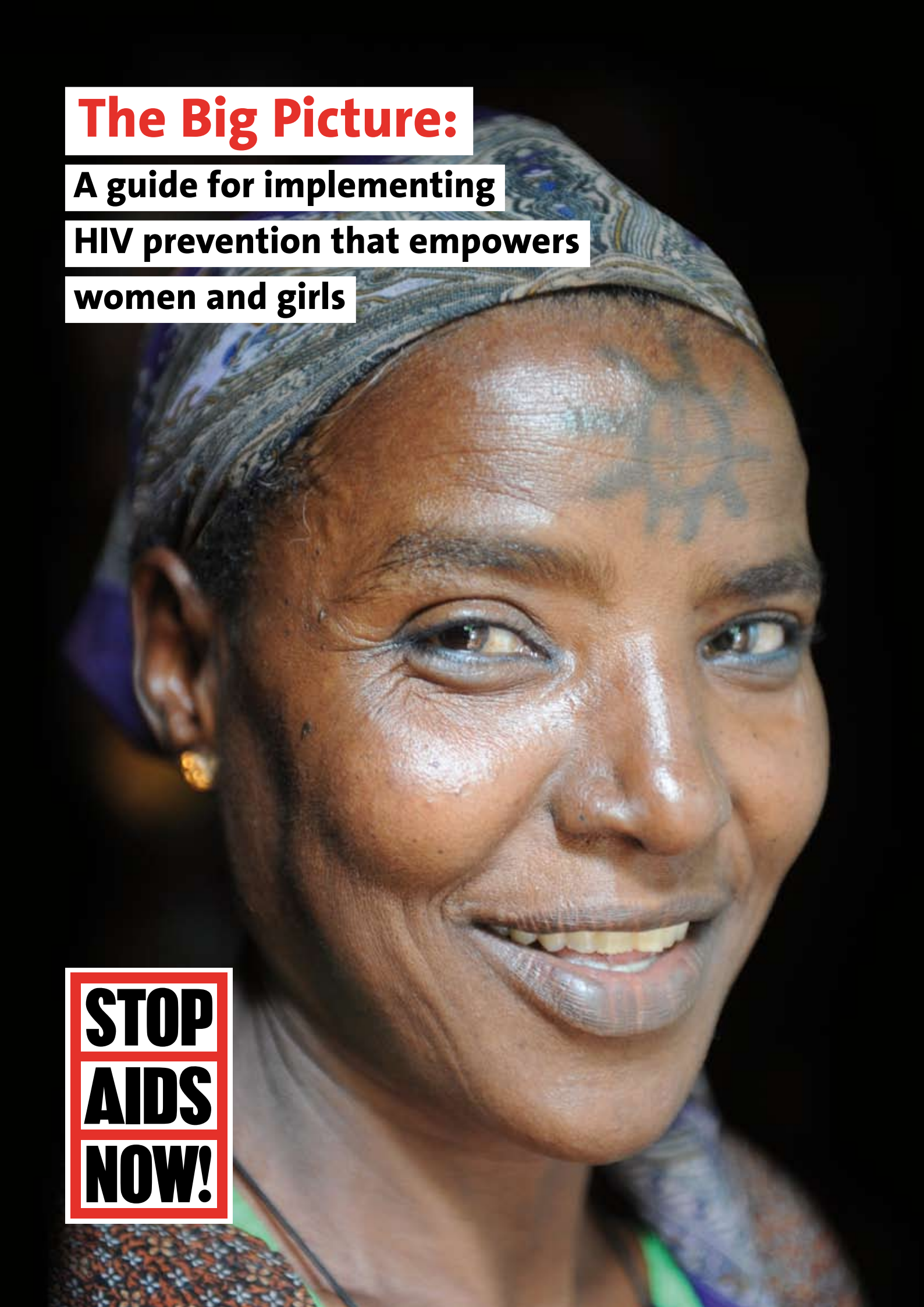


# **The Big Picture:**

**A guide for implementing  
HIV prevention that empowers  
women and girls**

**STOP  
AIDS  
NOW!**



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## Colophon

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STOP AIDS NOW! is a partnership of Aidsfonds and four Dutch development organisations: Cordaid, Hivos, ICCO and Oxfam-Novib. Our mission is “working together towards a world without AIDS”.

STOP AIDS NOW! uses a ‘learning by doing’ approach. We work with local partners to develop new strategies and methods, and redefine existing ones, and we take on applied research to find out which practices work. We widely share evidence and lessons from our projects so others can replicate successes in their own contexts, and to influence the policies and programmes of our Dutch partners. Our ‘learning by doing’ projects focus on different themes intimately linked to the HIV pandemic. From 2004-2010 they included: prevention for youth; managing HIV in the workplace; orphans and vulnerable children; and gender.

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# Table of contents

<b>1. Introduction to this guide</b> .....	4	What is the purpose of this guide? .....	4
		What does this guide offer? .....	4
		How to use this guide.....	5

## 2. Why tackle HIV, gender and rights together?

Links among HIV, gender and rights.....	9
ABC: as easy as 123?.....	11
HIV prevention and gender.....	12
Power and empowerment.....	13
The role of rights .....	15

## 3. Inspired to address the root causes of vulnerability to HIV? Address the big picture and initiate real change!

<b>Step 1: Analyse and map the inter-linkages among gender, HIV and rights in your context</b> .....	17	b. Develop broader community awareness-raising and help create a pro-woman, pro-girl environment!.....	34
<b>Step 2: Begin thinking about your HIV work using a transformative perspective</b> .....	18	c. Develop mechanisms to respond to experiences of discrimination and rights violations .....	34
<b>Step 3: Analyse who to work with to achieve change</b> .....	21	d. Support women to support themselves economically .....	35
<b>Step 4: Design your transformative activities</b> .....	32	e. Prioritise community ownership.....	36
a. Develop discussion sessions for direct beneficiaries or clients .....	32	f. Join forces with others!.....	37
		<b>Step 5: Monitor and evaluate your progress</b> .....	38

## 4. Case studies on transformative activities

Yayasan Harapan Permata Hati Kita (YAKITA).....	41
Community Mobilisation for Economic Development and Advancement (C-MEDA) .....	43
Women Fighting AIDS in Kenya (WOFAK).....	46
Dupoto-e-Maa .....	48

<b>Appendix 1: Partners participating in the Gender Development Project</b> .....	51
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<b>Appendix 2: Evidence about responding to the big picture</b> .....	53
Evidence from other programme trials.....	53
Evidence from the Gender Development Project .....	54

The four elements of our research to evaluate the Gender Development Project.....	54
Reflections on the process and outcomes for partners ....	54
Empowerment and cultural change in communities .....	56

# 1. Introduction to this guide

## What is the purpose of this guide?

We have written this guide to support non-governmental organisations, community based organisations, and individuals in developing countries to develop HIV prevention strategies and activities for women and girls that promote gender equality and women's rights.

## What does this guide offer?

This guide provides 'how-to' information for developing a 'transformative approach' to HIV prevention for women and girls. Such an approach addresses key root causes of vulnerability to HIV and seeks to reshape the beliefs, attitudes and behaviours of individuals and communities in favour of women and girls and gender equality. It also aims to empower women and girls to protect themselves from HIV infection and from the negative impact of living with HIV. The first box below summarises the results of the approach used in STOP AIDS NOW!'s Gender Development Project. The second box has additional background information.

It sets out the rationale for working on HIV prevention using a transformative approach. It also shares experiences and promising practices from the Gender Development Project.

It then provides steps based on these for developing HIV prevention work aimed at reducing the HIV risk of women and girl through promotion of gender equality and women's rights.

**This guide will be particularly interesting for people working at community level who want to address the structural factors behind the vulnerability of women and girls to HIV.**

We note that the advice in this guide is not fixed and definite; please read it as providing suggestions based on the experiences of the partners in the Gender Development Project. The advice should be adapted to fit local needs and the relevant social, political and cultural context.

We also note that this guide is not comprehensive and is not written to support the development of a whole project cycle. It gives guidance about how to think from a 'gender transformative' perspective, but it does not, for example, give step-by-step instructions for doing a needs assessment.

Finally, we note that this guide encourages readers to think differently about how to respond to HIV, using a holistic perspective, the so-called 'big picture'. Therefore, you should be able to find it relevant for different types of interventions, beyond prevention of HIV transmission.

**"As a girl I was not allowed to talk in public and my opinion did not count...I now have more confidence and can speak openly and confidently about HIV and AIDS and issues of gender."**

Youth peer educator supported by  
ACK Eldoret

## Key results of the Gender Development Project

### Community level quantitative survey results:

- In Kenya, the researchers compared respondents who had participated in the Gender Development Project activities against those who had not, controlling for organization, age, education, marital status and religion. They found strongly significant associations between participation and scores for decision making, control in relationships, gender norms and attitudes, condom norms and attitudes, and self-efficacy on condom use.
- In Indonesia the most significant change was in knowledge and attitudes about HIV/AIDS (starting from a low base), followed by improvements in norms and attitudes with regard to condoms. There was also a (statistically insignificant) shift towards rejecting traditional gender roles.

### Community level qualitative results from interviews, focus group discussions and observation:

- New public dialogue on gender issues—for example, cultural custodians speaking out for the first time about women's choice in widow inheritance, and against early marriage and violence against women;
- Changes in cultural practices—such as young men and boys taking up domestic tasks, and school girls refusing to be circumcised;
- Greater involvement of women in governance—with more women attending chiefs' meetings, sitting on school and water committees, becoming priests, and being elected to leadership positions in the community;

- Economic empowerment of women—with women starting a wide variety of individual and collective businesses;
- Women resisting violence, including sexual abuse—for example, challenging their partners about domestic violence;
- Greater willingness to report rights violations—including community members trained as paralegals assisting others to act on cases of gender based violence and inheritance issues;
- Improved self-esteem—such as school girls reporting higher levels of self-esteem, becoming more confident to speak in public, and feeling more able to say “no” to sex;
- Greater agency to prevent HIV transmission—including women insisting on condom use; and
- Reduced stigma regarding HIV infection and better care for people with HIV—such as improved understanding of HIV transmission, and better mutual support for positive living among groups of people living with HIV.

**Impact on participating partners:**

- Partners taking a broader and more holistic approach to HIV prevention;
- Some partners attempting to integrate gender, rights and HIV in all their work;
- Increased networking and collaboration by some partners; and
- Many partners developed gender and/or HIV policies as a result of their involvement in the project.

**“MAKOBAS support group helped a lady who had been chased by her relatives and her property taken way after her husband died... they involved the chief, DO [District Officer], DC [District Commissioner] and the police. The lady is back to her land and has built her home.”**

C-MEDA implementer

**How to use this guide**

Go to:

**Section 2: Why tackle HIV, gender and rights together?**

... if you would like to read more about the rationale for the ‘big picture’ approach of integrating gender and rights issues in HIV prevention work.

Go to:

**Section 3: Inspired to address the root causes of vulnerability to HIV? Address the big picture and initiate real change!**

... to learn about five steps to develop a transformative, ‘big picture’ approach to HIV prevention

- Step 1: Analyse and map the inter-linkages among gender, HIV and rights in your context
- Step 2: Begin thinking about your HIV work using a transformative perspective
- Step 3: Analyse who to work with to achieve change
- Step 4: Design your transformative activities
- Step 5: Monitor and evaluate your progress

Go to:

**Section 4: Case studies of transformative activities**

... if you would like to know more about the approaches the partners took.

## Information about the Gender Development Project

STOP AIDS NOW!'s Gender Development Project ran from 2006-2010 in Kenya and Indonesia.<sup>1</sup> We invited a range of partners<sup>2</sup> to take part, specifically targeting specialist organisations with a focus on rights, women's empowerment or HIV, as well as generalist development organisations, including faith based groups. We wanted a mix of partners to enable collaborative working, with different organisations being able to share their expertise and build each other's skills. By the time the project ended, 43 groups had participated.<sup>3</sup> Please see Appendix 1 for a list of the participating organisations.

The challenge for the partners was to implement evidence-based HIV prevention work which integrated gender transformative approaches developed from an explicit women's rights perspective. The project framework did not provide a predefined way of working, instead, partners could decide how they would do the HIV prevention work.

While some other HIV projects have aimed to change gender attitudes, norms and behaviours, the majority have focussed on masculinity, working with men and boys. The Gender Development Project encouraged partners to work primarily with women and girls, supporting their empowerment to address their vulnerabilities and to become agents of social change. However, the project did call for engaging men and boys in supporting gender equality and women's empowerment.

The Gender Development Project called upon the groups to form coalitions to take on lobbying and advocacy activities, and thus contribute to improving the legal and political environment for women and girls at national or sub-national levels. The Kenyan partners selected Women Fighting AIDS in Kenya (WOFAK) as their coordinating institution, while Koalisi Perempuan Indonesia had that role in the Javan coalition.

### Other distinctive features included:

- commitment to local ownership;
- commitment to seeking the meaningful engagement of women living with HIV in the management of the project;
- willingness to support partners to innovate and experiment in their methods;
- encouragement to develop strategies from a holistic understanding of the social, cultural and economic factors underlying women's vulnerability to HIV and AIDS;
- provision of training on gender, HIV/AIDS, rights, and gender transformation methods, as part of STOP AIDS NOW!'s commitment to building the capacity of civil society organisations; and
- asking partners to alter and improve their existing work, including working with groups with which they had already built trust, and adapting existing materials.

During the project STOP AIDS NOW! funded the costs of coordinating the coalitions and of capacity building support to the partners. It also provided small amounts of funding for the partners to adapt their work and take on small scale activities.

1 In Indonesia the project operated in the two areas with the highest HIV prevalence, Java and Papua. However, in Papua, the partners focused on more basic HIV awareness raising and general health activities. This document therefore does not feature their activities and results, but instead looks at the gender transformative approaches taken by partners in Java and in Kenya.

2 These organisations were all existing partners of STOP AIDS NOW!'s Dutch partners: Aidsfonds, Cordaid, Hivos, ICCO and Oxfam-Novib. The need to choose countries where all STOP AIDS NOW!'s Dutch partners had partners was another factor in the selection of Kenya and Indonesia as sites for the project.

3 Twenty-one in Kenya, and 22 in the two Indonesian locations.



## 2.

# Why tackle HIV, gender and rights together?

This section provides a refresher on terminology, and outlines how gender inequality and rights violations contribute to HIV transmission and increase the (negative) impact of living with HIV. If you feel you understand these issues very well, you may want to skip this section.

## Refresher on terminology

Our **sex** is what we are born as—either female, male or (rarely) intersex.

From birth, we are socialised to behave and dress as females and males according to **gender norms**. The norms vary from place to place, and over time. They have very powerful influences on us in many different ways. These include how we perceive ourselves and our potential, and how others view and treat us, both informally and formally such as in the law.

Most of us have a **gender identity** which matches our sex—most females feel themselves to be female, and most males feel themselves to be male. A minority of us are transgendered—females who feel they are male, and males who feel they are female.

Most of us have a heterosexual **sexual orientation**—most females are sexually attracted to males, and most males are attracted to females. Some of us are homosexuals—females who are attracted to females (also known as lesbians), and males who are attracted to males (also known as gays). Some of us are bisexuals—females and males who are sexually attracted to both females and males.

People who do not conform to gender norms may be stigmatised or even persecuted. For example, a woman who doesn't dress in a feminine way, who takes on leadership roles, or who doesn't have children, may attract negative attention. Transgendered people, gays, lesbians and bisexuals are particularly discriminated against, and homosexual sex is illegal in many countries. For an easy-to-read document about rights, sexual minorities and HIV, see *Break Another Silence*<sup>4</sup>.

**“Most [...] agreed a husband has no right to physically punish his wife. However, some said there were circumstances when beating a wife would be warranted, such as: refusing to admit a mistake; infidelity; talking back; being too outspoken, rude or disrespectful; drunkenness; mistreating his family or his children by another woman; being unable to take care of the family adequately; and denying him sex.”**

STOP AIDS NOW! (2008). *That is how many women here survive: Baseline Report Kenya*<sup>5</sup>

## Links among HIV, gender and rights<sup>6</sup>

Why is it difficult to prevent HIV infection in the context of gender inequality and widespread unmet rights? There are many reasons, which vary from place to place, but we can identify some key points.

### Dominant gender norms increase vulnerability to HIV infection for women and men:

- Men may be expected to be sexually active from a young age, may gain status by having more sexual partners, and may believe sexual desires must be satisfied. An emphasis on men being self-reliant and unemotional may lead them not to seek information and help on sexual issues, and not to prioritise caring for their own health. Furthermore, economic needs and the gendered division of labour may lead to their long-term migration for work. These gender related norms and attitudes act against prevention methods of abstinence or faithfulness to one partner and health-seeking behaviour, making men and their sexual partners more susceptible to HIV infection.
- Women may be expected to have a single sexual partner, who is usually older than them, and so more sexually experienced

and with a higher likelihood of being HIV-positive. They may be expected to have sex on his demand, and without the right to refuse sex or to insist on condom use.

- The expectation that women should be faithful to one partner contributes to making women more reluctant than men to be checked and treated for sexually transmitted infections. Untreated infections greatly increase the risk of passing or acquiring HIV.
- Where it is important for women to prove their virginity at marriage (that they have not had vaginal sex), they may instead have anal sex, which carries a much higher risk of HIV infection. Cultural taboos about anal sex prevent many men and women from being aware of the increased risk of infection.

