Women and Men Together for HIV/AIDS Prevention

Literacy, Gender and HIV/AIDS

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UNESCO
Introduction

HIV/AIDS has reached crisis proportions in many parts of the world, particularly in Southern Africa. To curb its spread, political leaders as well as health care and development specialists and practitioners have made concerted efforts to generate awareness and introduce education relating to this disease. Nevertheless, despite the abundance and availability of educational programmes aimed at the general public on HIV/AIDS, people in poor countries are dying faster than ever before, especially in Southern Africa. This puzzle leaves observers asking questions, such as “Why is this happening?”, “Why has the infection rate increased?”, “Are the educational materials reaching the right people?”, “Are they affecting people who are at greatest risk?”, “What is missing or wrong with them?”, and “Where are the information gaps?”.

One critical component in the various explanations for this puzzle is without doubt the gender dimension which is often overlooked in many diagnostic analyses of the issue. Many studies have revealed that the risk of acquiring HIV/AIDS does not depend on knowledge alone but involves the freedom of individuals to make decisions. Gender inequality, particularly coupled with poverty, is a major contributing factor to the spread of HIV/AIDS (Farmer, Connors and Simmons 1996). The subservient role of women in many poor cultures simply does not allow this and a vital means of curbing the spread of the virus is then lost. Existing educational materials on HIV/AIDS to date have not largely succeeded in changing entrenched attitudes on equality of women and men and their sexual relations. For example, emphasis is normally on conveying technical information, means of transmission and consequences and is predominantly instructional, such as how to put on a condom. These materials do not touch the heart of the matter. Attempts in practicing safe sex are often hindered by gender discrimination that is buried deep in

1. Paul Farmer, M. Connors and J. Simmons argue that poverty and gender inequality are far more important causes to HIV risk than ignorance of transmission modes or even “cultural beliefs”.
traditional behaviour and culture, which in turn perpetuate gender inequalities in sex negotiations.¹

With its extensive experience in gender sensitization training for all of its programme initiatives, the Literacy and Non-formal Education Section of the Division of Basic Education at UNESCO has recognized the urgent need for reading materials that incorporate real-life experiences of, and relationships between, men and women and what they can do to look after themselves and others. It also acknowledges the need to tackle head-on the often sensitive and taboo topic of sex and sexuality in an effort to influence people’s attitudes, leading readers to reflect honestly on their own situations and to question their prevailing beliefs and behaviour. Therefore, UNESCO, together with its institutional partners, has mobilized resources, called upon its special experience in participatory processes and its knowledge and understanding of gender issues to meet the challenges represented by this pandemic. The purpose of this paper is to present the UNESCO-sponsored approach aimed at promoting gender and HIV/AIDS awareness and to describe their outputs.

Since February 2000, UNESCO has been supporting a series of hands-on training workshops to sensitize educators and professionals in health care and communication, law enforcement, the media, religion and counselling to gender concerns in seven countries in Southern Africa: Botswana, Kenya, Malawi, Namibia, Swaziland, Zambia and Zimbabwe. The contents of these materials aspire to help people change their behaviour towards practicing safe sex and ultimately to save their lives. These workshops are regarded as part of the endeavour to draw upon their experience and knowledge to tackle a pandemic that has reached tragic proportions in the region. In particular, they aimed at enabling participants to understand the influence of culture and gender on society’s handling of those infected and of those affected by HIV/AIDS, how HIV/AIDS is spread and how it can be prevented. While each country experience has been unique, recurring issues and themes have been identified at these workshops through in-depth, lively exchanges among workshop participants. So far, approximately 200 people have benefited from the training. Workshop proceedings have revealed layers of rich gender-sensitive research that shed light on how social, cultural, and economic factors influence the perception and spread of HIV/AIDS.

¹ Although HIV/AIDS is also transmitted by blood transfusion and intravenous drug through using contaminated needles, which are important modes of transmission to consider in the fight against AIDS, the focus of this publication concentrates on the sexual transmission of the disease.
The stereotyping of men and women reinforces unequal sexual practice; a vision of women as weak, innocent, passive and submissive while men are strong, virile, possessive and authoritative is conducive to rape and violence. The role of superstitious beliefs is an important factor; these generally take from women in various ways their right of choice and power of decision over their bodies. The special problems of living with HIV occur in all societies; the responsibility for honesty in sexual relations and proper care of sufferers. The simple financial cost is huge in poor societies; the cost of treatment, the loss of income of infected and affected persons. There is often little provision of counselling and services for AIDS sufferers and their families. Many of these factors will affect women unequally; it is women who mostly provide care and who are at greater risk because they have so little choice.

The unique contribution of UNESCO to these workshops was to train participants from diverse backgrounds to develop easy-to-read, easy-to-produce literacy materials through an interactive group process. This interaction enabled them to shed their own gender-biases and discover important issues relating to HIV/AIDS that are prevalent within their respective cultural and socio-economic contexts. Within this perspective, participants developed materials based on their exposure to real-life situations. As persons with a certain status in their community, they became aware that the HIV/AIDS pandemic is a complex problem affecting all layers of the population, especially women who
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are increasingly at risk of contracting the virus. They were able to acknowledge that this is a societal problem affected by individual as well as group actions. As a community, they recognized that they could no longer wait to act in preventing the spread of the disease and caring for those already suffering.

After this sharing of experience and knowledge and after the self-exploration that the context promotes, the participants became aware of the social complexity of the HIV/AIDS crisis and its impacts on all layers of the population, but especially the impacts on women who are increasingly at risk of contracting the virus, lack the means to manage their lives and generally pick up the costs. As persons with status, the participants are well placed to spread this message in their community and to act upon it. The participants at the end of the workshops understood and acknowledged that HIV/AIDS is a societal problem affected by individual as well as group actions.

The materials from the workshops are created by people who know, they speak from the heart and they speak honestly. Potential readers of these carefully crafted booklets are not treated as passive recipients of knowledge and inactive decision-makers. They are treated as people actively engaged in reflecting, deliberating and questioning their own beliefs as well as those of people around them. The booklets aim to enable them to decide for themselves, encourage them to know that they have a right to do so and thus avoid having someone else decide for them. Extracts from the booklets are given throughout this volume.

Women – the backbone of rural economy – need to be able to protect themselves from HIV/AIDS
In Crisis Proportions

At the epicentre of the HIV/AIDS crisis, Sub-Saharan Africa currently claims the highest number of people living with HIV/AIDS in the world. In some of these countries, more than 30 per cent of adults are infected. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), at every minute of every day approximately 11 people become newly infected with the virus (2002). Not surprisingly, HIV/AIDS is overwhelming health services that are inadequate and already under-funded in the developing countries of this region. The spill over effects of the pandemic have substantially affected other sectors of development, notably education and agriculture. AIDS kills people in the prime of their working lives. UNAIDS claims, “The epidemic is reversing development gains, robbing millions of their lives, widening the gap between rich and poor, and undermining social and economic security” (2002). In its current manifestations, HIV/AIDS is propelling families into a deeper cycle of poverty.

HIV/AIDS has cast a net wider than the stereotyped high-risk groups, such as those practicing single-sex relations and drug users. It is expected that the number of HIV cases through heterosexual transmission in already populous countries will greatly increase current global numbers. In fact, over 75 per cent of HIV infections are transmitted through sexual relations between men and women (UNFPA 2003). In Southern African countries, the dominant mode of HIV transmission is through unprotected heterosexual intercourse.

This 17 year old boy is an orphan. He lives with his grandmother on her homestead outside Bulawayo, Zimbabwe.
Initially infection was more common among men, but now most new cases are women, reflecting the current overall shift to heterosexual transmission and emphasizing the natural susceptibility of women to infection. According to UNAIDS, by the end of 2001, women comprised 47 per cent of all new infections. A United Nations report also shows that women now make up 50 per cent of those infected with HIV globally; in Sub-Saharan Africa, this figure jumps to 58 per cent (UNESCO 2003).

