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Swiss Agency for Development  
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FOCUS

## FOCUS ON HIV, AIDS and SRH 1/2012

Dear Colleagues,

This is FOCUS ON HIV, AIDS and Sexual and Reproductive Health – the electronic medium that lives through interaction. You are invited to send your suggestions, requests and information flashes to: [christina.biaggi@unibas.ch](mailto:christina.biaggi@unibas.ch) or [nathalie.vesco@deza.admin.ch](mailto:nathalie.vesco@deza.admin.ch).

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## SDC INTERNALS

### Revised SDC Toolkit “Mainstreaming HIV in Practice”: Out Now



In the last issue of this Newsletter we announced the launch of the revised SDC Toolkit on Mainstreaming HIV in Practice. The Toolkit is out now and we encourage you to get it. It is available free of charge in French and English as hard or electronic copy. The Toolkit is specifically designed for SDC staff at headquarters and in the cooperation offices, including programme and project staff, and SDC’s partners in Switzerland and abroad.

Use this link to download an electronic copy:

English: [http://www.deza.admin.ch/ressources/resource\\_en\\_24553.pdf](http://www.deza.admin.ch/ressources/resource_en_24553.pdf)

French: [http://www.deza.admin.ch/ressources/resource\\_fr\\_24553.pdf](http://www.deza.admin.ch/ressources/resource_fr_24553.pdf)

Order hard copies of the Toolkit at:

[http://www.sdc.admin.ch/en/Home/Documentation/Publications/Publication\\_Detail\\_View?itemID=24553](http://www.sdc.admin.ch/en/Home/Documentation/Publications/Publication_Detail_View?itemID=24553)

## INTERNATIONAL

### Sexual and Reproductive Health and Rights for Adolescents: Landmark Resolution adopted by CPD 2012



A huge proportion of the world's population – more than 1.75 billion – is young, aged between 10 and 24 years. This age group was the welcomed focus of the 45<sup>th</sup> Session of the Commission on Population and Development (CPD), held on 23-27 April 2012 in New York. Young people have specific health and development needs, and many face challenges that hinder their well being, including poverty, unsafe environments and a lack of access to health information and services.

After rather difficult negotiations the 45th session of the CPD resulted in the adoption of a progressive landmark resolution, addressing sexual and reproductive health and rights for adolescents. Key points of the final resolution include: the right of young people to decide on all matters related to their sexuality; access to sexual and reproductive health services, including safe abortion where legal, that respect confidentiality and do not discriminate; the right of youth to comprehensive sexuality education; and the protection and promotion of young people’s right to control their sexuality free from violence, discrimination and coercion.

The CDP follows the implementation of the Programme of Action of the International Conference on Population (ICPD). In recent years, progress has been slow with conservative forces pushing back on key issues particularly reproductive rights, human rights, gender, access to contraception, abortion and other reproductive health services including sexuality education for young people. The success reached at CPD shifts the political balance at an important time.

The Commission was vice-chaired among others by Pio Wennbust from Switzerland, who also chaired the informal consultations. The consensus Switzerland helped to orchestrate sets the stage for the renegotiations of ICPD in 2014. In September 2014, a Special Session of the United Nations General Assembly will meet to take action on the recommendations and results of the global review of the ICPD's Programme of Action currently under way.

**Sources and further information:**

<http://www.un.org/esa/population/cpd/cpd2012/cpd45.htm> and <http://icpdbeyond2014.org/about-icpd-beyond-2014/>

**“Turning the Tide Together”: XIX International AIDS Conference**



From 22-27 July this year, the HIV & AIDS community will meet for the 19<sup>th</sup> time. The international AIDS Conference is the largest gathering of professionals working in the field of HIV and AIDS and is expected to convene more than 20'000 delegates from nearly 200 countries, including more than 2'000 journalists. Scientific advances over the past year in HIV treatment and biomedical prevention have dramatically altered the landscape of AIDS. For the first time ever, the tools to turn the tide of the epidemic are available and there is great hope and optimism that AIDS 2012 will be the place where stakeholders come up with a blueprint that is going to mark the beginning of the end of the AIDS epidemic.

