was sure that I would be able to survive on it. This was a big mistake and please learn from it. Do not make any life changing decisions when you are still coming to grips with trauma. Your decisions will be based on emotions, and emotions change daily. Much rather take leave if you can, or cut down on your expenses. If you are a family member who deals with a traumatised person, give them time; take as much responsibility as you can off their shoulders. Don't ask him what you can do to help, think of something appropriate and do it. One golden rule though, keep his rape to yourself until he gives you permission to share it with others.

On a pamphlet someone at the hospital gave me was the telephone numbers of various support groups. All of them starting with words or phrases like stop woman abuse, or woman's help line, or organisations against rape of woman. Let me just say that what these people are doing is to be admired. They are saving 1000s of lives everyday. Then though, those words made me feel even more alone, that I was indeed the odd one out. I wanted an organisation where I could feel accepted, where no one will judge me. After all, as young boys we are taught to look after ourselves, that we must be able to defend ourselves.

I thought of killing myself. I thought, why on earth would I survive the rape and now want to take my own life? What was it that made me feel this useless? I was no longer with those men; I was now making my own decisions, responsible for my own actions. I could blame the rape for all my heartache and suffering to the end of days that will not change a thing. It was on that day that I took control of my life again. I started by searching the Internet for factual information on male rape. In S.A. we are unfortunately years behind on research into male rape. It took women close to 20 years to be noticed. I did however find an abundance of organisations internationally that specialised on the subject. They have support groups, dedicated research and a host of other useful information. This discovery empowered me to realise that male rape does happen. That it is a crime like any other and should receive the same if not more attention from the public.

I reclaimed my space on this earth by taking responsibility for my reactions to the rape. I started a new career and with it told people the truth when they asked me about the hijacking. Yes, not everyone is sympathetic to your situation and I did get some remarks that made me feel sad. But those were in the minority and I have come to understand those people are just scared of something they don't know. I knew how much it took from me to talk about the rape and I was proud of myself for doing it. Even more though was the fact that the men who raped me no longer had control over me. My decisions were based on what I wanted and not because of what they did to me. Speaking in public came after a journalist got to hear of my story and published a piece in a national magazine (women's magazine, ironic hey). The response from men who were raped was awe-inspiring. I cannot believe just how many there are. A marketing company who now represents me as a Motivational Speaker approached me. It

seems people are more interested in how I coped with the rape rather than the rape itself.

One more tool that helped me in a great way was to do selfless acts of kindness. The idea of giving made me happy. The art though is to give your most precious possession, your time, and to give it without expecting any gratitude in return. Whenever you feel yourself losing control, go out and do something good, give your time to someone.

I hope you will understand from what I have written that rape is not the end of the world. It is the beginning of a new one; you must just stick around long enough to find it. Remember that you will lose the joy of today if all you do is fear tomorrow.

Culture

3. Men, the Displaced Component of Society

By Douglas Kabanda, Pro-me-tra, South Africa

Introduction

- ✂ Men in tradition are studied in the context of family.
- ✂ Decision making is a collective action, mutual respect and understanding permeate.
- ✂ Series of negotiations i.e. on whether or not is the right time to reproduce.
- ✂ Men led rituals e.g. sacrifices, praying and leadership position in the home (walked in front to kill attacking serpents, today the proverbial serpent is AIDS, who is to take the lead now?)

Problem Description

- ✂ Social disorientation of today removed men from leadership positions.
- ✂ Men became indifferent, not minding, irresponsible and took a back seat in the problems of the day.
- ✂ What we hear today are the screams of the proverbial woman who sees a snake

Methodology

- ✂ Research training workshop covered nine provinces of South Africa over six months in 2002.
- ✂ Involved 180 participants (Traditional Healers, Community Leaders, Zionist Priest and Chiefs).
- ✂ Participative discussions.
- ✂ Scope: circumcision, polygamy, dry sex and scarification etc.

Results

- ✂ Men due, to incessant impediments in the home situation, have become more indifferent to social problems.
- ✂ Negotiations have dropped in men and women relationships
- ✂ Maintain culture and tradition but coupled with training and sensitisation for safe and best practices.
- ✂ Wife inheritance, circumcision, scarification, polygamy and dry sex should be in best practices.

Experiences/Conclusion

- ✂ Efforts involving men in HIV/AIDS fight should consider the man in the family context.
- ✂ Men to be brought back to mentorship position.
- ✂ Men need our support and training to take initiatives that will make difference.

4. The Role of Cultural Beliefs and Practices in Entrenching Gender Based Human Rights Abuses Against Women in the Context of HIV & AIDS

By Malala Sakufiwa, ZARAN, Zambia

The essence of this paper is not to blame men but to acknowledge them as partners in the fight against HIV/AIDS. Men must not be seen as some kind of problem but as part of the solution.

The paper is an attempt to illustrate the role of cultural beliefs and practices in worsening and perpetuating human rights abuses against women in the light of the HIV/AIDS pandemic.

Culture shapes what we believe and do and thus affects how and what we think. Culture also determines our gender relations. Unfortunately in most cases, culture is characterised by gender inequality. This arises from gender stereotypes which tend to define femininity and masculinity.

Definitions of femininity and masculinity

Women are viewed as subordinate to men, powerless and second class citizens. Women lack control over their lives and are taught from early childhood to be obedient and submissive to males who command power such as father, uncle, husband, elder brother or guardian. Men are expected to be physically strong, emotionally robust, daring and virile. They are expected to be providers and to rule. The superiority of men and the subordination of women basically translates into disregard for the rights of women in the context of HIV/AIDS

The ways in which culture contributes to the abuse of women's rights

- ✂ A women cannot refuse her husband sex.
- ✂ Polygamy
- ✂ Enhancement of male pleasure through dry sex which increases the vulnerability of women to infection by exposing them to bruising and laceration.
- ✂ Violence against women is seen as a sign of manliness and a form of disciplining women.
- ✂ Sex with a virgin cures AIDS.
- ✂ Economic Dependence
- ✂ Widow Cleansing and wife inheritance
- ✂ Initiation Rites

These traditions undermine the rights of women and they increase the severity of the pandemic.

