



> This issue was produced in collaboration with the International Community of Women living with HIV/AIDS (ICW)

## Women living with HIV

This issue of Exchange focuses on some pressing concerns of women living HIV and AIDS. An overview article written by guest editor Emma Bell of ICW (International Community of Women living with HIV/AIDS) together with her colleague Luisa Orza highlights some of these concerns. One of these is the balancing required by positive women to be able to manage the fears instilled by their positive status (of infecting one's loved ones, of being stigmatized and discriminated, of abandonment and violence, etc.) with the need for security and support and the desire for intimacy, love and children. Another concern is the lack of recognition of sexual and reproductive rights of women living HIV.

Some of the topics addressed in other articles in this issue are the much-discussed ABC approach to behaviour change and how that ignores complex issues like human needs and desires; the loss of property and land experienced by many women living with or affected by HIV and AIDS in India; and the approach of 'memory work' with mothers living with HIV and their children as developed by NACWOLA in Uganda some ten years ago.

We wish you pleasant reading and welcome your comments!

**Nel van Beelen**  
Managing editor

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Guest editor



Talking about love, sex and abstinence p.5



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## Understanding positive women's realities

**Despite growing recognition of the right of HIV-positive women to have healthy fulfilling sexual lives and reproductive choices, there remain myriad factors that make such rights only a dream for most of them. The reasons why women have sex and how they have it are influenced by various factors. It is widely known that violence, abandonment and blame on disclosure can be major problems for positive women, as are loss of land, livelihoods and children. The fear thus created can be an even more pervasive influence on how HIV-positive women live their sexual lives, including whether or not they will talk openly to their partners about their sexual health and needs.**

Then there are the very human desires of love, trust and intimacy that make practising ABC (Abstinence, Being faithful, Condom use) not as easy or desirable as it sounds. These often go unrecognized in sexual health programmes, which tend to render sex sterile and pragmatic, rather than the expression of a complex mix of emotions, identity and intimacy which is what many people experience. *"Messages are abstract and sterile. We need to bring love back into the whole thing,"* an International Community of Women Living with HIV/AIDS (ICW) member from Namibia said at a session entitled Love, Sex and Abstinence at the International AIDS Conference (IAC) in Toronto held in August 2006.

For many women, an HIV diagnosis brings about significant changes in the way they enact their sexuality and how they feel

about sexual relationships. There are many reasons why HIV-positive women continue to have sex or not. Some choose abstinence while others feel that abstinence is thrust upon them. For many, a period of time is needed before they discover that sexual relationships can still be a necessary and healing part of their lives. At the session in Toronto an ICW member from Zimbabwe said: *"At the time of my diagnosis, I was in a good relationship with someone and although we had always had protected sex, I could no longer have sex with him. I felt dirty, disgusting, used, defiled and as far from sexy as humanly possible. The relationship ended and I spent the next four years celibate."* In some cases, HIV-positive women are able to use their status to negotiate safer sex. An ICW member from the United Kingdom, who was interviewed for the Silent Voices Project, said: *"I grew*



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*to like condoms as there is no mess. And I felt as if I was in control and I wasn't prepared to let anybody have unsafe sex with me and throw it in my face .... So in some ways [HIV] has made me more assertive sexually."*

## Testing and rights

HIV and sexual and reproductive health programmes and policies generally fail to recognize the complexity of people's lives and the contexts in which their sexual and reproductive choices are situated. Take for example the drive to test as many people as possible for HIV. It is as though programmers equate knowing one's status with being able to act on that knowledge to improve one's well-being and that of one's partners and children. For many, this is not the case and services are not preparing people for the consequences of a positive result of an HIV test. In many cases, more women than men have access to voluntary counseling and testing (VCT) services, and though testing is usually framed as voluntary, the power imbalance existing between service providers and service users is often not taken into account, as the following testimony shows: *"When I was pregnant and went for antenatal care, I was told to have a blood test. They did not tell me what the test was for... I realized it was the AIDS test when I received the results."* (HIV-positive woman from Thailand)<sup>1</sup>

Testing, along with other HIV services, has to be carried out and projected within a sexual rights framework which takes into account the context of women and men's daily realities. This should include their sexual realities and the appropriate support services to enable them to manage the

complexities of their post-diagnosis lives. Voluntary, informed, confidential testing is the cornerstone of ICW's work in protecting the rights of people living with HIV. An example of good practice in this arena is the Liverpool Voluntary Counselling and Testing Project in Kenya. This project addresses HIV from a perspective of gender-based violence and their training addresses gender inequalities within relationships. Counsellors

**"Messages are abstract and sterile. We need to bring love back into the whole thing"**

are trained to discuss women's experience of sexual power relations with clients, and to provide them with strategies for sexual negotiation and disclosure.

## Understanding women's realities

Many HIV-positive women have sexual desires and sexual relationships, and services need to recognize this by providing them with contraceptive advice and services, sexual health check-ups and comprehensive advice on pre- and post-natal care for mother and child. There is need for service providers to understand that women's relationships impact on their ability to access treatment and other health services. Women's relationships also impact on their ability to act on advice given to them by service providers. Partner control can prevent women from accessing treatment and can also impede their ability to adhere to treatment regimes.

A woman from Tanzania said during a treatment mapping meeting organized by ICW: *"Most of us women living with HIV*



# KIC



Royal Tropical Institute

## Knowledge Infrastructure with and between Counterparts (KIC)

The KIC Project aims to boost dynamic knowledge sharing, collaborative learning and networking. It is an action-oriented, counterpart-driven pilot project, of which the first phase runs up to the end of 2006. Within the KIC Project Oxfam International and Exchange are collaborating to reinforce the learning on HIV/AIDS. Oxfam counterparts are invited to write articles about lessons learned related to these topics. The articles produced in the framework of

this collaboration are accompanied by an Oxfam logo in a green title box. The KIC Project also has an interactive website: [www.oxfamkic.org](http://www.oxfamkic.org), which enables Oxfam counterparts to share evidenced-based practices and documents, and to participate in online communities. For questions and comments about this edition or about the project, counterparts are encouraged to use the email address [aids.kic@oxfamnovib.nl](mailto:aids.kic@oxfamnovib.nl).

and who are using antiretrovirals (ARVs), we face a common problem that our husbands or partners tend to force us to give them our ARV dose while he has not tested for HIV and doesn't know his CD4 count. They do not want to go for testing while they show all HIV symptoms. Even if you refuse he will find out where you keep your medicine and steal them." Too often health care workers fail to recognize such pressures and label patients 'difficult to manage' or feel that their advice is ignored.

### The right to have sex and children

More problematic is that health care workers, under pressure themselves, often make harsh judgments concerning HIV-positive women's rights to have sex and children and pressure them into taking certain courses of action. HIV-positive women with children are frequently considered deviant in some way – to have made a mistake. Health care workers, community members, the media, even HIV activists have labeled HIV-positive women who get pregnant as irresponsible. In fact ICW members have reported that access to ARVs can sometimes be offered only to those who are on contraceptives; women in Lesotho and Namibia have reported that access to ARVs has been tied to use of certain types of contraceptives – either

The complexities of the lives and circumstances of women living with HIV require their involvement in policy and programme design in order to effectively address these issues

hormonal injections or IUDs, in both cases doctor-controlled methods – because it is believed that as HIV-positive women they should not get pregnant.<sup>2</sup> This is not only a violation of their reproductive rights, but also places them in danger of re-infection and STIs as safer sex is often negotiated around contraceptive use.

Conversely, others have been denied contraceptives because it is believed that



ICW members coming together at the International AIDS Conference

they should not be having sex, as one HIV-positive woman from Thailand learnt: "I'd been to hospital and was told to have an IUD fitted. Then, when he checked my medical file and learned that I had HIV, they said 'Oh! This one was infected! The HIV-infected should not use it'."<sup>1</sup> Under such circumstances when HIV-positive women do fall pregnant, the emphasis is on saving the life of the child, neglecting the health of the 'undeserving' mother, which not only reverses the impact of prevention of mother to child transmission (PMTCT) but also denies women their right to health: "You are only important when you get pregnant, the baby becomes important; once you are separated you have to see to yourself."<sup>3</sup>

### Balancing fear, security and desires

For many women, the balancing act requires them to manage the fear of abandonment from partners, fear of unwanted disclosure, fear of stigma, discrimination and violence, and fear of infecting infants and partners, with the need for security, support and the desire for intimacy, love and possibly

children. This can simply be too much to manage. "If you start using milk powder everyone will know you must be HIV positive. If you demand condom use, to stop repeated exposure, he will either hit you or just go off and have sex somewhere else and likely bring back other infections. So you just go on having unprotected sex and breast feeding even though you know you are doing exactly what they tell you you mustn't do..."<sup>3</sup>

Women are often left to research treatment options for themselves, and only those who have access to and confidence in the relevant information are successful in accessing the treatment they require, especially around reproductive choices. "[The Support group] is run by an NGO but if you get pregnant you have to go to the Federal AIDS Centre and they try to discourage you from having a child... It is very much frowned upon for a woman with HIV to have a child and a sex life... at the Federal AIDS Centre you are told to have an abortion. You can get information [about PMTCT] from the support group...

