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## **Men, gender equity and HIV/AIDS prevention, with case studies from South Africa and Brazil**

At a seminar at New York City's public library a few years ago, Andre de Zanger of the Creativity Institute mesmerized his audience by discussing a Soviet-devised problem-solving model called the Theory of Inventive Problem Solving, otherwise known as TRIZ. TRIZ, developed in a resource-poor nation, invites practitioners to invent new ways of using limited resources to solve problems. It encourages analysts and inventors to look for obvious but often hidden solutions within existing systems and structures. The management adage – the problem is part of the solution and the solution is part of the problem – encapsulates the TRIZ approach (Altshuller 1994).

One can begin applying TRIZ, says de Zanger, by imagining how people, and existing tools and equipment, might be used outside their normative functions. How can current functions be converted to create an entirely new system or machine? Several years ago, for example, the beverage industry found that their cans for fruit juices and fizzy drinks were collapsing during shipping, resulting in millions of dollars of lost sales. The industry was confronted with a need to make a stronger can without adding significant extra costs. With minimal expense, they fortified their aluminium cans by adding more nitrogen gas to the liquid *inside* the can rather than tinkering with its external structure (Altshuller 1994). TRIZ has a proven track record in manufacturing and industry, bringing innovation and huge cost savings to companies like Thales, Rolls Royce, Boeing and BAE Systems (Beeby 2005). Some commentators, like de Zanger, believe it may also be possible to apply it to social and political problems as well. How, for example, might TRIZ principles be applied to global efforts to prevent HIV/AIDS infections?

The HIV and gender violence prevention projects highlighted in this paper reflect a new and growing type of intervention in the fight against HIV/AIDS; one that focuses on men and boys as allies actively engaged in efforts to promote women's rights and to expand effective and equitable reproductive health for men and women. The two case studies from South Africa and Brazil illustrate the use of TRIZ looking at the involvement of men and boys and the roles they can play in HIV and gender violence prevention.

### **HIV prevention and TRIZ**

TRIZ may provide a useful approach to HIV prevention in resource-poor regions of the world. Sub-Saharan Africa, Asia, Eastern Europe and the former USSR all share common traits of chronic poverty, and poor health and social service infrastructure. Today, the vast majority of HIV/AIDS cases, approximately 90%, are found in sub-Saharan Africa.

In the USA, the Mentors in Violence Prevention Strategies, Inc. (MVP) employed TRIZ-style principles in a number of its projects. MVP's pedagogy explicitly calls for male

facilitators to interact with male participants as *bystanders* who have the potential to interrupt violence rather than as potential *perpetrators* who have the power to harm women. Using a teaching technique that does not blame or shame men, MVP has attracted hundreds of thousands of men and boys to work against gender violence in the last 15 years. It has established programmes and networks in the US Marine Corps and Navy, high schools, colleges and communities. It has also succeeded in opening new dialogue and partnerships between pro-feminist men and boys and female veterans of the battered women's movement globally. Jackson Katz, director of MVP, believes this same approach can be applied to HIV prevention, relying on men and boys' responsibility to themselves and family and community as a point of entry:

*There is a reason why men have not been speaking out about AIDS prevention, speaking out about men's responsibility on this subject. There are large numbers of men invested in a certain definition of manhood that keeps the current system in place, that is to say, sexual inequality, the subordinate position of women, the pressures to have multiple partners. If this is the case, then reframing the conversation of HIV prevention as a men's issue and directly challenging cultural definitions of manhood is a key strategy for change...we are challenging deeply seated ideas about manhood. That is why we face so much resistance. We need much more public honesty among men. Many men are trained to present themselves as invulnerable, especially men in leadership. Somehow any hint of our weaknesses, our mistakes, is a demonstration of our lack of power or authority. Some of the best leadership comes from men who admit they are not perfect. (Zoll 2004c)*

An important step in the TRIZ process is forming 'a new system that unites objects in such a way that a new feature appears' (Altshuller 1994). Could it be that a powerful new feature for reducing heterosexual HIV transmission might be found within the context of heterosexual transmission itself? Might the overlooked and underutilized resources in current HIV prevention work be the very men and boys who do care and respect the women in their lives, and who desperately want to protect them from infection?