4 You can find it at this site: [http://www.oxfam.org.uk/resources/policy/hivaids/downloads/break\\_another\\_silence\\_booklet.pdf](http://www.oxfam.org.uk/resources/policy/hivaids/downloads/break_another_silence_booklet.pdf)

5 [http://www.stopaidsnow.org/documents/gender\\_baseline%20report%20Kenya\\_Final.pdf](http://www.stopaidsnow.org/documents/gender_baseline%20report%20Kenya_Final.pdf)

6 For more detail on this topic, read ICASO's 2007 report Gender, Sexuality, Rights and HIV: An overview for community sector organizations, which you can download from [http://www.icaso.org/publications/genderreport\\_web\\_080331.pdf](http://www.icaso.org/publications/genderreport_web_080331.pdf)

- In some settings female genital cutting is seen as an important part of becoming a woman. The practice increases vulnerability to HIV infection to women who have experienced such cutting in three ways: at the time of cutting (if unsterilised tools are shared); during sex (because it leads to higher likelihood of tearing and bleeding); and in terms of type of sex (less willingness and ability to easily have vaginal sex may lead to more violent sex, or anal sex).<sup>7</sup>
- In their gender role of decision-makers with control over female relatives, men may use violence to discipline women and children. Women and girls in inequitable relationships and women who experience violence from their intimate partners are more likely to become HIV positive.<sup>8</sup>
- Women's lower access to education and to resources means they are, on average, economically disadvantaged compared to men. The gendered division of labour places women in the home, doing unpaid work. Women who are financially dependent on male partners are less able to assert themselves and to practice safer sex. This also applies to women who sell or trade sex as part or all of their livelihood.
- Economic dependence and fear of violence may stop a woman who is HIV-positive from disclosing her status to her partner, and therefore from taking action to seek care and support or to prevent transmission to him.
- In many settings it is important for men and women to have children, which creates the need to have unprotected sex, and undermines the use of condoms. HIV programmes do not often address the sexual and reproductive needs of couples, including how couples comprising one HIV-positive and one HIV-negative person (known as 'serodiscordant couples') can conceive and avoid HIV transmission.
- In some cultures a woman who leaves or is expelled from her marital home may lose access to her children. Her family may also have to repay the bride price (money and/or goods) received from her husband's family when

she married. These consequences act against women asserting themselves within marriage and leaving abusive relationships.

#### **Unequal rights make people more susceptible to HIV:**

- Women may have fewer rights in both formal and informal law, and so face discrimination. For example, where rape within marriage is legal, or where it is illegal but rarely acted upon, women are denied the right to refuse sex or to seek justice when they have been raped by their husbands. In general, women's unequal access to justice regarding gender based violence discourages them from taking action, enforces their submission, and supports behaviours that increase their vulnerability to HIV infection.
- Where laws and customs regarding property often mean women have less access to land and inheritance, the unequal rights make them more dependent on men. This dependence acts against women asserting themselves in many ways, including protecting themselves from HIV infection.
- Where non-heterosexual sex is illegal or stigmatised, lesbian, gay and transgendered people receive little or no information and support regarding HIV prevention. They are also discriminated against when seeking HIV testing and treatment, and are more likely to be subjected to violence, including rape.
- Where girls' right to an education and to choose their partner are not upheld, young girls may be forced into early marriage, at a time when they are highly biologically susceptible to HIV infection. Their husbands are usually much older than them, and are more likely to be HIV positive than the girls' male peers due to the longer time in which they have been sexually active.
- Where people's basic rights are not fulfilled—their right to health, to education, to a basic standard of living, to freedom from violence—then it is difficult for them to prioritise HIV prevention and hard to deliver prevention services to them.

7 While little research has been done on the topic, it is suspected that cutting (particularly the most severe form, infibulation) causes a higher risk of perinatal transmission of HIV during delivery, due to contact with blood. Women who have experienced infibulation also have higher risks of haemorrhaging, and thus of dying during birth.

8 In a study of 1,099 young HIV-negative women in South Africa between 2002 and 2006, 8.5% of those reporting low relationship power equity became HIV-positive, compared to 5.5% among those reporting medium or high relationship power equity. The incidence rate among

women who at baseline had reported more than one incidence of violence from their intimate partner was 9.6%, compared to 5.2% for those reporting one or no cases of intimate partner violence—see Jewkes R (2010): 'Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study', *The Lancet*, Volume 376, Issue 9734, Pages 41–48. The *Lancet's* articles are available free at [www.thelancet.com](http://www.thelancet.com). You just have to create a login to access them.

## ABC: as easy as 123?

Policy makers and development organisations may be tempted to think about HIV transmission in simple ways. Where there is a problem we like to think of a solution we can do in the short-term. To prevent HIV transmission through sex, the solution seems at hand: we simply have to persuade individuals not to have sex, be faithful to a single HIV-negative sexual partner, or always use condoms when having sex. While an ABC (Abstain, Be faithful, use Condoms) approach may involve other strategies, such as male circumcision and preventing perinatal transmission (often also referred to as 'mother-to-child transmission'), an ABC-focussed approach to behaviour change for HIV prevention does not deal with the big picture of gender inequity, power imbalances and rights.

We know prevention is not a simple matter. The factors that frustrate HIV prevention differ from place to place, and from

person to person. They include psychological issues, gender and culture, and religious, political, historical and economic influences. Sketching all the factors and links can quickly prove difficult.

Among the many factors influencing behaviour change, gender receives the most attention. At least, it seems to get the most attention in what is written about HIV and AIDS. Regrettably, our recognition that gender issues undermine HIV prevention often does not lead to a different strategy. We say gender is important, but mostly continue with HIV prevention as before. ABC makes intuitive sense to us because it links directly to HIV prevention: a solution linking straight to the problem. In comparison, tackling gender issues is indirect, and necessitates projects which address complex issues of culture and power.



# HIV prevention and gender

If we analyse HIV prevention programmes in terms of how they address gender issues, we see a continuum<sup>9</sup>:



**Damaging** approaches reinforce negative gender stereotypes. For example:

- women represented as helpless victims of HIV, reinforcing the idea that they are powerless;
- posters of female sex workers as the source of HIV, increasing their stigmatisation;
- failure to include images of men caring for HIV-positive people, reinforcing the idea that care is the responsibility of women alone;
- condom promotion using macho images, strengthening the notion that men are in charge and make the decisions;
- statements that reflect the stereotype that men have sex for fun while women only have sex out of duty or for money or gifts; and
- statements denying homosexuals exist, claiming they have no rights, or blaming them for HIV transmission, increasing marginalisation and discrimination against them.

**Neutral** programmes do not attend to gender issues. Examples of neutral programmes include prevention messages aimed at both men and women, or HIV testing that does not distinguish between the needs of men and women. Gender neutral approaches tend to be less effective, because often men and women have different needs. For example, when going for HIV testing many people would prefer to have a counsellor of their own sex, and men and women may need to attend at different times of the day due to their daily routines. Neutral programmes may be damaging if they are disempowering.

Gender **sensitive** approaches do take gender issues into account. For example, if women are reluctant to go to a clinic for sexually transmitted infections due to the social shame attendance might attract, the service might be integrated with family planning or other services. Another example is HIV prevention technologies over which women have more control: the female condom already exists, while microbicides are in development. However, these gender-sensitive prevention methods, while valuable, cannot address the contextual issues that constrain women's choices.

Gender sensitive prevention programmes usually focus on individual behaviour change, and do not attempt to create structural change. But individuals exist and act within networks of other people and within cultures which affect the options open to them. If we go back to 'ABC', we must acknowledge that a school girl may want to abstain and say

"no" to sex, but what if the person demanding sex is her head teacher? A woman might prefer to be faithful to one partner, but what if having sex for favours or for money is her only means of obtaining a livelihood? A woman may want to use a female condom when having sex with her husband, but what if he may beat and rape her for making that suggestion?

**Transformative** approaches seek change at all levels, from personal and intimate relationships up to community and societal levels. Referring back to the examples in the last paragraph, a transformational approach would seek to empower the school girl to report her head teacher for sexual abuse and have the community accept her doing so, while also creating the mechanisms by which he would be disciplined. The woman reliant on trading sex as part of her livelihood would be able to access the skills training, financial assistance and other resources for developing an alternative livelihood, or have the ability to use a condom in all sexual encounters if she opted to continue selling sex. And the woman and her husband would have a more equitable relationship in which they could negotiate condom use without fear, in a context in which marital rape and gender based violence are punished.

If we are to achieve higher and sustained levels of behaviour change we need to go beyond being gender sensitive.

**Working in a transformative way requires changing the policies, norms and practices which underlie gender inequality. This means addressing gender relations, issues of power and violence, and tackling the discrimination girls and women face in terms of their opportunities, resources, services, benefits, decision-making, and influence.**

Importantly, gender transformative approaches can lead to increases in violence against women. When women begin to take a greater role in decision-making, and challenge how power is distributed, those with more power may feel their status is being threatened and respond with violence.<sup>10</sup> This is one reason why it is important to engage men and boys in working towards gender equality.

Gender based discrimination and inequality are clearly complex. Therefore, gender transformative approaches also need to be complex, addressing many factors. There is no single strategy or 'magic bullet' for promoting gender equality. For example, microfinance is sometimes considered a solution to the problems of poor women. While access to finance can make an important contribution to household finances and well-being, it does not automatically empower women.<sup>11</sup> Steps 1 and 2 in Section 3 aim to help you think your way through the complexity.

# Power and empowerment

We often refer to ‘power’ as if it were a single thing, commonly referring to the power a dominant person holds over a subordinate one. In reality, there are different kinds of power. You may want to read about four types of power many analysts use<sup>12</sup>:

Type of power	Explanation	Example
<b>Power over</b>	Involves a relationship of domination and subordination, with the one person benefiting at the other's expense.	John is the household decision-maker. He is sometimes violent towards his wife, Proscovia.
<b>Power within</b>	Refers to self-awareness, self-esteem, self-identity and the ability to assert oneself.	Proscovia's father didn't hit her mother, and Proscovia doesn't think she deserves to be beaten. She knows about women's rights, and would like more say in decision-making in their household. She realises being beaten makes her subordinate, and she wants to change this.
<b>Power to</b>	Having the ability to make decisions, to have authority, and to find solutions to problems. It requires knowledge and economic means.	Proscovia asks for support from some relatives; they agree to help her if she has to leave John or is thrown out by him. She raises the issue with John, explaining her thoughts, and how both of their lives can be better without his violence towards her.
<b>Power with</b>	Social or political influence which develops when people work together towards a common objective.	Proscovia joins a women's group that decides to do something about gender based violence. They get the support of the religious leaders and elders, who talk about the issue publicly. They talk with other women. They get non-violent men to talk about the benefits of non-violence in their homes. Some of the women train as paralegals to assist in cases of gender-based violence.

**“The most common way people give up their power is by thinking they don't have any.”**  
 Alice Walker, African-American author and poet

It's worth noting that gaining ‘power over’ usually involves the dominant person holding power at the cost of the subordinate person. For example, in many contexts a man (and sometimes his mother) may acquire power over a woman when he marries her. But gaining the other three forms of power does not necessarily mean anyone loses, except perhaps in losing their ‘power over’. For example, if a woman gains ‘power within’ through developing her own business and improving her self-esteem, her gain will not necessarily have any negative impact on others. When a girl gains ‘power to’ by going to school, it is not to boys’

disadvantage. And when people collaborate to generate ‘power with’ for positive social and political change, they do not do so to dominate and exercise ‘power over’ others. Among these different kinds of power, developing greater ‘power within’, through raising self-esteem, appears to be particularly important. Some theorists suggest self-esteem is determined by at least two main things.<sup>13</sup> First, there is our sense of self-worth or self-liking. It is influenced by whether we have supportive relationships and whether we receive affirmation from others. Second, there is our sense of our competence. It stems mainly from whether or not we

9 This continuum was first described in Gupta G (2000): *Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How*, Plenary Address, XIII International AIDS Conference, Durban, South Africa, [http://www.steppingstonesfeedback.org/resources/9/SS\\_ICRW\\_Gupta\\_Gender\\_Sexuality\\_2000.pdf](http://www.steppingstonesfeedback.org/resources/9/SS_ICRW_Gupta_Gender_Sexuality_2000.pdf) Gupta also included a fifth level of ‘empowering approaches’. In our understanding transformative approaches are also empowering ones, hence we are not treating them as separate categories.

10 WOMANKIND Worldwide (2008): *Speaking Out: Promoting Women as Decision-makers Worldwide*, WOMANKIND Worldwide, London <http://www.womankind.org.uk/wp-content/uploads/2011/02/2008-Speaking-out-promoting-women-as-decision-makers-worldwide.pdf>

11 Kabeer, N (2005): ‘Is Microfinance a “Magic Bullet” for Women's Empowerment?: Analysis of Findings from South Asia’, *Economic and Political Weekly*, 29 October. [http://www.eledu.net/rrcusrn\\_data/Is%20Microfinance%20a%20%60Magic%20Bullet%60%20for%20Women%60s%20Empowerment.pdf](http://www.eledu.net/rrcusrn_data/Is%20Microfinance%20a%20%60Magic%20Bullet%60%20for%20Women%60s%20Empowerment.pdf)

12 For example, see Commission on Women and Development (2007): *The Women Empowerment Approach: A Methodological Guide*, [www.atol.be/docs/publ/gender/women\\_empowerment\\_approach\\_CVO.pdf](http://www.atol.be/docs/publ/gender/women_empowerment_approach_CVO.pdf) and Kabeer N (1994): *Reversed Realities: Gender Hierarchies in Development Thought*, Verso (most of the text is available at <http://books.google.co.uk/books>).

13 Tafari RW & WB Swann (1995): ‘Self-Liking and Self-Competence as Dimensions of Global Self-Esteem: Initial Validation of a Measure’, *Journal of Personality Assessment*, 65(2), pages 322-342, <http://www.psych.utoronto.ca/users/tafarodi/Papers/JPA95.pdf>

have experience of doing things successfully. Self-esteem enhancement theory suggests if we can support people to develop their self-worth and their self-competence, then they can form higher self-esteem and use it for the benefit of their health and other aspects of their lives.<sup>14</sup> One way of supporting people in these ways is to bring women together to provide each other with support, affirmation and constructive criticism, and to enable them to achieve things together. Working together also helps them to develop their 'power with'.

We've identified four types of power, but what about empowerment? There are a lot of different definitions! Most frame empowerment as a process, rather than as a single event. The definitions drawn from human rights and feminist perspectives generally concern disempowered people developing the sense that they should be able to make strategic choices about their lives, and developing the ability to make those choices.<sup>15</sup>

These definitions may also include the idea of transformation, at the personal and at the collective levels. Indeed, to achieve gender transformation women and men need to be empowered to generate change. The empowerment of women can be summed up as moving from a state of relative powerlessness ("I cannot") to one of shared self-confidence ("we can").<sup>16</sup> It's about women gaining the ability to control their own destiny. To do this they need more 'power to', in the form of better capabilities (grown through better education and health) and better access to resources and opportunities (such as land and employment). They also need the agency or 'power within' to make strategic choices, and the 'power with' of collective action to change laws, create new systems, and to transform norms, attitudes and behaviours.<sup>17</sup> When women and men are empowered, they can recognise, challenge and shift the inequality within gender relations.



# The role of rights

Where do rights fit in? Human rights define the rationale underpinning the goal of gender equality: girls and women have the same rights as boys and men. This is set out in the Universal Declaration of Human Rights<sup>14</sup>; we should all be treated the same way.

How can raising awareness about rights help women to achieve their rights? Where it is culturally accepted that females have fewer rights than males, awakening people to the notion of equal rights is a necessary first step towards achieving change. Women are sometimes complicit in their subordination, believing they are, for example, weaker, further from God, their husband's property, or not deserving of the same opportunities as men. Discovering they have the same rights as men and that it is possible to change gender norms can have a big effect on their sense of self-worth and self-esteem. Supporting girls and women to know and think about their rights is part of supporting them to develop their personal 'power within'.

Learning about rights also links directly to developing 'power to'. Women cannot claim their rights if they do not know them. And women and men cannot take responsibility for protecting the rights of other people if they believe the others have fewer rights. Where women explore the issue of rights together they can develop 'power with' through collective action.

Finally, it is useful for those who hold 'power over' to learn about and consider equal rights. Men who have followed the gender role of being more dominant and seeing women as inferior may change how they feel and how they behave. People in institutions responsible for upholding rights—for example, the police and local chiefs—can benefit from reflecting on their own attitudes and having up to date information about laws concerning the equal treatment of citizens.

## Tips for strengthening your background knowledge

- Understand the concept of gender and how it differs from the concept of sex.
- Understand how vulnerability to HIV is linked to gender inequality and failure to respect rights.
- Appreciate the complexity of that vulnerability, including how gender inequality and failure to respect rights are linked to economic status, level of education, culture, family, institutions, and so on.
- Apply your understanding of that complexity to analysis of HIV programming (ask yourself, for example: "what kind of programming is my organisation running, is it gender neutral, sensitive or transformative?").
- Grasp how 'rights' are an intrinsic or innate feature of all human beings, but also how society vests its institutions and its leaders to support and promote human rights.
- Understand the concept of power and its various personal and social manifestations; how it is present in all things and can be a negative as well as a positive force you can harness to create change.

**"Yes, he has a right [to beat me because] he removed me from my [parents'] home, and I am staying on their land. Therefore all my life is in his hands."**

Female focus group participant, STOP AIDS NOW! (2008), *That is how many women here survive: Baseline Report Kenya*.

14 DuBois DL, BR Flay and MC Fagen (2009): 'Self-esteem Enhancement Theory: Promoting Health Across the Lifespan', pages 97-130 in *Emerging Theories in Health Promotion Practice and Research* edited by RJ DiClemente, RA Crosby and MC Kegler. Much of this book is available at <http://books.google.co.uk/> (enter the book's title in the search box).

15 If you would like to read more about women's empowerment, there's a list of key texts, with a summary of each, at <http://www.bridge.ids.ac.uk/reports/bb14.pdf>.

16 Kabeer N (1994): *Reversed Realities: Gender Hierarchies in Development Thought*, Verso (most of the text is available at <http://books.google.co.uk/books>)

17 Grown C, G Rao Gupta & A Kes (2005): *Taking Action: Achieving Gender Equality and Empowering Women*, UN Millennium Project Task Force for Gender Equality, <http://www.unmillenniumproject.org/documents/Gender-complete.pdf>

18 There's a simplified version of the UDHR text at [http://www.bbc.co.uk/worldservice/people/features/ihavearightto/four\\_b/all\\_rights.shtml](http://www.bbc.co.uk/worldservice/people/features/ihavearightto/four_b/all_rights.shtml) and links to a case study for each of the 30 articles. This webpage also includes links to the original text, and to 300 different translations of it.

