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**Men and care in the context of HIV and AIDS: Structure, political will
and greater male involvement**

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Introduction: The problem

Over 33 million people worldwide are living with HIV/AIDS. In low and middle-income countries, nearly 10 million are in immediate need of treatment yet only 3 million are receiving it. This leaves 7 million people sick with AIDS and in need of intensive and long-term care.¹

AIDS is a long and debilitating illness that renders patients unable to fend for themselves and often unable to cope with the mental stress of knowing that death, in the absence of treatment, is inevitable. Caring for those with the virus therefore involves both physical care – feeding, cleaning and providing medicine to cure opportunistic infections – and emotional support. Many of those caring for AIDS patients find that it is a full-time occupation, which imposes great stresses on the carer's body, mind and finances.

In wealthy countries, health systems provide much of this care – sick people are taken into hospital or visited by health staff in their homes. Professional psychological support is also available. But in the developing world – and especially in the areas hardest hit by HIV/AIDS – a lethal mix of inadequate political will, failure by governments to fulfil commitments and the impact of structural adjustment policies have left health systems without the capacity to undertake such care. Instead of the state assuming its responsibility to provide the care needed, the burden is taken up by family and community members, who look after the sick person at home.

A large majority of home-based carers are women. In most countries, society expects wives, daughters, mothers, sisters and grandmothers, rather than men and boys, to care for sick family members. In South Africa, for example, a national time-use survey found that women carry out eight times more care work (for all illnesses) than men.² In the case of HIV/AIDS, a Kaiser Foundation survey found that over two-thirds of primary caregivers are women.³ Women are also the principal carers of children who have lost parents to HIV/AIDS. A South African study by Desmond and Desmond (2006) found that in households where the mother has died, only 30 per cent of surviving fathers are present, whereas in those where the father has died, 71 per cent of surviving mothers are present.⁴

The disproportionate burden on women at the household and community level matters for several reasons. It can have a crushing impact on women and girls. At the most basic level,

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caring for people with such AIDS related opportunistic infections is extremely tiring. Fatigue renders carers more vulnerable to illness themselves, including to the opportunistic infections that plague those with HIV themselves. The stress of caring for someone who is dying increases susceptibility to psychological problems; carers of those sick with AIDS in Botswana, for example, report being emotionally drained by their roles.⁵ Because caring for AIDS patients is a full-time occupation, moreover, women can become disconnected from their communities (and the stigma associated with the infection can exacerbate this), which heightens the risks to their health. Putnam (2000) has found that social capital helps people fight off illnesses; those who have close links to their families and communities have half the risk of dying from any cause compared to those who are socially disconnected.⁶ Social capital also relieves emotional stress, with self-help groups proven to improve mental health – such support is often not available to full-time carers of people living with AIDS.⁷

Girls orphaned as a result of AIDS are particularly vulnerable. In South Africa, for example, as communities across the country are denuded of productive adults, more and more households are headed by children. As of 2005, 1.2 million children under 18 had lost one or both parents to AIDS in South Africa, and millions more have been made vulnerable.⁸ In most child-headed households, it is girls that take on the responsibility of caring for their siblings. Children orphaned or made vulnerable by AIDS often struggle with food insecurity and malnutrition, and they are often excluded from society.⁹ Their plight is made worse when illness or overwhelm prevents their parents or guardians from registering them for child grants, and they are also more vulnerable to HIV infection themselves. Among sexually active youth in a study in KwaZulu-Natal, South Africa, orphans reported younger age of sexual intercourse with 23% of orphans having had sex by age 13 or younger compared to 15% of non-orphans.¹⁰ Studies in neighbouring Zimbabwe have shown that adolescent orphaned girls are significantly more likely to become infected with HIV than their non-orphaned (or male) peers.¹¹ This creates a vicious cycle of poverty, violence and HIV infection.