The next issue of Focus Newsletter on HIV&AIDS and SRH will be summarising the main issues and results from AIDS 2012. For more information please consult the Conference webpage that is continuously updated: <http://www.aids2012.org/>

**aidsfocus.ch Conference – HIV, AIDS and Advocacy**



aidsfocus.ch – the Swiss platform for exchange on HIV and AIDS in international cooperation – convened its annual aidsfocus.ch Conference on 17 April 2012 in Berne, Switzerland. The conference focussed on advocacy in the field of HIV and AIDS and opened up the space for discussion and joint learning from experiences. Selected speakers presented on

experiences of advocacy as a key instrument in their struggle towards the fulfilment of the right to health for all:

- *BHASO*, an organisation of young people living with HIV in Zimbabwe, is one example showing that support groups of people living with HIV turn more and more into advocacy groups to stand up for their interests and their rights. <http://www.bhaso.org/>
- The *Treatment Action Campaign (TAC)* is by no doubt the most well known example of successful advocacy and activism. Since 1998, TAC's campaigned against AIDS denialism and in favour of the provision of antiretroviral drugs. It challenged the world's leading pharmaceutical companies to make treatment more affordable. <http://www.tac.org.za/community/>
- *Citizen Voice and Action* in India empowers communities to advocate for themselves by holding community level government service providers accountable for the services they deliver. <http://www.worldvision.in/1452>
- *Nelico*, an NGO based in Tanzania, gives young people a say about what is important to them, enables them to create strategies for action to ameliorate their living conditions and to advocate for action on these conditions from the grassroots to upper levels. <http://nelicotz.org/home>

Should you want to learn more from these experiences, download the conference papers at [www.aidsfocus.ch](http://www.aidsfocus.ch). A reader of the Conference will be published as *Medicus Mundi Bulletin*, No 125 in August 2012.

#### **Sources and further information:**

aidsfocus.ch Platform: <http://www.aidsfocus.ch/platform/conference/Symposium.2012-02-08.2113/AFFileFolder.2012-04-18.3434> and <http://www.aidsfocus.ch/platform/conference/Symposium.2012-02-08.2113>

## AFRICA

### Need for Action: Remuneration and Social Protection for Caregivers in the Context of HIV and AIDS



Since the beginning of the HIV epidemic, family and community caregivers have been at the heart of the community response and their engagement has played a significant role in the scale up of antiretroviral treatment and linking patients to care and testing. In sub-Saharan Africa, an estimated 90% of care for people living with HIV and AIDS is done in the home by family or community-based caregivers.

But who are the caregivers for people living with HIV? Who is nursing the bedridden sick people? Who provides the psychological, nutritional and legal support, referrals into medical care and support with ARV adherence? Who cares for the orphaned children left behind?

Primary caregivers are family members – most notably older women who care for their adult children or orphaned grand children. Children and especially young girls living in households headed by older people often have more and physically heavier household duties. They have the burden of earning an income and many also provide care to their ageing grandparents. For primary caregivers, the costs of caring for HIV-positive family members can be devastating, putting great burdens on them. It often forces caregivers to abandon employment, other income generating activities or miss out on school. Because this work takes place within the extended family, it is outside both, the formal and informal economies, and therefore invisible.

Secondary caregivers such as individuals or staff (paid or volunteer) of clinics, NGOs, faith-based or community-based organisations, are a critical source of support for primary caregivers, providing advice and supplies to help them to care effectively for family members. Many secondary caregivers are also primary caregivers to their own family members. Many secondary caregivers are currently called ‘volunteers’ simply because they do not get paid. However, most of them do not choose to volunteer and would like to be remunerated for their work. These caregivers have a right to a living wage as do all workers.

Nowhere is the contribution of women and girls to the AIDS response more clear than as caregivers. Yet, largely because it is considered ‘women’s work’, primary and secondary caregivers receive very little if any recognition, psychological or financial support, equipment or training. In recent years, two trends have brought us closer to the full recognition and compensation of caregivers; firstly the growing recognition of the importance of community health workers in reducing the burden on health professionals, generally referred to as “task shifting approach”, and, secondly, the importance of community health workers in scaling up and extending the reach of crucial health services to populations that are not usually reached by formal health systems.

For primary caregivers, especially those unable to make a living due to their care responsibilities or their age, social protection is the only support they will receive. This ranges from cash transfers, care grants or allowances, loans and microcredit schemes to old age pensions, as well as in-kind support such as food parcels and caring equipment. The same types of support are critical for secondary carers, too, who often do not get remunerated for their work.

A number of NGOs across Africa, with donor support, do provide for example stipends or salaries for the caregivers who work for them. For example in South Africa, the government started to support NGOs to employ caregivers to promote voluntary HIV testing and support directly observed TB therapy. By 2003, home-based care workers were integrated into the government's Comprehensive Care, Management and Treatment Programme guiding anti-retroviral rollout as a bridge to formal employment for informal or unpaid workers. While a study has shown that HIV caregivers play a bridging role among patients, the wider community, and the health system, it also showed that the programme suffers from ambiguous remuneration policies. The state has deliberately avoided absorbing caregivers into the civil service, and instead finances NGOs to pay them stipends. In this system, caregivers do not have the same employment rights as other health workers. The stipends paid to home-based caregivers under the Extended Public Work Programme are lower than those paid to men engaged in infrastructure development, essentially formalising the gendered stigmatisation and demotion of care work.

