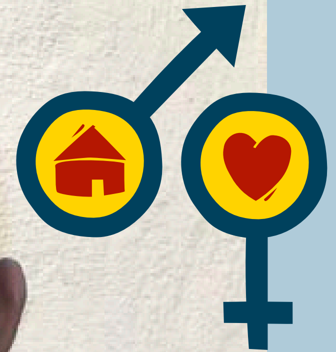
INCREASING Male Involvement in Home Based Care to REDUCE the Burden of Care on Women and Girls in Southern Africa

By Professor Exnevia Gomo for VSO-RAISA

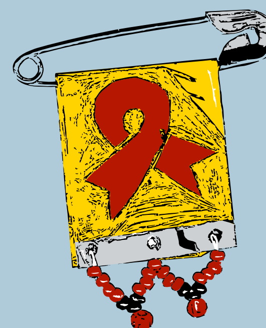


Men Of Quality
Are Not Afraid Of Equality

Acknowledgements

VSO-RAISA and its partners are engaged in a number of activities which support primary and community care providers across Southern Africa. The documentation of this study would not have been possible without their input and patience and of course, the home based care (HBC) clients who we are all aiming to support.

VSO-RAISA would like to sincerely thank all those involved in the study for their willingness to share their experiences and lessons learnt. The information will be used to further support VSO's advocacy efforts in the region to encourage greater involvement of men in home based care and a reduction in the burden of HIV & AIDS care on women and girls.



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Front cover: Eddington Mhonda, PADARE
Back cover: I need a caption for this group of men, HBC, from Thandizani's conference presentation

Acronyms

AIDS
Acquired Immune Deficiency Syndrome
CABA
children affected by HIV & AIDS
CBO
community based organisation
CCG
community care group
DACC
District AIDS Coordinating Committee
HBC
home based care
HIV
Human Immunodeficiency Virus
IEC
information, education and communication
MCH
maternal and child health
NGO
non-governmental organisation
PPTCT
prevention of mother to child transmission
RAISA
Regional AIDS Initiative of Southern Africa
SADC
Southern African Development Community
SAfAIDS
Southern Africa HIV and AIDS
Information Dissemination Service
UNAIDS
Joint United Nations Programme on HIV/AIDS
VCP
volunteer care provider
VCT
voluntary counselling and testing
VSO
Voluntary Service Overseas

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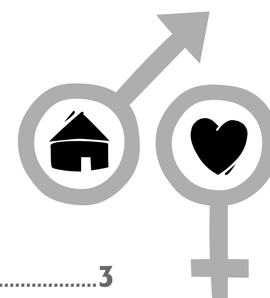

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Executive Summary

The feminisation of the HIV & AIDS epidemic and the responses to this are well documented, and policies and strategies have been developed to address women and girls' increasing burden of infection, disease, care and support. It is widely acknowledged that complex interactions of social, cultural and economic factors have fuelled the feminisation of the epidemic. Globally, it is recognised that women bear the full burden of care and support and HIV & AIDS has expanded women's care responsibilities within and outside their households. Although significant efforts have been made to address this gender divide in HIV & AIDS, male participation in care and support has remained very limited. As a result, many programmes across the world have begun to work with communities to involve men in HIV & AIDS responses including home-based care (HBC) and support to reduce the burden of care on women and girls. VSO-RAISA and its partners are involved in projects to increase male involvement in HBC. Through a horizontal learning approach, VSO-RAISA facilitated the sharing of experiences of partners in Malawi (Nsanje, Ntchisi and Chitipa Districts AIDS Coordinating Committees, and Tutulane), Zambia (Thandizani) and Zimbabwe (Padare and Loving Hand) to scale up male involvement activities. Following impressive reports on the male involvement activities in the three countries, VSO-RAISA commissioned a rapid appraisal of the partners' projects to provide an overview and to identify potential Best Practices. This report presents the findings of the study, challenges and recommendations for scaling up of male involvement.

The study shows that overall the participation of men in HBC has increased over the past three-five years. This is demonstrable through an increased number and proportion of male volunteer care providers (VCPs), increased HBC coverage and outreach activities as well as improved support. Male involvement appears to be reducing burden of care on women and girls but this needs further studies. The involvement of men has brought other benefits including enhanced knowledge and appreciation of the role of men in HIV & AIDS responses, openness about HIV & AIDS, gender and sexuality, and reduced stigma and discrimination. The study, albeit in a limited way, also shows that male involvement may be changing the gender norms in communities.

The overall conclusion from this study is that involving men in HBC is an innovative way of reducing the burden of care on women and girls and has the potential for far reaching socio-cultural changes that may effectively address contemporary gender disparities, and therefore ensure the rights of women and girls, and carers in general.

The mobilisation of men to become more involved in HBC has faced a number of challenges ranging from cultural to economic challenges. Culturally, men expect women to bear the responsibility of care. Men also consider themselves primarily breadwinners. Considering the achievements and challenges of the male involvement projects, **the following recommendations are made:**

- Intensify advocacy at all levels for increased male participation in HBC and other responses;
- The data generated by this study calls for a more detailed study of male involvement in HBC to develop a document on Best Practice in male involvement in HBC that can be used to scale up male involvement activities in the SADC region;
- There is need to conduct research to understand more about men and women's beliefs, attitudes and practices towards the rights of care providers and the promotion of men's involvement;
- Develop and/or strengthen the IEC materials and strategies for mobilising men by presenting men as partners capable of playing a positive role in the health and well-being of their partners, families and communities;
- Expand content and context of gender training and IEC within NGO/CBO sectors;
- Extend the male involvement campaign to include youths;
- Provide adequate equipment, materials and training required for care provision;
- Intensify the campaign to encourage men to participate in maternal and child health (MCH) programmes and prevention of mother to child transmission (PPTCT) programmes as entry points into care and support;
- Document the gaps in regional and national policies and legislation governing care and support in relation to male involvement in care and support;
- Document gaps in regional policies regarding the burden of care on women and girls.

I need an appropriate short caption here. This pic is used on the Moz poster.

Introduction

HIV & AIDS have brought many challenges to the development of human kind. Research has clearly established that there are complex interactive influences driving the epidemic, including social, cultural, economic and political factors. Equally complex interactions have shaped the response to HIV & AIDS. The feminisation of the epidemic has resulted in women largely bearing the burden of infection as well as of the response at all level.[1,2] This is evident from several international conventions and national policies and guidelines that have been developed to mainstream gender into HIV & AIDS responses, and socio-economic development in general.[2,3,4,5] However there have been limited practical steps taken to holistically address gender and to engage men in transforming the social practices and gender norms that increase risk of HIV infection and the burden of care on women and girls. What is clear however is that men are concerned about the health of their families and communities and can enhance their positive role in prevention, care and support.[6] This opportunity has simply not been fully explored and exploited to date.

Why Low Male Involvement in HIV & AIDS Responses?

There are several factors influencing male participation in not only home based care (HBC), but other HIV & AIDS interventions,[5,6,7] despite the high level of awareness and magnitude of the problem. These include historical, socio-cultural and economic factors. Studies on men's lack of involvement in care and support show that socially or culturally driven feminine and masculine stereotyping defines the gender roles in maintenance of health in society.[7,8,9] Other underrated factors are a lack of accurate information and limited access to information and services on HIV & AIDS by men, mainly because HIV & AIDS awareness has been conducted through health facility based programme such as reproductive and maternal and child health services. These services have traditionally targeted women at the exclusion of men.