Caring also places an economic burden on women and girls. Women who have to stay at home to perform care work are less able to seek other forms of paid work, and if they are already employed, they face enormous difficulties juggling their care duties with their work obligations and sometimes have to give up their jobs. This weakens them economically and leaves them more dependent upon their husbands, thereby strengthening gender inequality in the household and, because wealth makes it easier to access health services and obtain better nutrition, potentially imperilling women's health. If women have to withdraw from the workplace to care for relatives, whole families will be poorer and thus more vulnerable to illness. These effects extend to society as a whole: if women are unable to participate in the economy, the economy's productive potential is reduced. Girls who have to take care of sick family members are often withdrawn from school.¹² In Swaziland, enrolment in school has fallen by 36 per cent since the epidemic hit the country, and enrolment among girls has fallen more precipitously than among boys.¹³ Being removed from school diminishes girls' chances of obtaining a job in adulthood and therefore harms their economic prospects. It is also a risk factor for HIV infection, gender based violence and being in an inequitable relationship later in life.^{14,15,16,17,18,19,20} Women whose partners die as a result of AIDS can face particularly severe economic hardship. In many parts of Africa, women are denied the right to own or inherit land, so they often lose their homes and possessions when their husbands pass away. They are therefore left without the resources to care for themselves and their remaining family members, much less to help their families climb out of poverty. In Uganda, women's lack of property and inheritance rights has left female-headed households more vulnerable to the impacts of HIV/AIDS.²¹

Stephanie Urdang captures the multi-faceted impact of HIV care on women's lives writing:

“The role of primary care giver is an undertow that pulls women out of regular employment (whether formal or informal), extracts girls from school to assist in the caregiving, prevents women from seeking medical treatment when they have no one to care for children and their homes in their absence, escalates household tension into violence when women cannot provide food on time or adequately perform other aspects of their expected domestic roles. The burden on women and girls to look after the ill can create a time poverty so severe that households implode under the strain. Although this reality undermines virtually every step taken to stem a pandemic of global proportions, most governments – quintessential patriarchal structures – do not, or believe they cannot, provide the social protection measures needed to deflect a crisis that is rapidly spinning out of control. In southern Africa, where the epidemic is at its most intense, the impact of AIDS on women's work in the household is most acute and is threatening the survival of family, household and community in dire and multi-faceted ways.

The quadruple burden placed by AIDS care on women – weaker health, social exclusion, lack of education and reduced economic power - makes it more difficult for women to advocate for change and engage in efforts to transform their lives and communities. Women's engagement in advocacy and activism is crucial to achieving gender equality, yet those who are fully occupied caring for relatives who are sick with AIDS are less able to participate in such activism.

The imbalance in AIDS care, then, can have harmful consequences for women, men and societies as a whole. In the next section of this paper, we outline some of the causes of this imbalance, and in the final section we make recommendations for governments as they attempt to address the problem.

One: Causes of the problem

The disproportionate burden of care borne by women and girls in the context of high HIV and AIDS prevalence undermines efforts to achieve gender equality and requires urgent attention. In this section, we examine the structural forces driving this phenomenon. Rather than focusing simply on ways to increase men's participation in shouldering a more equitable share of the current burden, we look first at the causes of the enormous burden of informal care and identify ways to reduce it. We start by analysing the ways in which global economic policies and forces affect how AIDS care is provided and then discuss the relationship between these policies and the lack of health systems capacity available in most high HIV prevalence settings. We then focus on what currently prevents men and boys from being more fully involved and identify strategies for increasing their involvement.

Government inaction on HIV prevention and treatment has increased the burden for carers of those sick with AIDS. If fewer people fell ill, both women and men would have reduced caring responsibilities, but the slow response by rich and poor governments alike to the epidemic allowed infection rates to soar. Their prevarication in providing treatment to those infected inflated the number of people needing care and their failure to take on the responsibility for providing that care has added enormously to the difficulties of households trying to meet the needs of a family member facing frequent opportunistic infections and a slowly deteriorating immune system.

There are two main reasons for government inaction: a lack of capacity and a lack of political will.

Global economic policies, the erosion of the public sector and the displacement of care into the household and onto women and girls.

In wealthy countries, governments, aided by civil society, have taken on much of the responsibility of HIV prevention, treatment and care. Their capacity for doing so is, of course, greater than that of poorer countries as they generally have quite well-functioning health systems and the money to expand those systems to address new threats. Many developing country governments lack this capacity.

