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Gender and AIDS: time to act

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Abstract

Gender has long been recognized as being key to understanding and addressing HIV and AIDS. Gender roles and relations that structure and legitimate women's subordination and simultaneously foster models of masculinity that justify and reproduce men's dominance over women exacerbate the spread and impact of the epidemic. Notions of masculinity prevalent in many parts of the world that equate being a man with dominance over women, sexual conquest and risk-taking are associated with less condom use, more sexually transmitted infections, more partners, including more casual partners, more frequent sex, more abuse of alcohol and more transactional sex. They also contribute to men accessing treatment later than women and at greater cost to public health systems. The imperative of addressing the gender dimensions of AIDS has been clearly and repeatedly articulated. Many interventions have been shown to be effective in addressing gender-related risks and vulnerabilities including programmes designed to reach and engage men, improve women's legal and economic position, integrate gender-based violence prevention into HIV services, and increase girls' access to secondary and tertiary education. Despite this, the political will to act has been sorely lacking and not nearly enough has been done to hold governments and multilateral institutions to account. This paper argues that we can no longer simply pay lip service to the urgent need to act on what we know about gender and AIDS. Simply put, it is time to act.

Keywords

accountability; advocacy; gender; HIV/AIDS; political will

Introduction

'Countries should ensure a massive political and social mobilization to address gender inequities, sexual norms and their roles in increasing HIV risk and vulnerability' (UN Secretary, Ban Ki Moon, 1 April 2008) [1].

Globally, women constitute half of all adults living with HIV, but in sub-Saharan Africa there are 14 infected women for every 10 infected men [2]. Gender roles and relations are key to understanding the nature of the epidemic. Sexual and physical violence against

women and other controlling behaviours of men, as well as practices of transactional sex and men partnering with much younger women, markedly increase the risk to women of becoming infected with HIV [3–5]. Ideas of manhood that equate ‘being a man’ with sexual risk-taking and being in control (of women) have been shown to be associated with more negative attitudes towards condoms and less use, more sexually transmitted infections, more partners, including more casual partners, more frequent sex, more abuse of alcohol and more transactional sex [6–11]. The stigmatization of men who have non-heterosexual identities or practices has resulted in neglect in prevention programming in most countries and huge barriers to access to services [12]. Lesbian women face widespread ‘corrective’ sexual violence that increases their vulnerability to HIV infection [13].

In addition to the ways in which norms of masculinity encourage men to put their own and their partners’ health at risk, these same constructions of masculinity discourage men from seeking healthcare services, including HIV testing and treatment, for fear of appearing weak. Men’s reluctance to use HIV and other health services means men typically access treatment later than women, with severely compromised immune systems and advanced opportunistic infections that are difficult and costly to treat. The fact that fewer men get tested than women means that women end up bearing the brunt of the huge burden of status disclosure to men, with attendant risks of stigma and abandonment [14].

The impact of gender inequalities also manifests itself in the low value placed on services aimed at women’s health needs, or those of men and women that are seen as ‘unmanly’. This is reflected in massive neglect of services for survivors of rape and of mental health services, which results in critical gaps in both preventing HIV infections and supporting those living with HIV.

The imperative of addressing the gender dimensions of AIDS has been clearly and repeatedly articulated. This paper argues that we can no longer simply pay lip service to the urgent need to act on what we know about gender and AIDS. Simply put, it is time to act.

Gender and AIDS: who has the power?

The need to address gender in HIV programming has been clearly and repeatedly articulated for much of the past two decades. In 1992, Elizabeth Reid, then Director of UNDP’s HIV and Development Program, asserted that ‘one of the most striking features of the response to the HIV epidemic to date is how few of the policies and programs we have developed relate to women’s life situations.’ [15]. It is reasonable then to ask: why has it not been done? Who is responsible for the lack of social mobilization to address gender inequities and sexual roles and norms? The UN Secretary-General, in the report quoted above, assigns responsibility to national governments, in line with the national-level framework for leading and coordinating action on HIV/AIDS (the Three Ones) outlined by UNAIDS. Although the call for national ‘ownership’ is laudable, political will is still sorely lacking. Patriarchal values continue to characterize political cultures and systems the world over. The progress made at the conferences in Cairo and Beijing on securing international agreements on gender equity and women’s empowerment is being rolled back. This is particularly conspicuous in the resistance of the US President’s Emergency Plan for AIDS Relief (PEPFAR) to promote approaches that integrate HIV and sexual and reproductive health services, resistance to sexuality education and condom promotion for young people, and the promotion of gender-insensitive approaches to HIV prevention such as abstinence.