However, it is becoming increasingly obvious on a global scale that the involvement of men in HIV & AIDS responses including HBC offers men, women and girls important benefits, and will significantly reduce the burden of both infection and care on women and girls.[2,3,7,10] Some HBC programmes have successfully involved men and demonstrated that working with men helps improve service delivery and also changes traditional and cultural beliefs and attitudes about gender roles, thereby redefining the role and contribution by women to community development.[11,12,13] HBC programmes should therefore promote male involvement as part of the strategy of not only improving the effectiveness of HBC in caring for and supporting people living with HIV & AIDS and their families, but of changing the gender constructs that disadvantage women.

VSO's Response

Voluntary Service Overseas - Regional AIDS Initiative of Southern Africa (VSO-RAISA) and their partners consider male involvement a critical component for all HIV & AIDS responses. VSO and their partners have conducted pioneering research and produced position papers on gender and burden of care.[14,15,16,17] It has become clear that the failure to effectively place gender concerns at the heart of the responses to the epidemic has denied women and girls their rights and exacerbated the impact of HIV & AIDS on women and girls while at the same time studies have also shown that men can play a positive role in care and support.

Based on the research, VSO developed a regional advocacy strategy to enhance national and international efforts to address gender in HIV & AIDS responses.[18] At the VSO-RAISA regional conference in 2007 *Challenges of Care*, the work that partners were conducting in promoting male involvement in home based care (HBC) was highlighted in a number of presentations. Participants recognised that these projects represented innovative responses to remedying some of the socio-cultural issues related to HIV & AIDS, as well as providing a more holistic model of HIV & AIDS care and support. Additionally, these responses appear to be replicable given that VSO-RAISA supported exchange visits locally and from Zambia and Malawi to Zimbabwe made partners from these countries aware of other strategies for scaling up male involvement activities.

As a follow up to this conference VSO-RAISA commissioned a rapid appraisal of the male involvement activities in the HBC programme of partners in Malawi, Zambia and Zimbabwe. **The objectives of the study were:**

1) To develop an understanding of partners' individual projects on the male involvement in HBC;
2) To provide analysis in relation to the Southern African Development Community (SADC) guidelines on the effectiveness, ethical soundness, cost effectiveness, relevance, replicability, innovativeness and sustainability of partners interventions that have enhanced male involvement;
3) To comment on how VSO-RAISA's horizontal learning approach has enabled partners from across the region to enhance their male involvement activities.

It has become clear that the failure to effectively place gender concerns at the heart of the responses to the epidemic has denied women and girls their rights and exacerbated the impact of HIV & AIDS on women and girls while at the same time studies have also shown that men can play a positive role in care and support.

This report provides some background information on the HIV & AIDS burden of care in Southern Africa, and outlines the methodologies used in conducting the study. The report presents the findings, challenges and a preliminary outline of potential Best Practice (within the SADC Best Practice framework)[19] arising out of the male involvement project. Lastly there are recommendations proposed which outline how this area of work should be taken forward.

Background

The Southern African region is the epicentre of the epidemic and accounts for nearly 50% of the HIV & AIDS burden in sub-Saharan Africa or 35% of the world's people living with HIV & AIDS and almost one third (32%) of all new HIV infections and AIDS deaths globally in 2007.[20] The HIV & AIDS epidemic disproportionately affects women in Africa and more so in the southern Africa region.[21] Infection rates and mortality are higher in women. The HIV & AIDS burden on women has not been limited to infection status, but extends to care and support where young and old women are most affected. The reasons for the disproportionate burden of infection and care on women are many, and include socio-cultural and economic factors that determine the gender inequalities that make women more vulnerable to infection and increased burden of care.[22,23,24,25]

Increasing Burden of Care on Women and Girls

All over the world, in most cultures, women are traditionally responsible for the health and physical well being of households, while men are involved in formal or informal activities to earn an income for the family. HIV & AIDS significantly increase the existing burden of care on women and children, especially girls. As their male partners become sick and die, women assume the responsibility of being the head of household and hence breadwinner, bearing the costs of caring for self and sick family members. Consequently women are now doing "triple duty," responsible for home and family, providing the majority of agricultural labour, and caring for family members living with HIV & AIDS.

Poverty and the inability of public health services to provide adequate care have further imposed more demands on care in the community, and especially on women and girls. Owing to the severe limitations of health care in southern Africa, the concept of community and HBC[26] evolved rapidly in the SADC region, promoted by national governments, international and national non-governmental organisations (NGOs). The emergence of organised HBC has created different but often dual roles for carers. UNAIDS refers to 'informal volunteers' as friends and neighbours who care for sick people they know out of a sense of love or duty. 'Formal volunteers' are recognised as those who have been recruited, and supervised by an organisation.[27] VSO uses community caregiver as a term that reflects all of the above. In this document, primary care providers are family members who care for relatives in the home while volunteer (or secondary) care providers (VCP) are those that are recruited and trained by AIDS service organisations (ASOs) running HBC programmes and are equivalent to the 'formal' volunteers. However VCP, most of who are women, can also be primary care givers in their households further increasing the burden of care. The organisation of HBC and the nature of the disease itself have thus expanded the responsibilities of women. Volunteers are recruited from the communities and trained in basic aspects of HBC including nursing care and counselling. They visit homes of sick people, walk long distances to offer care, counselling, health education, provide nutrition education and psychosocial support. Additional demands include training, management and supervision to ensure quality of care, protection of care providers from infection and sustainability of the community based care initiatives.

Often this extra burden falls on women who are themselves HIV infected, hastening the progression to AIDS and possibly death, increasing the number of orphans and the disintegration of the community. Further, the added responsibilities take most of the woman's time from her normal daily duties in the household and this worsens the economic burden of the already impoverished volunteer care provider. "*This is the case of the poor helping the destitute*".[28] In many instances the women have lost their partners. Children, especially girls, bear the burden of caring and providing for their sick parents and their siblings. When parents die children often become heads of households, bearing the full burden of caring for siblings. School-aged children; especially girls increasingly drop out of school to take care of the sick and to assume household responsibilities previously carried out by their parents. For example, a study in Zimbabwe showed that 76% of children who left school to provide care were girls.[29]

It is critical, therefore that efforts are strengthened to reduce the HIV & AIDS burden, inclusive of risk of infection, burden of disease and care on women and girls. VSO states that '*a rights-based approach enables the HBC providers to demand their rights and holds the duty-bearers accountable for non-fulfillment of those rights*',[4,5] and emphasises that this should be the premise from which efforts to reduce burden of HIV & AIDS care on women and girls should be founded.

It is critical, therefore that efforts are strengthened to reduce the HIV & AIDS burden, inclusive of risk of infection, burden of disease and care on women and girls.

