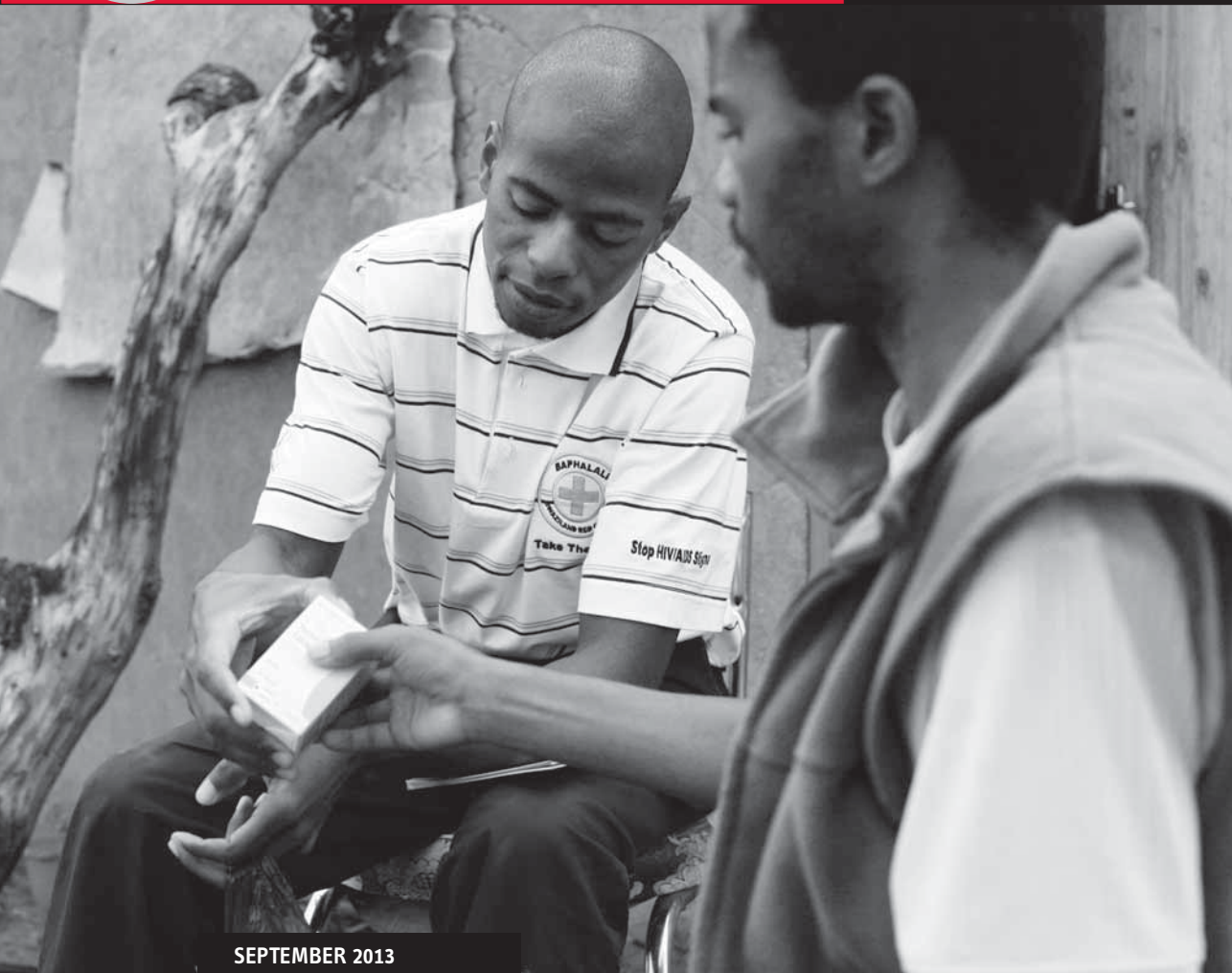




Bulletin 129

Medicus Mundi Schweiz

Netzwerk Gesundheit für alle
Réseau Santé pour tous
Network Health for All



SEPTEMBER 2013

A FUTURE WITHOUT AIDS – APPROACHING A VISION

Reader of the aidsfocus.ch conference

IMPRESSUM

MEDICUS MUNDI SCHWEIZ
Netzwerk Gesundheit für alle
Réseau Santé pour tous
Network Health for All

Bulletin Nr. 129, September 2013
A Future Without Aids –
Approaching a Vision

NETZWERK MEDICUS MUNDI SCHWEIZ
 Die gemeinsame und verbindende Vision der Mitglieder des Netzwerks Medicus Mundi Schweiz ist Gesundheit für alle: ein grösstmögliches Mass an Gesundheit für alle Menschen, insbesondere auch für benachteiligte Bevölkerungen. Medicus Mundi Schweiz vernetzt die Organisationen der internationalen Gesundheitszusammenarbeit, fördert den Austausch von Wissen und Erfahrungen, vermittelt ihnen Impulse für die Weiterentwicklung ihrer Tätigkeit und macht ihre Tätigkeit einem weiteren Publikum bekannt. Das Bulletin von Medicus Mundi Schweiz erscheint viermal jährlich. Jede Ausgabe ist einem Schwerpunktthema gewidmet und enthält aktuelle Hinweise und Informationen. Medicus Mundi Schweiz profitiert in seiner Arbeit von der langjährigen Partnerschaft mit der schweizerischen Direktion für Entwicklung und Zusammenarbeit DEZA, die auch die Herausgabe des vorliegenden Bulletins mit einem grosszügigen Beitrag unterstützt.

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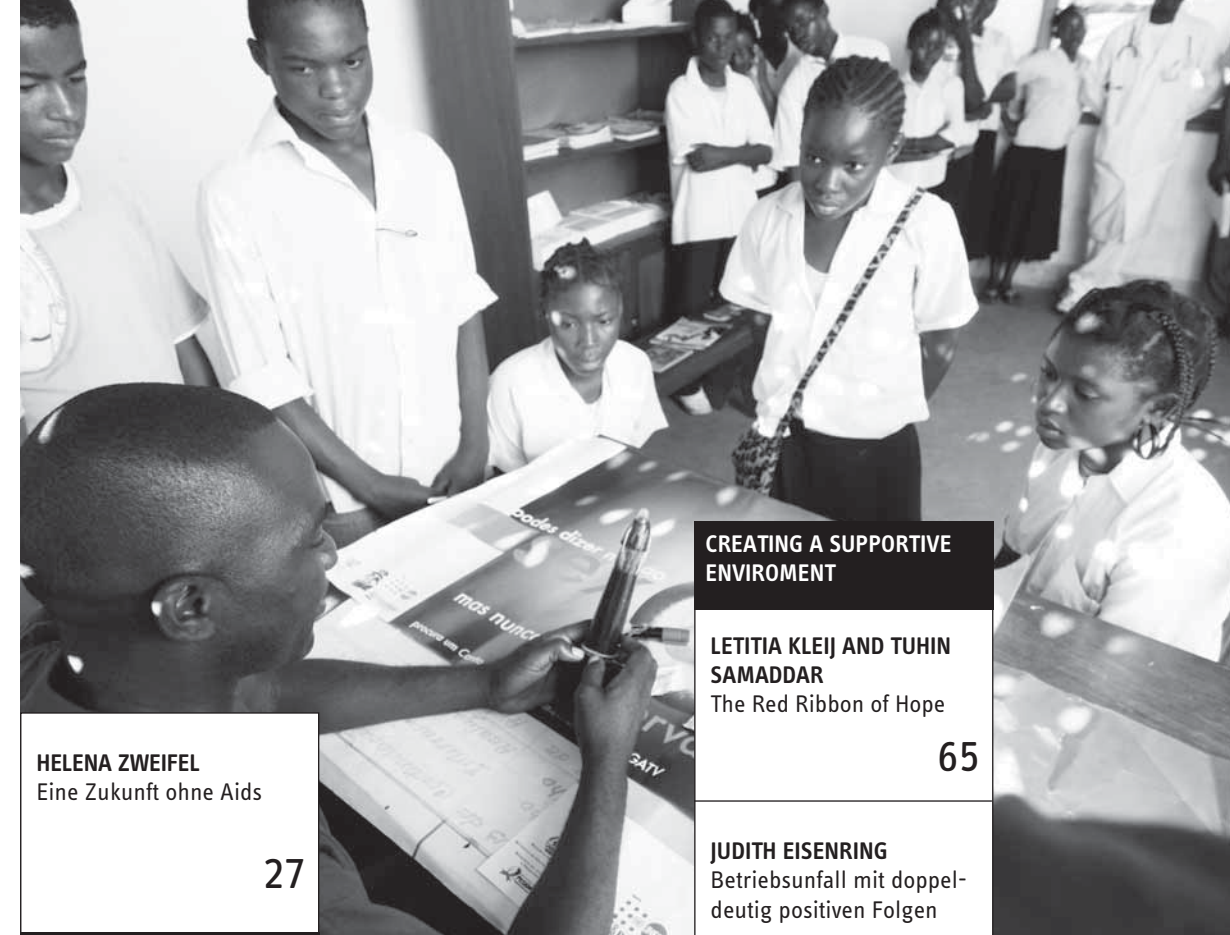
NETZWERK

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 Schweizerisches Rotes Kreuz
 Schweizerisches Tropen- und Public-Health Institut (Swiss TPH)
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 Service de médecine internationale et humanitaire (SMIH)
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 SolidarMed
 Stiftung Terre des Hommes
 Verein Partnerschaft Kinderspitäler Biel-Haiti
 women's hope international (WHI)
 World Vision Schweiz

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Eine künftige Welt ohne Aids – Traum oder Wirklichkeit?

Wie nie zuvor in der Geschichte der globalen Gesundheit ist es der Aidsbewegung gelungen, eine weltweite Solidarität zu wecken und innert weniger Jahren die lebensnotwendige Aidsbehandlung so vielen Menschen zugänglich zu machen. 25 Ländern ist es gelungen, die Neuinfektionsrate zwischen 2002 und 2011 um mehr als 50% zu senken – ein wichtiger Schritt, um die Aids-Epidemie einzudämmen.

Heute sind die technischen Mittel vorhanden, Szenarien errechnet und Strategien ausgearbeitet worden, um Aids bis ins Jahr 2050 zu beenden. «Die mathematischen Modelle zeigen, dass wenn wir weltweit einen hundertprozentigen Zugang zu antiretroviraler Behandlung und die Elimination der Mutter-Kind-Übertragung erreichen, zusammen mit bekannten Präventionsmethoden, wir die HIV-Epidemie bis ins Jahr 2050 kontrollieren könnten», erklärte die Präsidentin der Internationalen AIDS Society (IAS), Françoise Barré-Sinoussi, im März 2013.

In den betroffenen Ländern haben lokale Gemeinschaften und Organisationen zusammen mit Menschen, die mit HIV leben, Verantwortung übernommen und – wie Beispiele aus Zimbabwe, Indien und weiteren Ländern zeigen – innovative, lokal angepasste Strategien entwickelt und umgesetzt. Sie haben Stigma und Ausgrenzung bekämpft, Verhaltensänderungen erzielt, politische Entscheidungsträger zur Rechenschaft gezogen und so massgeblich dazu beigetragen, die Zahl der Neuinfektionen zu senken und die Zahl der Behandelten zu erhöhen.

Doch unsere Arbeit ist noch nicht getan. Es braucht weiterhin beachtliche finanzielle Investitionen und das politische Engagement von Regierungen in Nord und Süd, aber auch von aidsfocus.ch und seinen Partnerorganisationen. Wir müssen uns weiterhin mit voller Kraft engagieren und strategisch investieren, um die Aids-Epidemie zu besiegen, wollen wir die Resultate unserer bisherigen Investitionen sehen. In den Worten von Nelson Mandela: “Just as the water is about to boil, it is foolish to turn off the heat.”

Helena Zweifel

Geschäftsführerin Medicus Mundi Schweiz
Kordinatorin aidsfocus.ch



MMI Discussion Paper

QUESTIONS AND ANSWERS ON UNIVERSAL HEALTH COVERAGE

Like many other actors in global health, the Medicus Mundi International Network (MMI) is overwhelmed by the attention given to the concept of Universal Health Coverage (UHC) in the last two years, mainly by the World Health Organization and related to the debate on health in the post-2015 development agenda. We have followed this debate with great interest (see: MMI thematic guide), as the “UHC hype” brought health systems strengthening, a core concern of MMI, back to the top of the global health agenda.

THE CURRENT discussion paper presents key elements of the concept of UHC as promoted by the World Health Organization and reflects them based on our own ambition of Health for All such as stated in the MMI Network Policy.

In the three sections (1) “What is in Universal Health Coverage?”, (2) “Financing UHC”, and (3) “UHC and health equity” of the discussion paper we will directly refer to two helpful “questions and answers” papers recently published by the World Health Organization and add some of our reflections and open questions, hoping to contribute with this to the further discussion within and beyond our Network.

The paper was drafted by an ad hoc working group of the MMI Network and adopted by the

MMI Board on 13 August 2013 as discussion paper for MMI Network members and partners. Your feedback is most welcome!

<http://bit.ly/175RV0u>

Universal Health Coverage: Breite MMS Debatte

La couverture sanitaire universelle:
Large débat dans le Réseau MMS

MMS ROUND TABLE

Universal Health Coverage:
Der Weg zur Gesundheit für alle?
Bern, 16. September 2013

Seit geraumer Zeit und jüngst mit dem Weltgesundheitsbericht engagiert sich die Weltgesundheitsorganisation (WHO) für Universal Health Coverage als umfassendes Konzept, um die Gesundheitsversorgung und deren Finanzierung weltweit sicher zu stellen. Es wird bereits überschwänglich als Konzept gelobt, das den Basisgesundheitsansatz von Alma Ata weiterführen, respektive überwinden könne. Am MMS Round Table machen sich die Teilnehmerinnen und Teilnehmer mit dem Universal Health Coverage Konzept vertraut und setzen sich kritisch damit auseinander. Ausgangspunkt des Round Tables bildet das eben veröffentlichte Diskussionspapiers von Medicus Mundi International. Mit: Thomas Schwarz, Geschäftsführer Medicus Mundi International.

www.medicusmundi.ch/mms/services/events/mms_round_table

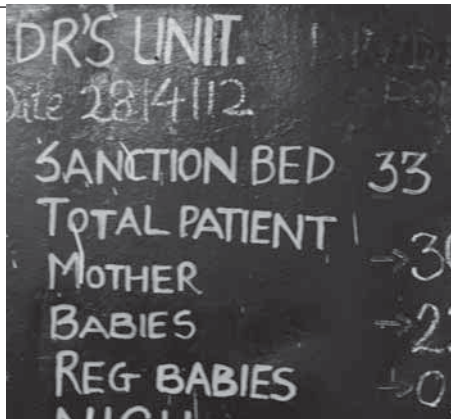


TABLE RONDE MMS

La couverture sanitaire universelle: vers la santé pour toutes et tous? Berne, 16 septembre 2013

«Universal Health Coverage», la couverture sanitaire universelle, est le concept d'ensemble que l'Organisation mondiale de la santé (OMS) défend depuis un certain temps déjà, et encore tout récemment avec le Rapport sur la santé dans le monde. Visant à garantir une prise en charge sanitaire et son financement à l'échelle globale, ce concept est fortement applaudi et certains considèrent qu'il pourra prolonger ou dépasser l'approche des soins de santé primaires de Alma Ata. Cette table ronde MMS permettra aux participantes et participants de découvrir les particularités du concept de la couverture sanitaire universelle et d'y réfléchir de manière critique. Le point de départ de la table ronde sera le document de discussion récemment publié par Medicus Mundi International à ce sujet.

www.medicusmundi.ch/mms-fr/services/events/mms_round_table

MMS SYMPOSIUM

Universal Health Coverage und die globale Gesundheit nach 2015 Basel, 6. November 2013

Wie soll die Gesundheitspolitik global gestaltet werden, um Gesundheit auch für die ärmsten Bevölkerungen in Entwicklungsländern zu

sichern? Darum geht es unter anderem bei der gegenwärtigen internationalen Debatte über die neuen Entwicklungsziele für die Zeit nach 2015. Die Weltgesundheitsorganisation propagiert Universal Health Coverage (UHC) als Mittel, um Gesundheit für alle finanzierbar und zugänglich zu machen. Am diesjährigen MMS Symposium werden die Teilnehmerinnen und Teilnehmer in die Debatte um Definition und Ausgestaltung von UHC eingeführt und inblick auf die neue entwicklungspolitische Agenda kritisch diskutieren.

www.medicusmundi.ch/mms/services/events/Symposium2013

SYMPOSIUM MMS

Couverture sanitaire universelle et santé mondiale après 2015 Bâle, 6 novembre 2013

Comment la politique de la santé doit-elle être façonnée au niveau mondial pour assurer la santé même des populations les plus pauvres des pays en voie de développement? C'est entre autres l'un des points qui est discuté dans le cadre du débat international sur les nouveaux objectifs de développement pour la période d'après 2015. L'organisation mondiale de la santé fait de la propagande pour la couverture sanitaire universelle en tant que moyen pour rendre la santé accessible et financable pour tous. Les participants et participantes vont être introduits dans le débat à la définition et l'organisation de l'UHC et vont discuter d'un œil critique du nouvel agenda de politique de développement.

www.medicusmundi.ch/mms-fr/services/events/Symposium2013

Schweiz fasst die Reaktionen und Hintergründe in einer Storify-Geschichte zusammen.

<http://bit.ly/Yya044>



Konferenzfotos: Werner Winterberger

Seiten 7-30

Beiträge der Tagung

«Gemeinsam eingesetzt wirken diese Strategien so gut, dass Experten von einer historischen Zäsur sprechen. Erstmals könnten wir die Epidemie nicht nur bekämpfen, sondern auch kontrollieren und zurückdrängen.» Dr. Jochen Ehmer

AN INVESTMENT FRAMEWORK FOR THE GLOBAL HIV RESPONSE

Substantial changes to the way global HIV investments are made, with an accompanied boost to investment by 2015, could dramatically change the future trajectory of the AIDS pandemic.

By Helena Zweifel*

THAT'S according to Dr. Bernhard Schwartländer and other members of the Investment Framework Study Group convened by the Joint United Nations Program on HIV/AIDS (UNAIDS), who developed a new model to the Global AIDS response that was published in *The Lancet* in June 2011.

By 2010, extraordinary amounts of political commitment, social mobilisation, and HIV/AIDS funding had resulted in an unprecedented scale-up of HIV/AIDS prevention, treatment, care, and support, a decline in incidence of new HIV infections in several countries, more than 6.5 million people receiving antiretroviral therapy, and millions of orphans able to receive basic education, health, and social protection. Such large-scale investments helped progress towards more tolerant and enabling social environments. However, despite these impressive gains, universal access to prevention, treatment, care, and support for HIV/AIDS is not available worldwide, and is unlikely to be achieved with the present pace of change and with the present approaches to investment.

The new framework proposes a paradigm shift in the way AIDS funding is approached, with a greater emphasis on priority setting and optimization of AIDS responses, a shift to community mobilization to deliver programmes and greater synergies between programme elements. Implementing the model would require 30% more funding than current-

ly available when expenditure would be projected to peak, in 2015.

The implementation of the new investment framework would avert 12.2 million new HIV infections and 7.4 million deaths from AIDS between 2011 and 2020 compared with continuation of present approaches, and result in 29.4 million life-years gained. The framework is cost effective at 1060 US-\$ per life-year gained, and the additional investment proposed would be largely offset from savings in treatment costs alone.

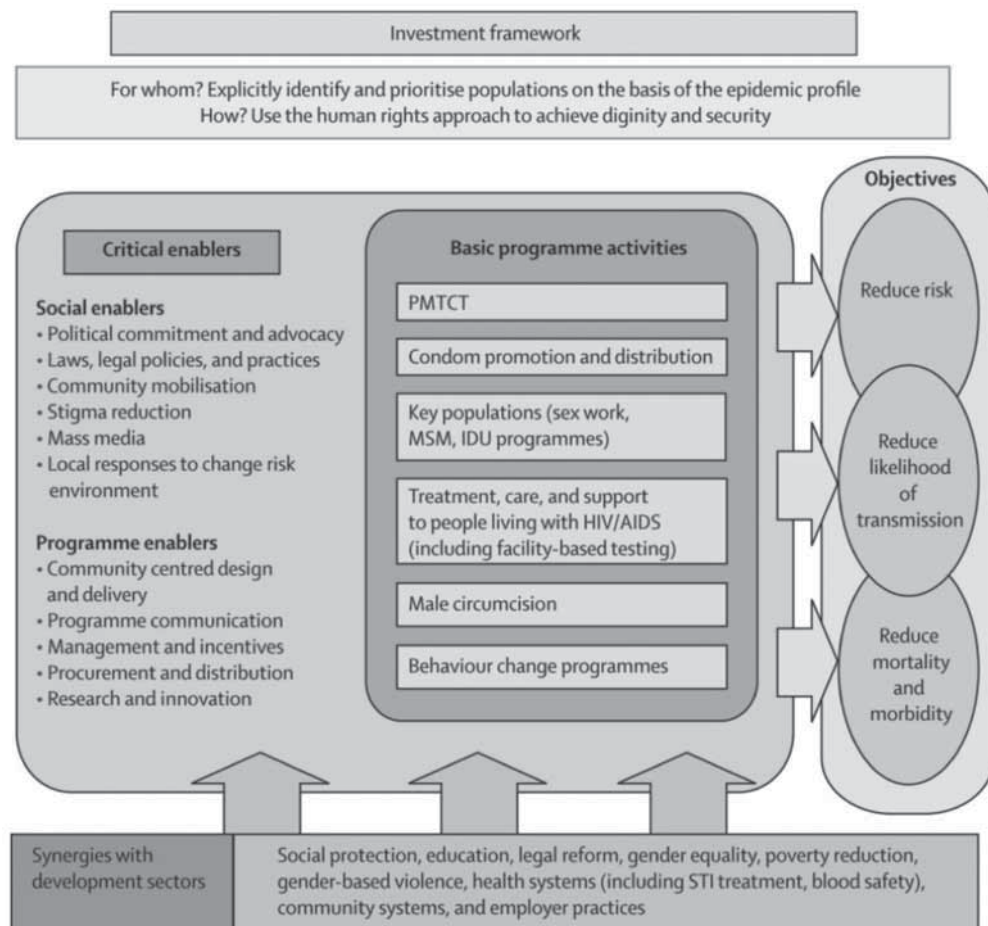
KEY COMPONENTS OF THE INVESTMENT FRAMEWORK

The approach is based on human rights, and is universal, equitable, and assures inclusion, participation, informed consent and accountability. The investment framework approach identifies 6 targeted HIV programming priorities, critical enablers and advocates for synergies with development sectors.

- PMTCT: Elimination of new HIV infections in children
- Condom promotion and distribution
- Programmes focusing on key populations at higher risk (particularly sex workers, men who have sex with men, and drug users)
- Treatment, care and support for people living with HIV (including facility based testing)
- Behaviour change programmes
- Voluntary medical male circumcision (Africa)



Gerhard Siegfried (DEZA), Farai Mahaso (BHASO), Helena Zweifel (aisfocus.ch) and Marjorie Opuni (UNAIDS)



Basic programme activities: Based on existing evidence, the framework identifies the following basic programme activities that should be delivered as a package, at scale, according to the size of the relevant population:

Critical enablers: Critical enablers are interventions that create an enabling environment for achieving maximum impact. These are defined in two categories:

1. Social enablers that create environments where responses can flourish, such as community mobilisation, stigma reduction, political commitment and enabling laws, policies and practices.
2. Programme enablers that support more effective programmes, such as community centred design and delivery, communication, management, procurement and research and innovation.

