Gender & AIDS

Best Practices/Programmes that Work

Best practices comprise examples of programmes, projects and activities that have been shown to contribute towards making interventions successful. They do not represent "perfection;" rather, they are part of a process of applying knowledge, improving it and documenting the experience to be shared with others. A key element in best practices is that they enable persons and organisations working in the field of HIV/AIDS to: 1) avoid "re-inventing the wheel" because they inform persons and organisations about lessons learned; and 2) continue learning how to improve and adapt strategies and activities through feedback, reflection and analysis.

Organisations around the world have been working at the international, regional and community levels to incorporate a gender-based perspective into their HIV/AIDS programmes, but experience in this field is still recent. The number of "best gender practices" is therefore somewhat limited; in some cases, programmes and projects have incorporated elements of a gender perspective before this was explicitly their aim. Focusing consciously on incorporating a gender perspective into HIV/AIDS-related work can help institutionalise practices that may previously have occurred infrequently or casually. The best practices described below have been drawn from UNAIDS publications and other published literature.

Description of "Best Practices"

The health promotion concept provides a time-tested framework in which to situate a gender-based approach to adolescents' HIV/AIDS and other sexual and reproductive health (SRH) problems and needs. The framework entails five main strategies: creating healthy public policies; building personal and organisational skills; reorienting health (and other social) services; creating a supportive environment; and strengthening community action. Some guiding principles for gender-based best practices regarding HIV/AIDS and SRH for young women and young men are presented for these five strategies. These principles are followed by case studies which help illustrate how programmes have incorporated best practices into their work.

The term "gender" is used to describe the various characteristics assigned to women and men by a given society. The term "sex" refers to biological characteristics. Gender is socially constructed, learned, and can vary from culture to culture, generation to generation, and over time due to societal changes. Gender roles reflect the behaviours and relationships that societies believe are appropriate for an individual based on his or her sex.

Summary:

Using the health promotion concept as a framework, this module focuses on best practice elements that contribute to making programmes successful in integrating a gender-based perspective. UNAIDS defines "best practices" as accumulated knowledge concerning strategies and activities that work or do not work, why they work or do not work and how they work. This module is a component of the *UNAIDS Resource Packet on Gender & AIDS*, which includes additional modules, fact sheets, and an almanac.

Goal:

To provide information on "best practices" and successful programmes involving a gender-based approach to working with young people aged 10-25 years.

Intended Audience:

Policy Makers

Programme Developers and Implementers

Health Educators

Service Providers

Creating Healthy Public Policies

Best practice programmes are based on policies that help guarantee the human and sexual/reproductive rights of both female and male adolescents.

Programmes which base their work on existing policies regarding the SRH rights of young people may be able to obtain valuable support and legitimacy. For example, programmes that work to enable young people to protect themselves against HIV and other sexually transmitted infections (STIs) can reference policies relating to access to health education, information, and high-quality health care.

To contribute towards implementation of the Convention on the Rights of the Child (CRC), UNICEF surveyed 11,852 Caribbean and Latin American children of both sexes aged 9-18 years. The study revealed that a majority of the young people felt insecure at home because of prevalent violent and aggressive behaviours. More than 50% said they are not heard, either at home or at school. When asked what they knew about AIDS, 36% stated that they were little or not at all informed about it; only 53% felt well informed about drug use. UNICEF can now use this information to advocate that the Latin American and Caribbean States (who have all ratified the Convention) honour their commitment to Article 17 of the CRC, which says that governments must ensure that each child has access to information that "promotes his or her social, spiritual and moral well-being and physical and mental health".[1] HIV/AIDS programmes can incorporate such policies as the CRC into their work to help ensure the SRH rights of programme participants.

Building Personal and Organisational Skills

Best practice programmes provide both young women and young men with adequate information on all aspects of sexuality and reproduction.

In many areas of the world, expectations about gender dictate that young men gain experience in sexual matters before marriage while young women remain virgins until marriage. As a consequence, young women often receive little sex education. At the same time, young men may receive limited information on HIV/STIs and condom use. Education on reproductive matters may target girls, leaving young men with no sense of responsibility in this area and a lack of information on issues such as contraception, emergency contraception, the risks of early pregnancy and unsafe abortion. In short, adolescents often learn that reproductive matters are the responsibility of either men or women exclusively.

Best practice programmes focus attention on risk factors and risk situations that are of particular relevance for young men or young women's SRH.

