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Exchange

on HIV/AIDS, sexuality and gender

> **Arumugam Kalamani, guest editor for the thematic section on:**

External HIV/AIDS mainstreaming

In this issue of *Exchange* particular attention has been paid to the issue of integration of HIV/AIDS in development programmes, especially those strengthening the livelihoods of HIV-positive individuals and affected households. The issue of mainstreaming remains a difficult one and there are many definitions. However, they all point to the general concept of evaluating an organization's (or sector's) programmes and policies in the light of HIV/AIDS: examining the impact of the pandemic on the communities they serve, re-aligning programmes and projects so as to better serve PLWHA and their families, and studying the differential effects of an organization's development work on HIV-affected and non-affected populations. In other words: it is about looking at development work through an HIV/AIDS lens. In this issue, the lessons learned of organizations in Tanzania and India have been described and some interesting programmes in Myanmar and Malawi have been highlighted.

Other issues addressed in this issue are the Senegalese solution to HIV prevention and health promotion for sex workers, and a promising intervention in Malawi in which young women tested their own ways of dealing with uninvited sexual advances by older men.

We wish you pleasant reading and welcome your comments!

Nel van Beelen
Managing editor

Arumugam Kalamani
Guest editor

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Mainstreaming of HIV/AIDS in livelihood programmes

A livelihood comprises of the capabilities, assets and activities required for people's means of living. Livelihoods can be destroyed by the impact of HIV/AIDS when economically active people succumb to the disease and die. Consequently, children drop out of school to cultivate the land and care for ill parents. This hampers the children's ability to acquire skills that could make them employable in the formal sector. To pay for medicines, hospital care or other expenses due to HIV/AIDS, a family may sell stocks of food, land or other property, farming tools, or send their sons and daughters to the city to find work.

External mainstreaming of HIV/AIDS in livelihoods programmes is a strategy aimed at reducing the impact of AIDS on communities and households. According to Sue Holden (*AIDS on the Agenda*, Oxfam 2003), external HIV/AIDS mainstreaming refers to "*adapting development and humanitarian programme work in order to take into account susceptibility to HIV transmission and vulnerability to the impacts of AIDS. The focus of external mainstreaming is on core programme work in the changing context created by AIDS.*" For development organizations, it is not simply about supporting the health sector to deliver HIV/AIDS-related outcomes, it is not about taking over specialist health-related functions, and not about changing their core functions and responsibilities. Instead it is about adapting their programming work to the changing needs of individuals and communities affected by HIV/AIDS.

Sustainable livelihoods

Sustainable livelihoods approaches (SLA) generally identify five types of household resources that can be affected: natural, physical, human, financial, and social capital (some add a sixth type: political capital.) A livelihood is sustainable when it can cope with and recover from stresses and shocks – including the ones caused by HIV/AIDS – and maintain or enhance its capabilities and resources both now and in the future, while not undermining the natural resource base. One of the ways to evaluate the impacts of HIV/AIDS on households and communities, and to address these, is to use a sustainable livelihood analysis. This analysis offers development organizations a tool for external mainstreaming of HIV/AIDS. It raises fundamental questions on the way people live, why they live that way and why and how this way of life changes.

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By applying an HIV/AIDS lens to SLA, the impacts of HIV/AIDS on livelihoods can be demonstrated and addressed.

The impacts of HIV/AIDS can be seen on the five groups of resources mentioned before:[1]

- HIV/AIDS affects *human capital* not only in terms of the health of PLWHA, but also the psychological and physical health of carers, and in terms of time and labour lost to caring from other work such as education or raising children. Particularly at the household level, gender relations are transformed. Women and children end up taking more tasks to fill labour and other gaps than it would be without HIV/AIDS.
- *Natural capital* is affected by changing and reduced land use due to household labour shortages. Natural resources close to home may be over-used; and land may be sold to cover medical expenses or burial costs. In many cultures, women lose their access to land after the death of their husbands.
- Access to *financial capital* in the form of credit is severely restricted for those affected by HIV/AIDS, as patients and their families are considered high-risk loan recipients.
- *Physical capital* – housing, community and farm infrastructure – becomes degraded in HIV/AIDS-affected communities/households due to labour shortages and priority shifts in investment. Physical capital can also be sold to pay associated expenses.
- Death and sickness erode existing social networks essential to *social capital*. Cultural and social networking through events diminishes, and may be inaccessible to those affected due to social stigma and misplaced fear of infection.

HIV/AIDS responses

Responses to the impact of HIV/AIDS on communities and households are usually limited to a small area and are short-term. Downshifts from progress that could be *developmental* to *struggle for just survival* are usually common. In the worst case, poor households fall into chronic poverty and destitution. By using an HIV/AIDS SLA, interventions can be tailored to strengthen one or more of the assets identified above (natural, physical, social, financial and human) and aim to decrease vulnerability. For instance, a *human capital* intervention in agriculture would be the introduction of less labour-intensive technologies to increase the chances of PLWHA to continue working on their land as long as possible. An example of a *financial capital* intervention is the increased use of savings and micro-credit schemes in HIV-affected communities. For instance, the UWESO Savings and Credit Union Scheme (USCS) in Uganda adapted its savings and credit scheme to the impact of HIV/AIDS, by:

> The process of exploring, building and maintaining partnerships for mainstreaming HIV/AIDS is always lengthier than one could imagine

- improved targeting and addressing specific needs of orphans and widows,
- establishment of an emergency fund,
- introduction of Children's Day where children narrate their life experiences and how they are coping with HIV/AIDS, and

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Knowledge Infrastructure with and between Counterparts (KIC)

The KIC project aims to boost dynamic knowledge sharing, collaborative learning and networking. It is an action-oriented, counterpart-driven pilot project, of which the first phase runs up to the end of 2006. Within the KIC project Oxfam International and *Exchange* are collaborating to reinforce the learning on HIV/AIDS. The following issues will be about Gender-based violence, Women living with HIV/AIDS and Sexual & Reproductive Rights Education. Oxfam counterparts are invited to write articles about lessons learned related to these topics. The articles produced in the framework of this collaboration are accompanied by an Oxfam logo in a green title box. The KIC project also has an interactive website: http://oxfam.kic.org/, which enables Oxfam counterparts to share evidenced-based practices and documents, and to participate in online communities. For questions and comments about this edition or about the project, counterparts are encouraged to use the email address aids.kic@oxfamnovib.nl.

Examples of interventions that strengthen human capital (skills, knowledge, ability to work, etc.):

- Farming schools for single women and orphans, e.g., the Farmer Field Schools project conducted by AfFOResT (African Farmers' Organic Research and Training Project) in Zimbabwe (aimed at widows and poor women farmers)[2]
- Mainstreaming HIV/AIDS in agricultural extension services, e.g., the introduction of less labour-intensive technologies and crop diversification
- Facilitation of labour exchanges among households, HIV-affected or not
- Vocational training for orphans, e.g., carpentry, nursing
- Anti-dropout programmes for vulnerable school youth

Examples of interventions that strengthen financial capital (cash and other liquid resources):

- Micro-credit schemes and savings clubs, e.g., the UWESO Savings and Credit Union Scheme (USCS) in Uganda (www.uweso.org)
- Economic support for foster families caring for AIDS orphans, e.g., by CHIN (Children in Need Network) in Zambia (www.chin.org.zm)
- Food and nutrition programmes, e.g., by the Indlunkhulu project in Swaziland: development of community fields to feed orphans and vulnerable children (www.sarpn.org.za/documents/d0001394/index.php)
- Prevention of transactional sex by economic empowerment of girls
- Health insurance schemes

Examples of interventions that strengthen social and political capital

- Advocating access to land inheritance for widows and orphans, e.g., by KANCO (Kenya AIDS NGOs Consortium, www.kanco.org)
- Prevention of property grabbing, e.g., by Africa Institutional Management Services (AIMS) in Namibia (www.aims.com.na)
- Social networks/support groups for PLWHA
- Awareness raising, care and support (promotion of positive living, etc.)