Such a suggestion does not always fall easily on the ears of seasoned veterans within the field of international development. Discussions about funding programmes specifically for men and boys are often perceived as a direct strike against the already limited funding mechanisms earmarked for women and girls. Given the slow history of integrating any kind of substantial gender analysis and equity goals into development objectives, women's advocates have a legitimate reason to feel threatened.

It was only a decade ago in 1994 that decision-makers at the International Conference on Population and Development in Cairo, Egypt, agreed to make women the centrepiece of a new development paradigm. At this historic gathering, the international community agreed that targeting resources at women was more likely to lift families out of poverty and sustain basic development goals, such as education, health care and nutrition. From Cairo, a new language came into being, including 'gender mainstreaming' and new

strategies for integrating gender equity into all levels of development, not just the typically under-funded and under-staffed women's divisions and agencies.

While the Cairo paradigm proved successful in a vast number of development scenarios, the AIDS pandemic has drastically offset goals in poverty alleviation, maternal and child health, girls' education, and access to health care. At this point of time in the evolution of the HIV/AIDS pandemic in which infection accelerates via male-to-female transmission, another paradigm may need to be invented and implemented. This time, it may need to focus more intensely on men and boys as agents of dramatic intervention.

### **Increased female HIV/AIDS infection**

Patterns of HIV/AIDS infection vary from country to country. Information provided by the Joint United Nations Programme on HIV/AIDS (UNAIDS) shows that dirty needles, contaminated blood and men having sex with men continue to pose serious risks of HIV infection globally. Heterosexual sex, however, appears to be the fastest growing route of infection today, particularly among women (UNAIDS et al 2004). UNAIDS has reported a trend of higher infections among young women aged 15-24 in many regions of Africa, and some areas of Asia and Eastern Europe. In Zambia, Zimbabwe and South Africa, the number of infections among 15-24 year old girls and young women is four to six times higher than their male peers (Quinn 2005).

According to the UNAIDS 2004 'Global report on the HIV/AIDS epidemic':

- In sub-Saharan Africa an estimated 25 million people are HIV positive. Of these, 57% of infected adults are women and 75% of infected young people are women and girls between the ages of 15 and 24. Many equate these high numbers of female infection to extreme poverty among women and poor enforcement of women's human, economic and educational rights.
- In China, as many as 10 million people may be infected by 2010. Public health officials have tracked early HIV infections to tainted blood transfusions in poor rural areas but injecting drug use is also fuelling transmission. Today heterosexual transmission is escalating, particularly among women.
- The Russian Federation has the largest number of people living with HIV in the region, estimated at 860,000 (range: 420 000-1.4 million). During the last ten years, economic and political upheaval in the former Soviet Union has created a black market economy that has reduced the cost of heroine to that of a bottle of Coca-Cola, making it that much easier for frustrated, unemployed young men to buy (Zoll 2003a). Male intravenous drug users under the age of 30 were the first demographic group to register HIV-positive but transmission is now spreading fastest among their female sexual partners.

- India has the largest number of people living with HIV outside South Africa, an estimated at 4.6 million in 2002. Most infections are thought to be acquired through heterosexual sex, while a small proportion is acquired through injecting drug use.

From this growing rate of increased female infection globally, we may conclude that many HIV prevention strategies are not protecting women and girls, and most are likely not challenging the inequitable gender norms that increase women and girls level of risk of infection.

### **Gender roles**

The inequalities and dysfunctions of contemporary male-female gender roles and power dynamics lie at the heart of the HIV/AIDS pandemic. With women and girls becoming infected more often than men, it is imperative that prevention initiatives begin to integrate gender-sensitive perspectives into overall school-based and community prevention education programmes (Barroso 2005). At the 13th International AIDS Conference in Durban, South Africa, Geeta Rao Gupta of the International Center for Research on Women (ICRW), based in Washington DC, discussed the issue of power between men and women engaged in heterosexual relationships:

*Power is fundamental to both sexuality and gender. The unequal power balance in gender relations that favours men, translates into an unequal power balance in heterosexual interactions, in which male pleasure supersedes female pleasure and men have greater control than women over when, where, and how sex takes place. An understanding of individual sexual behaviour, male or female, thus, necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural, and economic forces that determine the distribution of power. Research supported by ICRW and conducted by researchers worldwide has identified the different ways in which the imbalance in power between women and men in gender relations curtails women's sexual autonomy and expands male sexual freedom, thereby increasing women AND men's risk and vulnerability to HIV. (Gupta 2000)*

Gender research conducted over the last 20 years in Latin America, Asia and Africa reveals that despite social, cultural and religious differences, there are many universally shared beliefs about how men and women should behave socially and sexually. For men, this might include pursuing sexual relations with multiple partners, engaging in unprotected sex, and ignoring important reproductive health and general health needs (International HIV/AIDS Alliance 2003).