*but the doctors will convince you that it's not effective... If a woman does decide and insists on having a child they will help."*<sup>4</sup>

### Towards more meaningful involvement

The complexities of the lives and circumstances of women living with HIV require their involvement in policy and programme design in order to effectively address these issues. More often than not, people living with HIV, and especially women, are still excluded from decision making fora, and when they are invited to participate, it is still someone else who has set the agenda. Such situations can be intimidating and overwhelming, and many ICW members report having felt sidelined once they have delivered a personal testimony on how they became infected. Yet these same policy makers claim to embrace the principle of Greater Involvement of People living with HIV and AIDS (GIPA). ICW actually prefers the term MIPA: Meaningful Involvement of People living with HIV and AIDS – including HIV-positive women – in all decision making that affects their lives. This means that policy makers need to ensure that such inclusiveness is developed. At present the onus still lies with the people who are living with HIV to push for their own inclusion.

### Challenging stereotypes and inequalities

Examples of good practice in the areas described here do not abound, but they do exist. An example is the MTCT Plus Initiative

**Programmes need to be non-stigmatizing and be slotted into the realities people living with HIV already face, rather than burdening them with a whole host of new ones**

in clinics in South Africa operated by MSF (Médecins Sans Frontières) in Cape Town. The programme involves HIV-positive women who have already been through the programme to support new mothers and families entering the scheme. The initiative provides long-term follow-up care for HIV-positive mothers, their children and their partners, fostering caring and healthy families in which the responsibility for childbearing and rearing is shared.

Programmes need to be non-stigmatizing and reflect the realities people living with HIV already face, rather than burdening them with a whole host of new ones. They need to challenge existing stereotypes and inequalities and if possible, be led by

women living with HIV. If not, then they need to involve HIV-positive women at every level – from planning and consultation to development of the budget, implementation, training, monitoring and evaluation.

ICW's vision is a world where women have the right to make choices concerning their reproductive and sexual lives. This cannot be achieved through top-down calls for abstinence or fidelity or tokenistic strategically placed boxes of condoms, but by changing the conditions of all women's lives. It also involves challenging the existing power relations between men and women and inequalities that influence these women's reproductive and sexual lives. Only then will HIV-positive women realize their sexual and reproductive rights. ■

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Meaningful involvement? Part of a poster developed by ICW to show the different types of involving women living with HIV: from manipulation and tokenism to real participation.  
Download poster: [www.icw.org/icw/files/icw\\_poster.jpg](http://www.icw.org/icw/files/icw_poster.jpg)

1. Quoted in S. Paxton, A. Welbourn, P. Kousalya, et al, *Oh! This one is infected. Women, HIV and Human Rights in the Asia/Pacific Region*. Paper prepared for UNHCHR, 2004: [www.icw.org/tiki-download\\_file.php?fileId=79](http://www.icw.org/tiki-download_file.php?fileId=79)
2. J. Gatsi, *ICW treatment mapping project report, Namibia, ICW (forthcoming)*; and M. de Bruyn, *Reproductive rights for women affected by HIV/AIDS? A project to monitor Millennium Development Goals 5 and 6*, Ipas, 2005: [www.icw.org/tiki-download\\_file.php?fileId=185](http://www.icw.org/tiki-download_file.php?fileId=185)
3. ICW members from South Africa and Swaziland, interviews conducted during a policy development and training project in Durban, South Africa, 2005, report available from ICW.
4. ICW member from Russia, interview for *ICW News*, Issue 35, 2006 (forthcoming): [www.icw.org](http://www.icw.org)

# Love, sex and abstinence: the positive women's perspective

Article produced as part of the KIC Project

Luisa Orza



Women sharing intimate issues during the session Love, Sex and Abstinence

**As USAID and PEPFAR-funded programmes increasingly insist on the ABC approach, in particular one that focuses on the A and B but leaves out the C, HIV-positive women from Uganda, Zimbabwe and Namibia concur that this approach is failing women and are now demanding a different approach to sexual and reproductive rights. The women converged at the International AIDS Conference in August 2006 in Toronto, during a dialogue organized by the International Community of Women living with HIV/AIDS (ICW). Approximately 50 people attended the session. The session was coordinated by four ICW members, but the discussion was interactive and participants were both HIV-positive and negative women and men.**

All sexual activity is carried out in the context of power relations in any given society. Societal gender inequalities are among the factors informing the power relations of the intimate realm, which means that women's sexual activity is often enacted from a position of lower status vis-à-vis a male partner. Most women living with HIV are infected through heterosexual sex, and most often by a regular partner or spouse. Under such situations, all three of the options that the ABC approach promotes are ineffective, sometimes impossible to act out, and women in all cases bear the brunt – and often the consequences – of failing to act them out. Abstinence (the A of ABC) is not only difficult to enact if one is in a relationship, it is also a choice not many people would wish to make. Abstinence-only campaigns could stigmatize people living with HIV and even label them as promiscuous, especially women, whose sexual activity of any kind tends to provoke more disapproval than men's in most countries. Abstinence-only campaigns are also especially stigmatizing for HIV-positive women among discordant couples – where their partners are HIV-negative – as they levy a burden of guilt against the positive member of the couple.

The B ('Be faithful') and C ('use Condoms') of ABC campaigns are equally problematic for women. Arguably, anyone can control his or her faithfulness to a partner (except in cases of rape, sexual violence or coercion), but nobody can have control over his or her

partner's sexual behaviour, and it is unrealistic to talk about faithfulness in cultures that permit polygamy and/or promote masculinity based on the number of sexual 'conquests' the individual male is able to make. The use of condoms, and other safer-sex methods, currently still requires at least the consent – if not the actual application – from a male partner, though the female condom gives more control to women in this

**Women living with HIV, and negative or untested women, should be able to exercise their right to choose when, how, why and with whom to have sex**

respect. HIV-positive women from Zimbabwe and Uganda said that they were tired of hearing about how it is only disempowered poverty-stricken women who are unable to negotiate condom use. *"Educated, economically independent women are equally unable to negotiate safe sex"*, one of them said.

## Factors behind disempowerment

Undoubtedly, choosing abstinence, or a period of abstinence, whether alone or in a relationship, can be empowering. However, this choice is often made for a number of disempowering reasons including fear (of becoming infected, or infecting others); the negative associations with sex that an HIV-positive diagnosis may result in; guilt; shame; or the internalization of

stigma which may lead people living with HIV to feel that they are not worthy, and do not deserve love and sex any more. Many women living with HIV experience a loss of sexual identity following a positive diagnosis. Where abstinence is born out of any of the negative feelings mentioned above, a false sense of empowerment may prevail, if women encounter circumstances in which they are clearly not in control of the situation, such as incidents of sexual violence, coercion or the simple realization that the choice of abstinence was motivated by external rather than internal factors.

What should be aimed for, according to a young HIV-positive woman living in Zimbabwe, is a situation in which “No means No, but Yes also means Yes”. In other

**There is a need to broaden cultural definitions of sex and sexuality to include intimacy, pleasure and love, and ensure that these are reflected in prevention messages**

words, where women living with HIV, and negative or untested women, should be able to exercise their right to choose when, how, why and with whom to have sex. “There is sex after an HIV diagnosis,” she said, just as there is sex after menopause for older women, sex after becoming physically disabled, and sex after widowhood. Some of her initial experiences of sex-after-diagnosis were accompanied by ignorance from male partners, some of whom expected her gratitude for the pains they were going through in order to give her pleasure while protecting themselves, others whose fear of becoming infected was so great that it dominated the sexual act.

### Lack of leadership

These women feel let down by their leaders, especially the first ladies of some of their countries, who are often at the forefront of prevention campaigns, but who support the Bush administration’s promotion of abstinence-led campaigns, with reference to ‘illicit’ and ‘immoral’ sex which stigmatizes those already living with the virus. To them, abstinence has proved to be unsuccessful as a long-term prevention message. Female HIV/AIDS activists in Uganda have been branded ‘the Women AIDS Mafia’ for pushing to at least keep condoms on the political agenda despite president Yoweri Museveni’s announcement at the International AIDS Conference in Bangkok in 2004 that “condoms do not work with all sex styles.”

There is a strong feeling also, that their leaders are out of touch – or choose to ignore – the realities on the

ground in their countries. Kanjoo, a young HIV-positive woman from Namibia said: “*Maybe there is an abstinence movement running across Africa very fast. But at the same time there are plenty of stories of teenage pregnancies. ... Sex before marriage is being condemned everywhere you look, but it appears to be happening at a greater rate than ever before. ... Abstinence and prevention messages have removed the love from the whole thing. Messages are abstract and sterile. We need to bring love back into the whole thing.*”

### Burden of responsibility

Relationships with an emphasis on partnership, caring, and a fulfilling sex life, can be very healing, but the enactment of such relationships, especially in sero-discordant couples – is difficult. Where do the rights of one partner end and the other’s begin? Whose responsibility is it to ensure that the other remains protected, when it may already be the woman (in this case, also the HIV-positive partner) who is struggling to ensure that the couple practices safer sex? With the advent of criminalization of HIV transmission in many countries, the burden of responsibility lies heavily on the person living with the virus, yet when that person is a woman, she may be powerless in terms of ensuring that her partner protects himself.