While both young women and young men need information and education on all aspects of SRH, programmes need to ensure that extra emphasis is given to the information that can have the greatest impact on reducing their vulnerability to SRH problems. For example, education regarding alcohol and drug abuse is important for all adolescents, both regarding its effects on protected sex (e.g., forgetting to use condoms; greater risk of incorrect use) and its potential for increasing HIV infection through shared unsterilised injecting equipment. However, this information is especially relevant for young men since UNAIDS reports that four-fifths of drug injectors are male.[2]

Reorienting Health (and Other Social) Services

Best practice programmes recognise the diversity of the adolescent population so that particular needs are addressed.

Though many SRH concerns and needs are shared by young women and young men, their needs also differ according to whether they are single or married, rural or urban residents, in early or later adolescence, working or studying, heading households or living on the streets, etc. It is necessary to target programmes to such sub-groups of young persons, often differentiated by sex, so that their particular needs receive adequate attention.

In Belgium, the Better You Know Yourself, the Better You are Protected project tested and adapted methodologies and information tools to reduce the risk of young homosexual men from becoming HIV-positive during the period in which they were learning about their sexual orientation.[3] The messages that were developed included testimonies by young men who described their "coming out" (publicly defining their homosexual identity) in a positive way. The messages were transmitted through free telephone hotlines, radio ads, posters on public transportation vehicles and brochures distributed through family planning and youth centres. Written responses to the brochures indicated that young people found the campaign to be optimistic and hopeful, and this made it easier for them to adopt healthy behaviours which take AIDS into account. A lesson learned was that the campaign would have benefited from having similar materials available for girls who are uncertain about their sexual orientation.

Best practice programmes make services appropriate, accessible and available to both young women and young men.

In numerous countries, young unmarried people cannot attend family-planning clinics where they could gain information about condoms and other contraceptives. The young women may face stigmatisation if they are seen entering such facilities because of speculations about their "morality," while young men may be discouraged from attending them at all because of provider attitudes that contraception is "women's business." Programmes must ensure that persons of both sexes are welcomed. This may necessitate extra measures to attract young men. In a few places, separate clinics may be opened for men, but it is also possible for services such as family-planning and rural health clinics to offer special attendance hours for men where they can discuss not only their concerns related to HIV/STIs but also issues such as sexual orientation, sexual problems, urological problems, etc.

In 1988-89, a group of politicians in Gothenburg, Sweden, endorsed the funding of clinics where both male and female youth could have access to social and health workers free of charge.[4] By 1995, 150 of these youth walk-in clinics had been established throughout the country. The clinic staff are equipped to handle a broad range of youth concerns, such as general health check-ups, condoms and other contraceptives, STI testing and treatment, problems in relationships with parents and friends, problems at school and other psychological problems. Parental response has been quite positive overall and the young people have indicated via anonymous questionnaires and in-depth interviews that they especially appreciate the clinics' policy on confidentiality, staff skills in listening and the chance to see health and counselling professionals in the same place.

Best practice programmes recognise the links between multiple SRH problems and take measures to address them simultaneously.

Various SRH problems, such as STIs, can increase the probability of HIV infection. Programmes need to recognise the links and take a holistic approach to HIV/AIDS prevention. For example, in the tragic circumstance in which adolescents are victims of rape, antiretroviral therapy in the form of post-exposure prophylaxis (PEP) may help protect them from HIV infection.

A clinic in São Paulo, Brazil, offers comprehensive services to female rape victims—including large numbers of adolescents—that include emergency contraception and PEP when the case is reported within 72 hours, STI diagnosis and treatment, and abortion for unwanted pregnancies. A study conducted since PEP has been offered showed that none of 182 women treated with PEP became infected, while four of 145 (2.7%) in a control group without PEP did acquire HIV infection.[5] Calls for such treatment were frequent during the Durban AIDS Conference and WHO is assessing the evidence for post-rape PEP effectiveness. It should not be forgotten, however, that male adolescents also suffer from rape, albeit in smaller numbers than female teenagers—they, too, should have access to this possibly life-saving measure.

Best practice programmes recognise the special concerns of both young women and young men living with HIV/AIDS.

Policies and programmes must begin acknowledging—especially in countries with high HIV infection rates—that large numbers of the adolescent population receiving educational messages are already HIV+. This requires a reorientation of education so that it addresses not only preventing HIV infection but also living with HIV, including the importance of avoiding re-infection with HIV/STIs, the urgent need to have STIs treated, rights and responsibilities concerning sexual relationships, planning for a family or deciding not to have children, etc.[6]

Young pregnant women, for example, must be offered the option of voluntary HIV testing with pre-test counselling that emphasises how knowing their HIV status may help them best plan their prenatal care. If they test negative, they may be able to take extra precautions to avoid HIV/STI infections; if they test positive, they must be informed of the available options to avoid perinatal HIV transmission.