Synergies with other development sectors: The final component of the framework calls for links between HIV programmes, critical enablers and other development sectors including social protection, education, legal reform, gender equality, poverty reduction, gender-based violence, health systems, community systems, and employer practices.

The International HIV/AIDS Alliance confirms that the proposed targeted key intervention and implementation of HIV programs is based evidence what works:

- Funding must be targeted to interventions that focus on communities most at risk and affected by HIV and AIDS.
- People must have access to ARV treatment (responding to the increasing new evidence of the significant health improvements and HIV/TB prevention potential of ART).
- Values and supports community mobilization and service delivery by communities themselves as critical enablers.
- Human rights-based programming (such as advocacy, stigma reduction and efforts towards supportive laws) is “critical” to the model, rather than optional or additional.
- Gender

Aidsfocus.ch appreciates that the Investment Framework focuses on the most effective program activities for prevention and treatment which need to be accompanied by “critical enablers” that make these programs work. It also appreciates that the framework takes as its starting point a human rights approach to the HIV response, to ensure that it is universal, equitable, inclusive, and fosters participation. These are relevant concepts for the partner organisations of aidsfocus.ch and their work, and it is about the first time that a technical model of the AIDS response gives these “soft factors” high recognition, even recognises them as “critical” in the global AIDS response. This is one of the main reasons why aidsfocus.ch took this model as framework for the discussions at the aidsfocus.ch conference.

*HELENA ZWEIFEL ist Geschäftsführerin von Medicus Mundi Schweiz, und Koordinatorin der Fachplattform aidsfocus.ch. hzweifel@medicumundi.ch

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UNAIDS issue brief 2011: A new investment framework for the global HIV response www.riatt-esa.org/resources/new-investment-framework-global-hiv-response-unaid-brief

UNAIDS: HIV treatment: Reducing deaths, illness and HIV infections while keeping costs down (Press release 8 June 2011) www.unaids.org/en/resources/presscentre/featurestories/2011/june/20110607dtreatment

UNAIDS Investment Framework for AIDS: Questions and answers www.riatt-esa.org/resources/unaid-investment-framework-aids-questions-and-answers

International HIV/AIDS Alliance discussion paper: What is the Investment Framework for HIV/AIDS and what does it mean for the Alliance? www.aidsalliance.org/publicationsdetails.aspx?id=90547

SUPPORT GROUPS BELONG TO THE COMMUNITY AND NOT TO BHASO

One of BHASO's main objectives is to build capacities of people infected and affected by HIV and AIDS for positive living. Support groups are the cornerstone of the network of the people who are living with HIV.

By Farai Mahaso*

BATANAI HIV and AIDS Service Organisation (BHASO) is a registered local HIV and AIDS Service Organisation (PVO No 16/36) operating in Masvingo Province in 5 rural Districts and 1 urban District. It started as Batanai HIV and AIDS Support Group, a support group for people living with HIV that was formed by the late Auxillia Chimusoro in 1992. Auxillia Chimusoro was the first person in Zimbabwe to disclose her HIV-status to the general public of Zimbabwe. During those days the government and the people in the communities were still in denial mode and were not yet open up to the obvious presence of HIV and AIDS. She disclosed her HIV positive status and started Batanai support group because she wanted to give HIV a face. This was also an effort targeted at fighting stigma about HIV.

Auxillia Chimusoro helped to open doors for the government to be able to start to do something concrete towards addressing HIV and also for people living with HIV in her community to fight for support and for a place where they could meet and carry out their activities as a support group. Looking back at that time there were no ARVs and no treatment: Many people living with HIV were surviving with hope and gave each other support and advice on health, nutrition and social issues while hoping to live longer and positive lives.

I still remember when I started to work with HIV support groups, we were usually busy trying to register members for medical policies and to look for transport to take those who were seriously ill to their rural homes where they could die. Studies which have been done over the years show that people are surviving and live longer. So the vision of ending HIV is possible. We can see that in Africa. If we see someone who dies of AIDS, we feel that no one is supposed to die because there is an option for everyone to survive.

BHASO'S VISION IS: TOTAL EMPOWERMENT FOR POSITIVE LIVING

Auxillia believed in it and we also believe in the truth of that spirit. We want people living with HIV to fight and to be in the forefront of managing and ending HIV and AIDS respectively and because they understand their situation better and understand each other. However, they need skills; that is where we come in. That is our vision.

BHASO's Mission is to empower people infected by HIV and AIDS by providing services that will enable them to improve the quality of their lives. We facilitate empowerment; everything in the communities should be done by the people themselves after we have given them the skills. This way the whole process becomes sustainable.



“We have to continue to link the medical side of HIV with the community side of aid otherwise infections will go up again.”

If we look at the evidenced based programming that we do, the issue of ownership and making sure that people themselves understand everything we can see that the concept is working well. Zimbabwe has managed to reduce the HIV infection rate from around 20-30% to about 13.7% and this has happened mainly because of behaviour change. So we believe that if you invest in the people you will get results.

One of BHASO's main objectives is to build capacities of people infected and affected by HIV&AIDS for positive living. We train people because if you want to empower people you have to give them information and skills. You need to give them the opportunities to do something for themselves so that at least they are able to work for themselves. This is our approach and our recommendation.

Some people ask me: “Why do you include food in your programming?” My response is: “I believe that people need to take food to get stronger and healthier and be able to take ARVs. We also believe, if the people are going to do all these things, it will help to shape their personality and their quality of life will be improved.

SUPPORT GROUPS

We are currently operating in eight districts of Masvingo Province. We realized over the years that the support groups are the cornerstone of the network of the people who are living with HIV. We work with about 700 HIV support groups.

These support groups help each other, they give each emotional support. Unlike other support groups in Africa they are open for everyone; people in the communities know where they meet. They give the people information and they also support people on the ground.

In terms of prevention and care, support group members support each other and also help each other to adhere to treatment. So in the end what we see is a community that is organized. We train them on leadership skills and on how to organise and run their groups and activities. Because of the support groups' visibility service providers coming into their communities are better positioned to direct resources where they are most needed. If a service provider comes with a program and tells them what to do, they are empowered enough to say this is how we want things done for our community. We are passing this way. We can prevent our brothers and sisters from getting HIV.



We developed a model of expert agents which we called Community HIV Support Agents (CHASA). This people are identified from the support groups as people who are living with HIV. They are supposed to be on treatment for a year or so. These people understand what is happening. We train them for ten days on treatment, they get all the important information and they volunteer to work for two days to work at the health centre.

This is very helpful and improving the work because when people living with HIV (PLHIV) are coming to the health centre they can see a face that they are familiar with and then they are able to talk about the ARVs. And also the health staff realized that there is now a greater engagement and that adherence is improving. This is because they know each other in the support groups.

The people within this network of PLHIV support each other and the adherence to medication is high. We realized that the people who are in the support groups survive more than the people who are not in the support groups. That is what we learned over the years.

MEANINGFUL INVOLVEMENT OF PEOPLE LIVING WITH HIV AT ALL LEVELS

BHASO targets people living with HIV at all levels of HIV. We help them to be able to raise their voice, to fight for their rights and becoming recognized. We have developed a concept and encouraged them to participate during its development. We have empowered them to participate in different committees put in place at clinics and hospitals. So if they are in there, they are able to influence what happens in the community and be influential enough to change unfavourable policies.

At BHASO we strongly believe in the promotion and protection of the rights of people living with HIV. We advocate from a human rights based approach. What is it that needs to be done to protect the rights of people with HIV? We were asking the government. We developed advocacy strategies that have community structures starting from a local ward level to a district, to a provincial and up to a national level. We have trained Advocacy Teams who in turn identify advocacy issues in their communities and advocate for them.

For example: We found that the ARVs were not arriving, that they are stored somewhere in Zimbabwe. It was found that the drugs were stored in the capital city and it would need some action to bring them to the province where they are needed. Advocacy teams investigated and found out that drugs were not ordered. Maybe there was someone who was not doing his job. So the people demonstrated in front of the Medical Provincial Director's office until the office agreed to look into the problem. This way the local level advocacy structures started to negotiate for their interests and their rights.

We try to implement our activities at low costs because we know that if people are empowered they know what is supposed to be done and they are organized enough to do it themselves. We realized that by the end of the day most of the work is done by the people themselves and as an organisation we then don't need to do much. People realize that by getting information and skills they can do things for themselves. Now we feel that people do understand what they are fighting for and what their rights are.

We also try to link people with the health system and to the continuum of care from the community – people in the community know what is happening. We have developed a concept whereby people living with HIV on ART volunteer to support each other when they come to collect their medication from the Health centres. They also follow up on those who may be defaulting.

NETWORKING AND BUILDING ALLIANCES

We realized that when doing advocacy and talking to ministers and other high ranking officials you need to be well prepared and equipped, especially when you want to change the laws. As an organization we started to network with the Zimbabwean Lawyers for Human Rights and also with the National Network for People living with HIV. We started networking with other organizations outside of Zimbabwe in order to get information at international levels. This way when we went and sat down with policy makers we realized that we can actually put our cases forward and be heard. We realized that we could do it, we could tell them what we want.

Working with relevant government ministries, community leaders and traditional leaders is another element of our strategy. We are supposed to adhere to the Zimbabwe National HIV & AIDS Strategic Plan (ZINASPII). This way we can make our plans comply with the national plans of our country. Our role is to take care of the needs of the communities. So we have to say the truth about what people need and follow up on what government says it will do. We have to align between the needs of the community and the policy of the government.

HOLDING GOVERNMENT TO ACCOUNT

BHASO does a lot of work holding government to account about the funds allocated for HIV work. The Zimbabwe government has put a tax that every employee and employer is charged to contribute towards the fight against HIV. Zimbabwe actually is one of the few countries in the world that has such a national fund on HIV. This means that we are not just waiting for donations from donors and if we are looking for funding from the Global Fund we are in a position to put down our own contribution. This best practice has been well documented. But when we looked at how the government allocates the money and whether it is used properly we discovered that a lot of money is going to administration – and this is not the right way to do it.

BHASO managed to discuss with the government officials asking them to ensure proper allocation and distribution of funds in a transparent way. We also requested the government to stop buying expensive drugs when cheaper varieties are available on the market. When the government didn't cooperate we engaged with the Zimbabwe Lawyers for Human Rights and presented our demands. We went to court

to file our complaint and demanded for information from the National AIDS Council. They still refused.

In Zimbabwe it is very difficult to organize a demonstration. We organized around one hundred people and arrived at the office of the National AIDS Council. People came from different directions with posters and slogans – it was impressive. It was captured by everyone. The people in the government and the National AIDS Council got nervous because the event was reported in the international media. Donors were asking what is happening. So it was a way to try to hold government to account.

After that demonstration we also continued to engage the national director of the National AIDS Council. We are doing this because we are tightening our demands. However we are not yet near the fundamental issues regarding what is supposed to be done. We are still communicating and so now they really understand if they are doing anything now there are people who are watching what is happening and what is going on. This is one concrete example that happened.

WE NEED TO CONTINUE OUR EFFORTS

We can't say that there is medication and we are reaching universal health coverage. No, HIV is still there. And if we don't continue our efforts, HIV infections are still going to increase. This is what people need to know.

We have to continue to link the medical side of HIV with the community side of aid otherwise infections will go up again. Some people say that it would be more convenient to buy ARVs. But our experience is that you just can't use ARVs alone without the community support.

We also need to increase more funding for HIV into the Global Fund to fight AIDS, Tuberculosis and Malaria. Some donor countries are pledging money to the Global Fund but are not paying. We need to make sure that they are paying. We also need to go to some of our governments to tell them that it is important to invest in the HIV response because we are saving lives.

We also need to encourage our governments to increase domestic funding because it is more sustainable. We are trying to tell them to admit to the Abuja commitment of 15% government funds to health, because health is a human right.

COMMUNITIES MAKE IT POSSIBLE

Empowerment and collectivization are the drivers of sustained risk reduction. If you want to go fast, go alone. If you want to go far, go together.

By Sanghamitra Iyengar*

SAMRAKSHA is an NGO working in North Karnataka, a developmentally deprived area in South India with poor development indices. It has been travelling with people vulnerable to, living with and affected by HIV for the past 20 years, learning, strategizing and changing. It strongly believes that individuals and communities have the capacity to deal with the issues they face including HIV/AIDS and that they need to be at the centre of any HIV response. It also believes that transformational change has to come from within.

Samraksha's work has focused on the Continuum of Prevention to Care, helping to strengthen the capacity of communities. It works with – populations of women in sex work, men who have sex with men, vulnerable youth, village communities and people living with and affected by HIV – to reduce risk, overcome vulnerability and to mitigate impact.

This paper will examine the concept of critical enablers proposed by the Investment Framework conceptualized by UNAIDS (Lancet, 2011) through Samraksha's experiences in HIV prevention work with women in sex work.

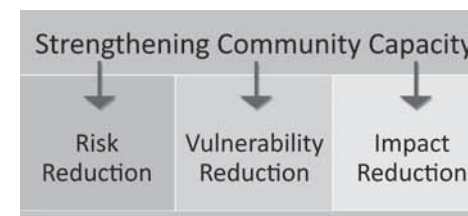
WOMEN IN SEX WORK

The women in sex work that Samraksha is associated with are predominantly from rural communities, largely from lower socioeconomic backgrounds with low literacy, living usually in the community with families. They are geographically dispersed.

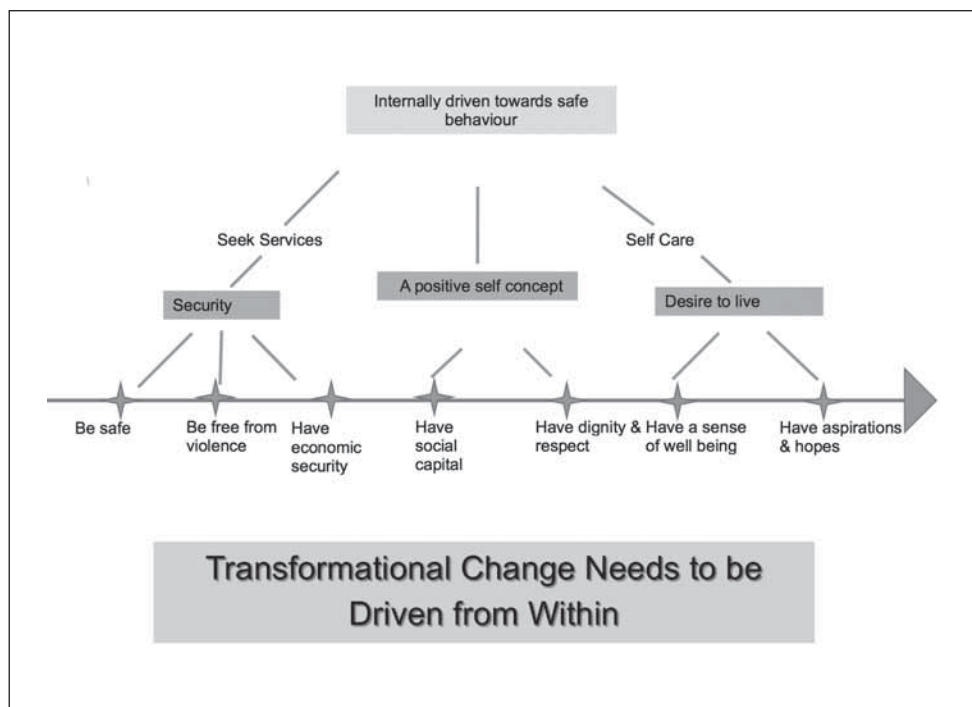
Many of them have another occupation and sex work provides supplementary income. A majority of them enter sex work after marriage or a failed relationship. It is mostly economically driven, but it is a choice. The Pan India Survey (2013) of women in sex work revealed that 70% of sex workers in India choose sex work over other occupations. Ironically they report exploitation, abuse, sexual harassment and low pay and poor working conditions as the reason for crossing over from those occupations to sex work.

The context in which they operate is challenging. Largely, their sex work identity has not been disclosed to their family, children or neighbours. Where this identity has been openly disclosed, they report facing stigma and discrimination, harassment from the police, the neighbours and even the family. There is lack of dignity and social status. Where the identity is hidden, the vulnerability increases as they have to tolerate violence, exploitation and blackmail to keep their identity hidden. In such a situation, dealing with consequences of disclosure or prevention of disclosure takes priority over reducing HIV risk for oneself or others.

In this context, the cornerstones of HIV prevention, behaviour change communication,



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condom distribution, STI treatment and HIV testing can be construed as “supply”. What needs to be created is “demand”. Women need to feel that their health is the priority, that self-care and self-protection are paramount. For this, the action needs to come from within and be enabled from outside.

The motivation to practice safe sex and to have regular health check-ups are critical health behaviours for women in sex work. However, in order to get there, they need to feel secure, value themselves, and aspire to a good life. The drivers of health seeking behaviours, thus, are self worth and a desire to live, against a background of social and economic security.

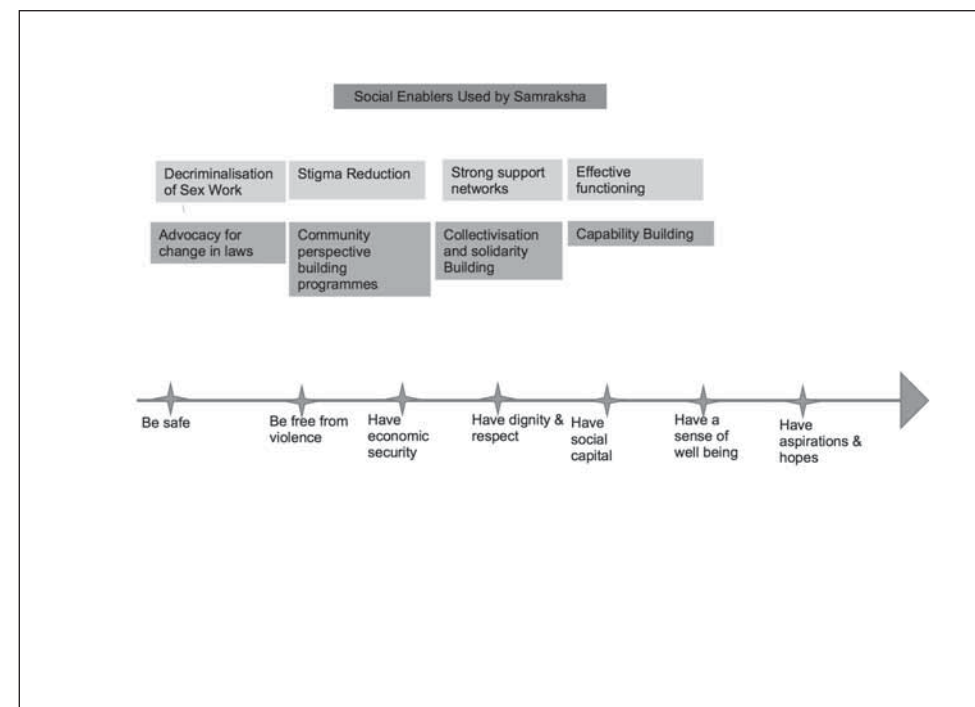
The Investment Framework recognizes that to reduce risk and the likelihood of transmission, when working with key populations core interventions such as behavior change communication, condom promotion, testing, treatment, care and support are priority. However, there are critical enablers, supported by key developmental factors which catalyse these outcomes. Working with women in sex work, Samraksha looked at 4 key social enablers to build motivation for health seeking behavior: decriminaliza-

tion in sex work, stigma reduction, strong support networks and effective functioning.

It also created access and linkages to address core development needs like social protection, literacy, gender equality, poverty reduction, gender-based violence, legal reforms and health and community systems.

1. DECRIMINALISATION OF SEX WORK

It is now widely recognized that the criminalisation of sex work is strongly associated with the violence that women in sex work face at the hands of agents, clients as well as the police. Advocacy for change in laws to decriminalise sex work was, thus, one of the key intervention that Samraksha took up through national level partnerships and coalitions of communities in sex work and organizations working with them. This took the form of workshops with the women for them to create a large scale understanding of the existing law. This was critical because although paid consensual sex is not a crime in India. In the law are clauses which are often used by the police to criminalise sex work as part of “moral clean-ups”. Creating this widespread understanding, helped women in sex work to question the reasons for their ar-



rest, legally fight cases of trumped-up charges and develop a sense of agency.

In the last few years, there has been an increased conflation of human trafficking and sex work. Policy makers, media and even civil society organizations have been unable to make the distinction between coerced sex and voluntary sex work. Amendments are being proposed to “rescue and rehabilitate” and to introduce the Swedish model of criminalizing clients. The first violates the fundamental rights laid down by the Indian constitution: freedom of occupation. In the second instance, when sex work itself is not a crime, buying sex cannot be a crime. There is evidence from across the world that criminalizing sex work actually drives it underground and is a major barrier to HIV prevention.

Through creating a deeper understanding of the law and issues surrounding it among the women themselves, Samraksha helped them to advocate for law reform. Strategies included arranging meetings between parliamentarians and women in sex work, educating the media on the issue, organising regional consultations of women in sex work to contribute to national policy and deposing before the Supreme Court

panel looking into sex work issues. As safety and freedom from violence are necessary to create the security that enables health seeking behaviours, these were critical interventions.

2. DEALING WITH SOCIAL STIGMA

The major challenge of HIV prevention programmes in increasing saturation of key populations like women in sex work has been the resistance to disclose sex work status. The major factor that prevents women from claiming the sex work identity is social stigma. Stigma strips people of dignity and respect and lowers self-confidence and self esteem and creates barriers to accessing healthcare and other social entitlements. It also reduces economic opportunities outside of sex work .

Samraksha’s strategies to reduce stigma were at two levels: those initiated by Samraksha and those initiated by the women in sex work themselves .

Building perspectives on sex work among a range of individuals and groups was a very effective strategy. This included academic institutions, policy makers, counsellors and health providers, judges, lawyers, police, media, intellectuals and different civil society organisa-

tions and social movements. It took the form of discussions, workshops, meetings or position papers. Samraksha also developed a methodology of initiating layered discussions in the community on HIV prevention where paid sex was discussed. These “community conversations” on sex work helped to move community attitudes from total rejection to a less judgemental view. An understanding and “live and let live” attitude could be fostered. Changes though gradual have been significant. Women in sex work and their organisations are represented in various community forums and government committees. They share the dias with judges and senior police officers to talk about violence against women. Civil Society organisations have moved from a highly judgemental position on sex work to sharing common platforms on various social justice issues.

The strategies to decrease stigma which sex worker organisations were helped to use have been building platforms with organisations and movements beyond sex work and HIV prevention on a common cause. One example of this is the major event organised in February, this year, related to “One Billion Rising against Violence”. The organisations of women in sex work led these events and they were joined by other civil society and faith based organisations and government officials.

Members of the Sex worker organisations have joined public forums on issues such as electoral reform, climate change and social security. All this has created their gradual acceptance in the mainstream, reducing stigma for the group.

3. BUILDING STRONG SUPPORT NETWORKS

Most women in sex work that Samraksha works with, are community-based sex workers who do not claim the identity of sex work publicly. There is limited disclosure of identity to clients, agents or some friends. Usually family and neighbours do not know. As the sex work identity is hidden, their social capital in those identities is minimal.

Research has established the negative effects of reduced social capital. Lack of shared spaces in the sex work identity, reduces voice and creates a sense of isolation and reinforces low self esteem. It also affects access to opportunities. Conversely, there is evidence that social capital through social networks and collectives has a protective influence on health. It also has an impact on health risk behaviour and helps achieve health goals (Lin, 2005) Collectivisation strengthens the struggle for rights and entitlements, but also instills hope and promotes a sense of well being which creates the motivation for self care.