Justification of the Study

The expansion of women's responsibilities represents a significant social change that has important consequences for entire families and communities in Southern Africa. Yet men, who have thus far dominated the socio-cultural discourse and decision-making, have generally not been actively and deliberately involved in such interventions. HBC is one example of a deficit model of male involvement in HIV & AIDS responses. This study was conducted to document the strategies employed and achievements of VSO-RAISA and their partners in Malawi, Zambia and Zimbabwe in increasing male participation in HBC. The information provides insight into the processes, challenges and lessons from the approaches used to increase male involvement in HBC, and therefore an essential tool for advocacy on the benefits of male involvement in HIV & AIDS responses. The study also provides empirical evidence that can be used to further evaluate the male involvement activities as potential Best Practices.

SADC promotes and has developed guidelines for the documentation of Best Practices in HIV & AIDS responses.[15] According to the SADC framework, the primary purpose of a Best Practice is to provide a practical instrument that facilitates the sharing of valuable information within and between Member States in order to scale-up interventions based on what is known to work. The essential criteria for a SADC Best Practice are effectiveness, ethical soundness, cost effectiveness, relevance, replicability and innovativeness. This study provides preliminary data on the potential of the male involvement activities of VSO-RAISA and its partners to be a Best Practice.

Methodology

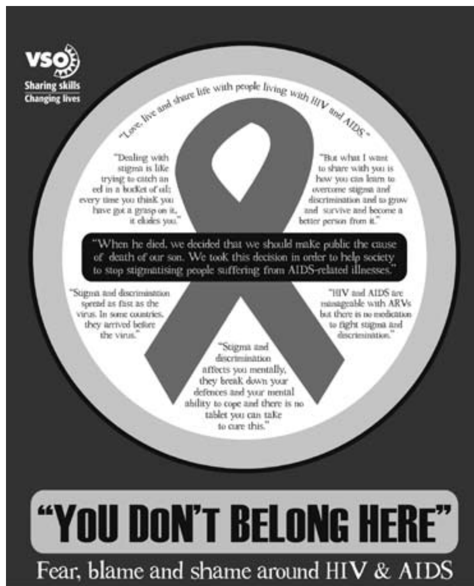
A rapid assessment of male involvement in HBC was conducted from 25 February to 7 March 2008. The assessment involved a selected number of VSO-RAISA partners in Malawi, Zambia and Zimbabwe. The partners were Nsanje, Ntchisi and Chitipa District AIDS Coordinating Committees (DACCs) and Tutulane (Chitipa) in Malawi, Thandizani (local NGO) in Lundazi, Zambia, and Padare Men's Forum on Gender (Harare) and Loving Hand (Bulawayo) in Zimbabwe.

The study methods employed were review of documents, group discussions and in-depth interviews with key informants. Documents collected from VSO-RAISA and partners included strategic and implementation plans, project reports (quarterly, annual, evaluation reports) and financial reports. These documents provided some quantitative and qualitative information on the baseline situation and after initiation of the project, as well as the relevance of the project, ethical considerations, outputs and outcomes. Primary data was gathered through group discussions and interviews with key informants including partner programme staff, traditional leaders and HBC clients. Checklists of essential documents and for the interviews and group discussions were developed in consultation with VSO-RAISA.

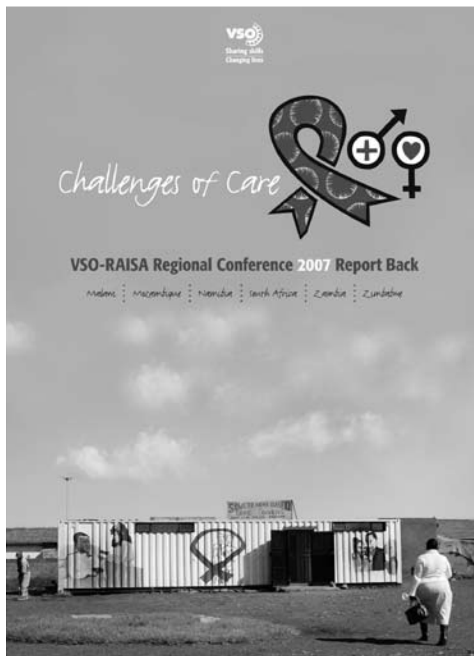
The assessment focused on the following themes:

- Conceptualisation of the male involvement project – goal and relevance;
- Stakeholder mapping and engagement – who is involved;
- Implementation – how does the project work with men;
- Outputs and Outcomes – what are the results of the male involvement activities;
- The policy and legal environment – what policies govern engagement and participation of men, and what is the impact of male involvement on the policy discourse and framework; and
- Lessons learned.

Interviews were conducted with partner programme staff in all countries. Interviews were also conducted with VSO-RAISA country programme officers in Malawi and Zambia, and a VSO volunteer attached to Tutulane, Malawi. Two female HBC clients in Zambia, four female clients and one Group Village Headman in Nsanje, Malawi were also interviewed. Overall, four group discussions were conducted, three in Zambia and one in Malawi. Group discussions were conducted separately for one group of female VCP (12 participants), one group of male VCP (9 participants), and one group of village heads (9 participants) in the Thandizani project. In Nsanje, Malawi, one group discussion involved male (7) and female (6) VCP. Due to travel restrictions, the consultant could not travel to Zimbabwe to collect primary data from VSO-RAISA programme officers, HBC volunteers and clients.[30]



2005 VSO-RAISA Regional Conference
Stigma & Discrimination REPORT BACK



The Male Involvement Project

VSO builds the capacity of partners to improve the support given to secondary care community volunteers, and recognises that advocacy is more effective when it is rooted in realities at the local level as this ensures that programme experience is more meaningful and relevant. The programme experience will provide key lessons and feed into the strategies to reduce the burden of HIV & AIDS care on women and girls. Between November 2004 and March 2006 there were consultations with a number of key stakeholders including donors and regional and international NGOs. The aim was to explore current activities and the main concerns relating to HIV & AIDS and gender. One major issue identified was the very limited participation of men in HBC. At a VSO-RAISA regional conference in 2005 on stigma and discrimination *You Don't Belong Here: Fear, blame and shame around HIV & AIDS*, it was evident that some partners had made significant strides in involving men in HIV & AIDS responses including HBC, and that this could be strengthened and replicated in other organisations.

In line with its advocacy strategy on gender and HIV & AIDS,[14] through its shared learning approach, VSO-RAISA facilitated regional exchange visits to Zimbabwe for its partners in Malawi and Zambia. Local exchange visits were also encouraged to enable local community based organisations (CBOs) to learn from each other. In addition small grants and professional volunteers were provided to support organisational development and training initiatives for VCPs. A follow up VSO-RAISA regional conference in 2007 *Challenges of Care* held in South Africa, showed that the male involvement initiative had taken root and that male involvement in HBC was an innovative intervention[11] that had potential of being a Best Practice and hence required more critical analysis.

VSO builds the capacity of partners to improve the support given to secondary care community volunteers, and recognises that advocacy is more effective when it is rooted in realities at the local level as this ensures that programme experience is more meaningful and relevant.

Findings

This section is divided into three sub-sections. The FIRST sub-section details the implementation processes (conceptualisation, strategies and major activities) and outputs of the male involvement projects separately for each participating organisation. The SECOND sub-section presents a consolidated synthesis of the outcomes to emphasise the relevance and benefits of male involvement in HBC. The THIRD sub-section summarises the challenges faced by all the participating organisations.