An important step for gender-based services is to support young people in their decisions about parenting. Women living with HIV who do not wish to become pregnant, either in the short or long term, should be informed of their options, including longer-term contraceptives such as injectables or implants, sterilisation and, where permitted by law, safe abortion if needed. Young men living with HIV can be informed about the possibility of vasectomies. Both young women and young men can be assisted to consider possibilities such as adoption.

The Indian Network of People Living with HIV (INP+) organises support group meetings for women and men living with HIV/AIDS in the city of Chennai.[7] The meetings focus on themes, such as the right of HIV+ people to marry and have children, an issue after the Indian Supreme Court made marriage by people living with HIV a punishable offence. INP+ is now carrying out advocacy to have the law changed. Men and women attend the support group meetings in equal numbers. In addition, the women have organised their own network where they can discuss sensitive issues more freely, such as menstrual hygiene and HIV and handling heavy domestic workloads while suffering from symptoms of HIV infection.

Creating a Supportive Environment

Best practice programmes make concerted efforts to gain the support of community leaders, senior community members, parents, teachers, employers and health sector staff for policies, activities and services that address the needs of young women and young men equally.

Programmes that are supported by the local community have a greater chance of success. Assistance and advocacy from local community members can help a programme overcome obstacles and help ensure that the programme is addressing the needs of the local residents. For example, community members can help programmes succeed by voicing their support in public for including young people in advisory and planning groups. Such community support is especially important if a programme runs into conflict because of subject matters that may be sensitive and possibly controversial. Community support can help legitimise the programme and provide many voices to help overcome possible resistance. Programmes can help sustain the community support by organising interventions designed to assist those community members who influence youth and by providing the community members with regular feedback on monitoring and evaluation results in order to sustain their support.

The Mexican Institute of Research on the Family and Population (IMIFAP) carried out a study that revealed both female and male adolescents wished to communicate more with their mothers and fathers about sexual issues.[8] They also found that parents had the same wish so they developed a programme to promote family communication about sexuality and HIV/STI prevention. A series of educational tools were used:

- a video for parents and adolescents showing examples of positive and negative communication as well as a condom demonstration.
- a parental course focusing on negotiating and establishing limits for adolescents, gender roles, talking about difficult topics and trusting adolescent children.
- a widely-used school curriculum for adolescents.

Evaluation showed that the mothers and fathers found the video realistic and helpful in addressing communication problems and issues such as HIV/STI and pregnancy prevention. The adolescents also believed that the lack of communication between parents and children shown was realistic. There was some evidence that adolescent girls found communication with their mothers to be less problematic after the intervention. However, none of the male adolescents perceived any improvements in parental communication, leading the researchers to conclude that more efforts are needed to involve fathers.

Best practice programmes ensure that "adult intermediaries"—those who enable and facilitate young people's access to services, such as parents, teachers, school health staff, health facility staff, development workers, NGO staff and policy makers—are provided with training to understand the need for a gender-based approach.

If young people are to be successful in adopting behaviours and practices that protect them from HIV and STIs, they must receive support from the adults around them, such as praise and encouragement when they demonstrate gender awareness and sensitivity. In addition, young people should receive permission from adults to join in organised prevention efforts such as peer education. Many organisations have developed curricula that can be used to train adults on issues such as gender disparities affecting the HIV/AIDS epidemic, gender issues in relationships and personal values regarding prevention efforts to be used by young women and young men. Such curricula—available from organisations such as Ipas, PAHO and UNIFEM—can be applied in numerous settings with a variety of target groups.[9-11]

The Group of Men Against Violence (GMAV), founded in Nicaragua in July 1993, originally began educating male staff of participating NGOs about gender issues and violence.[12] They then organised workshops, courses on masculinity and support activities for men in various communities. By 1998, GMAV was conducting seven youth groups in the capital city of Managua led by adults who had completed the training. The young male participants were enthusiastic, suggesting their own topics for discussion, such as the influence of drugs and alcohol on their sexual behaviour. An impact evaluation in late 1997 of one of the participating NGOs' courses showed changes in gender norms among the adult men who are important in educating their adolescent counterparts.

Best practice programmes help ensure that young women and young men living with HIV/AIDS enjoy the same human rights as other people.