Over the last two to three decades, most developing countries have been pressured by the World Bank, the International Monetary Fund and other financial institutions to pursue neoliberal development policies characterized by a reduction in public spending, privatisation of public services, flexible labour laws, and an emphasis on attracting foreign investment.²²

The strictures of international financial institutions led to steep declines in spending on vital public services such as education and health and were often accompanied by the imposition of user fees aimed at “cost recovery” in the areas of education, health services, electricity, water and sanitation. With clinics and hospital infrastructure crumbling, patient loads increasing and salaries decreasing, large numbers of doctors and nurses emigrated for better pay and working conditions. The legacy of these policies is made clear in a recent report from Medecins Sans Frontieres. The report compares the number of health care providers per 100,000 inhabitants in Southern Africa against the US, the UK and WHO minimum standards and reveals that whereas the US and the UK have 247 and 222 doctors per 100,000 inhabitants respectively, South Africa has on average 74 doctors per 100 000 inhabitants whereas Lesotho has only five. Malawi and Mozambique have only two. The World Health Organisation’s minimum standard is 20. The number of nurses per 100 000 in the UK is 1,170, in the US 901, in South Africa 393, and 62 in Lesotho. The WHO’s minimum standards for nurses is 228²³

Hein Marais makes clear what this gutting of the health sector has meant for women. He writes, “Patients and their care-givers must subsidise many aspects of care provision, and bear the costs of not receiving the levels of care and support they require ... Although thrust into the roles of mediators, counsellors and saviours, care-givers often are unable to -provide things as basic as pain-killers or a meal... This form of value extraction subsidises the economy at every level from the household outward, yet remains invisible in political and economic discourse.”

Government inaction and the burden of AIDS care

The second reason for government inaction is that governments failed to invest sufficiently in health care in general and AIDS care in particular. Even when prevalence rates had become shockingly high, many authorities delayed – still delay - in making antiretroviral treatment available. Globally, millions of adults with advanced AIDS are dying or posing a heavy burden on their families and, later on in the illness trajectory, often to public health systems because they are not receiving antiretroviral drugs.²⁴ Few pregnant women infected with HIV in Africa, moreover, receive the antiretroviral treatment that can stop them passing the virus to their unborn child – in low and middle-income countries, just 11% of pregnant women infected with HIV received such treatment in 2005.²⁵

They have been even slower to provide care, and poor families have been unable to force them to take on more responsibility. A large proportion of those infected with HIV are poor and, as we have seen, most of those caring for them are women. The poor in general and

poor women in particular have a muted voice in national decision-making in most of the developing world, so since the vast majority of policy-makers are men, who often have little idea of or little interest in the problems faced by female carers, the latter's needs are rarely attended to.

Hein Marais draws attention to the ways in which government policies on AIDS care reflect and reinforce class and gender inequalities and injustices: "Home-based care appears to be a more "realistic" or "affordable" option because its true costs are hidden, deflected back into the domestic zones of the poor. In doing so, it adheres to the same polarising logic that defines our society. Not only is this unjust, it also undermines the sustainability of care provision in the face of a crisis set to continue well into the future. Aids is meshing with the routine distress endured by millions of South Africans -- but to pummelling effect, as it intensifies those hardships, and drives an even thicker wedge between the privileged and the deprived."²⁶

Harmful gender norms and the care economy

Gender norms are a further key cause of the excessive care burden on women. Gender norms across the world expect women to bear the burden of caring for the ill, even when they also work. Many men believe that caring is "women's work" and that it is beneath them, that their traditional role as breadwinners is more important and should exclude them from having to carry out domestic chores. Studies show that these gender norms operate also operate in more insidious ways; even when men recognise they should be providing care their fear that they will be ostracised for doing "women's work" stops them from providing care. In a survey carried out in Soweto, South Africa, men said they did not participate in caring activities even when they felt they should because of the fear that they would lose respect among their peers if they did so.²⁷ Similarly, a study in Tanzania found that some male heads of households wanted to do more when their partners fell ill with AIDS but were prevented from doing so by "cultural definitions of maleness and the defined roles which determine masculinity."²⁸

Government policies often underpin these harmful gender norms. We have seen that most governments have not done enough to reduce the total burden of HIV and AIDS. However, it is not just in the case of HIV or health services that this is true. In most countries, for example, mothers are expected to take maternity leave to look after their newborn babies, but paternity leave is nearly always much shorter if it exists at all. This entrenches an image of women, and not men, as carers. Even in places where child care grants are supposed to go to the carer irrespective of whether they are a man or a woman, many men report difficulties in accessing the grant.