What needs to be done?

- ✂ Promotion and protection of human rights for both men and women is critical. HIV/AIDS interventions must promote and protect the rights of individuals.
- ✂ We need to revisit culture. There is need to review the culture and rid society of those aspects of that make women vulnerable to HIV infection.
- ✂ Sex and reproductive health education.

Role of gender inequality and equity is a key determinant in the success in the struggle against AIDS.

Conclusion

The role that culture plays in the abuse of women's rights and ultimately spread of HIV infection can not be overemphasised. It is time that men rose up to the challenge of promoting these rights. Perhaps it is only a real man that can respect a woman's rights and not feel threatened.

5. Shades of Masculinity: Junkies, Body Builders and Drag Queens

By Sebastian Matroos, Youth Skills Development, South Africa

Introduction

In my search to discover how young men relate to the HIV/AIDS crisis, I've found that men have been described as a "problem" in the field of sexual health and HIV/AIDS. There are negative connotations ascribed to their behaviour, to their values and their social attitudes. It would seem that young men, though often neglected in this epidemic, are generally viewed as being irresponsible, sexually intolerant, aggressive, uncaring and unwilling to seek help.

Assumptions are often also made about the health and development of adolescent boys - it is assumed that they are faring well, and supposedly have fewer health needs and developmental risks compared to adolescent girls. Furthermore, adolescent boys are viewed as disruptive, aggressive and hard to work with. This renders them a "hard to reach" group.

Such generalisations do not take into account the fact that adolescent boys, like adolescent girls, are very diverse in character and background. I don't want to suggest for a minute that all men, are innocent, I merely wish to highlight that all men are not the same. There are good men too, loving fathers, responsible leaders, enlightened men, dependable men, trustworthy men, caring men, sensitive men and even attractive men. By problematising men and by blaming them we cannot get any closer to the greater involvement of men and a sense of responsibility and caring from men. I believe that stereotypes serve to alienate men even further from engaging fully.

Our knowledge of what adolescent boys need for healthy development and what health systems can do to help them can be improved by firstly recognising their complexity. This calls for a more careful and thorough understanding of how they are raised in their communities, That is; how they are socialised. We need to understand how they have constructed their sense of masculinity from the messages that are prevalent in their environment.

Stigma & Violence

6. Sex, Drugs, Abuse & Kids

By Newton Zulu & Carl Edmonds, Prison Fellowship, Zambia

Prison Fellowship Zambia (PFZ) is a Christian organisation which aims to deliver welfare and spiritual support to prisoners. Newton Zulu has been a health volunteer with Prison Fellowship for four years. As the team leader, his role is to supervise five other volunteers who carry out health education and counselling sessions in Ndola's prisons in Zambia's Copperbelt region. Carl Edmonds is a VSO volunteer who has been supporting the Prison Fellowship health department by strengthening its management systems and training programme.

Stage 1 – identifying the problem

Since we have been working in prison we have been aware of the exploitation and abuse experienced by juvenile

inmates. Sometimes in smaller groups, boys will discuss episodes of bullying and various assaults taking place in prison but would seldom go into detail or incriminate a fellow inmate or officer. On rare occasions PFZ volunteers would even witness some forms of mental or physical abuse. One day Newton Zulu in his capacity as a counsellor working in a centre for street kids confronted two boys having anal sex.

Stage 2 – why was this happening?

Through our research we discovered several reasons why boys were becoming involved in sexual relationships or taking part in sexual activity.

- ✂ Protection from older boys
- ✂ Food or gifts
- ✂ Pressure, coercion or fear
- ✂ Intimacy/enjoyment
- ✂ Ignorance or apathy from adult carers

Stage 3 – realising that something needed to be done

The rights of a child formulated by the United Nations and signed by Zambia clearly states that children should not be forced, manipulated or coerced into sexual activity. The law needs to protect those who are being abused and deal with perpetrators. Also we were aware that STD's were prevalent amongst the street kids and juveniles, therefore one can assume that the boys are in great risk of contracting HIV/AIDS.

Stage 4 – what must be done?

We immediately identified that street kids and their caretakers had little or no knowledge of abuse. There are seldom any abuse policies or procedures in place in the event of abuse and even if there were, staff were reluctant to use them. This was especially apparent in prison where the notion of abuse was completely absent. It has become a way of life for many of the prison staff and inmates and other issues such as clean water and food were considered to be a greater priority.

Stage 5 - the plan

After some consultation with juveniles, street kids and centre managers, we devised a five-day programme to operate in schools and shelters for street kids. We also conducted a management training workshop as a part of the programme preparation.

- ✂ Management workshop to discuss abuse definitions, policies and procedures and the training/education needs of staff and street kids.
- ✂ Abuse and listening skills with the staff covering abuse definitions, how to use the abuse procedures and supporting perpetrators and 'victims'.
- ✂ Sex education course with the kids covering rights and responsibilities, saying 'no', STD's, having sex, protection, self-esteem, relationships and decision-making.

The Future

We have already extended our programme to some mainstream schools in the area and to other shelters. We hope that eventually we can take our programme back into the prisons from where it initiated. However we first have to establish fundamentals such as human rights in the prisons. I don't think we will completely stop all abuse, especially in environments of extreme poverty, injustice and fear. However we can develop ways to limit its prevalence and impact by being aware of its occurrence and providing the right interventions for the staff, perpetrators and 'victims' of abuse, albeit physical, sexual or emotional. We hope that our programme has gone some way to achieve this with vulnerable youth in Zambia.

7. Men, Culture, HIV & AIDS in Mozambique

By Lutz Mocker & Cristina Marques, ADPP-TCE, Mozambique

ADPP is an international aid organisation (Ajuda e Desenvolvimento do Povo para o Povo, HUMANA People to People), we are responsible for the TCE (The Total Control of the Epidemic) programme. TCE is based on the philosophy that only people can liberate themselves from AIDS and focuses on every individual within the community. TCE works with all areas of problems in changing sexual behaviour, but without destroying the culture in which it works.