Unfortunately, adolescents and adults living with HIV/AIDS around the world still face considerable stigmatisation and discrimination. In addition to efforts to demystify and destigmatise the disease, such as public advocacy campaigns that combat stigma, efforts are needed to assist young persons who are suffering from discrimination. Such assistance may include lobbying health and social services to provide adequate and appropriate support and offering legal assistance. Many programmes and projects are not in a position to offer legal support, but there are groups in most countries that can do so—knowing about them and establishing referral links is an important step.

ACCSI, an NGO in Venezuela, focuses on advocacy, lobbying for the application of relevant legislation and the defence of human rights on behalf of people living with HIV/AIDS.[13] They provide legal counselling and assistance to persons who have suffered discrimination. In 1999, a team of four lawyers and a law student assisted 769 cases which included issues related to: gaining access to medications; disability benefits, inheritance, and employment; detention and imprisonment; confidentiality; and housing. Both women (23%) and men (77%) made use of the services; their ages ranged primarily from 21-50 years. ACCSI has also acted on behalf of adolescents living with HIV.

Strengthening Community Action

Best practice programmes allow young people to participate in project and programme planning, implementation and evaluation.

Greater efforts are needed to enable and encourage young people to participate in designing, implementing and evaluating SRH services so that they become truly youth-oriented and youth-friendly. One way to achieve this is to ensure that at least some female and male adolescents are included in advisory committees that guide projects. To ensure that their participation is not just "token," it may be necessary to have a separate advisory committee of young women and young men so that young people have more support to participate.

Stepping Stones, a programme developed in Uganda in 1995, is now used by some 2,000 organizations in 104 countries.[14,15] The programme involves groups of younger women, older women, younger men and older men who explore SRH risk situations and negotiate strategies to promote sustainable behaviour change. After working through activities that examine a progression of themes – co-operation and communication, relationships, HIV and safer sex, other aspects of SRH, gender roles and planning for the future—the single-sex age groups prepare "special requests" to the community in the form of role plays. This process makes it possible for adolescents to speak as a group and helps overcome gender and age barriers.

Case Studies

The following case studies, from two regions of the world, illustrate how organisations have applied some of the best practice principles in their gender-sensitive programmes. The first highlights education for young people, while the second addresses expansion of SRH services. Each case contains a short summary of the project, including its goals and strategies. Some challenges and achievements are also noted.

☑ Developing Gender-Based HIV/AIDS Education in Estonia

LIVING FOR TOMORROW was a pilot project that was carried out by The Nordic Institute for Women's Studies and Gender Research (NIKK) from 1998-2000 with young people (aged 15-17) in Tallinn, Estonia.[16-18] Based on gender-focused research, it sought to develop critical literacy about gender-biased attitudes and sexual behaviours that heighten risks for HIV/STI infection. Project facilitators included men and women—sex education in the Baltic States has traditionally been relegated mostly to women.

Care had to be taken with introducing the concept of "gender," since in Estonia ideas such as "emancipation of women" or "equality for men and women," are still associated with the ideology of a Soviet past or negative stereotypes of Western feminism. Participatory work allowed the participants to explore their own daily-life assumptions that shape masculinity and femininity so that the concept became relevant to their own situations, while the research yielded data about gender issues both in Estonia and around the world.

This project reflects many of the best practice principles listed in this module. For example, the project's recognition of the diversity among Estonian and Russian adolescents helped address their particular needs and set a context for building collaborations between them. In addition, the project aimed to build the young people's personal and organisational skills and confidence in their own agency. Placing HIV/AIDS education into a broader SRH context, which also focuses on gender, illustrated how health education can be reoriented. The involvement of researchers, educators, parents and schools contributed to a supportive environment. The project enabled the young people to design and produce informational materials relevant to their own cultural situations and prioritised their SRH concerns. Other best practice principles are reflected in the project as well.

Project goals aimed to help the young people:

- reflect critically on their assumptions about gender-appropriate sexual behaviours and their consequences for young women and young men.
- develop an understanding of the importance of gender in relation to HIV/AIDS.
- understand the importance of their efforts in helping to stem the spread of HIV among young people.

Strategies included:

- Organising a core team of collaborating researchers, educators/facilitators and young people willing to commit themselves to participation in the project.
- Designing adult and youth capacity-building learning strategies based on social transformation education models (e.g., interactive group activities, response improvisation, role-play, participatory drama, etc.).
- Collaborating with local educators and researchers to plan and hold week-long capacity-building workshops to develop knowledge and shared understanding of gender issues and youth perceptions for the facilitators of the planned sessions with young people.
- Generating project-related research as well as designing and testing a questionnaire on attitudes and beliefs related to gender and sexual behaviour.
- Linking the project to national, regional and international initiatives related to gender research, gender democracy concerns and HIV prevention initiatives.