Gender norms operate in yet another way to increase the burden of care on women; many men equate being a man with acting in ways that increase their risk of contracting HIV. At the same time, men are often reluctant to use health services because of the belief that it is unmanly and that doing so would indicate weakness to their peers.²⁹ In South Africa, only 21 per cent of those presenting to be tested for HIV are men, and there are similar gender gaps in Namibia, Swaziland and Zambia (in Uganda testing rates are more even).³⁰ Despite more or less equal infection rates, moreover, South African women are twice as likely as men to be on antiretroviral therapy and their CD4 counts are much higher than men's when they start treatment.³¹ Men's failure to access testing and treatment increases the number of people who need care for AIDS. Women, as the primary caregivers, bear the brunt of this extra burden.

Two: What strategies might reduce the burden on women?

Reduce the overall AIDS burden

The best way for states to relieve the burden of AIDS care is by reducing the overall level of HIV in a population. Governments and civil society must take urgent action to roll-out effective prevention approaches such as comprehensive sexuality education in schools,, community based HIV testing, ensuring widespread availability of male and female condoms and scaling up male circumcision as part of a comprehensive prevention package. Government and civil society should also make special efforts to target men, who we have seen are currently underserved by HIV services including especially testing, treatment and care.³²

Prevention of mother to child transmission programmes are especially relevant to this discussion given their implications for the care economy. When delivered well, PMTCT programmes are highly effective at reducing vertical transmission and are relatively easy to deliver. Yet globally only nine per cent of women have access to such programs.³³ This reflects a devastating lack of commitment to providing basic health services that are seen as 'women's services'. More fundamentally the design and delivery of such PMTCT programs are failing to ensure that opportunities presented by testing during pregnancy for identifying HIV infected women and their family members, and ensuring the provision of the adequate treatment, care and support are capitalized upon. PMTCT programs need to be both scaled up, funded to enable them to adopt a comprehensive approach to meeting the needs of all family members infected or affected by HIV/AIDS, including increasing men's involvement in PMTCT programs.^{34, 35}

In countries threatened by deadly epidemics such as HIV/AIDS, the historic underinvestment in health should be reversed; good health is a vital spur to poverty reduction and economic development, as well as a worthwhile goal in itself. Governments' sluggishness in responding to AIDS means large investments are now needed to recover lost ground. It is mostly men that make the macroeconomic decisions that determine the allocation of resources related to the care economy, whether at the national level or in institutions like the World Bank, the IMF or pharmaceutical companies and others in the private sector. To reduce the tremendous burden borne by women and girls who take care of the sick, men in positions of power in governments should be called to honour their commitments to aid and debt relief, to functioning health services and to clean running water. When these commitments are not met, this inaction should be named as evidence of disregard for women's lives.

Government inaction is not inevitable. Activism by civil society can make a big difference. South Africa's Treatment Action Campaign and their allies, for example, successfully forced international pharmaceutical companies to reduce the price of AIDS treatment, then took the South African government to court to force it to commit to clear numerical targets for the provision of AIDS medication and subsequently carried out widespread treatment literacy amongst its membership to ensure community members understood the politics and the science of AIDS as well as their rights and how to action them. In addition, faced with government refusal to provide data on ART roll-out, TAC worked with other civil society organisations to establish the Joint Civil Society Monitoring Forum to gather data on ART uptake from clinics across the country and in this way kept pressure on government to deliver on its commitments.³⁶

Now in 2008, South Africa has over 500,000 people on treatment – the largest number of any country in the world. TAC leader Zackie Achmat describes the organisation behind this

remarkable success: “The TAC that few people see or understand is an army of 10,000 members and volunteers across the country, working continuously in their communities to educate people about HIV and their own health on a scale unmatched by any other HIV NGO. The real TAC is (150 branches) varying in size from a couple of dozen up to 200 members, who are working in their communities, trying to do condom workshops, educate health care workers, gather information on the extent and availability of health services, build relations with doctors, nurses and administrators, help people access services, and educate communities³⁷.” Critical to TAC’s success has been educating citizens about their rights through

Organisations like the TAC offer important lessons in how to hold governments accountable to their commitments and obligations. Few civil society organisations involved in responding to HIV and AIDS utilise advocacy approaches and instead focus on providing a range of prevention, treatment and care related services – many of which should properly be provided by the state. Civil society has a critical advocacy role to play yet few are doing so. To ensure that governments act on the many binding commitments they have made at UNGASS and elsewhere, civil society organisations will need to play a more activist role. This will require building new skills and relationships – including with trade unions and other social movements – and it will require that donors become more willing to fund both advocacy and training on the use of advocacy approaches instead of focusing so exclusively on reaching large numbers of people with services.