A male volunteer in Zambia involved in home based care

1. Project Implementation and Outputs/Outcomes

PADARE, Zimbabwe

Implementation strategy

Padare/Enkundleni Men's Forum on Gender (from here on Padare) is a male membership organisation established in Harare in 1995. The name refers to a tradition whereby men gather around a fire or under a tree to discuss and make decisions about community issues. The organisation aims to bring about gender equality through public and focused discourse on gender and sexuality, gender violence as well as mobilising men to participate in HIV & AIDS interventions. Padare has public education and media programmes that discuss youth and adult male sexuality and their gender roles in society. With several chapters countrywide, Padare has significant coverage and is recognised as one of the organisations that has made important contributions towards engaging men in the HIV & AIDS discourse in Zimbabwe and the region.

In 2003, Padare attended the VSO-RAISA regional conference *Men, HIV & AIDS*[31] where the organisation's work on male involvement in HIV & AIDS responses was profiled. Although not involved in HBC then, the strategy of involving males received a lot of interest by participants from the region. On learning the potential role men could play in HBC, from that regional conference, Padare decided to mobilise and train male HBC providers. Through its "Young People: We Care" programme, Padare is now educating young men on the need to share the caring burden of AIDS with women and girls. The theme of the programme is *"We need to catch them young so that when they grow up they will be able to redefine their roles"*.[32] Further, Padare's participation in the development of the RAISA Regional Advocacy Strategy, whose focus is on reducing the burden of care on women and girls, broadened its scope in terms of approaches to gender issues in HBC.

Outputs

With support from VSO-RAISA, 43 male HBC care providers were trained in Harare (2005) and this has since developed into a successful HBC programme with each of the 13 Padare Chapters across the country having trained 30 male VCP by 2008. This became a flagship programme involving men in HBC and hosted Malawian and Zambian partners in exchange programmes. In 2007, Padare also hosted a group of seven RAISA partners from within Zimbabwe in a male HBC study tour, and also visited Africare male HBC projects[13] in the country. The exchange visits enabled the partner organisations to engage with men who are involved in HBC and find out firsthand what their motivations were, and how they coped with the social pressures caused by traditional gender roles.

Loving Hand, Zimbabwe

Implementation strategy

One of the seven Zimbabwean partners in the 2007 study tour was Loving Hand, an NGO established in 1998 to support communities in peri-urban areas around Bulawayo City on HIV & AIDS related problems through training of care providers and peer educators. Participation in the Zimbabwe national conference on men, HIV & AIDS, and ensuing association with Padare helped Loving Hand develop a gender sensitive HBC programme.

Outputs

Loving Hand initially worked with women care providers only. Since the tour of Padare's HBC projects, Loving Hand has trained over 20 male care providers. Loving Hand reported that involvement of men had improved the management of HBC activities. Because men are more mobile, supervision of HBC activities and information exchange between VCP in different localities has improved. Further, the programme coordinator reported coverage had also increased. However, the organisation is experiencing problems with retention of the men and this is attributed in part to the approach used to mobilise the men as well as the issue of incentives. Mobilisation focused on involvement of men in HBC at the exclusion of the wider and influential gender related issues. Having seen the benefits in carrying out wider male empowerment campaigns Loving Hand has strengthened its campaign by involving community leaders such as councilours and other opinion leaders when recruiting volunteers for HBC.

Thandizani, Zambia

Implementation strategy

Thandizani is a community based HIV & AIDS prevention and care organisation established in 1999 in Lundazi District, eastern Zambia bordering Malawi. Thandizani, in Nyanja, means '*Help Each Other'* and this is the philosophy behind Thandizani's programmes. Thandizani began as a voluntary counselling and testing (VCT) organisation. The information, education and communication (IEC) strategy used to mobilise the community for VCT included engagement of local authorities, relevant government departments such as Ministry of Health and traditional leaders, through public and focused group discussion, and training on gender and sexuality. Community leaders, including religious leaders were trained in HIV & AIDS prevention, care and support. The gender awareness campaign revealed the gender related barriers to accessing not only VCT but other services, as well as the community's participation in care and support.

The open discussion on gender and sexuality attracted positive response from the community in general. VCT uptake increased rapidly and by 2002 nearly 4000 people had been tested for HIV, representing 4% of Lundazi district's population. The VCT campaign brought with it the challenges of care and support. Hence Thandizani embarked on HBC and support. The HBC programme is built on a community franchising model where community care groups (CCGs) are established and affiliated to Thandizani. The CCGs are run by committees selected by the communities. The community also selects the VCP. The requirements for membership in the CCG are that one is tested for HIV (the result is inconsequential to participation and does not necessarily have to be declared) and annual contribution in cash or kind as determined by the community.

The IEC campaign by Thandizani led the community, including men, to recognise the limited role men played in care in general. One female VCP reported that when she started volunteer work in 1999, there were no men involved and that her spouse discouraged her. However, with the continued IEC campaign by Thandizani, more men, including her spouse became aware that their contribution could significantly reduce the time and effort that women put into HBC. A group discussion with men confirmed the low participation of men in the early stages of the project. The reasons cited for the low participation were culture and lack of information. The men felt that care was for women hence involvement in HBC led to stigmatisation by other men. The men also indicated that men did not want to be involved in activities that took their time but did not generate income, a role they consider the prerogative of men. The men reported that they became more aware of the burden on women as their wives were spending more and more time on volunteer work, often leading to disagreements in the household. Others believed that since men were more educated than females in their communities, men would more effectively support clients on antiretroviral therapy (ARVs) by monitoring adherence. While acknowledging the high burden of care, women were also concerned about involving men mainly because of the perceived possibility of male dominance and hence women losing control of the programme. The mobilisation for male involvement addressed these and other issues. In particular the engagement and active participation of traditional leaders contributed significantly to men's change in attitude to one that balances the needs of both men and women.

Through partnership with VSO-RAISA, Thandizani went on study tours to Zimbabwe (2005) and the Copperbelt Health Education Project in Zambia 2006. On return, male involvement activities were scaled up. Community leaders (chiefs, headman and other influential people) were made aware of the role of men were playing in HBC in other organisations and countries. VSO volunteers placed in Thandizani provided technical support in VCT, HBC, fund raising and laboratory services. Training workshops were conducted separately for the community leaders, men, women and youths where culture and traditional issues related to care and support were discussed. Seminars specifically addressing male involvement were organised for village heads and community members. HBC committees and VCP were engaged in discussion on male involvement.

One female VCP reported that when she started volunteer work in 1999, there were no men involved and that her spouse discouraged her. However, with the continued IEC campaign by Thandizani, more men, including her spouse became aware that their contribution could significantly reduce the time and effort that women put into HBC.

Outputs

The number of care groups increased from 15 in four chiefdoms in 2002 to over 100 in seven of the eleven chiefdoms in Lundazi by 2008. Overall about 140 volunteers were trained and several others yet to be trained are providing care. The proportion of male VCP has consistently increased over the years to about 50% at the time of this assessment. Since the beginning of HBC programme, the VCPs have provided care and support to about 8,000 clients of whom about 40% were males.