Should you wish to read more about different models of remuneration and social protection have a look at the Policy Briefing by The UK Consortium on AIDS and International Development which draws out a number of models of compensation in use and explores their strengths and weaknesses with the aim of stimulating further research and planning for a global effort to devise and promote rights-based and sustainable remuneration and social protection policies for caregivers.

#### **Sources and further information:**

Policy Briefing by The UK Consortium on AIDS and International Development:

<http://aidsconsortium.org.uk/wp-content/uploads/2011/11/UK-AIDS-Consortium-policy-briefing-remuneration-of-caregivers.pdf>

Community health workers and the response to HIV/AIDS in South Africa:

<http://heapol.oxfordjournals.org/content/23/3/179.full>

UNAIDS Expanded Business Case: Enhancing Social Protection:

[http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2010/jc1879\\_social\\_protection\\_business\\_case\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2010/jc1879_social_protection_business_case_en.pdf)

Report by the Huairou Commission:

[http://www.huairou.org/sites/default/files/HBC\\_final%5B1%5D.pdf](http://www.huairou.org/sites/default/files/HBC_final%5B1%5D.pdf)

## **ASIA**

### **Maternal Health in India: Accountability in Action**



Globally, the accountability of power holders is increasingly being monitored through a variety of institutions and processes at all levels of society. The term 'power holder' refers to actors that hold political, financial or other forms of power and includes government officials, the private sector, international financial institutions and civil society organisations. Accountability can therefore be political, legal, managerial and professional. Creating accountability to improve maternal health outcomes therefore calls for the involvement of a wide range of

actors from civil society organisations, government, the health sector, the private sector, media and the donor community.

Examples of demands for accountability to answer for the slow progress of Maternal Health have been growing - even in high income countries such as the United States with a 2011 “Maternal Health Accountability Act [H.R. 894]” that is currently awaiting a decision at Congress. In developing countries, the use of legal accountability strategies to improve maternal healthcare have been witnessed in Uganda and more recently in Bihar, an eastern state of India.

In March 2012, the State High Court of Bihar passed an unprecedented order that held the state responsible for failing to protect, respect and fulfil the rights of pregnant women. The order required the state government to account for funds that had been ear-marked for maternal health initiatives, most of which had never reached the intended beneficiaries.

The coalition of local NGOs supported by The Centre for Reproductive Rights (CRR) presented evidence of a high incidence of avoidable maternal deaths simply because facilities were lacking essential drugs and equipment, as well as adequate staffing and infrastructure. As the Government of India is legally obliged to protect women from dying of preventable maternal causes, the High Court made a decision in favour of the NGO coalition. This case is part of a broader national high court litigation strategy which aims to hold the government of India to account for maternal deaths and morbidity using a human rights framework.

To read more on the topic: <http://reproductiverights.org/en/press-room/progress-on-accountability-for-maternal-health-care-and-mortality-in-bihar-india>

## EASTERN EUROPE & CENTRAL ASIA

### Linking HIV and TB: Experiences from Uzbekistan and Georgia



Tuberculosis (TB), a curable and preventable disease, occurs in every part of the world and remains a global health threat. In 2010, 8.8 million people fell ill with TB and 1.4 million died from it. A vast majority of TB deaths occur in low- and middle-income countries and is among the top three causes of death for women aged 15 to 44. About one-third of the world's population has latent TB, i.e. they are infected with the bacterium, but are not (yet) ill. The lifetime risk to fall ill with TB once infected is 10%. However, the situation is much more risky for people infected with HIV. HIV-positive people are 21 to 34 times more likely to develop active TB than people without HIV. The two diseases form a lethal combination, each speeding the other's progress. In 2010 about 350 000 people died of HIV-associated TB.

Eastern Europe and Central Asia are regions where HIV prevalence rates are clearly on the rise with an estimated number of 110 000 new infections in 2008. These regions are therefore considered to be at high risk of dual epidemics, even though Africa accounted for 79% of all TB/HIV co-infections in 2007. Due to inappropriate and incorrect treatment, TB has become resistant against standard anti-TB drugs – or even against second line treatment options. Eastern Europe and Central Asia are the regions with the highest prevalence of multi-drug resistant TB.