Reduce the care burden

Even if prevention and treatment efforts are greatly expanded, however, there will still be patients who require care and support, at least in the short- and medium-term. Not only women but entire societies will benefit if governments shoulder more of the burden. AIDS care is a public good in that its benefits are not limited just to those who receive it (patients’ children, partners, communities and economies also benefit if they are kept healthy for longer and if they do not pose great emotional, physical and financial strains on those close to them). Public health systems, which have the knowledge, equipment and skills needed to provide care and benefit from economies of scale in procurement and delivery of drugs and other supplies, are better placed than families to provide care efficiently and cheaply.

Where health systems are unable to take on the full burden of care, financial support should be considered to compensate women for easing the demands on state resources. Professional carers in the West, such as nursing homes for the elderly or private hospitals for the sick, are well paid by their patients or by governments who contract the work out, but home-based individuals caring for family members are rarely rewarded either in rich or poor countries. This entrenches the notion that care work is somehow not a valuable activity and discourages men who see their role as breadwinners from engaging in it. It also maintains women’s position of inferiority by keeping them financially dependent on the men of the household. Compensation for care work not only helps relieve the economic strain on women; it is also likely to strengthen their status relative to men and persuade more men to share caring duties.

In addition, to make life easier for carers, health systems must become more responsive to their needs. Participation by women in the design of public AIDS care services is crucial if their needs are to be attended to.

Further, work through health systems should assist home carers by providing the training and supplies needed to look after those sick with AIDS. Special efforts should be made to reach households isolated from communities by the stigma of the epidemic or by their

poverty. Psychological counselling to both carers and their sick family members and advice for carers on how to deal with their relatives' emotional difficulties are also important in relieving the strain of caring.

Carers of those sick with AIDS generally need adequate supplies of water for cleaning and laundry as well as sanitation facilities. In communities affected by the virus, governments can help ease the burden by halting and rolling back the privatisation of electricity, water and sanitation services.

Government interventions not directly related to health can also make carers' lives easier and redress gender inequalities and women's vulnerabilities. Legislative and policy change strengthens women's rights to own property and land and allows them to inherit possessions increases women's ability to absorb the burden of care and support. Empowering women economically can render them and their families less vulnerable to HIV infection as well as helping them if they have to care for the sick and mitigating the impact on them of the death of a husband.

Broader workplace measures can also help address the gender imbalance in care. Rules that prohibit gender discrimination in recruitment, pay and promotion can open up economic opportunities to women and thereby strengthen their position within households. Economic clout can give women more control over family affairs and more leverage to insist that men participate in caring duties. Governments' own employment policies should also proscribe such discrimination.

Governments, then, can take steps to improve gender equality among those caring for patients with AIDS, and they can also alleviate many of the difficulties facing carers of both sexes. These steps involve health ministries as well as other parts of government. In countries where HIV/AIDS is already crippling societies and in those where it still poses a potential future threat, a multi-sectoral response is required. Greater government action on HIV/AIDS not only helps mitigate the problem – by relieving the heavy burden on women carers, it can promote gender equality and thereby trigger broad benefits for all members of society.

Civil society organisations, too, have an important role to play in drawing attention and responding to the burden carried by women. This is perhaps especially true of trade unions who should be advocating for the needs of caregivers in collective bargaining discussions. To date, however, neither trade unions nor advocacy focused AIDS organisations have made the care economy a significant focus of their work. This will need to change.

Use a range of strategies to engage men as part of the solution

We have seen that gender identities and particular constructions of masculinity compound and contribute to the structural and political causes of the unfair and debilitating burden of care provided by women – especially in the context of HIV and AIDS. It stands to reason then that it is important to work with men and boys to change their attitudes and practices related to their role in the care economy.