The past 15 years have seen considerable progress in the development of technical approaches to addressing gender dimensions of AIDS, which are critical in building the capacity to act, but failure of implementation, or lack of impact, has resulted from neglect of the political conditions that are needed to address such dimensions adequately. The literature

on gender main-streaming in development programmes emphasizes the limitations inherent in a narrowly technical view of meeting the challenge of addressing the gender dimensions of the HIV epidemic in the absence of attention to institutional cultures, policies and practices [16].

The root of this problem lies with the issue of power. Whereas gender refers to sets of social expectations and ideas about appropriate behaviours of men and women, gender differences are fundamentally underpinned by power inequalities, which result in a subordination of women and their interests in a gender order that privileges men and is organized by male power. We can acknowledge that the experience of power of individual men and women is also fundamentally shaped by a range of other life circumstances, including access to economic resources, education, age, race and geographical location, and that in some circumstances women have considerable power over men and agency, but acknowledging this does not alter the widespread reality of a gendered distribution of power that privilege men over women and heterosexual men over men with other gender identities.

To move beyond the rhetoric and actually to make a difference, the roll-out of technical approaches to addressing gender dimensions of AIDS needs to be integrally linked to a broader political project of demanding greater gender equity at all levels within a country, in a manner that is linked to broader advocacy for service delivery, social justice and human rights. Work for gender equity related to HIV/AIDS will only be successful when there is a foundation of recognition of the value and importance of social justice and respect for human rights generally, and when this does not exist it needs to be built with impact at all levels of society. Gender equity, of necessity, requires an inevitable degree of surrender of male power, and ultimately this is only achievable if support can be won on the grounds that inequity is inherently both unfair and a violation of rights. Achieving this will also require highlighting the costs of rigid norms of masculinity, and then mobilizing men around their investment in less restrictive ways of being men. For example, it will be important to draw attention to the ways in which dominant ideas of masculinity that glorify particular types of strength and risk-taking and denigrate caring are harmful to men's health and wellbeing by, for example, placing harmful psychological pressures on men by expectations that they should be successful providers at home, when very often economic and other circumstances conspire to prevent this; or by drawing attention to the pain caused to men when women they love and care for are harmed through the violent, controlling and risk-taking behaviour of other men.

It is only through support for interventions to address the political dimensions of gender that we will be able to move from a situation in which the institutional architecture of governmental and intergovernmental responses to the HIV epidemic regard gender equity as an additional concern, often embodied in the marginal figure of the gender focal point, rather than as a central foundation for any effective response. Key funders and influential governments, globally and regionally, have a critical role to play in galvanizing such political commitment by supporting initiatives to mobilize from within civil society to build gender equity, as well as ensuring that there is a vigorous civil society presence inside HIV policy machineries advocating for gender equity [17]. Such a presence and pressure is critical for the ability of civil society generally and social movements in particular, to hold governments and donors accountable for action on gender and AIDS, and to counter the active or passive resistance by programme planners and implementers to the principles of human rights and gender equality.

So what can be done to address the gender dimensions of AIDS? There is enough evidence to act now, especially in relation to community norms and gender violence, economic empowerment, access to quality education, health service delivery and the architecture of

national AIDS responses. This paper argues that there is evidence to support the integration of action on community norms and gender violence, economic empowerment, access to quality education, strengthening health services and the architecture of national AIDS responses. It makes specific recommendations for action within these areas.

Interventions at an individual and community level to change ideals of masculinity and femininity and reduce gender-based violence

Community-based work with men and boys, as well as with women and girls, which promotes new ideals of manhood based on respect for women, responsible sexual behaviour and the non-use of gender-based violence, as well as greater involvement in HIV-related caring, is essential [18,19]. There are examples of interventions with men and boys that have been evaluated and shown to be successful. A recent review of 57 of these, published by the World Health Organization, 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 [15]. A good example of this kind of intervention is the Stepping Stones programme [20], which is a participatory HIV prevention programme that aims to improve sexual health through building stronger, more gender-equitable relationships. Developed over a decade ago, it has been used in over 40 countries, adapted for 17 settings, translated into 13 languages and used with hundreds of thousands of individuals on all continents [21]. It has just been evaluated with rural youth in South Africa in a randomized controlled trial. With 2 years follow-up, Stepping Stones lowered the incidence of herpes simplex virus 2 in men and women by approximately 33%, and men reported less perpetration of intimate partner violence across 2 years of follow-up, as well as changes in several other HIV risk behaviours [22]. This is the first HIV behavioural intervention in Africa to be evaluated in a randomized trial and shown to reduce sexually transmitted infections. The evidence suggests that Stepping Stones may have been particularly effective as an HIV preventive intervention because it addressed gender norms and provided communication skills that could be used to build better relationships, which was seen as a valued outcome by both men and women. This project also highlighted the role of interventions with women and girls that empower them with relationship skills and challenge the acceptability of gender-based violence, and help them navigate a safer route between ideals of femininity predicated on subservience to men and empowered femininities that celebrate having multiple partners and engaging in transactional sex, which entail considerable risk of acquiring HIV.