What is the solution? The participants in this dialogue urged for greater openness about sex and sexuality, starting with the family – with parents talking to their children about sex, including the right kinds and the wrong kinds of sex, so that girls in particular are more able to understand from an early age how to avoid coercion and potentially dangerous situations. A second step is to keep the pressure on governments through dialogue and the media so that national laws and strategies are not based on political opportunism only, but also take into account the realities of women and men on the ground. Thirdly, there is a need to broaden cultural definitions of sex and sexuality to include intimacy, pleasure and love, and ensure that these are reflected in prevention messages. ■



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Seconde Nsabimana at the RBP+ office

## Taking action against HIV and AIDS in Burundi

### The experience of Seconde Nsabimana of RBP+

*Article produced as part of the KIC project*

**In Burundi, HIV and AIDS, as in many African countries, bears a feminine face. According to a 2002 national investigation, the seroprevalence rate among women was 13% in urban areas compared to 5.5% among men. In rural areas, 2.9% of the women were infected with HIV whereas only 2.1% of men were living with the virus. By the end of 2005, the number of people living with HIV (PLWHA) in Burundi was estimated to be 150,000, of which 60% were women.**

The first organization to rise to the challenge of HIV and AIDS was the Society for Women and AIDS in Africa (SWAA-Burundi), which was established in 1992. It was followed by the National Association of Support for Seropositives (ANSS) in 1994. Some years later, RBP+ was founded, the Burundian Network of People Living with HIV and AIDS. SWAA, ANSS and RBP+ were the principal organizations that realized the need to engage PLWHA in their structures, especially women living with HIV, who joined these organizations and took up leadership positions. HIV-positive women occupy key positions in RBP+. For instance, the board is composed of five members, three of whom are women.

For me, a new experience began in 1988, a period in which being infected with HIV almost meant death. I went to a family doctor who presented me with what I thought was a false HIV test result. My determination to learn the truth took me to an expatriate doctor who confirmed my seropositivity. It was too hard for me, I was just married, and with this development I thought life had nothing to offer anymore. I resigned from my marital obligations –

having intimate relations disgusted me instead of giving me pleasure. The only concern I had were my two children. I breastfed my three-months-old baby at the time. My doctor had assured me that there was no risk of infecting my baby with HIV through breast milk. Six months later, I

**From that moment a force was born inside me that now drives me into taking actions to enable me to live positively**

learned from the radio that it was strictly forbidden to breastfeed when one is seropositive. The picture that will never leave my memory is that of my baby girl. One morning as she anxiously waited to be breastfed as usual, she was instead given cow milk in a bottle. She reacted badly by screaming and throwing away the milk bottle. This greatly alarmed me.

I endured my initial years of seropositivity in loneliness because my husband was in denial about my HIV status. In the hospital where I worked, emaciated faces, particularly of women confined to their

bed, desperate, rejected by their loved ones who nicknamed them 'candidates for death', scared me. Wherever I went, the shadow of death seemed to follow me. I devoted myself from that time to bringing hope and happiness to the hospitalized women, who, like me, lived with HIV.

### Starting to live positively

From that moment a force was born inside me that now drives me into taking actions to enable me to live positively. This is what motivated me to join SWAA-Burundi in 1992 to support positive women. It was the start of my living positively. Now, almost 15 years later, I am the Vice-President of RBP+ and a member of the Centre GIPA, an association that initiates HIV and AIDS-related activities at workplaces.

It is not easy for HIV-positive people to become involved in the fight against AIDS. If one is seropositive, the principal barrier to him or her becoming more active in this fight is that the people in charge of NGOs treat one as a beneficiary of their services and tend to avoid involving PLWHA in management. They expect you to wait and receive the services they offer. This is a form of stigmatization and discrimination. Further, because of the remarkably active involvement of HIV-infected persons in NGOs, staff considers the PLWHA as competitors when paid jobs are available.

# Resources

## on women living with HIV

### Sexual and reproductive health of women living with HIV/AIDS

*Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings*  
UNFPA/WHO, 2006 (83 p.)



This publication addresses the specific sexual and reproductive health needs of women living with HIV/AIDS and contains recommendations for counselling, antiretroviral therapy, care and other interventions. The document argues that sexual and reproductive health services are uniquely positioned to improve women's sexual and reproductive health, treat HIV infections and prevent new ones.

[www.unfpa.org/upload/lib\\_pub\\_file/616\\_filename\\_srh\\_hiv-aids.pdf](http://www.unfpa.org/upload/lib_pub_file/616_filename_srh_hiv-aids.pdf)

### ICW/GCWA Fact sheets (2006)

With support from the UNAIDS-led Global Coalition on Women and AIDS (GCWA), ICW has produced three fact sheets. These frame key advocacy messages based on the findings of ICW project work on:

- Violence against women:  
[www.icw.org/files/VAW-ICW\\_fact\\_sheet-06.doc](http://www.icw.org/files/VAW-ICW_fact_sheet-06.doc)
- Sexual and reproductive health rights:  
[www.icw.org/files/SRHR-ICW\\_fact\\_sheet-06.doc](http://www.icw.org/files/SRHR-ICW_fact_sheet-06.doc)
- Access to care, treatment and support: [www.icw.org/files/ACTS-ICW\\_fact\\_sheet-06.doc](http://www.icw.org/files/ACTS-ICW_fact_sheet-06.doc)

I do not let anyone point a finger at me. Instead, I prefer to say what I want to say in a vocal manner. The most important thing is that I have informed my family and friends of my status. My spouse only allowed me to speak openly about my seropositivity later in 2000, when he was a volunteer with the United Nations. He at last understood the necessity to break the silence and crack the shell bothering us all – stigmatization. Support can be the motor of change for PLWHA. Earlier, my husband prohibited me from my seropositivity to doctors when I went for consultation. He advised me, to leave them to do their own diagnosis and to guess what was wrong with me. Can you imagine? He even was not comfortable with me disclosing my HIV status to my brothers and sisters.

It was very difficult to disclose our status to our children. The day that I decided to do that, the children said: *“we knew this for a long time mom, the other children nastily told us that we are infected with AIDS like our parents. What's more, dad takes medicines, doesn't he?”* This was the ideal moment to sensitize them on HIV and AIDS and also explain to them the importance of having joined support organizations and to prepare them for voluntary testing.

### Becoming more active

In 1992, one of the founding members of SWAA whom I had disclosed my HIV status to asked me if I was interested in joining the new association. I joined them without hesitation because I was motivated by my experiences and my knowledge of the needs of infected women. At SWAA, I learned to talk about my status during the pre- and post test counselling I gave. From 1998 to 2000, I participated in the prevention activities of ANSS because I wanted to make a contribution through exchanging experiences with other PLWHA. In 2001, I joined a pilot project on GIPA initiated by the United Nations Development Programme (UNDP). Today, I am a member of the Centre GIPA. At the end of 2001, we put in place the structures of RBP+, of which I soon became the Vice-President.

Involvement of PLWHA like me in organizations such as SWAA and the Centre GIPA was a lesson and a model for not only public services but also NGOs in the fight against HIV and AIDS. At SWAA, we proved that it was easier for infected women to disclose their status and that psychosocial care could be satisfactory due to the exchange of life experiences. What is more, the people who came for voluntary counselling and testing (VCT) were more confident, more open, reassured and more inclined to behaviour change.

The testimonies given with open minds were an added value for the members of SWAA. At the Centre GIPA, PLWHA's expertise contributed in a remarkable manner to the workplace programmes. It led to more disclosures by PLWHA and to responses such as the setting up of special company-level solidarity funds for purchasing medicines and the development of workplace policies to sensitize management on the need to mainstream HIV and AIDS in programmes.