Samraksha’s strategy here was to help to build a collective identity of women in sex work across caste, class, ethnicity and typology (such as brothel-based, street-based, family-based sex work). This was further strengthened by facilitating the development of collectives with a shared vision and purpose. Leadership development within the collectives and linking them with other national networks helped to increase the social capital within the sex work identity.

4. EFFECTIVE FUNCTIONING

Seeing possibilities in the future and having aspirations is a key element in motivating individuals for self-care and for building capabilities in terms of valuing self, and having information, skills and freedom to move towards that aspiration is critical.

The approach that Samraksha uses was to initiate activities that promoted self-worth and confidence: entrepreneurship development, exposure to people and ideas, communication and advocacy skills; and helping the women to understand patriarchal power structures and learn-



“There is evidence from across the world that criminalizing sex work actually drives it underground and is a major barrier to HIV prevention.”

ing to deal with them. It also supports women to acquire literacy, helping to claim social entitlements and fight for social justice. This in turn enables risk and vulnerability reduction in the HIV context.

CONCLUSION

The experience of Samraksha with women in sex work validates the importance of the critical enablers and the enhanced development proposed by the Investment Framework. However, unless the three segments are tightly interlinked and resourced, it will not be effective. By investing only on the behavior change communication, condom distribution, testing and treatment components, and expecting general advances in development and ad hoc collectivization of key populations, we cannot move towards zero new infections. The resources for collectivization, social inclusion and personal, social and economic development of the key populations has to be part of the main HIV prevention efforts. Only with these can the prevention efforts be sustained.

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WARUM WIR HIV ANDERS UND STÄRKER BEKÄMPFEN SOLLTEN

Zum ersten Mal besteht die Chance HIV ein- und zurückdämmen zu können. Die Orientierung an sieben Handlungsleitlinien, die wissenschaftlich begründet und die Rechte der Menschen ernst nehmen, könnten eine Generation ohne Aids ermöglichen.

Von Dr. Jochen Ehmer*

AM 24. September 2012 berichtet der ägyptische Virologe Mohamed Zaki im Internet von einem rätselhaften Todesfall: Ein 60-jähriger Mann ist an einer seltsamen Lungentzündung gestorben. Im Gewebe wird ein Virus mit strahlenförmigen Ausläufern gefunden, ein Coronavirus. Weitere Fälle treten auf, die Medien werden aufmerksam.

Bis zum 1. Juni 2013 sind 30 der 53 bekannten Patienten gestorben. Niemand weiss, wie sich die Krankheit weiter ausbreiten wird, WHO – Direktorin Chan bezeichnet die als MERS-CoV getaufte Krankheit als ihre «derzeit grösste Sorge».

DER BEGINN

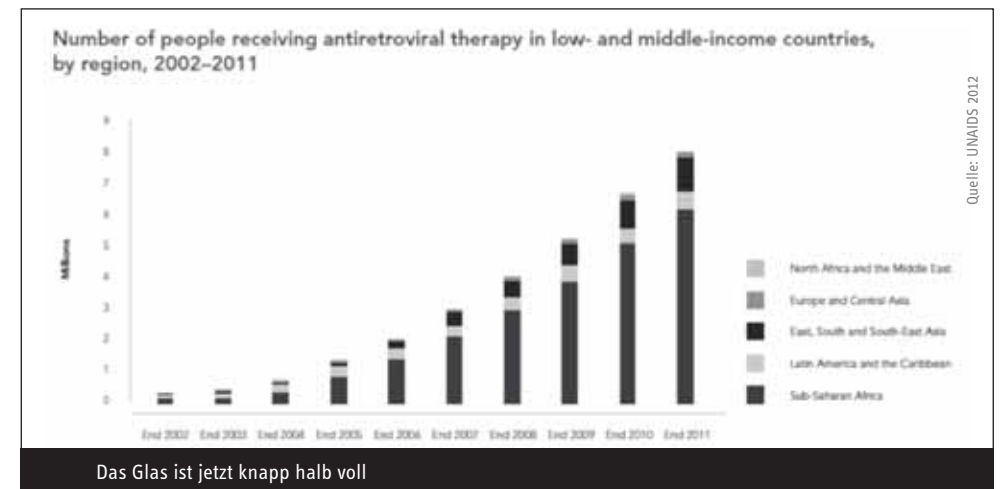
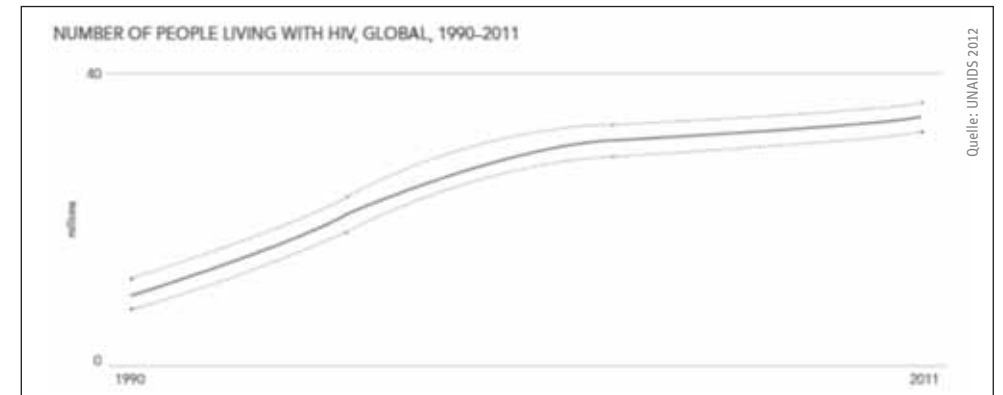
Für Epidemien ist das ein typischer Beginn: Unbeachtet, unvorhergesehen, begrenzt. Dann anschwellend, Grenzen überschreitend. Meist stehen wir solch neuen Krankheiten hilflos und voller Angst gegenüber, ohne Impfstoff, ohne Behandlung.

So war es auch vor 30 Jahren: In Los Angeles erkrankten fünf homosexuelle Männer an einer seltenen Lungentzündung, zwei davon starben. Am 5ten Juni 1981 beschreibt die Gesundheitsbehörde im monatlichen epidemiologischen Bulletin die Fälle. Wenige nur nehmen davon Kenntnis. Niemand hätte gedacht, dass dies der Beginn einer Tragödie sei, die bis heute mehr als 30 Millionen Menschen das Leben kosten würde.

Es ist heute schwer vorstellbar, wie hilflos man Aids damals gegenüberstand, die Krankheit war das sichere Todesurteil. Erst 1983 konnten Ursache und Übertragungsweg der als GRID (Gay Related Immuno Deficiency) bezeichneten Krankheit geklärt werden, die Grundlage zur Entwicklung von Tests und Medikamenten. Luc Montagnier erhielt dafür später den Nobelpreis. Erst im vierten Jahr der Epidemie (1985) konnte man einen Aids-Test machen. Ein Jahr danach kam mit AZT das erste Medikament auf den Markt, eine Brücke zum Leben und der Beginn einer neuen Ära. Doch es sollte noch Jahre dauern, bis die Medikamente als Kombinationsbehandlung besser wirkten. Aids hatte in diesen Jahren ein amerikanisches Gesicht, geprägt von Rock Hudson, Keith Haring oder Magic Johnson.

AIDS IN AFRIKA

Dann passierte etwas Unerwartetes: Die Epidemie schwappte nach Afrika, fegte über den Kontinent wie ein Tsunami, eine moderne Pest, traf Menschen und Länder unvorbereitet, wehrlos, mit voller Wucht. Landstriche und Generationen starben aus, ein Heer von Aidswaisen wuchs heran. Bis 1996 waren 15 Millionen Afrikaner infiziert, ohne Chance aufs Überleben. Zu den medizinischen, sozialen und kulturellen Dimensionen der Krankheit kam eine weitere hinzu: HIV wurde Entwicklungshemmnis der ärmsten Staaten der Welt.



Diese aussergewöhnliche Tragödie wurde zum Ausgang einer der grössten Erfolgsgeschichten der Entwicklungszusammenarbeit. Die Staatengemeinschaft reagierte. 1996 wurde UNAIDS gegründet, 2002 der Global Fund, 2003 PEPFAR. Der Kampf gegen HIV wurde in die Millennium-Entwicklungsziele geschrieben, die zur Bekämpfung von Aids in armen Staaten bereitgestellten Mittel stiegen von 2 auf 17 Mrd USD an (2002; 2011). Was früher niemand auch nur zu träumen wagte, wurde Realität: Die Behandlung von HIV in Afrika war möglich. 2011 erhielten erstmals mehr als die Hälfte der Behandlungsbedürftigen in armen Ländern eine Behandlung. Die entspricht knapp einem Viertel aller 34 Millionen Infizierten weltweit.

FORSCHUNG UND NEUE WEGE DER PRÄVENTION

Gleichzeitig haben Fortschritte in Wissenschaft und Forschung unser Verständnis von

Aids mehrmals auf den Kopf gestellt: Wir wissen nun, dass HIV vom Affen stammt und nicht aus einem US-Labor; dass die Krankheit in Afrika begonnen hat und von einem Retrovirus verursacht wird; dass HIV menschliche Abwehrzellen zerstört und mit einer Kombination unterschiedlicher Medikamente behandelt werden muss, von denen 26 zugelassen sind. Wir wissen, wo sich HIV im Körper versteckt und wie man diese Reservoirs leeren kann. Wir kennen Infektionsrisiken, Übertragungswege, epidemiologische Muster und Labormethoden.

Erst dieses Wissen hat in den letzten Jahren die Entwicklung wirksamerer Strategien zur HIV Prävention ermöglicht: Mit Medikamenten und Kaiserschnitt beispielsweise kann heute das Risiko einer Mutter-Kind-Übertragung von bis zu 45% auf unter 2% pro Schwangerschaft reduziert werden. Die Behandlung mit antiretroviralen Medikamenten reduziert das Übertragungsrisiko bei Erwachsenen um 96%,



« Wir sollten in Strategien investieren, die wissenschaftlich abgesichert sind und den grössten Mehrwert bringen; und nicht in Strategien, die teilweise, etwas oder vielleicht wirken. »

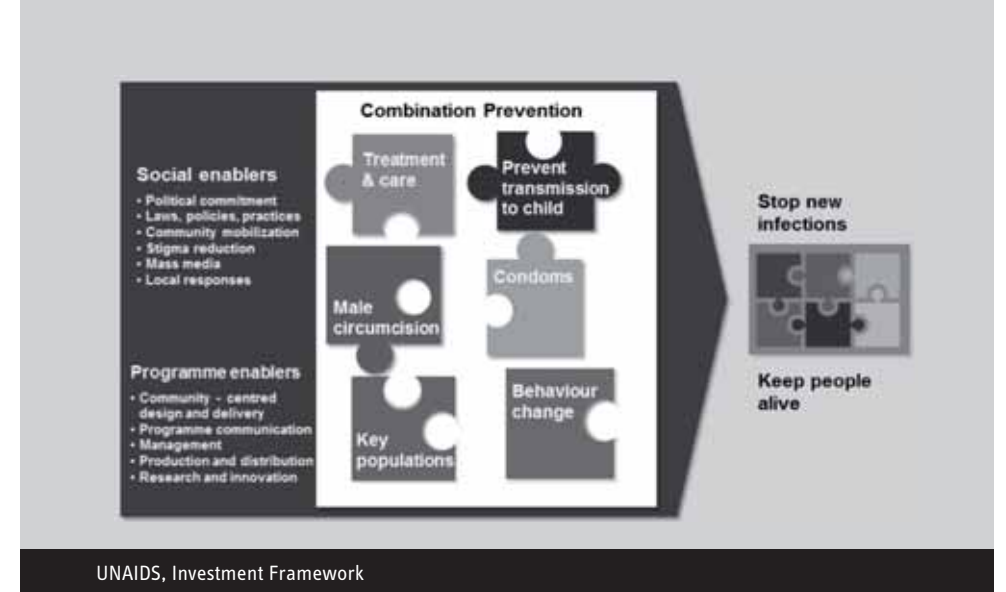
die Beschneidung von Männern deren Infektionsrisiko um 60%. Und es gibt weitere Strategien: Kondome, Vaginalcremes, Präexpositionsprophylaxe, Postexpositionsprophylaxe, Beschränkung der Zahl von Sexualpartnern, Behandlung von genitalem Herpes, Aufklärung der Bevölkerung, Selbsthilfegruppen und viele mehr.

Nicht jede dieser Strategien jedoch wirkt gleich gut. UNAIDS hat die Effektivsten deshalb in einem «Investment Framework» zusammengestellt und ihre Bedingungsfaktoren («enablers») benannt. Es besteht heute Konsens, dass «highly active combination prevention» auf einer kontextspezifischen Kombination biomedizinischer und struktureller Massnahmen beruhen sollte, mit den Hauptpfeilern I) Behandlung mit antiretroviralen Medikamenten, II) Vorbeugung vertikaler Übertragung, III) Beschneidung von Männern, IV) Kondome, V) Fokussieren auf spezielle Zielgruppen, VI) Verhaltensveränderung.

AM SCHEIDEWEG

Gemeinsam eingesetzt wirken diese Strategien so gut, dass Experten von einer historischen Zäsur sprechen. Erstmals könnten wir die Epidemie nicht nur bekämpfen, sondern auch kontrollieren und zurückdrängen. Françoise Barre-Sinoussi, die für die Entdeckung von HIV zusammen mit Luc Montagnier den Nobelpreis erhielt, sagte im März 2013: «Models indicate that if we achieve access to ART and the elimination of mother to child transmission together with ongoing prevention techniques – we could control the HIV epidemic by 2050.»

Doch während Fachleute aufgrund dieser historischen Chance mehr Engagement und Geld für HIV fordern, haben viele Entwicklungsakteure Mühe, dies gegenüber ihren Direktoren und Parlamenten zu begründen. Zu komplex und fachtechnisch das Thema, zu gross der Fokus auf neue globale Trends geographischer (BRICS), thematischer (Klimawandel) oder politischer (arabischer Frühling; MDG+) Art.



EINIGE GRUNDSÄTZE

An welchen Leitlinien also könnten wir uns orientieren? Welche Grundsätze könnten einem verstärkten und doch veränderten Engagement zur Bekämpfung der HIV Pandemie zugrunde liegen? Womit könnten wir solch ein Engagement begründen? Hier einige Vorschläge:

- Zum ersten Mal hat die Menschheit die historische Chance, HIV nicht nur zu bekämpfen, sondern auch zurückzudrängen und zu kontrollieren.
- Dazu sollten wir in Strategien investieren, die wissenschaftlich abgesichert sind und den grössten Mehrwert bringen; und nicht in Strategien, die teilweise, etwas oder vielleicht wirken. Der Investment-Framework von UNAIDS hat sie aufgezeigt. Nur so können Ausgaben in Zeiten knapper Kassen begründet werden. Let science guide our efforts!
- Die bisher erzielten Erfolge sind beeindruckend, doch fragil. Betroffene Staaten müssen sich operationell und finanziell noch stärker engagieren, und dazu gedrängt werden. Ohne engen und fachkompetenten Dialog von Seiten der Geberländer scheint das nur schwer vorstellbar. Die USA beispielsweise haben jetzt dazu ein Institut für Gesundheitsdiplomatie geschaffen. Bewährte und effektive Mechanismen zur Bündelung von Expertise und Funds (z.B. Global Fund) sollten wir deshalb stärken und unterstützen.
- Angepasste Labortests und erschwingliche Medikamente wurden nur möglich durch intelligente Koalitionen zwischen Staaten,

Stiftungen, Universitäten und Zivilgesellschaft, begleitet von kontinuierlichem Lobbying durch Patientengruppen. In der fragmentierten globalen Gesundheitslandschaft kann HIV nur gemeinsam eindämmen werden, in Zusammenarbeit und Arbeitsteilung.

- Investitionen im Bereich HIV schaffen Wohlstand, auch bei uns. Durch Förderung von Forschung, Privatwirtschaft und NGOs entsteht ein «return on investment» mit Mehrwert für den Wissens- und Innovationsstandort Schweiz oder Europa. Jeder jetzt zusätzlich investierte Rappen erspart ausserdem zukünftigen Generationen höhere Ausgaben, denn: Während wir erstmals die Epidemie eindämmen können, wird sie dann weiter anschwellen, wenn wir unsere Anstrengungen nicht verstärken. «Buisness as usual» wird die Zahl der HIV-Infizierten bis 2050 verdoppeln.
- Die Globalisierung birgt ein erhöhtes Risiko neu auftretender Erkrankungen, vor allem aus Zentralafrika oder Südostasien. Erreger gehen vom Tier auf den Menschen über, verändern sich und werden infektiös. Globale Risiken halten sich nicht an Ländergrenzen. MERS-CoV und H7N9 sind dafür Beispiele. Starke und effektive Referenzlaboratorien, Gesundheitssysteme oder Qualitätskontrollen vor Ort sind im Interesse unserer Sicherheit in der Schweiz und in Europa. Dazu zählt auch gut ausgebildetes und motiviertes Gesundheitspersonal. Investitionen im Bereich HIV tragen zu all dem massgeblich bei.



EINE ZUKUNFT OHNE AIDS

Wie investieren wir unsere beschränkten Ressourcen am wirksamsten mit dem Ziel, eine Welt ohne Aids zu verwirklichen? Dies war eine der Kernfragen, die PartnerInnen von aidsfocus.ch mit Fachpersonen aus Nord und Süd und Interessierten an der Fachtagung von aidsfocus.ch am 11. April in Bern diskutierten.

Von Helena Zweifel*

***DR. JOCHEN EHMER** ist Arzt und leitet die internationalen Programme von SolidarMed (www.solidarmed.ch). Kontakt: j.ehmer@solidarmed.ch

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- Stabilität, Sicherheit und Wohlstand kann es nur dann nachhaltig geben, wenn eine Gesellschaftsordnung auf Gerechtigkeit und Freiheit gründet. Freiheit als Entwicklungspotential ist ohne Gesundheit nicht vorstellbar. Doch gemäss der Global Burden of Disease – Studie ist HIV noch immer einer der Hauptgründe für Krankheit und Tod, vor allem in Afrika. Investitionen in diesen Bereich sind also Investitionen in zunehmende Freiheit und damit in unserem eigenen Interesse.

Die USA haben die aussergewöhnliche, historische und erstmalige Chance einer möglichen Eindämmung von HIV erkannt und ihre Gesundheitsaussenpolitik daran ausgerichtet. Am 29ten November 2012 sagte Aussenministerin Hillary Clinton:

«Scientific advances and their successful implementation have brought the world to a tipping point in the fight against AIDS. The United States believes that by making smart investments based on sound science and shared global responsibility, we can save millions of lives and achieve an AIDS – free generation.» Barack Obama hat dies im Juni 2013 in seiner Rede vorm Brandenburger Tor bekräftigt.

Von diesen Worten sollten wir uns inspirieren und ermutigen lassen.

EINE WELT ohne Aids ist möglich. Davon ist aidsfocus.ch, die Fachplattform von schweizerischen Entwicklungsorganisationen zu HIV und Aids überzeugt. Wir haben die technischen Möglichkeiten, Aids zu beenden, nicht nur bei uns in der Schweiz sondern weltweit. Was vor zehn Jahren noch undenkbar schien – etwa die Zahl der HIV-Neuinfektionen zu senken und über acht Millionen HIV-positive Menschen weltweit mit antiretroviralen Medikamenten zu behandeln – wird heute erreicht. Jetzt gilt es, diese Chance zu nutzen und alle Kräfte zu mobilisieren, um die technischen Möglichkeiten auszuschöpfen und das realistische Ziel einer Welt ohne Aids zu verwirklichen. Die Frage ist: wie?

STRATEGISCH INVESTIEREN

«Um eine Welt ohne Aids zu verwirklichen müssen wir strategische Investitionen machen und uns auf jene Interventionen konzentrieren, die sich als wirkungsvoll erwiesen haben», erklärte in Bern Marjorie Opuni von UNAIDS, der Aidsorganisation der Vereinten Nationen. Marjorie war Mitglied des internationalen Expertenteams mit VertreterInnen von UNAIDS, des Global Fund zur Bekämpfung von Aids, TB und Malaria, der Weltgesundheitsorganisation etc., welches unter der Leitung Bernard Schwartländer den «New investment framework for the Global HIV response» (2011) entwickelte.

Der Investment Framework fokussiert auf die wirksamsten Programmaktivitäten für Prävention und Behandlung: Prävention der HIV-Übertragung aufs Kind, Kondome, Fokussieren auf spezifische Bevölkerungsgruppen (SexarbeiterInnen, MSM, DrogennutzerInnen), Zugang aller zu medizinischer Behandlung, Pflege und Unterstützung, Verhaltensänderungsprogramme und die Beschneidung von Männern. Diese Programminterventionen müssen begleitet und unterstützt werden durch kritische Bedingungsfaktoren («critical enablers»), die diese Programmarbeit erst ermöglichen. Dazu gehören politisches Engagement, Advocacy, Bekämpfung von Stigma und die Mobilisierung von Gemeinschaften. Zwischen HIV-Programmen, kritischen Enablers und anderen Entwicklungssektoren wie Bildung, Rechtsreformen, Geschlechtergerechtigkeit, Armutsreduktion und Gesundheitssystemen sollen Synergien gebildet werden. Der Investment Framework basiert auf einem Menschenrechtsansatz in der HIV-Antwort, der sicherstellt, dass er universell, gleichberechtigt und inklusiv ist und die Partizipation und Rechenschaft fördert. (vgl. dazu auch den Artikel «An investment framework for the global HIV response» in diesem Bulletin).

Für eine Zukunft ohne Aids braucht es auch finanzielle Investitionen. Der Framework projiziert eine Erhöhung der Ausgaben für HIV und Aids bis ins Jahr 2015, gefolgt von sinkenden Ausgaben zwischen 2015 bis 2020. Durch gezielte finanzielle Investitionen jetzt kann ei-

ne hohe Zahl an Infektionen und Todesfällen verhindert werden. Erstmals ist ein Modell entwickelt worden, das ein vermindertes künftiges Engagement im Bereich von HIV-Programmen und Dienstleistungen zeigt, als Resultat von zielgerichteten Investitionen heute, um den Wendepunkt zu erreichen. Danach werden HIV-Investitionen und HIV-Raten sinken.

Jochen Ehmer, Leiter des internationalen Programms von SolidarMed und Mitglied der Steuergruppe von aidsfocus.ch bekräftigte die historische Chance, Aids zu kontrollieren und zurückzudrängen. Dazu müssen wir «in Strategien investieren, die wissenschaftlich abgesichert sind und den grössten Mehrwert bringen; und nicht in Strategien, die teilweise, etwas oder vielleicht wirken... Let science guide our efforts!»

ENGAGEMENT VON GEMEINSCHAFTEN – EIN KRITISCHER ENABLER

Der Framework führt ein sehr wichtiges Konzept ein, die «kritischen Enabler». Zu den kritischen Enablern gehört die Mobilisierung und Einbezug der Gemeinschaft, ein Konzept, mit welchem sich viele PartnerInnen von aidsfocus.ch identifizieren, und dem in anderen Modellen bislang kaum die notwendige Anerkennung zugesprochen worden ist.

Die Beispiele von SüdpartnerInnen aus Simbabwe und Indien bezeugten die Relevanz der Beteiligung von Gemeinschaften und weiterer kritischer Enablers in einer erfolgreichen Aidsarbeit.