An estimated 1.4 million Mozambicans (10 to 14% of adults) are HIV+. The government of Mozambique has initiated a multi-sectorial, comprehensive National AIDS Strategic Plan. Now it is up to the country's leaders to ensure that this plan is carried out.

Men and HIV/AIDS in Mozambique

There are cultural obstacles in the fight against HIV/AIDS such as polygamy and adultery. Adultery is the rule, not the exception. Men who do not cheat on their wives are looked upon as weak, even female adultery is not

uncommon and usually does not lead to divorce or separation.

Another major problem is the refusal to practise family planning. Having a lot of children is very important for Mozambicans as a sign of fertility. Big families can also mean wealth and improve one's status within the community.

Migrant labour also leads to problems. Men who work long periods away from their family are at special risk of contracting HIV, because they are likely to seek casual partners. Men living and working in all-male settings are also at risk as sexual relations between men often involve practices which are generally more risky.

Sexism is a part of Mozambican culture - the woman is supposed to take care of the children, do the housework and accept what her husband tells her to do. This is not a matter of education, it is a matter of culture and tradition. Decisions regarding the use of condoms therefore usually belong to men.

This led us to the realisation that HIV/AIDS work should focus on men, especially young men. If we can get them to lead a safer sexual life, we will be assisting in the fight against HIV.

Generally men have much influence and authority in the society and therefore should live up to being good role models. Men can make a difference by showing the courage to break the silence and talk openly with their wives or partners. The traditional role assigned to men as the main decision makers can be used as a power to influence matters in a progressive way.

Practical rules for men

- ✘ Due to biological differences, women contract the HIV virus more easily than men.
- ✘ Always use condoms during any sexual intercourse.
- ✘ Reduce the number of partners, especially casual or little known partners.
- ✘ Seek medical treatment whenever falling sick.
- ✘ Be a good role model to your own children.
- ✘ Promote an open discussion about the importance of taking safety first and about taking your part of the responsibility to stop careless behaviour, violence, exaggerated use of alcohol, etc., in the family and in the community.
- ✘ Consider the actual number of sexual partners you have and the probable HIV status of these partners and eventually decide to reduce the number. Consider substituting sexual activities with other pleasant and satisfying activities.
- ✘ Take up the discussion in the family or among other men of how to create a common front as human beings towards the HIV/AIDS epidemic and put the pride and prejudice on the shelf.
- ✘ Have the courage to admit and agitate that men are just like everybody else. They are ordinary human beings with needs, feelings, dreams, qualities and much more.
- ✘ Inform boys and young men about HIV/AIDS and how it is transmitted. Encourage them to delay their first sexual encounter and when it takes place, teach them to use condoms as a protection.

Final remarks

Men are involved in more pre-marital and extra-marital sexual intercourse. On average, men have more sex partners than women. This increases their own and their partners' risk of contracting HIV. A man with HIV is more likely to infect more people over a lifetime. It is asserted that many women contract HIV from their regular but unfaithful male partners. Most married women contract HIV from their husbands.

As politicians and as front line workers, men should use their privileged positions to ensure the right policy and environment for a successful campaign against HIV. They should use their resources and reputation to support HIV prevention and care for those infected and affected by HIV/AIDS.

Men must be educated to respect the opinions and protect the interests of their sexual partners. They must discard those cultural attitudes that put women down and disable them from negotiating safe sex.

As fathers, as sons, as brothers and as friends, men must adopt positive behaviour and play a much greater role in caring for their partners and families. Although it is hard to combat adulterous practices in Mozambique, education must centre around the dangers of such actions and positive steps towards reducing such occurrences. Fathers and future fathers should be encouraged to consider the potential impact of their sexual behaviour on their partners and children.

8. Rights Based Approaches to HIV & AIDS Summoning and Empowering Affected Communities

By Kuambu Mwendela, ZARAN, Zambia

The Problem

- ✘ Sub-Saharan Africa is the hardest hit region, with 29.4 million people living with the virus. Zambia, with a population of close to 11 million people, has an HIV prevalence of 20-26% in Lusaka. This means that approximately 2 million Zambians are HIV+.
- ✘ Poverty continues to exacerbate the effects of the pandemic. Over 70% of Zambians are poor and cannot access good nutrition, basic medication etc. Urbanisation is very high, which means that there are more people than the formal sector can absorb. The trained, experienced and skilled manpower (20-45 years) is particularly affected by HIV/AIDS. Mortality and morbidity are reportedly high affecting productivity.
- ✘ Efforts at addressing the pandemic have largely focused on prevention efforts, and this is narrowly conceived as distributing HIV/AIDS leaflets and condoms.
- ✘ Stigma and discrimination have continued unabated. Affected communities are framed as victims and

perpetrators, with the effect of rendering the interventions. The absence of a culture in which human rights for all are protected, promoted, respected and guaranteed.

Rights based approaches

Human rights have been enumerated in several conventions and treaties. Some have even become legal rights.

For example

- ✘ The UN General Assembly Special Session on HIV/AIDS Declaration (UNGASS). The meeting on 25-27 June 2001 was a historic landmark. The Declaration of Commitment on HIV/AIDS adopted at the Session outlines 10 areas of action with specific goals and targets.
- ✘ The International Guidelines on HIV/AIDS and Human Rights published by the Office of the UN High Commissioner for Human Rights (OHCHR)/UNAIDS in 1998 as a tool for States in designing, co-ordinating and implementing effective national HIV/AIDS policies and strategies. The Guidelines provide the framework for a rights-based response to the HIV/AIDS epidemic.
- ✘ The Southern African Development Community (SADC) code on HIV/AIDS and Employment. The purpose of this policy is to guide states on the most effective and humane ways to respond to HIV/AIDS in the work place.
- ✘ Improvement of government capacity for multi-sectoral co-ordination and accountability.
- ✘ Reform of laws and legal support services, with a focus on anti-discrimination, protection of public health, and improvement of the status of women, children and marginalised groups.
- ✘ Support and increased private sector and community participation to respond ethically and effectively to HIV/AIDS.