United Nations statistics also demonstrate how HIV/AIDS has struck younger populations. Of the 42 million people living with HIV/AIDS, more than a quarter are aged 15-24. According to UNAIDS, more than half of all new adult infections now occur among this age group (2002). More alarmingly, further analysis shows that the majority of young people living with HIV/AIDS are women, amounting to 7.3 million women from a total of 11.8 million young adults (UNICEF, UNAIDS, WHO 2002). For example, in Swaziland UNAIDS estimates that in the younger population group, more women than men are HIV-positive. Between the ages of 15 and 19, young women are five times more likely to develop HIV/AIDS than young men of the same age (2002).

Children, too, are the hapless victims of this pandemic. This is especially true for girls who are obliged to become carers for other family members with the virus or have to fend, not only for themselves, but also for their orphaned brothers and sisters. In addition, all these children can be abused or exploited by adults. In 2001, there were 13 million children globally under the age of 15 who had lost one or both parents to AIDS. Of this figure, 11 million live in sub-Saharan Africa (UNAIDS 2003). By 2010, the number may reach 25 million. To be sure, this is affecting succeeding generations in this region (Panos Institute 2002). There is a real and imminent danger of children growing up to be uneducated, illiterate, unsocialized and disenfranchized young adults who are unskilled and unable to contribute to society (World Bank 2003).

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1. As defined by United Nations Agencies, these statistics generally define younger populations as aged between 15 and 24 years of age.
2. The figures are astounding. For example, AIDS has by now orphaned 11 per cent of Uganda’s children, 9 per cent in Zambia, 7 per cent in Zimbabwe and 6 per cent in Malawi.
3. Not only are children losing parents, but they are also losing their teachers. Nearly 1 million African students a year are deprived of a teacher because of the disease.
The HIV/AIDS statistics are alarming for Southern Africa, particularly when a gender dimension is added to the equation. This trend supports the dire need for co-ordinated and innovative approaches to address the gender dynamics of the pandemic, especially in relation to the greater vulnerability of women and girls. This is particularly pertinent in the efforts to prepare simple materials to reach as large a readership as possible.

**Gender and the Crisis**

Because a disproportionate number of women, both young and old, are adversely affected by HIV/AIDS, it is clear that gender roles and power dynamics greatly influence sexual risk calculations (UNFPA 2003).¹ Gender analysis in the context of HIV/AIDS encompasses, to a large extent, the power relationship between men and women. This is shaped by traditional and cultural norms, beliefs and practices, that discriminate between men and women and influence how vulnerable each group is to the virus. Although HIV/AIDS can strike anyone, women are more likely to be vulnerable to HIV exposure than men. Their physiological susceptibility to infection is estimated to be at least two to four times greater than that of men (UNFPA 2003). Moreover, social expectations, prescriptions and rules place women at greater risk of coercive sex both within and outside marriage and permits them little or no bargaining position. These norms leave women even more vulnerable to contracting the virus, as well as to the social and economic consequences of caring for infected people.

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¹ Gender dynamics are defined as the different roles, expectations, identities, needs, opportunities and obstacles that society assigns to women and men based on sex.
Social, cultural, economic and legal forms of discrimination further increase women’s vulnerability. Gender discrimination puts women and girls on a lower status, leaving them at a considerable disadvantage in terms of their access to resources, choices, decision-making power as well as opportunities across all spheres of life. This “lesser value” assigned to women hinders their ability to protect themselves from HIV infection and to respond to the aftermaths of infection for themselves and their families.

In general, girls and women have lower levels of education and literacy. This is one of the strongest determinants of sexual and reproductive health status overall (UNFPA 2003). They have inadequate access to information, education and services relating to safe sexual health. At home they have relatively little decision-making powers and are subjected to harmful traditions and customary practices (such as early and forced marriage, “wife inheritance” and “cleansing”).

The combination of these factors make women and girls susceptible to sexual trafficking and exploitation by “sugar daddies” and similar exchanges for material goods.

Women are also more vulnerable than men simply because they are poorer. Poverty stricken women often have no choice but to submit to sexual relations which put them at high risk of contracting the virus. Men, whether conscious or not of the vulnerability of poor women, take advantage of it (Mataure et al 2000, Panos Institute/UNAIDS 2000).

The stigma associated with HIV/AIDS reinforces prejudices and discrimination against people living with the virus and their families. As a result, those affected by HIV may hesitate to seek social and medical help even if these services are available. Women often
keep their HIV status to themselves for fear of punishment by their husbands or lovers. As the usual subjects of blame, women fret that they will be thought of as “whores” or “loose women”. Pregnant women are known to continue to breastfeed their babies despite knowing that by doing so they will infect their babies. Girls and women bear a disproportionate burden of care of the ill and orphaned. Not only is this burden physically and emotionally gruelling, but it can prevent schooling and damage their later life. In Swaziland, the United Nations reports that school enrolment has fallen 36 per cent due to AIDS because girls are compelled to leave school to care for sick family members (BBC 2001). At the same time, women and girls are left to fend for themselves in supporting their families with diminishing resources (UNFPA 2003).

In the light of numerous cultural constraints, development practitioners and material developers must recognize that women’s low social and economic status is a serious obstacle to positively responding to any HIV/AIDS prevention programmes. They need to consider other risk factors, such as women’s low literacy rates and lack of accurate knowledge of HIV/AIDS when designing programmes (Buseh et al 2002). Although women bear much of the burden of HIV/AIDS, focusing on women and omitting to study the sexual attitudes and behaviour of men is not sufficient. Careful examination of gender dynamics is vital to understand sexual behaviour in any culture and accordingly the root cause of HIV/AIDS transmission.

**Men’s Responsibilities and the Macho Concept**

In many Southern African countries, the AIDS virus is primarily transmitted by men through their sexual relations. One in five Swazi men reported having non-regular extra-marital sexual partnerships in the preceding twelve months, while the figure for women was just one in sixteen (Mataure et al 2000, Panos Institute 2000). Such a trend is common throughout many parts of Southern Africa. HIV is more easily transmitted sexually from men to women due to women’s biological make-up. Moreover, in most cases, men have the upper-hand when it comes to deciding where, when, how, with whom and how often sexual encounters occur. Studies have shown that where female sex workers or young female adolescents are concerned, they usually have some flexibility in deciding who their customers or boyfriends are but have very little negotiating power in terms of
how sex is conducted. Since the attitudes and behaviour of men directly influence the HIV pandemic, it is essential to involve men in any action to promote successfully safer sex practices and behaviour.

“Macho” is a term which generally refers to a culture where men are encouraged to have multiple female partners, to have extra-marital affairs and to engage in unprotected sexual activity from a very young age. In some cultures, a boy’s sexual organ is regarded as a precious gift to be celebrated and proudly displayed. In Zimbabwe, for example, boys learn at a very young age the value of their penis, often referred to as a “bird with two eggs”. Rituals such as “smoking” when female relations, like grandmothers, play with young boys’ genitals arouse them and generate their pride in being male. It also promotes the view that reproductive health issues are “women’s business” thus steering men away from responsible behaviour. In this type of culture, men are discouraged from talking to one another about health matters relating to them or their female partners. To save face, they hide their lack of knowledge and so are inhibited from asking questions and seeking the necessary information. Finally, the macho culture does not recognize as, or identify with, men who have sexual relationships with men unlike northern cultures (Christian Aid 2003).

The macho culture tends to reinforce male dominance over their female partners. Studies in Tanzania and Zambia point to the popular view that men in these societies believe they have the rights to the bodies of their wives, for procreation and for beating (Bujura and Baylies in Aggleton 1999). Likewise, older men involved with adolescent girls have more power over them in terms of controlling the conditions of sexual intercourse, including condom and contraceptive use as well as the level of violence involved. This kind of cross-generational and transactional sex is a common pattern throughout Southern Africa and it often results in older men with HIV transmitting the virus to one or more younger women (Luke, Kurz 2002, Aral 1993). In turn, the young women may pass on the virus to young men, or to their husbands when they marry. The circle of transmission is then complete when these young men become older men who then have younger girlfriends (Mateure et al 2000).