Injecting drug use is another factor of concern in relation to HIV and TB. In Central Asia the overlap of HIV and drug use is becoming a major problem and it is estimated that 30% to 90% of infections are a result of injecting drug use. Prisons in this regions struggle with high rates of TB and HIV co-infections due to unsafe sexual practices and unsafe injection taking place in an unhygienic, cramped and stressful setting. Without prompt diagnosis and proper treatment, many prisoners are at risk of death or endanger the general population or other prisoners upon being released or transferred to another facility.

What is being done to reduce these risks related to TB and HIV?

Over the last two decades, countries worldwide have increasingly expressed political commitment and support for a coordinated response to halt the spread of TB and, more recently, the threat posed by dual epidemics of TB/HIV. WHO recommends countries and partners to implement the Stop TB Strategy which calls for measures to:

- pursue high-quality DOTS (directly observed treatment short course) expansion and enhancement
- address TB-HIV, multi-drug resistant-TB, and the needs of poor and vulnerable populations;
- contribute to health system strengthening based on primary health care;
- engage all care providers;
- empower people with TB, and communities through partnership and
- enable and promote research.

The German Development Cooperation (GDC) has recently published the results and developments related to their support of national efforts to stop TB and HIV in the Caucasus and Central Asia. The report puts a special focus on Georgia and Uzbekistan. The efforts undertaken in these two countries – among others – have been guided by the Stop TB Strategy. The publication describes five distinguishing elements of the support provided by the GDC, one of it is the protection of prisoners.

GDC has closely collaborated with governments of Uzbekistan and Georgia to extend the coverage of TB diagnosis and treatment and other health services to prison settings. Initially, this was difficult and unpopular undertaking, because services for the general population were scarce or unavailable, too. Advocating the high prevalence of TB in prisons and the difficulty to control TB and HIV if prisons were excluded from free access to services were key in overcoming these difficulties. Today, prisons are equipped with clinics and trained prison staff and health workers provide new services and extend the Stop TB Strategy to the penitentiary system. Collaboration between the Ministries of Justice and the Ministries of Health ensure that detainees continue to receive treatment once they are released.

We encourage you to read on and learn about the other four elements of the support by GDE . Download the full publication at: [http://german-practice-collection.org/en/download-centre/doc\\_download/834](http://german-practice-collection.org/en/download-centre/doc_download/834)

**Other sources and further information:**

WHO Fact Sheet TB: <http://www.who.int/mediacentre/factsheets/fs104/en/index.html>

WHO policy on collaborative TB/HIV activities:

[http://www.who.int/tb/publications/2012/tb\\_hiv\\_policy\\_9789241503006/en/index.html](http://www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en/index.html)

# LATIN AMERICA & THE CARIBBEAN

## Protecting the Rights of LGBTI Persons



In January 2010, a new specialised unit was created in the Inter-American Commission on Human Rights (IACHR)<sup>1</sup> to strengthen the technical capacity to protect the rights of lesbian, gay, bisexual, trans, and intersex (LGBTI) people in the Americas.

Why are the rights of LGBTI people at stake in this region?

LGBTI persons in Latin America and the Caribbean have historically been the focus of serious discrimination, both in fact and in law. Recently, an increase in cases of intimidation and violence has been witnessed in countries in the region. Many LGBTI persons are also ostracised by their families or receive threats to their lives. According to *Transgender Europe* between January and June 2010 the world's media reported 93 cases of murder of transgender people worldwide. Eight out of ten of these murders occurred in Latin America.

In addition to serious discrimination and assault, LGBTI persons face significant barriers in their access to health, employment, justice and political participation. These barriers critically increase their vulnerability to HIV and human rights violations. The HIV epidemic in this region has changed little in recent years and is mainly concentrated in key populations. The prevalence rate among transgender people is estimated to be 35% and 20-25% among men who have sex with men.

In response to human rights violations and the lack of visibility and representation of the transgender community in Latin America, REDLACTRANS – a regional network of transgender people – has been established in 2005. REDLACTRANS has successfully brought together transgender leaders and organisations from across the region to develop joint strategies to tackle stigma, discrimination and human rights abuses against the trans population. Today, the organisation counts 95 volunteers and three staff in 18 countries of the region.

REDLACTRANS has been invited to the IACHR expert meeting at the end of February 2012 under the auspices of UNAIDS to discuss issues around violence and impunity against LGBTI people. This was the second of six meetings, which will contribute to the first report on sexual orientation and gender identity in the Americas, which IACHR is preparing through its newly created Unit on the Rights of LGBTI persons. In 2013, IACHR will need to evaluate the unit's work and will decide whether to create an Office of the Rapporteur on the Rights of LGBTI Persons.