- In Guatemala, research conducted in 1996 revealed a widely held perception among males *and* females that having numerous sexual partners was a necessary feature of young men's physical and mental development (Weiss et al 1996).

- In Nicaragua, where virginity is highly valued among young women, having multiple sexual partners is taken as a sign of virility in young men. Teenage boys face social pressures from older men, including fathers, older brothers and uncles, to have sex as early as possible. In the recent past, it was not uncommon for fathers to arrange for their son's sexual initiation with a sex worker (Zelaya et al 1997). For many young Nicaraguan men, the pressure to be sexually active and multi-partnered may be so great that those who do not fulfil this expectation are open to ridicule by their peers for not being a 'real man' (Rivers and Aggleton 1999).
- In Thailand, 15 year-old boys are not considered 'real men' until they have visited a commercial sex worker (Hata 1995).

In many regions of the world, men and boys place themselves and their partners at risk by ignoring their health needs and shunning available prevention and health care services (Hata 1995). Though HIV-positive men do not appear to suffer social stigma as severely as women and girls, many report that they are afraid to access services for fear of public humiliation or individual fears about the disease and its effect on their lives. In addition, men and boys are socially expected to be able to endure pain. Research shows that rather than seeking appropriate care, males tend often to self medicate with alcohol, substance abuse or risky behaviours, including sexual behaviours (Keijzer et al 2001).

Women and girls, on the other hand, are expected to remain passive and ignorant in the arena of sexuality (Gupta 2000), and to accept their subordinate position to men and boys. These social expectations, coupled with poor enforcement of women's human and economic rights, extreme poverty and illiteracy, greatly increase women and girl's risk of contracting HIV (UNAIDS et al 2004).

- In Zambia, a study by the World YWCA indicated that fewer than 25% of women believed a wife could refuse sex with her husband. Only 11% believed she had a right to ask him to use a condom (2002).
- In Zimbabwe, male and female high school students believed boys should have many girlfriends while girls should have only one boyfriend (UNAIDS 1999).

Given these examples, one might conclude that adolescents need much greater access to more gender-sensitive HIV prevention approaches. Jill Lewis is the co-founder of the Nordic Living for Tomorrow Project, a UNAIDS Best Practice gender-sensitive HIV prevention programme. For the last 20 years, Lewis has been conducting HIV prevention and gender training with educators and health care providers in Africa, Asia and Europe. One of the fundamental components of her successful training module has been facilitating open discourse between male and female participants about the ways in which gender roles and behaviours have and continue to change over time (Lewis 2001). She considers that:

*The ability to change is proof that gender systems are not fixed points in any one culture or religious system. (Zoll 2003a)*

The fact that most HIV prevention programmes do not integrate or operate from a gender-sensitive perspective is an indication of how many populations are accepting these roles as 'normal' or 'natural'. The notion that there is a 'natural and innate gender order' essentially silences efforts to talk about it, says Lewis.

There are more than three billion young people and children in the world today who are or will become sexually active in the very near future (UNFPA undated). These young adults are the most vulnerable to HIV infection. Many have little or no access to HIV prevention materials, condoms or public forums where they can comfortably discuss gender and sexuality (Zoll 2003b). Yet it is this same population that is the most likely to adopt new sexual behaviours and attitudes that can promote gender equity rather than perpetuate gender inequality. Perhaps as a result of witnessing the deaths of parents, siblings, relatives and friends, these young men and women are being forced out of a need for survival to re-evaluate how they communicate about and behave sexually, and how they interact with the opposite sex. Such endeavours may save their lives (Zoll 2004a).

### **Men and HIV prevention**

In 2003, the International HIV/AIDS Alliance with support from the US Agency for International Development (USAID) surveyed dozens of HIV/AIDS programmes in all regions of the world specifically working with men and boys to curb the pandemic and to reduce gender violence. The report highlights 13 case studies in Morocco, Botswana, Bangladesh, South Africa, Mongolia, Pakistan, India, Zambia and Belarus (International HIV/AIDS Alliance 2003).