There is a growing body of evidence that men's gender related attitudes and practices can change in relatively short periods of time. In his paper for this EGM Gary Barker points to rapid change amongst men in the US with regards to their involvement in childbirth with "27 percent of fathers in the U.S. ... present in childbirth in the 1970s, compared to 85 percent in the 1990s"³⁸ More recent research shows us that rigorously implemented interventions can bring about significant change in relatively short periods of time. A recent

review of 57 male involvement programmes published by the World Health Organisation found evidence that at least a quarter were effective in transforming harmful gender attitudes and behaviour, and many of the others were regarded as promising.³⁹ Similarly, an intervention implemented in South Africa's Eastern Cape province showed significant changes in men's attitudes and practices including significant reductions in intimate partner violence and other practices that are high risk for HIV transmission.^{40,41} In Brazil, *Instituto Promundo's* intervention with young men on promoting healthy relationships and HIV/STI prevention, showed significant shifts in gender norms at six months and twelve months.⁴²

To date, however, most interventions with men have been limited in size, impact and sustainability. To make a real difference in reducing the burden of care carried by women, interventions with men will need to be taken to scale to ensure far greater impact than has been the case to date. We propose a number of ways to do this. These include: recognising the positive contributions some men already make as a way of shifting social norms and prompting other men to do the same; training men and boys to provide care and support; building on existing civil society models and innovative initiatives aimed at engaging men; integrating a focus on engaging men and boys into existing AIDS plans and policies, including especially national AIDS plans; improving the health systems capacity to reach men with HIV prevention and treatment services so as to reduce the burden of care; and by taking gender transformative work with men to scale by integrating a focus on men and gender equality into national programmes and policies that can reach large numbers of men and boys.

Move beyond stereotypes and recognise the positive contributions men can make: It is important that we alter the terms of the discussion about men and AIDS in some significant ways. Governments and civil society organisations working to reduce gender inequality in AIDS care should start by approaching men differently - as potential partners and not just probable perpetrators of violence or inevitable obstacles to women's health and wellbeing.

Experience shows that it is possible to change men's care related attitudes and practices. As we have seen, men often know that they should be involved but lack a sense of permission to act on their convictions. The experiences of a group of men in Goromonzi, Zimbabwe are instructive in this regard. Luckson Murungweni describes the process whereby he and other men in Goromonzi became involved in home based care, saying "For years we watched with bleeding hearts as our daughters and sons came home from the towns and cities to die after having contracted HIV. Those who lived in the towns were also passing on the virus to the young in the area, and the burden of caring for the ill was left to women...As men, we never viewed ourselves as crucial in providing care to those being claimed by the AIDS pandemic, choosing instead to spend most of our time drinking beer. But things changed last year when councillors ... approached us and urged us to become involved." As a result of the intervention of the councillors, men like Murungweni became active in "bathing, feeding and doing chores for patients, ... fetching firewood and food (and providing) financial assistance for buying drugs, or when patients need to be taken to clinics or hospital to have opportunistic infections treated".⁴³

Reuben Mokae's story is also instructive. Reuben was a Soweto based gender activist with the Men as Partners Network until the time of his death from AIDS in 2005. Reuben often spoke publicly about his experiences as an HIV positive father. At a community event held in Soweto on Father's Day in 2004, he said, "Last October my wife passed on due to AIDS. It has been one of the most difficult times for my three boys and me. Now, though, life is starting to get back to normal. We often talk about her with the boys as a healing process. Sometimes we cry together holding hands when we do this".

There are lots of men like Reuben Mokae and Luckson Murungweni across southern Africa. However, instead of recognising and affirming them and in so doing encouraging other men to emulate them, the current discourse about men and AIDS too often trades in stereotypes and contributes to the self-reinforcing notion that men are unwilling to care for people they often love deeply.