Simbabwe, ein Land, in dem 1,2 Millionen Menschen mit HIV leben, ist mit einer Prävalenzrate von 14,9% eines der am härtesten von der Aids-Epidemie betroffenen Länder weltweit. Die simbabwische NGO BHASO (Bata nai HIV/AIDS Service Organisation) investiert primär in Gemeinschaften und Menschen, die mit HIV leben. «Wir wollen, dass Leute, die mit HIV leben, an vorderster Front kämpfen, um mit HIV und Aids umzugehen und zu beenden, denn sie verstehen ihre eigene Situation und einander besser», erklärte Farai Mahaso, Koordinator von BHASO. Für ein wirkungsvolles Engagement brauchen sie auch Kenntnisse und Fertigkeiten. Hier kommt BHASO ins Spiel, indem es HIV-positive Menschen mit den notwendigen Informationen ausstattet und darin unterstützt, ihre eigene Stimme zu erheben und gemeinsam für ihre Rechte und Anerkennung zu kämpfen als Teil der Gemeinschaft.

BHASO fokussiert auf die Umsetzung von kostengünstigen Aktivitäten und die betroffenen Menschen übernehmen selbst Verantwortung. Simbabwe ist es gelungen, die Infektionsrate von 20-30% auf etwa 13,7% zu senken, und dies vor allem dank Verhaltensänderungen.

Auch in Indien, einem anderen Kontinent und Kontext, einem Land mit konzentrierter Epidemie und einer relativ niedrigen Prävalenzrate in der allgemeinen Bevölkerung, spielen Gemeinschaften eine ausschlaggebende Rolle im Engagement gegen Aids. Die südindische NGO Samraksha arbeitet eng mit Gemeinschaften zusammen – Gruppen von Frauen in der Sexarbeit, Männern, die Sex mit Männern haben, gefährdeten Jugendlichen und Menschen, die mit HIV leben – also Bevölkerungsgruppen, die besonderen Risiken einer HIV-Infektion ausgesetzt sind. Im Investment Framework werden sie als zentrale Zielgruppe für HIV-Interventionen bezeichnet.

Wie in Simbabwe unterstützt Samraksha in Indien betroffene Menschen und ihre Gemeinschaften in deren Strategien und stärkt sie im Selbstwert und Selbstvertrauen. «Die Motivation um «safer sex» zu praktizieren und regelmässige Gesundheitschecks zu machen sind zentral für die Gesundheit von Frauen in der Sexarbeit», erklärte Sanghamitra Iyengar, Direktorin von Samraksha: «Frauen müssen fühlen, dass ihre Gesundheit Priorität hat und dass der eigene Schutz an erster Stelle kommt. Dazu müssen Veränderungen von innen kommen und von aussen unterstützt werden.» Samraksha arbeitet mit den Frauen zusammen an den Umfeldbedingungen, insbesondere der Entkriminalisierung der Sexarbeit, der Reduktion von Stigma und der Schaffung starker Unterstützungsnetze.

Die Erfahrungen von Samraksha mit Frauen im Sexgewerbe und von BHASO mit Menschen, die mit HIV leben, validieren die Bedeutung der kritischen Enabler und die Verknüpfung mit anderen Entwicklungsbereichen, wie vom Investment Framework vorgeschlagen.

VERNETZUNG UND ZUSAMMENARBEIT

Im World Café im Rahmen der Fachtagung entbrannten lebhaft Diskussionen unter den Teilnehmenden zur Fokussierung: Was heisst smart investieren, mit den vorhandenen Ressourcen möglichst effektiv umgehen in Hinblick auf das Ziel, eine künftige Welt ohne Aids? Sollen wir, Partnerorganisationen von



aidsfocus.ch, uns vermehrt auf medizinische HIV-Interventionen konzentrieren, deren Wirksamkeit wissenschaftlich erwiesen ist? Oder sollen wir auf die Kraft und Innovationsfähigkeit von lokalen Gemeinschaften und Basisorganisationen setzen, um Ergebnisse und wahrnehmbare Veränderungen vor Ort zu erzielen, die jedoch nicht mit «harten Daten» belegbar sind?

Die Debatten brachten die Heterogenität der Partner von aidsfocus.ch und weiterer Schweizer Akteure auf den Tisch. Viele Organisationen sehen ihre Stärke in der Basisarbeit und auf gesellschaftlicher Ebene, andere haben besonderen Kompetenzen und Aufgaben in der Basisgesundheits- und medizinischen Interventionen. Trotz unterschiedlicher Strategien und Prioritäten sind sich grundsätzlich alle einig, dass es «smarte» Investitionen in der Aidsbekämpfung und zielgerichtete HIV-Interventionen, wie Behandlung und die Prävention der HIV-Übertragung aufs Kind (PMTCT), braucht, die aber unabdingbar mit den kritischen Enablern verknüpft sind. Die Erfahrung hat uns wiederholt gelehrt, dass es nicht reicht, antiretrovirale

Medikamente anzubieten ohne dass die Betroffenen gut informiert und beraten und von der Gemeinschaft ganzheitlich unterstützt werden. So arbeitet BHASO erfolgreich mit den medizinisch ausgerichteten Organisationen SolidarMed und Médecins Sans Frontières (MSF) zusammen, sich gegenseitig ergänzend und unterstützend.

NOCH SIND WIR NICHT AM ZIEL

Die bislang erzielten Erfolge werden zunichete gemacht, wenn wir uns nicht jetzt mit voller Kraft für die Bekämpfung von HIV und Aids engagieren. Jochen Ehmer fordert daher, dass betroffene Staaten sich operationell und finanziell noch stärker engagieren müssen. Doch «ohne engen und fachkompetenten Dialog von Seiten der Geberländer scheint das nur schwer vorstellbar», ergänzt er. Ausserdem sollten wir «bewährte und effektive Mechanismen zur Bündelung von Expertise und Funds (z.B. Global Fund) stärken und unterstützen».

Die Direktion für Entwicklung und Zusammenarbeit (DEZA) ist eine globale Akteurin im HIV/AIDS-Bereich. Sie investiert im The-

ma auf drei unterschiedlichen Ebenen. Gerhard Siegfried, Leiter der Abteilung Ost- und Südliches Afrika und des Themenbereichs Gesundheit bei der DEZA führt aus, dass die politische Ebene des Themas für einen staatlichen Akteur hohe Priorität hat. Die DEZA leistet durch ihre Politikarbeit Beiträge zur Verbesserung der globalen Gouvernanz, in der multilaterale, bilaterale und zivilgesellschaftliche Organisationen und Regierungen in unterschiedlichen Rollen zusammenarbeiten; dies geht über das Engagement bei UNAIDS und anderen multilateralen Organisationen hinaus. Eine zweite Ebene ist die Advocacy (Anwaltschafts-)Rolle: hier geht es darum, dafür einzustehen, dass HIV und Aids auf der globalen Agenda eine wichtige Priorität auf der globalen Gesundheitsagenda bleibt. Dies geschieht mit unterschiedlichen Instrumenten, unter anderem die finanzielle Unterstützung von aidfocus.ch und der Finanzierung von, respektive die Teilnahme an internationalen Plattformen zu HIV und Aids. Eine dritte Ebene ist die Zusammenarbeit mit und Unterstützung von Partnerländern und Organisationen auf Programm-/Projektebene, wobei sich die DEZA auf zwei Subthemen fokussiert: Prävention und Kinder/Jugendliche als spezifische Zielgruppe.

Die in der Fachplattform aidfocus.ch organisierten Entwicklungsorganisationen werden sich weiterhin für eine Zukunft ohne Aids engagieren und ihre Kräfte vermehrt bündeln. Die Partnerorganisationen geben ihre Fachexpertise in den Austausch ein, auf dem die Sensibilisierungsarbeit und der entwicklungspolitische Dialog von aidfocus.ch aufbauen. Die Arbeit mit Partnern vor Ort gibt ihnen die Möglichkeit, die Erfahrung, Kenntnisse und Interessen von betroffenen Gemeinschaften, Ländern und Regionen miteinzubringen. Sowohl die Unterstützungsgruppen von BHASO wie auch von Samraksha bringen sich, ihre Anliegen und Kenntnisse in die nationale Debatten und HIV-Politik ein und bilden Netzwerke national und international. Veranstaltungen wie

die Fachtagung sind wichtige Orte, um miteinander und mit Südpartnern, multilateralen Organisationen und weiteren Fachleuten das Wissen zu teilen, voneinander zu lernen, Kontakte zu knüpfen und Allianzen zu schmieden für die entwicklungspolitische Arbeit. Dazu gehört das Engagement für einen starken Global Fund zur Bekämpfung von Aids, Tuberkulose und Malaria und für einen der wirtschaftlichen Kraft der Schweiz angemessenen finanziellen Beitrag für den Global Fund, der seine Expertise und Wirksamkeit bewiesen hat und im Engagement für eine Welt ohne Aids ein tatkräftiger Partner ist.

*HELENA ZWEIFEL ist Koordinatorin der Fachplattform aidfocus.ch und Geschäftsführerin des Netzwerkes Medicus Mundi Schweiz.



Foto: Thomas Schupisser

Seiten 31–63 Targeting the Critical Enablers

“In the African context and typically in our traditional and rural village set up, children are seen and not heard. As children we do not have a voice on issues of importance regarding our own welfare, rights, interests, privileges and concerns.” Thabisani Ncube



CHILDREN TODAY, ADULTS TOMORROW: MAKING A DIFFERENCE NOW!

The article is set in Nshamba Township; located in Muleba District in the Kagera Region of Tanzania. Nshamba is a small trading centre with about 8 000 inhabitants and a population total of 18'000 people inclusive of surrounding villages. The article will profile the work of orphans and vulnerable children supported by Humuliza Organisation, a local Non Governmental Organisation based and operating in Nshamba and surrounding villages whose psychosocial support interventions target children known as (Rafiki Mdogo) in Swahili and youth (Vijana Simama Imara [VSI]) infected or affected by HIV and AIDS.

By Thabisani Ncube*

HUMULIZA Organisation is a partner organisation supported by terre des hommes schweiz which has also come to strengthen the capacity of its psychosocial support interventions by integrating the Solution Focused Approach methodology whose impact and key principles will be highlighted in the article through the added value or difference it has brought to bear on the status and lives of children in Nshamba community.

The author of the article is merely consolidating the significant narrative, impressions, value judgments, hopes and aspirations of the principal actors, that is the children of Nshamba whose voices are present in this text through life interviews obtained. Assent of the children and consent of their guardians and parents was sought before production of this article. The story line is also a recollection of the authors' impressions on travels into the region on work assignment. It is my earnest hope and belief that the article will present a true picture of children taking small steps that will ultimately lead to big changes and inspire a selfless spir-

it to live for others and keep making a difference regardless of your social status, age, sex and material disposition in the journey of life.

Our hands, Our minds, Our destiny! Young people utilise platforms convened by Humuliza to brainstorm and exchange ideas on how they can contribute to the health and well being of the community

In the African context and typically in our traditional and rural village set up, children are seen and not heard. As children we do not have a voice on issues of importance regarding our own welfare, rights, interests, privileges and concerns. We are passive recipients of decisions passed on our behalf and for our own good through the tried and tested, vastly experienced and well intentioned goodwill of our parents or guardians whose sole existence and sustenance our lives and livelihoods depend. This largely owes to our traditional African society's norms and beliefs that attach reverence to maturity which is associated with age and rites of passage into adulthood which are attained when one gets married. This in-



self limits our voices being heard or taken seriously and therefore our active and meaningful participation in making decisions that guarantee or consider our views, interests, concerns and rights is placed lower down the family and community agenda. The adverse effects of the HIV and AIDS pandemic which has witnessed a growing number of households being left orphaned and child headed has in itself presented a challenge to this conservative traditional school of thought and demands that children be heard. HIV and AIDS has torn the traditional fabric of a sense of community where it was clearly spelt out in principle and practice, that it takes a village to raise a child.

Child headed and orphaned households due to the effects of HIV and AIDS have become even more impoverished with a bleak future in an already grim, survival of the fittest type of environment where everyone is either infected or affected and cannot escape from the firm grip of the vicious cycle of poverty, food insecurity, loss of disposable income, shelter, hope and vision for a better future, desperation for a possi-

ble cure which leads to children being sexually abused as a potent remedy to rid the infected of the virus as prescribed by greedy, clueless traditional healers, an outburst of domestic violence and dispossession of inheritance perpetrated against vulnerable child headed households without a protector by opportunist relatives and guardians who want to reap where they have not sown and the loss or absence of role models to set good examples of morals and reignite our aspirations to think of the unthinkable and do the impossible as our dreams and imagination remain our only enclave of refuge in these difficult circumstances.

STIGMA AND DISCRIMINATION

Moreover, this environment is punctuated by myths and misconceptions about the transmission of the virus and therefore the continued incidence of HIV is as a result of poor personal risk perception as discussions surrounding sex and sexuality are still considered a taboo. This environment is also breeding rife stigma and discrimination practices where there is no open



communication about one's status due to fear of being blamed for loose morals or irresponsible sexual behaviour coupled by poor health seeking behaviour as healthy facilities and access fees are beyond the reach of many families who are already struggling to make ends meet. Most children are forced to drop out of school to fend for their bed ridden parents and also risk infection due to unhygienic conditions of palliative home based care and this has also contributed to stigma and discrimination of affected households for fear of spreading the virus when they engage other children during play. Lack of adequate knowledge and the knowledge not translating into action to realise behaviour change through reduction of harmful traditional and religious practices such as girl child pledging and promotion of responsible sexual behaviour is still an unfortunate reality that dogs our rural landscape.

The work of Humuliza Organisation has over the years given impetus to the winds of change blowing over our rural landscape through the availing of platforms where young people meet to exchange and debate on critical issues regarding child centred community development with the support of communi-

ty leaders who command a large sphere of influence not only as change makers but as role models and advocates to create an enabling environment and platform for children to take an active part in meaningful community development not only for their present benefit but for posterity. The constant dialogue amongst ourselves and with community leaders has over the years pushed our interests, concerns, rights and expectations higher up the community agenda. We are now not only being seen but heard with a collective voice as we make our communities that in as much as we are children today, we will become adults tomorrow and therefore there is need to invest in us now as tomorrow's leaders in the making today. Young people are now actively taking part in resuscitating good values of community by assisting in the identification and provision material support to most vulnerable households.

Given our seemingly problem saturated environment it has become convincingly clear to us as young children that we do not only have rights but responsibilities in ensuring the best outcomes for an improved quality of life and wellbeing for other children and the community at large. To the outside world that is not fa-

miliar without context, it may seem as if our rights are being violated, which to some extent they are, however given what we aspire to become and the change that we envision for our community, we are sacrificing some of our childhood privileges to make a positive difference as tomorrow's leaders in this lifetime. Social and economic circumstances within our community have stripped child play of our hands and created space for children to take up responsibilities that match or surpass those of the adult community members as a survival strategy in this jungle of uncertainties. As young people we have chosen to live and not merely exist; stand up and be counted without forgetting to take a step back and reclaim our childhood because all play and no work makes as dull participants. Let it be categorically stated that we are not challenging any traditional systems or addressing any imbalances, we have simply reclaimed our small spot as important community players who not only learn today, but live the experiences to share for the benefit of future generations who should know that age discrimination was overhauled in our community by the sheer will power of children who took up spaces to actively and meaningfully participate in community development initiatives.

CHILDREN AS EXPERTS

The orientation trainings on the solution focused approach methodology which has strengthened the visibility and impact of our work in children's clubs facilitated by Humuliza organisation has given a huge boost to how we perceive our life circumstances not as victims, instead as experts because no one knows our life story better than us as the authors. The approach facilitated new thinking on focusing more on the solutions to presenting problems than analysing our problem saturated context. On first impressions the methodology was perceived as more of a fantasy or fairytale approach far divorced from the reality and complexities of our day to day living environment. Clearly we could not wish away our problems by way of a new way thinking as they were even older than us. Resilience for us simply meant bearing hardships that everyday life throws at us, without any hope in sight that the situation could ever improve. Humuliza as an organisation as well was virtually challenged on how to build upon or maintain the success-

es they had registered and as if God sent, this approach became a breath of fresh air to inspire life and strengthen the organisation's existing approaches in reaching out to children and the community as a whole.

The central theme for the methodology as we learned is: The client is the Expert. Referring to children as experts was pretty much inconceivable in our community as we still have a long way to travel the journey of life and pick up valuable and enriching life experiences to be effectively acknowledged as experts of our own lives. At first impressions it sounded like too much to ask however, the trainings were packaged in a very simple way where we were made to reflect on the strengths and resources we possess which we could use to find solutions to presenting problems. As this was an unusual question to be asked about you strengths we found it difficult to list at least three things we are good at or what we consider as essential resources in our lives. The facilitators proceeded to ask what others would say we are good at and this opened up possibilities to list our strengths even more confidently. It was also humbling to hear peers mentioning a strength which I considered unimportant but helped them see me in a different and positive light.

Sharing experiences with peers in a solution focused way makes us feel as if a burden has been lifted off our young shoulders as the focus is on what is working and doing more of what works and receiving compliments that drive you to want to make a difference. We further realised that with the solution focused approach is not dismissive of the problems that arise from the complexities and turbulence that people experience, instead is much more interested in processes that help people achieve the preferred futures they hope for. As ongoing learning we are beginning to appreciate that although we stay in problem saturated contexts, no problem happens all the time, there are times when things are going a tiny bit better, and focusing on these exceptional moments brings out underutilised strengths or resources that can be applied to find solutions to these challenges.

One of the lessons to be drawn from this approach stemming from the movement that we are witnessing being led by children in our community is the approach's emphasis on focusing on a doing level. Continuous exercis-



es to put into practice what we have learnt has given rise to children taking an active role in helping peers in difficult circumstances to also find meaningful solutions to presenting problems. We are becoming the change that we want to see in the community and as change agents and we are beginning to see that the community has a renewed energy to do more of what works and to keep making a difference in the lives of the less fortunate and empower them with this manner of thinking that improves the quality of interventions, relationships and community well being. Our message to our community is clear; we may be children now and adults tomorrow, however making a difference begins now! and that is our investment for the future with the belief that

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Swaziland

TOWARDS AN HIV-FREE NEW GENERATION

While socio-economic indicators have remained largely above the sub-Saharan countries average (for example literacy rate at 82%), Swaziland hit the international headlines for being the country the most affected by the HIV/AIDS pandemics. At the turn of the millennium, life expectancy became the lowest in the world, dropping from 61 year to 32 year as a result of the very high AIDS-related mortality. Since then, enormous efforts have been undertaken by the country with the support of the international community in the fight against HIV/AIDS.

By Sybille N'Zebo and Bruno Gremion*

OFTEN CALLED the “Switzerland of Southern Africa”, the Kingdom of Swaziland is a tiny mountainous and landlocked country with a population of 1.3 million inhabitants. Although rapidly changing, the country remains strongly influenced by the traditional monarchic power structure and a deep Christian faith. The Swazi society is essentially rural (77% of the population) and can be qualified as rather conservative and male-dominated.

The current National Multisectorial Strategic Framework for HIV and AIDS 2009 – 2014, provides a strong framework for HIV prevention and treatment countrywide. Public investment in the health sector has been steadily growing and the government has more than doubled its allocation for the Ministry of Health (MoH) between 2007 and 2012. As a result, the coverage for HIV/AIDS prevention and treatment has steadily increased, with over 100 health facilities providing free HIV/AIDS related services, including provider initiated HIV testing and counselling (HTC), prevention of mother to child transmission (PMTCT), as well as antiretroviral therapy (ART) for AIDS patients. Thanks to the high ART coverage, the negative trend could be reversed in the re-

cent years, with a reduction of mortality and increase of life-expectancy, which is now estimated at 49 years. The rapid increase of tuberculosis (TB) became a major source of concern in the past few years. About 80% of TB patients are co-infected with HIV/AIDS, and TB is responsible for about 50% of mortality amongst AIDS patients. In 2012, 70 health facilities are providing TB treatment, a sharp increase from 17 in 2009.

On the prevention side, efforts have brought mixed results. While PMTCT is well performing, it has been much harder to reach behavioural changes through promotion of abstinence, being faithful to the partner, delaying of sexual debut, reduction of number of sexual partners and consistent condom use. The prevailing traditional social, cultural and political environment does not favour a rapid behavioural change towards safer-sex practices. While stigmatisation towards people living with HIV/AIDS (PLWHA) has decreased, very conservative and judgemental positions in the society have certainly undermined prevention campaigns amongst high-risk groups, youth in particular. Condom promotion is still a taboo in schools, with the resulting risk of infection and a high rate of teenage pregnancies.



Foto: David Chancellor

By 2013, the HIV incidence is still very high (2.6% yearly), while the prevalence remains the highest in the world with 26% of the adult population living with HIV (peak of 45% in the 30-34 age group).

THE SWISS RED CROSS (SRC) SUPPORTED "HIV INTEGRATED PROGRAMME" IN A NUTSHELL

Since 2003, SRC has been partnering with the Baphalali Swaziland Red Cross Society (BSRCS), initially through supporting ART in BRSCS' primary health clinics and prevention activities with youth. Soon activities were broadened to a comprehensive HIV programme, including the following three pillars: prevention (HTC, PMTCT, community outreaches, youth peer education programme), treatment and care (ART for HIV-infected patients, TB treatment, home based care programme), as well as impact mitigation (food security and nutritional support, support to orphans and vulnerable children, stigma reduction).

While the youth programme has a national coverage, the other activities are centred on the catchment area of two clinics run by the Swazi Red Cross: Mahwalala located in a periurban area of the capital city Mbabane and Sigombeni located in a rural area. The Red Cross clinics provide affordable primary health care services, includes treatment of common diseases at outpatient level, antenatal care (ANC), family planning (FP), child welfare (CW), health education, community outreaches, as well as comprehensive services related to HIV/AIDS: HTC, PMTCT, treatment of opportunistic infections (OIs) including tuberculosis (TB).

SUCCESSES AND CHALLENGES

Over the years, the Red Cross clinics have acquired an excellent reputation amongst patients and authorities. Sigombeni clinics pioneered in the provision of ART in a rural environment, and the two clinics currently provide ART to over 1800 AIDS patients (out of 83000 countrywide). AIDS related morbidity and mortality dropped drastically over the past few years thanks to the free access to ART, although the recrudescence of TB is putting these recent progresses at risk.

The Red Cross clinics do follow the national protocols, and receive free supply of ARV, TB drugs and laboratory tests from the MoH. In 2013, the government has started subsidizing part of the salary costs for nurses, and it is expected that the clinics will soon be able to sustain themselves financially without the support of SRC. However, important institutional challenges still need to be addressed in order to maintain the quality standards and reduce the high staffs turnover, in a context where the number of nurses is critically insufficient countrywide.

Home based care (HBC) is provided in the catchment area of the clinics by a network of 100 Red Cross care facilitators, who are in the process of being integrated into the government network of community health motivators. More than 200 orphans and vulnerable children (OVC) receive material (payment of school fees and uniforms, food parcels to the most needy) and psycho-social support from the programme, while the establishment of backyard gardens aims at improving the nutritional status of the beneficiaries.

The youth programme is contributing to awareness raising, behaviour change and stigma reduction through a combination of drama play, class sessions and peer to peer education provided by Red Cross volunteers. The true impact of the youth programme remains however difficult to measure, and is confronted to the huge challenge of promoting behaviour change in such traditional environment. The decrease of 4% between 2010 and 2012 in the HIV prevalence rate (42% to 38%) amongst pregnant women attending ANC at the two clinics seems to indicate a moderate downward prevalence trend amongst young adults.



Foto: David Chancellor

PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)

In Swaziland, virtually all HIV infections in children are due to mother-to-child transmission, which can occur either during pregnancy, labour and delivery, as well as during breastfeeding. The risk of HIV transmission from a positive mother to the baby is estimated at 30-45%. As the current HIV prevalence amongst Swazi pregnant women is 41%, approximately 12-18% of all new-born would contract HIV within their first two years of life without PMTCT intervention. Therefore, in terms of prevention, the PMTCT component of the programme is certainly the most successful intervention.