With a focus on sexual health and reproductive responsibility linked to HIV and gender violence prevention, these programmes support women and men's rights in the following manner:

- Working on behalf of both women and men's right to access health care services, with strong emphasis on shifting men's attitudes about avoidance of health care. This work reframes health care as a man's issue, enabling men and boys to feel more comfortable seeking care.
- Encouraging men's support of women's human rights by reframing manhood to no longer equate manliness with domination over women and girls.
- Promoting health and human rights by improving understanding about relationship dynamics between heterosexual partners and creating a healthier environment for families.

This important publication highlights the accelerating growth of the global men's health movement. A major theme among the featured programmes was men's increasing

willingness to explore and examine their own and socially dictated attitudes and behaviours about manhood and masculinity. The report, and subsequent regional and global conferences, has further solidified this grassroots movement's credibility, and done much to forge stronger alliances between women and men's organizations dedicated to gender equity and universal human rights (Zoll 2004b).

A majority of these programmes provide men and boys with gender-equitable male role models to help them redefine manhood and manliness in ways that do not equate masculinity with aggression and domination (Barker 2000). With a goal of deconstructing masculinities, male programme leaders often encourage boys and men to examine their behaviour in relation to women, to assume greater sexual and reproductive health responsibility, including HIV prevention, and to help end gender violence. While this kind of approach to HIV prevention is still somewhat rare (Zoll 2003a), many male activists have successfully used the deconstruction model in programmes aimed at reducing domestic and sexual violence (Zoll 2004c). In South Africa, for example, men are calling upon the same men who helped tear down apartheid to interrupt the twin epidemics of HIV/AIDS and high rates of men's violence against women. Since 1997, the South African government and NGOs have helped organize men's marches, or *imbizos*, to mobilize massive community involvement in gender violence and HIV prevention efforts (South African Press Association 2002).

### **Case study: Men as Partners, South Africa**

In South Africa, the Men as Partners (MaP) project is challenging men and women's perspectives about gender roles and behaviours that elevate HIV infection. A project of Planned Parenthood South Africa and EngenderHealth, MaP is specifically working to reduce HIV/AIDS transmission and men's epidemic violence against women. The programme's ambitious goals include reaching more than 60,000 members of the South African Defence Force, 800,000 male union members and hundreds of thousands of men and boys involved in a vast network of HIV/AIDS organizations nationally (Peacock undated).

Dean Peacock, a MaP programme manager and technical advisor, came to the HIV prevention movement through gender violence prevention work in the USA. Based on his work with men who are violent with their female partners, Peacock says he realized how essential it was to create safe environments where men and boys could investigate and discuss gender roles, sexism, violence, and HIV prevention (Zoll 2003c). Peacock has found that men in the USA and South Africa, rich or poor, are 'very open to gender equitable work' (Zoll 2003c):

*The paradox about the [HIV/AIDS] epidemic is that it has opened the door to gender equality. We are certainly not three generations away from men playing a leadership role in HIV prevention and violence prevention. This notion that there is a monolithic African male who manifests all of these negative stereotypes is reactionary. Masculinity in all cultures is much more dynamic and fluid. I was*

*recently at training sponsored by the Commonwealth and was amazed by the men in the room. They were senior members of parliament, and many of them were doctors. They were all able to articulate the issues clearly, and they are the men in their 50s and 60s who some say are resisting this paradigm change that can shift men from being part of the problem to being part of the solution.*

Patrick Godana is a MaP graduate and trainer in the Eastern Cape who works with male truck drivers, one of the highest HIV risk groups. In Africa, as elsewhere in the developing world where poverty and gender inequality is pervasive, truck stops are often filled with young girls and women selling sex in exchange for money, food or other essentials. Godana says many of the drivers have told him it is ‘manly’ for them to have extramarital affairs while they are away from their families. In order to confront the dangers to which men were exposing themselves, Godana organized focus groups where the men could talk freely about fellow drivers who had died from AIDS and about condoms:

*You know, those guys never actually understood what a condom is. Some of them say it is a poison [that] it is from the whites who do not want us to have children. One actually has to go and listen to them and to try and interact and challenge them and let them open up so you can give them informed information. I say to them, “In any kind of work there are overalls, and this kind of work you are doing, you must use condoms as overalls and protect yourself as well so as to live longer.” (Peacock 2001)*