### Sources and further information:

Fact Sheet UNAIDS: [http://www.unaids.org/documents/20101123\\_FS\\_csa\\_em\\_en.pdf](http://www.unaids.org/documents/20101123_FS_csa_em_en.pdf)

UNAIDS Feature Story:

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<sup>1</sup> The IACHR is an autonomous body of the Organization of American States (OAS), with a mandate to promote and respect for human rights in the region and act as a consultative body to the OAS in this matter.

[http://www.unaids.org/en/resources/presscentre/featurestories/2012/march/20120314iachrlg\\_bti/](http://www.unaids.org/en/resources/presscentre/featurestories/2012/march/20120314iachrlg_bti/)

Transgender Europe: <http://www.scribd.com/doc/43040657/93-murdered-trans-persons-Jan-to-June-2010>

Aids Alliance: <http://www.aidsalliance.org/linkingorganisationdetails.aspx?id=10>

See also the “*Toolkit for Integrating LGBTI Issues into HIV & GBV Prevention*” in the Resource Section of this Newsletter.

## USEFUL RESOURCES



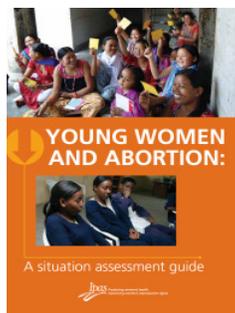
**Podcast – Sexual Risks among Young People:** Have you ever wondered why HIV prevalence is so high among young people, particularly young women, in southern Africa? Why are young women in South Africa more than 10 times as likely to have HIV as their counterparts in the United States? This Podcast is based on an article by Pettiflor and colleagues entitled “*A tale of two countries: rethinking sexual risk for HIV among young people in South Africa and the United States*”. It looks into the behavioural factors that might explain the striking differences in HIV prevalence among young people in these two countries.

<http://hivthisweek.unaids.org/content/multimedia>



**Toolkit for Integrating LGBTI Issues into HIV & GBV Prevention:** How do we best consider the rights and needs of lesbian, gay, bisexual, transgender and intersex people (LGBTI) in our HIV programmes and policies? This Toolkit shares information, tools, activities, skills building ideas and methods to support organisations and individuals to better understand the needs of (LGBTI) in HIV and gender-based violence work. It specifically addresses how sexual orientation and gender identity relates to and interconnects with HIV and gender based violence. The Toolkit consists of then components that can be used together or separate. Download them at:

<http://www.safaid.net/content/toolkit-integrating-lgbti-issues-hiv-gbv-prevention>

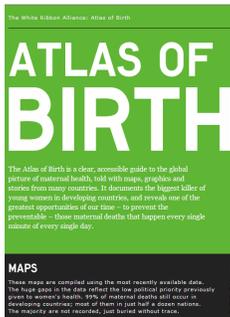


**Young Women and Abortion – A Situational Assessment Guide:** What are the factors that lead to unwanted pregnancies among young women? What barriers to safe abortion do young women face in their community? The purpose of a situation assessment with young women on abortion is to answer these and similar questions. This Guide was created to ensure that programmes related to abortion are accessible and appropriate for young women. It is designed to gain insights into the local context surrounding abortion care for young women to inform program design and to support meaningful youth participation in project design. It is a global resource for community groups, youth groups, peer educators, trainers, programme managers and technical advisors of abortion care programmes.

<http://www.ipas.org/~media/Files/Ipas%20Publications/CEMYOAS2E11.ashx>



**The Global Fistula Care Map:** Obstetric fistula – a hole in the birth canal caused by prolonged, obstructed labor – occurs disproportionately among impoverished girls and women who lack a skilled birth attendant or access to emergency obstetric care during childbirth. In most cases, fistula can be successfully treated through reconstructive surgery. Did you know that for every woman who receives fistula treatment and care, at least 50 women go without? This and more information on obstetric fistula can be found on the Global Fistula Care Map at: <http://www.globalfistulamap.org/>



**Atlas of Birth** is a guide to the global picture of maternal health, told with maps, graphics and stories from many countries. The Atlas of Birth allows you to create maps using the most recently available data. Create for example a map that shows the percentages of women now 20-24 years old who married before they were 18 and compare this map to literacy or female genital cutting. You will see in general that there are some huge gaps in the data, which reflects the low political priority previously given to women's health. <http://www.atlasofbirth.com/>