When PMTCT services were established in Swaziland in 2003, estimated 5400 infants contracted HIV from their mother each year. By 2009, this number was reduced to 2300, and the national objective is to eliminate the mother to child transmission by the year 2015 with a residual number of 250 cases per year (corresponding to 5% of infected infants born from HIV positive mothers).

The Guidelines for Prevention of Mother to Child Transmission of HIV provide the national framework for the implementation of PMTCT through a four pronged approach:

1. Primary prevention of HIV infection among women of child bearing age
2. Prevention of unintended pregnancies among HIV positive women
3. Prevention of MTCT from HIV positive women to their babies during pregnancy, labour and breastfeeding periods
4. Care, support and treatment for HIV positive women and their families.

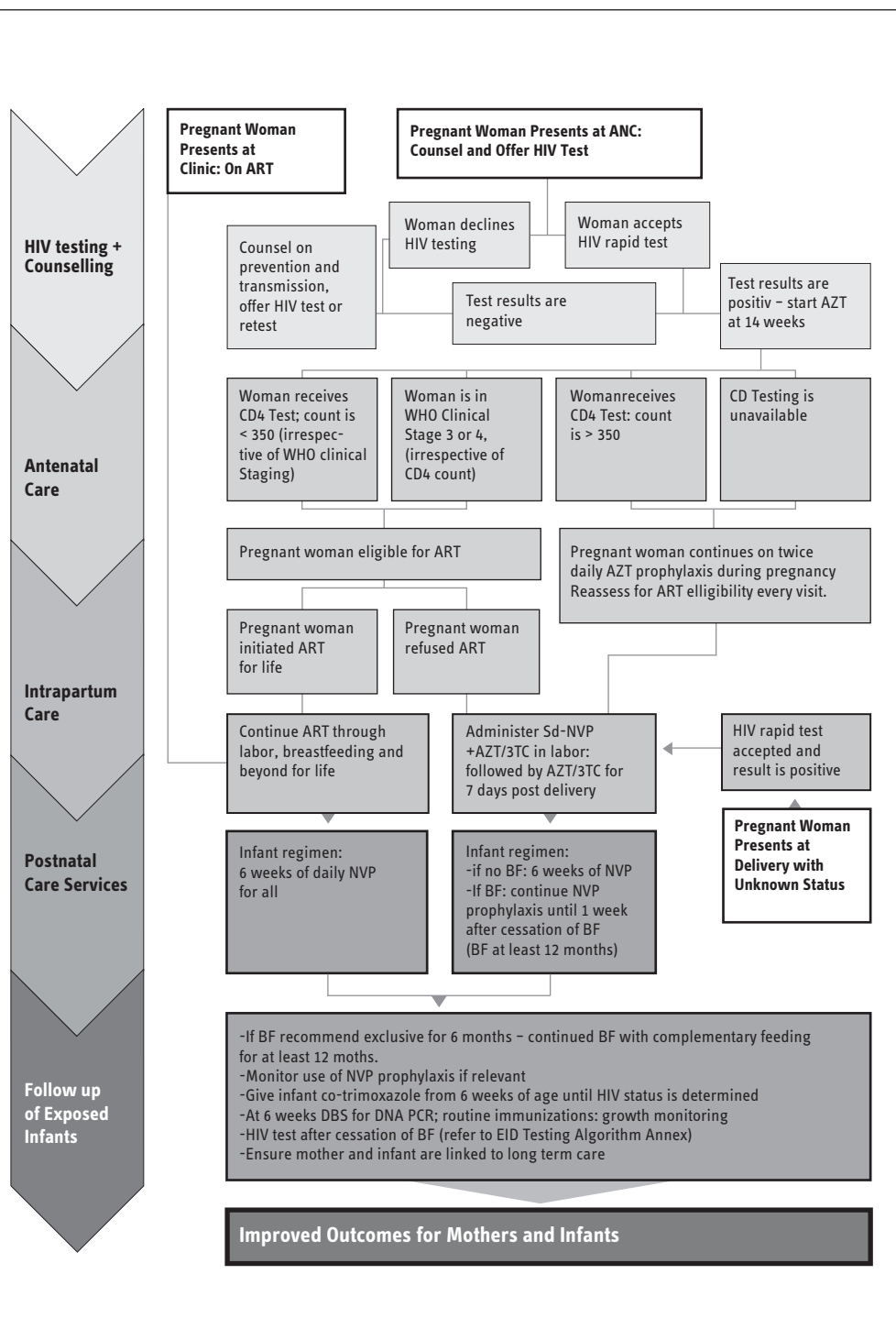
While progresses have been rather slow for prong 1, 2 and 4, spectacular results have been obtained in preventing the transmission from HIV infected pregnant women, through the provision of effective ARV prophylaxis given to both the woman and the infant according to the following algorithm:

THE RED CROSS CONTRIBUTION

In the two clinics supported by the SRC programme, 350 pregnant women are attending

Guidelines for Prevention of Mother to Child HIV Transmission

Figure 1. Delivery of PMTCT services in maternal and child health care settings



ANC services each year. Virtually all of them (99.6%) have accepted to be tested for HIV/AIDS, and the prevalence rate is 38%.

Depending on whether the woman is eligible for ART (respectively is already on ART), specific prophylaxis is provided to the HIV positive women following the national protocols (see chart above). In 2011, 98% of the exposed babies tested negative at the age of 6 weeks, while in 2012 the perfect score of 100% was achieved.

However, the excellent results obtained at the age of 6 weeks must be tempered by the difficulty met by the programme to follow-up the babies until they are weaned from breastfeeding. The clinic still needs to improve patient follow-up, through an increased networking with the community health motivators and efficient tracing by the follow-up assistants.

Another challenge is to regularly and systematically test all HIV negative pregnant women during each ANC visit in order to detect possible sero-conversions during pregnancy. Such repeated testing is vital, as newly infected persons do present a particular high viral load with an increased risk of infecting the foetus. This unfortunately occurred once in 2012, when a baby considered non-exposed did test positive at the age of 6-week. A lifelong treatment awaits him, unless future medical progresses will a day allow a complete healing.

Looking back in the mirror, tremendous progresses have been achieved over the past decade. Once considered an inaccessible dream for the developing world, PMTCT has now become accessible to virtually all pregnant women in Swaziland.

TOWARDS AN HIV FREE GENERATION: A VISION UNDER THREAT...

Once considered a utopia, the constant improvement of PMTCT services over the past 10 years has greatly contributed to approaching the vision of creating an HIV-free genera-

tion, and consolidating this success will remain within the future priorities. But dark threatening clouds are still obscuring the horizon...

The current prevention programmes targeting the youth are largely reflecting the local conservative environment, sometimes reinforced by the same conservative orientation of a few powerful donors. The inclusion of sexual and reproductive health (SRH) within the school curriculum is still in its infancy, and school-based peer education programmes do mainly focus on delaying sexual debut and preaching abstinence rather than informing and educating on safer sexual practices, in particular condom use.

As a result of the relative failure of the current prevention campaigns amongst youth, the teenage pregnancy rate remains extremely high (one out of four girls will have their first child in their teens), which is not surprising considering that only 43% of the sexually active young women have reported using a condom during their first sexual intercourse.

A lot of these early pregnancies are due to intergenerational sex, in particular through the widespread phenomenon of sugar daddies, usually elder males providing material support to young girls in exchange of sexual favours. Exposing this young generation to another age group with high prevalence provides an open door for a rapid transmission of HIV, first to the young women and then to their male peers, considering the high number of sexual partners and relatively low level of condom use. While the HIV prevalence is "only" 1.9% amongst boys aged 15-19 year old, it reaches 10.1% for girls in the same age group!

The main challenge for the coming 10-20 years will be to retain PMTCT successes and provide an appropriate combination of school-based sexual education, provision of youth-friendly SRH services and promotion of safer sex practices. With the involvement of all stakeholders, including the government, traditional leaders, development agencies and, last but not least the youth themselves, the next utopia will be to concretise this new vision to keep the new generation HIV-free!

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Bonsiwe's story

Bonsiwe is a 26 year old Swazi woman living in the outskirts of Mbabane. Mother of a nine year old daughter to whom she gave birth while she was still a schoolgirl, Bonsiwe married her current partner in June 2011. A year later, she got pregnant for the second time and attended antenatal care (ANC) at the nearby Mahwala clinic run by Baphalali Swaziland Red Cross.

During her first ANC visit in October 2012, Bonsiwe, who was unaware of her HIV status, accepted to test. She first became deeply shocked and cried a lot when she learned that she was HIV positive. Silungile, the nurse who attended Bonsiwe, provided her with the best possible counselling. Understanding that she had a chance to give birth to an HIV negative baby, Bonsiwe decided to fight and became stronger and stronger despite the bad news.

Due to her relatively high CD4 count and good health status, Bonsiwe was not eligible for ART initiation, but received instead the standard prophylaxis composed by AZT intake during pregnancy, intrapartum ARV combination during labour, followed by a tail treatment for 7 days post delivery.

Between October 2012 and March 2013, Bonsiwe attended a total of 4 ANC visits, during which she was not only monitored for her health status, but also further counselled and informed about the upcoming treatment and procedures, as well as the importance to adhere to exclusive breastfeeding would she elect to breastfeed. A strong relation established between Bonsiwe and her nurse Silungile who followed her throughout her pregnancy.

After her second ANC visit, Bonsiwe disclosed her HIV status to her husband. While he demonstrated a supportive attitude, he has so far refused to test. Bonsiwe is urging him to get tested, either on his own or during a couple counselling session.

On 17 March, Bonsiwe gave birth at Mbabane Hospital to Sokaya, a strong boy proudly weighing 3.5kg, who also has to receive nevi-

rapine (NVP) prophylaxis. As she has decided to breastfeed her child, she will need to continue administering Sokaya with the NVP prophylaxis until after stopping breastfeeding.

On 3rd May, Bonsiwe returned to the clinic for the Child Welfare consultation, during which a blood sample was taken from Sokaya and sent to the laboratory for the crucial 6-week HIV testing. As soon as the clinic received the results from the laboratory, Silungile called the mother to inform her that her child was negative. What a joy for Bonsiwe, who can now envision a bright future for her two children, the elder daughter being also negative. Her gratitude towards Silungile who took such good care of her is without limit.

But the fight is not over, as she needs to consistently give Sokaya his NVP prophylaxis until she stops breastfeeding. For herself, the fight is only starting, as she knows that sooner or later, she will have to start a lifelong ARV treatment, a condition sine qua non in order to see her two children growing up.

PRÄVENTION HIV/AIDS UND FOKUSSIERTE

Die Verbreitung des HI-Virus in Kuba ist in den letzten drei Jahren konstant geblieben. Von Ansteckungen sind vorwiegend Männer betroffen, die Sex mit Männern haben (MSM). mediCuba-Suisse engagiert sich seit elf Jahren in Präventionsprojekten der Provinz Matanzas. Die Erfahrungen zeigen: Der komunitäre Ansatz und die zielgruppenspezifische Ausrichtung sind Schlüssel-faktoren einer erfolgreichen Präventionsstrategie.

Von Marianne Widmer*

KUBA hat eine Wohnbevölkerung von 11'258 Millionen. 2010–2012 ist die Zahl der neuen Diagnosen von HIV mit jährlich rund 1800 pro Jahr stabil geblieben, nachdem sie bis 2009 stetig angestiegen war. (Datenquelle: Registro Informatizado VIH/Sida, MINSAP (Kubanisches Gesundheitsministerium) Seit 1986 wurden in Kuba 17'625 Ansteckungen mit HIV diagnostiziert. 2977 der HIV-Infizierten waren bis Ende 2012 gestorben. Ende 2012 lebten in Kuba 14'648 Personen mit diagnostizierter HIV-Infektion, davon sind 4738 an Aids erkrankt und 8012 erhalten antiretrovirale Medikamente (ARV).

Die geographische Verteilung der HIV-Diagnosen zeigen die Zentrumslast, welche die Hauptstadt Havanna auch bei HIV/Aids trägt: im vergangenen Jahr wurden über 50% der HIV-Infektionen in Havanna diagnostiziert. In Havanna leben aber weniger als 20% der kubanischen Wohnbevölkerung. Ungleich ist auch die Verteilung der Infektionen auf die Geschlechter: von den 17'625 Diagnosen entfallen 14'235 auf Männer, was gut 80% entspricht. Im Jahr 2012 hat sich dieses Bild wieder bestätigt: von den 1801 neuen Fällen wurden 1443 bei Männern und 358 bei Frauen diagnostiziert. Rund 88% der Infektionen bei

Männern betreffen Männer, die Sex mit Männern haben (MSM). In der Schweiz betreffen ca. 45% der Neudiagnosen MSM

DIE FOKUSSIERTE ARBEIT MIT UND FÜR MSM IST ZENTRAL FÜR DIE REDUKTION VON NEUANSTECKUNGEN

Es ist offensichtlich, dass zur Eindämmung von HIV/Aids und anderen sexuell übertragbaren Krankheiten (STI) geeignete Strategien umgesetzt werden müssen, welche die Ansteckungen dort verhindern, wo sie sich am leichtesten ereignen und am häufigsten vorkommen. Aus epidemiologischer Sicht braucht es Ansätze, welche sich über hartnäckige Stigmen und Tabus hinwegsetzen und MSM entschieden in den Fokus rücken. Seit 2003 ist im nationalen Präventionsprogramm HIV/Aids MSM als eigene Linie mit einer Reihe spezifischer Instrumente und Massnahmen definiert. Prävention von HIV und STI bei schwulen Männern ist für Kuba eine Priorität der öffentlichen Gesundheit, und «Bisexualität» ist wegen herrschender Tabus häufig. Über bisexuelle Männer sind auch Frauen von HIV betroffen.

Wichtig ist, die Prävention dorthin zu bringen, wo das Virus ist und wo Menschen Risiken eingehen. Dafür braucht es ein Wissen

über die Praktiken und Gewohnheiten der stark betroffenen MSM. Je mehr bekannt ist, desto besser können die Massnahmen für MSM angepasst und verfeinert werden, Botschaften für sicheren Sex werden spezifischer und nehmen Bezug auf die konkrete Praxis MSM. Welchen Stellenwert haben feste Beziehungen bei MSM, wie oft und nach welchen Mustern findet Sex mit wechselnden Partnern innerhalb einer festen Beziehungen oder innerhalb von Männergruppen statt, wie und wo kommt es zu zufälligen Kontakten, bei welchen Gelegenheiten werden Kondome verwendet? Wichtig sind auch möglichst genaue Kenntnisse darüber, zu welchem Zeitpunkt der Infektion die Diagnose gestellt wird. Je früher die Diagnose und je häufiger nach einem Risikokontakt ein vorsorglicher HIV-Test gemacht wird, desto eher lässt sich die Weitergabe des Virus verhindern. In den ersten 3–4 Monaten nach der Ansteckung ist die Virenlast 30–100mal höher als später in der latenten Phase. Mit Umfragen und Untersuchungen via Peers in der MSM-Community und in der Begleitung von Personen mit HIV-Diagnosen wird verifiziert, welches die Praxis ist und ob es bei MSM zu Veränderungen im Risikoverhalten kommt. Solche heikle Informationen können nur in einem Klima von Vertrauen und Sachlichkeit erhoben werden: es wird über Sex gesprochen, um individuelle und gesellschaftliche Risiken bewusst zu machen und abzuwägen. Die Person und ihr Sexleben werden auch nicht unterschwellig in Frage gestellt oder beurteilt. Verhaltensänderungen zu Gunsten von sicherem Sex hängen allerdings nicht nur vom Informationsstand und dem Bewusstsein ab, sondern auch von der Verfügbarkeit von Kondomen und dem einfachen Zugang zu Testmöglichkeiten. Die Tests zu haben und am richtigen Ort vornehmen zu können, ist in Kuba keine Selbstverständlichkeit.

AUSTAUSCH ZWISCHEN KUBANISCHEN UND SCHWEIZER PRÄVENTIONSFACHLEUTEN BEI MSM

Ende Mai 2013 kam eine Delegation von kubanischen Präventions- und MSM-Fachleuten für einen zehntägigen Austausch in die Schweiz. Der Austausch kam auf Einladung von mediCuba-Suisse und in Zusammenarbeit mit dem Bundesamt für Gesundheit (BAG) und der Zürcher Aidshilfe zustande. Zur kubanischen Delegation gehörte die leitende Ärztin für das Präventionsprogramm in Havanna, drei schwule

Fachmänner der Linie MSM in Havanna (ein Arzt, ein Psychologe und der Ausbildungsverantwortliche) sowie der langjährige MSM-Leiter im nationalen Präventionsprogramm, der seit 2010 für die vom UNDP-kofinanzierten Aidsprogramme in Kuba arbeitet. Die Fachleute aus Kuba lernten im BAG in Bern die nationalen, auf MSM ausgerichteten Strategien und Kampagnen kennen, verbrachten einen halben Tag am Universitätsspital Zürich und besuchten und studierten die Checkpoints in Zürich, Lausanne und Genf. Die Checkpoints (Gesundheitszentren für Schwule in den grossen Städten) setzen die Schweizer MSM-Strategie regional um. Basis für den Austausch war zunächst die Tatsache, dass wir es hier und dort mit einer ähnlichen – aber in Havanna doppelt dringlichen – epidemiologischen Ausgangslage zu tun haben und darum die Strategien und Massnahmen durchaus verglichen werden können. Es stellen sich die gleichen Schlüsselfragen: Wie schaffen wir den Zugang zu den Risikogruppen, was wissen wir über das Risikoverhalten, wann und wo finden die Ansteckungen am häufigsten statt, wie schaffen wir es, Diagnosen so früh wie möglich zu stellen, welche Botschaften und Kommunikationsformen verwenden wir, um möglichst rasch möglichst viele Ansteckungen zu verhindern, nachhaltige Verhaltensänderungen für sicheren Sex herbeizuführen und die Virenlast in der MSM-Community nachhaltig zu senken? Auch gesellschaftlich gibt es Parallelen: während in der Schweiz die MSM-Community beispielsweise durch Gruppen mit Migrationshintergrund unterschiedliche Zugangsformen erfordert, stellen in Kuba die afrokubanisch geprägten Gruppen die Arbeit vor besondere Herausforderungen. Die Unterschiede zeigen sich vor allem bei den verfügbaren Ressourcen, zum Beispiel bei den Schnelltests, den Kommunikationsträgern, den physischen Strukturen für die Präsenz an den wichtigen Orten, den Anreizen und Angeboten für freiwillige MultiplikatorInnen, bei der geeigneten Informationstechnologie und bei der Versorgung mit Medikamenten. Zudem wären Einrichtungen wie die Checkpoints in Kuba angesichts der knappen Ressourcen kaum zu realisieren; trotzdem braucht es spezifische Strukturen für die fokussierte MSM-Arbeit, welche die Regelversorgung ergänzen und stärken.



FACHAUSTAUSCH ALS TEIL DER INTERNATIONALEN PROJEKTARBEIT

Ab 2014 finanziert mediCuba-Suisse in Havanna ein Programm, das die Präventionszentren zunächst in drei Bezirken der Hauptstadt stärkt. Die Wirksamkeit von gezielter MSM-Arbeit ist ein entscheidender Faktor, um die Zahl der Neuinfektionen zu senken. Der diesjährige Austausch mit Schweizer Fachleuten und Institutionen fand im Vorfeld dieses Projekts statt und wird als Teil davon weitergeführt. Diese Modalität hat auch im Präventionsprojekt in Matanzas, das von mediCuba-Suisse seit 2002 kofinanziert wird, gute Resultate gezeigt. Seit 2008 beteiligt sich Roger Staub, Leiter der ehemaligen Sektion Aids im BAG (heute Sektion Prävention & Promotion), an den Evaluationen in Matanzas und nutzt seine Aufenthalte für konkrete Inputs bei den ProjektpartnerInnen und für den Fachaustausch. Er hat selber schon konkrete Ideen für die Aids-Arbeit in der Schweiz aus Kuba mitgebracht: Nach-

dem er die Workshops gesehen hat, die in Kuba mit neu diagnostizierten Personen durchgeführt werden, organisieren die Checkpoints mit HIV-Infizierten ein langes Wochenende in den Bergen, bei dem sie sich zusammen mit Fachleuten und Peers mit ihrer neuen Lebenssituation auseinandersetzen können.

ERFAHRUNGEN VON MEDICUBA-SUISSE MIT DER PRÄVENTIONSARBEIT IN DER PROVINZ MATANZAS

Seit 2002 beteiligt sich mediCuba-Suisse finanziell und mit einem Fachaustausch am Präventionsprogramm HIV/Aids in der östlich von Havanna gelegenen Provinz Matanzas. Wir entschieden uns damals für diese Unterstützung in Matanzas, weil das landesweit grösste Tourismuszentrum Varadero in Matanzas gelegen ist und für erhebliche, interne Migration sorgt: zahlreiche KubanerInnen aus den Zentrums- und Ostprovinzen arbeiten direkt in der Tourismusindustrie oder auf Baustellen für

Tourismusinfrastrukturen. Matanzas gehört zu den Provinzen, in welchen die Wohnbevölkerung zunimmt.

AIDS-DATEN MATANZAS

Die Situation bei HIV/Aids ist ähnlich wie der landesweite Durchschnitt: seit 1986 wurden 528 HIV-Diagnosen gestellt; 81 Infizierte sind gestorben und 447 infizierte Personen lebten Ende 2012 in Matanzas; davon waren 162 an Aids erkrankt und 266 erhielten ARV. Die Inzidenz ist im Jahr 2012 mit 62 Neudiagnosen leicht zurückgegangen und ähnlich wie im Jahr 2010. Von den 528 bisher diagnostizierten Fällen entfallen 464 (86,9%) auf Männer und 64 auf Frauen. Im Jahr 2012 wurden HIV bei 59 Männern und 3 Frauen diagnostiziert. 433 von den insgesamt 464 Männern mit einer HIV-Diagnose sind MSM. Dass die Konzentration bei Männern und bei MSM noch deutlicher ist als im landesweiten Durchschnitt, hat mit der männlichen Sexarbeit in Matanzas/Varadero zu tun.

DER KOMMUNITÄRE ANSATZ UND DIE ZIELGRUPPENSPEZIFISCHE AUSRICHTUNG SIND SCHLÜSSELELEMENTE.

1998 bis 2001 führte das Präventionsprogramm der Provinz Matanzas in Zusammenarbeit mit UNAIDS eine Abklärung und ein Pilotprojekt durch. Wichtigste Erkenntnisse und Leitlinien für die Weiterführung waren folgende: Die Prävention sollte sich als kommunitäre Arbeit ausserhalb der in Kuba starken Strukturen der öffentlichen Gesundheitsversorgung verstehen und durch basisnahe Aufklärung und die Arbeit mit Peers die Betroffenen und Zielgruppen einbeziehen. Daraus entstand das Projekt der kommunitären Präventionszentren (KPZ) in allen 14 Bezirken der Provinz, die im Rahmen des Provinzprogramms begleitet werden. Sie richten ihre Arbeit auf die lokalen Gegebenheiten aus und sind lokal verankert. Schon während der Pilotphase wurden in Varadero und dem Nachbarbezirk Cárdenas je ein KPZ eingerichtet, die ersten Massnahmen für das Monitoring dieses Projekts und dessen Integration ins Präventionsprogramm der Provinz getroffen. In der ersten von mediCuba-Suisse kofinanzierten Projektphase 2002 bis 2004 kamen vier weitere Bezirke dazu, und die Projektleitung in der Provinzhauptstadt Matanzas erhielt eigene Räumlichkeiten für das provinzwweite Monitoring und ein KPZ für Matanzas selber. Die

KPZ erhielten eine Basisausrüstung und begannen ihre Arbeit mit Beratung, Kondomabgabe, dem Angebot von anonymen HIV-Tests, als Bezugs- und Begegnungsort für Zielgruppen und HIV-Infizierte, der Begleitung von freiwilligen MultiplikatorInnen (Peers) in verschiedenen Zielgruppen und der Gassenarbeit/Präsenz im öffentlichen Raum. Die Zielgruppen waren damals allgemein definiert: Jugendliche, Frauen, Personen mit HIV und deren Familienangehörigen sowie MSM. In der Praxis jedoch waren die Handlungsstrategien für die einzelnen Zielgruppen nicht klar voneinander abgegrenzt. Die Ausbildung der KPZ-Fachleute (LeiterInnen, Linienverantwortliche, Kommunikationsfachleute) und der freiwilligen MultiplikatorInnen fand von Anfang an im Rahmen des Provinzprogramms und für sämtliche Bezirke statt.