### 3.

## **Inspired to address the root causes of vulnerability to HIV? Address the big picture and initiate real change!**

If we are to roll back the HIV epidemic we need to respond to the ‘big picture’. This means we need to develop approaches that don’t just address direct causes of transmission, but also address the gender based discrimination and rights violations that make people vulnerable to contracting HIV. From a clearer appreciation of human rights and gender issues, we can develop strategies that address key root causes of vulnerability to HIV infection and to the impact of living with HIV. Appendix 2 contains evidence from programmes that have done just that, including the Gender Development Project.

The ‘big picture’ approach gives you wider scope for doing HIV prevention work. It allows you to integrate HIV prevention in other work on gender and rights. It also allows you to respond more closely to the felt needs of girls and women. Crucially, the ‘big picture’ approach, over time, allows you to work in a ‘transformative’ way. This means it helps supports people to transform or change gender relations in ways that are beneficial to all, including—but by no means limited to—by reducing vulnerability to HIV transmission.

In this section we set out five steps to developing a transformative approach to HIV prevention.

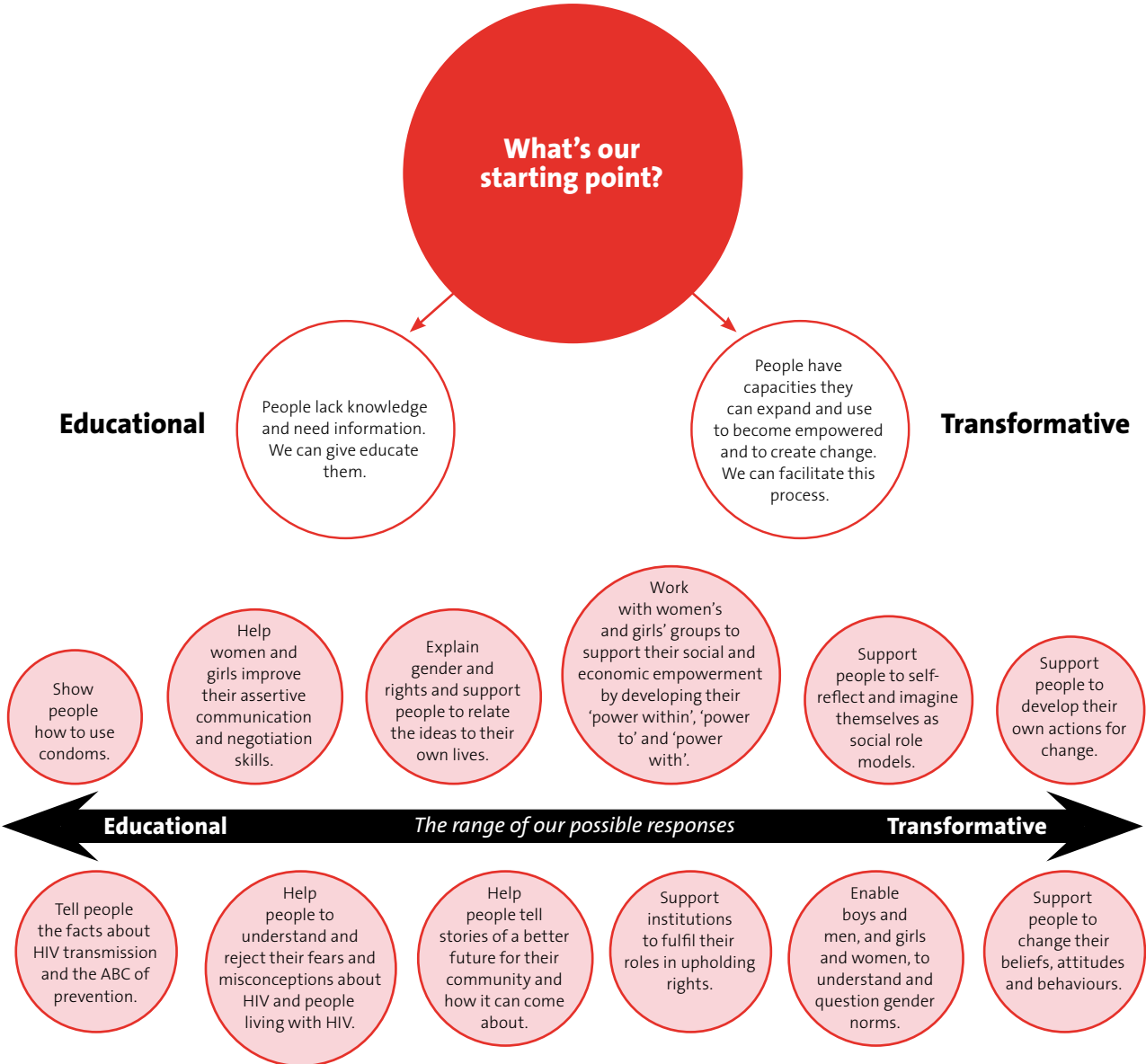


# Step 2: Begin thinking about your HIV work using a transformative perspective

Working on the 'big picture' means enabling people to think differently about gender and the position of women, with the aim of empowering community members to transform gender norms and claim their rights. This is very different from the more familiar strategy of aiming to 'educate' or 'raise awareness' about HIV and behaviour change.

We can think of 'educational' and 'transformative' approaches with regard to HIV prevention not as conflicting approaches but as different ends of a range. Figure 2 is a simplified illustration of this range. It presents two starting points from which you can view you or your organisation's approach and theory of change. It then gives examples of the types of activities you might do, depending on the starting point. Use it to consider where your organisation currently is, and how it can move towards a transformative approach.

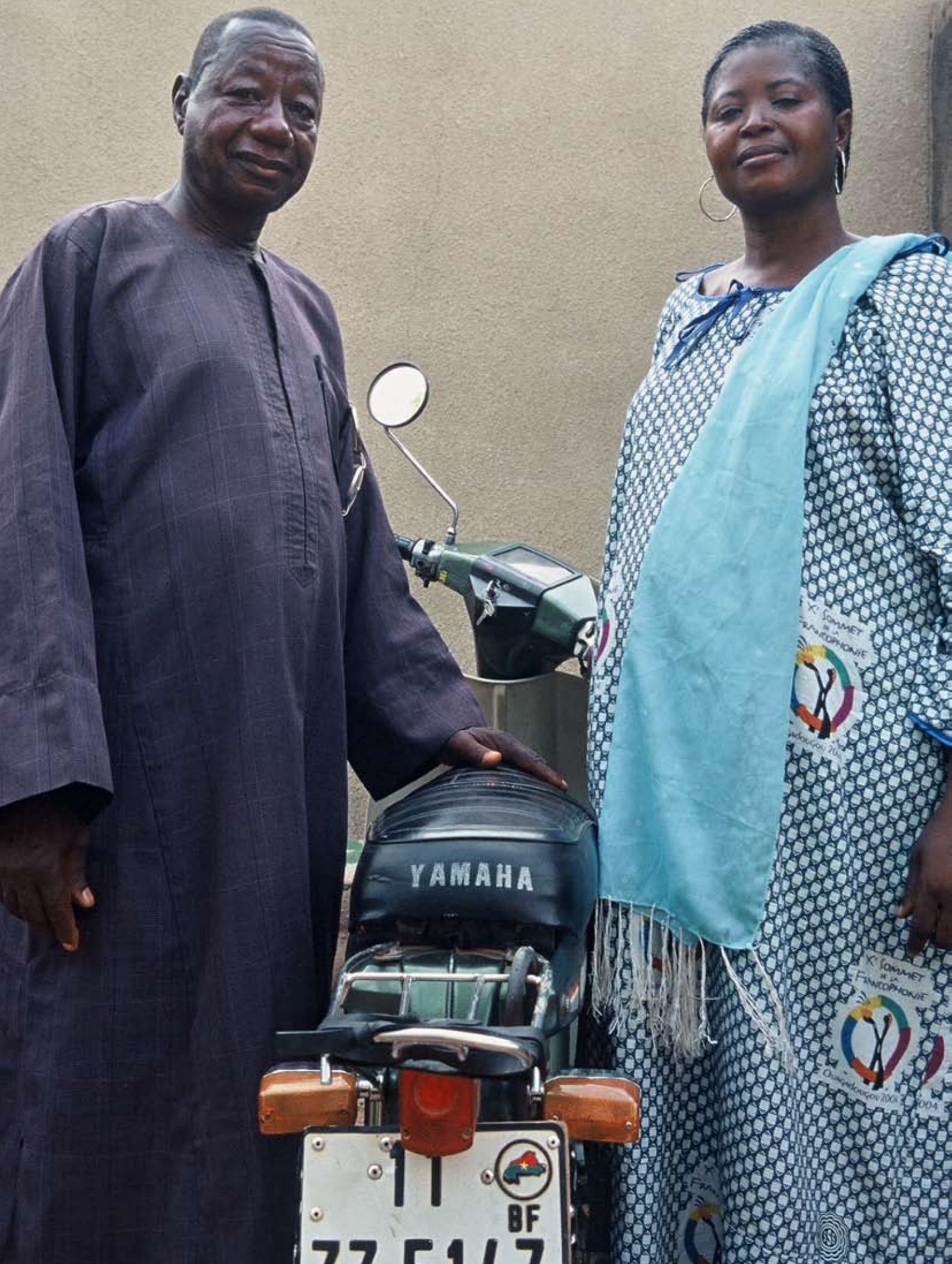
**Figure 2: From Educational to Transformative Approaches**



## Tips for shifting your thinking towards a transformative approach

- Look for the positive potential in each person and situation. Support people to see what is good in their community and in themselves, and build from there.
- Avoid defining a situation as a problem, with a certain group to blame for it. Instead, see situations as challenges or opportunities. Help people explore complexity, and look for outcomes which benefit all.
- Help people explore their inequitable norms, rather than rejecting the norms as 'wrong'.
- Discuss sensitive issues within groups of similar people, to enable participants to share experiences and build their confidence.
- Encourage self-reflection at all levels.
- Treat people equally.
- Trust that change is happening and that working together makes a difference, even if progress seems slow.
- Recognise that you should not control the process: you have responsibilities as a facilitator, but you cannot change peoples' norms for them. Significant and durable change can only come from people themselves, within themselves, and within their communities.

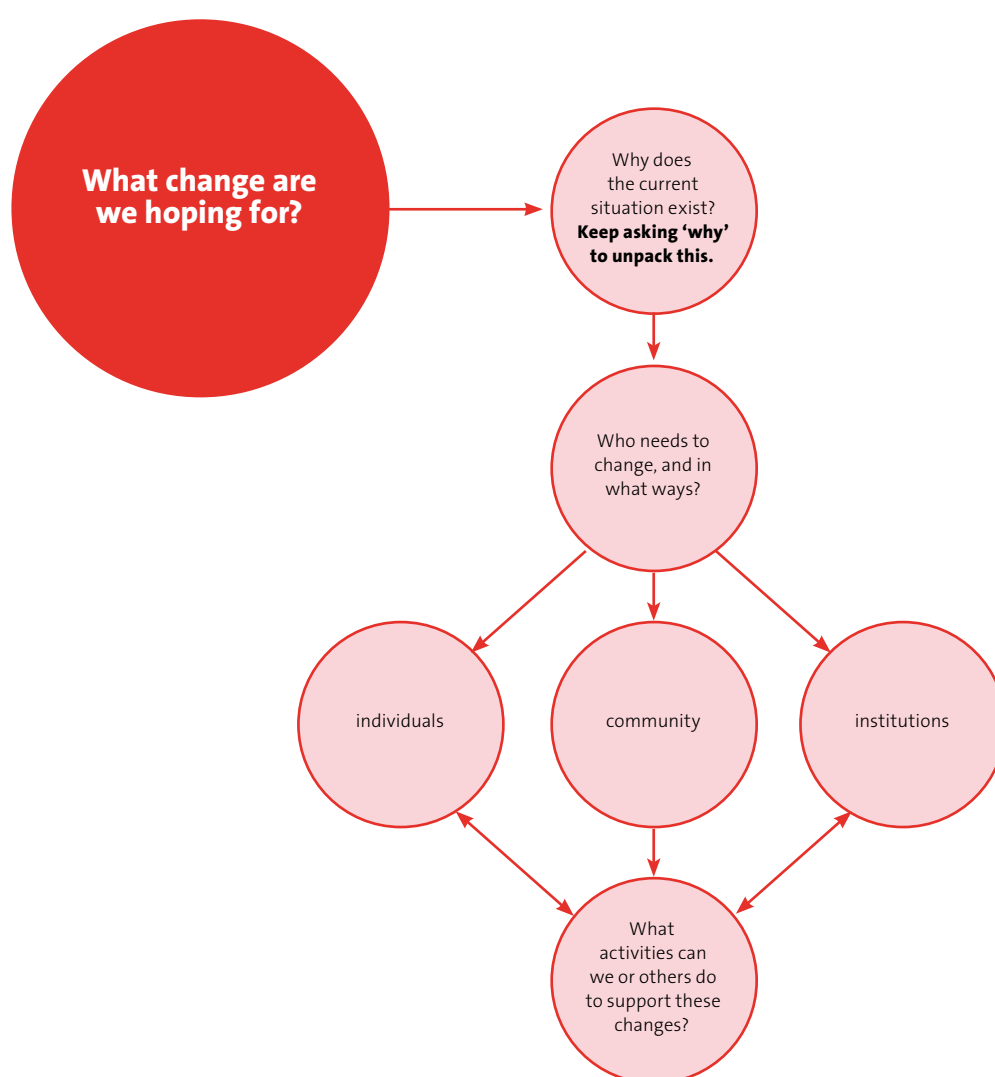




## Step 3: Analyse who to work with to achieve change

Figure 3 illustrates the analytic process of this step. Begin by agreeing on the change you seek (in other words, the overall aim of a project) and work backwards from that aim. Consider why the current situation exists, instead of the better situation which you want to create. To go deeper into the analysis, keep asking 'why?' After asking 'why?' three or four times, you should be reaching the root of the problem. Then consider who needs to change, *who* to work with, and *how*. Finally, think about what you, your organisation and others could do to support the different groups of people you've identified to change.

You may wonder why it is important to emphasise 'who' rather than 'what' needs to change. Transformation begins with people. Situations change because people change their minds, their behaviour, and the physical circumstances. Aside from natural events, situations do not change themselves; people change situations. Internalising that idea is a big part of working in a transformative way.



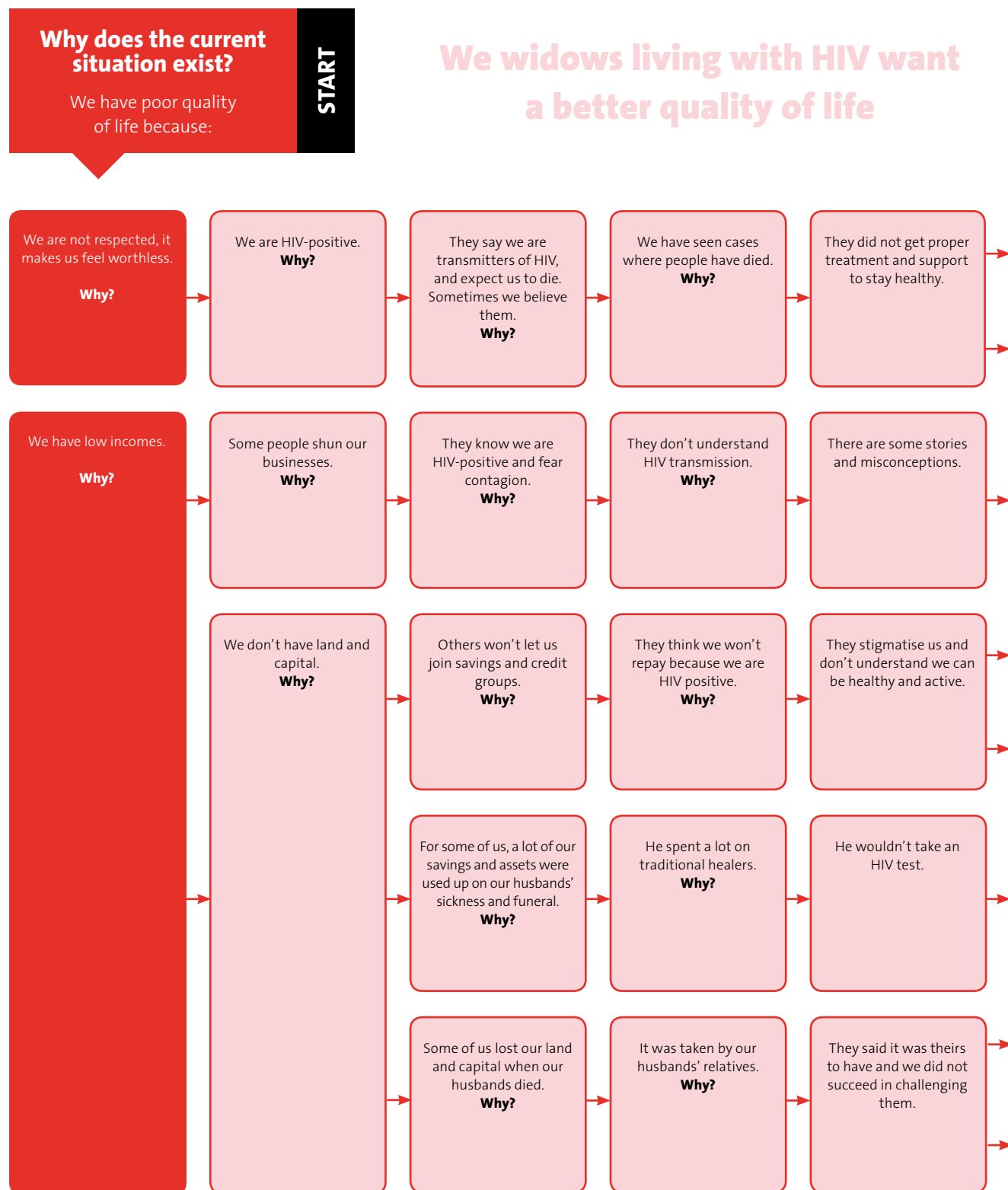
**Figure 3: Analysing Who to Work with to Achieve Change**

To help you to do Step 3, we've provided four specific examples to work through. Table 1 concerns a group of widows living with HIV wanting to take action to improve the quality of their lives. It reflects on the barriers widows experience to having a better quality of life (the 'why are we in this situation?' question followed by more 'whys'). It then

goes through an analysis of who the widows need to engage (the 'who needs to change' questions), and concludes with a series of potential responses/activities. Tables 2, 3 and 4 cover, respectively, supporting girls to stay in school, women wanting to negotiate condom use, and supporting women and girls to take action against gender based violence.