Challenges included:

- Recruitment of participants for the core group: the project wished to include people who were excited about creating new approaches rather than people who self-identified as experts on HIV/AIDS. They also needed to find people who were really interested in *this* project, in particular, rather than the possibilities it provided for funding.
- Participatory education is fairly unknown in Estonia, where educational methodologies have focused on transmitting expert knowledge to students. An Estonian saying—"children may talk when chickens pee" (i.e., never)—reflected the challenge that the project faced in training the adult facilitators to become youth-focused and in mobilising confident participation among the young people. The training workshops, to the extent possible, avoided the simple didactic presentation of research findings and other data.

Achievements included:

- Following the capacity-building, the core group designed and organised eight day-long workshops for 25 Estonian and Russian youth aged 15-16 years. The adolescents were recruited from Estonian and Russian schools and their parents were kept informed about the project. The workshops facilitated discussions among the teenagers on gender-based sexual behaviours in their cultural environ-

ments and supported them in envisioning a sexual health educational agenda that incorporates their perspectives and concerns about sexuality, gender and culture.

- A 68-page booklet, with text in three languages, was written and illustrated by the young people themselves. "How to Bridge the Gap Between Us? Gender and Sexual Safety" was launched in October 2000. It focuses on gender, sexual relations and safer sex and includes a 16-page vocabulary list in Estonian, Russian and English of words relating to sex and gender.
- The questionnaire development and utilisation process was shared with researchers and educators in 11 countries. A collaboratively revised version was piloted and developed for use as an education and research tool in different cultures.
- NIKK is publishing reports on issues raised by the Estonian questionnaire data, "Challenging Gender Issues," and on the project work process and strategies.
- The project participants were assisted in their autonomous initiative to establish the NGO Living for Tomorrow, which was formally registered in Estonia in August 1999. They acquired funding from UNDP to continue the processes of youth workshops begun in the NIKK project, and in 2000, they trained a new cohort of teenage volunteers.
- The adolescents, with support from the NGO and AIDS Prevention Centre, now propose to produce a quarterly newsletter on sexual and gender issues, in Estonian and Russian, for distribution in schools.

☑ Including Men in an HIV/AIDS Programme in Brazil

The Brazilian family planning association, BEMFAM, established an HIV/AIDS programme in 1993 with four components: staff training on integrating HIV/STIs into clinic services; implementing HIV/STIs and unwanted pregnancy prevention for adolescent students; AIDS community education; and small-group HIV/AIDS interventions for women.[19] BEMFAM decided to incorporate a new component into its existing HIV/AIDS programme to increase its gender sensitivity—the Men's Project: Participation, Health and Prevention. One goal of the project was to increase the use of clinical and educational services by male partners of female clients. Preparatory research was carried out with 80 participants in 10 focus groups. This revealed that men wished to: increase their access to health care; enhance their knowledge about male and female anatomy and physiology; gain greater skills in discussing gender and sexuality; achieve greater participation in providing sex education to their children; and become better able to negotiate condom use with their partners. One challenge that the programme faced was that some clinic staff had difficulty in working with men. In response, the project required continuous staff training. Project staff worked with men while they were waiting for their female partners during appointments. In its health clinics in Recife and Natal, the project established regular male reflection groups that addressed the men's concerns for their family's health.

BEMFAM's reorientation of existing services by including men sets the stage for building both staff skills and those of the new target group. Educating the men helped create a supportive environment for both their female partners and children. The establishment of men's reflection groups was a first step towards enhanced community action. These best practice principles were also reflected in other aspects of the project.

Goals included:

- Determine the effectiveness and feasibility of pilot small-group interventions for men alone and for men and women together.
- Increase clinical and educational services for men in two of BEMFAM's reproductive health clinics.
- Increase the availability of information on potentially effective HIV/STI prevention strategies.

Strategies included:

- Service promotion through targeted messages.
- Promotion of the reproductive health clinics as places not only for women.
- Production and distribution of educational materials targeted to men.
- Promotion of men's services among female clients.

Challenges included:

- A need to adapt the educational model that BEMFAM used thus far because the men's baseline knowledge levels were lower than expected.
- Developing educational work for mixed groups of men and women.
- Equipping staff to discuss violence issues with the male clients.

Achievements included:

- Workplaces have been found willing to allow BEMFAM to offer educational talks to their male employees, and condom distribution to men has increased.
- In 1999, the project entered its second phase which involved training 30 staff-members of four more reproductive health clinics.
- Evaluation in 2000 showed that the male reflection groups helped foster dialogue between sexual partners.

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