



Bulletin 109

Medicus Mundi Schweiz

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



AIDS AND LIVELIHOODS

SECURING PROPERTY AND INHERITANCE RIGHTS

Reader zur Tagung von aidsfocus.ch vom 10. April 2008

IMPRESSUM

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

Bulletin Nr. 109, August 2008
AIDS and Livelihoods

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

GESCHÄFTSSTELLE UND REDAKTIONSSSEKRETARIAT:
 Medicus Mundi Schweiz
 Netzwerk Gesundheit für alle
 Murbacherstrasse 34
 Postfach, CH-4013 Basel
 Tel (+41) 061 383 18 10
 info@medicusmundi.ch
 www.medicusmundi.ch

REDAKTIONSKOMMISSION:
 Martin Leschhorn Strebelt,
 Helena Zweifel

LAYOUT: VischerVettiger Basel

PRODUKTION:
 Geschäftsstelle Medicus Mundi Schweiz,
 Martin Leschhorn Strebelt
DRUCK: Birkhäuser + GBC

AUFLAGE DIESER NUMMER: 1500 Ex.
ERSCHEINUNGSWEISE: Vier Nummern im Jahr

NÄCHSTE NUMMER: Verstärkung und Gesundheit

REDAKTIONSSCHLUSS: 29. August 2008

TITELBILD: Eine Grossmutter mit ihren verwaisten Grosskindern. 70 000 Kinder haben in Swasiland bereits ihre Eltern durch Aids verloren. (Foto: SRK)

NETZWERK

Die 47 Mitgliedorganisationen von Medicus Mundi Schweiz:

Afro-European Medical and Research Network (AEMRN)
 Aids und Kind
 Aids-Hilfe Schweiz
 AO International
 Association Solidarité avec les Villages du Bénin
 Association Suisse Raoul Follereau
 Basler Förderverein für medizinische Zusammenarbeit
 Bündner Partnerschaft HAS Haiti
 Calcutta Project
 Christoffel Blindenmission (Schweiz)
 CO-OPERAID
 cooperation@epfl
 DM - Echange et Mission
 Enfants du Monde
 FMH Verbindung der Schweizer Ärzte
 Fondation PH Suisse
 Fondation Sociale Suisse du Nord Cameroun
 Fondation Suisse pour la Santé Mondiale
 Förderverein für Otorhinolaryngologie
 Freunde Behindertenintegration Kamerun
 Gemeinschaft der St. Anna-Schwester GRUHU
 Handicap International (Schweiz)
 IAMANEH Schweiz
 Institut Universitaire d'Etudes du Développement
 INTERTEAM
 Jura-Afrique, Programme Santé
 Kinderhilfe Bethlehem
 Leprahilfe Emmaus Schweiz
 Lungenliga Schweiz
 Médecins du Monde-Suisse
 medico international schweiz
 mediCuba-Suisse
 Mission 21
 Novartis Stiftung für Nachhaltige Entwicklung
 Pharmaciens sans Frontières Suisse
 Schweizerische Gesellschaft für Tropenmedizin und Parasitologie
 Schweizer Hilfsverein für das Albert Schweizer-Spital Lambarene
 Schweizer Indianerhilfe
 Schweizerisches Korps für humanitäre Hilfe
 Schweizerisches Rotes Kreuz
 Schweizerische Stiftung für die sexuelle und reproduktive Gesundheit PLANeS
 Schweizerisches Tropeninstitut
 Secours Dentaire International
 SolidarMed
 Stiftung Terre des Hommes
 Verein Partnerschaft Kinderspitäler Biel-Haiti

INHALT

EDITORIAL
 Helena Zweifel

4

EIGENTUMSRECHTE IM ZEITALTER VON HIV/AIDS

MARTIN LESCHHORN STREBEL
 Die Lebensgrundlage der Hinterbliebenen in Frage gestellt