1 Several studies reveal significant links between unsafe sexual behaviour, HIV risk and cross-generational sex.
Embedded social norms and expectations shape men’s perception of masculinity and of themselves and mould their opportunities, outlook and behaviour. These norms, as well as socio-economic circumstances, tend to facilitate men’s vulnerability to HIV contraction. For example, in the predominantly agrarian economies of Southern Africa, poverty leads men to migrate from the rural to the urban areas. These migrant labourers, victims of harsh conditions and loneliness, find comfort with women and after falling ill, they return to their village of origin and possibly infect their partners. As a result, rural communities bear a higher burden of the cost of HIV/AIDS; the flow of resources stops and the cost of caring begins. Even when they are living with HIV/AIDS, men are less likely than women to seek help or join support groups for their condition. The concept and practice of masculinity need to be adjusted in ways that fit new socio-economic realities, ranging from rural-urban migration, the rate of unemployment and to newer opportunities and advancement for women.

The last decade has witnessed a multitude of HIV/AIDS interventions that have targeted women and girls. However, they have had limited success because men’s needs and circumstances did not receive sufficient attention. In order to gain a more comprehensive picture of gender dynamics as they relate to the HIV/AIDS pandemic, it is critical to understand male identity and concepts of masculinity that lead to certain sexual behaviour and practices. This is especially urgent in the light of Southern Africa’s high rates of HIV/AIDS. The macho culture needs to be replaced by one that would enable men to talk openly and raise questions about HIV/AIDS and their health as well as that of their partners – a culture that would empower both men and boys to engage in more responsible sexual practice and participate actively in community affairs. Low self-esteem can often translate into HIV risk-prone sexual behaviour, often characterized by sex with several partners, unprotected sex and violence. Innovative approaches and programmes are
needed to introduce newer concepts of manhood that would raise men’s self esteem and challenge long-held stereotypes. Such a change would help a majority of men rise above the overwhelming sense of displacement and disorientation resulting from unemployment, disease and poverty in the ever-changing socio-economic environment of Southern Africa. Examples of successful approaches and programmes that are inclusive of men are two home-based AIDS care programmes in Malawi and Zambia. These programmes include men as volunteer caregivers, a role traditionally assumed by women. These male caregivers are especially coveted in cases involving sick men who need nursing and help in bathing. In addition, they are better able than female caregivers to distribute condoms to other men (UN 2003).

Any successful organization or intervention requires the participation of men of all generations. It is especially important to account for what men want and need and empower them to take responsibilities for themselves and for their partners and community. Men in their many personal and professional roles can take on the task of being positive role models by advocating respect towards women and people with HIV/AIDS. They can also promote preventive measures such as condom use. Finally, they can encourage a more expanded role of men in the family as co-caregivers for children, the sick and the elderly.

**Risk Perceptions, the Culture of Silence, Denial and Stigma**

Numerous studies in Southern Africa have shown the vital role of cultural analysis in epidemiological research on HIV/AIDS. Studies conducted for Africa reveal that entrenched cultural traditions are major factors in advancing the spread of HIV/AIDS in the rural areas of Africa (Caldwell, Caldwell and Quiggin 1989). Other research similarly shows that culturally sensitive knowledge of sexual beliefs and practices through a gendered lens is needed “in order to understand adequately patterns of HIV transmission, to evaluate the impacts of AIDS on different communities, and to design more effective intervention programmes” (Abramson and Herdt 1990). The concept of a “sexual culture” is needed to understand the systems of meaning, knowledge, beliefs and practices that determine how people engage in sexual activities. It is this sexual culture that shapes individual sexuality through roles, norms, and attitudes within religion, politics and economy.

Educational materials on HIV/AIDS are more likely to have positive results if they cover cultural norms influencing sexual behaviour rather than sexual identity. Nevertheless,
experiences in many regions of the world have shown that even the most culturally sensitive campaigns for safe sex practices founder on a culture of denial and silence. Many surveys have revealed that people choose not to use condoms because they do not see themselves at risk despite having adequate knowledge of safe sexual practices. Heterosexual respondents do not consider themselves to be vulnerable to infection. They deny the risks to them as individuals since they associate transmission of the virus with certain “high risk groups” as portrayed in the popular media.

The stigma of HIV/AIDS is widespread and assumes multiple forms of behaviour in various cultural settings. It provokes a host of negative actions and attitudes that are commonly directed at HIV-positive people. It can happen at the social, political, psychological and institutional levels. It leads to overt discrimination towards those infected or to behaviour believed to lead to infection (Panos Institute 2003). As the first groups of affected people were already socially marginalized, it follows that the stigma attached to HIV/AIDS is often compounded upon pre-existing stigmas of sexual conduct and drug use (Panos Institute 2003). Hence, the general public is likely to associate HIV/AIDS suffers with members of these pre-determined groups. In so doing they tend to overlook their own individual vulnerability to the virus. This kind of stigmatization prevents adequate care and appropriate prevention measures. “At the heart of the stigma of AIDS lies shame, the perception that those with the virus have done something wrong for which they and their families should be ashamed” (Mataure et al 2000).
Because HIV/AIDS is connected with sex, and thus taboo, it carries a stigma. People avoid talking about it. Living in denial to keep the family from social condemnation is a norm not an exception. It is common to hear the relation of a dead person at the funeral identify the cause of the death as witchcraft or poison. While this could be due in part to the froth or salt found around the deceased’s mouth in their last days, it is also motivated by a subconscious or conscious refusal to admit the terrible truth. Even the official cause of death is often explained away as “a long illness”, maybe pneumonia or meningitis if the person suffered severe headaches. Denial is one driving factor behind the alarming death rate of the young generation. Often, mothers continue breast-feeding their babies knowing that they are HIV-positive. The fear of being “found out” far surpasses the risk of exposing the infant to HIV/AIDS. This type of fear is only human, particularly bearing in mind the hypocrisy surrounding sex. Sexual partners normally avoid discussing sex. When women find out their HIV status, they fret that their partner, and consequently society, will accuse them of being “whores”. Simultaneously, many men become violently angry at the suggestion that they might be a virus carrier.

Gender, class, and generational differences shape the perception of HIV/AIDS in Southern Africa. Men in positions of power are particularly prone to point their fingers at
others and deflect the blame from themselves. The macho man concept worsens the situation with the “it won’t happen to me” syndrome. Accordingly, men with high-risk behaviour of having multiple partners regularly refuse to be tested and are oblivious to the risk to which they are exposing their partners. Not knowing one’s own HIV status prevents one from learning how to prolong one’s own life and to protect one’s partners. Such ignorance helps spread the virus. Village leaders also tend to blame the HIV/AIDS problem on young women who have fled to towns and embraced “immoral” ways. Once HIV is contracted, they then return to their villages to die, often destitute and in complete isolation. In such cases, most of the blame is directed at these poor, weak, vulnerable individuals who become the focal point of discrimination. For the most part, society conveniently overlooks the role men play in transmitting the virus and, as a whole, tends to be more indulgent to them.

Studies show that women hesitate to discuss sex with their partners because it not only challenges male authority, but also compromises their reputations. The culture of silence is prevalent because breaking the silence entails particular risks and ultimately necessitates a politics involving challenging patriarchal systems which have given men control over women’s body and sexuality (Alonso and Koreck 1999). Consequently, many women fear stigmatization resulting from society’s treatment of them as sexually promiscuous. This fear of stigmatization also applies to men, but in terms of their socio-economic status and position and not so much their sexual conduct since society condones their sexual promiscuity.