Male and female VCPs perceived their central role as facilitating improvements in the care provided by primary caregivers through the provision of materials and the sharing of information. The male VCPs receive similar training and provide similar services to clients as female VCPs. The group discussion with women revealed that female VCP felt that involvement of males had reduced the burden of care, mainly the physically challenging activities related to care and support. During the home visits, the male VCPs effectively and consistently perform duties that are within their comfort zone – i.e., those that are traditionally performed by men. These include fetching water, cleaning the environment, repairing or constructing physical structures for clients, counselling, spiritual support and exercising the patient. Activities that are not traditionally assigned to men were less readily undertaken, including bathing, wound care, and feeding of clients.

Both male and female care providers categorically stated that they did not expect any remuneration. According to one male volunteer *'I derive my satisfaction and motivation seeing clients I assisted to get ARVs get up and walk and fend for themselves'*. Thandizani does not give any incentives except bicycles and HBC kits which are considered '*tools of the trade*'. However this needs to be viewed from a rights based perspective [33] as well as the economic reasons for low male involvement reported by men in group discussions.

The traditional leaders have organised themselves into groups which they call '*Group Headmen Committees*' and conduct weekly meetings where various issues are discussed. These include the role of men in HIV & AIDS activities, as well as motivation and facilitation of other activities, such as income generation. A group discussion with village heads from Damso community showed that the traditional leaders were aware of the burden of care on women. The village heads had detailed statistics about the population, number of households, widows, orphans and vulnerable children, HBC and VCP in their villages. The village heads emphasised that their involvement in HBC made them role models, not only for other men, but for male youths.

Tutulane, Malawi

It is important to note that male involvement in HBC among the VSO-RAISA partners in Malawi only began after the partners engaged in a RAISA facilitated exchange visit to the Zimbabwe partner PADARE.

Implementation strategy

Tutulane is one of the largest CBOs in Chitipa district. Tutulane started HBC after VSO-RAISA facilitated an exchange visit to a CBO Tovwirane-Nsimba (Malawi) in 2003.[34] Using the community mobilisation lessons learned from the CBO, Tutulane recruited its first ten volunteers, all female. Through RAISA facilitated exchange visits and conferences, and the attachment of a VSO volunteer, Tutulane embarked on an intensive male involvement programme. The programme was premised on the lessons learned from partners, that gender and cultural norms impede male participation in HBC. To address this, Tutulane approached traditional authorities and engaged them in discussion and information sharing. The traditional authorities are now at the fore front of recruitment of males. Tutulane also formed a men's forum called Pasaka, adopting the Padare concept. Pasaka is a team of volunteer men who champion gender equity, PPTCT and women's rights in the community, while advocating for male involvement to reduce the burden of care on women. The team has 65 members of whom four are group village headmen. Men and traditional leaders were further mobilised by their inclusion in village HBC committees, involving traditional leaders in management of Pasaka committees, offering free training to volunteers and establishment of income generating projects (IGPs).

Outputs

The efforts to increase male involvement in HBC have yielded positive results. The number of care providers has increased from 10 (all female) in 2003 to 64 (20 men) in 2006. Thus the proportion of male volunteers increased from zero to 31% respectively. The proportion of male volunteers further increased to 45% by end of 2007. The care providers work harmoniously with their female counterparts, conducting on average seven home visits per client per month. The male care providers provide all aspects of care as available in HBC but do not bath female clients.

District AIDS Coordinating Committees, Malawi

The National AIDS Commission (NAC) strategy of building community ownership of interventions, in 2007, restructured HIV & AIDS service delivery and promotes establishment of CBOs. The CBOs are coordinated by the District AIDS Coordinating Committee (DACC). There are several CBOs with HBC programmes in the three districts. Due to limited data, the implementation and outputs are not presented separately.

Nsanje district is on the south eastern border with Mozambique. It has 75 CBOs with over 2000 volunteers, most of whom are women. Nearly half of these volunteers have been trained in HBC. A group discussion was conducted with seven male and six female VCP of an urban based CBO. Similar to the finding in Zambia, women in the group discussion indicated that HIV & AIDS had increased the work beyond their traditional care role in the family, and that they welcomed the participation of men. Male participation in HBC was very low at the inception of HBC. The group discussion also revealed that male participation was limited by tradition and culture. Men said that it was considered traditionally and culturally unacceptable for men to be involved in care. In addition male volunteers cited lack of monetary incentives.

Following a horizontal learning visit by the Nsanje DACC coordinator to Zimbabwe in 2005, efforts to involve males in HBC were intensified. Mobilisation of men was conducted through engagement of community leaders (group village headmen and village development committees), and men in open discussion on the role of men in HIV & AIDS responses. Following the sensitisation, the proportion of male volunteers is increasing. Of the 40 members in one CBO in Nsanje urban, 15 (38%) were men. As reported in Zambia, the women in Nsanje said that men, although equally trained, still restricted themselves primarily to the physically challenging HBC activities such as repairing physical structures, fetching firewood and ferrying clients to and from hospital. The four female HBC clients interviewed welcomed the participation of men and expressed satisfaction with the support provided by male volunteers. The clients reported that some of their colleagues request male VCPs especially when they need physical support. Further male participation in HBC is now generally accepted by the community, according to male and female VCP of the CBO who were involved in a group discussion.

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Ntchisi district is in the central eastern zone of Malawi. Through horizontal learning from other local organisations, the DACC embarked on male involvement initiative. Using similar approaches of first targeting community leaders, opinion leaders and traditional healers, the DACC managed to train eight CBOs in HBC. In 2007 alone, a total of 165 care providers were trained, of whom 47% were men.

Chitipa district, through support from VSO, organised local exchange visits for five CBOs. Prior to the visits, the ratio of male:female volunteers was 1:4. Through engaging community leaders and men, this increased to 2:3 by end of 2007. Of particular significance, the DACC partners have since made it a requirement that any CBO should ensure a minimum 40% proportion of male volunteers.

* While there is limited data from the districts, it is important to note the willingness of national response organs to adopt strategies that increase male involvement in HIV & AIDS responses. This is of strategic importance in the creation of an enabling policy environment for male participation in HBC and other interventions.

2. Outcomes (All Partners)

Because the outcomes reported by the partners were generally the same, they are presented together. The major outcomes that can be synthesised from the findings in the three countries are:

Increasing knowledge, understanding and openness about HIV & AIDS and gender among men: Men's knowledge and understanding of HIV & AIDS, and participation in interventions is increasing. The group discussions in Malawi and Zambia, and reports by programme staff suggest that the male involvement initiative has afforded men better access to information and services. Men and women now engage in open discussion on gender and sexuality issues. According to female and male VCP in the group discussions, *'discussions during training and regular support meetings for volunteers have become richer and much more interesting and balanced with a gender mix'.* Programme staff and village heads in Zambia reported that the male involvement programme has managed to attract youths who are invited to sit in men-only community meetings. However the discussion on sexuality is still limited by culture and tradition which prohibits such discourse between parents and children. In Zambia, increased open discussion about gender based violence and sexual abuse of children was reported by programme staff, VCP and village heads. A cited indicator was the increased number of criminal cases reported to police or in courts of law. At the time of this study, there were two high profile courts cases of sexual abuse of minors by respected citizens in Lundazi, Zambia.