Finally, I regard RBP+ as my *oeuvre*, a result of my long-time involvement in the fight against HIV and AIDS. Its initiation facilitated the mobilization of PLWHA of all walks of life to become actively involved in advocacy in defence of their basic rights. When we established RBP+ in 2001, people still made fun of us. Stigmatization was rampant and the responses to the epidemic were limited. United we stand! Nowadays, I can confirm without hesitation that in Burundi, despite the fact that access to care is not satisfactory, HIV-positive people and especially women, have an ideal structure through which to express their worries – a network of peers. ■

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# Women, property rights and HIV in India

Dipika Jain



Photo: Annelies van Brink

**In 2006, UNAIDS reported that almost half of the adults living with HIV and AIDS today were women. According to estimates, 38% of HIV-positive adults in India are women, and the number of young women, aged 15-24, living with HIV and AIDS is twice that of young men.<sup>1</sup> HIV/AIDS has exposed the social inequities that predispose girls and women to HIV infection, but women need more than rights in order to protect themselves. In India, the AIDS epidemic magnifies the devastation of women's property violations. In this country, women and their children are likely to face not only stigma against people affected by HIV and AIDS, but also deprivations caused by their inability to own and access property.**

This inability to own and access property is one of the biggest difficulties facing women in households affected by HIV/AIDS. HIV-positive women who have been abandoned by their husbands and ostracized from their communities and widows who have lost their husbands to AIDS-related illnesses are very often denied a rightful share of their husbands' property. The community or their in-laws throw them out, leaving them destitute and homeless. Sometimes, the women are sent back to their parents without a dowry, making it difficult for their families to support them.<sup>2</sup>

Laws and customs prohibit widows from inheriting property. This leads to their being evicted from their lands and homes by in-laws, and stripped of their possessions. Evidence shows that women whose partners fall sick and die due to AIDS-related illnesses suffer discrimination, abandonment, and even violence. In some places,

**This inability to own and access property is one of the biggest difficulties facing women in households affected by HIV/AIDS**

women lose their homes, inheritance, possessions, livelihoods and even their children when their husbands die. Such insecurity forces many of them to adopt survival strategies that increase their chances of contracting HIV.

In many families, the women – daughters, wives and daughters-in-law living with HIV – face more discrimination than sons, husbands and sons-in-laws.<sup>3</sup> Married women testify that they may not disclose their HIV-positive status to their husbands for fear of being victimized

and deserted. Women are often blamed by their in-laws when husbands are infected with HIV. They are seen as vectors of the infection even if the family has knowledge that the husband had visited sex workers. This blame is made in the belief that the wife was unable to satisfy her husband sexually resulting in his seeking sex workers. Ironically, the wives are still expected to provide care for husbands living with HIV/AIDS. After the husband's death, however, the usefulness of the wife will have ended. This is demonstrated by the in-laws denying the wife a share of her husband's property or pension.<sup>3</sup>

Human Rights Law Network (HRLN) is a not for profit NGO based in India. It is a network of lawyers and social activists working towards ensuring that the poor and vulnerable access justice. In the last few years, we documented cases of property grabbing by in-laws of people living with HIV and AIDS in several Indian states. Some examples suffice:<sup>4</sup>



- Suniti Chauhan's husband died of an AIDS-related illness a year ago. They lived in the district of Kishanganj in Bihar State. Suniti is also HIV-positive. Currently, she is staying with her father. Her in-laws have refused to acknowledge her stake in the household's property.
- Rukmaniu from Ethah district in Uttar Pradesh State is also HIV-positive. Her husband also died of an AIDS-related illness after a few years of marriage. She has a son who is living with HIV. She was beaten up and thrown out of her marital home and was not allowed to take even her clothes, because her in-laws blamed her for their son's death. She has filed a case for return of her property. She is currently staying with her brother.
- Roshani Singh from Varanasi was thrown out of her in-law's house after her HIV status was known. Her husband died of fever two years ago. She was beaten up by the husband's three elder brothers and denied a share in the property. She begged for a year on the streets to support her two-year-old child.

## Property laws in India

In India, as in other parts of the world, women's rights to property are limited compared to men. The denial and violations of women's property rights widens the economic disparity between men and women. Women's property rights are affected by a complex web of statutory laws, personal laws and social norms and customs.

Photo: Annelies van Brink



Personal laws govern family law matters and determine a woman's share in her parents' or matrimonial property. The applicability of any set of personal laws depends on a person's religious affiliation. For instance, Hindus, Sikhs, Buddhists and Jains are governed by the Hindu Marriage Act, 1955 and the Hindu Succession Act, 1956, whereas Muslim women are governed by the Muslim Personal Law (Shariat) Application Act, 1937 and the Muslim Women's (Protection of Rights on Divorce) Act, 1986. Additionally, tribal women's property rights are governed by the customs and norms of their tribe. It is clear that there is no uniform body of law governing Indian women's property rights. An Indian woman's property rights depend on her religion, her marital status, which part of the country she comes from, her tribal association and so on.

### Hindu women

It will be useful to take the example of property rights of Hindu women. Their property rights, as well as those of Sikh, Buddhist and Jain women in India, depend not only on religion and region, but also on their status in the family: whether the woman is a daughter, mother, married or unmarried or deserted or widowed. Her property rights also depend on the kind of property at issue, that is, whether the property is hereditary/ancestral or self-acquired, land or dwelling or matrimonial property.

The recent amendments to the Hindu Succession Act of 1956 (September 2005), have improved the property rights of Hindu women. The Act now covers agricultural holdings whereby a daughter is recognized as heir by birth in the same manner as her brothers. The sections of the Act that prevented a female residing in the family house from asking for a partition (dividing up) of the house and did not allow widows remarrying to inherit the property of their deceased husband, have been repealed. However, under the Hindu Succession Act, daughters still have limited rights regarding ancestral property. For example, in the case of *Narashimha Murthy v. Smt. Susheelabai and others* (1996), the Supreme Court of India held that the right of the female heir to claim partition is restricted by the rights of the male heirs; she cannot seek partition unless and until the male heirs decide to partition the house.

Additionally, a will can deny a daughter all rights to parental property. This is because Hindu parents' right to hand down self-earned property is unrestricted and therefore they can and often do leave such property only to their sons.

### Access to justice

Ensuring equality of property rights protects a woman and ensures her family's economic security, while also empowering her to fight against social and political injustices. However, it is pertinent to emphasize that having gender-just laws does not necessarily ensure access to justice. Despite equal rights provided to women in India, women remain deprived of equal status compared with men. Hence, at HRLN, the Women's Justice Initiative and the HIV/AIDS and the Law Initiative oppose all forms of gender-based discrimination and violence against women and aim at enabling women's access to the justice system, as a vital means to their empowerment.

In keeping with our philosophy, we provide comprehensive *free legal services* to poor and marginalized women. We attempt to demystify legal terms, concepts and procedures so that those neglected by the system of justice can also realise their rights. To achieve this goal, we emphasize the role of legal education. We also campaign among the population for better understanding of the law and the judicial system through different channels in a variety of

### The denial and violations of women's property rights widens the economic disparity between men and women

Indian languages. Campaigns are carried out through material that is designed to meet the specific demands of the target audience. HRLN also fosters the formation of *community-based legal teams* and *national law collectives* to achieve these goals on a larger scale by helping activists network with lawyers and by sharing our knowledge and practical experience. Finally, *public interest litigation* is another legal tool which we use to redress the violations of property and inheritance rights of women affected by or living with HIV and AIDS. Crucial and professional interventions at the level of the Supreme Court can bring about changes in conservative state policies and bring relief to millions of Indian women. ■

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1. Kaiser Family Foundation, *Fact sheet HIV/AIDS in India*, September 2006: [www.kff.org/hiv/aids/7312.cfm](http://www.kff.org/hiv/aids/7312.cfm)
2. A dowry is a gift of money or valuables given by the bride's family to that of the groom to permit their marriage.
3. UNAIDS, *India: HIV and AIDS-related Discrimination, Stigmatization and Denial*, August 2001: [http://data.unaids.org/Publications/IRC-pub02/JC587-India\\_en.pdf](http://data.unaids.org/Publications/IRC-pub02/JC587-India_en.pdf)
4. Names have been changed to protect confidentiality.



Page of an Ethiopian memory book

## Memory work: Learning from the Ugandan experience

*Nicola Ward, Jacqueline Nabwire, Jacinta Magero & Annet Biryetega*

**Memory work is becoming a widespread community approach in the reduction of stigma and discrimination and planning for children's future in communities affected by AIDS, principally in Africa. The first memory project was started by the National Community of Women Living with HIV and AIDS in Uganda (NACWOLA) in 1997.<sup>1</sup> Their initial training for parents and children took place in 1998. At the time, the project targeted women living with HIV and AIDS and their children. However, after several years the decision was taken to include the fathers and husbands.**

Memory work is a practical child-centred community-led approach that encourages families to communicate openly about HIV and AIDS.<sup>2</sup> It focuses on improving communication between guardians and parents living with HIV and their children; disclosing HIV status and other important information; succession planning and writing important family history in a memory book. A variety of activities take place around these four main pillars including training and peer support groups for parents, guardians and children. The memory book is a tool that is also used to facilitate the process. This book is a written record of family and individual history, important facts, memories, hopes and messages. It can be written by parents or guardians with or for children; or by children themselves.

NACWOLA's successful implementation of memory work is partly due to the fact that it is deeply rooted in the communities and also because the people who are imple-

menting the project feel a sense of ownership of the programme. The trainers and follow-up team are NACWOLA members – women living with HIV – who have been memory project beneficiaries and can therefore create strong bonds with other beneficiaries. Other trainer selection criteria include a minimum education qualification,

experience in writing a personal memory book and a disclosed HIV status to children or foster ones.