A study by Montgomery et al in KwaZulu-Natal provides useful insights into the disjuncture between what men do and how men are described. In their field work in rural KwaZulu-Natal, usually considered a bastion of patriarchal attitudes and practices, they found that some men were indeed involved in caring for their families but that this often went unacknowledged. They argue that whilst there is a “linguistic and conceptual locus for the discussion of ‘deficient’ men, no such language appears to exist to talk about men who are positively involved in their families”. They point out, though, that their study revealed that men were involved in care-giving activities, and that they “care for patients and children, financially support immediate and extended family members and are present at home, thereby enabling women to work or support other households”. However, they write that these activities were seldom acknowledged by community members or by the field workers conducting research who continue to hold the perception that “men are not caring for their families because they are irresponsible and profligate”. They conclude by calling for more research on men’s roles in the family and argue that this has the potential to “inform the development of new programmatic approaches that might feasibly engage men’s concerns and needs, and more effectively involve men as actors in community coping strategies”⁴⁴. Similarly, a study on the impact on caring provided by teachers to their students due to AIDS indicates that “teachers in schools with the least resources are frequently those required to provide the most demanding forms of support and care to learners” and points out that in the schools they studied, “the work of caring does not seem to be confined to women teachers. Male teachers, in our study, do emotional work”. They argue, “...the state provides neither adequate staff to deal with the challenge of care, nor the training necessary to support teachers who find themselves at the frontline”. The authors insist that “much more recognition must be given to teachers for providing care...in schools” and call for “professional counsellors to be employed in each school”⁴⁵. We reiterate this call; publicising the stories of men involved in care work is likely to strengthen the resolve of those men and it also increases the likelihood that other men will find the courage to challenge restrictive gender norms and act on their conviction that they have an important role to play.

Build on existing models and strategies: Many models exist that indicate that men can be supported to play a more active role in meeting the care needs of children made vulnerable by HIV and AIDS. Sonke Gender Justice, the organisation for which the authors work, has developed a model for working with men to increase their involvement in meeting the needs of orphans and children affected by HIV and AIDS. The One Man Can Campaign’s Fatherhood and Child Security Initiative has two primary objectives. The first objective is to increase men’s involvement, not only in the lives of their own children, but also in ensuring that children in general, and orphans and vulnerable children in particular, have access to essential social services. As such, men of all walks of life—traditional and religious leaders, representatives of local government, teachers and coaches, fathers and social fathers—are supported to play an active role in making sure that children are able to access child grants, attend school, benefit from school feeding schemes and have their psycho-social and educational needs met. The second objective is to develop men’s capacity to be advocates and activists in efforts to eliminate violence against women and children, prevent the spread of HIV and AIDS and promote health, care and support for orphans and vulnerable children. As a result of the project, local government in Nkandla, a rural district in KwaZulu-Natal,

has now integrated a focus on reaching men and boys for gender equality into their annual integrated development process, an outcome that may lead to a sustained focus on involving men and boys in achieving gender equality.

The success of the project is then measured against very concrete impact indicators that determine whether men are in fact playing a more active role in meeting the care related needs of orphans and vulnerable children. These indicators include: men spend more time actively parenting their children; men assist their children with homework; men decrease their use of physical punishment of children and report increased understanding of alternatives to corporal punishment; men decrease their use of violence against children and their mothers; men demonstrate improved understanding of their children's nutritional needs and report doing more to ensure that children's nutritional needs are met and men become more actively involved in local childcare forums. This in turn should lead to an increased number of orphans and vulnerable children accessing social grants, attending school, and demonstrating improved nutrition.

Build the capacity of health systems to reach and engage men: To achieve further involvement by men in the care economy, states can take steps to improve health systems to make them more friendly to men who either want to or are already involved in care and support activities. Nurses and clinics that provide care to the sick are not always set up to deal with male carers – like society as a whole, health systems expect women to do care work and are therefore sometimes unfriendly to men who wish to become involved⁴⁶. Health ministries should train their employees to be more supportive of men's involvement in care. As discussed above, many men believe they lack the skills to participate, and health systems can play a valuable role in providing training and counselling to potential male carers. Outsourcing such training to civil society organisations that work with men should also be considered, with governments providing the funding and materials needed and monitoring programs' effectiveness. Significant evidence shows that working with men and boys to promote gender equality and engage them in household responsibilities can be effective, and governments should encourage and support such work.⁴⁷

Use legal and policy approaches to engage men: Governments can also use policy levers to increase men's involvement in the care economy. UNAIDS report that “little is said about the involvement of men in care work in either international or national AIDS frameworks”⁴⁸. The report points out that a number of countries have attempted to address this and offer potentially useful examples of how to increase men's involvement. In Malawi, according to UNAIDS, “the Chitipa District AIDS Coordinating Committee requires that community home-based care programmes should ensure a minimum of 40% male volunteers.”⁴⁹ The South African National Strategic Plan on HIV and AIDS also calls for “programmes to empower women and educate men and women on women's rights and human rights” and notes that “The fact that the burden of the epidemic falls more on women and girls than on men and boys remains a central challenge to the national response.” It commits government to “Recruit and train new community care givers, with emphasis on men and sets a minimum target of 20% trained male care givers.”⁵⁰