The UNESCO Initiative

The Approach
In the light of the foregoing, it is apparent that there are serious disparities between the real life as led by women and men and the type of training and educational materials being produced to help them understand and deal with HIV/AIDS. To respond to this need, UNESCO and its partners launched an initiative to produce post-literacy educational materials that explore the links among gender, culture and HIV/AIDS.
Since 2001, UNESCO has been organizing national and regional workshops for education, health care and communication professionals from various Southern African countries. The purpose of the workshops is to train local stakeholders to prepare materials that help people change their behaviour, practice safe sex and ultimately save their lives. The workshops go beyond discussions relating to the usual technical information and go to the roots of HIV related problems – the cultural practices and gender issues influencing relationships between men and women.

Initially intended for practitioners on the ground, later workshops were open to a more diverse community from HIV/AIDS concerned sectors, such as government officials, religious figures, non-governmental organizations (NGOs) active in community development, literacy and non-formal education, gender, health, religion, HIV/AIDS, as well as persons living with HIV/AIDS.

UNESCO’s non-formal education approach to alleviate the spread of HIV/AIDS in the developing world is gaining recognition. The impact of HIV/AIDS varies among communities, so UNESCO’s approach is anchored on understanding how gender dynamics are shaped by sexual beliefs and practices. The training aims to create programmes of prevention and intervention which centre on the promotion of behavioural changes. On the whole, this approach embraces gender sensitization and analyses as well as open discussions on the socio-sexual relationship among people that goes beyond biology.

The UNESCO activity recognizes that HIV/AIDS prevention programmes must embody local cultural knowledge if they are to be effective. Any interventions used to
promote safe sex need to build on an understanding of the social and cultural practices that influence transmission of HIV/AIDS. Understanding sexual practices and their cultural meanings entails local knowledge and participation to work towards effective locally-driven solutions. The non-formal educational approach that UNESCO adopts is designed to respond to these considerations; it is also designed to give a voice to “voiceless” groups such as poor and illiterate women and girls. Recent research from thirty-two countries demonstrates that education, especially among women and girls, generates awareness and knowledge of HIV/AIDS related problems. A case study in Zambia showed that infection rates among educated women declined in the mid-1990s, while the rate among women without any formal education have remained constant. Similar cases can be found in Uganda. The findings point to the vulnerability of illiterate women compared to their more educated counterparts (Watkins 2001). Women’s organizational capacities should be fully utilized to offer a broader sense of community, mutual protection, and collective action. However, education alone is not sufficient. There needs to be awareness and empathy for both men and women that would enable learners to adapt their sexual behaviour to enduring safe sexual practices.
The Approach

The participation of both men and women at these workshops has been vital. At each workshop some thirty women and men met with the intent to develop this type of sensitivity towards HIV/AIDS as well as compassion for those living with the condition. Following the UNESCO manual, *Gender Sensitivity*, the workshops incorporated a variety of activities to help participants become more sensitive to the nature of power relationships between the sexes and how these influence the spread of HIV/AIDS. More importantly, the activities helped participants to appreciate the reasons why people behave the way they do and why getting people to practice safe sex is so difficult. The participants concluded that these were two main issues: the influence of traditional views on prevailing attitudes and the relationships between men and women. Having established that, they then chose a topic based on research done with the target group in their countries and prepared literacy materials in the form of booklets that would carry these ideas to the readers.

Subsequent workshops have built on this approach and they typically encompass two parts. The first part uses participatory exercises focusing on the roles of men and women in the participating countries and the accompanying implications of these roles for material development for HIV/AIDS prevention and management. These exercises include discussion groups and presentations, games, role plays, testifying, drawing, writing, debates, analysis of case studies, critiques of radio and television programmes and post-literacy materials produced in earlier workshops and elsewhere, as well as field visits.
Participants were sometimes asked to consider common sayings or proverbs which reflect traditional views about women and men in their society, such as:

- A boy inherits my name. A girl has no name.
- Daughters-in-law feel like ghosts in the house.
- Having a baby boy brings more joy than having a horse.
- A hundred sons are not a burden but one daughter bows our heads.
- Men are rice grains and women cooked rice.
- Women are vines — they cling to whatever they reach, are capricious and untrustworthy.
- Three steps out of the house, the man is a bachelor.
- A son is a master, a husband, a god.
- An ideal woman is a good wife and a wise mother.
- Women should be barefoot in winter and pregnant in summer.
- A man is master in the house.
- A woman’s place is in the kitchen.
- Men are the elephant’s front legs and women are its hind legs.
- Women are flowers of the world.
- Long hair, short mind.

The participatory nature of the workshops allows for much open discussion and soul searching on relationships between women and men and their perception of these relationships. The range of participatory methods mentioned above is used to facilitate participation and reflection within the workshop.

The second part of the workshop involves a field visit and analysis of the needs of women and men at the field visit site. This exposure enables participants to concentrate on the principles of hands-on experience in the preparation of post-literacy, easy-to-read materials for HIV/AIDS. All materials are produced by the participants themselves who team up, in groups of two or more, discuss contents, listen to and learn from each other. They all take full responsibility for the booklets produced at the end of the workshops.

They are also required, for example, to analyze critically different case studies on the relationships between women and men. Many of the case studies are directly about HIV/AIDS. In one case a doctor living with HIV tried to inject his own infected blood into his wife. This true story stimulated animated discussion. Another case described a
South African girl living with her aunt and uncle in the city. One night, she had to give in to her uncle because he threatened to stop paying her school fees. This story shows how the girl frets that she might have become HIV-positive from that encounter. It also shows her resourcefulness in surviving and staying in school.

Many participants come to the sessions with well established ideas and personal experience on HIV/AIDS and various points of view through having had personal encounters with the virus. Yet other people bring photographs, sculptures or small mementos of loved ones, sometimes five or six in the same family, living with the virus or who had passed on. Some people come with a poem they had written. Others, although not touched personally, know of someone who is. They sit in circles and tell their stories. They share the difficulties, heartbreaks, emotions.

One participant had a brother who had died. Another brother used this death as an excuse to visit the three new widows to “cleanse” them. Later his daughter was in an accident and he was required to donate his blood to her. Unbeknown to him, his brother had died of an AIDS-related disease. But the damage had been done. He had already been infected with the virus and passed it on to his own daughter. And so the cycle continues.

One man said that he, as well as many other men, had wanted to marry a girl from the next village. He was lucky. He found out in time that her first husband had died of the AIDS virus. Many families had to care for the children of their brothers and
sisters, left orphans when both parents died. This only added to their already heavy burden, especially the financial one of having to provide for so many extra people.

I have lost close relatives through HIV/AIDS. I nursed all of them.
Two died in my house.
It is costly to look after such patients – socially, emotionally, economically, psychologically.
I am now looking after 7 orphans.

(Testimony of a Workshop participant)

Workshops include presentations and interventions from medical doctors and religious leaders. In particular one whole workshop session was led by a religious personality who had been personally touched by the consequences of the virus and was devoted to the role of the church in the prevention of infection and caring for people with the virus. His testimony as to why he had joined the growing movement to fight the spread of the virus was particularly moving. The discussions were frank and open and dealt with the reasons why the church has, up till now, not taken a leading role and has remained on the side lines. But the mood was positive and looked to the future with concrete proposals for action.

Why I am in the HIV/AIDS fight

I have lost dear ones due to HIV/AIDS. I had two younger brothers whom I loved very much. I cherished them. I loved them, my father’s and mother’s sons. They had so much to offer and made me feel like an older brother.
Mac and Jo are no more now. I nursed and saw Mac die. He was a strong young father and husband who fought for his bread. However, he chose the way of life he wanted and HIV/AIDS came his way and though he was strong and courageous, he could not win the fight against AIDS. He died. As for Jo I only saw a corpse of him on a hospital tray after 5 years of not seeing each other. I had longed to see my baby brother and wished him to see his nieces and new nephews but to no avail.
He had been infected by HIV/AIDS and in no time, before we could help, he was gone. HIV/AIDS is a killer.
I have suffered this pain. If I can help someone in the fight against HIV/AIDS, I will gladly do so.