Those selected participate in a memory work training for trainers, which can last for 8 to 10 days. In 2005, a training manual was published to assist them in their work.<sup>3</sup> Trainers have also benefited from other trainings, e.g. on home-based care, PMTCT, nutritional counselling, handling stigma and palliative care. NACWOLA has trained 141 memory work trainers since 1998. Some of these women have passed away while some are now staff or volunteers in HIV clinics and other AIDS service organizations in Uganda. Others are staff and volunteers

### Opportunities for HIV prevention?

Memory work can be viewed as an entry point for HIV and AIDS work at the family level. It can be a good start for families to commence communication around HIV and AIDS issues, disclosure of HIV status to children and planning for the future. All these are fundamental issues critical for the success of HIV and AIDS programmes. In areas where memory work has taken place, there is evidence of increased demand for other HIV and AIDS programmes, from access to antiretroviral treatment, access to voluntary testing and counselling facilities and access to information concerning HIV prevention.

In the case of HIV prevention work, as more families start discussing important HIV and AIDS awareness issues at home, the raised awareness empowers children to access prevention information. As more families become involved in memory work, it becomes a community concern, and neighbours, other relatives and friends also become more aware of the situation and the need to become involved in prevention programmes.



## Handout 2: Some key points about disclosing to children

### Preparing

- Be clear about what you want to say and what the child needs to know.
- Break this down into smaller pieces that can be given to the child one at a time. For children aged four to six, it helps to put the information in the form of a story. For older children who can read, you could prepare a letter to start the process. The child can read it at a quiet time and think about it before you speak together.
- Make sure the information you give is appropriate to the child's level of understanding.
- Practise what you want to say with an adult you can trust before you disclose.
- Think about the signs your child shows when they are upset and be ready to stop if you see these signs. Some children feel more comfortable talking to another adult outside the immediate family. This might – but not always – be true for children between the ages of 7 and 12, who often admire other adults in their lives such as uncles, aunts and teachers. You will need to be able to trust and feel comfortable with such a person before you share this responsibility with them.
- Think of the questions they might ask and think through your possible answers.
- It helps if you have already started thinking about plans for the future, so you can reassure your children they will not be left alone.
- When you know what you want to say, be ready for the right time to say it: for example, when your child raises the subject of illness or has AIDS lessons at school. Make sure both you and the child are calm and that you will not be interrupted before you begin.

### Telling

- Decide what to begin with and do not talk for too long.
- Be clear and ready to summarise the important points.
- Be honest and calm.
- One way to start is to talk about illness generally, then about your own personal illness, and then HIV and AIDS in the family.
- Stop if your child shows signs of distress, becomes quiet, looks away or changes the subject. Comfort the child.
- Be ready to answer questions like: "How did you get it?", "Have I got it?" and "When will you die?"
- Be ready for shock, anger, blame and denial. Remember, these reactions will pass with time.

Disclosing to children. Handout for participants in memory book project trainings from The Memory Work Trainer's Manual<sup>3</sup>

in NACWOLA or resource persons at the district level where they assist in monitoring memory work.

### Learning from experience

Participants in memory work go through a process of improving communication in the family setting with their children and planning for the future. The programme is flexible and allows for families to take different lengths of time to achieve improved communication. Between the training of the parents/guardians and the children, there is a three-month gap to allow parents time to disclose their status to their children, a pre-requisite before the children can participate in their training. Separate post-training support groups are established for the parents and children. This accords the children and the parents space and time to share experiences and improve communication.

Memory book clubs have been set up to support the parents in writing memory books. The memory work process is based on interpersonal interaction between the trainer, follow-up team and the communities in which they work. Participants are encouraged to share their own experiences of the challenges they faced while preparing to disclose their HIV status, facing stigma and discrimination and how they communicated with their children. The programme is cost-efficient because it reaches out to large numbers of individuals with minimum capital input. Another key factor behind its success is the commitment of the trainers.

### Impact

The impact of the project is felt at the grassroots level and it starts with the participants in the programme who then share their experiences with others in the community. The following is a testimony

from a participant in the memory work project: *"I disclosed my HIV status to my son after going through a memory project training. My son now understands why I can't provide him with everything because we discuss family issues. When I gave him money to pay for his educational trip, he was so happy and told me that his teacher had told him that he can't afford a school trip because his parent died of AIDS-related illness".* (A parent from the Busia branch of NACWOLA)

Children who have benefited from the trainings have also become more supportive to their parents living with HIV: *"I saw the way my father was suffering before his death. I knew we would have nobody to care for us. However, my mother has been supportive. She told us she's HIV positive but she is still able to care for us. We always remind her to take ARV drugs",* a child from Luweero said. A child from Busia said: *"I am able to counsel my young brother and sister at home how to avoid early pregnancy, marriage, HIV/AIDS and I am a peer educator."*<sup>4</sup>

The project has expanded due to the ripple effect. Previous beneficiaries tell others about it hence creating an ever-increasing demand. Originally implemented in only one district, NACWOLA now has scaled up the memory work to cover five districts where it has branch offices, as part of the International Memory Project which started in 2004. Since then, some 150 parents and guardians and 150 children have been trained and commenced memory work. Children's peer support clubs have been established in all the five districts and they meet either during school holidays or on Saturdays. Issues discussed depend on the interests of the children and include topics around STI, HIV and AIDS awareness. The clubs are a safe space for sharing life experiences, developing a sense of self-confidence, raising self-esteem and increasing resilience.

Following the trainings with the parents and guardians, each participant receives a copy of a memory book and can request more copies depending on the number of children

they have per household. Since the start of the International Memory Project, 210 memory books have been completed or are in progress. Challenges encountered while compiling memory books include difficulty in getting family information on deceased husbands, and the issue of disclosure and the high levels of illiteracy in the rural areas. The children and literate mothers in the memory book clubs assist the illiterate parents to write memory books. Memory book guides have also been translated into three local languages to overcome some of the barriers.

### Involving men

Through the process of learning from the years of experience in memory work, NACWOLA has modified the programme to include some new components. One of the most important changes is the inclusion of men in the programme. NACWOLA took a conscious decision to implement the memory project outside its core membership – women living with HIV – due to the high demand. It has now implemented memory projects together with other organizations working with men, notably Lumero, The AIDS Support Organisation (TASO), UWESO and Reach the Child Uganda.

There were various reasons for this change in approach. In the Ugandan culture, men head families and are, therefore, influential in family decision making. It is important to

involve them so that they become an integral part of the memory work process and support the plans made for the children by their mothers. Including men in training workshops and group meetings opens up gender discussions. An example of such a discussion may be on why a female child may have to stop school to care for her ill mother when there is an older male child in the household. Finally, a supportive family environment created through fathers' engagement builds psychosocial support, which is very important not only for the children, but also for the parents.

### Smooth take-over

Other changes in the approach of implementing the memory work project included developing a child-centred approach which involved children in planning for their future and home responsibilities for a smooth future take-over of the household tasks after the death of their parents. This led to the establishment of linkages with other organizations such as Heifer International to help parents set up income-generating activities. Thereafter children's clubs were set up and have now expanded into all memory project implementing districts in Uganda. The other benefit of children's clubs is that they can play the role of peer support groups. Memory book clubs for parents who are completing memory books have also started playing the role of support groups. The sharing of experiences assists parents to face the challenges and complete their memory book.

Refresher trainings are now carried out to enable beneficiaries and facilitators to share experiences and find ways of addressing challenges. It was recognized that due to the increase in numbers of orphans, the guardians and carers needed to be involved in the project so that the orphans are supported and could also benefit from the memory project. Community leaders are also involved and sensitized to enable them to support the implementation of the project.

The successful concept of memory work developed in Uganda by NACWOLA has

been borrowed and adapted in different countries in Africa. In the framework of the International Memory Project initiated by Healthlink Worldwide, memory work has also been introduced in Ethiopia, Tanzania and Zimbabwe and further expanded in Uganda and Kenya. NACWOLA plays an important role in this project. A mid-term evaluation of the International Memory Project including the Ugandan component is underway. The results are expected by the end of 2006. ■

*In the next issue of Exchange, an example will be taken from Tanzania to see how organizations are adapting memory work to their own contexts.*

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### Lessons learned

- A supportive family environment created through fathers' engagement in memory work builds psychosocial support, which is very important not only for the children, but also for the parents.
- A child-centred approach ensure that children are involved in planning for their future and a smooth take-over of the household tasks after the death of their parents.
- Memory book clubs for parents who are completing memory books can play an important role in offering peer support. The sharing of experiences assists parents to face the challenges and complete their memory book.