Die Evaluation der ersten Phase im Jahr 2004 bestätigte die Erwartungen an den Präventionsansatz mit dezentralen KPZ. Die wichtigsten Empfehlungen waren:

- den kommunitären Charakter der KPZ zu stärken (ohne sie an Gesundheitsstrukturen anzunähern),
- die KPZ besser in das Aidsprogramm der Provinz zu integrieren,
- klarere Strategien für die Arbeit mit den einzelnen Zielgruppen zu entwickeln,
- Kondommarketing und anonyme Tests zu verbessern,
- Kampagnen- und Medienarbeit zu verstärken,
- ein systematisches Datenmonitoring einzuführen,
- die Aus- und Weiterbildung von Fachleuten und Freiwilligen beharrlich fortzusetzen.

Dafür war die Verstärkung des provinzwweiten Programm-Monitorings nötig. Dies waren die Leitlinien für die zweite Phase von 2005 bis 2008, in welcher drei weitere KPZ eingerichtet wurden. Für die alten KPZ aus der Pilotphase in Varadero und Cárdenas, die zusammen gleichviele Einwohner aufweisen wie die Provinzhauptstadt selber, mussten neue, geeignetere Standorte gesucht werden.

Auch 2008 ergab die externe Evaluation eine durchaus positive Bilanz des bisher Erreichten. Dennoch war die zunehmende Verbreitung so alarmierend, dass sich neue Forderungen stellten. Das Provinzprogramm müsse die Struktur der KPZ für eine klar definierte Strategie zur fokussierten Zielgruppenarbeit nutzen. Für die Verhinderung von Neuansteckun-

gen genügte eine allgemeine Präventions- und Aufklärungsarbeit nicht, sondern nur die spezifische Ausrichtung auf Bevölkerungsgruppen, welche aus epidemiologischer und biologischer Sicht die grössten Risiken für die Verbreitung von HIV und STI bergen. Daraus ergab sich eine für alle KPZ verbindliche Ausrichtung auf die folgenden Risikogruppen: Männer, die Sex mit Männern haben (MSM), SexarbeiterInnen (Personas que practican sexo transaccional PST; wobei es dabei auch um KubanerInnen handelt, die Sex mit AusländerInnen, TouristInnen haben) und Personen mit HIV-Infektion. Diese drei Linien sollten in allen KPZ zum Standard gehören, ohne die sozialen und demographischen Gegebenheiten des Bezirks aus dem Auge zu verlieren. Daneben sollten auch die verbleibenden Bezirke ein eigenes KPZ erhalten. Die Daten aus Umfragen zeigen nämlich, dass das Risikoverhalten in ländlichen Gegenden grösser geblieben ist. Dies rechtfertigt den Aufbau von KPZ-Strukturen auch in abgelegenen Bezirken mit einer geringen Zahl von «eigenen» HIV-Betroffenen. Diese Leitlinien werden seit 2009 umgesetzt.

Die Arbeit mit MSM hat ihre Massnahmen und Instrumente angepasst und erweitert: spezifische Weiterbildungen, Kampagnen, Aufklärungs- und Informationsmaterial, Einbezug von Peers, Präsenz an Gay-Treffs und Partyorten, Umfragen und Untersuchungen zu Sexualpraktiken und Risikoverhalten bei MSM mit entsprechender Rückkoppelung auf Weiterbildung, Kampagnen und Information. Im Vergleich zur Situation vor fünf Jahren ist heute mehr bekannt darüber, unter welchen Umständen und in welcher Phase der Infektion Ansteckungen am häufigsten passieren. Die Datenlage ist heute vollständiger als noch vor fünf Jahren, die Verbindungen via Peers und freiwillige PromotorInnen hat sich quantitativ und qualitativ vervielfacht, die Präsenz mit Kondomen und HIV-Tests ist gezielter.

Die Prävention bei Sexarbeitenden (PST) ist eine besondere Herausforderung, denn Prostitution ist in Kuba verboten und gesellschaft-

lich geächtet, obschon in der Realität verschiedene Formen von Sex gegen materielle, finanzielle oder sonstige Anreize vorkommen und durchaus akzeptiert sein können. Auch hier geht es häufig um MSM, denn die männliche Sexarbeit ist gerade im Zusammenhang mit dem Tourismus erwiesenermassen verbreitet. Die Projektleitenden in Matanzas verfolgen verschiedene Strategien, um sich dieser Szene anzunähern: Sie bilden PolizistInnen und Bic-taxistas (Velotaxifahrer) weiter, machen Workshops mit den Tourismusangestellten und bei den Bauarbeitern auf den grossen Baustellen von Varadero; die Bauarbeiter kommen oft aus den Ostprovinzen Kubas und leben in Camps in unmittelbarer Nähe zur Tourismusmeile. Die Präventionsfachleute sind mit Peers und freiwilligen PromotorInnen an den Treffpunkten für Sex unter Männern präsent.

Der Einbezug von Personen mit HIV-Infektion in die allgemeine und zielgruppenfokussierte Präventionsarbeit dient der Verhinderung von Neuansteckungen und der Aufklärung. Sie geht einher mit der medizinischen und sozialen Begleitung von HIV-Infizierten, ihren PartnerInnen und Angehörigen. Ihre Rollen in den HIV-Aids-Programmen haben sich in den letzten Jahren verstärkt und diversifiziert.

Nach zehn Jahren zeigt das Projekt der kommunitären Präventionsarbeit in Matanzas beachtliche Resultate: Die lokal ausgerichteten KPZ mit gemeinsamen qualitativen Standards hat sich als geeignete Struktur für die Umsetzung einer provinzwweiten Strategie erwiesen. Die KPZ können sich an veränderte Realitäten und Bedürfnisse anpassen. Die lokale Verankerung bringt die Präventionsarbeit an die Basis, setzt sie auf die Agenden der Bezirksbehörden und macht die Risiken von HIV und STI auch in ländlichen Gegenden gruppenspezifisch sichtbar. Auf Provinzebene ist das Projekt heute ein tragender Bestandteil im Programm HIV/Aids der Provinz Matanzas. Nach der Schliessung des HIV-Sanatoriums in Matanzas im Jahr 2010 hat das neue Provinzzentrum für die KPZ, welches im Rahmen des Projekts entstanden ist, neue Aufgaben übernommen und ist heute mit mehr Kompetenzen ausgestattet; es ist zuständig für die Systematisierung und Auswertung der Daten sowie mit der epidemiologische Beobachtung und es beherbergt die Arztpraxis für die Begleitung von Personen mit HIV-Infektion.

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Hat das Projekt mit den KPZ auch dazu beigetragen, dass die Zahl der Neuansteckungen im letzten Jahr nicht gestiegen ist? In einer Zwischenevaluation von Mai 2012 sind Roger Staub und der kubanische Ko-Evaluator dieser Frage nachgegangen. Ihrer Ansicht nach gibt es mindestens zwei Indizien dafür, dass das inzwischen flächendeckende Netz der KPZ in

Strukturelle Faktoren für den Erfolg der Präventionsarbeit mit lokalen kommunitären Zentren (KPZ) sind:

- Die KPZ brauchen lokalen Rückhalt und Verankerung. Lokale Persönlichkeiten aus verschiedenen Bereichen (Politik, Kultur, Sport, Medien) sollen sich dafür engagieren. Sie müssen zentral gelegen sein, um wahrgenommen zu werden, als Begegnungszentrum offen sein, eine positive Ausstrahlung und eine gewisse Distanz zu den Einrichtungen des Gesundheitswesens haben.
- Die Arbeit mit Freiwilligen (Peers) benötigt offene Strukturen und Abläufe, echte Partizipationsmöglichkeiten und Anreize. Betroffene, Gefährdete oder latent oder offen Stigmatisierte werden zu AkteurInnen und Agents of Change.
- Die lokalen KPZ müssen eigenständige Akteure in einem provinzwweiten Netz sein. Gleichzeitig brauchen die KPZ fachlichen und methodischen Input und Austausch, aber auch Arbeitsmaterial und Unterhalt und Erneuerung der Ausrüstung.

der Provinz, seine Integration ins Provinzprogramm und die Kapazität, Strategien an der Basis umzusetzen, zur Stabilisierung der Zahl der Ansteckungen in der exponierten Provinz Matanzas beiträgt, deren Bevölkerungszahl:

1. In den Bezirken Cárdenas und Varadero, die in den letzten zehn Jahren stark gewachsen sind, ist die Zahl der Neuansteckungen seit 2010 annähernd stabil. In diesen Bezirken wurden bereits in der Pilotphase KPZ eingerichtet.
2. Die Forschungsarbeit bei MSM hat gezeigt, dass Schwulenpaare in den letzten zehn Jahren im Allgemeinen stabiler geworden sind. Dies ist ein Indiz für eine gewisse «Normalisierung» und gesellschaftliche Akzeptanz von schwulen Partnerschaften. Der Gebrauch des Kondoms beim Sex unter Männern hat gemäss Untersuchungen und Gesprächen mit MSM seit 2001 um 27% zugenommen.

ACCESS TO TREATMENT AND SUPPORT FOR CHILDREN AFFECTED BY HIV/AIDS

Zambia is a successful example to show, that reversal of the HIV/aids-epidemic is possible, even with limited resources. Especially nearly Access to HIV-Treatment for All by more than 80% shows the impressive Upscale of Support for People affected by HIV/Aids in Zambia. But one important Group is neglected: Children. The Coverage for children till 14 Years of Age put on ARV is only by 28.1% in Comparison to Zambians 15 Years and Older with 90% Treatment-Coverage (National Aids Council 2012, p.3).

Von Frank Mischo*

THE ARTICLE will give a closer look on, what the injustice of different access opportunities means for the affected children. It compares the data of UNAIDS and the National Aids Council of Zambia with impressions from the HIV/Aids-Work of Kindernothilfe partners in Zambia, where examples from local and family level collected by a questionnaire, give a clearer picture and an outlook for the real situation on the ground.

ENDING AIDS: ZAMBIA AS A POSITIVE EXAMPLE
Zambia is a country with a high political priority to fight HIV/Aids. The Government of Zambia affirmed its commitment to reach Universal Access of HIV-prevention, treatment and mitigation services for Zambians affected by HIV/Aids. From the 23.5 million people living with HIV in Sub-Saharan Africa in 2011, 970'000 live in Zambia (UNAIDS 2013: p. 7). Currently the national response against the epidemic is guided by the 2011-2015 National Aids Strategic Framework (NASF) which also adopted a human rights approach (National Aids Council 2012: p. 9 and 43). Critical is still the enor-

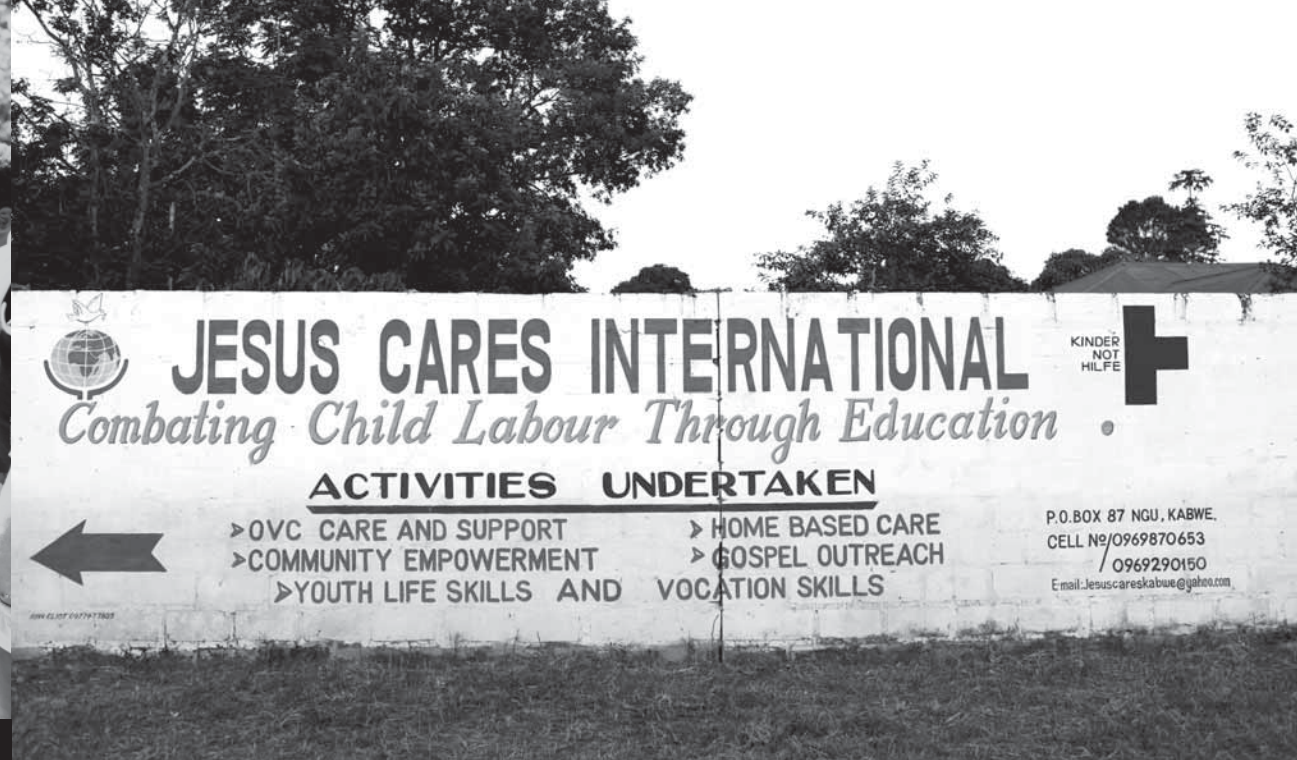
mous donor dependence (National Aids Council 2012: p. 44). Even when Zambia has massively increased its domestic investments in the health budget by 45% or 5 million US-\$ in 2012 (UNAIDS 2012: p. 21) Zambia's health budget is still below the Abuja Commitment of 15% (National Aids Council 2012: p. 43).

The starting point of improving access was to integrate the HIV/Aids response in health care to get HIV/Aids services in all public health facilities (National Aids Council 2012: p. 12).

TOWARDS ZERO NEW INFECTIONS
Today fewer people are becoming newly infected with HIV, millions are receiving HIV-treatment, fewer babies become infected with HIV and African Governments are investing more than ever in the Aids-response. One key sign of the turnaround is the steady decline in new HIV-infections each year, which are now below one third below the peak of 1998 due to successful prevention approaches. (UNAIDS 2013: p. 28f).



Children in Zambia are as much affected by HIV/Aids but get much less support



In Zambia the rate of new infections has declined by 58% (UNAIDS 2012: p. 12-14). Prevention is the important tool to reduce new infections. Since the early days of the epidemic, countries have implemented Aids-education and awareness campaigns, as well as condom distribution programmes.

TOWARDS TREATMENT FOR ALL

In 2011 there were 33% fewer Aids-related deaths in Africa than in 2005. In Zambia the total number of Aids-related deaths went down by 56% in the same time period. From 70'685 to 31'282 persons in total numbers (UNAIDS 2013: p. 8).

Today more than seven million people across Africa have access to lifesaving antiretroviral therapy (ART). The therapy costs decreased from more than 10'000 US-\$ to around 100 US-\$ per year and person. The total number of people receiving treatment grew in the time from 2005 till 2012 by 805%. So more

and more people live longer, healthier and can live their life more productive. (UNAIDS 2013: p. 28f). Zambia is one of the five countries in the Region with more than 80% HIV-treatment Coverage (UNAIDS 2012: p. 17).

LESS HIV-INFECTIONS AMONG CHILDREN

Also the Global Plan towards the elimination of new HIV-infections among children by 2015 and keeping their mothers alive was very successful. Only from 2009 till 2011 the new infections among children decreased by 24%. (UNAIDS 2013: p. 15). Zambia is one of the six African countries, where the number of newly infected children decreased highest by 59% from 21'000 to 9.500 (UNAIDS 2012: p. 27 and 31). Zambia was one of the 22 countries focussing on this issue.

The UNAIDS target is reducing the new infections among children by 90% till 2015 in comparison to 2009. In the preliminary results of 2012, Zambia is with 85% (UNAIDS 2012:

p. 30) one of the 17 countries where more than 75% of pregnant women receive antiretroviral treatment (UNAIDS 2013: p. 28f). The percentage of children contracting HIV born to mothers infected with HIV decreased from a peak of 7.72% in 1997 to 1.99% in the Year 2011. National coverage of this prevention is with 80% approaching universal access levels (National Aids Council 2012: p. 1). This led with 1.51% in 1997 and 0.33% in 2011 to a reduction of about 78.1% of the death rate among children due to HIV/Aids.

Prevention is the key to reduce new infections. Also access to education by building new schools, putting HIV-prevention in the curricula and the training of teachers was helping reducing new infections. It was researched, that HIV-prevalence had reduced among young people who had spent more years in school (National Aids Council 2012: p. 26).

THE PROBLEM OF ACCESSING ANTIRETROVIRAL THERAPY FOR CHILDREN

The Minister of Health made clear, that the national targets for Zambia shouldn't be below the Global Targets of the 2011-2015 HIV-Interventions Strategic Plan. All targets should deliver the service to all (National Aids Council 2012: PII).

Already the growing number of orphan and vulnerable children affected by HIV/Aids is an example to make it obvious, how difficult it is, to fulfil their human rights to have access to adequate food, shelter basic education and health services. With around 92% in comparison to the non-orphaned children, there is no increase in improved school attendance since years (National Aids Council 2012: p. 48).

In 2011 90% of the adults 15 years and older received antiretroviral therapy (ART). But only 28.1% of the children under 14 years received ART (National Aids Council 2012: p. 3). This extreme injustice is a Child and Human

Rights Issue. Tremendous effort is needed before 2015 to reach access for all and to stop child rights violations.

The number of health facilities providing HIV/Aids services was impressingly increased from 420 in 2005 up to 1'784 in 2010. But HIV-Testing for children isn't included (National Aids Council 2012: p. 13-14). That is the reason, why Kindernothilfe and its partners want to put the focus on improving access for children.

ADVOCACY OF KINDERNOTHILFE AND ITS PARTNERS IN ZAMBIA

The interaction between Kindernothilfe and its partners in Zambia on this issue started with a questionnaire about the access situation to treatment and support in Zambia. With Africa Directions, BIC-Choma Children Development Project, Women for Change and Jesus Cares Ministries four partner organisations of Kindernothilfe took part intensively by giving an overview about the situation in different regions for children and their families and giving an outlook for opportunities by working out recommendations.

TESTING, COUNSELLING AND TREATMENT OF CHILDREN

The health centres are still up to 25 km walking distance in remote areas. The facilities are overcrowded and drug shortages happen often. But all organisations named first, that even when the Health Facility-Coverage increased tremendously missing counselling and testing facilities for children are one of the biggest gaps to improve the treatment situation for children.

And when there is the opportunity to test children it is not used, because nobody knows about it or it is closed because of missing health workers. And often the facilities are not child friendly. Children have to wait for hours; they wait between hundreds of adults and the health personnel is not trained to talk to children.

Often children can't be tested because both parents must permit the health personnel to test the child. And often both parents are not available or not interested to test the child. Because of the missing tests and sensitization for the issue by their parents and the health institutions, very few children can be put on antiretroviral treatment programmes.

HIV-PREVENTION

The focus on Preventing Mother-to-Child-Transmission with reaching nearly access for all is a key for reducing new infections among children countrywide. Flexibilities with giving pregnant women after testing and counselling their antiretrovirals even for birth at home with control visits afterwards made it possible for most of the pregnant women to be put immediately on treatment.

A big improvement is the taking up of HIV/Aids-prevention in the school curricula. Especially reproductive health and life skill lessons make prevention work by creating awareness and coming to a responsible behavioral change.

But often especially the most vulnerable children and orphans miss HIV-prevention in school, because they have to work or to take care for ill family members. Much more girls than boys are at risk to get infected and need protection.

The five main recommendations for next steps to improve the Situation of Children as Results of the Experiences are:

1. More domestic and international health financing to reach universal coverage with the focus on building more child counselling and testing facilities and to have a better payment, that health workers keep on their work and to get more funds for child formula for the antiretroviral treatment.
2. Sensitizing the parents affected by HIV/Aids by media campaigns and in self-help-groups for child rights to make have a better use of child test and treatment opportunities or to protect the children better not to be infected.
3. More social protection and support for the most vulnerable groups most at risk like young girls and orphans.
4. Improving the just introduced HIV-prevention in school curricula by training teachers and peer groups and giving more space in schools for the issue.
5. Giving critical enablers like local leaders an important role in the HIV-prevention by sensitizing and informing them about their responsibility and to become a role model in HIV-protection and to advocate to support access for treatment for all. This would also reduce stigma and discrimination for people affected by HIV/Aids.

Kindernothilfe and its partners invite other interested actor in this field and will continue to work on this issue by information exchange and advocacy; work for children affected by HIV/Aids to get the same chances to get support and into antiretroviral treatment programmes.

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INVESTING IN ONE BILLION PEOPLE WITH DISABILITIES AROUND THE WORLD

HIV and AIDS remains one of the most widespread disabling epidemics worldwide. The disease leads to impairments, activity limitations and reduced social participation. Moreover, people with disabilities who constitute approximately 15% of the global population (more than one billion people), have a heightened risk to HIV infection compared to non-disabled people due to various reasons. To address this, Handicap International (HI) has been involved in the global HIV response in relation to disability since 1994. The article summarises: the intersection between HIV and disability, the work of Handicap International on HIV and AIDS among people with disabilities in Sub-Sahara Africa and South East-Asia, lessons learned and good practices in the inclusion of disability in HIV programming, and ways forwards and recommendations.

By Muriel Mac-Seing*

TO DATE, HIV and AIDS remains one of the most widespread disabling epidemics worldwide. The disease leads to impairments, activity limitations and reduced social participation. This has a severe impact on quality of life, both for people infected with HIV and AIDS and their affected families and communities. (Hanass-Hancock & Nixon, 2010). More specifically, HIV is now considered a chronic and cyclical disease, with periods of wellness and illness. HIV is a complex and multi-systemic disease affecting the cardio-respiratory and musculoskeletal systems of the body. This, in turn, requires a multi-dimensional response to disease prevention and rehabilitation interventions. (Canadian Working Group on HIV and Rehabilitation, 2011) Indeed, any person living with HIV is likely to experience temporary and/or chronic impairments (such as mus-

culoskeletal impairments, neuro-cognitive disorders, blindness and hearing impairments), at different phases of the illness, due to acquired infections and/or side effects from taking antiretroviral drugs. People with disabilities who become HIV positive might also undergo similar processes of activity limitations, in addition to existing impairment(s).