HIV/AIDS and Human Rights in the Work Place Guideline #5

Target

- ✘ Employers and their employees, e.g. Zambia Revenue Authority, Zambia Sugar PLC, Zambia Bottlers and NGOs.

Principles Emphasised include

- ✘ Non-discrimination
- ✘ No mandatory HIV testing, all testing to be voluntary with specific and informed consent.
- ✘ All disclosure of HIV status is to be treated with utmost confidentiality.
- ✘ Reasonable accommodation
- ✘ Discriminatory practices should be addressed in disciplinary codes.
- ✘ Medical schemes should include AIDS drugs.

Results

- ✘ Companies are in the process and in some cases completed draft work place policies in consultation between management and staff.
- ✘ There is an increase in the number of employees (who are HIV+) seeking redress for their grievances.
- ✘ More employers have begun to include AZT in employees medical schemes.

HIV/AIDS and the Law Guideline #5

Target

- ✘ PWHA's, students and NGOs.

Issue

- ✘ Using the law to protect and promote the rights of PWHA.

Content

- ✘ Took participants through the Zambian Constitution and relevant legislation (though few) in such areas as employment, health, insurance, legal process. Also referred to examples internationally/regionally in Canada, Brazil, SA, India, Australia and Namibia.

Results

- ✘ Increased awareness of the rights of PWHA.
- ✘ Increased incidence of the challenging of discrimination.
- ✘ Most people who have stuck around after the training and also most of the "complainants" have been male.

Human Rights and VCT (Again, Guideline #5 refers)

Target

- ✘ Society for Family Health/New Start Centre Counsellors.

Issues

- ✘ Confidentiality; duty to disclose/partner notification, breaches of confidentiality and consent.

HIV/AIDS, Human Rights & Communities Guidelines

Target

- ✘ Youth organisations, police Victim Support Unit (VSU), community school teachers and health care providers.

Issues

- ✘ Fostering a human rights culture
- ✘ Non-discrimination
- ✘ Rights to benefit from scientific advancement
- ✘ Right to marry and found families

Conclusion

- ✂ Rights based approaches have proved to have a mobilising and empowering effect, particularly on affected communities.
- ✂ Rights based approaches provide a framework within which governments etc can be held to account regarding human rights.
- ✂ In order for the rights based initiatives to yield success, there is need for increased human rights education and literacy.

9. DEBATE: Do Cultural Practices Contribute to the HIV & AIDS Epidemic?

For:

Yes, Cultural Beliefs and Practices Propagate HIV/AIDS

1. George Kampango, MANET+, Malawi

Nature of Culture

- ✂ Dynamic
- ✂ Not static
- ✂ Seasonal as it is dictated by the changing times
- ✂ Plays with the mind
- ✂ Based on a particular society's strong beliefs

Examples of Cultures that have Changed

- ✂ Celebration of mass in the Catholic Church. The belief was that it had to be celebrated in Latin, but that has since changed.
- ✂ Friday as a day Christians should not eat any kind of meat - that has also changed.
- ✂ Woman's place was in the kitchen, today that has changed.

But does Culture really Contribute to HIV/AIDS?

- ✂ Certain cultural practices contribute negatively to HIV/AIDS. We need to 'deculture' men so that they actively and meaningfully contribute to HIV/AIDS work.
- ✂ Some emerging cultural practices can be used to advance/promote positive responses to HIV/AIDS.

Negative Cultures

All these need to be reviewed and modified where possible:

- ✂ Cultures that encourage unprotected sexual intercourse.
- ✂ Wife inheritance/widow inheritance.
- ✂ Widow cleansing.
- ✂ Certain forms of circumcision.
- ✂ Female mutilation.
- ✂ Early marriages.
- ✂ Initiation ceremonies when perceived as a mark of sexual growth and maturity.
- ✂ Dry sex, and use of herbs to make the vagina tight and dry.
- ✂ Culture of denial.
- ✂ Culture of economic dependence on men by women.

Emerging Cultures in the Context of HIV/AIDS

- ✂ Culture of silence, we need to develop a culture that breaks the silence surrounding HIV/AIDS.
- ✂ Use of protective measures to prevent HIV infection.

What Needs to be Done?

We are all aware that HIV/AIDS is a life threatening disease.

Therefore, we need to:

- ✂ Deculture men.
- ✂ Change/modify cultural practices that predispose people to HIV infection.
- ✂ Put in place programmes that address cultures that are risky.

Some Key HIV Infection Indicators

- ✂ Age at first sexual intercourse.
- ✂ Age at first marriage.
- ✂ Gap between age at first sex and age at marriage.
- ✂ Serial monogamy.
- ✂ Sexual mixing patterns.

2. Jedidah Nyongesa, African Population Advisory Council, Kenya

The Problem

Mythology, misconceptions and taboos thrive and inadvertently serve to camouflage facts and rationality. Culture influences the way people interact and is therefore crucial to the understanding of behavioural change needed to reduce HIV transmission. Control and prevention of HIV transmission demands changes in social relations and alterations in institutional values and norms. In Kenya there is a gap between preventive and control efforts and culture specific focused development.

Description and Results of the Project

Socialisation and enculturation: Children are socialised based on their gender and age. For girls, the emphasis is on virginity, fidelity, controlled mobility, and submission to men's (husband) sexual desires. Boys are socialised into masculinity culture and grow up expecting their sexual desires to be met on demand. This behaviour greatly enhances vulnerability to HIV infection and indiscriminate, unprotected sex.

Kinship and Social Structure

In most African communities, sex and sexual practices are linked to issues of paternity and sexual identity, and remain one of the most intimate and guarded areas of social life.

Marriage

For a girl, marriage means leaving her parental home, joining her husband's family and entering into closely guarded marital faithfulness. Marriage does not decisively change the life of a man.