1. See for instance J. Nabwire, *Sexual Health Exchange* No. 1, 2000 ([www.kit.nl/ils/exchange\\_content/html/2000\\_1\\_uganda\\_memory\\_project.asp](http://www.kit.nl/ils/exchange_content/html/2000_1_uganda_memory_project.asp), and A. Biryetega, *MMS Bulletin*, No. 97, 2005 ([www.medicusmundi.ch/mms/services/bulletin/bulletin200503/kap03/07biryetega.html](http://www.medicusmundi.ch/mms/services/bulletin/bulletin200503/kap03/07biryetega.html))
2. *Starting to do memory work: A guide to the stages of implementation (draft)*. N. Ward, Healthlink Worldwide, 2005: [www.healthlink.org.uk/PDFs/imp\\_stages\\_draft.pdf](http://www.healthlink.org.uk/PDFs/imp_stages_draft.pdf)
3. *The Memory Work Trainer's Manual. Supporting families affected by HIV and AIDS*. NACWOLA/Healthlink Worldwide, 2005 (144 p.): [www.healthlink.org.uk/PDFs/imp\\_manual.pdf](http://www.healthlink.org.uk/PDFs/imp_manual.pdf). Hard copies are available free for CBOs and £20 a copy for international organizations.
4. *Policy Brief: Building children's resilience in a supportive environment: Reflecting on opportunities for Memory Work in HIV responses*. Healthlink Worldwide, 2006 (4 p): [www.healthlink.org.uk/PDFs/memory\\_policy.pdf](http://www.healthlink.org.uk/PDFs/memory_policy.pdf)

# Reintegrating residents of rehabilitation camps in Northern Vietnam

The Cactus Blossom support group for female ex-IDUs

Pauline Oosterhoff & Nguyen Thi Hien



Cactus Blossom poster

**Thousands of Vietnamese drug users and sex workers, many of whom are also HIV infected, are forcefully incarcerated in rehabilitation centres. Forced rehabilitation of drug users and sex workers in this country has been unsuccessful because the majority of released residents relapse within 18 months. This, therefore, calls for a new approach in addressing the plight of drug users and sex workers upon their release from incarceration. Together with the authorities and a group of returning female residents, the Medical Committee Netherlands-Vietnam (MCNV) piloted a voluntary community-based reintegration programme for women in Hanoi: the Cactus Blossom support group.**

Intravenous drug use has been the main factor behind the spread of HIV in Vietnam. The highest rates of seropositivity (up to 80%) are found among intravenous drug users in the large cities, including Hanoi. The majority of these are men. The overall rate among female sex workers in 2005 was 6.5%. However, many female sex workers also inject drugs. Five rehabilitation centres in Ba Vi, 70 km from Hanoi, house roughly over 7000 ex-IDUs and sex workers, 700 of them being women. These rehabilitation camps are supposed to help people reduce their dependency on drugs and offer them vocational skills to make a living. All camps have voluntary and involuntary residents. The state pays for the involuntary residents while volunteers in the camps are supported by their families. ‘Volunteer’ does not necessarily mean that the individual has volunteered; it can mean that the family has ‘volunteered’ him or her and pays for the time spent by the family member in camp. Volunteers can, therefore, not always leave when they want but when their families desire that they leave. About 30% of those in the camps test HIV positive upon enrolment.

Returning residents of Hanoi receive mandatory state support upon rejoining their communities to enable them stay off drugs through the so-called B93 clubs. The clubs target male IDUs and their purpose is to provide a forum at community level for moral support to reduce the sense of isolation that causes ex-drug users to relapse into the old habit of drug taking. Only Hanoi, in the north of the country, has such clubs. Other provinces lack state mechanisms to support their ex-residents through such facilities.

It is not easy to trace female ex-residents and enlist them to the B93 clubs because many of them disappear almost immediately upon release. Their families and communities reject them because of stigma attached to sex work, drugs and possibly HIV-positive status. Also, some families prefer to keep daughters at home for fear of their likelihood to relapse when they meet other (ex) users at the B93 clubs. Some families even opt to take their daughters to a different province. Men, especially the eldest sons, easily return to their families. And as is always the case, stigma

associated with HIV is stronger among women than men.

## From mandatory to voluntary community rehabilitation

In July 2005, the Medical Committee Netherlands-Vietnam (MCNV) and a group of state and parastatal agencies initiated a support group for female ex-IDUs called the ‘Cactus Blossom’, at the Red Cross in Dong Da, Hanoi. Unlike the B93 groups where membership is compulsory, the membership to the Cactus Blossom support group is voluntary. The programme chose to focus on female residents because this group was considered the hardest to reach by the authorities due to gender inequities and stigma in and outside the camps.

The emphasis of the project is on improving access to and quality of existing social and health services. Women elect core members who work in specific fields such as health, income generation or social support; presenting their job results and their plans is part of the election process. Through the group, individual members gain access to a range of services including antiretroviral therapy, loans and vocational trainings offered by state authorities in collaboration with the Women’s Union, the Red Cross, and a group of hospitals.

This multisectoral group receives feedback about their services from the core members of the Cactus Blossom group. Representatives of these agencies also visit the group to discuss their experiences. The

## Lessons learned

- Women who cannot rely on their families find it hard to cope due to lack of community and state support structures. When families realize that their daughters intend to stay with them, they support their plans, therewith increasing their daughters' chances to succeed.
- Many women have brothers, boyfriends or male friends who were taking drugs together with them and who might still be doing so. If male partners do not receive the same support, it will be hard for women to stay off drugs.
- A voluntary approach that involves peers and families and focuses on accessing services is more successful in reaching female ex-residents than mandatory programmes that focus on crime control.

Department of Social Evils in Hanoi, the authority that is in charge of the B93 clubs, has been an active counterpart in this project. It facilitates visits of core members to the rehabilitation camps to inform potential members and share their experience working with recovering drug users. In order to build the capacity of the whole group, the leaders take part in courses on office management, leadership and facilitation, English, and proposal writing. Civil servants pursue the same courses as the core members and are sometimes surprised to learn that recovering drug users are as educated as themselves.

## Understanding each other's needs

One assumption of the programme was that women who have been inside the camps understand each other's needs and want to help each other even when their personal backgrounds are diverse. A second assumption is that their families are isolated and need support. And thirdly, that support must be based on consent; only people who want help can be helped. These principles seem to work. The group is diverse and has seropositive and seronegative members, pregnant women, women with and without children, and women with and without male partners. Starting with two women, membership has grown to 35, of whom

half are seen weekly or bi-weekly and are either completely 'clean' or can manage their addiction. All women are supported to prevent mother to child transmission while those in need of antiretrovirals (ARVs) are able to access them.

The direct language, the bold fashion styles and manners that are exhibited during interpersonal communication in the Cactus Blossom group are unusual for ordinary Vietnamese women. But it is clear that members can offer appropriate peer support. For example, with job seeking, group members share job advertisements and advise each other. This helps members to find jobs that are realistic such as selling swimming pool tickets for the ex-drug user with coloured teeth, or selling make-up products for the glamorous former sex worker. Some women take loans together or share resources such as sewing machines.

Families of group members are more understanding and supportive to their daughters. When families realize that their daughters intend to stay with them, they support their plans, therewith increasing their daughters' chances to succeed. When one member who dropped out of school because of drug use received a letter of invitation to a management training course from the project, her whole family was so happy that her mother called her husband asking him to come back from the remote suburbs to share the excitement.

The authorities gain confidence and experience working with this group. Dialogue between families, authorities and members initiated by the project clarified that families' restrictions on their daughters movements were well intentioned but ineffective. Authorities heard directly from



the families that lack of services, fear of relapse and desire to remain anonymous were behind the lack of support for B93 programmes. This year, based on the results of this project, the Department of Labour, Invalids and Social Affairs will assess the strengths and weaknesses of both the MCNV voluntary system and the state-supported B93 approaches in order to adapt their community rehabilitation strategy.

## The health dangers of relapses

Lack of a comprehensive national harm reduction programme, especially substitution drugs, is a main challenge. Methadone has become legally available in 2006 but is not yet accessible in Hanoi.<sup>1</sup> Although the support group agrees that its ultimate aim is to enable members stay off drugs, relapses do happen. Relapses have immediate social and medical consequences. Members who stay off drugs and whose health is good enough to start ARVs adhere well. But members who relapse also are at risk of failing to adhere to their ARV prescriptions. One member received ARVs but relapsed, started stealing and after a few weeks as a sex worker on the street near the family's residence, was 'volunteered' by her family back to the camp. ARVs are not available in the camp and it is therefore highly unlikely that she will survive her two-year sentence.

Women who cannot rely on their families find it hard to cope due to lack of community and state support structures. Reintegration into their families is difficult. Sex work, by contrast, pays enough for those in the trade to rent a room with (former) colleagues, many of them active drug users. Given the difficulties in accessing cheap housing without family



# Resources

## on women living with HIV

### ICW News

Newsletter of the International Community of Women living with HIV/AIDS

ICW News has been produced quarterly since 1996. It has proved an important tool in reducing the isolation of HIV-positive women. Currently it is distributed to over 5,000 ICW members and other organizations involved in HIV/AIDS work. It is also available online.

[www.icw.org/publications](http://www.icw.org/publications)



### WomenLead in the Fight Against AIDS

CEDPA, 2006 (36 p.)

In 2005, CEDPA organized a workshop entitled 'WomenLead in the Fight Against AIDS' in Washington DC. A collection of stories of 12 women leaders attending that meeting was published by CEDPA to help understand how the pandemic affects the lives of women and their families, and the way forward.