- establishing partnerships with the private sector for community insurance services.[2]

Challenges for CSOs

Some of the challenges for civil society organizations (CSOs) with regard to external mainstreaming are:

- The impact of HIV/AIDS is more evident at the micro level (individual, households) than at the macro level (district, national). CSOs should avoid the generalized approach to exploring the impact and focus instead on lower community (household and intra-household) units.
- Defining entry points for engaging in external mainstreaming of HIV/AIDS depends on context and situations, while many of us would like to have ready-made templates, which do not exist.
- Critical linkages and partnerships are not readily achieved: the process of exploring, building and maintaining partnerships for mainstreaming HIV/AIDS is always lengthier than one could imagine. These partnerships usually involve health and non-health specialist institutions. Non-health organizations should avoid reinventing the wheel, but instead work with health partners in developing health-related interventions.
- Experiences of successful external HIV/AIDS mainstreaming are still irregular and concentrated in certain regions, making it difficult to stimulate wide learning by policy makers and practitioners.
- Lack of political will in government institutions has been a critical barrier to the implementation of external mainstreaming. Both central and local government levels should take the responsibility to guide, facilitate and encourage organizations to mainstream HIV/AIDS. They can then direct information and resources to other actors to explore and build collaborations and lobby for wider adoption.

Photo: Oxfam Novib

At the projects and programmes level, the two sides of mainstreaming HIV/AIDS – internal and external – are usually complementary. It is important to emphasize that starting with internal mainstreaming, i.e., developing HIV/AIDS workplace policies and programmes,[3] can easily open doors to external mainstreaming. This is a prerequisite, since people you expect to be ambassadors for external mainstreaming should be able to understand that we all are vulnerable to becoming HIV in- and affected. Practising this thinking by personalizing HIV/AIDS within the organization and looking for coping strategies at the organizational level is a good step towards effectively coping with the impact of HIV/AIDS in the community. ■

This article was produced as part of the KIC project.

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1. J. Seeley, *Thinking with the livelihoods framework in the context of the HIV/AIDS epidemic.* Paper University of East Anglia, DEV/ODG, 2002: www.livelihoods.org/info/docs/SLFraHIV.doc
2. These examples are described, among others, in *Facing the challenge. NGO experiences of mitigating the impacts of HIV/AIDS in sub-Saharan Africa.* J. White (Ed.), Natural Resources Institute, 2002: www.nri.org/news/pdfaidsreportnov2002.pdf. For more examples, see the side-boxes.
3. See also *Exchange on HIV/AIDS, Sexuality and Gender,* No. 1, 2005: www.exchange-magazine.info

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Promising practices

Addressing HIV/AIDS in the Shire Highlands of Malawi

Photo: Martin Ryan

Article produced as part of the KIC project

Very few external mainstreaming programmes have been evaluated and well documented. One of the exceptions is the Shire Highlands Sustainable Livelihoods Programme (SHSLP), part of the Joint Oxfam Programme in Malawi. The core business of this programme is to diversify and increase agricultural production, improve soil fertility through crop selection and manure production, agro-forestry, and gaining access to markets.

With a quarter of adults being HIV-infected in the area, it was not long before the impact of HIV/AIDS became very clear to SHSLP staff and management. In response, the programme opted for a mainstreaming strategy because it believed it could serve its clients better by adapting its core business, rather than become an 'HIV/AIDS-specific' organization. This meant including issues of HIV and AIDS at all levels of programming and policy development, in order to reduce the impact on people, communities and organizations.

The first step was for SHSLP to increase levels of awareness and skills of their staff around HIV/AIDS. The programme works through government extension services and village development committees (VDCs). It starts in each village with the community assessing its problems and possible solutions, and drawing up an action plan. A VDC is then chosen, consisting of equal numbers of female and male members. Two of its members are elected to represent the interests of households that might be marginalized and left out of programme interventions.

Labour shortages

HIV and AIDS have changed households in the community. There are more chronically ill households, women are taking on untenable additional workloads, and this is making many livelihoods interventions irrelevant for a large number of people. The programme, therefore, needed to adapt its interventions to ensure they were relevant in light of such labour shortages. A number of new ideas have evolved. Most have a labour-saving element – this being one of the biggest constraints to HIV-affected households – but many have other benefits, such as improving people's nutritional status (particularly relevant for chronically sick, elderly, and young people). Some increased income security by creating a 'living bank' (livestock providing flexible financial reserves in times of emergency and serve as 'insurance' against crop failure) to rely on rather than forcing people into risky survival strategies such as migration or sex work.

As a result of these adaptations, poor farming households have seen their production of maize (their staple crop) more than tripled since adopting low-cost, environment-friendly agricultural practices. Some 3,500 vulnerable households have acquired chickens, guinea fowl, or goats through revolving loan schemes. During the 'lean' period in 2004-05, when food was scarce, villages identified some 11,000 of the most vulnerable households to receive food aid. Some children have been able to go back to school, and some chronically sick women and men have been able to work in their fields, do light work at home, or start activities to raise an income.

Community involvement

The community structures that have been established by the programme are helping to ensure that the most vulnerable members of communities are included in development activities, and are identified for support during the lean season of the year. The example set by the community volunteers has encouraged others to become involved, and has encouraged greater collaboration between traditional leaders and communities, in responding to the needs of HIV-affected people, including orphans. As of July 2005, almost 12,000 households affected by HIV/AIDS have been receiving support from local volunteers under a home-based care scheme, run by the Social Welfare Department and 27 community-based organizations. Through Oxfam's collaboration with Médecins sans Frontières, people can also be referred for counselling and treatment at health centres and clinics.

The SHSLP has had some success at mainstreaming HIV/AIDS into its core development work. The use of a mainstreaming strategy has helped the rural livelihoods programme take a critical look at its work from an HIV/AIDS viewpoint, and resulted in change at every level from personnel policies to programme activities. ■

A larger version of this article – including some lessons learned – can be found on our website: www.exchange-magazine.info.

More information:

- Factsheet SHSLP: www.oxfam.org.uk/what_we_do/issues/hivaids/downloads/malawi_bangkok.pdf
- July 2005 Programme Impact Report of Oxfam Great Britain: www.oxfam.org.uk/what_we_do/issues/evaluation/downloads/pir_2005.pdf
- E-mail: info@oxfam.org.uk

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Igogo, an unplanned settlement at the shores of Lake Victoria, Mwanza
Photo: Daan Van Tassel

Working with resource-poor urban communities in Mwanza City, Tanzania

Experiences on external HIV/AIDS mainstreaming

Article produced as part of the KIC project

Datus Paul Ng'wanangwa

About 74% of the population in Mwanza City in North-western Tanzania lives in informal settlements. The unplanned settlements of Ilemela and Pasiansi wards are characterized by high population density, lack of basic social services and generally poor infrastructure. The Mwanza Urban Livelihood Programme of ACORD (Agency for Co-operation and Research in Development) started working with resource-poor urban households in the unplanned areas in 1999, through interventions focusing on increasing community access to micro-finance services, environmental sanitation and education, and on HIV/AIDS and gender issues.