Reduced stigma and discrimination of people living with HIV & AIDS by men: According to the men and women in group discussions in Zambia and Malawi, prior to the male involvement initiatives, men's attitude was that having HIV & AIDS was a 'disgrace' and did not want to be associated with an HIV positive family member or friend. Now there is increasing acceptance of people living with HIV & AIDS within households and in communities in general. In addition the number of people seeking VCT services has increased and more men are declaring their HIV status and participating in support groups for people living with HIV & AIDS. Increased participation in HBC, hence interaction between male VCPs and HBC clients was considered to be an important indicator of reduced stigma, conveying the message that men are part and parcel of the fight against HIV & AIDS.

Reduced burden of HIV & AIDS care on women and girls: All partners indicated, and female VCPs reported that the greater involvement of men had freed time for women to attend to household and other duties. However men's contribution has been confined mainly to the physical aspects of HBC such as fetching fire wood and water, ferrying clients to health facilities, constructing or repairing shelter for clients, as well as the physical labour in income generating projects. According to Damso community village heads in the group discussion in Zambia, there were 36 school aged children affected by HIV & AIDS (CABA) in 2005 who were not attending school compared to 11 in 2008. This may suggest that the involvement of men could be improving the support provided to affected households, especially child headed households. This respite may extend benefits to girls who often become primary care givers and drop out of school to care for their sick parents or siblings when the parents die. Male VCPs have also become advocates for greater male involvement in caring for the sick.

Improved coverage and quality of HBC: According to Loving Hand and Thandizani, male involvement has enabled them to expand their HBC programmes, and improve outreach because of the higher mobility of men. Further, involvement of men in HBC committees has strengthened management and supervision of activities at community level. Because men are more mobile, they are able to conduct more follow up visits to cover the furthest VCP and clients. While there is no direct evidence that male involvement in HBC has improved the quality of life of people living with HIV & AIDS, the increased participation of men has also improved the referral of clients to health facilities as men are physically more capable than females to ferry clients. Male involvement has further improved the physical environment of clients by building and repairing physical structures such as huts and fowl runs, and general hygiene activities. Moreover, the male care providers provide support and counselling to male clients on sensitive sexual issues that they would feel generally uncomfortable to discuss with female volunteers.

Retention of volunteer care providers: Women VCP reported that male involvement had reduced stress and burnout. Some of the women in the group discussion in Zambia started HBC as far back as 1999 and attributed their continued participation partly to reduced burden of care as a result of an increase in male involvement. According to programme staff in Malawi and Zambia, because of the increased understanding of HIV & AIDS issues by men and the community in general, there are fewer VCP drop-outs. Previously some female and male volunteers were forced by peer pressure and spouses to drop out of care and support.

Community mobilisation for HIV & AIDS interventions: Involvement of men has significantly increased opportunities and effectiveness of community mobilisation. Men are highly mobile and their voices, especially traditional leaders, are heard and respected in the community. Men have therefore become powerful agents for information, education and communication (IEC) on HIV & AIDS issues.

Involvement of men has significantly increased opportunities and effectiveness of community mobilisation.

Sexual behavioural changes: While there is no definitive evidence of changes in sexual behaviour, in the group discussions in Zambia, both men and women agreed that spousal sexual relationship had improved in households due to the increased interaction and open discussion about sexuality. Both men and women in the group discussions concurred that extramarital sexual relationships had declined. On the other hand, programme staff reported that there was an increased demand for VCT by couples, married and those planning to marry. This has been previously reported for Thandizani.[12]

Cultural changes: Male involvement appears to be influencing tradition and culture. Men, including those outside the care groups, are reportedly supporting their partners in various day to day activities that have always been considered '*women's responsibilities'.* According to one village head in Zambia, *'men used to laugh at their colleagues in HBC for doing women's work. Now society accepts that care is equally the responsibility of men.'* In Zambia and Malawi, men and women in the group discussion reported men are now seen accompanying their partners to antenatal care (ANC) and maternal and child health (MCH) services, or taking their children to health facilities. The DACC coordinators interviewed in Malawi reported that PPTCT services in their districts on average registered between 75% and 100% of antenatal care (ANC) clients being accompanied by their partners. Acceptance of an HIV test for the pregnant women and their partners as well as PPTCT interventions also increased in similar proportions. However this could not be verified because relevant data could not collected from health centres due to time limitations. In Malawi and Zambia, it was reported that traditional leaders were mobilising men to fight the cultural practices of wife inheritance and wife cleansing. Establishment of support groups of wife cleansers in Nsanje, Malawi is one indicator of the nascent changes in tradition and culture. The group has since started to implement safer non-penetrative alternatives of wife cleansing. For example, the group has introduced an alternative practice where a married brother or cousin to the deceased has sex with his wife instead of bringing in a wife cleanser to have penetrative sex with the widow. Further, men and women in group discussions and interviews reported that parents were becoming more open in discussing sexual issues with children at home, but this could not be verified with the children.

Empowerment of women as community leaders: The mix of men and women in HBC committees has led to greater acceptance and appreciation of women as leaders in the community. In the Thandizani HBC project, communities are selecting women as HBC committee members and chairpersons. In the same communities, two chiefs have appointed women as village heads.

The mix of men and women in HBC committees has led to greater acceptance and appreciation of women as leaders in the community.

Ownership of HBC: Data from interviews and group discussions suggest that, because men by nature want to possess and control, their involvement has led to increased acceptance and ownership of the HBC activities as truly community based initiatives instead of being externally driven programmes. This is buttressed by the apparently committed involvement of traditional leaders.

Policy and Legal Environment

The study was not able to collect data on national policies related to HIV, AIDS and gender, and specifically HBC. However from the HBC and HIV & AIDS policy documents analysed by VSO-RAISA in 2006,[18] there is no policy that refers to the greater involvement of men. There is therefore a huge gap in policy that encourages greater involvement of men at national level. However, in Malawi, the DACC coordinators in Nsanje, Chitipa and Ntchisi reported that the National AIDS Commission (NAC) was encouraging male involvement by requiring that all CBOs ensure at least 40% of members and/or volunteers are male. While these are not formalised policy changes, the involvement of national response coordination structures, and hence policy makers, is an important achievement and step in ensuring the development or strengthening of relevant policies to promote and institutionalise not only male involvement, but gender and rights-based approaches into national responses. There also may be potential impact of HBC and male involvement at local level. For example in Lundazi, one of the chiefs has led the formulation of an HIV & AIDS policy for his community.

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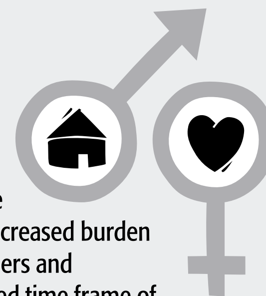
3. Challenges

A number of challenges are influencing male participation and contributions to HBC:

1. The availability of men is hindered by their primary responsibility of being the breadwinner. In environments of high unemployment, as is often the case in rural areas, men balance their participation in volunteer work with fending for their families. They therefore expect to get some tangible benefit from the time invested in HBC. Other men also expect the voluntary work to lead to employment. This is an area that needs to be addressed through rights based approaches for sustainable participation of men and women in HBC.
2. Some organisations offer monetary incentives to volunteers in the same community. This poses major challenges with motivation and retention of volunteers who do not receive any incentives.
3. Peer pressure from some men who continue to believe that care is *'women's work'* and discourage their counterparts.
4. Although there is no gender specific preference for care providers, it is culturally unacceptable for male care providers to bath female clients.
5. The male involvement initiative has focused on adults. The challenge is to involve male youths to ensure sustainability of male participation in community based interventions.
6. Lack of appropriate IEC materials that can be used by the community.