Other examples of successful interventions with men can be seen in the work of Promundo with young men in Brazil, which has successfully challenged norms of masculinity that put them and their partners at risk of HIV infection. Significant shifts in gender attitudes were reported at 6 and 12 months, and those young men with more equitable attitudes were 2.4 times as likely to report using condoms with a primary partner the last time they had sex [23].

There are several examples of programmes in which condom promotion has been used as an important opportunity to educate men about sexual violence and challenge widespread misconceptions about what constitutes sexual consent. It is important to fund and replicate interventions such as Promundo's Program H Alliance [24] and Sonke Gender Justice's One Man Can campaign [25] that use condom education as a vehicle to educate and empower men to take a stand against sexual violence.

The roll-out of male circumcision presents obvious opportunities for programmes that seek to shift social ideals of manhood in a population who have indicated their willingness to change part of their embodied male identity through surgery. The debates about the impact of circumcision for HIV prevention have often been concerned with the much feared

consequence of increased risk-taking after circumcision and concerns that male circumcision has been shown to reduce HIV acquisition from women to men, but not as yet transmission from men to women [26]. These have been somewhat countered by mathematical modelling, which reminds us that any intervention that reduces transmission will have a potential general public health impact [27]. The implications for women of men thinking they have surgical protection from HIV are, however, not known and could be wide ranging, from increased risk if men were to think they do not need condoms or to reduce partner numbers, to increased blame if men assume that because they have been circumcised they should be HIV negative. Perhaps of critical importance is also the issue of missed opportunity, as changing ideals of masculinity is critical for building more gender equitable relationships and reducing gender-based violence. Circumcision roll-out presents an opportunity for such an intervention, and now is the time to seize this.

Recommendation 1: Scale up interventions that empower women and men to protect themselves against HIV by transforming harmful gender attitudes and behaviour, and challenge the acceptability of gender-based violence.

Recommendation 2: Provide interventions to transform harmful gender attitudes and behaviour as part of programming of the roll-out of male circumcision as an HIV prevention intervention and condom promotion.

Economic empowerment of women

Poverty and gender interact in devastating ways to increase vulnerability to HIV infection and the impacts of AIDS. Women produce two-thirds of the food in the developing world but own less than 15% of land worldwide [2]. In the many societies where women are denied the right to own, buy or inherit land and other economic assets, they often lose their homes, inheritance, possessions and livelihoods when their husbands die [28]. A study in Uganda found that women's lack of property and inheritance rights meant that female-headed households were more vulnerable to the impact of AIDS than male-headed counterparts [29]. When women's property and inheritance rights are upheld, women acting as heads or primary caregivers of HIV-affected households are better able to mitigate the negative economic and social consequences of AIDS [28].

There is also a growing recognition of the need for legislative and policy change securing women's rights in terms of credit access, property ownership and inheritance rights in order to reduce their vulnerability to HIV and its impacts [28,29]. This is critical as economic empowerment of women reduces their risk of HIV [30], and economic protection is important in mitigating the impact of death on widows and orphans [31]. Here concerted action by civil society has been shown to be effective. In Mozambique, in 2005, after a 10-year effort by a coalition of women's rights organizations, the President signed the new Family Law. This law transforms women's legal status within society, by recognizing their right to work outside the home without the permission of a husband or male relative, and to buy, own, and manage property or other financial assets.

It is also critical that legal and human rights education and monitoring be undertaken to ensure that women are able to claim their economic rights and that such claims are enforced by legal authorities (customary and statutory). Further investment is needed in projects such as the Rwanda Women's Network and the Justice for Widows and Orphans Project in Zambia. Both projects train community paralegals, village chiefs and members of land boards and tribunals about women's property, inheritance and legal rights, as well as helping women navigate the legal process.