[www.cedpa.org/files/871\\_file\\_WomenLead\\_in\\_the\\_Fight\\_Against\\_AIDS\\_CEDPA.pdf](http://www.cedpa.org/files/871_file_WomenLead_in_the_Fight_Against_AIDS_CEDPA.pdf)

### Meeting the reproductive health needs of HIV-positive women: Using evidence to advocate for change

*Target of Opportunity Final Report*

POLICY Project, 2006

This advocacy tool was designed and implemented by the Swaziland Sikanyekanye core package project in partnership with ICW in South Africa and Swaziland. The tool aims to build HIV-positive women's capacity to raise awareness of their reproductive health needs by creating and implementing advocacy plans to reduce policy and operational barriers at facility, community, and national levels. Another objective was to synthesize and facilitate the sharing of tools and the lessons learned across countries striving to meet the reproductive health needs of HIV-positive women.

[www.policyproject.com/pubs/corepackages/TOO RH Swaziland and South Africa.pdf](http://www.policyproject.com/pubs/corepackages/TOO RH Swaziland and South Africa.pdf)

support and the cultural importance of the family in Vietnam, it is not surprising that the most successful women are those who have family support. Insufficient support for male drug users and male returning residents is another key issue. Many women have brothers, boyfriends or male friends who were taking drugs together with them and who might still be doing so. If male partners do not receive the same support, it will be hard for women to continue alone. Suicide, overdose or arrests of a male partner have all caused women who were determined to quit to relapse.

The pilot programme only started in July 2005 and given the fact that drug rehabilitation is a long process, it is prudent to avoid premature conclusions. However, it appears to be possible to develop relationships with female ex-residents of rehabilitation camps based on their own free will using the existing state structures. A voluntary approach that involves peers and families and focuses on accessing services is more successful in reaching female ex-residents than mandatory programmes that focus on crime control. ■

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1. Methadone is a rigorously well-tested medication that is safe and efficacious for the treatment of narcotic withdrawal and dependence. Taken orally once a day, methadone suppresses narcotic withdrawal for between 24 and 36 hours. Because methadone is effective in eliminating withdrawal symptoms, it is used in detoxifying opiate addicts.

Photo: Debra Jones



All members of the support group will receive ART when they need it

**Magaly Caram, Jane Galvão & Jessica Halverson**

## Introducing HIV treatment into two sexual and reproductive health clinics in the Dominican Republic

The lessons learned by PROFAMILIA

**Today, AIDS-related illnesses are the leading cause of death among women of reproductive age in the Dominican Republic, and yet the public health system is ill equipped to provide antiretroviral treatment (ART) on a wider scale. According to UNAIDS, only 10% of Dominicans in need of ART in 2005 actually received it. This situation has led to many deaths and the problem is further aggravated by widespread poverty, gender inequities, and stigma and discrimination around HIV/AIDS. PROFAMILIA, an NGO that has provided sexual and reproductive health (SRH) services for nearly 40 years in the country, recognized the need for HIV treatment and care, both in the general community as well as among its clients and started addressing the issue.**

Integration of HIV within SRH services was not new to PROFAMILIA; the organization had incorporated voluntary HIV counselling and testing (VCT) into its spectrum of services in the 1990s, and it also hosted a client-run support group for people living with HIV and AIDS (PLWHA). But the introduction of antiretrovirals presented a more complicated and daunting challenge,

not to mention some ethical concerns about long-term sustainability of providing ART. Nonetheless, PROFAMILIA was willing to face the challenges. It joined the Models of Care Global Initiative sponsored by the International Planned Parenthood Federation (IPPF) of which PROFAMILIA is a member association, and developed a one-year project to start this process in two of its clinics in the cities of Santo Domingo and Santiago. The project commenced in mid-2004 and ended in mid-2005 and was supported by GTZ, the German agency for technical cooperation. After the completion of the project, all services, including ART provision, continued and now PROFAMILIA plans to sustain them.

### A little ray of light

A support group, entitled Rayito de Luz ('little ray of light') was founded by several of the HIV-positive clients at the Dra. Evangelina Rodríguez clinic seven years ago. Although it started with only a few members, its participation has since grown to approximately sixty members. The support group continues to be completely self-run by the HIV-positive clients themselves, with meetings held inside PROFAMILIA facilities. A 52-year-old female participant explained that there is much harmony in the group. When someone is feeling sick, she said that the group would call him/her or visit him/her. The group is always in phone contact, checking up on each other. A 51-year-old female client in Santiago said: "I learned about PROFAMILIA's HIV/AIDS programme through my niece. I feel like the support group is my family."

### Multi-disciplinary approach

The first key lesson to integrating HIV treatment lies in partnerships. Staff from Columbia University in New York trains PROFAMILIA physicians and nurses in treatment of HIV and opportunistic infections. The Clinton Foundation helps the organization to procure antiretroviral medicines from abroad, including negotiating reasonable prices. IPPF/Central Office and the Western Hemisphere Regional Office provide programmatic and evaluation support. PROFAMILIA

### Lessons learned

- Successful integration of HIV treatment in existing sexual and reproductive health services requires a multi-disciplinary approach: combining the provision of clinical care with adherence support, emotional support, family and partner education and safer sex counselling.
- Client confidentiality can be promoted and stigma prevented by integrating HIV services into existing services and client flow; by encouraging HIV-positive clients to follow the same intake procedures as all other clients and offering HIV/AIDS-related counselling in the same area as other types of counselling.
- Because sexual and reproductive health clinics are already reaching sexually active people (especially women), they are an ideal avenue for offering VCT, and then continuing client care with those testing positive for HIV.
- Sensitization of staff, through raising awareness about the myths and prejudices surrounding HIV and AIDS, is crucial to securing support from staff at all levels.

also collaborates with a local network of HIV-positive people, which holds meetings at one of the clinics. During the implementation of the project, a model care team was formed, whose three key members (a doctor/internist, a counsellor/educator, and a licensed nurse) received extensive training in HIV/AIDS care and sensitization on issues faced by HIV-positive people. This multi-disciplinary team works to provide clinical care and treatment and ensure adherence to ART. It also offers emotional support, family and partner education and safer sex counselling.

Project activities have been integrated into existing services and client flow. Clients attending the clinics for HIV/AIDS services follow the same intake procedures as all other clients; signing in at the reception area and confidentially selecting the services they require. HIV/AIDS counselling takes place in the same area as other types of counselling, further protecting client confidentiality throughout the process. *“I feel like any other person in the waiting room. We sit in the same seats and share the same room as everyone else, and thus, I do not feel pinpointed. No one knows in the waiting room that I am HIV positive,”* a PROFAMILIA client said.

PROFAMILIA conducts monitoring and evaluation activities throughout project implementation. Staff from IPPF/WHI and Columbia University also conduct on-site visits and have frequent contact with project administrators to offer evaluation support and to help facilitate adjustments when required.

### Key successes

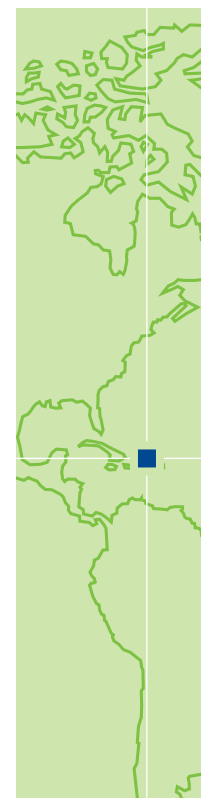
During the 2004-2005 project period, PROFAMILIA began receiving antiretrovirals from the Dominican Ministry of Health, as well as support for other costs including laboratory analyses, vitamins, treatment for opportunistic infections, hospitalization, X-rays and sonograms. Thus, the organization could offer a comprehensive HIV care package to clients at no cost – a significant achievement given the limited access and economic disparity across the country. Because the clinics were already reaching sexually active individuals (especially women), they were an ideal avenue for offering VCT, and then continuing client care with those testing positive for HIV.

Project administrators select clients for the ART programme through one of three criteria: 1) active members of the support group; 2) HIV-positive clients who are not involved in the support group; and 3) critical stage clients referred from other PROFAMILIA clinics. Clients who are clinically eligible for ART receive counselling on why they should consider treatment, including how antiretrovirals work with the immunological system and the importance of adherence.

Before commencing treatment, clients take vitamins for a four-week period to establish their habits of taking pills twice a day and also to strengthen their immune systems. Once a client is put on ART, he or she returns to the clinic weekly for counselling and to replenish the medicines. This allows the nurse to maintain close contact with the client during the beginning phase of treatment to determine if he or she is experiencing side-effects from the medications, and to address any questions or problems.

Clients are even given the home telephone numbers of PROFAMILIA staff in case they have problems during unofficial hours. Once stable on ART, clients meet with the nurse monthly and see the internist every three months, or when needs arise. The strength of the relationships that develop between clients and staff is considered to be a key factor in the success of the programme.