Polygamy

Cultural conservationists argue that AIDS is a disease of the west and western lifestyle whose cure is embedded in a return to the African traditional way of life. While this assertion could be true to a certain extent, it is also true that HIV is facilitated through social relations and institutionalised cultural values such as the imbalance in gender power and sexual relations.

Widow Inheritance/Levirate

Proponents of widow inheritance believe that a woman marries into a lineage and death does not constitute end of marriage. This practice has had detrimental effects in situations where the husband's death is AIDS related.

Condom Use

Any form of barrier, real or imagined, to sexual pleasures is instinctively resisted. Due to this perception, there is a resistance to condom use on grounds that condoms are un-African.

Migration

These casual extra marital relationships are highly risky and they stem from the attitudes of male domination where they expect to have their sexual demands met whenever they want.

Sexual Violence

Factors that expose many African women to HIV infections are tied to the issue of male domination and female submission. Many women are in a position of powerlessness physically, morally, emotionally and financially, rendering them vulnerable and hampering safe sex negotiations.

The Culture of Silence

Sex is clouded with uneasiness, shyness and sensitivity. These attitudes have made sex education and discussion a subject of controversy.

Health Seeking Behaviour

Many patients initially question the HIV/AIDS diagnosis and consult traditional healers and quacks for treatment. Many of the healers and quacks give a false impression that AIDS is curable.

Conclusion

Yes, there is definitely a link between risky cultural activities and behaviour and HIV/AIDS transmission. Central to the weaknesses of policy and programmes in response to HIV/AIDS are the issues of misdefining the problem. The HIV pandemic was first seen as a public health issue followed in recent times as a development issue with no specific link to culture. Consequently, fundamental conflicts have emerged in relation to campaigns promoting monogamous sexual relations, premarital sexual abstinence and promoting the use of condoms. This conflict has created a demand for continuous operational research to establish accurate and up to date information needed to influence men's belief and practices in relation to gender sex, sexuality and sexual health.

Against:

No! Cultural Practices do not Contribute to the HIV Epidemic

1. & 2. Paul Botha & Moeti Lesuthu, DramAidE, South Africa

Our colleagues presented an argument supporting the view that cultural practices contribute to aggravating the HIV/AIDS epidemic and efforts to curb the disease. **In response to their perception, we argue the following points:**

- ✂ Hegemony based approaches and perceptions regarding culture and cultural practices need to be redefined. This needs to be done pragmatically and sensitively.
- ✂ 'Common-sense' approaches to culture, cultural perceptions and HIV/AIDS need to be questioned. They often do not take cognisance of the meanings inherent in complex socio-economic factors that forge cultural responses to the epidemic.
- ✂ Educators, development and community workers have to find ways to harness the power of traditional cultural activities and use them to develop healthy behaviours.

Human rights, gender and culture as barriers in HIV/AIDS education

It is true, that culture and some cultural practices, are perceived as barriers to HIV/AIDS education in Africa. Numerous traditional practices contravene human rights. These practices sometimes challenge the physical and emotional well being of individuals and communities. However, this is not true for all cultural practices and belief systems - most are based on co-operation and respect.

Judgmental perceptions of 'culture' alienate communities and slow response to the epidemic

The notion that cultural practices contribute to the spread of HIV has negative consequences for people's cultural perceptions of themselves. It has the potential to censor, limit and undermine the value of communities and their identities. When presented devoid of a cultural framework, these practices are often not fully understood and are perceived as 'barbaric' and devoid of social value.

Contributions of 'othering' to the epidemic

African culture is viewed as a separate and distinctly different 'culture' to that of 'other' cultures. Perceptual 'othering' of 'culture' and 'male roles' has been a contributory factor in alienating African males. Development workers perceptions of culture and male roles therefore may contribute to slowing social transformation.

'Participatory approaches' and deconstructing theoretical assumptions

Participation does not mean allowing people to communicate about HIV/AIDS through the channels prescribed. Many agencies and interventions are based on modernistic prescriptive approaches. Interventions should be truly participatory and make use of local systems of knowledge. The people themselves need to go through processes that will enable them change.

Approaches to using culture for HIV/AIDS education need to differentiate between proactive and dangerous practices

Cultural practices are important as long as people see value in them. It is important to differentiate between proactive and dangerous practices and to have a thorough understanding of a particular culture before making assumptions. People need to celebrate their cultural diversity.

The consequences of devaluing messages inherent in cultural practice

In most cases outsiders understand cultural practices only on superficial levels.

Culture, domestication and prescribed gender roles

The concept of manhood and responsibility is often posed as a core problem of the HIV/AIDS epidemic. The values people attached to sex are diverse. Cultural education and the development of young people's understandings of why they have sex may go a long way to helping young people to avoid risk situations.

Shaping and developing group efficacy as a response to HIV/AIDS challenges

Interventions have found that improving group efficacy in areas where cultural practices are perceived to be resistant is highly beneficial for appropriating new responses. Group efficacy effects behaviour in a cultural context.

Redefining personal and social roles and finding an appropriate response

Young men and women should be encouraged to redefine traditional perceptions of masculine and feminine roles. They need to share the responsibility of negotiating healthy, safer sexual relationships.

Working with culture rather than against it

Attempts that have been gender-based or gender-sensitive have focused mostly on the empowerment of women with limited success. Highly empowered women have admitted to failing to convince their partners to practice safer sex.

Challenges associated with using culture to find an appropriate community response to the epidemic

Most societies are patriarchal. Men are expected to take risks, have frequent sexual intercourse, more than one partner and exercise authority over women. These expectations encourage men to force sex on unwilling partners and to reject condom use. Caught between modern and traditional norms some men are uncertain as to the roles and behaviours expected of them. This often manifests itself in aggressive assertion of masculine dominance expressed through violence against women.

Power discourses in HIV/AIDS and gender

Research indicates that neither knowledge nor the intent to practice safer sex empowers young women and that the most significant factor seems to be the position taken by the male partner. If this is indeed true, it reinforces the view that women are often 'powerless' and 'victims' of their situation.