Women's lack of economic rights and consequent economic dependency on men can also increase their risk of HIV infection. In Gabarone, Botswana, it was found that women's economic independence was more strongly related to women's negotiating power in their sexual relationships than any other variable explored [32]. Research from South Africa has revealed that poorer women are more likely to have experienced early sexual debut, a non-consensual first sexual encounter and higher rates of physically forced sex or having exchanged sex for money, goods, or favours – all significant risk factors for HIV. These women also had more sexual partners and were less likely to use condoms [33]. There is some research to suggest that women who have access to, ownership of and control over land and other assets are better able to avoid relationships in which they may be more vulnerable to HIV and the impact of AIDS [34].

A number of initiatives worldwide are using microfinance and skills training to improve women's access to credit and marketable skills in order to help them secure a degree of economic independence. Evidence for the effectiveness of microfinance initiatives in accomplishing this goal remains mixed, and experience suggests that for the very poor, microfinance is simply not enough, and may risk getting people into debt they cannot repay [35]. When such initiatives have been carefully designed and targeted, however, there are some indications that they can play a role in enabling female-headed households to mitigate the impacts of AIDS. World Vision has successfully combined HIV/AIDS education with the provision of microfinance to groups of 20–30 women through its community banking programmes. Evaluations found that the women showed greater economic resilience, higher levels of HIV awareness and prevention behaviours, improved educational attainment among their children, and better nutrition within their families [36].

The Microfinance for AIDS and Gender Equity (IMAGE) study, which was a randomized controlled trial of a microfinance programme combined with a behavioural intervention and community action on gender-based violence in rural South Africa showed a dramatic reduction in exposure to one HIV risk, namely intimate partner violence, which was nearly halved after 2 years [37]. For women's economic empowerment initiatives to have an impact on their vulnerability to HIV and its impacts, they must combine a range of empowerment options (including microfinance, vocational training, legal rights training, income-generating activities) with interventions on gender norms and relations and HIV risk reduction.

Recommendation 3: Promote initiatives that aim to accord women the same economic rights as men and in so doing improve women's property and inheritance rights.

Recommendation 4: Expand economic empowerment initiatives targeting women and combine them with interventions on gender norms and relations and HIV risk reduction.

Access to quality education

Research in sub-Saharan Africa and Latin America suggests that education lowers women's risk of HIV infection and the prevalence of risky sexual behaviours, and increases their ability to discuss HIV with a partner, ask for condom use, negotiate sex with a spouse or leave abusive relationships [38–44]. In a recent analysis of eight sub-Saharan countries, women with 8 or more years of schooling were less likely to have sex before the age of 18 years than women with no schooling [45]. A systematic review of educational attainment and HIV-1 infection in serial prevalence studies in developing countries found a lower HIV prevalence among people with more education in Uganda, Zambia and Thailand [46]. Education can play a crucial role in reducing women's vulnerability to gender-based violence [47,48], with particular protection found among those who have attained some form of post-school qualifications [49].

More generally, education is a cornerstone of gender equity and empowerment of women. Education provides a basis for economic empowerment, access to political power, access to information about HIV, and knowledge and ideas that can be used to change attitudes and make independent life decisions. There is also evidence that the power advantage of women's education is transmitted through generations such that children of more educated mothers are themselves relatively more empowered [50]. In many developing countries, however, the quality of education may be very variable, and life skills and sex education are still often not taught, or inappropriately focus on abstinence at the expense of other HIV risk-reduction approaches. Schools are often a setting in which sexual harassment of female students by teachers and other learners is rife [51,52]. Here too, political will is needed to ensure the provision of high quality education in a safe school environment.

Evidence points to the importance of life skills education, with a clear focus on gender and sexuality, in reducing young people's vulnerability to HIV. Providing comprehensive sexuality education can both delay sexual debut and increase the practice of safer sex [53]. A study of the effectiveness of a life skills curriculum in KwaZulu-Natal Province in South Africa found that young people exposed to such education were more likely to use condoms than those who were not. The more years they were involved in life skills education, the higher the rate of condom use [54].