**Table 1: Who might widows living with HIV need to work with to gain a better quality of life?**

# What change are we hoping for?



# We widows living with HIV want a better quality of life

**Who needs to change, and in what ways?**

**What activities can we or others do to support these changes?**

**FINISH**

→ **HIV-positive people** need to support each other to live positively, including getting treatment. **A**

→ **Community members** need to develop empathy for people who are HIV-positive. **B**

→ **Community members** need to understand fully about HIV transmission. **B**

→ **Savings & credit members** need to understand how modern HIV treatment extends lives and enables people who are HIV-positive to be productive. **B**

→ **HIV-positive people** need to persuade others to let them join savings groups, or access savings and credits in another way. **C**

→ **Community members** need to understand the benefits of testing for HIV and getting biomedical treatment. **B**

→ **Institutions** responsible for settling cases need to know women's inheritance rights. **D**

→ **Women** need to know their economic and inheritance rights and how to claim them. **Adults** need to write wills, making it clear who should inherit what if they die. **Community members** may need to explore traditional practices with regard to inheritance, and if they need to be adapted. **E**

**A**

Work with the widows' group to improve the way they support each other to live positively, and to help them realise their worth and make more of their potential.

**B**

HIV education and reflection at community level, preferably led by or involving the widows, to ensure accurate knowledge, counter denial, challenge stigma, and increase empathy with those who are known to be HIV-positive.

**C**

Advocacy by the widows to join an existing savings and credit scheme, or support to them to form their own group.

**D**

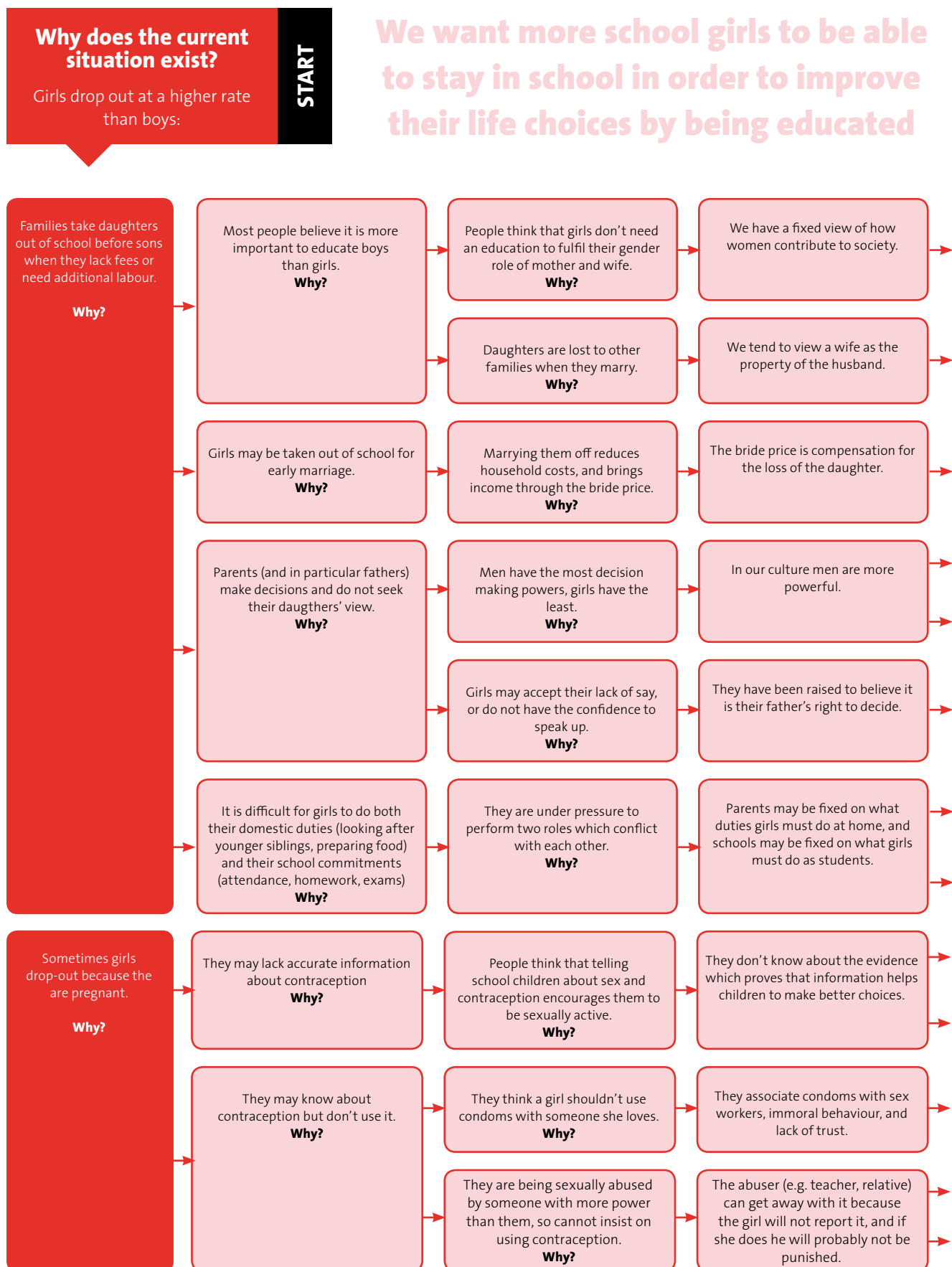
Work with institutions responsible for settling disagreements about inheritance to improve their knowledge, attitudes, systems and practices with regard to women's access to justice. Support organisations to give better legal assistance to women.

**E**

A debate at community level to explore the issues, to raise awareness of women's economic and inheritance rights, and to encourage will writing.

**Table 2: Who might we work with to support school girls to stay in school?**

# What change are we hoping for?

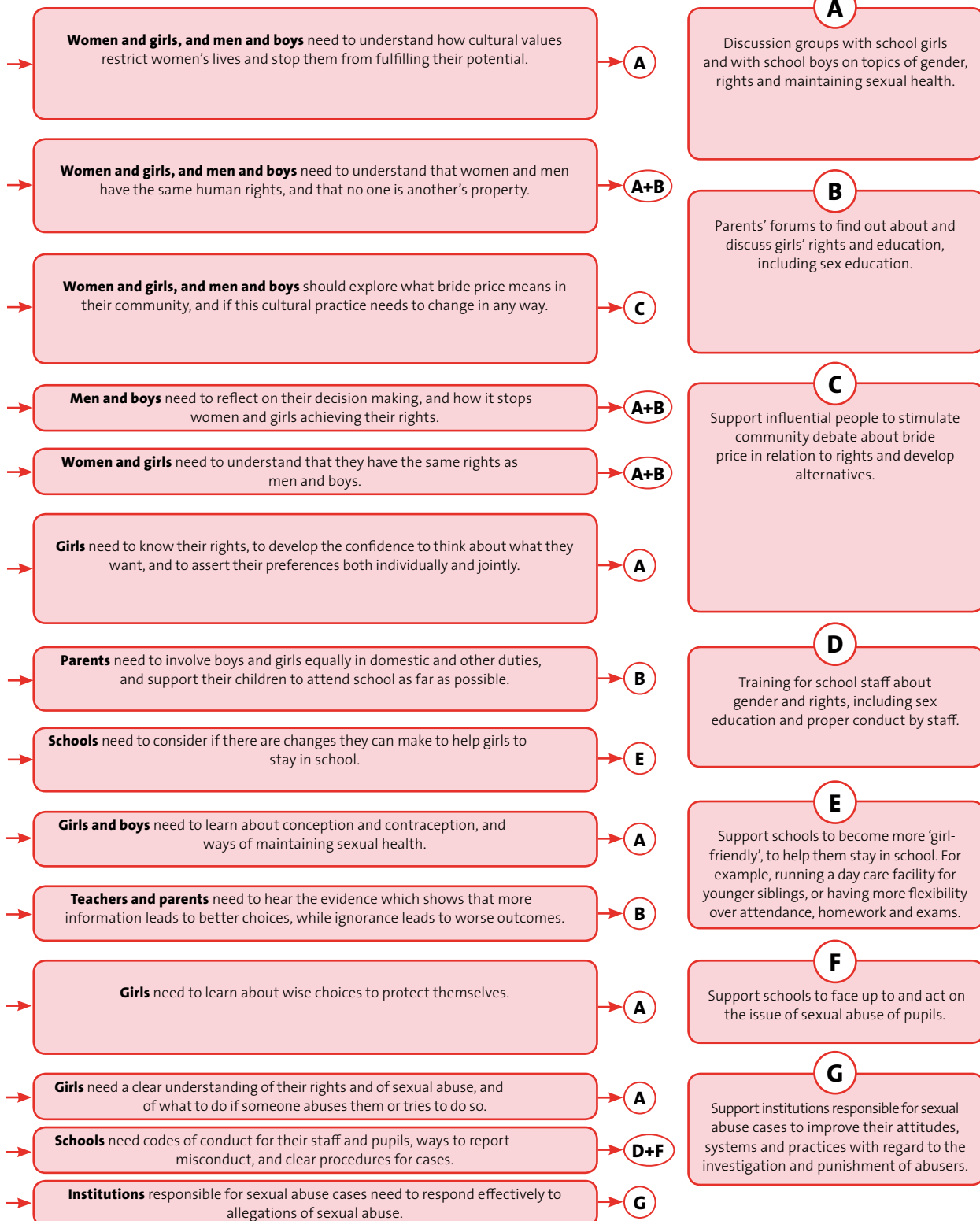


# We want more school girls to be able to stay in school in order to improve their life choices by being educated

## Who needs to change, and in what ways?

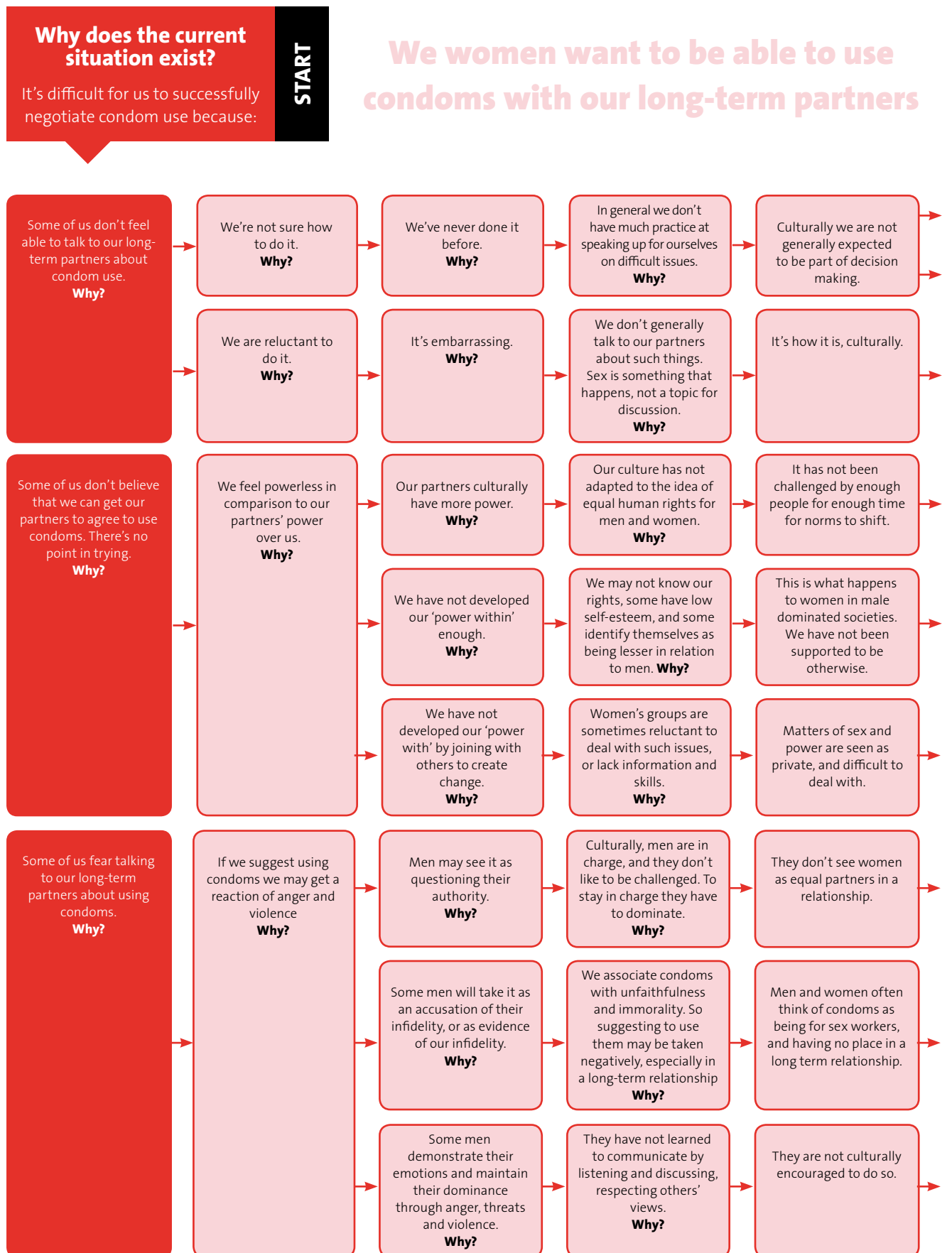
## What activities can we or others do to support these changes?

FINISH



**Table 3: Who might a women's group work with to support its members in long term relationships to negotiate condom use?**

# What change are we hoping for?



# We women want to be able to use condoms with our long-term partners

## Who needs to change, and in what ways?

## What activities can we or others do to support these changes?

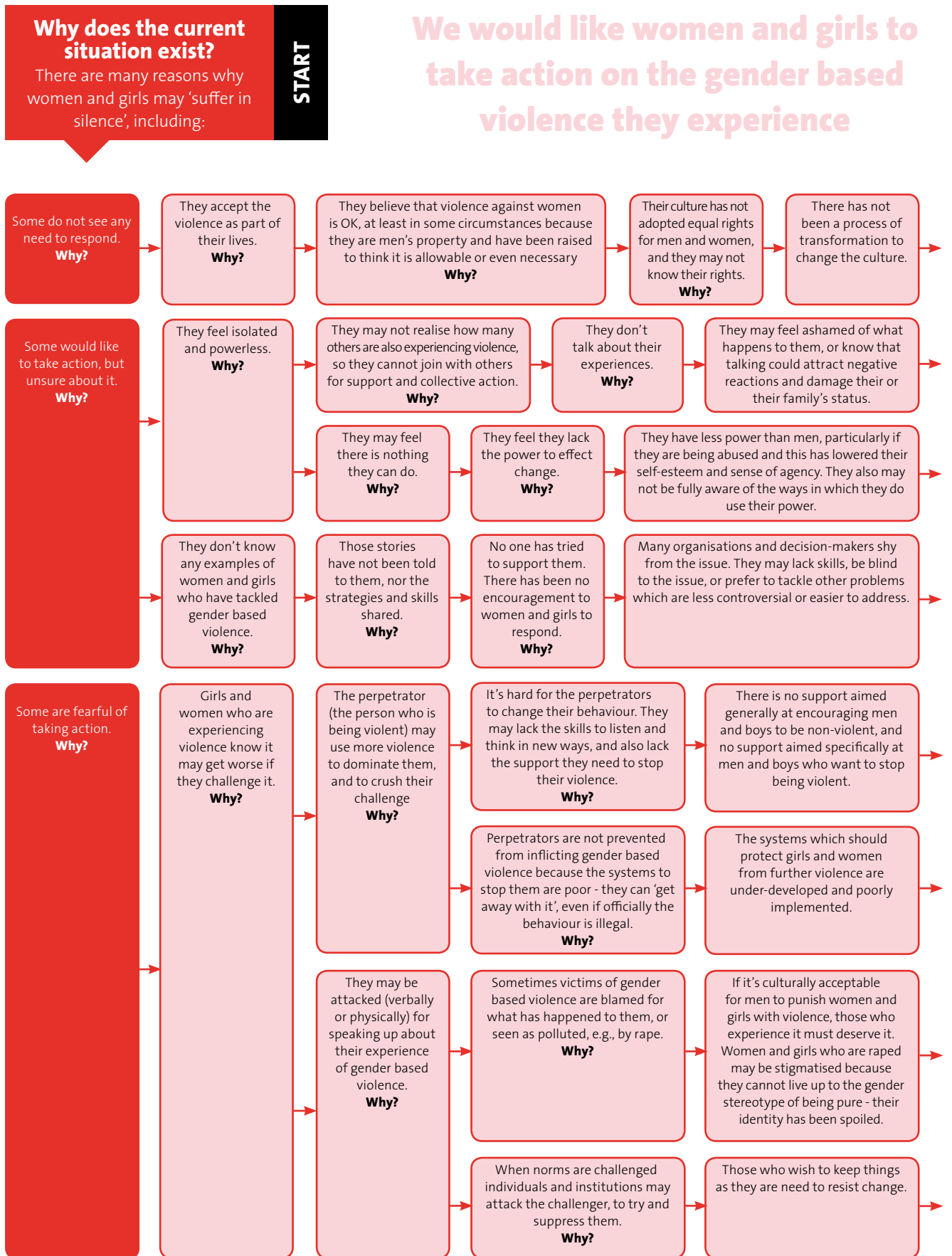
FINISH

- We **women** need to develop our 'power within' and our 'power to' so that we can speak up in our households. A+B
- **Our partners** need to appreciate women's rights, including within the household. A
- With **our partners we** need to learn to communicate within our relationships, including on sexual issues. B
- **Women and men** need to know that we have the same human rights, and to understand the negative effects which unequal norms have on women's and men's lives. We then need to take action to change attitudes, norms and behaviours. A
- We **women** need to develop our knowledge and self-esteem. We need to see ourselves as people who deserve to have more control over our lives, including protecting our sexual health. A+C
- **Women's groups** need to develop their ability to tackle sexual health issues, and to gain 'power with' by working with women and men. D
- **Our partners** need to appreciate women's rights, and to substitute their 'power over' us for 'power with', where couples work together for common goals. A+B
- We **women and our partners** need to recognise condoms as a tool for sexual health, including preventing unwanted pregnancy.  
We also need to find ways of seeking sexual health. This may involve using condoms, fewer sexual partners, and HIV and STI testing. E
- **Our partners** need to reject gender based violence as a means of exerting power, and instead learn how to communicate well. B

- A**  
Discussion groups with women and men exploring HIV, rights and gender issues, including gender based violence. Everyone needs to understand that culture can be changed for the better.
- B**  
Skills building work with women and men to learn better ways of communicating within their relationships, including on sexual issues.
- C**  
Support women's groups to develop members' knowledge, self-esteem, and self-identity.
- D**  
Support women's groups to develop their capacity, and to work effectively with other parties. They might aim to achieve cultural change on the right of women to have a say in their households, free of fear. Or they might focus on seeking and maintaining sexual health.
- E**  
Sexual health education which takes stigma away from condoms and encourages men and women to make good choices for their sexual health.