6

KAORI IZUMI
 Property grabbing from women and children in the context of AIDS

9

STORIES: FELOMON
 The bonanza is over

16

HELENA ZWEIFEL
 Ressources and Tools

18

DER LEBENSGRUNDLAGEN BERAUBT

MAIMUNA KANYAMALA
 "SASA!" Women, violence and HIV/AIDS. Innovative strategies from grassroot activism

20

FRANK MISCHO
 Double Trauma: Land grabbing from Aids orphans when the parents pass away

26

STORIES: MUKABALISA
 Step by Step - The Road to Recovery

31

MERCY WAHOME
 Gaps, violations and barriers to women's rights

33

STORIES: KAATANO
 No boy child, no land

36

PRÄVENTION, FRAUENRECHTE UND COMMUNITY HEALTH

ANNETTE GODINEZ
 «Es dreht sich alles um Aids»

38

STEPHAN GERMANN ET AL.
 Mobilizing and strengthening community-led child-care

41

VIVIANE FISCHER ET AL.
 Progrès médicaux et difficultés sociales

50

DEBATTE
 Roger England

53

MAGAZIN

55

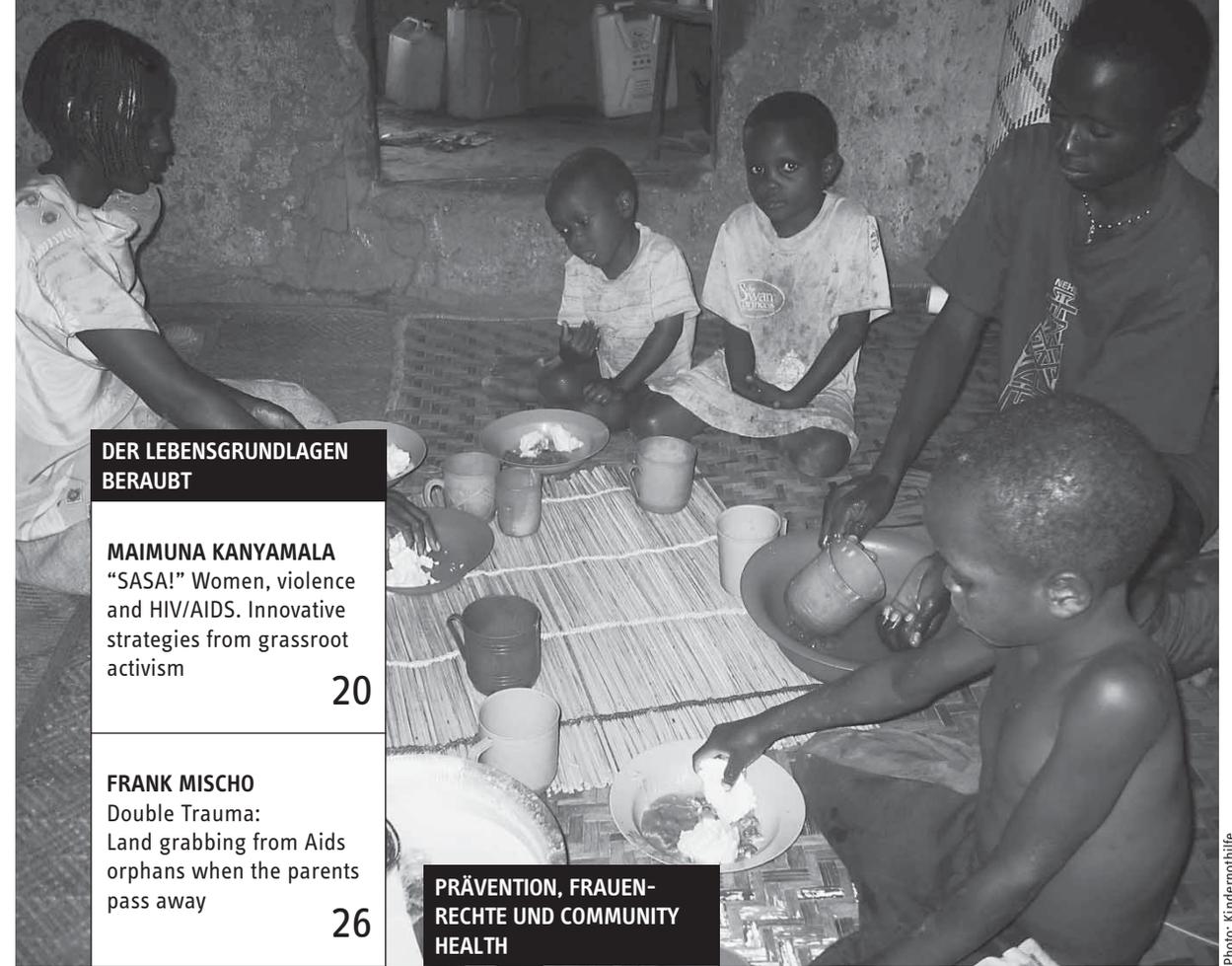


Photo: Kindermothilfe

Stolz und selbstbewusst steht Sunita vor ihrem Häuschen in Prittapalli, einem entlegenen Dorf in Orissa, Indien: «Was immer auch passieren mag, niemand kann mich von hier wegjagen. Das Haus ist in meinem Namen registriert». Noch nach Jahren erscheint dieses Bild sehr plastisch vor meinem inneren Auge. Wie sehr hebt es sich ab von vielen andern Bildern und Geschichten, die ich während meiner Arbeit in Indien zu hören bekam, von Frauen, die aus x-beliebigen Gründen von Ehemann oder Schwiegereltern aus dem Haus gejagt wurden.



Mit der Verbreitung von HIV in Indien und im südlichen Afrika mehren sich die Berichte, dass Frauen, nachdem sie ihren aids-kranken Mann bis zu dessen Tod aufopfernd gepflegt haben, aus dem Haus gejagt werden. Zu zahlreich sind auch Berichte, dass Frauen und Mütter nach der Diagnose HIV-positiv aus dem Haus geworfen werden. Vertrieben, ausgeschlossen und manchmal der Hexerei bezichtigt bleibt ihnen oft nur noch das Leben auf der Strasse.