Like Godana, Steven Ngobeni participated in MaP trainings and found himself challenging entrenched male peer culture and gender roles in his village. Despite difficult conversations and ridicule from both men and women, he eventually succeeded in shifting long-held beliefs about the division of labour based on gender (Peacock 2001). Shortly after his marriage, Ngobeni came face-to-face with the unfair burden of domestic chores his new wife was forced to attend to on a daily basis simply because she was a woman:

*What was expected from my wife was for her to wake up early in the morning—before I could even wake up—to sweep outside and prepare everything herself, you see, for the entire family. Just because she is the wife, it is what she is expected to do. They want to see this woman go to the veld and fetch that firewood, and come back with that firewood on her head. It is a very challenging situation.*

*In the village, the women have to carry water five kilometres. It was really working on me so I said that we must put money, each man, so we can hire men with pick-up trucks to take them water. Everyone was so angry with me, saying that I am collaborating, that the women have talked to me, that these women are sitting here doing nothing. If you look at our muscles they are big and we can carry that, but we say the women must carry.*

*So I challenged that and it changed my home. No more are the women carrying big buckets. We arranged to hire somebody and we have pick-ups. Why not take this truck and get in the back and ask the young man to get some water? Basically they say it is our tradition and culture that women must bring this water. But the water is the same. They drink the same water. So it is very challenging for me as a person to change the system. (Peacock 2003)*

In the context of the HIV/AIDS pandemic, Ngobeni's actions probably had far-reaching positive effects on the women in his village. Throughout the entire Southern Africa region, governments and donors are relying on communities to provide care and support to those infected and affected by the pandemic. Women and girls comprise the backbone of these unpaid care networks, juggling the majority of care for millions of orphans and people living with the virus (Zoll 2005). According to the UN Development Fund for Women (UNIFEM), an AIDS patient in Zimbabwe requires an estimated 24 buckets of water per day (Heyzer 2002). Some of this is used for cooking, some for constant cleaning, laundry and bathing of those who are sick or dying from AIDS, or for millions of children made vulnerable or orphaned as a result of the pandemic. The job of hauling water can take anywhere from four to six hours a day or longer, depending on the distance from a village to a water well. Studies in Burkina Faso, Uganda and Zambia indicate that women and girls could save hundreds of hours a year if walking to sources of fuel-wood and water were reduced to 30 minutes or less (UNDP undated).

Ngobeni's decision to organize men to hire a truck was an exceptional example of TRIZ in action. By utilizing one tool—the truck—he was able to offset rigid gender roles and to solve a time and labour burden thereby creating more 'free' time for the girls and women in his village. Although there has been no formal follow-up to Ngobeni's actions, it is likely that some girls in his village were able to return to school during the same hours they used to spend hauling water. It is also possible that some women who were forced to quit paid employment in order to care for the sick or orphaned may have returned to work. Both education and economic autonomy are important strategies for reducing women and girls' risk of HIV infection (UNFPA 2004).

Dynamic male leadership like that demonstrated by Ngobeni is often missing from broader global efforts to promote HIV prevention, gender equity and sexual health responsibility. This is due in part to the very nature of masculinity, its codes and peer pressures, which often interfere with caring men's ability to publicly stand up for women or other men. It also stems from women's historic and often realistic mistrust of men, and women's desire to liberate themselves without assistance from men.

### **Case study: Instituto Promundo, Brazil**

In the busy streets of Rio de Janeiro, the staff at Instituto Promundo (IP) are studying how young boys and men are socialized, and how their peer culture influences behaviours that put them at risk to HIV infection. Since 1998, IP's gender, health and adolescence programmes have involved young men in the promotion of responsible health care and

gender equity in intimate and professional relationships with women and girls. Reaching more than 1500 men annually, IP works in collaboration and partnership with ECOS, an NGO in Sao Paulo, PAPA in Recife, and Salud y Genero in Mexico. It also works with the Pan American Health Organization and the International Planned Parenthood Federation (John Snow Inc 2005).