**Table 4: Who might we work with to support woman and girls to take action on the gender based violence they experience?**

# What change are we hoping for?

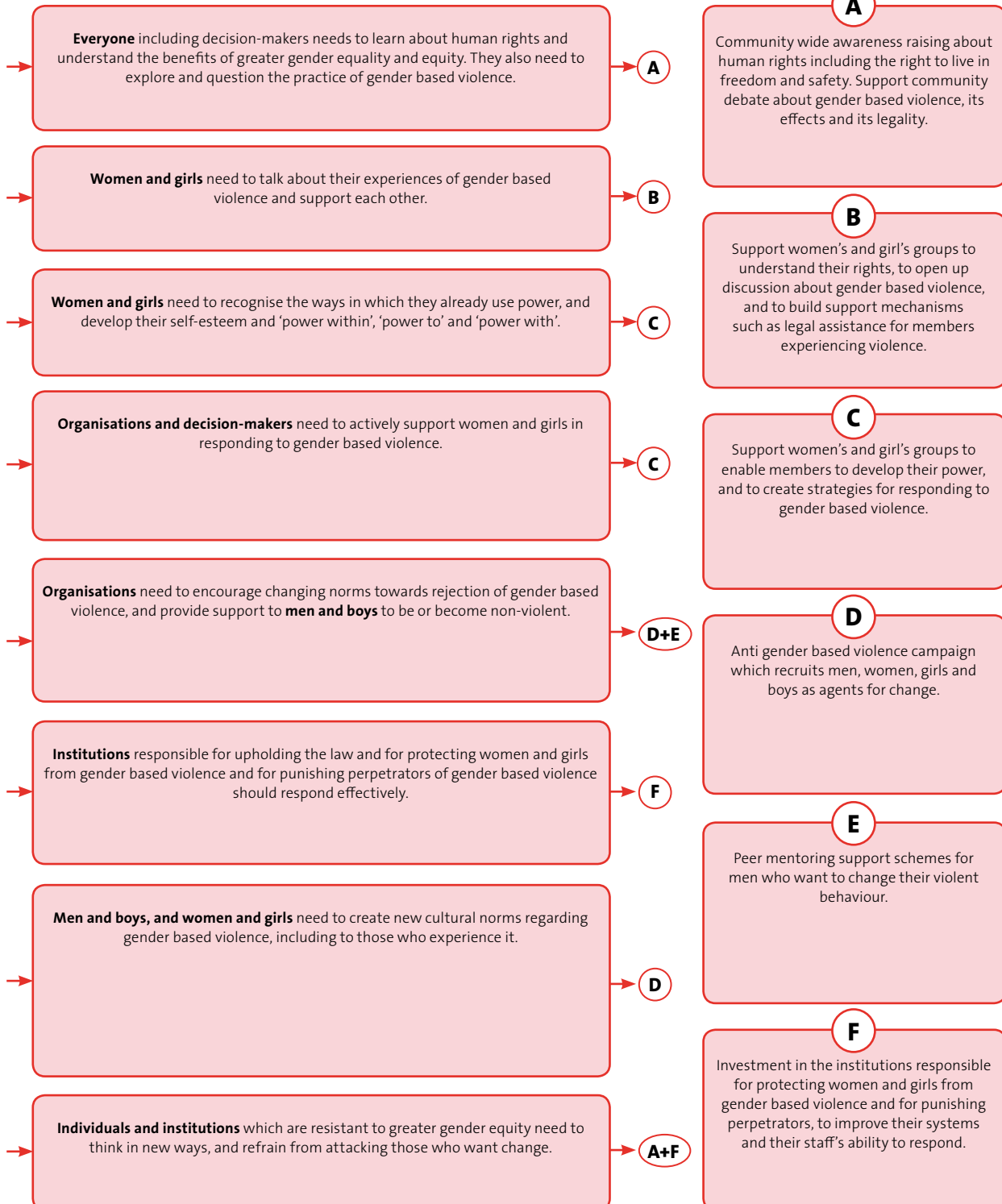


# We would like women and girls to take action on the gender based violence they experience

## Who needs to change, and in what ways?

## What activities can we or others do to support these changes?

FINISH





## Who did the Gender Development Project partners involve in their work?

Most of them worked with groups of women and girls. These included women living with HIV, school girls, female religious leaders in Islamic schools, female migrant labourers, and members of women's community-based groups. However, the majority of partners did not work only with women and girls but also worked with men and boys. They generally found that involving men was challenging but that it enhanced their work. Some reported young men are more effective as peer educators than adult men.

### There are several reasons why it may make sense to work with men and boys as well as with women and girls:

- Working with both sexes can create greater potential for change if they have been reflecting on the same issues, for example, girls *and* boys learning about the right to say 'no' to sex.
- Engaging the men who are the partners or family members of the female participants helps the women and girls to attend activities. Partners observed this in Kenya and Indonesia; when they engaged men, the men understood the benefit of their relatives' participation, and encouraged them to attend meetings regularly.
- Working with men and women can create more collaboration, seeking change to benefit all. This may reduce the 'men versus women' friction which can occur. In Kenya, partners found that by involving men in thinking about gender and rights, the men became more supportive of women's property rights.
- The lives of boys and men are often negatively affected by gender norms of what it is to be masculine; they can benefit from changes to those norms.
- Sometimes men are highly vulnerable to gender based violence and abuse and need support to become empowered. For example, a partner in Java, Gaya Nusantara, worked with male sex workers.

Furthermore, supporting a marginalised group to achieve the change they want usually involves getting others in the wider community to change too. To achieve cultural change it may also be necessary to work with 'gatekeepers' such as local leaders, school head teachers, religious leaders, or sex workers' managers (pimps).

## Tips for broadening the scope of who you work with (since you can't usually work with everyone)

- Link up with other organisations with relevant expertise to share the workload and integrate the right kind of expertise.
- Use a phased approach. For example, first work intensively with women or girls, and then support them to influence the wider community and institutions.
- Run fewer projects but do them more holistically, so that it becomes possible to work with more of the relevant people in each project.



# Step 4: Design your transformative activities

## a) Develop discussion sessions for direct beneficiaries or clients

The key technique Gender Development Project partners used in their transformative approach was discussion groups. The purpose was to enable women and girls (and in some cases men and boys) to understand how they have been socialised, to see how cultural beliefs and practices

affect their lives, and to become empowered to think and act differently. In other words, the partners encouraged participants in the discussion sessions to engage in a relatively intensive process of self-reflection. Through the groups, women were able to build trust, explore ideas, change their own attitudes and behaviour, and launch into other empowering activities.

### Tips for successful discussion groups

- Have many and regular sessions with the same participants. A WHO review<sup>19</sup> of programmes working with men and boys echoes this. The review found that, although a single well designed session can lead to changes in participants' attitudes and behaviour, a series of 10 or more sessions of around 2 hours seems to be the most effective strategy.
- Give participants enough time (2 or 3 weeks) between sessions to reflect on what they've talked about, and to apply it to real life.
- Have a small group of 10-20 participants, so discussions can involve everyone and be intensive. This helps participants become agents for change in their own lives and in their communities.
- Make sure the sessions are peer-led (in other words, not run by an outsider with little in common with the participants). Facilitators may need training, and also need to have reflected on the issues themselves. Where facilitators lack technical expertise, invite resource persons from other organisations.
- Use community issues of relevance to gender, rights and HIV as starting points.
- Include relevant facts and information, without becoming 'information-only' sessions.
- Use case studies from the community (such as stories of domestic violence) to ensure the discussions relate closely to the participants' lives and experiences.
- Include opportunities to develop skills, for example, using role play to improve communication skills.
- Have systems, for example, linking participants to micro-finance institutions and providing referrals for medical, legal, and psycho-social support, so you can deal with issues that emerge in the discussions.
- Use participatory action theatre methods to stimulate lively discussion and broach sensitive issues. Integrate different participatory techniques, like role plays, in your sessions so messages are communicated in different forms (this facilitates learning), and participants are actively engaged and stay interested.

19 WHO (2007): *Engaging Men and Boys in Changing Gender-based Inequity in Health: Evidence from Programme Interventions*, Geneva, [www.who.int](http://www.who.int)

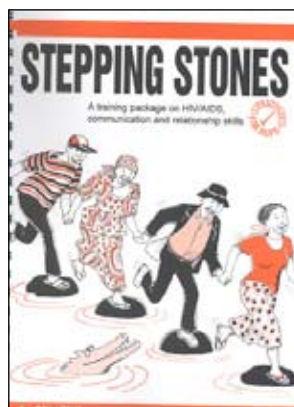
If you would like to use discussion groups to support transformation, you could use an existing manual as a starting point. You may need to adapt the activities to suit your context, but all these materials contain outlines of interactive sessions which enable participants to reflect and learn.



The Gender Development Project partners in Kenya developed a manual based on their experiences and other materials. It's called **Healthy Woman, Healthy Man, Healthy Family**. It comes with a CD containing all the handouts. You can request a free copy by sending an e-mail to Charissa van der Vlies at STOP AIDS NOW!

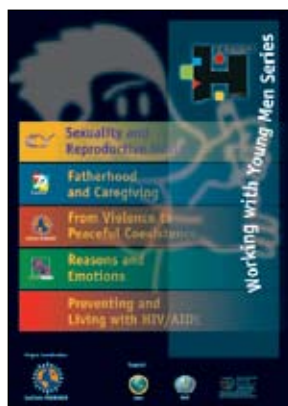
([CvanderVlies@stopaidsnow.nl](mailto:CvanderVlies@stopaidsnow.nl)), or you can download the manual from [www.stopaidsnow.org/downloads](http://www.stopaidsnow.org/downloads).

The **Stepping Stones** manual and video are available for sale from <http://www.talcuk.org/shop.htm>. The French version is called *Parcours* and the Portuguese is *Caminhando de Mãos Dadas*. To contact organisations that have translated and adapted the manual (for example, in Tanzania, Russia, Indonesia, Panama and Bangladesh) go to <http://www.steppingstonesfeedback.org/>.

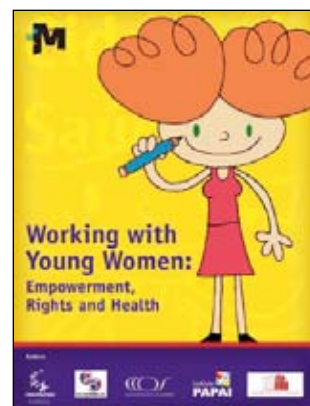


You can download **Keep the Best, Change the Rest: participatory tools for working with communities on gender and sexuality** for free from [www.aidsalliance.org](http://www.aidsalliance.org).

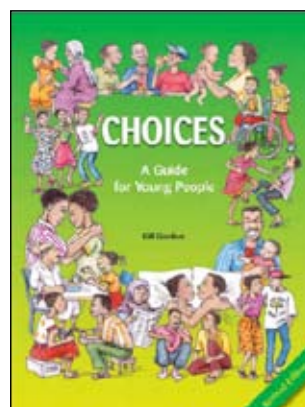
This manual provides a series of activities to do with communities, from exploring gender and vulnerability, sex and relationships, and sexual violence, to thinking about working together and then making a plan.



**Project H: Working with Young Men Series** was developed in Brazil, followed by **Working with Young Women: Empowerment, Rights and Health**. These manuals are both available for free download (or purchase a hard copy) in English and Portuguese from [www.promundo.org.br/en](http://www.promundo.org.br/en). The one for working with young men is also available in Spanish.



**One Man Can: working with men and boys to reduce the spread and impact of HIV and AIDS** is part of the larger One Man Can campaign in South Africa. You can download the manual in English and French for free from [www.genderjustice.org.za](http://www.genderjustice.org.za). You'll also find other campaign materials there, including One Man Can posters and videos, and other information from the Sonke Gender Justice Network, which focuses on HIV/AIDS, gender equality and human rights.



**Choices** was developed in Zambia for young people, and covers topics of culture, growing up, friendship and love, choosing a good partner, contraception, and HIV. It can be used by young people, or by facilitators working with them. It's available at low cost from [www.talc.org/shop.htm](http://www.talc.org/shop.htm). If you want

to preview its contents before buying it, go to [www.macmillaneducationbookstore.com](http://www.macmillaneducationbookstore.com).

## **b) Develop broader community awareness-raising and help create a pro-woman, pro-girl environment!**

Working at the broader community level—so, beyond your group of direct beneficiaries—can provide support and sustainability for change. Research shows that attitudes and behaviour change is greater where community level campaigning is done in addition to discussion groups.<sup>20</sup>

There are a variety of ways to work at the broader community level. As learned through the Gender Development Project, there are three principal mutually compatible ways of doing so. One way is to give visibility to the issues of HIV, gender and women's rights at public events at your church or mosque, or at community council or chief's meetings. Organise a theatre piece, ask to give a speech or presentation, or opportunistically take speaking time at a relevant moment.

Another way is to organise a campaign that might include a march or 'road show', handing out informative brochures, a petition to address a specific problem, giving away t-shirts with key messages, and handing out male and/or female condoms.

The third, and perhaps most important way, from a strategic point of view, is to invite municipal, opinion, or religious leaders to participate at your own events. These might include your regular discussion sessions on HIV, gender and women's rights with your clients, a training workshop, a strategic planning meeting of your organisation, or a special advocacy event. Inviting leaders to participate in your activities helps secure the cooperation and support of key stakeholders.

The Gender Development Project partners took care to engage and secure the cooperation of stakeholders such as local government officials and community leaders. Doing so reduced the potential for gatekeepers to frustrate their work. More positively, by being involved and themselves having some ownership of the project, influential people were better able to help create change.<sup>21</sup>

If you are not sure how to engage with your broader community or which leaders you should target, re-read, 'Step 3: Analyse who to work with to achieve change'. Information in Step 3 is relevant to both developing transformative activities with direct beneficiaries or clients and for engaging the broader community, including leaders. Also, be sure to read the case studies in Section 4 for further inspiration.

## **c) Develop mechanisms to respond to experiences of discrimination and rights violations**

The discussion groups organised as part of the Gender Development Project brought forwards lots of experiences of neglect and abuse. As participants gained 'power within', shifting their self-identities from people who accept abuses to people who know they deserve better, they demanded assistance and support for redress in response to these experiences.

A key strategy among the Gender Development Project partners, in particular in Kenya, was to train group members to be paralegals or advocates. This response enabled those group members to attain greater knowledge of legal systems and rights, and further enhance their self-esteem, thus creating local systems of support. The existence of paralegals in the community, either working door-to-door, staffing legal desks in local organisations, or responding to cases as they arose, meant women and girls in the community had someone to go to for advice and assistance.

Systematic support is crucial if cultural norms are to shift and rights violations are to stop. For example, higher dissatisfaction among women about domestic violence may not necessarily lead to positive change. They may continue to suffer in silence. But if women who are subjected to violence know there are people who will support them, and help them to seek fair treatment, then they are more likely to take action. In this way, a problem which was mostly hidden becomes exposed, talked about, and can be mitigated.

The local groups that developed the strongest support mechanisms also worked with other relevant institutions. These included the police and other officials with regard to legal issues, the Ministry of Health, and providers of medical and psycho-social support.

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20 See the Program H trial aimed to change young men's attitudes and behaviours. Pulerwitz J et al (2006): *Promoting More Gender-equitable Norms and Behaviors Among Young Men as an HIV/AIDS Prevention Strategy*, Horizons Final Report, Population Council, Washington DC, available for free download at <http://www.promundo.org.br/en/wp-content/uploads/2010/03/10ing.pdf>

21 For example, as a result, some village chiefs began speaking out on issues such as domestic violence for the first time.

## d) Support women to support themselves economically

Several partners provided some form of economic empowerment for participants.<sup>22</sup> Women with low incomes stated their priority as finding ways to make money and to develop greater livelihood security. Some partners helped them to access savings and credit, and gave technical help to start businesses. Others referred them to organisations with more expertise in providing economic empowerment services. In either case, the support was aimed at helping participants meet their practical need for an income. Businesses included growing food, bee-keeping, rearing chickens and goats, keeping cows to sell milk, selling items (detergents, charcoal, dried maize, water), and providing money transfers by mobile phone.