The programme especially targets poor female-headed households. It supports women in formulation of women's groups to access micro credit, or providing home-based care and support to people living with HIV/AIDS (PLWHAs) and families affected by the pandemic. Some women were trained to become community facilitators – on hygiene education, HIV/AIDS awareness, etc. and two women were trained as local artisans who also provide hygiene education. Further, the project supports community members in the formulation of Gender Action Groups (consisting of three women and two men) with the aim to improve gender relations and fight discrimination and abuse of women.

After a participatory mid-term review conducted in 2001, local stakeholders including local government, civil society organizations and poor community members recommended that households affected by HIV/AIDS should be targeted and supported better by the programme. It was felt that especially the micro-finance and environmental sanitation interventions should be examined, so as to ensure they respond to the changing needs of households due to HIV/AIDS and its impact.

The reviewed programme emphasized that the interventions should target individuals (especially women) and households affected by HIV/AIDS in a focused manner, to improve their economic and health conditions. The idea behind this was to ensure that households affected by HIV/AIDS benefit from micro credit and better sanitation. Resource-poor PLWHAs have almost no opportunity to access credit from traditional sources and households with poor sanitation are often affected by waterborne diseases, bringing about medication costs.

The *Hisa* system

In order to ensure that the existing micro-finance programme benefits PLWHAs or households affected by HIV/AIDS, the *Hisa* system (a Swahili word literally meaning share system) was introduced. It involves the formation of a group of 10 to 25 people whereby each member is required to buy shares. The interest from the deposited money is loaned to account owners. Each group has its own range of shares to be bought; generally, shares are between TZS 2,000-5,000 each (USD 1.70-4.20). Shares are sold during the weekly group meetings. Initially, the Hisa groups were trained by ACORD in collaboration with CARE International on business management, group cohesion, management of financial schemes, household budgeting and strategies for coping with HIV/AIDS. Currently, ACORD provides training and monitoring to 10 groups running a share scheme.

Through the share system, a support group connected to Tanzanian Women Living with HIV/AIDS (TAWOLIHA) emerged. The group became an outstanding example in advocating for women's rights, particularly access to quality social and economic support services.

The latrine project

The environmental sanitation programme supported poor urban households, especially those affected by HIV/AIDS, through provision of non-locally available materials such as cement, corrugated iron sheets, wire mesh, iron bars and paint for construction of low-cost latrines. The supported households provided labour and locally available materials such as sand and stones. Twenty four local artisans were identified and trained on construction of double vault latrines and facilitation skills on hygienic practices to prevent outbreaks of

Resources
on external mainstreaming

Mainstreaming HIV/AIDS in development and humanitarian programmes
S. Holden, Oxfam, 2004 (135 p.)

Mainstreaming HIV/AIDS in development and humanitarian programmes is a shorter and simpler version of the book *AIDS on the agenda* (Oxfam 2003, 256 p.). It aims to make the idea and practice of mainstreaming accessible to those involved in development and humanitarian work.

www.oxfam.org.uk/what_we_do/resources/downloads/mhivaids.pdf
hardcopy: oxfam@bebc.co.uk (£8.50)

HIV/AIDS and agriculture: impacts and responses
Case studies from Namibia, Uganda and Zambia
IP/FAO, 2003 (36 p.)

This report summarizes three case studies from Uganda, Zambia and Namibia. In addition to illustrating how different aspects of the epidemic impact rural livelihoods, the report also looks at the implications of the epidemic on the policy environment.

ftp://ftp.fao.org/sd/SDW/SDWW/ip_summary_2003-webversion.pdf

cholera and diarrhoeal diseases. Some of the latrines were for households affected by HIV/AIDS and some were given to elderly women.

Through focus group discussions and reports from street health workers and the health unit it was noted that improved hygienic conditions in the unplanned settlements led to a reduction of reported cholera and diarrhoeal cases, especially among PLWHAs and households affected by HIV/AIDS. The reduction of cholera and diarrhoeal cases thus relieved affected households, as well as others, of the burden of care and medical costs.

Lessons learned

We have identified some key lessons learned from both interventions. First, the *Hisa* scheme improved the economic status of individuals and households affected by HIV/AIDS. The micro-finance scheme made a significant shift in economic well-being and social status of individuals and households affected by HIV/AIDS from being dependent to self reliant.

Some fifty households reported to have improved their situation – affording to pay school fees, medical costs, maintain a balanced diet, and create savings, reducing their dependence on relatives and friends: *"Prior to joining ACORD's micro-finance scheme, I used to depend on economic support from relatives and friends who used to tease me and nicknamed me 'omba omba' (literally meaning a beggar). Through the Hisa system, I am now self-reliant, healthy and able to support my children."* (Mary Joseph, TAWOLIHA member, 2004)

We believe that the involvement of individuals and households affected by HIV/AIDS in shaping interventions contributed to the identification of appropriate coping strategies in their communities. The individuals identified their needs, came up with their own solutions and participated in decision-making and monitoring processes. We also found that the participation of PLWHAs and affected households in interventions aiming at improving their social and economic well-being contributes to the reduction of stigmatization (as well as self-stigma) and discrimination. For instance, households that constructed low-cost latrines or participated in micro-finance schemes made their neighbours realize that PLWHAs or households affected by the epidemic have rights to access socio-economic support. Initially, PLWHAs and their families were stigmatized and discriminated. We believe that the programmes instil confidence in the community members that PLWHAs are human beings and need to be supported. However, such interventions should be complemented by raising awareness at community and household levels on impacts of HIV/AIDS and ensuring that one's social status is upheld through coaching and mentoring, and use of participatory approaches.

Finally, the interventions contributed towards improving gender relations, especially in families where a woman was diagnosed HIV positive. Due to cultural factors, women are not held in high esteem by men – decision making in the household or in the community is male-centred. Through the trained Gender Action Groups, the project has contributed towards building better relationships among men and women. It was learnt that women who participated in the programme contributed to the household livelihood strategies, improving their social status in the process. On the other hand, self-esteem and confidence among women in mixed groups greatly improved to an extent that women aspired to leadership positions in the groups. ■

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Shattered dreams – Sriramulu's story

Photo: Annelies van Brink

Article produced as part of the KIC project

I was born to illiterate parents at Koulepalli village in Anantapur district, India, in 1969 and I am the youngest of five siblings. My parents were agricultural labourers. All my family members, except me, are illiterate. When my father died in 1985 aged 55, the burden of providing for the family fell on my mother's shoulders.

When I was young, I migrated to the nearest city and found a job as a cycle-rickshaw puller, and later as an auto-rickshaw driver. I owned the rickshaw. Unfortunately, in the first half of 1997, my auto rickshaw ran over a boy causing him serious multiple injuries. I sold my rickshaw to pay for the boy's hospitalization expenses. After the incident, I did not want to stay in the city and returned back to my native village.