Legislation is important for improving gender equality more broadly as well with implications for the care economy. Legislation governing maternity and paternity leave in South Africa allows mothers four months leave from work and fathers just three days. This conveys a message that women are responsible for caring duties and helps turn this message into reality. In Norway and Sweden, parental leave is not allocated to one parent in particular but can be shared by mother and father. After this law was passed, few fathers took up their leave so their governments made it obligatory for them to take at least a month

off work. Over seventy per cent of fathers in both countries now use this month.⁵¹ Smith (2001) has shown that the Scandinavian measures have helped increase the time spent by fathers performing caring duties,⁵² while Aldous and co-authors (1998) found that fathers' early engagement in child care makes them more likely to continue to provide care later.⁵³ Similar interventions are possible in poorer countries, and they could help ease the burden on women. For instance, in Brazil, a number of states offer one month parenting leave for fathers and discussions are being held to make this national policy. It is important to note, however, that in some instances having men at home during the postnatal period simply increases the burden of care on the new mother who can end up taking care of both the child and the stay-at-home father⁵⁴. To address this, it is critical that policy changes are accompanied by efforts to shift social norms.

Education, too, is important to promoting gender equality in caring. In schools, the importance of men's involvement in care should be emphasised to boys and girls, not least through increasing the number of male pre-school, primary and secondary school teachers who serve as role models in this regard. Communication messages to adult men and women, perhaps delivered by non-governmental organisations, should highlight the importance of keeping girls in school rather than removing them to care for sick relatives. Messages should also attempt to reduce the stigma of caring through peer education by existing male carers, demonstrating positive role models at the same time as teaching caring skills.

Recommendations

While by no means an exhaustive list, the following recommendations are offered as next steps worth considering. They are directed at government, multilateral institutions, philanthropic organizations, the private sector and those working with activist and service provision organizations in the NGO sector.⁵⁵

Government

- Men in government should lead by example and use their status and influence to convey the importance of greater male involvement in the care economy through their personal and professional actions. They should commit the resources necessary to care, support and treat those affected by HIV/AIDS. They should use the public platforms available to them to speak out frequently about the importance of greater male involvement.
- Governments should provide a mix of public services and cash transfers to those who provide care and support to people ill with AIDS related illnesses, and should ensure that grants and services are well publicised, and available to all who need them.
- Governments should ensure that those infected and affected by AIDS related illnesses have access to necessary health and household services such as treatment, housing, electricity and running water.
- Governments should develop and advocate for coordinated public, private and civil society initiatives aimed at increasing men's support for gender equality.
- Departments of Education should take measures to ensure that children affected by HIV and AIDS have access to high quality psycho-social support at schools and put in place strategies aimed at preventing children from having to leave school to take care of sick relatives.
- Departments of Health and Education should develop training curricula for teachers' training colleges, social work programs and nursing programs to encourage men's greater involvement in care and support in both the formal and informal sector.

Funding bodies: government, multilateral institutions and philanthropic organizations

- Government, multilateral institutions and philanthropic organizations should provide long-term funding to allow successful programs to increase their reach and impact, including far greater support for advocacy and activist approaches aimed at holding governments to their obligations.
- Government, multilateral institutions and philanthropic organizations should fund research to learn more about men's attitudes and practices, including factors that promote men's involvement.
- Government, multilateral institutions and philanthropic organizations should fund evaluations of men and gender equality programmes to learn what strategies are most effective and why.

Private sector

- The private sector should develop effective workplace prevention, care and treatment services and should promote men's active involvement.
- The private sector should participate actively in corporate social responsibility activities that promote gender equality and constructive male involvement.
- Men in management should use their positions of influence to promote a culture of male involvement by demonstrating corporate and personal commitments to HIV/AIDS prevention, care and support.

HIV/AIDS activists and the NGO sector

- Activists and advocacy groups should challenge aid and trade policies that weaken public sector services and impose cost recovery user fees.
- Provide training to civil society organisations and to community members on the use of advocacy approaches to demand government accountability.
- Educate funding organizations and service providers about the importance of increasing men's involvement in care and support activities.

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