IP's community condom campaign, *Hora H*, is situated in a low-income suburb in the western stretches of Bangu, a population of 600,000, comprised mostly of low-income and working class families. With support from Durex Condoms, Europe's largest condom distributor, IP asked boys aged 15-22 for their ideas on how they would move condoms out into the community among their peers (Barker undated). The boys came up with the idea of the *Hora H* brand condom, which translates from the Portuguese into English as: 'In the heat of the moment.'

While IP's primary goals strive for HIV and gender violence prevention, it is equally committed to building a gender equitable generation among the young men and women in Rio de Janeiro, and throughout Brazil and the world. The success of the *Hora H* campaign is being measured not only through condom sales and distribution to peers in the neighbourhood. It is also being measured by how equitably the young men and women in the community treat one another (Barker undated).

Rooted in the idea of promoting a lifestyle among young men that enables them to care for their own sexual health and that of their partners, the condom is used as a way of marketing gender equitable behaviours and attitudes. In the case of young men, according to Gary Barker and Marcos Nascimento who direct and conduct research at IP, condom use is one of the factors highly associated with gender equitable behaviour. Whether a young man uses a condom depends on whether he buys into traditional notions of masculinity or not (Barker 2000). In his research, Barker has found that young men less attached to traditional ideas of masculinity were more likely to use condoms and less likely to engage in violence against women (Barker 2000). As Zoll notes:

*The young men who were more rigid in their gender identification did not use condoms as often, and were more likely to feel entitled about engaging in sexual relations with multiple partners. Young people's sexual activity is driven by social norms and peer culture. IP's focus on young men and HIV prevention revolves around the question of: how do you build condom use into the idea of building a gender equitable lifestyle that young men, and women, can embrace? (Zoll 2004d)*

IP's qualitative research has found more gender equitable behaviours among men and boys who have reflected about the costs of traditional versions of masculinity, either alone or in a group. According to Barker's 1999 research study, 'Gender equitable boys in a gender equitable world' (Barker 2000), young men and women need a physical space or some kind of social structure where they can evaluate and discuss what these costs have meant to them personally. This kind of social structure and peer group support enables non-traditional behaviours to flourish in a safe environment. In Malawi, Save the

Children, CARE and UN agencies have put this theory to work by sponsoring Girls Clubs and Youth Clubs that revolve around teaching young people life skills, including HIV prevention and male-female gender roles (USAID et al 2004).

## **Conclusions**

The HIV prevention projects highlighted here reflect a new and growing type of intervention in the fight against HIV/AIDS. Partially as a result of witnessing the HIV/AIDS pandemic, a new generation of pro-feminist men is challenging entrenched gender norms and behaviours that contribute to infection and violence against women. This kind of visible male leadership is directly and indirectly granting permission to thousands of boys and young men in all regions of the world to redefine and question ideas and perceptions of masculinities. The growth of the global men's health movement, and the integration of gender-sensitive perspectives into HIV prevention strategies, is one positive outcome of the HIV/AIDS pandemic. Initiatives such as Men as Partners and *Hora H* are providing men and boys with new opportunities to redefine what it means to be a man in the age of AIDS. This new framework is creating enormous opportunities for activists from around the world to call upon men and boys to demonstrate leadership where little male leadership until now may have been demonstrated.

The absence of a gender equitable peer network, as demonstrated by the Brazilian case study, makes it difficult for men and boys to sustain egalitarian behaviours. A young man choosing to be in a monogamous relationship, for example, may be ridiculed by his primary male peer group that pressures him to prove his manhood by engaging with multiple sexual partners. This same peer policing dynamic was visible in the South African village where Steven Ngobeni proposed hiring a truck to haul water. When he first proposed the idea, the men teased him and accused him of collaborating with the women.

Sexually active young people between the ages of 15 and 24, and children orphaned by AIDS, are most vulnerable to HIV/AIDS infection, particularly young women in sub-Saharan Africa, a region steeped in gender inequality, economic deprivation and poor quality and delivery of health services. While they are most at risk, this young population is also most likely to become aware of and adopt new gendered sexual behaviours and attitudes that embody greater equality between women and men.

Until now, prescribed gender roles in almost every culture have encouraged men to dominate and women to appear passive, not only in sexual relations but in the world at large. The fulfilment of women and girls' human and economic rights is a central building block in curbing the spread of HIV/AIDS. Expanding attention and greater funds toward men's participation in HIV/AIDS prevention and sexual and reproductive health programmes will probably accelerate efforts to meet these important gender equity goals.

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