The process of developing businesses also resulted in greater self-esteem among participants, and more ‘power with’ in groups that had successful collective enterprises. It also helped some women to reduce their vulnerability to HIV infection, as they created alternatives to selling sex or trading sex for favours. Importantly, the economic empowerment work was always integrated with the work on HIV prevention and promotion of gender equality and women’s rights.

**“I used to spend time drinking and doing nothing but through the group I now rear chicken, sell eggs and support myself and my child.”**

Young woman, waitresses & brewers’ group, supported by YWCAA

### Tips for developing support mechanisms

- Invest in the skills and knowledge of group members to provide practical support for the gender, HIV and rights issues that emerge from the group.
- Be sure to develop the necessary range of support mechanisms, from psychological to legal, depending on the needs assessed.
- Make sure the peer advisors are located where the women can reach them, are in a place where they are able to maintain confidentiality, and are available at convenient times.
- Link to relevant institutions for cooperation and their provision of support. This is especially important, as it is highly likely your organisation cannot provide all the necessary support mechanisms.
- Include support for economic empowerment. This can at least be referring participants to organisations specialised in income generation or micro-finance, for example.

<sup>22</sup> A large majority of the partners initiated economic empowerment activities after they had themselves become more aware of gender-based issues and inequality. They realized how important financial independence was for the women participants to exercise their agency. The partners explained to STOP AIDS NOW! that they had learned to appreciate that empowerment could only be sustainable if women could act in practical ways on the basis of it. Also, the partners reported that the participants experienced the same realization, and so themselves expressed the need for more economic empowerment activities.

## e) Prioritise community ownership

For transformative projects to work they need to be run by local organisations genuinely active at community level. In addition to working closely with communities, the Gender Development Project partners used two main strategies to create community ownership.

### Invest in local people as agents for change

‘Experts’ were involved in activities for strategic reasons, such as building higher level political support and providing technical advice on HIV. However, the bulk of the activities were carried out by the local people. This was in large part able to happen, because the organisations participating in Gender Development Project invested in building their capacity and agency to change norms. By working with existing community groups, and investing in the skills and knowledge of their members, the partners supported the development of ‘power within’, ‘power to’ and ‘power with’ among those community members. Those groups of individuals were then able to assist and influence others.

For example, prior to the Gender Development Project, WOFAK had helped establish support groups for people living with HIV. To extend their work from HIV to include rights and gender, WOFAK trained support group members as advocates. They became change agents, helping others to discuss and reflect on the gender and rights issues most important to them, and to decide what to do. Please see the case study, page 46, for more on WOFAK’s work in the Gender Development Project. As another example, ACK-Western trained men and women from local self-help groups as paralegals. Others in the community go to them for assistance when they need help to fight for their rights.

**“A lady had given birth to five girls—her husband was not willing to let her and the girls inherit anything and was chasing them away. We intervened and advised the lady to report the matter, the man was called by the administration and ordered to let the woman and her children to stay.”**

Bisunu Sensitisation CBO,  
supported by ACK Western

In some contexts religious leaders have a lot of influence over gender norms. Where conservative views enforce gender inequality it is important but very challenging to reach and influence religious leaders. In Indonesia, Rahima’s approach was to work intensively with female teachers of Islam (*ustadzahs*). This had direct effects on the teachers’ attitudes and practices, with spill-over effects for their pupils by improving the sexual health sessions that they teach. The *ustadzahs* are also able to include the topics of gender and rights in their preaching to Koran recital groups and in certain forums, such as after-prayer meetings. It is Rahima’s hope the teachers are now also better placed to influence male religious leaders within the local councils.

This approach is very practical in terms of cost, but more importantly in terms of appropriateness and sustainability. Community members are well placed to know which changes are achievable within their context, and how best to seek them. There is also little danger of the cultural misunderstandings which occur when outsiders are involved. There is also less resistance within the community, because the people proposing change are themselves community members.

### Address local priorities

The ‘big picture’ approach of gender, rights and HIV allows organisations to respond to local issues, rather than adhere to a distant donor’s focus on HIV alone. The training the partners gave on rights, gender and HIV ensured local organisations and change agents gave attention to those themes, but with the freedom to respond to community priorities and to particular cases as they arose. This meant their work could be relevant and responsive. For example, some groups of widows living with HIV set up their own income generating projects in order to improve their quality of life, as well as improve their self-esteem and standing in the community. Why? Because that was their priority.

Being responsive can be challenging. Some faith-based organisations found themselves caught between their church’s position on condoms and demands from women for them. They initially opted to refer the women to nearby health facilities which were giving out condoms, but then started stocking supplies which women could access. One of them started actively distributing condoms. Being responsive also meant dealing with a wider range of issues. For example, one local group successfully intervened to protect a first born male twin who, according to tradition, should be killed. A gender and rights issue, but not of the type we anticipated.

Addressing local priorities did not mean local groups could not tackle ‘taboo’ topics (which by their nature are not much talked about). On the contrary, the training given to local groups by the partners, and their participation in

dialogue groups, allowed such issues to surface and be discussed. Local groups—having learned about sexual rights and knowing that sexual abuse was prevalent but not spoken of—were able to proceed based on their knowledge of the local context. In Java, Rahima’s work with *ustadzahs* led to the women opening up to each other and to Rahima facilitators about their experiences within their marriages, including domestic violence. This in turn enabled some of them to speak more publicly about such issues, for example, by including them in discussions with their students.

### f) Join forces with others!

Creating a pro-woman/pro-girl environment also means working for broader, more structural change, for example, by improving local, provincial or national level policy, law and implementation of the law. No individual or organisation can do this alone; you need to join forces with others organisations with different skills and areas of influence. For example, if you are working for an AIDS-focussed organisation you may already be collaborating with similar organisations. However, that will not likely be sufficient to create a ‘facilitative environment’ for women and girls. You may need to reach out to human rights groups, pro-democracy groups, or religious organisations, for example. It all depends on the circumstances in your community, district, province and/or country. In any event, do bear in mind that multisectoral and broad based responses to HIV tend to be more successful.

In the Gender Development Project partners in each country formed a coalition. Partners used the coalitions to take on lobbying and advocacy activities and to contribute to improving the legal and political environment for women and girls at national or sub-national levels. In Java, the coalition proved very valuable for joint lobbying and advocacy. Through campaigning, collaboration and investment in relations with key ministries and commissions, the coalition succeeded in securing a place for gender and women’s rights in the national HIV response. The National AIDS Commission now runs a joint civil society working group on gender and rights.

The Java coalition also took on a series of other activities, for example, fighting the Indonesian anti-pornography law and a proposed regulation to ban people with transmissible diseases from appearing in public. Although they lost the battle on the anti-pornography bill, they succeeded in bringing visibility to the increased influence of extremist religious politics on sexual life. Their actions against the regulation were more successful, leading to removal of references to people living with HIV from the regulation. A new draft regulation on HIV and protecting the rights of people living with HIV has been brought for debate before Parliament.

Joining forces can also be particularly useful for networking and facilitating mutual learning and capacity building. For example, in Kenya, Dupoto-e-Maa invited WOFAK to provide training on HIV, and various partners invited KEFEADO to provide training on gender.



# Step 5: Monitor and evaluate your progress

Monitoring and evaluation are important if we are to measure and learn about the impact of our work, and have evidence to share with others of effective strategies and ones which have not worked.<sup>23</sup>

In the Gender Development Project we used four monitoring and evaluation elements in both Kenya and Java: a baseline and endline study; yearly retrospective reports from the coordinating organisation; a midterm review; and a results assessment. These were in addition to on-going communications between the coordinators, and opportunities to gather feedback from partners at training events.<sup>24</sup>

Here, we share with you some of the dos and don'ts from our experience.

## Do learn from what others have done

When designing our monitoring and evaluation methods, we looked at what other organisations working on gender transformation had done. For its Program H, Instituto Promundo had begun by learning about the attitudes and behaviours of young men in the communities who were already relatively gender-equitable.<sup>25</sup> This helped to define outcomes which were realistic, because they were based on what some young men were already doing. Promundo also talked to girls and women about the outcomes they wanted if boys and men were to change. Through this process they identified four ways young men could behave that would be desirable as outcomes for the program:

- to seek relationships with women based on equality and intimacy, rather than sexual conquest;
- to seek to be involved fathers;
- to assume some responsibility for reproductive health and disease prevention issues; and
- to oppose violence against women.

From these key behaviours, Promundo developed a 'Gender Equitable Male Scale': a questionnaire containing 35 statements, such as 'There are times when a woman deserves to be beaten' and 'A man and a woman should decide together what kind of contraceptive to use'. Respondents answered using a scale to show how much they agreed with each statement.

Another tool of interest to us was the Sexual Relationship Power Scale, which looks at two dimensions of relationship power: relationship control and decision-making dominance.<sup>26</sup> This scale includes 23 items, such as 'My partner always wants to know where I am' and 'Who usually has more to say about whether you have sex?'

We used both these tried-and-tested tools to create our own survey, with the following six initially defined indicators (indicators were adjusted for each location where the

research took place, see Appendix 2 for more information): (1) Gender-based attitudes, perceptions and beliefs; (2) sexual and/or romantic relationship power; (3) presence of violence in sexual and/or romantic relationships; (4) intentional or actual condom use; (5) HIV/AIDS knowledge; and (6) communication about sexual matters and condom use.<sup>27</sup>

## Do collect qualitative data

Surveys give us quantitative data (numbers and percentages), but it is also good to use qualitative methods to find out more from participants and other stakeholders, ideally in a way that you can compare what they say before and after the project.

We used focus group discussions and in-depth interviews to gather data as part of the endline research, and particularly during the results assessments which took place in 2010. Many of the lessons learned in this guide are derived from the results assessments.

The qualitative research provided much more textured information on partners' and participants' feelings and experiences, and helped corroborate the quantitative findings of the endline survey.

This aspect of the monitoring and evaluation was also negatively affected by funding constraints, the professionalism with which the research was carried out, and the number of organisations that could participate. Other challenges included:

- sometimes the recording of focus groups failed, and researchers had to take notes instead;
- there was some loss of data in some cases in the translation process; and
- in one instance, insufficient trust between female respondents and a male researcher led to inaccurate data, as the women did not feel safe to express themselves.

## Don't try to do everything you want with too little funding

Cater for the true costs of monitoring and evaluation, both for implementing partners and any external researchers. We lacked sufficient funding from the outset to invest in high quality and comprehensive research. Cost-cutting restricted the number of partners that participated and took place at the cost of good quality research implementation, as head researchers 'farmed out' work to less experienced and qualified students. Weak implementation translated into a small sample size in Java, and the need to repeat some surveying in Kenya. Furthermore, it is important to bear in mind that with small grant sizes, it is easy for the cost of monitoring and evaluation activities to exceed the costs of project activities.



### Don't misalign your M&E planning with your project planning

Develop clear and realistic research outcomes. Delays in undertaking the baseline survey combined with uncertainty about the project's future meant our endline survey was conducted after only 12 to 18 months of project activities, before the project was extended for a further two years.

### Do improvise if necessary

The election violence in Kenya led to the displacement of participants and to changes in the groups partners were targeting. These phenomena prevented researchers from having the same group of people participate in the baseline and in the endline. So, instead, the researchers did a cross-sectional analysis of the endline data, comparing people who had participated in the project with people who had not.

- 23 A useful resource for developing M&E activities is this guide: STOP AIDS NOW! (2011), *Are you on the right track? Six steps to measure the effects of your programme activities*. You can download it at <http://www.stopaidsnow.org/downloads>.
- 24 To read more about the initial M&E plan for the Gender Development Project, please turn to the STOP AIDS NOW! website, at [http://www.stopaidsnow.org/our\\_work\\_article/gender](http://www.stopaidsnow.org/our_work_article/gender).
- 25 Barker et al (2004): *How do we know if men have changed? Promoting and measuring attitude change with young men: lessons from Program H in Latin America*, download from [www.promundo.org.br/en](http://www.promundo.org.br/en)
- 26 Pulerwitz J, S Gortmaker & W DeJong W (2000): 'Measuring sexual relationship power in HIV/STD research', *Sex Roles* 42(7/8): 637–660. This article is not available for free on the internet, but there is a summary of the Sexual Relationship Power Scale here <http://www.c-changeprogram.org/content/gender-scales-compendium/sexual.html>
- 27 You may also be able to adapt and use other organisations' surveys: <http://www.c-changeprogram.org/content/gender-scales-compendium/index.html> gives eight relevant scales you could use or modify.

## 4.

# Case studies on transformative activities

This section contains case studies from four organisations that participated in the Gender Development Project—one in Java, Indonesia, and three in Kenya—and worked from a transformative perspective. The four examples include the context of work of the organisations, a description of their activities and a summary of the outcomes they achieved.

We have included the case studies to provide you with a more complete picture of how an organisation can work on HIV from a gender transformative perspective. They are meant, in particular, for those of who you have at least gone through steps 1-4 above and are looking to fill gaps for conceptualising an overall programme or coherent set of activities.

# Yayasan Harapan Permata Hati Kita (YAKITA)

## The context

Indonesia has the fastest growing HIV epidemic in Asia, with shared use of injecting drug equipment being a major mode of HIV transmission.<sup>28</sup> In parts of Indonesia, over half of injecting drug users are HIV positive<sup>29</sup>, but as only about 10% of injecting drug users are women, they and their specific needs have received less attention.<sup>30</sup> Their rate of infection is slightly higher than for men<sup>31</sup>, as they are more likely to provide sex in exchange for drugs, have lower capacity to negotiate safer injection practices and safer sex, and suffer from high levels of violence and rape. Women who inject drugs are stigmatised both for injecting drugs and for violating traditional gender roles, leading to discrimination and their isolation.

Women who are not drug users but who are partners of injecting drug users also experience discrimination and narrowed social support networks. Their vulnerability to HIV infection is increased by their partners' high risk behaviour, their weak capacity to negotiate safer sex, and their dependency on their partners. In household contexts of drug addiction and insecure livelihoods, many women affected by drug use fall into a cycle of depression and self-blaming, made worse if they are also HIV positive.

## YAKITA's response

YAKITA is a community based organisation that seeks to improve the quality of life of people addicted to illegal drugs. It recognised that women affected by drug use need specific support, and started a comprehensive project in Bogor, called Empowering Female Addicts and Female Partners of Addicts. At the heart of this was the formation of the Bogor Female Support group, or BFS.

The primary beneficiaries were the BFS members, a group of twenty women drug users, former users and/or partners of users aged between 20 and 35 years old. Some of them were living with HIV, all were affected by HIV. They generally had low self-esteem, and devalued themselves as mere 'junkies' (a slang term for injecting drug users). The secondary beneficiaries were their partners, extended family members, and the broader community.

### The main activities were:

- BFS group meetings twice a month for two years. The participants were heavily involved in organising these discussions, and sometimes invited nurses or human rights workers to provide expertise. Themes were tailored to the needs and interests of participants, and centred on three issues: sex and STI and HIV prevention; gender roles; and addiction, recovery, and co-dependency. The sessions on STIs and HIV included

condom negotiation, and health seeking behaviour, and the programme made condoms freely available to the women.

- Support to develop income generating activities, leading to training on how to make and sell sandals. The BFS members worked together twice a month, and marketed the sandals first as 'BFemaleS' but then, to include men's sandals, under the 'JUNKIES' brand. The profits were shared among the beneficiaries and the YAKITA programme.
- Some of the women took part in training to improve their skills for formal employment. Six of them trained once a week on computer skills, and five accessed a twice-weekly English language course.
- Women living with HIV and their families attended a family support group. Ten of the participating families have a child who is HIV positive. The sessions helped the families understand HIV and its treatment, and to develop mutual support for taking care of themselves and for avoiding stigma (including self-stigma) and discrimination.

## Results of YAKITA's work

YAKITA witnessed the women experience an empowerment process, both individually and collectively. They first moved from a starting point of depression and low self-esteem to greater acceptance of their reality, and then progressed to developing a greater sense of self-worth. Once their self-confidence was strengthened they started sharing information and networking with others, and developed a sense of solidarity with each other. More knowledge helped them react against being depressed and to improve their self-esteem, including developing the courage to negotiate safer sex and to talk about stigma and self-stigma. The economic skills they gained also gave them hope and assurance that life is possible without having to depend on others. Within the family support group sessions, the HIV positive women won greater acceptance and understanding from their relatives, though gaining acceptance from others remained a challenge.

28 HIV and AIDS in Asia, Avert webpage <http://www.avert.org/aids-asia.htm>

29 UNAIDS (2010) *Global Report*, UNAIDS, Geneva (p35) [http://www.unaids.org/globalreport/Globa\\_report.htm](http://www.unaids.org/globalreport/Globa_report.htm)

30 *Indonesia HIV policy fails women drug users*, report on Radio Australia 22 October 2010, <http://www.radioaustralia.net.au/connectasia/stories/201010/s3045304.htm>

31 One Indonesian study found that 56.1% of female injecting drug users were HIV positive, compared to 52.2% of male injecting drug users <http://www.unodc.org/eastasiaandpacific/en/topics/hiv-and-aids/overview.html>.



This empowerment process indirectly supported the women to prevent HIV transmission (both to themselves or to their partners) and to improve how they cope with living with HIV. The training sessions on condom negotiation directly served HIV prevention purposes. Initially, some of the women viewed condoms only as a tool to prevent pregnancy. Through the discussions they learned that condoms also prevent STI and HIV transmission, and that women who buy condoms are not necessarily 'prostitutes' or cheating on their partners. As more of the women managed to negotiate condom use with their partners YAKITA noticed that it no longer needed to offer condoms to the participants, as the women were proactively asking for them. As one woman explained in a focus group discussion to assess the programme, "After getting involved actively in YAKITA, I started to grow courage to negotiate and force my husband to wear a condom, otherwise no sex at all." YAKITA also observed improved health seeking behaviour among the women, including higher uptake of their three-monthly health check-ups.