(Testimony by the Rev. Lemmy Mwale)
Group activities were key to the workshops. Participants were asked to work in groups and act out scenes about different people in different types of relationships. For example, a doctor diagnosing an HIV-positive status, work colleagues, spouses, in-laws, bosses and community members. After the groups acted out the scenes, the entire workshop analyzed them one by one thereby identifying the complex net of human relationships that are likely to further complicate the life of someone living with HIV. Issues such as stigma, shame, denial, despair, acceptance, support, and other subsequent coping skills were then introduced and discussed.

In yet another session, participants again organized themselves into groups and were given a few cut out paper figures of human beings of both sexes and of all ages. They were then asked to place each one within a family relationship. Each group received different paper figures from which they concocted their own family structure. For instance a woman-headed household with a teenage daughter who is a school dropout, a younger brother who works in town and an aged mother who has to look after her young grandchildren. There might be a young couple just starting a family living with the husband’s parents. The husband may have a weakness for drinking and pretty girls, and marital conflicts may have already started. Maybe the woman was married too young and resents the marriage so she starts to have an affair with her brother-in-law. After the different family scenarios were worked out, a facilitator visited each group and marked one or two paper figures with a cross, signalling that those characters were HIV-positive. Following this, each group prepared a story about their family’s struggle to cope and live with HIV/AIDS. Perhaps one of the family’s youngest daughters became infected because her father raped her. Maybe the grandmother was infected because her son’s blood was injected into her during her operation. Whatever the stories turned out to be, an important thing happened at this session. The participants had a solid anchor of real life situations on which to build their discussions on the different issues that are invariably linked to living with HIV/AIDS.

The next step of the exercise was to ask each group to act their designated role, alternating the HIV-positive person as female or male and other characters. Then the characters had to act how they treated the men and women living with AIDS. In all groups, it became clear that women living with AIDS were discriminated against, blamed for their HIV status and largely discarded. Much more sympathy and empathy was shown
to men living with the virus than to women. Once again, the inferior status of women and discrimination against them were manifested by the participants themselves.

Some exercises were intended to clarify the values of participants by obliging them to take a clear stand on a given belief and then defend it. Some statements used to elicit response during this exercise included, “Homosexuality is an abnormality”, “You can’t catch AIDS from clean and well dressed people”, “Women catch AIDS because they are promiscuous”, “Good women should be innocent when it comes to sex”, or “Only prostitutes enjoy sex”. This exercise forced people to face, and even question, their own misconceptions not only regarding sexuality and HIV/AIDS but also other prevalent prejudices concerning women’s roles in the home and community.

All the methods used worked well in obtaining maximum participation from the participants, which was invaluable in the preparation of the ensuing educational materials. The booklets prepared at these workshops complement others prepared at earlier UNESCO workshops in places as far apart as Bangkok, Dar-es-Salaam and Nairobi. They all have one thing in common, they are gender sensitive and aim to change people’s attitudes and behaviour about HIV/AIDS. With funding support from UNDP and DANIDA, UNESCO has trained people to use the non-formal education approach combining gender, culture and literacy in reaching out to people most at risk. The added-value of this approach is that it responds to the immediate needs of the respective countries.

A booklet entitled “Johanne, Fatima, Gregory and the Others … The AIDS Years” was used, with permission of Edition Hachette, to stimulate discussions. This valuable booklet provided a stimulus and an opening for discussions on the various aspects of HIV/AIDS and covers subjects ranging from the practical (how the virus spreads, its effect on the body, retroviral drugs, how to protect oneself, loss of family and possessions) to the emotional (feelings of frustration, despair, loss, and hope) as a consequence of the virus. The story is told by Johanne, a young girl left an orphan, together with her two brothers, after their parents die. Her anguish and unhappiness, her longing to see her mother on her return from school and feel her loving hands brushing her hair, the question “why did it happen?” are simply but eloquently put. Their father, before he died, handed over all his possessions to his brother thinking that his children would thus be well looked after and provided for.

1. Translated from French – Johanne, Fatima, Gregory et les Autres … les années SIDA.
However, their uncle took everything and left them destitute. The booklet describes their struggle to survive. The participants at the workshop were able to relate to the situation of these children and translate the story into the reality of their own lives, or of the lives of others living in their village or community.

Not surprisingly, the materials subsequently produced at these workshops are targeted at the people who are most at risk: poor rural people, particularly women and girls. They are also designed to reach men, who have been singled out as important actors in bringing about successful HIV/AIDS prevention. Further, they aim to reach younger audiences of men and women to help shape their future actions. And finally, they hope to draw together community actors towards safekeeping the community’s health.

The general lessons learned during the workshops are clear. First, there is hope. Second, communication about HIV/AIDS must be conducted with sensitivity and compassion towards all concerned if it is to have a positive effect.

**The Materials**

Participants are requested to identify a target group in their community or village and to carry out a study or survey prior to coming to the workshop. Thus the materials produced at these workshops are unique for each country setting. Nevertheless, what emerges is a pattern of common themes centred on HIV/AIDS across national borders. The themes addressed through the various materials produced are broadly categorized as follows:

1. **Stereotyped portrayals of men and women**: Sex roles and relationships representations of women living with HIV/AIDS; the assertion that rape victims must have “asked for it”; macho behaviour; and widespread acceptance of violence between sexual partners as constituting “normal” behaviour (women are portrayed as weak, innocent, passive and submissive partners. Men are projected as strong, virile, possessive and authoritative).
2. **Superstitious and popular beliefs and cultural practices:** Seeking virgins for a cure and regarding wealthy presentable persons as immune to HIV/AIDS; payment of “lobola” or bride price; and traditions, beliefs and practices that contribute to the spread of HIV/AIDS such as “inheriting” wives, “cleansing”, polygamy, hyena practice\(^1\) and other initiation rites.

3. **Living with HIV/AIDS:** The responsibility of HIV-positive persons to disclose their condition to past and present sexual partners; the need to continue to practice safe sex at all times; the importance of strict adherence to a medical regime; diet, exercise and positive thinking; the importance of knowing one’s HIV status, the value of support groups, home-based care, spiritual support, medical care including the role of traditional healing systems and healers.

4. **Cost of HIV/AIDS for families and societies:** Caring for those living with AIDS; the financial consequences of treatment and loss of income; consequences of HIV/AIDS on family members and caregivers, caring for the orphans and old people whose parents/children have died; the loss of skilled workers and teachers; physical and psychological costs of caregivers and community members affected and infected with HIV/AIDS.

5. **Counselling and services:** Interpersonal communications in HIV/AIDS prevention and care programmes, services for people living with AIDS; respect of their wishes and psychological support.

6. **Age-specific factors and their implications in HIV/AIDS prevention:** Different generational views of HIV/AIDS; contemporary attitudes about sex and relationships for younger people.

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1. The hyena practice is the custom of exposing young virgins to sex with an unidentified man as part of their initiation rites.
The easy-to-read booklets contain narratives of the various stages and manifestations of HIV/AIDS endured by victims and their families and friends in different social settings.

Traditional medicine is the first resort for most affected persons. The story from Namibia deals with the role of traditional medicine and the strong influence that this type of treatment has for many men and women. However, many healers take advantage of the ignorance and trust of their patients as happened to Ndadilepo, the heroine of *The Wicked Healer* (UNESCO: 2003). Married for seven years, Ndadilepo has no children and is desperate to have a baby because she is afraid her husband will leave her for another woman. So she turns to the healer for help. But far from helping her, he rapes her trying to persuade her that this is all part of the treatment. Shocked and suffering, she finally goes to see a nurse who tests her for sexually transmitted diseases and AIDS. Ndadilepo is upset and angry and worried that her husband will not believe her story and think she has been having affairs with other men. With the help of the nurse and support from the Women and Child Protection Unit, she finds the courage to report the incident and bring the healer to justice. Many women in this situation do nothing because they are afraid of the repercussions and accusations from their husbands thinking they are “loose women” or prostitutes. The booklet underlines the fear and frustration of women in their inferior role but also explains that every woman has a right to protect herself and to be protected.
Being aware and protecting oneself from HIV contraction is important in itself but in many societies, such protective measures as condom use are not even an option. In many societies women find it difficult to get men to agree to use condoms. In the booklet, *Real Men Take Responsibility* (UNESCO: 2003), the issue of introducing condom use even within a marriage becomes a formidable challenge for women. The story takes place in Zimbabwe and opens with the funeral of the last member of the Sibanda family. MaKhumalo and MaNdlovu, a couple of friends of the family, suspect that the family succumbed to AIDS. They comment that Mrs. Sibanda could not protect herself from contracting AIDS through her husband since he paid “lobola” or bride price to her parents. Widespread cultural practices, such as “lobola” often lowers a woman’s status to that of her husband’s possession. Negotiation about anything is extremely difficult, much less a highly taboo subject like sex.