Back in the village, my family forced me to marry Rajeswari, an illiterate 12-year old girl closely related to my family. At the time of our marriage, I was jobless and had no source of income. However, the parents of the bride and my relatives were hopeful that my skills in driving auto rickshaws would enable me to get a job.

Quarantined

My wife and I spent a pleasant marital life for almost a year. I was totally dependent upon my mother's earnings. When doctors disclosed to me in 1999 that I had tested positive for HIV, I did not even have a faint idea of what it meant. The only thing I knew was that HIV/AIDS was a fatal disease. I had never imagined that I could be infected with HIV.

I did not disclose my HIV status to anyone, not even my pregnant wife. Instead, I told my family and neighbours that I was suffering from acute tuberculosis. About one year later, my relatives found out about my HIV status during a medical check-up in Tirupati government hospital. When I returned to my village, I was quarantined along with my wife and newborn son, in a house in the outskirts of the village. When the villagers inquired about our health condition, my family told them that doctors at Tirupati hospital had advised them to keep us in isolation so as not to infect people with TB.

Drastic changes

Currently, I am unable to work. At one point, I even had to beg for money so that I could go to Tirupati for treatment. I am now totally dependent on my wife's earnings for everything, including food and medication. My wife

> "When I was unable to pay the rent for five months, the landlord sold off all our belongings and threw us out of his house"

earns a paltry sum of Rs 150 (USD 3.40) a week. My in-laws are also poor and unable to provide for my family. They think that I have TB and I am on the verge of dying. They are illiterate and ignorant about HIV/AIDS.

I have no resources. When I was unable to pay the rent for five months, the landlord sold off all our belongings and threw us out of his house. When I requested accommodation from my mother, she gave me one room and then moved to Hyderabad to live with my sister. I visited my sisters to request some kitchen utensils. But I was shocked when I was rudely told not to visit them again as they "*consider me to be dead*". They even refused to touch me. It is as if I do not have a family any more. All my family members have rejected me.

I have experienced drastic changes in my life since I contracted HIV. It is a story of, as it were – from grace to grass! After being a high-earning auto-rickshaw driver, I have been reduced to a mere beggar. ■

This case study was compiled by CWS (Centre for World Solidarity), India (see the article on the next page).

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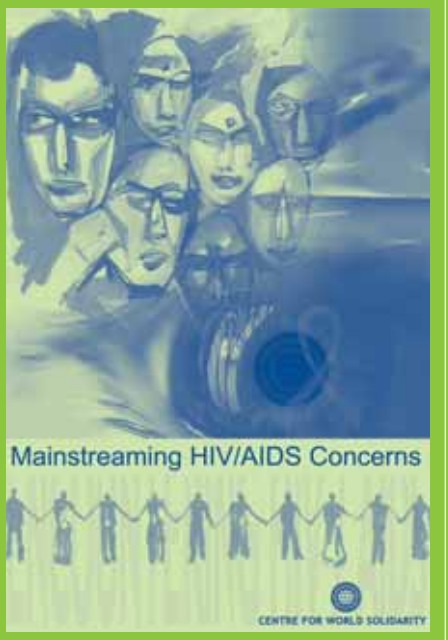

Starting HIV/AIDS mainstreaming in Andhra Pradesh, India

The case of Centre for World Solidarity

Article produced as part of the KIC project

Arumugam Kalamani

India has an estimated 5.1 million people living with HIV/AIDS (PLWHA). The burden of AIDS cases is beginning to be felt in the states that were affected first. HIV is a generalized epidemic in seven states, among which Andhra Pradesh (AP) is second-most affected. The state is in the southeast of the country with a population of 76.2 million and has one of the fastest growing HIV/AIDS prevalence rates in the sub-continent. Its antenatal care rate was 2% in 2004 and the National AIDS Control Organization (NACO) estimated that there were around 568,000 PLWHA in the state. Eighty-eight percent of the infections occur through sexual transmission.

HIV/AIDS thus is a growing concern for AP. The AP State AIDS Control Society (APSACS) is working across the state in controlling the epidemic and caring for the infected. Despite best efforts and scale up of operations, the epidemic continues to grow. There is a need to step up efforts and increase the sense of urgency in addressing the problem. Many development agencies are working flat out to combat HIV/AIDS in the state. One of them is Centre for World Solidarity (CWS). We are currently facilitating various development programmes to empower the vulnerable rural communities, particularly women, dalits ('untouchables'), tribal people and other minorities, through 300 grassroots NGOs in the states of AP, Bihar, Orissa, Jharkhand and Tamil Nadu. Our partners at the grassroots are provided with skills, perspective and financial resources to empower the rural communities to assert their socio-economic and political rights.

Photo: Oxfam Novib

The organization is driven by the belief that HIV/AIDS – being a development problem and not just a health issue – should not be addressed only by (health) specialists or scientists but should be treated as a cross-cutting issue to be tackled through development programmes. There is an urgent need to start mainstreaming efforts so that the spread of HIV can be curtailed and the associated stigma and discrimination minimized.

Internal and external mainstreaming

With this belief, CWS initiated mainstreaming processes with the support of our board and partners. The process started with an internal mainstreaming effort, comprising orientations on HIV/AIDS for CWS staff, workshops, circulation of materials, development of a workplace policy, and documentation of case studies of PLWHAs from the general population to understand the dimensions related to development and human rights (see the story of Sriramulu on p. 7).

Simultaneously, the external mainstreaming process started through a partnership and collaboration with APSACS. We felt it was important to work with, and stimulate, the government to create an enabling environment for external mainstreaming. APSACS was also keen to collaborate since it believed that CWS would be able to reach out to the general population.

The process began at the end of 2004 when a comprehensive list of questions was sent to partners in AP with the aim of understanding the status of HIV/AIDS. It was clear from the responses that the HIV/AIDS situation was grave and needed to be addressed urgently. With funding through APSACS the following project was implemented:

As a first step, 196 staff (63% women) from 56 grassroots NGOs were trained as master trainers for 19 districts. They are now resource persons at the

Lessons learned

- It is necessary to sensitize the government and other stakeholders on the need to mainstream HIV/AIDS externally.
- Specific interventions are needed to create community care and support systems through development programmes, particularly at grassroots level.
- It is of great importance to create an infrastructure that concurrently develops health-care networks, education programmes, improvement of the livelihoods base for marginalized people, and community participation.

(sub)district level in government and NGOs programmes. These master trainers identified and trained 5828 (51% women) village level resource persons (VRPs) in some 3200 villages and informal settlements on HIV/AIDS awareness, prevention, care and treatment and provided them with training materials. These VRPs are leaders and members of community-based organizations (CBOs) and youth groups.

Lastly, around 1,760,000 people consisting of women (53%), adolescent girls (13%), men and youth (34%) were sensitized on HIV/AIDS through group discussions, cultural programmes, audio and video cassettes. Appropriate resource materials including numerous pictorials were also circulated to the communities.

The VRPs are now the focal persons in the villages whom the communities could approach for further information and inputs. The government has started setting up AASHA[1] information centres for referral services either with the local governments, CBOs or youth groups in the villages, considering the VRPs as an important resource.