# Community Mobilisation for Economic Development and Advancement (C-MEDA)

## The context

In Nyanza, the poorest province in Kenya, life has become harder for the men and women involved in the fish trade since fish stocks have reduced. Smaller catches have heightened competition among women to get fish to sell, forcing them to participate in the jaboya system. 'Jaboya' originally meant 'customer', but now refers to the exchange of sex for fish; women forming sexual relationships with fishermen in exchange for wholesale fish. Individual fishermen and fish sellers may have more than one jaboya relationship at a time, in addition to their long term partners. Some older fish sellers use their daughters and nieces in the system. Furthermore, there is fierce competition to get fish transported quickly and cheaply to market, so some fish sellers trade sex with mini-bus drivers in exchange for transport.

At the last national survey in 2007<sup>32</sup>, Nyanza Province had the highest rates of infection for HSV-2 (genital herpes) and syphilis. It also had the highest HIV prevalence, with 14.9% of adults (17.2% of women and 11.6% of men) being HIV-positive, compared to the national average of 7.1%. HIV infection is more common in Nyanza's fishing communities, where prevalence is estimated to be around 30%<sup>33</sup>. Among the youthful and mobile population of the fishing communities there are high levels of sexual networking and low levels of consistent condom use. Nyanza also has higher than average rates of gender based violence, with as many as 60% of women having experienced it since the age of 15<sup>34</sup>.

## C-MEDA's response

C-MEDA's approach is one of holistic and community-driven development. From its base in Kisumu, C-MEDA works with the most vulnerable community members through projects on food security, health, gender and rights.

As part of its participation in the Gender Development Project, C-MEDA aimed to respond to the problems faced by women who are vulnerable to HIV and AIDS and in a weak socio-economic position. C-MEDA focused on four strategies:

1. Empower the women to know and understand their rights, why they are violated, and how these issues link to HIV;
2. Support women and girls to claim their rights and take action against violations;
3. Provide the women with alternatives for earning an income in order to gain greater independence and reduce the risk of HIV transmission;
4. Persuade the broader community of the importance for

community survival of achieving gender equality in the face of a formidable HIV epidemic.

### The main activities were:

- Approximately eighty intensive discussion sessions per year with members of community based women's groups, many of whom were HIV-positive. Over the four years of the project, the number of women taking part rose from around 150 to 200. The discussions were facilitated by women from the groups, and topics included antiretrovirals and living positively, gender-based violence, widow inheritance, property succession rights, and sexual negotiation.
- Through the discussion groups, members also received advice on income generating activities, and were linked with microfinance providers. The resource people for these sessions included peers who had managed to develop alternative livelihood strategies and so leave the jaboya system.
- Sixty local women became 'focal points', receiving two sessions of specialised paralegal and conflict mediation training. The focal points then established and staffed three 'gender desks' in chiefs' offices and five on beaches. These gender desks are places where women and girls can bring forward cases of gender based violence and other rights violations, with the focal points providing counselling and referral for legal or medical assistance as well as social support. Around five hundred women received support from the gender desks. Training was also given to the Beach Management Unit leaders (pre-existing government organisations in each fishing community) to improve their support to the focal points and the gender desks.
- Sensitisation of the broader community, reaching about 600 community members and 20 community leaders. C-MEDA supported the performance of plays and staging of dialogue forums about HIV, women's rights and gender equality at chiefs' barazas<sup>35</sup> and on beaches. The plays had been developed in a different project involving 60 members of women's groups and 80 boys and girls from schools, and were also performed as 'ice-breakers' during the small group discussion sessions.

32 NCAPD & PRB (2007): *Kenya AIDS Indicator Survey (KAIS) Data Sheet*, <http://www.prb.org/pdf09/kaiskenyadatasheet.pdf>

33 Kenya National AIDS Control Council (2009): *Kenya Analysis of HIV Prevention Response and Modes of HIV Transmission Study*, <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/KenyaMOT22March09Final.pdf>

34 World Bank (2006): *Republic of Kenya, Country Social Analysis*, [http://siteresources.worldbank.org/BOLIVIA/Resources/Republic\\_of\\_Kenya-CSA.pdf](http://siteresources.worldbank.org/BOLIVIA/Resources/Republic_of_Kenya-CSA.pdf)

35 Barazas are public meetings involving the Chief and elders, intended to address community problems and issues.

## Results of C-MEDA's work

C-MEDA's activities are nested, working outwards, starting with the individuals in the support groups, going to the wider community of women on the beaches, and then to the broader community. This approach enables social change processes to build on and strengthen each other.

The discussion group participants reported feeling empowered to speak about sex more openly, and to negotiate sexual relations and condom use thanks to the sessions. At the beginning of the project, during general discussion sessions about HIV, rights and gender, around 5% of the women were able to speak about their experiences of gender based violence. However, towards the conclusion of the project this had risen to half of the women. This shows partly how C-MEDA succeeded in building trust through the small group discussions, using stories from the community, to support women to open up about 'taboo' subjects such as sex and gender based violence. It is a significant sign of their growing sense of power that so many of them were able to speak out about this issue.

The other factor which enabled the women participants and other women to come forward about gender based violence was the support provided through the gender desks. The focal points gave concrete assistance and emotional support to women who had experienced gender based violence, giving them more reason to speak up about the violation of their rights. As one group member stated, "Ogal Beach Support Group reported a case where a young girl was raped by a known offender in the area and their persistent follow-up of the case with the local chief and the police led to the arrest of the culprit. This has served as a warning to others." Furthermore, the gender desks did not focus only on gender based violence; taking a holistic approach, they also succeeded in stimulating increased uptake of HIV testing among the women of the beach communities.

With regard to economic empowerment, 60 women successfully moved from the *jaboya* system to growing food to eat and food to sell such as melons, as well as working on farms irrigating fields. Thirty of them accessed microfinance support (as provided by another partner of the Gender Development Project, the Women in the Fishing Industries Project) to develop their fish commerce independently from the *jaboya* system.

There were two particularly noteworthy outcomes regarding the wider community and improving the environment for women and girls in and around Kisumu. First, there were some positive shifts among the community leaders. For example, they demonstrated more support for women's rights and gender equality by calling for cases of rape to be handled through the court system rather than

through the traditional family compensation approach<sup>36</sup>. They also called for widowed women to have the right to decide whether to be inherited, and advocated that those who opted for it should know their inheritor's HIV status and should expect a condom to be used as part of the sexual rites. Second, some of the women who participated in the discussion sessions have taken on the role of change agents in their communities. More specifically, three groups with around 25 members each have gone on to organise their own discussion sessions with new participants even though the project has ended. As C-MEDA reported, "Cases of wife battering have reduced because the women groups have been trained and have in turn trained others."

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<sup>36</sup> In the compensation approach the family of the perpetrator of rape will compensate the woman or girl's family through, for example, giving a cow, or a marriage will be arranged between the perpetrator and the woman or girl.



# Women Fighting AIDS in Kenya (WOFAK)

## The context

In common with many other places in the world, women in Kenya typically experience more highly negative consequences due to HIV infection than men. Much of this is due to their lower status and economic dependence on men. The many challenges women living with HIV face include how to secure a sustainable livelihood, how to live positively including accessing care and treatment, and how to rebuild their sense of self-worth. In Nyanza Province high levels of poverty, HIV infection and gender based violence make for a challenging context.

## WOFAK Bumala's response

Women fighting AIDS in Kenya (WOFAK) runs seven centres. They provide comprehensive care and support to women and children living with and affected by HIV/AIDS. In addition to coordinating the Gender Development Project in

Kenya, WOFAK also ran field activities through its centre in Bumala in Nyanza Province.

WOFAK responded to the high levels of poverty, gender based violence and related stigma and discrimination that affect women living with HIV by training and empowering them to become 'Human Rights Champions'. WOFAK trained a core group of women living with HIV as champions, with the role of educating others on issues including: the right to inherit and own property; the right to education, training, and employment; the right to have children; and addressing harmful cultural practices. They also covered health issues such as living with HIV positively, and prevention of perinatal transmission of HIV.

The Human Rights Champions also engaged in community advocacy on gender, HIV and women's rights, targeting men and youths. They led discussions at Chiefs' barazas (public meetings) and at support group meetings of people living with HIV. They also made emergency home visits to



address violations or threats of violations to the human rights of women living with HIV. Through their advocacy work, the Human Rights Champions became a point of reference to community members on HIV, gender and rights issues. In collaboration with other organisations (including FIDA, Kenyatta Hospital, Rural Education and Economic Enhancement Programme and the Kenya Red Cross), they also handled referrals for women in need of legal, medical or social assistance in response to rights violations.

#### The main activities were:

- An introductory two-day workshop for ten members at each of the three project locations (Siamia, Busia and Siaya districts) and in collaboration with the Ministry of Health and TAPWAK. This was to train the members as Human Rights Champions.
- Monthly rights and empowerment sessions took place in each location. They covered issues like widow cleansing, property inheritance, and stigma and discrimination. These sessions were run in collaboration with the local administration, Ministry of Health and other HIV/AIDS organisations. Participants include women from the community and the Human Rights Champions.
- The Human Rights Champions took part in community meetings of around 200 participants every two weeks, and advocated for the rights of people living with and affected by HIV/AIDS.
- WOFAK Field Officers provided collaborative support to the Human Rights Champions' advocacy work, visiting them to discuss the issues that had arisen.

### Results of WOFAK Bumala's work

WOFAK witnessed an empowerment process taking place among women living with HIV. For example, some women chose for themselves whether they wanted to be 'inherited' or not. Others sought action on violations of their property rights, both for current threats to remove them from their homes or take property from them and for seeking redress for past property rights violations. The empowerment sessions raised the self-esteem of the women, helping them see themselves as human beings with rights rather than as movable property. In addition, more women became involved in community development committees. Prior to the Gender Development Project activities, women were not encouraged to participate in such spheres of power in the community. Women were not viewed as sufficiently competent decision makers. Since the project, women are not only welcome in these committees, some of them has sought and obtained positions of leadership within them.

The women were supported to act on their new attitude because there were also changes in the broader community. A large percentage of the community now feels that,

despite men being custodians and heads of families, women deserve a chance to make decisions previously only left to men. In addition, more girls have been able to go on to secondary school without the resistance which community members had previously shown. Shifts were also seen in gender roles in terms of men becoming more involved in caring for people who are ill. And, with regard to family planning and HIV prevention, WOFAK saw greater appreciation and use of condoms among men.

There were also specific outcomes related to the direct intervention of the Human Rights Champions in situations where women's rights were being threatened or violated. In one case, a Human Rights Champion visited a couple where the woman was experiencing domestic violence, and had been forced to living in a cowshed since her diagnosis of being HIV-positive. After talking through the issues, her husband began eating the food she cooked, allowed her to live in her late mother-in-law's home, and allowed her to plough the family land and use the proceeds to care for the children. He has now apparently agreed to build her a house. She feels confident that when the time comes for her to have sex with him (as the culture demands before she can live in the house), she will be able to refuse and ask him to go for testing. In another case, direct intervention and requests for help from the elder in the community resulted in a woman being allowed to keep property which had belonged to her deceased husband. The information spread within the locality and served as a deterrent to similar cases.

WOFAK attributes the successes to targeting advocacy to the people in a position to bring about change, such as elders, cultural custodians, opinion leaders, and local administrators. Involving men during sensitization sessions and having them reverse gender roles during role plays also proved useful, as it allowed them to understand better what women go through. WOFAK also worked with the police and government official to improve follow up on rights violations, such as cases of rape. As with C-MEDA, the fact that the Human Rights Champions ensured follow up and referral of cases doubtless contributed to the positive impact. Women living with HIV saw that breaking the silence on rights violations could benefit them directly.

# Dupoto-e-Maa

## The context

In Kajiado District in Kenya's Rift Valley, the majority of people are Maasai, and many still practice a semi-nomadic pastoralist mode of life, with a strict gender division. Men are the community leaders and the decision makers. Women perform domestic tasks and manage home-based herds, but have no legal claim over livestock. A daughter's marriage is arranged by her father, including a bride price paid to her father by the man she marries. It is common for girls to be married when they are young, which contributes to the Maasai preference for sending boys to school, as girls will be given at an early age to another family.

Culturally, Maasai girls cannot refuse sex, so many have early sexual initiation. To be considered a woman and to get married girls must be circumcised. Sexual networking and polygamy define much of sexual experience, and use of condoms is rare. Women should not talk about sex and have little decision making control over sex and reproduction.

HIV prevalence among Kenya's Maasai people thought to be relatively high at 7.9%.<sup>37</sup> In addition to the factors outlined above, other factors facilitating HIV transmission include men buying sex but not using condoms when travelling to trade cattle, sexual networking and wife sharing among age mates, marriage of young girls to older men, and using the same knife with several girls during female genital cutting rituals.<sup>38</sup>

## Dupoto's response

Dupoto-e-Maa ('Dupoto') is a Maasai membership organisation based in Kajiado, involving men and women from all age groups, clans, and sections. Its mission is to facilitate and contribute towards the development and sustainability of Maasai pastoralist communities in the drier parts of Kajiado District.

Dupoto's strategy was to hold sessions on gender, HIV and rights and to integrate the themes as crosscutting issues in all its programs. Their aim was to enhance efforts to achieve gender equity in access to health, including sexual and reproductive health, and education and economic development. Initially, the programme targeted women and girls, but later on Dupoto saw the need to involve men and local leaders. Using a 'training of trainers' approach, Dupoto targeted the same participants in all its programme activities, but in different contexts. In this way, the few trained became responsible for disseminating the information to more people in the society. Dupoto's activities were done in collaboration with the Gender Empowerment Forum, MAAP, World vision, Child Care, and—particularly for referrals for voluntary counselling and testing and HIV treatment—the Ministry of Health.

## The main activities were:

- Group discussion sessions for two to four hours every two weeks with a total of 30 women, and of 50 girls aged 12 to 15. The sessions brought out the issues affecting the women and girls, including those which increase their vulnerability to HIV infection, such as early marriage and female circumcision. The participants were encouraged to discuss the issues with their husbands and family members. The facilitators were Dupoto implementers who are from the Kajiado Maasai community. Other resource people included village elders, church representatives, staff from the voluntary counselling and testing centre in Kajiado, opinion leaders, women elders and teachers.
- Workshops every two months involving around 50 women and girls, and allowing deeper discussion on gender issues. These workshops were aimed at bringing women and girls into the mainstream of development. The content focused on creating an understanding of the root causes of gender disparities, (such as exclusive male property ownership, and the absence of women in leadership positions and school management committees), and determining ways of creating change. Similar workshops were also held with men (using funding from other sources).
- Quarterly meetings with 80 girls and boys in primary schools, and with 20 community women, focusing on agency and decision making.
- Radio discussion and debate in the Maa language on gender, HIV, land issues and education with a direct outreach to about 200 people (men, women and youths).
- Publication of articles in the quarterly organisational newsletter produced for people who can read.

## Results of Dupoto's work

The participants gained knowledge about HIV and AIDS and about voluntary counselling and testing, leading to higher rates of HIV testing. They increased their awareness on gender issues, basic human rights and children's rights, and acquired skills on how to claim their rights and where to turn for support when they experience violence. Deeper change also occurred in favour of women and girls. Attitudes in the community have altered with regard

37 Kenya National Bureau of Statistics (2010): Demographic and Health Survey 2008-09, page 217, <http://apps.who.int/medicinedocs/documents/s17116e/s17116e.pdf>. However we note that the sample of Maasai respondents was small.

38 National Coordinating Agency for Population and Development (2005): Kajiado District Strategic Plan 2005-2010 for Implementation of the National Population Policy for Sustainable Development, <http://www.ncapd-ke.org/UserFiles/File/District%20Strategic%20Plans/Kajiado%20FINAL%20Modified.pdf>



to a variety of issues, including violence against women, property rights, and women's leadership. Women are now represented in various groups such as chief barazas, school committees, and hospital, water and environmental committees. They are now better able to express their ideas at meetings about development issues in the community, whereas before they may have attended but sat silently. Some have even been elected as councillors in the last general election. Women's sphere of influence has begun to grow beyond that of family relations to include the political and public domains of social life.

At the household level, attitudes have also improved in favour of women. Some men are now sharing domestic duties, such as assisting women in fetching water and firewood using donkeys, and there is more blurring of gender roles. Women are sharing decision making roles more, and are now better able to keep the proceeds from their businesses. However, these changes have not come easily for everyone. Gender equality is often viewed as a threat to existing social structures, and people are deeply rooted in their cultural practices. Although change has been initiated, it is a slow process.

**“Separation of roles among the Maasai is distinct, however younger women and men now share roles when at home... We encourage both boys and girls to share house chores...The men now seek our opinion before selling a cow.”**

Women's group supported by  
Dupoto-e-Maa

We hope this guide has helped you develop your ideas and activities to respond to HIV and attend to issues of gender inequality and rights. Please contact Jennifer Bushee at STOP AIDS NOW!, [jbushee@stopaidsnow.nl](mailto:jbushee@stopaidsnow.nl), to provide us with your feedback and experiences of using this guide. We thank all our partners for their willingness to engage with the big picture, and hope that their promising practices inspire further progress towards a more just and gender equitable world.