THE INTERSECTION BETWEEN HIV AND DISABILITY

According to the World Health Organization's Community-based Rehabilitation Guidelines (WHO/UNESCO/ILO/IDDC, 2010), rehabilitation becomes increasingly important for people who may be experiencing disability as a result of HIV and AIDS. Furthermore, in light of the 2007 Convention on the Rights of Persons with Disabilities, which 130 countries have rat-

ified to date (www.un.org/disabilities/), asymptomatic people living with HIV can also be considered as disabled, due to exclusion from social participation as a result of stigma and attitudinal and environmental barriers related to their health status. To this effect, the UNAIDS Disability and HIV Policy Brief (UNAIDS/WHO/OHCHR, 2009) recognises the interrelations between HIV and disability and stresses the importance of addressing both sectors in an integrated fashion. The salient points of the UNAIDS Policy Brief are:

- HIV risk behaviours among people with disabilities;
- their high vulnerability to sexual violence;
- their low access to HIV education, information and prevention services;
- their limited access to treatment, care and support; and
- importance of addressing rehabilitation needs among people living with HIV.

Although limited, the epidemiological evidence available on HIV and disability suggests that people with physical, intellectual, mental or sensory disabilities are as likely, if not more likely, to be at risk of HIV infection. (Groce, 2004) The few available HIV prevalence studies that include people with disabilities support this claim as they indicate similar or higher HIV infection rates among this group. For instance: a survey from South Africa reports HIV prevalence among people with disabilities at 14.1% (against 10.9% in the national HIV prevalence in 2008; Shisana et al., 2009); a study from Kenya among deaf people reports HIV prevalence at 7% (against 6.7% in the national HIV prevalence in 2007; Taegtmeier, et al, 2008); and unpublished data from Senegal suggest that HIV prevalence among people with disabilities in the Dakar region is almost double (1.2%) that of the non-disabled population. (RARS/APAPS, 2011)

FROM SUB-SAHARA AFRICA TO SOUTH EAST ASIA: HANDICAP INTERNATIONAL'S WORK ON DISABILITY AND HIV

As a key development issue, HI has been involved in the global HIV response since 1994, with its first HIV field interventions in Burundi. HI was one of the first organisations to speak about the interrelation between HIV and disability in the context of developing countries, spearheading the Africa Campaign on Disabil-

ity and HIV and AIDS. (More information on the Africa Campaign on Disability and HIV and AIDS: [/www.africacampaign.info](http://www.africacampaign.info)) The primary rationale for HI's operational strategy on HIV and AIDS concerns the marked vulnerabilities to HIV of people with disabilities who constitute approximately 15.6 % (11.8-18.0 %) of the world's population (the rate is estimated to be 19% among the female population; World Report on Disability 2011).

As stated previously, people with disabilities have an equal or heightened risk to HIV infection compared to non-disabled people. This challenges the common misconceptions that people with disabilities are sexually inactive and do not require HIV or sexual reproductive health services. Indeed there is a broad range of discriminatory practices and social stigma that contribute to the vulnerability and social exclusion of women, men and children with disabilities, such as limited access to basic services (in particular health, education, transportation) and specifically a lack of accessible HIV and sexual and reproductive health information and services. (Groce, 2004; World Health Organization and UNFPA, 2009).

For the various actions undertaken by HI in HIV prevention, treatment, care and support, the main targets and beneficiaries are: people with physical, vision, hearing, intellectual and mental impairments; and other vulnerable groups, such as women and girls, youth in and out of school, orphans and vulnerable children and people living with HIV. Furthermore, HI works in close partnership with Disabled People's Organisations (DPOs), mainstream AIDS Organisations, Associations of People Living with HIV and National AIDS Authorities.

So far, HI has been active in the sector of HIV and AIDS in 11 countries throughout the world: Ethiopia, Kenya, Somalia (Somaliland and Puntland regions), Rwanda, Burundi, Mozambique, Mali, Senegal, Cambodia, Vietnam and Laos. In most of these countries, HI exerts an emphasis on promoting the inclusion of people with different impairments and other vulnerable groups within existing HIV prevention, treatment, care and support services. Various strategies and interventions have been selected by HI to address inclusion and accessibility of HIV and AIDS services to all, for example:

- Institutional strengthening of local authorities and policy-makers



- Capacity building and reinforcement of partner organisations as well as health/HIV related service providers
- Awareness-raising that is responsive to the different communication needs of people with disabilities
- Removing barriers and promoting facilitating factors which promote enhanced accessibility to quality services
- Use of advocacy evidence-based to influence policy change
- Significant participation of people with disabilities and involvement of DPOs
- Collection, disaggregation and utilisation of data based on sex, age and impairment
- Monitoring and evaluation combined with research and studies which inform strategic and programmatic decision-making and projects' design

Not only are people with disabilities more vulnerable to HIV – they also are at significantly heightened risk and vulnerability to sexual and reproductive health problems (Handicap International, 2011) and gender-based violence. (Barile, 2002; INWWD, 2010) Indeed these three critical sectors are very much seen as intersecting, sharing the common pervasive root causes of gender inequality, poverty, stigmatisation and social marginalisation. As such, Handicap International has developed and promotes an holistic, integrated and inclusive vision for HIV and AIDS programming (Handicap International, 2012) which addresses these complex and multi-dimensional needs and priorities for target populations including women, men and children with disabilities.

LESSONS LEARNED AND GOOD PRACTICES ON DISABILITY INCLUSION IN THE HIV AND AIDS RESPONSE

HI continues to undertake various lesson learning processes in order to identify and analyse our experiences of disability-inclusive HIV and AIDS programming. Here we briefly present three examples of good practice which offer an insight into the scope and diversity of our projects and illustrate some of the positive changes achieved for key stakeholders:

1st Good Practice at HIV counselling and testing level: adaptation of methodologies for increased uptake of HIV services among people with visual and hearing impairments in Kenya

In 2012-2013, with the financial support of the Kenya Government and the World Bank, HI implemented two HIV prevention projects for people with visual and hearing impairments in the Nairobi and Kitale regions of Kenya. Adaption of information, education and communication (IEC) materials in accessible formats for people with sensory impairments was vital for ensuring more targeted interventions. This was further enhanced by the ongoing participation and critical feedback of people with disabilities in the design, utilisation and monitoring of IEC tools and materials. From this project experience, we have learned that packaging health/HIV communication messages in accessible, user-friendly formats for people with hearing and visual impairments and then disseminating them through peer education has significantly strengthened the uptake of voluntary counselling and testing services.

2nd Good Practice at Disabled People's Organisations (DPO) level: organisational development leading to resource mobilisation in Rwanda

From 2008 to 2013, HI implemented a project on HIV prevention, sexual violence protection and services for people with disabilities in 18/30 districts in Rwanda, using funding from HRSA/PEPFAR. (HSRA)The project's specific objective was to strengthen the organizational, managerial and technical capacities of local stakeholders to provide quality HIV prevention and care to people with disabilities. As part of the lesson learning process at the end of the project, an in-depth, multi-stakeholder, qualitative study (Handicap International, 2013) was conducted over a period of three months, to analyse the most significant changes from the

project and to model specific good practices for further adaptation or replication in other contexts. This study involved an extensive literature review, field visits and semi-structured interviews with key staff, partners and beneficiaries. Five good practice case studies were recorded in the study, one of which concerned the ongoing organisational development and strengthening of local DPOs to improve their governance mechanisms, programme development and activity implementation skills. As a result of this practice, two of the main project partnering DPOs – the Umbrella of Persons with Disabilities in the Fight against HIV and AIDS in Rwanda (UPHLS) and The General Association of People with Disability in Rwanda (AGHR) – were able to successfully mobilise funds to develop HIV projects targeting women and men with disabilities of different counties of Rwanda. This was essential for the institutional development of the DPOs, enabling them to continue and sustain their actions.

3rd Good Practices at individual level: a tailored initiative for rural deaf women on HIV prevention and sexual violence protection in Cambodia

Working in rural communities with deaf women, through awareness-raising on HIV, sexual and reproductive health and sexual violence protection, was a pivotal component of HI's HIV project in Cambodia, funded by the AFD (2008-2011). The activities were centred on supporting deaf women to learn more about HIV and sexual violence prevention and services. There were a number of key good practices identified, including:

- Mapping of people with disabilities and in particular, deaf people living in target villages
- Conducting home visits and mobilizing local leaders to encourage community 'buy-in' (as a result of which, sign language classes and HIV and sexual violence prevention sessions were organised in the commune council halls)
- Close partnership with the Deaf Development Programme of Maryknoll to devise a joint sign language curriculum in Khmer and HIV prevention and education
- Training of educated deaf women to become future trainers and facilitators of awareness-raising of deaf women. These

newly trained deaf women were paired with a member of HI's staff that had received basic sign language training, to foster coaching and shared learning

- Design and utilisation of pictures, simple messages, and role play as well as guided tours of local service and facilities
- Capturing regular feedback from target beneficiaries and implementing partners to improve or revise project implementation

WAYS FORWARD: INVESTING IN ONE OF THE LARGEST MINORITIES AT RISK OF HIV, DISCRIMINATION AND INVISIBILITY

There are over one billion people with disabilities in the world of whom 110-190 million people (2-3% of the global population) experience very significant difficulties. (World Report on Disability 2011) The prevalence of disability is growing due to an ageing population and the global increase in chronic health conditions, including HIV and AIDS. These are percentages which can no longer be ignored by policy- and decision-makers who are mapping a national strategy towards universal access and targeting zero.

According to the UNAIDS' Investment Framework (UNAIDS 2011), as featured in the Lancet (Schwartlander et al., 2011), in order to 1) maximize the benefits of the HIV response, 2) support more rational resource allocation based on country epidemiology and context, 3) encourage countries to prioritize and implement the most effective programmatic activities, and 4) increase efficiency in HIV prevention, treatment, care and support programming, it is of utmost importance to fully understand how the HIV epidemic impacts different vulnerable groups before mobilising resources, designing programmes, delivering interventions or sustaining existing initiatives.

In light of the above, it is argued that the inclusion of disability must be seriously considered as a key priority in both global and national AIDS responses worldwide. Continued exclusion of people with disabilities would raise serious ethical and accountability concerns among key international/national stakeholders as well as organisations and service providers involved in both prevention and response to HIV and AIDS. Hence, HI strongly recommends that key decision-makers on HIV and AIDS response comprehensively address the following:

- Guarantee equal access to HIV prevention, treatment, care and support services (including rehabilitation) so as to significantly decrease or eliminate the heightened risk of women, men and children with disabilities contracting HIV
- Mainstream accessibility standards and disability inclusion as cross-cutting at all levels of the HIV and AIDS response (including organisation development, recruitment of staff, prevention, services, products, policies, etc.)
- Ensure that IEC and behaviour change and communication materials/tools are accessible to people with disabilities, addressing their different communication needs (e.g. using large print, use of audiovisual, Braille, sign language, more pictures including images of people with disabilities as well as pictograms, using less words and more simplified language)
- Build the capacity of all HIV prevention and response service providers to enable the provision of disability- and gender-sensitive information and services
- Directly involve women, men and children with disabilities/DPOs, especially organizations of women and girls with disabilities in the design, implementation, monitoring and evaluation of HIV prevention and response services
- Prohibit all forms of discrimination that may hinder access to justice, medical, legal and psychosocial services among people living with HIV
- Ensure that women, men and children with disabilities and their families have access to information on their HIV and disability rights – particularly those who do not have access to mainstream education – so that they can identify, prevent and act upon their risks and vulnerability
- Ensure data in monitoring and evaluation system tools are disaggregated by sex, age and impairment
- Ensure disability budgeting and funding are appropriate in order to “keep the promise” in reaching and serving all people in face of the AIDS epidemic
- Ensure accountability of international structures, government and civil society in preventing and responding to HIV and AIDS among those most at risk and those who have been made invisible in the course of the HIV response, such as the significant population of people with disabilities.



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ANSWER: AFRICAN NET SURVEY – WE RESPOND !

Between the end of August and December 2013, an internet based survey named ANSWER will collect data about sexual health, sexual behavior and risk taking among Sub-Saharan African migrants (SSAm) living in Switzerland. This research is carried out by the Institut de médecine sociale et préventive (IUMSP, Lausanne) on a mandate from the Federal Office of Public Health (FOPH), in cooperation with the Swiss Aids Federation (AHS) and other institutions addressing the prevention and information needs of the African population living in Switzerland.

By Luciano Ruggia, Raphaël Bize and Françoise Dubois-Arber*

THE MAIN aims of the ANSWER Survey are the following:

- To establish a first baseline for the HIV/STI related behavioral surveillance among the SSAm population.
- To test the methodology of an internet based approach among SSAm and of the corresponding recruitment and communication strategy.
- To collect data on HIV/STI knowledge and perception, on sexual behavior, prevention, testing and access to care and treatment among this population.
- To provide the evidence needed to adapt, increase and improve prevention work for and with this community.

SITUATION

In Switzerland, SSAm are identified as being a population with a high HIV prevalence, according to the relevant epidemiological data, second only to MSM (men having sex with other men). (1) It is also recognized that there is a general lack of behavioral surveillance data for SSAm. In particular surveillance data about sexual behavior is lacking. (2)

The SSAm population living in Switzerland mostly come from countries with a generalized HIV epidemic (> 1% HIV prevalence) and it is estimated that the HIV prevalence in SSA population living in Switzerland is high although no reliable prevalence studies are available. For other STI, very little data is available among SSAm.

In 2009, according to the Federal Office of Statistics (FOS), between 70'000 and 100'000 SSAm (approximately 3% of the foreign resident population) were living in Switzerland. Also according to FOS, the main nationalities represented in 2009 were the following: Eritrea 7368; Somalia 6394, Congo (Kinshasa) 5844; Angola 4362; Cameroun 4333; Nigeria 2862; Ethiopia 2803; etc. (3)

They also constitute a very young population, 80% are younger than 40 years old (therefore highly sexually active), and living mainly in large cities (Zurich, Genève, Lausanne, Berne, Fribourg, Bienne). (3) It can also be considered that this population is growing and that the estimation of the FOS is missing the amount of undocumented SSA living in Switzerland.

The socioeconomic differences among SSAm are extremely large, especially if we consider the illegal migrants and the refugees. Country of origin, language and culture only add to the complex situation of this population, which should never be approached as a unique and coherent group. Stigma and discrimination towards HIV positive people still run strong among SSAm and are therefore additional factors of complexity to any analytical or intervention effort.

The HIV epidemiological data for SSAm suggest a worrying public health impact of HIV on this group. In 2002, 191 new HIV diagnosis were registered among SSAm living in Switzerland (43.6% of the heterosexual transmissions); in 2012, 73 new diagnosis were registered among them (27% of the heterosexual transmissions). Late detection is also a major problem in this population, more than in any other group.

THE QUESTIONNAIRE

The questionnaire has been prepared by the IUMSP in a similar way as other behavioral surveillance surveys in Switzerland, such as the GaySurvey which targeted MSM (conducted on a regular base since 1987). When possible, existing indicators or questions, already used before or compatible with other surveys have been used. Contact with similar initiatives in other countries has also been established and, when possible, questions have been shared. All those elements will help with data analysis and results interpretation.

Attention has been given to create a narrative experience in the questionnaire, helping people not to abandon it at mid-way. Community sensitive terminology has also been used whenever possible. Cognitive testing was used to check for discrepancies between what was conceived by researchers and what is actually understood by the target audience. Finally, the duration has also been measured and filling in the questionnaire should not take more than 30 minutes.

Beside socio-demographic data, questions target knowledge of HIV and STI, general health status as perceived by the respondent, intimate life and relationships, circumcision, contraception, use of condoms, residence status and integration in Switzerland, perception on HIV discrimination, drug use, etc.

AN INTERNET BASED RESEARCH

It is generally recognized that the SSAm community is difficult to reach and that conducting a survey in this population raises difficult methodological questions. Any approach will have advantages and limitations that need to be clearly recognized and discussed.

For our survey we decided to use an internet based questionnaire, which is increasingly used in behavioural surveillance in hard to reach populations.

The choice of using an internet based approach was taken after discussing with SSAm about their own use of internet and their opinion about this approach. SSAm make an intensive use of internet, although sometime in different ways to those an educated Swiss person would. Clearly computer and internet are used as a communication instrument, to keep in contact with the family in the country of origin or in order to communicate with other community members. SSAm do not necessarily "read" much text on internet, but they watch a lot of videos with all kinds of contents. Social networks are also extremely important and widely used for the auto-organization inside the community.

COMMUNICATION CAMPAIGN

In order to overcome some of the mentioned obstacles and to reach a maximum number of respondents, we have designed a communication campaign fitting the research design.

Firstly, we will focus on internet by producing a series of videos of well-known African personalities in the SSAm community in Switzerland, carrying the message of the importance of taking part in this survey. We strongly believe that, because of the importance of oral communication among Africans, those videos will better carry the message than any lengthy written text. A specific facebook (FB) group dedicated to the survey will be set up. This FB page will be used to distribute the videos, to link other existing groups as well as to provide information about all events related to the survey, either at national or at local level. The FB page will be animated and moderated during all the data collection period.

Secondly, in order to reach people using internet in a less intensive or different way, an information campaign will be set up focusing on sport, culture, religious and other events aimed at the African community or in settings (health



consultations, hairdressers, internet cafés, etc.) frequented by them. This will be mainly organized locally by AHS branches and by the Afrimedia mediators (cultural mediators of the AHS). An information leaflet will be produced to support those actions.

COMMUNITY MOBILIZATION

A central point of the project is a strong involvement of the community in all phases of the project. Getting SSAm involved in this survey won't be an easy task, because of the fragmented composition of this population (languages, cultures, countries of origin, socio-economic status, etc.).

In order to achieve a strong involvement, we set up first a Steering Group, charged of discussing and validating all the strategic elements of the project. The Steering Group is composed of a well balanced mix of professionals and of community representatives. This group started to meet regularly at the initial development phase of the project and will continue to do so until the very end, including supporting the dissemination of the project's results.

Other forms of involvement are the implication of SSAm in the different testing phases of the questionnaire (cognitive testing, field test) as well as for the translations and for the communication work. The promotion phase of the survey will also rely on a strong field activity conducted by the mediators of the Afrimedia program during events aimed at the SSAm community or in specific settings.

RESULTS

The end of the data collection is planned for December 31st, 2013. This will be followed by an analytical phase and the full report will be published by the IUMSP during 2014. Dissemination of results is also planned, including dissemination among the SSAm community itself.

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The questionnaire ANSWER is available in different languages (English / German / French / Italian / Portuguese / Somali / Tigrinya) at the following address: www.afric-answer.ch

In order to maximize the participation rate, we ask every member of the SSAm community or any person working with them to help disseminate the information and the link about our survey.

Questions and enquiries at: luciano.ruggia@bag.admin.ch



“The HIV/AIDS Fund was unique in the sense that it mainly considered local or grass root organizations which are very active within their communities but had difficulties to compete for funds with well-established organizations.” Cecilia Chulu Muyinda

THE RED RIBBON OF HOPE

In 2005, the Confidential Approach to AIDS Prevention Programme (CAAP) with the support of SRC started to provide anti-retroviral therapy (ART) to HIV/AIDS patients in Bangladesh. This happened in a time when no clinical services were available, because the Government was neither prepared nor equipped. Currently CAAP is one out of only three NGOs in Bangladesh who runs a specialised clinic for diagnostic and long term treatment of HIV and AIDS. and a population total of 18'000 people inclusive of surrounding villages. The article will profile the work of orphans and vulnerable children supported by Humuliza Organisation, a local Non Governmental Organisation based and operating in Nshamba and surrounding villages whose psychosocial support interventions target children known as (Rafiki Mdogo) in Swahili and youth (Vijana Simama Imara [VSI]) infected or affected by HIV and AIDS.

By Letitia Kleij and Tuhin Samaddar*

In its third National Strategic Plan for HIV/AIDS 2011-2015, the Government of Bangladesh finally included the provision of treatment next to the strengthening of prevention, coordination and information sharing. Given that the Government provides treatment, the Swiss Red Cross revised its programme strategy on HIV/AIDS for Bangladesh with the aim that by 2015 the patients of CAAP on ART support will be fully integrated in the Government programme.

This approach strengthens the scope of the health system as well as it fosters an integrated approach to HIV/AIDS.

Her first two deliveries were conducted by a caesarean section. By then she was still HIV negative. When she was in her sixth month in her third pregnancy, she visited CAAP where her husband was registered as a person living with HIV. She was discovered as being HIV positive. The day she started labour, the CAAP team took her to a private hospital for delivery. Despite the agreement between CAAP and that hospital to admit HIV positive women, the doc-

tor refused to admit her. In anguish they turned to a public hospital, which also refused to assist her due to her HIV status. Then CAAP took the patient to the third hospital, a public one, where she was finally admitted. A healthy baby was born. However, she was made to leave the hospital quickly, because she was HIV positive. This case study shows that people living with HIV are still struggling to receive adequate health services in Bangladesh.

PREVENTION

The first case of HIV/AIDS in Bangladesh was detected in 1989 and currently with an estimated rate of 0.1 to 0.2%, the prevalence is low in comparison to other countries in the region (Myanmar with 0.7% and India with 0.3%) according to WHO/UNAIDS. From early on, the Government endeavoured to keep the HIV infection rate low through prevention programs. Its major role has been in drafting policies, assuring coordination and regulation, and implementation of country wide HIV/AIDS aware-

ness programs. To complement the efforts of the government, a large number of NGOs are actively working on HIV and AIDS, primarily in prevention. CAAP is one out of three National NGOs that raises awareness in the community since 1996. Secondly CAAP negotiates with recruiting agencies to be able to give information to departing migrant workers related to HIV prevention. Partnerships are established with medical check-up centres/pathological laboratories that transfer HIV positive people to CAAPs clinic for treatment and health care.

COUNSELLING

Access to voluntary counselling and testing services is still limited and very few Bangladeshis are aware of their HIV status. CAAP along with other development partners provides voluntary counselling and testing (VCT) to people who are willing to disclose their status and rapid test to confirm the diagnosis. From January 2009 till December 2012 CAAP conducted 2994 VCTs. A 'hot line' exists and information is given to people who call and have HIV/STI related questions and concerns. A fully equipped laboratory provided 9,887 tests from 2009 to 2012 that included various biochemical tests for example related to sexually transmitted infections (STI). Laboratory services have been extended to other organisations over the years and UNICEF and the two national NGO's Mukto Akash Bangladesh and Ashar Alo are referring their clients for pathological tests.

TREATMENT

It is estimated that in Bangladesh around 7500 people (UNAIDS, 2012) are in need of treatment while only 852 are receiving ART. According to a recent progress report (WHO, 2011) Bangladesh has not moved closer to the universal goal of achieving access to ART by

2015 even though this is part of their National Strategy. Bottlenecks are the lack of finance for ARV treatment for all the HIV/AIDS cases, limitation of management skills of government bodies and bureaucratic processes within various governmental departments.

CAAP was the first one to providing ART for HIV positive people and AIDS patients in Bangladesh in 2005 with support of SRC. Currently CAAP and two other National NGOs provide ART to people living with HIV/AIDS and collectively they are providing ARV medicine to these 852 HIV infected patients.

Complete adherence to ART is the key to successful therapy and counselling sessions are organised for the patients in order to share the importance of continuing ART drugs. To prevent mother to child transmission any newborn baby is given milk substitute for a period of two years. Till to date no baby was found HIV positive when tested after these two years of milk substitute. CAAP encourages people with HIV to live a healthy life as that has been proven to show positive effects on the health status. In addition caregivers/family members receive training in home based care.