Peer pressure from some men who continue to believe that care is 'women's work' and discourage their counterparts.

Conclusion



The primary purpose of the study was to document the strategies, activities, outputs and outcomes of partners' male involvement projects in order to identify good practices. In that vein, the study did not attempt to demonstrate the increased burden of care on women and girls. This has been amply demonstrated and documented in several publications by researchers and organisations including VSO.[4,9] This rapid appraisal of seven partners in three countries was conducted within a limited time frame of seven days. Therefore coverage was limited, and inevitably the data generated also inadequate to address all the desired components outlined in the methods. In particular, only six HBC clients and no primary care providers were interviewed. It was also not possible, within the time frame to collect primary data from other service sectors such as health, education, justice and labour.

Despite these limitations the data collected provides insights into the strategies, processes, some achievements and challenges of involving men in HBC. **The data allows a number of lessons to be drawn from the partners' experiences**.

Lessons Learned

- Men can participate as HBC volunteers as effectively as women. The programme has demonstrated that male and female volunteers can work together harmoniously, each contributing to quality of care in different ways. Men bring the added value of physical and counselling support to HBC. Involving men can therefore lead to improvement in care and support of people living with HIV & AIDS.
- Addressing gender issues and risky cultural/traditional practices can be more effective when men and traditional leaders are involved. Engaging communities through appropriately designed gender and sexuality based IEC empower the communities to appreciate the role of culture and tradition on worsening or reducing the burden of infection, disease and care on women. Communities are therefore able to make decisions on what and how to address the cultural and traditional factors. In Nsanje, a support group of anti-wife cleansers was established to address wife cleansing.
- Targeting traditional leadership is critical in mobilising men to become more involved in care and support of people living with HIV & AIDS. Traditional leaders play an important role in mobilising men and communities to access HIV & AIDS services, and to change attitudes, beliefs and practices related to care that are driven by tradition and culture.
- The increased participation of men in HBC and other HIV related activities contribute to reduction in stigma and discrimination of people living with HIV & AIDS.
- Male involvement provides an opportunity to improve information dissemination in the community as men are highly mobile and vocal. Armed with the appropriate and adequate HIV & AIDS information, men are effective agents through which to educate communities.
- Involving men and community leadership (especially traditional) in the conceptualisation, planning, implementation and management of HBC and other activities promotes mutual respect between men and women, which, supported by traditional leaders leads to ownership and sustainability.

This study has generated data that suggest that efforts to increase male participation in HBC are feasible, strategies used to mobilise and retain men as VCP could be effective in the short-term, and that there is potential of significant impact in reducing burden of care on women and girls. This apparent success of the scaling up of male involvement activities in the participating organisations, facilitated by horizontal learning, is an indication that the activities are replicable. This, therefore, suggest that the partners' male involvement activities could potentially be Best Practices. While this requires more detailed studies, a preliminary indication of Best Practice is presented below, guided by the SADC Best Practice Framework.[35]

SADC Best Practice Criteria

Effectiveness: Quantitative and qualitative assessment has shown that the male involvement project is achieving the objective of increasing male involvement in HBC. Although there are challenges in documentation by partner organisations, it is clear that not only the proportion of men in HBC has increased rapidly, but the level of participation of the men in some partners' HBC programmes has also increased. Evidence suggests that male involvement is beginning to stimulate positive changes in the community. Stigma, especially by men, has reduced while women are being more accepted in leadership positions.

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The burden of care on women and girls is reducing and more girls and CABA are attending school. Traditional leaders are leading HBC activities and campaigns to abolish some risky cultural practices. Gender roles are changing in communities as men become more involved in care and support both in households and in the community. Thus male involvement is likely to have impact well beyond HIV & AIDS. Indications are that male involvement has the potential to change the socio-cultural and economic development paradigm in communities.

Gender roles are changing in communities as men become more involved in care and support both in households and in the community.

Ethical Soundness: The strategies used to engage men have primarily been the sensitisation of communities on general HIV & AIDS issues and highlighting the burden of care. Some partners have used gender and sexuality as the entry point and vehicle of sensitisation. These strategies sent powerful messages to the community and men in particular. While the society would generally not discuss sexuality issues openly, discussions with traditional leaders and community members suggest that the campaign did not infringe on principles and values of the communities. Instead, the programme has helped the community appreciate the gender issues and men to appreciate and act on the barriers to participation and contribute to mitigation of the HIV & AIDS problem in their community. Thandizani community care group membership requires that one be tested for HIV. This could be considered unethical, but the members emphasised that this was what the community had agreed on in constituting the care groups. Further, members are not forced to disclose their status but only to show evidence that they had been tested. The care groups emphasise leading by example and their motto is *'if you do not know your status, you are an ignorant person'*. Communities and volunteers have recognised and accepted that male volunteers can only bath male clients. To ensure this, male and female volunteers are often paired during home visits.

The care groups emphasise leading by example and their motto is 'if you do not know your status, you are an ignorant person'.

Cost Effectiveness: The male involvement initiative was formulated on existing community based activities and therefore complemented already ongoing efforts to involve men in various HIV & AIDS programmes. Because the male involvement initiative was integrated into HBC, it did not require substantial capital investment. VSO-RAISA placed professional volunteers and provided funding for exchange visits and one-off small grants (not exceeding £1000 per partner) to facilitate the programme. Therefore implementing male involvement initiatives within existing programmes does not require large funding. However there is need for continued support of the core care and support programmes to ensure that the males recruited can provide the services.

Relevance: Women and girls are suffering a high burden of HIV infection as well as care and support. This is despite the high level of awareness and knowledge about HIV & AIDS in the community. Most interventions have targeted women, thereby feminising the epidemic, and most gender mainstreaming initiatives have not actively engaged men. The male involvement initiative specifically aimed to engage men in discourse and action that would increase their participation in HBC and reduce the burden on women. The initiative, in this short period, has significantly increased the proportion of men involved in HBC in the partners assessed. This development is highly appreciated by the communities, emphasizing the relevance of increasing male participation in are. The involvement of men appears to be stimulating positive socio-cultural changes that could potentially impact significantly on not only HIV transmission, prevention and care and support, but community development in general, thereby sustaining the reduction of burden of care on women and girls.