After the training, awareness programmes and the AASHA campaign, many people started enquiring about the availability of care and support services such as counselling and testing centres, antiretroviral therapy clinics, hospitals that provide free medication, institutional services for PLWHA and shelters for orphans. Many children who are either orphans or partial orphans were identified. Currently, we are establishing partnerships with care and treatment providers to extend support to people infected and affected by HIV/AIDS.

New projects

Recently, CWS identified two grassroots NGOs, Society for Women's Awareness and Rural Development (SWARD) and Modern Architects for Rural India (MARI), in Telangana region of AP. As a pilot, both organizations will support mainstreaming processes in two villages each, in which the focus will be on livelihood support for PLWHA and affected families. Another project focuses on mainstreaming of HIV/AIDS through local organizations in post-Tsunami rehabilitation programmes in the states of Tamil Nadu and AP. These states were devastated by the Tsunami in December 2004. Victims of the Tsunami are vulnerable to diseases, poor nutrition and unhealthy living conditions. Further, the relief and rehabilitation work in Tsunami-hit areas has brought in different people from different cultures, which may aggravate HIV infection. Over one year after the flood, the Tsunami response has now moved from the immediate humanitarian relief response to the developmental phase, which creates new opportunities for mainstreaming of HIV/AIDS in existing and new development programmes.

Some lessons learned from our programmes are:

- Continuous and constant efforts are needed to reach out to different stakeholders. Each department or programme of government/non-governmental organizations and private sectors need to mainstream HIV/AIDS concerns and plan accordingly. Collaborations and linkages are necessary between government, civil society organizations, religious groups, political parties, etc.
- Apart from strengthening the public health system, specific interventions are needed to create community care and support systems through development programmes, particularly at grassroots level.
- Medical care and treatment is still inadequate for poor communities. Appropriate mechanisms are necessary to bring the private health sector to address HIV/AIDS with accountability.
- Poor marginalized groups, and particularly women and girls, are more vulnerable to HIV/AIDS due to increasing poverty and diminishing livelihoods. Focused interventions are required to address the issues related to migration and poverty.
- One of the keys to successfully combating the HIV/AIDS epidemic is the creation of an infrastructure that concurrently develops health-care networks, education programmes, improvement of the livelihoods base for marginalized people, and community participation.

Mainstreaming efforts are gaining momentum in India and CWS is lobbying the state governments for mainstreaming efforts to be initiated by both government and private sectors. The mainstreaming process initiated by CWS and our partners is being reviewed on a monthly basis to assess the impact of HIV/AIDS on the communities and to work out strategies to maximize the interventions towards effective external mainstreaming. However we realize we have taken only a first step and that there is still a long way to go… ■

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1. AASHA was the government-initiated month-long intensive campaign in AP to create 100% awareness in the entire state on HIV/AIDS, in July 2005. The campaign was undertaken in collaboration with NGOs, CBOs, media, private sector, local governments, etc.

Reframing and addressing cross-generational relationships in Malawi

Amy Weissman, Janine Cocker, Lisa Sherburne et al.

Intergenerational relationships between an older man ('Sugar Daddy') and a girl are quite common in Malawi
Photo: Mick Yates

In 2002, the Malawi National AIDS Commission estimated that there were higher rates of HIV infections among young women than young men. The relationship between HIV prevalence and the practice of cross-generational sex in sub-Saharan Africa is well documented.[1] Through discussions with young women, Save the Children (SC) Malawi too identified cross-generational relationships as a critical mode of HIV transmission. A cross-generational relationship is defined as a non-marital sexual relationship between an adult and a young person, with an age difference of at least 10 years.

As the issue of cross-generational relationships was gaining momentum and being framed as a 'problem' by the international community, SC/Malawi raised a number of questions:

- Are these relationships inherently negative and/or what about them is negative?
- Is it the size of the age difference and/or the age of the individuals that is important?

SC realized that certain assumptions would guide a response. First, young people do not always have the power to use the behaviours they know are protective; therefore, a norm where protective practices are allowed must be created. Second, young people are the keepers of the issue definition and solution. Learning from them in each context will ensure effective responses. Third, public dialogue and peer pressure can create demand for change, and finally, although economic resources can come into play, there are other gains to consider. These questions and assumptions, among others, led SC to reframe the issue of cross-generational sex.

The Continuum of Volition

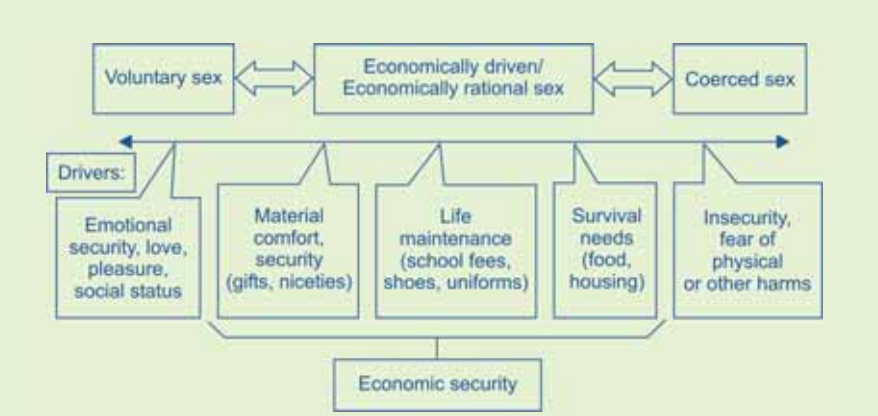
SC views the drivers of cross-generational relationships along a 'Continuum of Volition' – from emotional security, financial security, survival security, to coercion. This suggests that not all young people may be vulnerable and/or passive. Some empowered youth choose to engage in relationships for 'security gains', whether they be emotional or economic. Moving further along the continuum is 'economically rational sex', which is neither strictly voluntary nor involuntary and ranges from sex for 'desired things' to survival. On the far right is coerced sex.

Various drivers require different responses. For instance, if a young person is voluntarily in a relationship, an appropriate response is to make that relationship safe. Alternatively, if a young person is forced into a relationship, an appropriate response is to ensure protection.

In 2003, SC/Malawi applied the continuum to develop programme responses, beginning with a series of eight focus group discussions with 10 to 12 young women between the ages of 14 and 17 and six groups of men, half from Lake Malawi's shore and half from upland areas. Young women revealed that more than half of unmarried peers have cross-generational relationships. They believed that the primary reason is to receive cash or gifts for desired things, although some young women need these relationships for survival, while others engage in them for pleasure, due to peer pressure or force. All felt that the relationships are shameful and asked for alternatives and support. Participants validated the Continuum of Volition, created a programme planning tool and identified potential programmatic strategies during the focus group discussions.