In order to check drug adherence and status of the patients, the computerised database is a great asset to monitor the ART patients and react immediately on defaulters.

CAN THERE BE A BANGLADESH WITHOUT AIDS?

Even though Bangladesh is (still) a low prevalence country, increasing labour migration, a high prevalence among people who inject drugs and high levels of prostitution increase the likelihood of HIV infections. The fact that only 10% of the positive people which require treatment, actually get it, enhances the danger of transmission.

Major gaps were also found in the knowledge and awareness about safe sex among the population aged 15 to 49 years. A national survey in 2008 found that they lack knowledge and awareness about HIV and that many are engaged in risky sexual practices while having limited access to reproductive health information and services. A majority of the people surveyed (90%) had heard about HIV/AIDS but their level of knowledge of the disease was low. Only 38% of the people surveyed could correctly identify two or more routes of HIV transmission and only 40% could identify two or more routes of prevention (The World Bank, 2012).



The role of men and women in Bangladesh society is another important factor to concern. Around 35 percent of the women diagnosed with HIV get infections from their male partners. In this highly male-dominated society, men exercise their power to influence women's sexual and reproductive health choices. Therefore, involving only women is not enough to prevent HIV (The Daily Star, 21st November, 2011).

In addition, a lack of biosafety and correct sterilization procedures for syringes and unsafe blood transfusions are further important risk factors for HIV in Bangladesh.

THE RED RIBBON OF HOPE

The still low prevalence rate is a window of opportunity in Bangladesh, if bold action from the government in cooperation with the non-governmental sector, development partners and other stakeholders can be launched in a coordinated and efficient manner. An important step forward has been taken since December 2012. The government of Bangladesh is currently supplying free drugs to the previous mentioned number of 852 people living with HIV/AIDS through three national NGOs and drugs will also be made available at five public hospitals. For 2013 the government plans to assist 1100 people and by 2014 there will be 3300 people on ART. However, more and immediate action is needed to address the remaining 50% of HIV positive people in need for drugs.

Next to the treatment, key tasks include the provision of comprehensive care, support & treatment for people living with HIV through public health facilities. This requires reduction of stigma and discrimination against people living with HIV/AIDS through appropriate advocacy, policies, and related measures.

Actions are required in an increased effort of prevention among young people, scaling up behaviour change activities and health promotion interventions for key populations and empowering men and women to jointly take decisions on reproductive health choices.

As result of all the interventions we hope for more people fearlessly disclosing their HIV status, we hope for all positive people to receive ART and that no HIV positive pregnant women will be going to a hospital in vain. That is The Red Ribbon of hope.

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BETRIEBSUNFALL MIT DOPPELDEUTIG POSITIVEN FOLGEN

Über alle Landes- und Kulturgrenzen hinaus werden kranken Menschen Gefühle von Mitleid entgegengebracht. Nicht so erleben es die meisten HIV-positiven oder AIDS-kranken Menschen. Ihnen schwingt immer der Vorwurf von Selbstverschulden entgegen. «Hätten sie sich doch geschützt oder keine gesundheitsgefährdende Sexualität praktiziert, dann wären sie noch gesund und arbeitsfähig». Niemand assoziiert zu HIV und AIDS einen Arbeitsunfall, auch früher in Kuba nicht. Das hat sich verändert seit Medizinpersonal, das sich im Ausland angesteckt hat, mit seiner Geschichte an die Öffentlichkeit geht und Fachwissen vermittelt.

Von Judith Eisenring*

IN Schweizer Spitälern ist eine Ansteckung des Gesundheitspersonals mit dem Virus fast ausgeschlossen, da mittlerweile sehr viele Vorsichtsmassnahmen getroffen werden und bei Stichverletzungen routinemässig eine Postexpositionsprophylaxe (HIV-PEP ist eine Kombination von Medikamenten gegen HIV) durchgeführt wird. HIV hat hier das Thema Hygiene und Umgang mit menschlichen Sekreten geprägt. Die Berufshaftpflichtversicherung nimmt die Arbeitgeber in die Pflicht, somit sind Desinfektion und Handschuhe als Schutz auch für das Personal nicht mehr wegzudenken.

In Kuba zurzeit ohne AIDS-Erfahrung wurden nebst Soldaten kubanische Gesundheitsarbeiterinnen im Auftrag der Regierung (Zeichen des kubanischen Internationalismus, z. B. mit Angola) in befreundeten Ländern eingesetzt. In den Spitälern vor Ort haben sie Kriegsverletzte und andere Verletzte operiert oder gepflegt. Mit grosser Wahrscheinlichkeit haben sie sich dort mit HIV angesteckt. Ohne von ihrer HIV-Infektion zu wissen, kehrten sie in ihre Heimat zurück. Wenn sie in Kuba mit einem HIV-positiven Befund getestet wurden, waren sie ge-

zwungen in sogenannten Sanatorien zu leben. Zwischen 1986 und 1993 wurde dies landesweit so praktiziert. Erst danach wurden die Menschen mit HIV/Aids wieder sozial integriert und ihnen das Leben mit den Familien und der beruflichen Tätigkeit wieder gestattet.

ERFOLGE EINER SELBSTHILFEGRUPPE

Betroffene, die sich gegen die stalinartigen Internierungsmassnahmen wehrten, haben sich als Selbsthilfegruppe «Grupo de Prevención de SIDA» (GPSIDA) zusammengeschlossen. Ihr Ziel ist es noch heute, sich und andere über HIV zu informieren und AIDS-Präventionsarbeit zu leisten. Es ist ihnen zu verdanken, dass der Staat seine Strategie im Umgang mit der Krankheit um 180 Grad änderte. Mittlerweile gibt es für AIDS-Kranke ein ärztliches Behandlungsprogramm in einer dafür spezialisierten Klinik. Vier Mal jährlich werden sie zu einem medizinischen Check aufgeboten und dort wird ihnen auch das Recht auf die staatlich garantierte Zusatznahrung bescheinigt. Alle erhalten in Kuba die benötigten retroviralen Medikamente. Von den rund 22 heute weltweit ab-



gegebenen Aidsmedikamenten können zwölf in Kuba selber als Generika hergestellt werden. Die weiteren Medikamente kauft Kuba auf dem Weltmarkt.

GPSIDA ist in das nationale kubanische HIV/Aids-Programm involviert und mit ihren AIDS-Präventionskampagnen sind sie in allen Provinzen bekannt. Längst sind es nicht mehr nur Betroffene und nicht nur Gesundheitspersonal, die in den Gemeinden, z.B. bei Jugendgruppen, aktiv sind. GPSIDA hat mit ihrer Geschichte und mit ihren fundierten Fachkenntnissen eine internationale Bekanntheit erreicht. Auch das Gesundheitsministerium will auf die

Arbeit der GPSIDA nicht mehr verzichten. Im Gegenteil, sie nutzen Synergien. Dies ist möglich, weil GPSIDA gut vernetzt ist und digital den Austausch der aktuellsten Daten garantieren kann. Kubanische Fachleute beraten heute auch überregionale AIDS-Programme, so z.B. Haiti und andere Länder Zentralamerikas.

Medico durfte die Entwicklung von GPSIDA von «Betriebsunfallopfern» zu Experten für Gesundheitsförderung und Prävention teilweise mitverfolgen und unterstützen. Aktuell finanzieren wir die Evaluation ihrer Arbeit und deren Publikation. Wir sind sehr interessiert, Fakten bezüglich AIDS zu Kuba in den Händen zu haben, und sind gespannt, welche Rückschlüsse sich bezüglich Präventionsarbeit daraus ergeben. Ein Wissen, dass wir medico-Partnerorganisationen in andern Ländern gerne zur Verfügung stellen, denn es sollen sich keine Menschen mehr mit HIV infizieren und bestimmt keine Berufstätige im Gesundheitsdienst.

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A GRASS ROOT FUND TO FIGHT AIDS

Zambia is one of the countries in the sub-Saharan Africa that has continued to experience the effects that the HIV/AIDS pandemic has brought to mankind. A country with a population of thirteen million people, the prevalence rate stands at 17 % in adults (15 to 45 years of age). However, despite the many efforts by many stakeholders in terms of information dissemination, sensitization and awareness creation, the pandemic has continued to pose many challenges to the Zambian socio-economic sector.

By Cecilia Chulu Muyinda*

MANY organizations ranging from the civil society organizations, Non/Governmental, and Faith Based Organizations have endeavored to fight the scourge with different approaches or rather technique. The HIV/AIDS Fund under the Bethlehem Mission Immensee (BMI) is one such type of the organization that has contributed towards the prevention and care of the affected and infected persons.

The BMI HIV/AIDS Fund usually classified as “an exception” was the result of an emanation of a particular situation. A documentary was done at Our Lady’s Hospice one of the biggest Hospices in Zambia for the terminally ill and palliative care services for HIV/AIDS related cases. The documentary attracted many people in Switzerland who started forwarding donations to contribute to the same cause. These donations resulted in the creation of the HIV/AIDS Fund. A fund limited in time until the donations were used according to donors’ intentions.

The activities which were supported through the fund were prevention and care and projects dealing with social and economic consequences of the HIV/AIDS pandemic. The Fund was introduced in 2006 and the to-

tal number of projects supported is over thirty. The Fund was officially closed in 2013.

SUSTAINABILITY IS KEY

The HIV/AIDS Fund was unique in the sense that it mainly considered local or grass root organizations which are very active within their communities but had difficulties to compete for funds with well-established organizations. The HIV/AIDS Fund had established a “Board” which came up with criteria for funding which stimulates the following; the organization implementing the project can be an institution of ecclesiastical and non-ecclesiastical character, a NGO or communities. A key criterion in the screening of a project is sustainability. The project should benefit as many people as possible, the organization supported should work towards networking with related organizations. In 2009 a new criterion for funding was introduced. All projects had to be an Income Generating Activity (IGA) aiming at increasing the financial and institutional sustainability. The board for the HIV/AIDS Fund was responsible for screening and selection of the projects.

A HIV/AIDS Fund team, consisting of 3 persons was responsible to monitor the implementation of the selected projects. For that reason it had put in place measures to sustain the projects funded and to ensure efficiency and effectiveness in terms of implementing the projects from the funded partner organizations. Before a potential project was funded, a baseline assessment was conducted. This provided detailed information about the project which assists both the donor and the implementers on the clear objectives of the project and its attainment. Crucial for the success of the IGA projects was very close monitoring of the spending at project sites and technical support as well as capacity building in the field of the accounting and marketing. Projects that did not follow the agreed basic accounting standards were closed.

SURVIVAL SKILLS AND EMPLOYMENT

Two successful examples of organizations that have received funding and technical support are Kanyama Savings and Credit Union (KASU) and Kamanga Tithandizane Open Community School.

Kanyama Savings and Credit Union is a non-partisan Community Based Organization (CBO) whose services are to supplement efforts in poverty and HIV/AIDS reduction among its members within and outside Kanyama (township in Lusaka). The majority of members of KASU, who benefit from the activities of the organization, are widows and most of them are living positive. KASU offers educational program for orphans and vulnerable children (OVCs and literacy, HIV/AIDS sensitization through Home Based Care and nutritional support, entrepreneurship trainings, outreach programs and provide psychological support). It is registered under the Registrar of Companies under the Ministry of Community Development. It received the total amount of ZMK 120’634 (ca. 22’000 CHF) from the HIV/AIDS Fund to start a “sausage making business”. KASU’s aim was to use the money made through the sales of the sausages to sustain itself in terms of running costs and to support some of the activities. So far the income generated from the IGA has provided assistance for some children towards their education which is a good investment for the future. Other IGAs were reactivated with some small investments. Further the existing revolving fund of the support group was increased.

The IGA has also created jobs for some of the members who are now sales agent and receive a 10% commission from every sale made. This corresponded in striving to improve the socio-economic deterioration that the HIV/AIDS has imposed on the disadvantaged people.

The sausage making project has benefited 100 direct beneficiaries and more than 200 indirect beneficiaries. The direct beneficiaries are the women who are taking part in the activities of the organization, including the production and sale of sausages and also orphaned children who are being sponsored with school requirements such as books, bags and school fees for those in junior secondary. The indirect beneficiaries have been provided with the services within the community, they are able to have a balanced meal once in a while as they can afford to buy the local product (sausage) at an affordable price.

During the final evaluation, the HIV/AIDS Fund team had the chance of meeting the beneficiaries during one to one interviews and they had this to say:

“Despite being HIV/AIDS positive, the project is keeping me busy. I have acquired some survival skills which are a life tool and it helps me raise money to take my children to school.” (Susen Chilekwa)

“I have learnt a lot concerning HIV/AIDS, knitting and making sausages. It is a unique project, it has provided some employment which I never thought of, the skills learnt is not only for now but for the future, two of my children have benefited for education support in terms of books and bags”. (Veronica Banda)

SUPPORT OF ORPHANS AND VULNERABLE CHILDREN

Kamanga Tithandizane Open Community School is another organization that had received funds from the BMI HIV/AIDS Fund. The School was established early 1999 and is registered by the Registrar of Societies and the Ministry of Education. The school provides primary education (grades 1 to 7) to the vulnerable and orphaned children with the first priority being given to the girl child. The children at this school are mostly single or double orphans. The same state of affairs has been brought about by the HIV/AIDS pandemic and most of these children are being kept by their grandparents who can’t afford to pay the fees demanded by the government schools and private schools



respectively. The teachers at the school are voluntary teachers. Some of the teachers are fully trained teachers but have offered to volunteer and to help shape the lives of the future generation. The school has the total number of 524 pupils with the breakdown of 224 boys and 300 girls. The total number of teachers is, inclusive the Coordinator and the Head Teacher, 3 males and 5 females.

The school has received funds to start an IGA in hammer milling. The total amount received was ZMK 126'500 (ca 24'000 CHF). With this money a hammer mill house was build and the hammer mill purchased. The objective of the income generating activity is to raise money to purchase school requisites such as chalk, text books and exercise books for extreme vulnerable pupils. The income generated will also be used to cushion the allowances for volunteers which are very low at the moment, thus motivating them. This will help on the part of volunteer retention which has been the biggest challenge of the school. The project is on its way to benefit 524 direct beneficiaries and more than 54'000 persons living in Kamanga compound who will benefit from the grinding services offered by the community school as indirect beneficiaries. So far, the project is beneficial to the school in terms of buying small

items such as chalk, pencils and exercise books.

"This is the first project the school has embarked on since its inception on 2.02.99. Fourteen years down the line, as a school Coordinator, we are optimistic that the project will succeed and will guide it jealously". (John Saini Phiri, school coordinator)

"Many thanks to the donors, the investment given to us will go a long way, we are hopeful that the money raised will assist in the purchase of teaching and learning materials to make this school a place to be," (Moses Kaumba, teacher).

"Many thanks to BMI, the support given to us will improve our learning here at the community school." (Simon Mwale, pupil)

Both organizations faced a lot of challenges. The production of sausages needs electricity; needless to say that a power cut can destroy a full production. KASU had to improvise and find solutions like working in night shifts when power was not likely to go. Prices for the construction of the hammer mill house went up. Voluntary work, improving negotiation skills and commitment made it possible nevertheless.

In summary, a total of 38 projects were supported by the BMI HIV/AIDS Fund. 19 of those were IGAs aiming at the financial sustainability of the organizations. In 8 projects

the funds were used to organize workshops to raise awareness on HIV/AIDS and/or to learn life skills. In 2 projects bikes were purchased to support and motivate care givers. A rural health center and a hospice used the funds to buy live saving medicaments they did not receive from the government. One radio program about HIV/AIDS was produced and successfully transmitted several weeks. In one project 10 houses were built to replace the huts of widows and OVCs. And 4 projects received support to cover their running costs for a certain time.

Altogether close to 700'000 CHF were spent, benefiting over 7'000 persons directly. The number of direct beneficiaries will further increase with the continuous support that some of the organization receive through their in some cases recently build up IGAs.

IT TAKES TIME

The lessons learned from the IGA projects were that it takes time to start a business and even more time until it makes profit. The dedication of the project managers to learn new skills and to invest time in a new activity (IGA) are crucial, and human resource changes are therefore a high risk for the success of an IGA. In all IGA projects it was necessary to build up capacity in the field of accounting and reporting. Some of this will help the organizations also to apply for further funding from other do-

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HOW FAR ARE WE OF A FUTURE WITHOUT AIDS?

MSF has been one of the leading non governmental organizations engaged in the fight against HIV/AIDS in limited resource settings (LRS). Many people will remember the pioneers from the organization that in the late 90s, looking powerless at their patients dying of AIDS, had decided to smuggle antiretrovirals into places where the needs were devastating; a few persons would have believed that this initiative would lead the MSF to start such commitment along the last 15 years

By Johnny Lujan*

MSF has implemented different strategies to increase access to life saving antiretroviral therapy (ART). Testing, adaptation and innovation of these strategies have been among the founding principles to achieve and promote access to ART.

Today, in low and middle income countries, very much progress has been achieved and many deaths have been prevented due to ART, the number of people receiving ART rose from less than 200.000 persons in 2011 to around 9.6 million today. But in despite of this progress, we also have to accept that a lot has to be done yet. Extremely low access to ART is the case in some countries yet (in the Democratic Republic of Congo –DRC- and Central African Republic, extremely low coverage of ART in adults is a clear example of this precariousness). And we cannot do other things in these days than just observe how much evidence has science provided and how scarce the means to implement this evidence are, it is a tragedy that only 2% of HIV infected pregnant women got access to PMTCT in DRC in 2011.

INVESTING FRAMEWORK FOR HIV

In regards of the UNAIDS sponsored strategy (Schwartländer et al. 2011), the following program activities can explain how MSF has invested its main efforts against HIV/AIDS in the last years:

MSF main aim in HIV/AIDS action is keeping patients alive. Meeting patients' needs being the principal priority for MSF, the organization is contributing currently to follow around 40'000 patients under ART, out of which, nearly 7% are children. This achievement has been possible through our work on strategies aiming to expand ART such as decentralization of care, task shifting and simplification

Prevention of mother to child transmission of HIV (PMTCT); MSF is well aware of the importance of this activity and is investing important efforts in backing up for some time already, the implementation of the 2013 WHO recommendations (PMTCT B+: All pregnant women being HIV infected should start ART regardless their CD4 counts); some of our projects (Swaziland, Myanmar and Mozambique) are highly involved in this activity.

Acknowledging that community participation is a main social enabler, MSF works with lay counselors and expert patients to provide literacy and counseling support for our patients. Involving communities to expand testing and linking those tested as HIV positive to the health structures are currently activities highly prioritized by MSF. Community based ART delivery is in the loop as one of the main points to be developed in the following years.

In South East Asia (Myanmar), we have as objective for the following years to work with most at risk populations; testing Men who have Sex with Men, sex workers and drug users and linking them to care for ART initiation regardless of CD4 counts is going to be one of the main goals of these actions.

Finally, in highly endemic countries, MSF promotes early initiation of ART for all HIV infected patients. A test and treat approach for all HIV infected patients will be implemented in Swaziland in the following years looking for getting a better knowledge of how to implement such enormous strategy which main objective is to curb the epidemic.

A FUTURE WITHOUT AIDS: HAPPENING SOON?

MSF believes that a future without AIDS is possible but based on our field experience we remain a bit skeptical about it happening soon. There are enormous challenges yet to be overcome.

The progress and achievements made so far are weak; sustainability of political and programmatic commitment as well as international – and national-funding are among the main difficulties to be solved. There are still countries with extremely low access to basic care and ART, and where not much has evolved in the last time; there, the implementation of the

innovative 2013 WHO recommendations remains uncertain.

Even doing big efforts to beat tuberculosis (TB) and especially multidrug resistant TB, we are not providing solutions to the mortality by other killers in HIV infected patients; cryptococcal meningitis recognized by WHO as a main cause of mortality in sub Saharan Africa, even far ahead of TB, is not being faced to as it should. And patients without access to HIV care and ART are still dying of undiagnosed opportunistic infections. Comorbidities such as Hepatitis B and C remain not tackled.

Moreover, due to the characteristics of the HIV infected population, other diseases are also threatening them; this is the case of chronic diseases that will affect much more HIV people than the not HIV infected population; and as patients on ART are aging and reaching comparative quality of life as the not HIV infected, cancers are starting to be considered also as an important menace.

Other basic challenges remain unsolved; patients require to achieve undetectability of viral load in order to control HIV; getting patients alive and cutting transmission depends on undetectability of viral load; currently, we do not know how the big cohorts in LRS are doing on this aspect, many could be already failing to ART and thus, in need of alternative antiretrovirals.

Additionally, we realize nowadays that HIV infection is spreading further in most at risk populations such as drug users in Eastern Europe and central Asia; HIV is also scattering to previously not affected populations, such as injecting drugs users and men who have sex with men in some parts of Africa, where widespread homophobia does not allow these men to get access to HIV care and ART.

To conclude, and paraphrasing Dr Piot, the former executive of UNAIDS (Piot/Quinn 2013): even when the most effective HIV interventions are used, most mathematical models suggest that by 2031 there may still be as many as 1 million new infections globally every year. These programs will require universal access, large scale implementation, careful monitoring and evaluation, financial and technical resources, and robust commitment. Only then may we begin to see a substantial effect on the global spread on HIV infection.

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Ressources

Bernhard Schwartländer et al: Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet* 2011; 377: 2031 – 2041

Peter Piot and Thomas C Quinn. Response to the AIDS Pandemic – A Global Health Model. *N Engl J Med* 2013; 368: 2210 – 8

UNIVERSAL HEALTH COVERAGE UND DIE GLOBALE GESUNDHEIT NACH 2015

COUVERTURE SANITAIRE UNIVERSELLE ET SANTÉ MONDIALE APRÈS 2015



Bildquelle: United Nations
Photo # 536946

Wie soll die Gesundheitspolitik global gestaltet werden, um Gesundheit auch für die ärmsten Bevölkerungen in Entwicklungsländern zu sichern? Darum geht es unter anderem bei der gegenwärtigen internationalen Debatte über die neuen Entwicklungsziele für die Zeit nach 2015. Die Weltgesundheitsorganisation propagiert Universal Health Coverage (UHC) als Mittel, um Gesundheit für alle finanzierbar und zugänglich zu machen. Am diesjährigen MMS Symposium diskutieren wir die Debatte um Definition und Ausgestaltung von UHC in Hinblick auf die neue entwicklungspolitische Agenda kritisch.

Ort: Basel, Hotel Hilton

Zeit: Mittwoch, den 6. November 2013,
9.00–16.45 Uhr

Kontakt: Martin Leschhorn Strelbel,
mleschhorn@medicumundi.ch
[www.medicumundi.ch/mms/services/events/
Symposium2013](http://www.medicumundi.ch/mms/services/events/Symposium2013)

Comment la politique de la santé doit-elle être façonnée au niveau mondial pour assurer la santé même des populations les plus pauvres des pays en voie de développement? C'est entre autres l'un des points qui est discuté dans le cadre du débat international sur les nouveaux objectifs de développement pour la période d'après 2015. L'organisation mondiale de la santé fait de la propagande pour la couverture sanitaire universelle en tant que moyen pour rendre la santé accessible et finançable pour tous. Les participants et participantes de la conférence vont être introduits dans le débat à la définition et l'organisation de l'UHC et vont discuter d'un œil critique du nouvel agenda de politique de développement.

Lieu: Bâle, Hotel Hilton

Date: Mercredi, le 6 novembre 2013,
9 heures à 16 heures 45

Contact: Martin Leschhorn Strelbel,
mleschhorn@medicumundi.ch
[www.medicumundi.ch/mms-fr/services/
events/Symposium2013](http://www.medicumundi.ch/mms-fr/services/events/Symposium2013)