Developing responsible dialogue to address denial and risk taking

Open and equal channels of communication between men and women are not always considered culturally acceptable. The stigma of HIV/AIDS has further developed a culture of fear. People live in denial of HIV/AIDS and their own personal risk. Gender responsibility in sexual behaviour and in HIV/AIDS prevention is inextricably linked. Issues around male and female sexuality and power need to be addressed if the spread of HIV/AIDS is to be curbed.

Male liberation from myth and generalisation

Men require liberation from myths, from misogyny, from the cycles of violence that are derived from hunter/warrior roles and patronising perspectives. Feminism may insinuate transference of power, which threatens masculine concepts of status. There is also fear of HIV/AIDS and its threat to masculine concepts of virility and sexual opportunity. These threats and fears have developed a masculine cultural landscape that is both paranoid and devoid of masculine markers.

Radical transformation of gender roles and traditional patterns of communication

Men have begun to object to what they feel is a degrading and stereotypical view of 'them' as 'unfeeling, sex driven thugs' who do not have the capacity nor will to negotiate a mutually satisfying relationship with a woman. In order for young men and women to develop healthier and more fulfilling relationships a radical transformation needs to take place. **Communication problems, which cause relationship problem areas, include:**

- ✂ Assumed similarity: Although there are differences between the sexes, it is not productive to assume that all men love sports any more than it is constructive to assume that all women love sewing and cooking.
- ✂ Language and non-verbal misrepresentation: Gender influences, and is a product of communication. From an early age, girls and boys are taught different communication behaviours that are considered appropriate. The way in which we communicate reflects notions about gender and creates cultural concepts of gender. The way in which verbal and non-verbal language is used is important in identifying these roles.
- ✂ Anxiety: In Africa the response to people living with HIV/AIDS and to women, is often abusive. Combined with the cultural ramifications of traditionally highly sex-segregated societies, anxiety develops and is a factor in challenging gender relations and communication.

Educators play an important role in helping young men and women to express their feelings and often need to be both counsellor and therapist. Information, understanding and skills are vital for young people living the realities of the HIV/AIDS epidemic.

In Summary

If we preclude, censor or attempt to stop cultural practices there is the danger that we will force people to hide their practices. Once we have alienated people, destroyed their self and group efficacy it is unlikely that they will trust us and adopt new responses to disease, risk and behaviour.

- ✂ Perceptions and attitudes to 'culture' affect the nature of the discourse between educator and client. This discourse has the potential to alienate and engender passive resistance. Alternatively it can celebrate cultural practices and develop a climate of interactive debate. DramAidE has found that using cultural issues, as a departure point for deepening discussion, unpacking core values and beliefs within a cultural framework, is a positive experience for communities effected by HIV/AIDS.
- ✂ Cultural activities and events can be used to explore messages inherent in cultural practice with beneficial understandings and outcomes for all.
- ✂ By not valuing the diversity of cultural practices we devalue communities and this is accompanied by an associated loss of personal and social efficacy.
- ✂ Cultural education is important in developing values and behaviours that are healthy. Understanding the underlying reasons and ways in which communities work, has the potential to empower young people to make choices regarding what is right for them.

- ✘ Discussion, interactive games, drama based activities which are culturally based are popular with young men and women. Reflection helps young people to understand and make meaning of themselves, their peers and their culture. Using culture to address HIV/AIDS challenges is vital in transforming the way we think and act when faced by 'action-response' problems posed by HIV/AIDS.
- ✘ Forums can be created using cultural activities and events which both reinforce the positive aspects of perceived gender roles and which pose questions regarding appropriate behaviours. This helps to recontextualise gender roles appropriately to effecting safer behaviours.
- ✘ Culture is not segregated to specific times and places and it defines who we are. People have the ability to perceive benefits and limitations of cultural practices if correctly approached.
- ✘ Communication barriers to developing fulfilling and healthier relationships can be explored with safety in the context of the forums that the educator creates. For example, the community may sanction a workshop at school, which explores pressures that young men and women experience in their communities. Communities and young people see the benefits of these workshops if they are consulted, involved in the development process and if the facilitator is not culturally judgmental.

Rapporteur Report, Day 3

Culture

Douglas Kabanda from Pro-me-tra said that traditionally, men are viewed as the head of the family. This implies leadership and responsibilities. Men need to be brought back to their initial role as leaders.

Malala Sakufiwa from ZARAN said the role that culture plays in the abuse of women's rights and ultimately in the spread of HIV/AIDS can not be overemphasised. The promotion and protection of human rights is critical. Sex and RH education are needed and culture needs to be revisited as laws without cultural implications will not succeed.

Sebastian Matroos, Youth Skills Development, suggests that generally young men are seen as problems. Speaking to young men about their sexuality is an important step as there is a need to further educate young men especially about their sexual and reproductive health and HIV/AIDS.

Stigma & Violence

Newton Zulu and Carl Edmonds from Prison Fellowship discussed the different types of abuse in prisons (emotional, physical, sexual and drug) and the reasons (lack of food, no recreation, no staff concern, a survival mechanism, bitterness and revenge and boosting self esteem and power). They also highlighted different forms of abuse among street children and juveniles. Staff at the shelter and the prison are unsure about abuse policies and how to use them. Actions taken include staff training (using policy and listening skills) and youth training (identity, body parts, development, love, drugs, relationships, conception).

Outcomes

- ✘ Physical abuse reports have increased
- ✘ Drug task force
- ✘ Boys talk more easily to staff
- ✘ Contacts being made with parents who neglect their children
- ✘ Long term goal is to take the programme to prisons.

ADPP-TCE, Mozambique

TCE focuses on speaking to every individual within the community. TCE also works with all areas of problems in changing sexual behaviour without compromising or destroying the culture in which it works.

ZARAN, Zambia

The human rights based approach is advanced through four different areas:

- ✘ HIV & AIDS in the work place.
- ✘ HIV & AIDS and the law.
- ✘ HIV & AIDS human rights and communities.
- ✘ Human rights and VCT.