In the course of their conversation, MaKhumalo warns MaNdlovu about her husband’s probable infidelity, pointing out that his work takes him to town and only allows him to be home at the end of the month. Confronted with ideas about protecting her health and that of her family, MaNdlovu brings forth her concerns with her husband. At the mere discussion of HIV/AIDS and the suggestion of using condoms, Ndlovu reacts negatively to his wife’s concerns and becomes indignant about what he perceives as his wife’s accusations that he sleeps with other women. In trying to dismiss AIDS as a killer disease, Ndlovu attributes the Sibanda deaths to malaria or other diseases. In private, however, Ndlovu ponders whether he indeed has HIV/AIDS and whether his sexual partners in town also have many partners. The next day, he discusses his concerns with his best friend who urges him to be more responsible for protecting himself and his family. This means understanding that condoms are effective in preventing contracting HIV.
Ndlovu’s initial reaction, typically described as denial, is common throughout the region. In such a society, the euphemisms for AIDS are common and also exacerbate the denial problem. For example, AIDS is often referred to as the “slim” disease in Kenya since people living with it lose a lot of weight. Evidently, talking around HIV/AIDS does nothing to alleviate the situation. With the apparent availability of materials on HIV/AIDS in urban areas, particularly with respect to the use of condoms, it is of critical concern that the death rate remains so high. The major problem, in spite of the abundance of these materials, remains that men still don’t feel they need them. Women are unable to convince their men to use them. To add to an already very complicated situation, practicing safe sex through condom use seems a remote possibility. UNAIDS’ study shows that there are still places where entire villages have never seen a condom, let alone been instructed on how to use one correctly. While efforts to extend availability of condoms are still badly needed, it is equally important that women and men be physiologically and practically prepared to use them.

Fidelity is potentially the most effective means of protection. But, based on sexual cultural norms across Southern Africa, the promotion of fidelity as a prevention method needs to be re-examined and refined. For fidelity to be effective, it has to mean fidelity to one partner for life. This concept has little relevance for places where casual sex is the norm rather than the exception, even in cases involving married couples like Ndlovu and MaNdlovu. Responsible behaviour is the starting point. As any one man can have a number of sexual partners, the risk for the entire population is beyond imagination. Moreover, in terms of “negotiating safe sex”, women generally feel that their efforts are futile. In these countries, women legally become minors under their husband’s care upon marriage. This is even more ingrained where men pay “lobola” or bride price, such as the case of Mrs. Sibanda in the above story.

Fidelity and infidelity and the sensitive subjects of coming to terms with living with the virus and being able to tell one’s partner, are at the heart of the story *Breaking the*

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1. Typically, when condoms are mentioned, they refer to ones for men’s use. At one workshop, when the question of female condoms arose, many participants looked perplexed. In Swaziland, as it turned out, examples of female condoms were in fact available at the World Health Organization (WHO) office which is a very unlikely place for local women to casually visit.
Women and Men Together for HIV/AIDS Prevention

Silence (UNESCO: 2003). from Namibia. Hafeni has been away for six months working in a factory in Outjo to make money for his family. He joyously returns to his home village, to his wife, Ndinelao, and his son whom he loves very much. However, he is eaten up with remorse. He is HIV-positive. He felt lonely in the city. To survive he needed comfort and so he turned to other women from whom he contracted the virus. His love for his wife compels him to use a condom when making love to her. But he cannot bring himself to tell her why. He thinks she will stop loving him if she knows. Ndinelao knows that something has changed, something is different. She in her turn is reluctant to ask in case Hafeni thinks she is a whore. One day a Counsellor visits the village and gives a talk about AIDS and the use of condoms. Ndinelao wonders if this can be the problem and tries to speak to her husband about it. Still Hafeni keeps quiet. Only the realization that that his wife and son need him makes him pluck up the courage to seek advice, first from the Counsellor and then the Pastor who talks to them together. And together they face the problem although it was not easy for either of them to accept the situation.

Another traditional practice, which promotes the spread of HIV/AIDS, is wife inheritance. In several African countries like Kenya, Swaziland and Zimbabwe, when a man dies his wife almost automatically becomes the possession of one of his brothers along with his cattle, cart, house and land. Elaborate ceremonies involve the woman placing a bowl of water in front of the brother-in-law she “chooses” to be her next husband while he still lives with his other wife or wives. Although sons and aunts could theoretically be among those
inheriting a widow, in general it is a brother-in-law that is expected to be chosen. The Zimbabwean story, *Inherit Me, Inherit My HIV* (UNESCO: 2003), tells of the widespread practice of wife inheritance and its effects on the spread of HIV.

**Inherit Me, Inherit My HIV**

At her husband’s death from a long illness, the story’s main character and her possessions are passed down to her husband’s brother for ownership. In a society that offers women few opportunities for economic and social independence, the heroine gives in to pressure and accepts this arrangement. The story depicts the widow’s anguish over her choice, fear of HIV/AIDS, as well as her frustration and despair. She discovers later that life is no better than if she had stayed on her own. Her new husband takes over her possessions and treats her shabbily. His wife and family detest her. A few months later, he falls ill and dies of AIDS. She then wonders whether she had the disease and acted irresponsibly by spreading it to him and possibly his wife and lovers. She decides to take matters into her own hands and takes an HIV test. If the results are positive, she plans to pursue a course of action which includes caring for herself and her children as well as choosing her son as her next inheritor.

A booklet from Swaziland deals with the same topic but from the perspective of a man about to inherit his brother’s wife. Delighted by the prospect of having a woman in her prime, who looks attractive and healthy, the man in the story forgets to ask himself how safe he would be with her or to question if the same disease infected her as it did his dead brother. Both booklets cleverly weave in the very real risk into the web of social pressure and traditional thinking that governs individual actions. Indeed, each time wife inheritance occurs, several more people are at risk of HIV infection; the widow herself, her brother-in-law, his wife, his lovers, their lovers, their unborn and unweaned babies are all potential HIV/AIDS victims. The arithmetic of this is frightening.

Tackling tradition, as with many others, is a delicate matter as people who are role models in society practice these very traditions. It must be recognized that wife inheritance and polygamy, like most traditions, have their origins in necessity, hence their legitimacy and continued endorsement. Through wife inheritance, widows and their children were supposed to be protected and provided for. No doubt this custom may have served
well to promote social cohesion. As times change, and more and more women can provide for themselves, the need for protection and provision will become less pronounced. As a result, cultural practice, such as wife inheritance and the tradition known as the “hyena practice” that engender negative consequences for any group of people should be reconsidered at least, if not categorically challenged. This is especially critical with the looming danger of HIV/AIDS.