Young women tested their ideas through Trials of Improved Practices (TIPs), a research tool developed by the Manoff Group to help programme planners select and pretest the actual practices that the programme will promote. The young women met individually with a youth researcher and

Programme planning tool		Driving motivation			
		Emotional security	Economically driven/ desired things	Economic and physical survival	Coercion (due to insecurity)
Programmatic options	Emotional support/ praise for refusals	X	X		
	Training in alternative income generation	X	X	X	
	Life skills education	X	X		X
	Parental/elder support and communication	X	X		X
	Community protection and reporting system		X		X



The Continuum of Volition

agreed on what they would try. The researcher returned after several weeks to explore young women's experiences and recommendations. Three programmatic options were selected:

- *Self-praise* (Table row 1): Fifteen young women tested the idea to praise themselves each time they refused a man by completing one of the smiley face drawings on a sheet of paper. After three weeks, all but one young woman reported that multiple older men had made advances to them and that they refused each proposal and praised themselves. They reported no problems and liked the tool. As one stated: "*Refusing older men is easy because now I know what to say and I have learned that I can do anything, even refuse these people*."
- *Training in business skills* (Table row 2): Fifteen young women participated in a two-day training on selecting a small business, managing it and saving money, with a life-skills component on values clarification and goal-setting. Participants reported understanding most of the content, liking the training, and knowing what they would do to start their own business. One 17-year-old woman described her reaction: "*I have been given a light to illuminate a new path which would make things work for me in my life and avoid other things like unnecessary relationships.*"
- *Community Auntie* (Table row 4): Fourteen young women tested the idea of seeking support from a 'Community Auntie'. The young women identified a woman in each community known for her kindness and interest in protecting young women. After three weeks, only the four youngest participants had visited the aunties. These young women reported each proposition to the aunties. One explained: "*Before, men's intimidation made me unable to refuse, but now the auntie gives me confidence to enable me to refuse the men*." The aunties provided counselling and confronted the men. The older girls did not feel comfortable visiting the aunties because they felt old enough to make their own decisions.

Lessons learned

- Taking into account differences in motivations of young women to become involved with older men helps to develop appropriate choice of interventions for young women with different needs.
- Exploring what aspects of cross-generational relationships are of concern and understanding the choices (or lack thereof) that young women have, may be a better approach than just fighting this type of relationships.
- Intensive community mobilization is needed to create sanctions and support male leaders to positively influence their peers.

Addressing cross-generational relationships

The Continuum of Volition assisted young women to respond to cross-generational relationships on their own terms. Some of SC's youth programmes in Malawi will implement the self-praise tool and the small business training with life skills, as well as the community aunties component for younger women in two rural districts reaching more than 100,000 young women. One major challenge is the lack of community leader commitment (row 5 in the Table). Intensive community mobilization is therefore needed to create sanctions and support male leaders to positively influence their peers. Plans are underway to develop effective community mobilization activities.

Although the growing disparity in HIV infection rates between young women and men in sub-Saharan Africa is of great concern, SC hesitates to define cross-generational relationships, a key driver of this disparity, as a problem. Rather, SC proposes exploring what aspects are of concern and understanding the choices (or lack thereof) that young women have and, moreover, addressing inequality within the socio-economic context. ■

Amy Weissman, Janine Cocker, Lisa Sherburne, Mary Beth Powers, Ronnie Lovich and Mary Mukaka

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1. N. Luke & K. Kurz, *Cross-generational and transactional sexual relations in sub-Saharan Africa: Prevalence of behaviour and implications for negotiating safer sexual practices.* ICRW, 2002 (48 p.): www.icrw.org/docs/CrossGenSex_Report_902.pdf

The Trishaw Club: pedalling against HIV/AIDS in Myanmar

Naw Dora Tha

A trishaw is a slow vehicle with three wheels which Burmese people mainly use for short distance transport. It is cheaper compared to other public transport. It is also convenient in carrying goods in the narrow lanes where cars cannot manoeuvre. Trishaws are a common feature and can be easily spotted parked together at termini, stations or markets ready for passengers. They are operated by pedallers who rent them for a fee from the owners. A business called *The Trishaw Club* was established for people living with HIV/AIDS (PLWHA) in Myanmar under the auspices of the Myanmar Council of Churches (MCC).

The idea was born in early 2003 when a Norwegian Church Aid (NCA) team – one of the donor agencies of MCC – met one PLWHA who earned a living by riding trishaws and realized that trishaw rental might be an ideal income-generation programme to support its existing PLWHA project. NCA later discussed the issue with MCC with the aim of establishing this new project. The broader objective of the project is to provide materials and technical assistance and gradually strengthening the financial security of the target group – vulnerable PLWHA who cannot find any job for a living – by means of income-generating activities.

Before the start of the project, a needs assessment was done and information was gathered on the need for a trishaw business. The project is managed by local church committees, which select vulnerable PLWHA, some of them widows, to become trishaw 'owners'. The trishaw pedallers are all HIV-negative people who work for the HIV-positive owners. Each committee meets every three months and is attended by the committee members, trishaw owners and sometimes pedallers.

Using pedallers as peer educators

One requirement is that trishaw pedallers should be in good health as their work is physically demanding. They work under conditions that expose them to factors that can lead to ill health. The pedallers are trained by the committees and the owners to become HIV/AIDS peer educators. They are expected to initiate discussions with their clients by distributing IEC materials. Their trishaws are also decorated with HIV/AIDS stickers and sometimes they wear T-shirts or hats with HIV/AIDS messages. The initiative therefore benefits pedallers as well as trishaw users. It is an income earner for the pedallers and the owners, while it is an avenue for trishaw users to access information on HIV/AIDS.

> "Before, I couldn't find any job and wasn't in good health to be an employee. My life is better since I have a regular income through the trishaw"

On average, each trishaw is shared by two families, the HIV-positive owner and his/her family and the pedaller and his family. The pedallers pay a daily rental fee, which is collected by the Trishaw Club. The club keeps 40% of the income and gives the rest to the owners. The 40% is kept as a saving fund to cover PLWHA's future needs. For instance, the PLWHA can take a loan to start a home business or buy a trishaw and become a real owner. Also, health expenses, children's education and other emergency needs can be paid from the fund.

Strengthening the livelihoods of former drug users

In May 2003 this small project was implemented in Myitkyina, the capital of Kachin State – located in the northernmost part of the country – starting with five trishaws. The choice of the location was based on the high HIV infection rate. Myitkyina has a big population of immigrants who move to the city with the aim of making a living. The high rate of infection can be partly attributed to the use of injecting drugs, which is often done via needle sharing. The majority of drug addicts are males who are sexually active. Most immigrants get infected while in Myitkyina and later infect their spouses when they return to their homes.

Partly as a result of this, there are many HIV-positive pregnant women and widows in Kachin State. The number of children orphaned by AIDS is on the increase. Given this background, it was imperative to start the project in Myitkyina in order to address the needs of PLWHA and their families. Almost all of the male beneficiaries (trishaw owners) in Myitkyina are former drug users. More importantly, awareness is raised on the current HIV/AIDS situation in the community by using the trishaw pedallers.

After initiation, the project got a boost with funds from Norway which enabled it to expand in the capital, Yangon, particularly in Oakkalapa Township. This area was selected because it mainly depends on trishaw transportation and the demand from PLWHA for less demanding work was high. Yangon area also formed a committee which became responsible for the supervision of the project activities.

Economic and mental security

The fruits of the project include PLWHA improving their lives through regular income earning, as one Yangon trishaw owner who is living with HIV/AIDS expressed:

"Thanks to the donors and related organizations for providing this trishaw to me. Before, I couldn't find any job and wasn't in good health to be an employee. My life is better since I have a regular income through the trishaw."