ZARAN has worked on issues related to the re-orientation of domestic laws to address human rights issues related to HIV & AIDS and with the corporate sector in Zambia to draft work place policies.

Achievements

- ✘ Increased incidence of challenging discrimination at the work place.
- ✘ More employers have begun to include ARVs in employers medical schemes.
- ✘ The rights based approaches have proved to have a mobilising and empowering effect, particularly on affected communities.

- ✂ Rights based approaches provide a framework within which governments, etc can be held accountable regarding human rights.

DEBATE

Do Cultural Practices Contribute to the HIV & AIDS Epidemic?

FOR

1.
 - ✂ Negative affects of socialisation contribute to the effects of HIV & AIDS.
 - ✂ Language that is used to bring up kids is negative.
 - ✂ Assigning of gender roles patterns dominance, risk taking and power for boys.
 - ✂ Girls are taught submission and powerlessness.
 - ✂ All these effects happen during initiation.
 - ✂ Boys taught to experiment with sex and that there is nothing wrong with multiple partners.
 - ✂ Sex is seen for procreation and therefore condom use becomes difficult.
 - ✂ Widow inheritance.
2.
 - ✂ Culture plays with the mind, it is based on societal belief.
 - ✂ Culture is dynamic, it changes with time and situations.
 - ✂ With HIV & AIDS we should identify the cultural practices which are risky.
 - ✂ Wife inheritance/widow cleansing is an example of risky practice that should change.

Summaries for

- ✂ Cultural practices do lead to HIV & AIDS.
- ✂ There are “modern cultures” based on silence and denial and the economic dependence of women on men.
- ✂ Have a bearing on age at 1st sexual practice and marriage and on serial monogamy and sexual mixing patterns.

AGAINST

1.
 - ✂ “Men are from Mars, Women are from Venus.”
 - ✂ Cultural practices make us who we are. They develop people’s identities and their relationships in the community.
 - ✂ Cultural practices are a response to the needs of that community.
 - ✂ Need to look at the underlying reasons for these practices.
 - ✂ We act in different ways depending on the context we are in.
2.
 - ✂ Cultural practices are changeable. Need to find ways of challenging cultural practices.
 - ✂ There is a lack of scientific information in the community which makes them use culture as an excuse, e.g. rape of virgins.
 - ✂ Underlying beliefs of culture do not change.
 - ✂ Maintain a culture and move within the continuum. Behaviour change models should be applied within a cultural context.
 - ✂ Group efficacy, apply this and this will lead to self efficacy.

Summaries against

- ✂ We tend to focus on the negative and destructive cultural practices.
- ✂ The fact that we are and are concerned is testimony to that cultural institution.
- ✂ We need to address cultural symptoms and change some of the cultural practices.

From the floor

- ✂ There is common ground between the opposing views.
- ✂ Culture as a present value system and all the traditional behaviours can be changed on the basis of the present day value system.
- ✂ Some negative cultural practices can be changed to positive values.
- ✂ Young people live in a world with conflicting cultures between school, home and the media.
- ✂ Do researchers and academics, or the people influenced by that culture say that cultural practices contribute negatively or positively to HIV/AIDS?
- ✂ Unfair to blame culture entirely for HIV, need to target risky cultural practices.
- ✂ Absence of human rights culture, this conflicts with traditional practices. A rights based approach should be used to press for change.
- ✂ Traditional practices and beliefs co-exist in human beings, how to change them?

Final comments

When defining masculinity we are looking at role models and leaders. Need to start from somewhere and the place to start is with the men who have attended this conference.

Enlisting men

- ⌘ Power relations between men and women.
- ⌘ Empowerment of men.
- ⌘ Blame is not productive.
- ⌘ Rights, need rights based approach.
- ⌘ What responsibility can each of us take?

Socialisation of boy child, how are they socialised, and what produces the masculinity construct?

- ⌘ Race & class issues are very important.
- ⌘ Unemployment contributing to men's identities.
- ⌘ Culture is dynamic and men's perceptions of identities are changing.
- ⌘ That the definition of masculinity is changing is very interesting and needs to be followed up and supported.
- ⌘ Question of what to do when we go back home, how do we go back to villages and towns.
- ⌘ Men traditionally focused on survival, hunting and procreation. The context is now changing and the time has come for "new heroes". To overcome the current problems, masculinity has to open up. Masculinity is about survival and growth.
- ⌘ Important to point out what men will be gaining not losing. "No person likes to lose, look at what I've gained with positive status," Brett Anderson.
- ⌘ Role is not to blame people but provide information and let them come up with informed choices, slogans like "Men, drivers of the epidemic" are not helpful, the slogan has outlived its usefulness and is now in danger of becoming counter productive. We must move away from blame to responsibility, what do we all need to do as family members, community members, shakers of society, what about me, you, all of us, what are we doing??
- ⌘ The family unit is the springboard for better communities. Men are the heads of households, what they are gaining by everyone being equal should be part of the growth of the new man. Men should be proud that women are empowered. "I'm not a man without a woman/partner and family".
- ⌘ We must not blame culture, men and women have to take on responsibility.
- ⌘ Society has beliefs, cultural norms and human rights, men are in charge of them all. We need to take these areas to policy makers to implement and make sure that they trickle down to all levels of society.
- ⌘ What are men doing to put structures in place for a positive person to disclose status? Nothing because we have empowered women to do it.

⌘ Quote of the week:

"There is a need for a spiritual transformation in constructions of masculinity"

Prof Graham Lindegger

Wrapping up

Evaluations

53 evaluations were completed, out of 71 participants. The comments between quote marks are extracted from the evaluations.

Objective 1

To share experiences of each organisation highlighting their strategies for engaging men within the pandemic in regards to behaviour change, caring, and active community responsibility.

Fully met 47  Partially met 5  Not met 0

Objective 2

To explore the potential issues of both increased and decreased male involvement with regards to HIV & AIDS.

Fully met 37  Partially met 15  Not met 0

Objective 3

Explore opportunities and strategies for increasing the sharing of experiences and lessons learnt across the region.