The “hyena practice” symbolizes society’s view of women as sex objects whose functions are limited to serving men and caring for children. This ritual of becoming a woman is seen as a necessary part of a young girl’s education. Girls who were subjected to this custom testify to its horror. A virgin is given a piece of white cloth to be used during the “hyena’s” visit and brandished the next morning as proof before a congregation of women that the necessary was done during the night. While each girl’s mother promoted the hyena practice, these very same mothers were incensed at the possibility of the hyena being the cause of their innocent daughters’ illnesses. The Malawian story, *The Wicked Hyena* (UNESCO: 2003), shows the pain of each mother trying to protect her daughter’s innocence while at the same time searching for the culprit. The anger, the fear, the frustration of having been let down by the man they had paid to perform a traditional function are very real. Coupled with the risk of HIV/AIDS and other sex-related diseases, this practice has been targeted as a campaign issue with the first lady of Malawi calling for its abolition.

Other traditions or misconceptions help spread HIV/AIDS. For example, a common perception is that clean and well-dressed people are not and cannot be infected. Worse still, the prevalent myth that sleeping with virgins offers a sure cure to HIV/AIDS presents urgent and serious cause for alarm. Young and even infant girls have become the target of HIV-positive men on the hunt for a cure. These prevalent misconceptions about HIV/AIDS are especially a concern when any discussion of HIV/AIDS is taboo and cannot be challenged. It is not easy to change traditions, values and beliefs, as they are people’s security blankets. Changing them has to be done with sensitivity. Information campaigns to date have not reaped the desired results. They have failed to reach the people from either their own perspective or their social, cultural and financial reality. Certainly, for people to change their attitude, they need to come into conflict with their own beliefs. Literacy is the vehicle for this examination of self.
Because of the widespread misperceptions of HIV/AIDS, sufferers have faced difficulties living with the disease without the support of their family and community. *Kaba’s Story* (UNESCO: 2003) from Togo aptly illustrates one young man’s difficult journey with the disease.

**Kaba’s Story**

*Kaba feels dejected because both his parents and his friends have alienated him, fearing that being near him might put them in jeopardy. A social worker encounters his friends and starts educating them about how the disease is spread. She informs them that physical contact with a carrier poses no risk so long as care is taken and demonstrates her point with a handshake to Kaba. The theme of trust, compassion, and support runs through the story and enables AIDS sufferers and their friends to overcome prejudices relating to HIV/AIDS through open communication and informed knowledge about the disease.*

The next story, *Home, the Best Medicine* (UNESCO: 2003), goes a step farther by illustrating how the Tafara family copes with an AIDS-stricken child after accepting his illness. This Zimbabwean story paints an honest portrait of a family who understand that home is where the best care can be found for their loved one and that caring is not only for women and girls, but that men and boys have useful roles to play. The mother in the story is determined to follow the hospital’s advice and care for her son at home. A health worker educates the family about how to care for someone with the virus and minimize
the risk of contracting it. As the days pass, the reality of caring sets in and the mother breaks down one day because she has had to shoulder the bulk of the caring on top of tending to her other menial domestic tasks. At the same time, the cost of caring for the sick has taken a toll on the family’s financial resources. To meet these unexpected challenges, a nurse informs the family about ways to alleviate the costs of caring through improvisation.

Despite their physical, financial and psychological difficulties, the family still believes that home is where the best care can be offered for their loved one. Indeed, this is a story that demonstrates the importance of family support from all family members for an AIDS sufferer. The care-giving tasks should not be assigned solely to women and girls. Men and boys have a critical role to play in this arena.

**Take Care of those You Love**

Mrs. Toivo’s daughter, Emma, was ill and getting worse. Although she knew her daughter would never get better she did her best to comfort her. However, she was frightened to touch her with her bare hands in case she caught the virus. She decides that she must get help so she consults the nurse at the local clinic. The nurse is very helpful and explains how to take Emma’s temperature, how to cool her down when she is too hot, how to wash her. She explains when Mrs. Toivo can touch her daughter with her bare hands and when she should use gloves. Caring for Emma also taught her a lot about looking after people with the virus. She decided to pass on the knowledge she had gained with her community so that the lives of HIV-positive person(s) would be prolonged in comfort.
Moreover, this story tackles the often-neglected issue about the detrimental effect of HIV/AIDS on a family and its finances. In confusion and despair, people lose their life savings going back and forth from modern doctors to traditional healers. Those with more money go to South Africa hoping that the facilities there will provide the answer. What is often forgotten is that the burden on the relatives of those living with AIDS is enormous, particularly when it is a full-blown AIDS case. As shown in the story, this responsibility often rests with the women and children, particularly girls, whose hardships become doubled without the power to negotiate. The economic productivity of any household containing an HIV/AIDS infected person declines; they are unable to continue with their routine daily functions. Their labour and/or financial contributions to the household, as well as that of their caregiver, ceases. At the same time, the family savings are used for treatment. The family is then thrown into a vicious cycle of poverty, influencing the next generation of children whose schooling becomes affected in the above scenario (FAO 2003).

But there is hope for HIV/AIDS sufferers and their families as the Zimbabwean story *Positively Living* (UNESCO: 2003) portrays. This story deals with how HIV-positive people face their HIV status and learn to come to terms with it. It opens with the scene of a woman, Chipo, who has just learned that she is HIV-positive. Her thoughts reveal the depths of her emotions and the state of her shock and confusion as to how she acquired the disease and how others around her will react to this news. With support from an AIDS counsellor, she learns to accept her condition and adopt a positive approach to living with the disease through a healthy diet, a daily regime of exercise and plenty of rest, urgent response to the slightest symptoms of any illness, as well as positive thinking. More importantly, she learns that people with the virus can live for 10 or 15 years with the right lifestyle. Chipo informs her husband of the disease and by being open with each other, they accept the disease and vow to support each other, live a healthy lifestyle including using condoms.

This story portrays a married couple coping with the disease. Indeed, there are more drugs existing today
to prolong and enrich the lives of infected people. However, they must be made available and affordable to people living with HIV/AIDS in the developing world.

In all of these stories, the vital role of health workers, social workers, nurses, and counsellors cannot be overstated. They interface with people living with, and affected by, HIV/AIDS on a daily basis. Moreover, the roles of traditional healers and religious figures require further examination. Southern Africa is home to a host of diverse religious traditions and belief systems. Religious leaders have the power to influence their congregations’ behaviour and actions, as well as that of the community-at-large. Their resources should be tapped towards a collective community response to the treatment and prevention of HIV/AIDS.

The Namibian story of Annie and her friends in Who’s the Real Chicken? (UNESCO: 2003) demonstrates the pressures young girls and boys face in dealing with contemporary attitudes regarding sexual relationships. At the beginning of the story, Annie’s friend, Toini, teases her about not having a boyfriend. Toini brags about her trusting relationship with her boyfriend, John, revealing that they stopped using condoms because they planned to get married after finishing school. Meanwhile, John boasts to another friend about a new girlfriend and claims proudly that he is popular with the girls. His friend chastises him about his promiscuous behaviour. Two years later, John falls ill and eventually dies. His death is attributed to AIDS, often referred to as the “shameful disease”. Toini is then confronted with the fact that she, too, may be at risk of AIDS through her intimate relationship with John. At Annie’s persuasion, Toini agonizingly decides to test for HIV. With Annie’s unwavering support at the end of the story, Toini realizes that she needs to be responsible for her own health.

Girls are “second rate” children in traditional societies everywhere. During hard times, parents respond preferentially to the needs of their sons rather than to those of their daughters. Many of Annie’s friends see the material benefits of having boyfriends. In some cases, needy, and sometimes greedy, schoolgirls become easy prey for older men believing that sex with virgins is safe. As a result, the “sugar daddy” phenomenon is rampant. Many girls willingly trade sexual favours for material goods beyond their reach like the
ever-popular hand phone, cosmetics or a trip to a big city (the four Cs phenomenon – cash, car, cell phone and clothes). Although this story takes place in Namibia, its plot can very well echo that of other cultural settings. The issues raised in the story are helpful for younger generations to reflect on the importance of not bending to peer pressure, of condom use and other protective alternatives, as well as realizing one’s vulnerability to HIV/AIDS and recognizing the necessity of testing for HIV. To be sure, reading materials must take into account the views of younger generations about sex and relationships.