The project is also beneficial for the pedallers in several ways, including social and economic benefits and the opportunity for pedallers to receive education on HIV/AIDS. A grateful trishaw pedaller in Myitkyina stated: "*Compared to other trishaw owners, renting a trishaw from the PLWHA project is convenient as I need to pay less fees compared to others who rent them out. It is easy to communicate with the club members as well. They are very kind and understanding. I'm also glad that I'm part of the fight against HIV/AIDS*."

Overall, the income-generating project has been successful except for some minor challenges regarding acquisition of licenses for the trishaws. However, this was overcome. This project has contributed immensely towards the economic improvement of the PLWHA who have been participating. It has also brought about mental security for its beneficiaries. This initiative, although small in scope, has changed the lives of PLWHA for the better and can be easily replicated to benefit other impoverished PLWHA in other areas. Such initiatives can be made sustainable through injection of further funds.■

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Some websites on poverty, livelihoods, food insecurity and HIV/AIDS

- Southern African Regional Poverty Network HIV/AIDS page: www.sarpn.org.za/rpp/hiv.php
- Livelihoods Connect: www.livelihoods.org
- DFID Key Sheets for Sustainable Livelihoods: www.keysheets.org/red_21_hiv_and_development.html
- Eldis HIV and AIDS and livelihoods pages: www.eldis.org/hivaids/livelihoods.htm

- FAO HIV/AIDS Programme fact sheets: www.fao.org/waicent/faoinfo/sustdev/dim_pe3/pe3_041201_en.htm

- KIT Special HIV/AIDS & Livelihoods: www.kit.nl/specials/html/al_aids___livelihoods.asp
- International Food Policy Research Institute: www.ifpri.org/themes/hiv/hiv.htm

Senegal's success in containing HIV lies in its mobilization of people at all levels in addressing the issue
Photo: Gianni Fornara

Taking a step towards prevention

Senegal's policy of legalizing the sex trade

Nazaneen Homaifar

TIn 1969 – many years before the identification of the first AIDS cases in the world – Senegal implemented a law to curb the spread of potentially dangerous sexually transmitted infections (STIs) by making routine and legal the registration of sex workers. The landmark governmental programme was designed to address widespread transmission of STIs, which the government attributed to extramarital sex. The effort led to the creation of the National Bureau for the Fight against STDs (Bureau National de la Lutte Contre les MST) and the construction of several STI treatment centres in different regions of the country.

This law institutionalized the medical follow-up and examination of self-identified female sex workers who are encouraged to enrol with a health service centre in their region. The law was amended in 1979 to prohibit registration of women under the age of 21. All registered sex workers are required to visit their regional treatment centre to receive monthly check-ups that include a vaginal examination, laboratory tests, counselling, condom delivery, and education on STIs and contraception. The programme even extends health and dental benefits to the children of sex workers who comply with the registry.

Presently, Senegal has one of the lowest rates of HIV/AIDS in Africa. A 2004 fact sheet disseminated by UNAIDS, reported a 0.8% HIV prevalence rate among adults. Senegal's success in containing HIV lies in its early response to the disease which included vigorous preventative action, care of people with AIDS, and most importantly, the mobilization of people at all levels, including teachers, soldiers, women, religious leaders, and NGOs in addressing the issue. A 1999 UNAIDS publication, *Acting early to prevent AIDS: the case of Senegal*, stresses three major factors as directly contributing to low levels of HIV transmission: sexual activity begins relatively late and extramarital sex is relatively limited; condom use during extramarital sex, especially during commercial sex, is high; and STI control programmes are well established and proven to be quite effective.

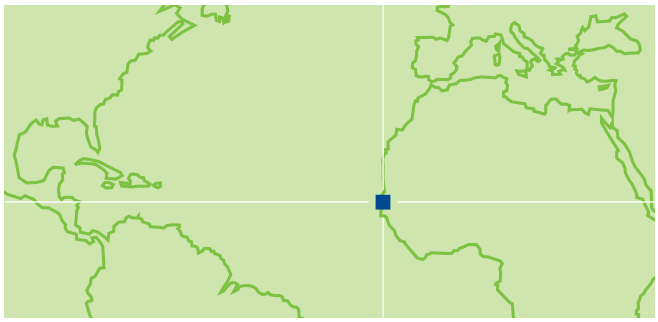
Political leadership

Although traditional and cultural norms have played a role, the Senegalese government can be credited for much of the success in keeping infection rates low. Having channelled most of the limited resources towards prevention and primary health care programmes, the government has expanded family planning services and established STI control programmes around the country while promoting safe motherhood, health education, blood transfusion safety, and contraceptive use.

At the same time, the political leadership has helped establish the foundation for an open and productive dialogue with religious and other community leaders. Since the initiation of the STI programmes, government officials and Islamic and Christian leaders (who hold integral positions in Senegalese society) have agreed to allow more open discussion about sexual behaviour and its possible effect on HIV infection. Government and religious leaders have fostered an environment conducive to addressing the concern of HIV/AIDS in the society (over 95% of the population is Muslim). Community involvement takes various forms such as peer education programmes or focus group discussions among women's organizations and has been central to HIV/AIDS education and prevention.

Sex workers

The identification of sex workers from the onset as both a vulnerable and high-risk group in contracting and transmitting HIV and the



consequent public health intervention implemented through the protocol for registration gave Senegal a significant advantage over other countries when formulating HIV prevention programmes. The prevalence of HIV-1 among sex workers in Dakar increased rapidly from 0.1% in 1986 to more than 10% in 1994 and 19% in 1997. However, in 1998, it declined to 6% and has been steady at 19% since 2001. About 20% prevalence rate is common among sex workers in different regions of the country. Whether or not the Senegalese registration programme reduced HIV transmission, it has significantly prevented a far worse scenario of the epidemic as evidenced in other African nations. In fact, a 2002 WHO Surveillance Update found that among female sex workers in selected countries in sub-Saharan Africa, sex workers in Dakar, Senegal had the lowest HIV prevalence (19%) compared to women in the Democratic Republic of Congo (23% in Kinshasa), Tanzania (26% in Moshi), Angola (33% in Luanda), and Guinea (42% in Conakry). In Angola, Tanzania, and Congo, there is no existing policy legalizing the sex trade.

> Until health inequalities and matters of poverty are addressed directly, we cannot expect a decline in numbers of women who work in the sex trade and the prevalence of infectious diseases

Two recent studies conducted on registered and unregistered sex workers in Dakar have raised some eyebrows over the effectiveness and benefit of Senegal's policy.[1-2] While some may regard the data as an opportunity to criticize the country's public health intervention programme, I believe it sheds light on opportunities to improve the current model of prevention targeting sex workers in the city. Among others, the studies found that compared with recent data on registered female sex workers in Dakar, the HIV seroprevalence was significantly lower in unregistered workers (19% among registered versus 10% among unregistered). However, researchers hold the view that lower HIV seroprevalence could be attributed to lower exposure, as the unregistered workers had spent a shorter time in prostitution (mean 3.3 years versus 5.8 years for registered workers) and fewer clients (mean 1.8 versus 5.0 per week), which were counterbalanced by higher condom use among registered women (84% versus 65%). Among reasons given for non-registration, a majority of women cited ignorance of the legal system and its procedures, postponement of registration, and lack of identity papers. Moreover, many young women in the clandestine sex trade do not meet the legal age for registration and are consequently denied access to specific clinical, educational, and preventative services.