Fully met 28  Partially met 23  Not met 0

Objective 4

Discuss how VSO, other international and national agencies can further commit to support and strengthen the response of current and potential partners both nationally and regionally to ensure that there is more involvement of men at appropriate levels in future.

Fully met 21  Partially met 23  Not met 8

Unmet Expectations

The unmet expectations refer mostly to two issues. The first is the absence of a “way forward” component. Many participants expressed the need for “*action-oriented discussions*” and “*opportunities to learn strategies that I can take home and roll out.*”

A variety of men and HIV/AIDS issues were examined and examples of involving men in HIV/AIDS described. However, no space was budgeted for “*concrete outcomes.*” “*There was a lot of talk about problems without giving strategies.*”

“*More examples of projects or programmes on the ground, targeting and mobilising men, more ideas on best practices is working with men,*” requested one.

The second most frequent unmet expectation was the need for discussions in small groups. “*More opportunities to process the information obtained during the day,*” said one. “*Round ups were good but the audience was too large and at the end of the day too tired.*”

Conversely, several participants wanted longer plenary sessions at the end of the day. “*Discussion sessions were good/vibrant but often stopped in the middle of the flow.*” Chairs finished sessions on time, regardless of the chemistry happening.

More than half of the participants felt that Objective 4 (how can VSO and other agencies support current and potential partners) required more debate.

And many wondered about follow-up. “*What will happen next?*”

Other Feedback

⌘

Uneven quality of presenters, mostly good but some rambled.

⌘

Uneven quality of rapporteurs who summarised parallel sessions in the plenary at the end of each day.

⌘

Absence of government officials.

⌘

Need for a field visit.

Suggestions

⌘

Overwhelmingly, participants want similar conferences to be held at national or regional level *“to create a platform for new strategies”*.

⌘

Go deeper into the field of culture and HIV/AIDS.

⌘

Send the report to policy-makers to raise their awareness.

⌘

Invite participants from non-English speaking African countries.

⌘

Have an all-male *imbizo* (meeting) that *“would yield different chemistry and potentially useful chemistry”*.

⌘

Include more black male researchers/activists.

⌘

Include an analysis of donor’s constructions of interventions for behaviour change.

On the Plus Side

Overall, participants found the conference useful and successful. It led to *“personal transformation”, “motivation and inspiration”*.

The analysis of construction and deconstruction of masculinity got high marks. One participant said the outcome was: *“An increased awareness of the diversity and complexity of masculinity and its relationship to HIV/AIDS, of gender, culture and sexuality, understanding (...) the way in which they intersect.”*

Several participants valued the analysis of the relationship between culture, tradition and HIV/AIDS. *“The research presented was an eye-opener.” “The things we do must take cognisance of the underlying social and cultural beliefs.”*

For many, the conference provided fresh exposure to controversial issues and an opportunity to talk extensively and frankly about men who have sex with men, sex in prisons and male rape. *“We were able to discuss things one cannot normally discuss. This helps with stigma and discrimination,”* said one.

The group included heterosexual men, gay men, male rape survivors, researchers and activists who work with gay and bisexual men, religious men, in all, a variety of male experiences of sexuality engaged in dialogue over three days. *“A great spirit of sharing was present throughout the conference.” “The conference allowed an openness that was quite amazing, with great value placed on diversity of gender and ethnicity.”*

However, one participant warned *“to be careful that gay issues don’t hijack the main issues.”*

The take-home message was one of optimism. *“Men are open to transform and to make a difference.”*

Most participants felt the conference was a call to action. *“I feel energised and inspired, ready to go back to work on these issues with renewed strength,”* said one. *“Now we have to decide what we do with it, we have no excuses”*. Another said, *“Men DO care, now we just need to DO something.”*

Logistics, organisations and venue were praised, although a few would have preferred to be closer to the city. One participant summed it up: *“Slick, smooth and splendid.”*

Said another: *“One of the best conferences I’ve ever been to (...) a sense that a lot of ideas and energy will be put into practice.”*

Way Forward

Recommendations for VSO were put forward at small country groups that met briefly at the end of the conference.



To have similar events at national level, engaging both community activists and government officials in dialogue.



To have similar regional conferences once a year.



VSO country offices to implement strategies for men and HIV/AIDS and to work at grassroots level with men.



To set up working groups on specific topics to move forward with strategies and action.



To develop a network to maintain discussion and information-sharing.

Countries Report Back

Malawi

- ⌘ Not enough time for discussion in conference, need for behaviour change in all programmes.

Zambia

- ⌘ Conference positive as able to discuss things cannot normally discuss. This helps with stigma and discrimination.
- ⌘ A bit too much on homosexuality.
- ⌘ Was more on theory than practice.
- ⌘ VSO country offices should activate policies, bring in grass roots programmes working with men.

Namibia

- ⌘ Feel very renewed and recharged.
- ⌘ Feel we are not alone in fight and able to discuss men as in Namibia there is more discussion around orphans and vulnerable children (OVC) and women. Now we can head in the direction of men.
- ⌘ Would like the network to be continued to maintain discussion and information sharing. Should keep each other informed of developments.

South Africa

- ⌘ Very positive conference and enjoyed speakers, discussions have been lively and sparked thought.
- ⌘ Recommendation for what to do next, get specialist work groups together to discuss specific topics.

Zimbabwe

- ⌘ More value in small groups work than plenary.
- ⌘ Logistics were fantastic.
- ⌘ Point 4 of evaluation was not fully covered, hopefully VSO can have workshops to adapt programmes to implement strategies.
- ⌘ Problem of focusing on strategies, problem that both VSO and Zimbabwe partners share. Zimbabwe also has no main national support organisations.

Rest of the world

- ⌘ Conference allowed openness which was quite amazing and there was great value placed in diversity of gender and ethnicity. This allowed participants to learn a lot.
- ⌘ Allowed us to identify commonalities.
- ⌘ Recommendation, RAISA region very lucky and we'd like to have a similar event annually, working groups to take something forward with grass roots organisations and governments.

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