Gender education for young men within the school curriculum, through initiatives such as the Better Life Options for Boys, which was implemented across 11 Indian states with over 8000 boys, has shown some promise with regard to changing harmful gender attitudes among young men that are associated with young women's HIV risk [55]. There are, however, also examples of school programmes being constrained in their ability to discuss and demonstrate key HIV prevention approaches, especially condoms [56], which have had potentially important consequences in terms of intervention effectiveness [57]. Political leadership is required to ensure the roll-out of curricula that comprehensively address sexual and reproductive health and HIV prevention, including aspects of gender and sexuality across all schooling systems. This is especially important given the failure to secure explicit international commitment to sexuality education in schools at the UNGASS +5 meeting in 2006.

Given the acknowledged relationship between violence against women and their vulnerability to HIV, investment in 'safer schools' initiatives, such as USAID's Safe Schools programme, is a clear priority. Within such work, building a general climate that is respectful of human rights is crucial and there is need for an explicit focus on gender. This should ensure that male learners and teachers not only do not perpetrate such violence, but that they get involved, as active 'bystanders', in working with young women and young men to stop the violence. Inspiring examples, such as the Safe Dates programme, which was effective in reducing dating violence within US schools, provide a foundation on which such work can be built [58].

Recommendation 5: Support initiatives to promote higher levels of educational attainment, particularly those targeting girls, and to improve the overall quality of education.

Recommendation 6: Integrate comprehensive gender and sexuality education into primary and secondary curricula, with adequate training and support for teachers and administrators.

Recommendation 7: Expand 'safer schools' initiatives.

Health service delivery

The improvement of education and health services is fundamentally hampered in many countries by the effects of structural adjustment plans imposed by the International Monetary Fund and public sector spending caps required by the World Bank, which leave them chronically short-staffed and incapable of meeting the health and educational needs of the majority of their citizens [59]. An effective response to the gender dimensions of AIDS must entail a commitment to reversing the devastating effects of structural adjustment.

The uptake of HIV services and engagement in HIV-related caring is distinctly gendered. Reports on testing and treatment uptake from many parts of the world indicate that men are underutilizing testing and treatment services [60,61]. A study of access to HAART in clinics in 13 countries found that the proportion of women accessing HAART was equal to or higher than UNAIDS estimates of the proportion of HIV-infected women in all but two centres, and women were younger than men and had less advanced HIV infection at HAART initiation [14]. Men's reluctance to get tested or to access antiretroviral therapy in a timely manner has serious implications for men's lives as well as for the lives of their partners and family members. It also places a great strain on hospitals and health systems. Efforts to increase men's use of HIV services must be a priority.

Gender roles in most societies dictate that women are the carers, and thus must bear the overwhelming burden of AIDS care within families and communities. Caring for the sick depletes household resources and reduces the time of women and girls involved in care and support to engage in other productive activities such as earning an income, securing food or going to school. This may ultimately heighten their vulnerability to HIV. Although some men and boys do perform roles as carers, there is evidence that others may be inhibited from doing more because of a fear being stigmatized as 'doing women's work' [62].

Prevention of mother-to-child transmission (PMTCT) programmes are potentially highly effective and straight-forward to deliver, and yet globally only 9% of women have access to such programmes [12]. 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 programmes 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 programmes need to be both scaled up and 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 programmes [63,64]. Promising interventions such as mothers2mothers, which train and employ new mothers to offer support to HIV-positive pregnant women should be scaled up [2,65].

Despite pervasive rape worldwide in peacetime and conflict settings, few countries have high quality services providing comprehensive healthcare after sexual assault, and few high HIV prevalence countries routinely provide post-exposure prophylaxis. Many countries have very weak laws on rape and no specialized training of staff on post-rape healthcare or appropriate service provision. The new South African law on sexual offences, which was adopted in 2007, recognizes the very wide range of circumstances in which sex is coerced, and legislates the provision of HIV post-exposure prophylaxis to survivors and the need for appropriate training for healthcare providers. All countries should be supported to develop post-sexual assault health services, with national policy, trained service providers, and the availability of medication and supplies, including post-exposure prophylaxis. Support for the development of models of service provision that enable continuity of care and psychological

treatment for posttraumatic stress disorder are critical for the effective prevention of HIV acquisition as direct and indirect consequences of rape.

Investment is also urgently needed to address the current gender gap in condom provision. There is abundant literature on the problems faced by women in negotiating condom use, and acceptability trials suggesting that women want to have access to female condoms [65]. Yet women in low and middle-income countries have virtually no access to the female condom, which remains the only woman-initiated HIV prevention method produced since the start of the HIV epidemic [66].