By the end of the one-year project period (in mid-2005), PROFAMILIA was providing HIV treatment and care to more than 165 clients, 67 of whom were receiving ART. The majority of these clients were women, and nearly a quarter was youth. The project resulted in good levels of adherence – monitoring and evaluation revealed that 95% of clients were staying on ART. This success, according to the team, is attributable to their multi-





disciplinary approach and especially the in-depth counselling and education services. Sensitization was another key element of the programme's success. Raising awareness about the myths and prejudices surrounding HIV/AIDS was crucial to securing support from staff at all levels. In addition, one-on-one training of HIV personnel helped to create a highly competent team, and a welcoming environment, free of stigma and not judgmental. Also, by integrating, rather than segregating HIV-positive clients, the clinics helped to protect client confidentiality and reduced stigma.

### Challenges

Subsidizing of HIV treatment and care is instrumental in getting clients to start and maintain ART, especially as most of the clients come from impoverished communities. However, this presents a significant programmatic and financial challenge. The sustainability of such an initiative is uncertain, and continuation of the service requires that PROFAMILIA and its partners, including the Dominican Ministry of Health, continuously seek alternative methods of subsidizing medication.

Another problem that needs to be solved is the continuing discrimination of PLWHA in public hospitals in the Dominican Republic. PROFAMILIA clients with opportunistic infections who require hospitalization have been referred to and rejected by the few public clinics and hospitals that offer medical services for PLWHA. The Santiago programme initially covered hospitalization for HIV-positive clients but found that the cost was excessive. Clients in both clinics consider hospitalization costs as one of their greatest concerns, as well as the inhumane treatment that HIV-positive people receive at public hospitals.

Another challenge PROFAMILIA faces is that the project is demanding in terms of labour requirement and the hours that staff need to put in. However, PROFAMILIA as an institution, is committed to ensuring that HIV treatment and care is sustained in its facilities. At the start of the programme, 41% of Santiago clinic staff had

not received training on HIV and AIDS in more than three years. Therefore, the organization had to invest heavily in continuous training, as well as on issues such as client's rights to confidential services, workers rights and HIV, sexual practices, and HIV and the rights of pregnant women. Dr Isaac Brito, an internist at the Rosa Cisneros Clinic in Santiago said: *"Constant training of personnel is critical because there are always new developments regarding HIV/AIDS. It is important that the team stay up-to-date on such developments."*

An unforeseen factor was the difference in client composition between the two clinics. The programme was first implemented in Santo Domingo and then expanded to Santiago. As the Santiago clients were significantly younger, providers there were unexpectedly presented with the need for PMTCT services for young and pregnant women living with HIV, whereas this scenario had not presented itself in the first client group at Santo Domingo. This necessitated a quick response from the supervising medical professionals at Columbia University, who provided immediate guidance and supervision in determining a treatment regimen for these women.

PROFAMILIA staff has demonstrated impressive dedication to their clients who are HIV positive. Much of the initial hesitation about integrating these services diminished when staff realized the dramatic impact they had. Ana Gloria, one of the educators commented: *"PROFAMILIA has compensated in one and a half years for the impotence of the past decade. We are saving lives."* Finally, the integrated, multi-disciplinary approach to HIV/AIDS care and treatment has become an effective model that will be replicated in the Dominican Republic through the National HIV/AIDS Strategic Plan. ■

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AssociationID=7

## → Manuals & Guidelines

### **Let's talk about voluntary HIV counselling and testing.**

International HIV/AIDS Alliance, 2006 (84 p.)  
Pdf: [http://synkronweb.aidsalliance.org/graphics/secretariat/publications/VCT\\_Tools\\_English.pdf](http://synkronweb.aidsalliance.org/graphics/secretariat/publications/VCT_Tools_English.pdf)

This toolkit is designed to help NGOs, CBOs and other civil society organizations responding to HIV/AIDS in developing countries increase their knowledge and improve the quality of their work on voluntary HIV counselling and testing. The resource is intended for use by NGOs and trainers who support such groups and has been designed to be used flexibly, either in capacity building workshops or during technical support visits.

### **Zero tolerance: Stop the violence against women and children.**

Global AIDS Alliance, 2006 (48 p.)  
Pdf: [www.globalaidsalliance.org/docs/Zero\\_Tolerance\\_Advocacy\\_Brief.pdf](http://www.globalaidsalliance.org/docs/Zero_Tolerance_Advocacy_Brief.pdf)  
Order hardcopy: [lschechtman@globalaidsalliance.org](mailto:lschechtman@globalaidsalliance.org) (Lisa Schechtman)

This advocacy brief describes a framework for a comprehensive response to violence against women and children, including the resources that would be needed, political and financial, for full implementation.

**Engaging communities in youth reproductive health and HIV projects. A guide to participatory assessments.** Family Health International, 2006 (126 p.)  
Pdf: [www.fhi.org/en/Youth/YouthNet/Publications/Clresources/index.htm](http://www.fhi.org/en/Youth/YouthNet/Publications/Clresources/index.htm)



*Engaging communities* is a manual which discusses how to conduct participatory assessments with youth and community members for improved youth reproductive health and HIV prevention. The manual draws on YouthNet's experience in Namibia, Tanzania and Ethiopia

with youth-led projects using these tools.

### **Keeping the promise: An Agenda for Action on women and AIDS.**

UNAIDS, 2006 (32 p.)  
Pdf: [www.unfpa.org/upload/lib\\_pub\\_file/597\\_filename\\_keeping-the-promise.pdf](http://www.unfpa.org/upload/lib_pub_file/597_filename_keeping-the-promise.pdf)



The Global Coalition on Women and AIDS is calling for a massive scaling up of AIDS responses for women and girls. This Agenda identifies three major areas for collective action: 1) secure women's rights; 2) invest more money in AIDS programmes that work for women; and 3) allocate more seats at the table to women.

## → Research reports & Reviews

### **Girl Power. The impact of girls' education on HIV and sexual behaviour.**

ActionAid International, 2006 (45 p.)  
Pdf: [www.actionaid.org/wps/content/documents/GIRL\\_POWER\\_ENGLISH\\_FINAL\\_792006\\_152655.pdf](http://www.actionaid.org/wps/content/documents/GIRL_POWER_ENGLISH_FINAL_792006_152655.pdf)



*Girl Power* summarizes the results from a systematic review of over 600 peer-reviewed articles on the impact of girls' education on sexual behaviour and HIV in sub-Saharan Africa. The review shows that as the epidemic has evolved, the relationship between girls'

education and HIV has also changed. Now, more highly educated women are better able to negotiate safer sex and reduce HIV rates. *Girl Power* also examines the underlying feminization of the epidemic.

### **More than words? Action for orphans and vulnerable children in Africa.**

World Vision UK, 2005 (67 p.)  
Pdf: [www.crin.org/docs/resources/publications/hrbap/More\\_than\\_words\\_UNGASS.pdf](http://www.crin.org/docs/resources/publications/hrbap/More_than_words_UNGASS.pdf)

*More than words?* is a qualitative investigation of how far the rights and needs of orphans and vulnerable children are being met in four of the worst-affected countries in sub-Saharan Africa. Based on surveys and focus group discussions with children, parents, caregivers and officials in Ethiopia, Mozambique, Uganda and Zambia, this report offers an insight into how far the commitments are being met and provides practical recommendations for action at both national and international level.

## → CD-ROMs and other Resources

### **CD-ROM: Review of the evidence: Girls' education and HIV prevention.**

The UNAIDS Inter-Agency Task Team (IATT) on Education, 2006  
Order (free of charge): [info-iatt@unesco.org](mailto:info-iatt@unesco.org)

This CD-ROM aims to expand the evidence base on the link between girls' education and HIV prevention. It contains more than 100 recent resources produced by members of the UNAIDS IATT on Education and other organizations. Included are policy documents, case studies, reports, tools, curricula and other materials from a range of settings and in several languages. Resources included on this CD-ROM demonstrate the importance of girls' education as a strategy for reducing the vulnerability of girls to HIV infection; provide examples of progress to date and suggestions for how the education sector can better meet the needs of girls; and advocate for intensified action around girls' education as part of national responses to HIV and AIDS.

### **Child-centred responses to HIV and AIDS: Memory work CD-ROM.**

Healthlink Worldwide/Source, 2006  
Order: Source, c/o Institute of Child Health, 30 Guilford Street, London WC1N 1EH, United Kingdom  
e-mail: [source@ich.ucl.ac.uk](mailto:source@ich.ucl.ac.uk)  
Online: [www.asksource.info/about/news\\_impdcd.htm](http://www.asksource.info/about/news_impdcd.htm)

This CD-ROM gathers together tools, manuals, case studies and useful contacts for organizations interested in using the memory work approach to psychosocial interventions with communities. This pilot CD contains links to full-text documents on the Internet for those with access. It is available free of charge. The content is currently being evaluated and a final version containing full-text documents will be available in 2007.

## Exchange

on HIV/AIDS, sexuality and gender

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