# Appendix 1: Partners participating in the Gender Development Project

## Partners in Java, Indonesia:

1. Gaya Nusantara
2. Koalisi Perempuan Indonesia (Coalition Coordinator)
3. Lembaga Bhakti Kemanusiaan Umat Beragama (LBK-UB)
4. Lembaga Gemawan
5. Médecins du Monde (MDM) Jakarta (in the first two years of the project)
6. PKBI (Indonesian Planned Parenthood Association) Jakarta
7. PKBI (Indonesian Planned Parenthood Association) Yogyakarta
8. Plip Mitra Wacana
9. Rahima
10. Solidaritas Perempuan
11. Syarikat
12. Women's Crisis Centre Mawar Balqis
13. Yayasan Harapan Permata Hati Kita (YAKITA)
14. Yayasan Jurnal Perempuan
15. Yayasan Pita

## Partners in Kenya

1. African Women and Child Feature Service (contracted on a consultancy basis in the last two years of the project)
2. The Anglican Church of Kenya (ACK) Eldoret Region Christian Community Services (ELRECO)
3. The Anglican Church of Kenya Nakuru Region Inter-Diocese Christian Community Services (ACK-NRIDCCS)
4. The Anglican Church of Kenya (ACK) Western Region Christian Community Services (ACK-WRCCS)
5. Citizens Coalition for Constitutional Change (4Cs)
6. Community Aid International (CAI)
7. Community Mobilisation for Economic Development and Advancement (C-MEDA)
8. Development Through Media (contracted on a consultancy basis in the last two years of the project)
9. Dupoto-e-Maa
10. Help Self Help Centre (HSHC)
11. Inter-Diocesan Christian Community Services (IDCCS) (for the first two years of the project)
12. Kenya AIDS NGOs Consortium (KANCO)
13. Kenya Female Advisory Organisation (KEFEADO)
14. Kenya Network of Women with AIDS (KENWA)
15. Kenya Solidarity Network (KSN; formerly Kenya Coffee Solidarity Network)
16. Legal Resources Foundation (LRF) Trust
17. Society for Women and AIDS in Kenya (SWAK; for the first year of the project)
18. TAABCO (contracted on a consultancy basis in the last two years of the project)
19. The Association of People Living with AIDS in Kenya (TAPWAK)
20. The Health Rights Advocacy Forum (HERAF; initially under the Kenya Human Rights Commission)
21. Women Fighting AIDS in Kenya (WOFAK; Coalition Coordinator)
22. Women in the Fishing Industries Project (WIFIP)
23. Women's Shadow Parliament-Kenya (WSP-K)
24. Young Women's Campaign Against AIDS (YWCAA)
25. YWCA Kisii (for the first two years of the project)





# Appendix 2: Evidence about responding to the big picture

You may be thinking that doing HIV prevention work through the bigger picture sounds fine in theory, but wondering if it works in practice. In this appendix we present an overview of the data from other programme trials and from the Gender Development Project.

## Evidence from other programme trials

We don't have a great deal of evidence, because not many trials have been run to research this properly. However, a recent WHO consultation<sup>39</sup> found that HIV prevention programmes are more effective when they address violence against women and gender inequality. Another WHO review<sup>40</sup> states that programmes working with men and boys that include deliberate discussions of gender and masculinity, and which work to transform such gender norms, seem to be more effective than programmes that only mention gender norms and roles.

### Here are some trial results:

**Stepping Stones**<sup>41</sup> uses small group participatory learning activities to enable peer groups of women and men to reflect on their lives and to develop more gender-equitable relationships. A trial in South Africa<sup>42</sup> demonstrated:

- A reduction of a third in the incidence of herpes simplex type 2 infection among male and female participants, compared to the control group;
- A 38% reduction in young men's reported acts of violence against their intimate partners.

**Program H** engages young men and their communities in a critical reflection of the gender norms expected of them. A trial of Program H<sup>43</sup> in Brazil showed<sup>44</sup>:

- Significant changes in attitude towards greater support for gender equity among the participants, as compared to the control group;
- The men who changed their attitudes were four to eight times less likely to report an STI; and
- Increased reported condom use with their primary partner among participants. At one site the increase was statistically significant; this was the place where group work was accompanied by a lifestyle campaign which promoted the idea that it's 'cool' to respect your partner, not to use violence, and to practise safer sex.

The **IMAGE** programme combined microfinance loans to women with a year-long participatory gender-training programme called Sisters for Life. A trial<sup>45</sup> in twelve rural communities in South Africa compared 3 groups: those that took part in IMAGE, those that accessed microfinance alone, and a control group. It found:

- A reduction of 55% in reported experience of intimate partner violence by women who took part in the IMAGE

programme compared to the control group;

- Younger participants (up to 25 years old) of the IMAGE groups had higher levels of HIV-related communication, were more likely to have accessed voluntary counselling and testing, and were less likely to have had unprotected sex at last intercourse with a partner who was not their spouse;
- The microfinance-alone group mainly had the best economic outcomes, but the IMAGE group also showed improvements for all the economic indicators relative to the control group; and
- The IMAGE group outperformed the microfinance-alone and control groups for all of the indicators of empowerment, intimate partner violence, and HIV risk behaviours.

39 WHO (2010): *Addressing Violence Against Women and HIV/AIDS: What Works?*, Geneva, [www.who.int](http://www.who.int)

40 WHO (2007): *Engaging Men and Boys in Changing Gender-based Inequity in Health: Evidence from Programme Interventions*, Geneva, [www.who.int](http://www.who.int)

41 For more on Stepping Stones, including adaptations of the original manual and to make contact with people using it, go to <http://www.steppingstonesfeedback.org/>

42 Note that this trial adapted the original Stepping Stones approach. In particular, it worked only with young men and young women and did not include groups for older men and older women. The trial's results are presented in Jewkes et al (2008): 'Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial', *British Medical Journal* volume 337: a506, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2505093/>

43 For more information on Program H see <http://www.promundo.org.br/en/activities/activities-posts/program-h/>

44 For a summary of the trial's results see Pulerwitz et al (2006): *Promoting More Gender-equitable Norms and Behaviors Among Young Men as an HIV/AIDS Prevention Strategy*, Horizons Final Report, Population Council, Washington DC <http://www.promundo.org.br/en/wp-content/uploads/2010/03/10ing.pdf>

45 Kim J et al (2009): 'Assessing the incremental effects of combining economic and health interventions: the IMAGE study in South Africa', *Bulletin of the World Health Organisation*, volume 87 pages 824–832, <http://www.who.int/bulletin/volumes/87/11/08-056580.pdf>

## Evidence from the Gender Development Project

### The four elements of our research to evaluate the Gender Development Project

First, we organised a baseline and endline study to identify the impact of the project on HIV-prevention related constructs. In Kenya, the specific factors to be studied were: (1) Decision-making dominance and control; (2) Domestic gender norms; (3) condom norms and attitudes; (4) self-efficacy regarding condom use; (5) actual condom use; and (6) Knowledge of HIV/AIDS. Focus group discussions explored issues of safety and security of women and girls within their communities related to gender-based violence. In Java the constructs examined were: (1) Gender based attitudes, perceptions and beliefs on issues affecting women and girls; (2) the sexual and/or romantic relationships and power between men and women; (3) forms of violence and how families and communities respond; (4) intentional and actual condom use by women and girls; and (5) HIV/AIDS knowledge.

The endline study took place in what became the middle of the project, before we knew that the project would be extended for two further years. This, combined with delays in completing the baseline, meant that in some cases the time between baseline and endline was as little as 12 months. Key findings included:

- In Kenya, the researchers compared respondents who had participated in the Gender Development Project activities against those who had not, controlling for organization, age, education, marital status and religion. They found strongly significant associations between participation and scores for decision making, control in relationships, gender norms and attitudes, condom norms and attitudes, and self-efficacy on condom use<sup>46</sup>. They found there was no significant association between exposure to the intervention and HIV/AIDS knowledge and attitudes (which was already very high at baseline), and condom use frequency.
- In Indonesia the most significant change was in knowledge and attitudes about HIV/AIDS (starting from a low base), followed by improvements in norms and attitudes with regard to condoms. There was also a (statistically insignificant) shift towards rejecting traditional gender roles<sup>47</sup>.

Our second element of monitoring and evaluation was that the coordinating organisations, WOFAK and Koalisi Perempuan Indonesia, compiled yearly reports containing the lessons learned from the activities of all the partners.

Third, we organised a midterm review (in 2008) of the Gender Development Project, in which all partners

completed a feedback questionnaire and attended a self-evaluation workshop. The review looked into partners' experiences with the project's approach, their successes and challenges in implementing their activities, and their thoughts on the capacity building element. It also investigated the project's impact on the partners, the networking among them, and the project's management.

Fourth, toward the completion of the project (in 2010) we coordinated external results assessments in Kenya and Java, looking for effects on the partner organisations, the primary beneficiaries, and the communities. The researchers conducted interviews with project partners, implementers and participants, and ran focus group discussions with project beneficiaries. The results are based on those people's impressions of what has been achieved, and their stories of change.

### Reflections on the process and outcomes for partners

Many of the partners found that their participation in the project changed their attitude to HIV work. In Java, partners said the project helped them see the broad consequences of HIV/AIDS, and to shift from seeing it as a disease for the health sector alone. In both Java and Kenya partners found the training on gender and women's rights made them more sensitive to the needs of the women in their communities. As a result, most partners reported that integrating HIV, gender and rights helped them gain a broader and more holistic approach. They also appreciated the freedom they had to broaden their work. In particular each partner was able to choose the best entry point for their work. For example:

- In Java in a community where AIDS organisations had previously been sent away, Lembaga Gemawan first focussed on issues of economic empowerment, education, and religion in its work with women's groups. The topic of HIV was broached later. Lembaga Gemawan felt they were able to work on the issue of HIV partly because they are not a HIV/AIDS-specific organisation.
- KEFEADO's work with pupils in Kenyan schools began with discussions about school-related problems before

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46 The researchers conducted a cross sectional analysis of the endline data because many of the endline respondents had not been surveyed at baseline, due to changes in target groups and displacement of people in the post-election violence. However, they note that the cross sectional analysis has limitations including insufficient sample size, difficulty in controlling for selection bias, and difficulty in measuring different degrees of exposure to the project Impact Research and Development Organisation (no date): STOP AIDS NOW! Gender Development Project Endline Final Report (Kenya) [www.stopaidsnow.org/downloads](http://www.stopaidsnow.org/downloads)

47 Beelen N (2010): STOP AIDS NOW! Gender Development Project research projects in Indonesia and Kenya: Summary of the endline reports [www.stopaidsnow.org/downloads](http://www.stopaidsnow.org/downloads).

moving on to personal and family issues and finally relationship and sexual issues. This made it more acceptable to students, parents and staff.

Some partners—including Dupoto-e-Maa, ACK Eldoret and WOFAK—reported they were seeking to **integrate gender, rights and HIV in all their work**. Others appreciated how the project **broadened the scope of their work** and improved their networking, with some working for the first time with civil servants and community leaders. For example:

- Staff of the Javan partner Mitra Wacana had struggled with accepting issues concerning lesbians, gays, bisexuals and transsexuals. The project’s emphasis on human rights and culture enabled the organisation to move beyond negative judgements and less inclusive attitudes towards non-heterosexuals; and
- KENWA used to focus on HIV and interact mainly with HIV/AIDS-specific organisations, but now does broader work within a wider network of actors.

The partners in Kenya developed an understanding of the need to develop economic empowerment activities for the women and girls with whom they work. They grew to realise that, without economic empowerment, women cannot act on their own newly developed awareness of gender equality and women’s rights, and that their empowerment is difficult to sustain without greater financial independence.

In terms of their own organisations’ functioning, many of the partners developed gender and/or HIV policies as a result of their involvement in the project. Some partners, such as Dupoto-e-Maa, instituted policies for gender parity in their human resources.

**“When we started, our programs like livelihoods and economic empowerment did not teach the women these issues and Gender Development Project came in to integrate the three themes.”**

Dupoto-e-Maa



## Empowerment and cultural change in communities

The stories told by project participants and partners include many examples of shifts in attitudes and behaviour among women and girls, and at community level<sup>48</sup>. Here are some of them:

### New public dialogue on gender issues:

- Greater willingness by religious students and clerics to discuss the previously taboo topic of sex;
- Female teachers of Islam including issues of sexual relations in their lectures;
- Cultural custodians speaking out for the first time about women's choice in widow inheritance, and against early marriage and violence against women;
- Women supported to publish a Friday bulletin about gender, rights and Islam, to counter the materials distributed in communities which use Islam to justify women's repression.

### Changes in cultural practices:

- A shift from in-laws deciding about widow inheritance to widows themselves having the responsibility to decide;
- Young men and boys taking up roles that were formerly for women only, such as fetching water, carrying babies in public, and household chores;
- Fewer cases of early and forced marriages;
- School girls refusing to get circumcised, and boys and men being circumcised in health settings; and
- Women challenging a Bukusu<sup>49</sup> tradition that only men may eat chicken.

### Greater involvement of women in governance:

- More women attending barazas, sitting on school and water committees, becoming priests, and being elected to leadership positions in the community.

### Economic empowerment of women:

- Women shifting from trading sex for fish to other ways of earning money;

**“In the society of us Luos, men are the ones who were the head but now with teachings we had on ‘gender’ it makes us to try in our homes that if there is an issue we sit down and solve it as two people.”**

C-MEDA project participant

- Women starting savings groups and using the savings to start businesses;
- Women living with HIV supported to start businesses and become more financially independent.

### Women resisting sexual abuse:

- Women challenging their partners about domestic violence and rape;
- Women refusing police officers' demands for sex when arrested.

### Greater willingness to report rights violations:

- Community members trained as paralegals to assist others to act on cases of gender based violence and inheritance issues;
- Women reporting more cases of gender based violence in the home to the authorities;
- Girls reporting more cases of sexual abuse within schools to the authorities; and
- Cases of widows' inheritance losses successfully disputed and rights upheld.

### Improved self-esteem:

- School girls reporting higher levels of self-esteem, becoming more confident to speak in public, and feeling more able to say 'no' to sex; and
- Women living with HIV reporting higher self-confidence due to working together and starting businesses.

### Greater agency to prevent HIV transmission:

- Women insisting on condom use and increased use of condoms;
- More men and women taking HIV tests;
- More women seeking services to prevent perinatal transmission of HIV; and
- Greater disclosure of HIV status.

### Reduced stigma regarding HIV infection and better care for people with HIV:

- Improved understanding of HIV transmission, and of how gender inequality and certain cultural issues increase vulnerability to HIV infection;
- Better mutual support for positive living among groups of people living with HIV; and
- Paralegals assisting people living with HIV to access treatment when they had been displaced by post-election violence.

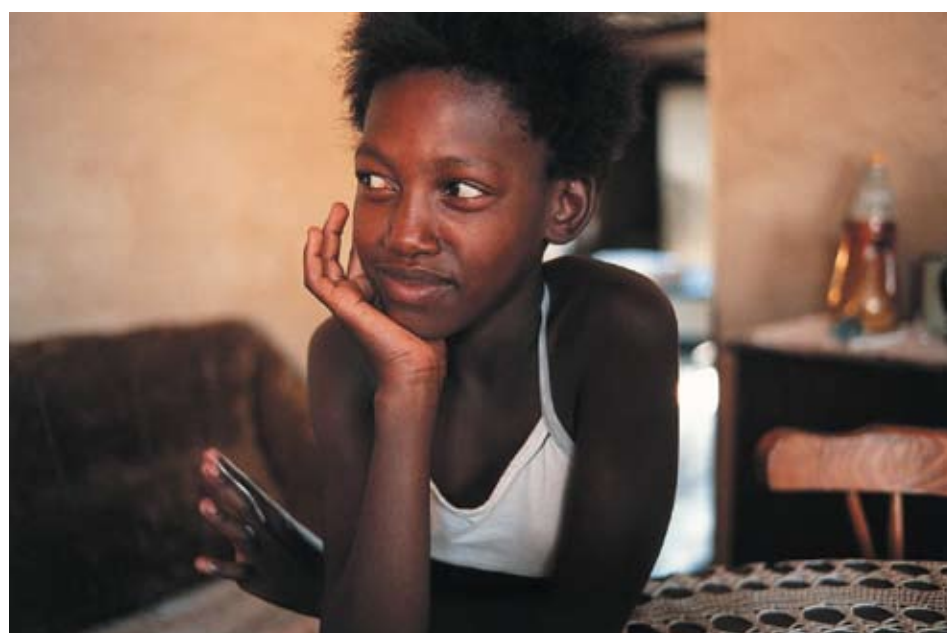
48 For more detail, see the Results Assessment reports from Kenya and Java, which will be available from [www.stopaidsnow.org/downloads](http://www.stopaidsnow.org/downloads) once they are finalised.

49 The Bukusu are one of the 17 Kenyan tribes, mainly living in Western Province.

Naturally, there are limits to what the partners could achieve in a short time. For example, in Indonesia the Cirebon Women's Crisis Centre supported a woman who had been forced into sex work to get treatment for her HIV infection and to regain her health. However, the woman then moved away. A year later she returned, having given birth to a baby which had died, and feeling unable to reveal her HIV status to her new husband.

Cultural change takes time, particularly because achieving full and sustained change requires shifting norms and behaviours among individuals, communities and institutions. Several partners found it frustrating that the rate of change can be so slow. Sometimes positive change seems insufficient to those of us who are seeking gender equity. As an example, one Kenyan woman praised the project saying her participation meant, "There is peace in my home, and I am able to plan better with the little money my husband gives me, and this has avoided him beating me like before." Clearly things have improved for her, but she is not yet her husband's equal.

Another example is that of one of the Kenyan partners, the Women's Shadow Parliament, which supported school girls to learn about their rights, to become more assertive in their communication, and to develop the determination to stay in school and to refuse early marriage. However, they believe that abuse of school girls by teachers and head teachers continues, and that cases against them are often dropped due to corruption. This illustrates the need to work with institutions which have a duty to uphold women's rights, and to support community members to demand that they fulfil that duty.



**"If rape cases occur, earlier they used to stress finishing the cases amicably at home, but this has now changed and people are reporting cases to the authorities - we as a group help the victims to get help through the correct way, referral to hospital."**

St. Peters women's group, supported by ACK Eldoret

**"We have learnt to treat each other as equals following discussions with our partners after GDP sessions....we now have consensual sex and nobody has power over the other when it comes to sex ....for me, she is able to convince me because before, there are things I would not just listen to from her."**

Male project participant, KANCO