Many women identify their fear of being stigmatized, abandoned and experiencing violence if they test positive for HIV, but HIV testing strategies and counselling rarely address issues related to gender inequity (including coercive testing), the risk of discrimination and violence after disclosure [67]. Vezimfihlo! is a training programme for voluntary counselling and testing (VCT) counsellors developed in South Africa, which aims to equip counsellors who work in VCT settings to address gender issues and particularly gender-based violence [68]. Training programmes that address gender issues should be developed further and properly evaluated so that they can be mainstreamed into programmes training VCT counsellors in all settings.

Recommendation 8: Increase access to PMTCT programmes and promote policies and funding for PMTCT such that it can be an entry point for care for all family members living with HIV.

Recommendation 9: Ensure the provision of high quality, comprehensive post-rape healthcare, which meets survivors' mental health needs as well as increasing access to post-exposure prophylaxis.

Recommendation 10: Promote HIV testing for men and ensure that gender issues in prevention, disclosure and living positively are addressed in all training programmes for staff providing HIV-related counselling.

Gender foundations for the architecture of AIDS response

Despite the many commitments that have been made to address the gendered dimensions of the HIV epidemic, and the calls for 'taking to scale' interventions that focus on gender and AIDS, most gender transformative interventions remain small in scale and are seldom rooted in national plans.

A review of gender activities within national AIDS responses in nine Southern African countries, carried out by the Open Society Initiative for Southern Africa (OSISA) in early 2007, found that interventions that seek to address AIDS by transforming gender relations are often included within the national response as an after-thought or as the result of lobbying, rather than through planning and foresight [69]. They thus tend not to be seen as comprising 'mainstream' responses. Furthermore, the study found that groups working on gender and AIDS are often excluded from national planning processes, or are provided funding for one-off exercises, often to cater to the requests of politicians who may be under pressure 'to do something on gender'.

To some extent the failure to take gender transformative interventions to scale reflects familiar obstacles: active or passive resistance by programme planners and implementers to the principles of human rights and gender equality, difficulty turning gender analysis into concrete programmes and a lack of technical capacity to develop and implement good programmes. It is increasingly clear, however, that the architecture of national, regional and

global AIDS responses often compound the problem by excluding women's rights advocates and ignoring gender transformative interventions.

The UNAIDS and Global Fund imperatives to develop national strategic plans on HIV/AIDS hold tremendous potential for mainstreaming gender transformative approaches into national, provincial and local strategies. National plans increasingly acknowledge the gendered dimensions of AIDS and urge action. Few operationalize these directives however. Each of the structures constituting national, regional and global AIDS architecture (national AIDS councils, country coordinating mechanisms, national associations of people living with AIDS, national 'networks' of AIDS service organizations) should involve women's rights groupings and organizations working on gender. In reality many gender-focussed organizations struggle to secure funding for policy and advocacy work, and are thus unable to participate in such meetings and processes. Even those organizations that do participate often do so at the expense of their operational work; as non-governmental organizations, they often derive their funding from their ability to carry out project activities.

Gender transformative approaches must be integrated into national AIDS architecture. Women's rights organizations and organizations working with men for gender equality should be actively involved in national AIDS councils and in the development of gender guidelines for operationalizing commitments to gender equality within the 'Three Ones' framework of national AIDS responses. Such organizations should also contribute to the integration of gender transformative approaches into national AIDS plans, which must be costed and resources set aside in national and subnational budgets.

Recommendation 11: Ensure that aspects of national and global plans that relate to gender are given implementation priority and resources to see that they are translated into programmes, and that all levels of the AIDS architecture are required to report on the implementation and coverage of interventions to address gender and AIDS.

Recommendation 12: Ensure that structures of the national, regional and global AIDS architecture involve women's rights groupings and organizations working on gender, and that these have adequate resources to be able to work effectively and ensure that governments are held accountable for addressing the gender dimensions of AIDS.

To achieve the social and political mobilization on gender and AIDS called for by the UN Secretary-General, our efforts must focus on building the accountability function of civil society, including the willingness and capacity to be un-civil when needed to demand action from those in power. If we are to demand more and excuse less in relation to the gender dimensions of AIDS, we would do well to address the question posed by Mary Robinson, Patron of the International Community of Women Living with HIV/AIDS, at the Toronto AIDS Conference, when she asked: 'Who has the power?' For although donor and recipient governments have the responsibility to act, both recent history and current conditions suggest that political commitment will be unforthcoming unless pressure is brought to bear and the costs of inaction become politically untenable. They must be held accountable for their failures to act, and the power to do so rests with us.

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