Two other booklets from Namibia, *Don’t Play with your Life!* (UNESCO: 2003) and *Open your Eyes or be Blind Forever* (UNESCO: 2003) also examine the behaviour of young, educated college girls and boys. This group is aware of the consequences of their acts and know all about prevention. However, like young people everywhere they tend to live for the moment, are very much influenced by their friends and other adolescents. They have a “let’s do it now” attitude. They are at the age when “parents don’t understand” and parental control is perceived as restricting and constricting, designed to stop them enjoying themselves. These two booklets weave the stories around these natural teenage tendencies and too much alcohol which lowers resistance and inhibitions, makes them lose control and do irresponsible things.

*Open your Eyes or be Blind Forever* (UNESCO: 2003) is the story of a group of senior secondary school girls who go to watch a soccer match. After the match, the boys flirt with the girls. At first the girls resist, in spite of the fact that they are attracted by these young, strong, healthy looking boys. In the end, they give in and accept the offered alcohol. From there they go on to a club to dance and drink some more. Although aware that they should be home early, the drink makes the girls feel happy and they want more until finally it is too late to go home. The boys come to the rescue and take them to a hotel, paying for the rooms. They all pair off for the night. Teresia ends up with Thomas. Fortunately, Thomas is still lucid enough to know that he must use a condom. For him, not using one is dangerous, irresponsible and stupid. Teresia is offended. To her, using a condom means that he
thinks she is a whore. Of course, Thomas was only thinking about protecting himself, but at the same time he protected his partner. Not so lucky was one of the other girls, Savina, who discovers, later, that not only is she HIV-positive but also pregnant. And her partner, Abraham, was so good looking, strong and healthy! After much persuasion, he agrees to be tested and is found to have syphilis and AIDS. He is so depressed that he spends six months in a psychiatric clinic for counselling and treatment. He is educated but because of drinking he has ended up sick.

**Don’t Play with Your Life!**

Maria wants to go to the disco to dance and have a little fun. Her mother agrees but not before giving her a little talk about the dangers she can encounter and pleading for her to be responsible for herself. Maria thinks her mother is being over anxious and that she can take care of herself. At the disco she meets John who seems to have a lot of money. They meet friends, the music is fast and loud, lights flicker, the boys are drinking and smoking; they are all having a lot of fun. Then Maria remembers her mother’s advice and goes home. Her parents are angry and worried because she is so late. The next evening, Maria returns to the disco, without telling her parents or asking permission. There she meets another boy, Leon, and her friends Sara and Sam. Sara warns her about getting carried away by someone she has only just met. But Leon is so nice looking, big, strong and rich. How can there be a problem? Leon buys her drinks and so the evening passes until Maria is too drunk to make decisions for herself. Leon takes her to his house. Next morning, Maria is horrified at what she has done. Her parents also realize that she has been with a man all night and refuse to talk to her. Her Aunt Elena comes to the rescue and takes Maria to have an AIDS test. The three months waiting for the results of the test are a living hell. She cannot eat, sleep and cries all the time. Leon is completely forgotten. Maria is lucky. The test is negative. From then on she vows to listen to her parents.

The other side of the story is that of Anna Maria in Educate a Woman, Educate a Nation (UNESCO: 2003), also from Namibia.
Anna Maria learns about AIDS in school and decides that she must do something about it. The opportunity comes when she returns to her village for the summer holidays. She talks to her Aunt Aune who is a much respected person in the community. People listen to her. At first Aunt Aune is shocked by her niece’s conversation. Sex is not a subject of conversation for children. Nor is it a subject to be discussed between women and men. Anna Maria is talking as if she is living in the street. Anna Maria persuades her Aunt to help. Meetings are organized with the headman, the elders, the pastor and a nurse. After the meeting villagers living with AIDS found the courage to come and share their experiences. Finally, the men got together and decided to form a group to go around and talk to other men.

These booklets are only a few examples of the creative talents of workshop participants. They offer different scenarios for people who are both directly and indirectly affected by HIV/AIDS. At the end of each booklet, there is a set of questions to facilitate discussions around the topics raised in the stories.
Conclusion

It is clear that the consolidated action of all people – men and women, government agencies, NGOs, United Nations Agencies, civil societies and countries – is both crucial and urgent if HIV/AIDS is to be eliminated before it destroys whole cultures. More and immediate efforts are now needed to develop and disseminate the easy-to-read materials and their messages which reflect the daily experiences of people within a given cultural setting. Exhorting groups of men and women to change their sexual behaviour alone is insufficient in tackling what has proved to be a complex set of issues relating to HIV/AIDS. Government policy and direct interventions can help reduce the number of deaths and rate of transmission but the responsibility rests with individuals through their decisions and actions, which in turn depends, partly, on persuasive and relevant, culturally and gender sensitive, educational materials.

Although women are relatively more affected by HIV/AIDS, it is not sufficient to target only women for defeating HIV/AIDS. The effective engagement of men is vital. Most importantly, young adults should be well integrated into any programme strategy against HIV/AIDS. For any programme to be successful, it must accurately incorporate the attitudes and views of both young men and women. It must promote positive gender norms and relationships as well as ensure a supportive environment in the family, school and community. Reading materials and radio programmes as agents of change can contribute to this effort and should especially reach and involve these young adults who are still forming attitudes, beliefs and opinions about human sexuality and gender relations. These preventive efforts will likely help them avoid behaviours and practices that put themselves and their partners at risk. Moreover, it will save the lives of the children they will have in the future.

In Southern Africa unprotected heterosexual intercourse is now the main mode of transmission of HIV. Interventions for HIV/AIDS prevention will need to address
the man-woman relationships which are intricately determined by social and cultural factors. It is inevitable that the expression of sex in society will be affected by the pervasive imbalance in the powers and influence of women and men -- the gender dimension. Many studies have shown that prevention of HIV/AIDS does not depend on knowledge alone, but needs the freedom of individuals to make decisions. The subservient role of women in many poor cultures simply does not allow this and a vital means of curbing the spread of the disease is then lost. Gender inequality, especially when coupled with poverty, is a major contributing factor to the spread of HIV/AIDS.

The bulk of existing educational materials do not address this asymmetry of power in sexual relations and its implications. The emphasis is normally on conveying technical information about the virus, means of transmission and consequences and is predominantly instructional. This type of materials does not touch the heart of the matter. As a result, they have not succeeded in changing attitudes of women and men to their sexual relations, attitudes that are based on beliefs and practices buried deep in traditional behaviour and culture.

To provide basic reading materials that deconstruct the systemic social inequality in the treatment of women and men is a priority of UNESCO. In the case of HIV/AIDS, this means creating reading materials that describe real sexual relations between men and women and what they can do to look after themselves and others. Tackled head-on are the sensitivities and taboos of sex and sexuality, leading readers to reflect honestly on their situations and to question their prevailing beliefs and behaviour. UNESCO, together with its partners, has brought its special experience in managing participatory processes, its knowledge about material development and understanding of gender issues to help meet the challenge of curbing the spread of HIV/AIDS. This publication presents the UNESCO training approach to getting women and men to understand the nature of the relationships that govern their intimate relationships and to help them work together to limit, and eventually prevent, the spread of HIV/AIDS.

Workshop proceedings have revealed layers of rich gender-sensitive research that shed light on how social, cultural and economic factors influence the perception and spread of HIV/AIDS.

The unique contribution of UNESCO to these workshops was to create an environment which facilitates the participants’ creation of easy-to-read, easy-to-produce
materials. The gender sensitization part of the workshop enabled them to re-examine
their own gender biases and uncover prevalent factors in their own cultural and socio-
economic contexts that drive the spread of HIV/AIDS. Participants drew on their own
experience and social practices to create materials that speak to their people. The basic
reading materials created within these workshops narrate in simple but powerful terms
typical events where traditional social and cultural behaviour prevent safe sexual practices,
impede the proper management of the disease and obstruct care for the sufferers and
other affected people.
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