Some recommendations

The Senegalese government must allocate resources to educate its population about the availability and accessibility of its public health programme – specifically that designed for sex workers. Furthermore, the legal age for registration should be lowered so as to include younger women who might turn to the profession. Since many sex workers will continue to remain unregistered, the government must devise alternative methods or create venues for the provision of basic medical services, education, and contraception to such women who are at risk.

For a vast majority of women not coerced into prostitution, as in the case of trafficking, engagement in the sex trade is largely due to poverty and economic instability. Many women, who are breadwinners for their families, turn to the sex trade when there is no viable alternative to meeting basic needs such as food, clothing, and shelter. Women may engage in informal sex transactions even when working in low-paid jobs in factories, bars, restaurants, etc. in attempts to secure adequate food and pay house rent.

Until health inequalities and matters of poverty are addressed directly, we cannot expect a decline in numbers of women who work in the sex trade and the prevalence of infectious diseases. Indeed, policy makers and leaders would do well to pay heed to Dr Paul Farmer who writes: "*Stopping exploitative prostitution would require addressing poverty, gender inequality, and racism, but in the absence of serious societal programmes with such aims, public health authorities can make a priority of protecting, rather than punishing sex workers.*"[3] We must think seriously about the most effective, feasible, and accessible prevention strategies that will empower women who may grapple with the risk of HIV infection on a daily basis. With improvement, Senegal's proactive policy towards safeguarding women's health and the containment of HIV/AIDS through the legalization and monitoring of sex workers can serve as a precursor for successful strategies in the fight against the global spread of HIV. ■

More information about the Senegalese approach can be found in Homaifar, N. & Wasik, S., Interviews with Senegalese commercial sex trade workers and implications for social programming.* Health Care for Women International*, Vol. 26, Nr 2, 2005, pp. 118-133(16).

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1. C. Laurent, K. Seck, N. Coumba, T. Kane, N. Samb, A. Wade, et al., Prevalence of HIV and other sexually transmitted infections, and risk behaviours in unregistered sex workers in Dakar Senegal. *AIDS*, 2003, 17, p. 1811-1816
2. *Bulletin Épidémiologique N° 9 de Surveillance du VIH/SIDA* (in French). Conseil National de Lutte contre le SIDA, Senegal, 2002
3. P. Farmer, *Infections and inequalities: The modern plague*. University of California Press, Berkeley, 1999

Online resources

➔ Manuals & Guidelines

Tools together now: participatory tools to facilitate mobilising communities for HIV/AIDS.
International HIV/AIDS Alliance, 2005 (250 p.)
Pdf: http://synkronweb.aidsalliance.org/sw31815.asp

This toolkit is intended to help organisations and community groups mobilise and work together to address HIV/AIDS issues. It provides a selection of 100 Participatory Learning and Action tools which can be used for community mobilisation. The toolkit is designed to help put *All Together Now*, a sourcebook on community mobilisation, into practice.

Positive voices & Making it happen. Strategies for Hope Trust, 2005 (40 & 44 p.)
Pdf: www.stratshope.org/b-books.htm
Hardcopy: Teaching-aids at Low Cost (TALC),
PO Box 49, St Albans AL1 5TX, United Kingdom
fax: +44 1727 846852
e-mail: info@talcuk.org
www.talcuk.org/catalog (£2.40 each)

Positive voices contains testimonies by 14 African religious leaders (12 Christians, two Muslims) who are living with or personally affected by HIV. The tool is designed for use by church and community leaders who want to take practical action to address the challenges of HIV/AIDS.

Making it happen is a mini-manual which aims to guide and support church groups through the processes of planning, establishing and managing an HIV/AIDS project. It includes sections on planning, decision-making, writing a project proposal, preparing a budget, accounting for funds, monitoring and evaluation.

➔ Research reports & Reviews

Deadly inertia: A cross country study of educational responses to HIV/AIDS. T. Boler & A. Jellema, Global Campaign for Education, 2005 (50 p.)
Pdf: www.campaignforeducation.org/resources/resources_latest.php (available in English, French and Spanish)
Hardcopy (free, only in English): Tania Boler,
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This report records the educational responses to HIV and AIDS in 18 countries across Asia, Africa and Latin America. The main finding is that Ministries of Education are still unprepared to respond effectively and minimize

the impact of AIDS. Moreover, the international donor community has also failed to deliver leadership and political commitment. An action plan to strengthen the educational response to HIV/AIDS is included.

AIDS and the health workforce in Africa: Making sense. G. Kegels & B. Marchal (Institute of Tropical Medicine, Belgium), Medicus Mundi, 2005 (52 p.)
Pdf: www.medicusmundi.org/Files/2005HR_AIDS.pdf

The two-way interaction between the health workforce and HIV/AIDS is the main subject of this report, which was commissioned by Medicus Mundi International.

➔ Factsheets & Issues briefs

Resource Pack on Gender & HIV/AIDS. Royal Tropical Institute/UNAIDS, 2005 (110 p.)
Pdf: www.kit.nl/development/html/publications_db.asp?ItemID=1868

This initiative of the UNAIDS Inter-agency Task Team on HIV/AIDS and Gender Resource Pack analyses the impact of gender relations on the different aspects of the AIDS pandemic and makes recommendations for effective programme and policy options. It includes a review paper for expert consultation prepared by the International Center for Research on Women on behalf of the WHO, and 16 fact sheets with concise information on gender-related aspects of HIV/AIDS, prepared by the different UN agencies involved.

Sexual and reproductive health & HIV/AIDS. A framework for priority linkages. WHO, IPPF, UNAIDS & UNFPA, 2005 (4 p.)
Pdf: www.unfpa.org/upload/lib_pub_file/501_filename_framework_priority_linkages.pdf

This framework proposes a set of key policy and programme actions to strengthen linkages between sexual and reproductive health (SRH) and HIV/AIDS programmes. These linkages work in both directions, by integrating HIV/AIDS issues into SRH programmes and SRH issues into HIV/AIDS programmes.

➔ CD-ROMs

YouthNet Publications 2002-2005. YouthNet/FHI, 2005
Order (free): youthnetpubs@fhi.org

The CD-ROM contains all of YouthNet's publications from 2002 through 2005, including the interactive *Adolescent Reproductive Health Module* (in English, Spanish, and French); the *Youth Participation Guide* (English and Spanish); *HIV counseling and testing for youth: A manual for providers*; and several youth-related papers and briefs including YouthLens 1-18 featuring briefs on youth-friendly pharmacies, gender roles for boys, and early marriage (in English, Spanish, and French).

Gender and HIV/AIDS Electronic Library. UNIFEM 2005
Order (free): unifem@genderandaids.org, or
download (400 MB!): www.genderandaids.org/modules.php?name=Content&pa=showpage&pid=14

Produced by UNIFEM, this CD-ROM compiles resources from the portal *Gender and HIV/AIDS* (www.genderandaids.org). It includes research and studies, training resources and tools, and multimedia advocacy materials on the gender dimensions of the HIV/AIDS epidemic produced by a variety of organizations. The CD-ROM is fully searchable by keyword and includes a tool called "e-Course Builder," which supports the creation of a tailored training course using the resources on the CD-ROM.

All resources are accessible through our website: www.exchange-magazine.info

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