Replicability: The exchange visits enabled partners to learn from each other. The lessons were applied in scaling up or improving the partners' strategies for male involvement. The success in mobilisation and retaining men in HBC in the different countries and settings indicates that the strategies are replicable. The assessment conducted suggests that the strategies were effective and acceptable to the communities serviced by the partner organisations involved in the male involvement initiative. The strategies are easily adaptable as demonstrated by Tutulane in Malawi, who have successfully established effective Pasakas or men's forum groups, a concept adapted from Padare in Zimbabwe. In Lundazi, traditional leaders are using Mpala's (traditional gathering place or hut), to conduct weekly meetings for men and male youths, also building on the Padare concept. In Nsanje, a support group of men against wife cleansing practices was established, again adopting the Padare concept. It is quite likely that the programme can be successfully replicated in other SADC countries considering that there are similarities in culture and tradition.

The assessment conducted suggests that the strategies were effective and acceptable to the communities serviced by the partner organisations involved in the male involvement initiative.

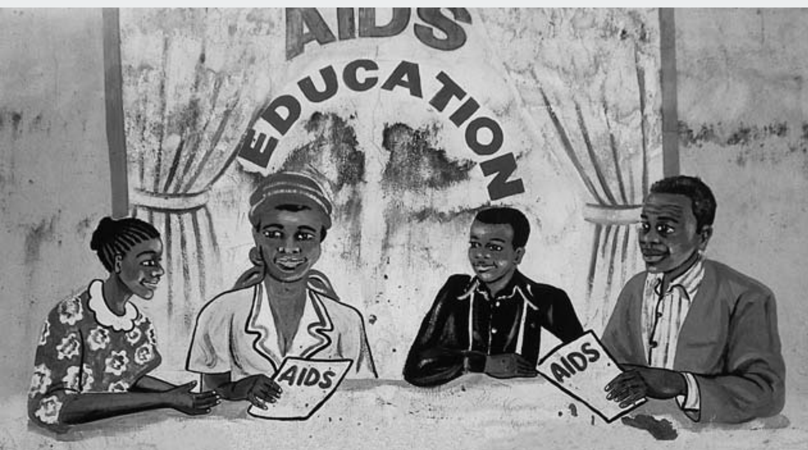
Innovativeness: The innovations in the initiative were: (1) the horizontal learning facilitated by VSO-RAISA, to share information and experience through conferences, the exchange visits or study tours and provision of technical expertise by VSO professional volunteers. This enabled partners to learn from each other and be able to adaptively replicate male involvement activities in their areas and to improve organisational development. (2) Targeting and involving traditional leaders in gender and sexuality discourse and mobilising men has proved to be an innovative approach in securing their understanding, commitment and support. Because of their position of authority, traditional leaders are able to initiate change to traditional and cultural norms.

Sustainability: The male involvement programme was integrated in community based care activities through established CBOs that are run and managed by the community. Partners have generally not introduced incentives for HBC, except for tools of the trade (bicycles and HBC kits). In Lundazi there was an emphatic message that the CBOs would continue with the HBC activities even in the absence of Thandizani coordination and support. The involvement of community leaders and men in the HBC activities and establishment of HBC committees is one of the strategies to ensure sustainability of HBC. Since continued male involvement in voluntary care giving is challenged by the men's role as breadwinners, the partners have encouraged and supported the establishment of income generating projects (IGPs) that are aimed at generating resources that will benefit both clients and volunteers. Success of the IGPs will ensure retention of male volunteers and even attract more males. This could eventually transform into a fully fledged economic activity in the community. Some partners are also encouraging establishment of nutrition gardens to provide food for clients and volunteers. Finally, partners have also fostered close collaboration and institutional linkages with other AIDS service organisations (ASOs) and government departments and programmes. Thandizani is now the major entry point for most HIV & AIDS initiatives by NGOs and government, and is a member of the DACC. In Malawi, all CBOs are directly coordinated by district assemblies; hence their activities are linked to the national response coordinated by the National AIDS Commission (NAC).

Recommendations

The study has described the male involvement projects, highlighting the implementation process, the outputs, outcomes and challenges facing this initiative. Based on the information available, the following recommendations are made, with the view to (1) improving project implementation and (2) enhancing the advocacy agenda for male involvement in HIV & AIDS responses:

- Continue to document – during the consultative workshops in 2008/9 with World Health Organization (WHO) – the gaps in national policies and legislation governing care and support, in particular relating to male involvement. The present study was not able to gather relevant information to assess the availability and relevance of such policies, if any. This is essential for advocacy for a rights based approach to addressing the burden of care on women.
- Intensify advocacy for increased involvement of HBC and other responses. This study provides some evidence on the relevance and positive impact of male involvement in not only reducing burden of care on women and girls, but on gender dynamics in the community.



HIV & AIDS wall painting, South Africa, Copyright VSO

- Develop and/or strengthen the IEC materials and strategies for mobilising men by presenting men as partners capable of playing a positive role in the health and well being of their partners, families and communities. Although fewer men are involved in care and support to date, they care deeply about the women in their lives including their partners and family members, and as such, have a stake in challenging the current gender order. Given the opportunity and the know-how many men are eager to challenge customs and practices that endanger women's health and support the well being of women.
- Expand content and context of gender training and IEC within NGO/CBO sector. The gender and sexuality approach employed by Thandizani to engage communities made communities more open about gender providing an opportunity for communities to review some of the gender constructs that disadvantage men. However such training needs to be carefully designed so that it does not raise controversies that may play against the objective of male involvement.
- Extend the male involvement campaign to youths. Youths have not been specifically targeted for involvement in care and support. However, in Zambia, anecdotal evidence suggests that youths are willing to and capable of participating in organised care and support.
- Provide adequate equipment (bicycles), materials (HBC kits) and training incentives required for care provision. This is essential not only to improve quality of HBC, but for retention of both male and female VCPs.
- Intensify the campaign to encourage men to participate in maternal and child health (MCH) programmes and prevention of mother to child transmission (PPTCT) programmes as entry points into care and support. This study has shown the male involvement project has resulted in more men accompanying their wives to either VCT or MCH services. This should be further promoted.
- Conduct further research to understand more about men and women's beliefs, attitudes and practices towards the rights of care providers and the promotion of men's involvement.

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33 VSO is calling for financial and/or compensation for the labour of VCP through various mechanisms including reimbursements, stipends, salaries etc. Source: VSO, 2003. Reducing the burden of care on women and girls.
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VSO-RAISA

Regional AIDS Initiative of Southern Africa

Who we are • VSO 'Focus for change' • Advocacy • Donor support • RAISA tools • Making the region matter • Highlights

VSO-RAISA: Who we are

Regional AIDS Initiative of Southern Africa (RAISA) is an initiative of Voluntary Service Overseas (VSO) seeking to strengthen the response to the HIV & AIDS pandemic in six Southern African countries (**Malawi**, **Mozambique**, **Namibia**, **South Africa**, **Zambia** and **Zimbabwe**) by joining forces with government institutions and civil society organisations to provide effective prevention, treatment, care and advocacy support for people affected by HIV & AIDS, and to mitigate the personal, social and economic impact of the pandemic.

The essence of RAISA is to provide in-country partners with building blocks, which strengthen their capacity to develop their multi-sectoral programmes and to increase their impact. The tools, which RAISA provides, can include skilled volunteer development workers (VDWs), training, small grants and opportunities to network and create national and Regional links between AIDS service organisations.

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INCREASING Male Involvement in Home Based Care to REDUCE the Burden of Care on Women and Girls in Southern Africa