Es waren die Partnerorganisationen von aidsfocus.ch, die die Problematik fehlender Eigentums- und Erbrechte im Kontext von HIV und Aids in die Diskussion einbrachten und die Fachtagung zum Thema «AIDS and livelihoods. Securing property and inheritance rights» anregten. CO-OPERAID hatte in Uganda und die Stiftung Terre des hommes in Burundi festgestellt, dass Kinder nach dem Tod der Eltern plötzlich nicht mehr da waren und später verwaist auf den Strassen der nahen Stadt gesichtet wurden. Andere Organisationen mussten erfahren, wie Frauen die antiretrovirale Behandlung abbrachen und aus Programmen verschwanden.

Dass die Ursache für das «Drop out» und den Abbruch von HIV-Projekten mangelnde Erb- und Eigentumsrechte sein können, bedurfte näheres Hinsehen. Nach dem Tod des männlichen Familienoberhauptes hatten sich Verwandte stillschweigend Haus und Land der Familie angeeignet. Erb- und Eigentumsrechte von Frauen und Kindern werden in den Diskussionen rund um HIV und Aids auf dem internationalen Parkett höchst selten angeschnitten. Eine löbliche Ausnahme bildet die Nahrungs- und Landwirtschaftsorganisation der UNO (FAO), die sich seit Jahren für die Eigentums- und Erbrechte von Frauen und Kindern in Kontext von HIV und Aids engagiert.

Das an der Fachtagung von aidsfocus.ch im April 2008 aufgeworfene und in diesem Bulletin vertiefte Thema illustriert in aller Deutlichkeit, dass die Problematik von HIV und Aids weit über den Gesundheitssektor hinauswirkt. Umfassende, multisektorielle Strategien sind notwendig, welche die Zusammenarbeit aller Organisationen der internationalen Zusammenarbeit erfordern.

Helena Zweifel
Geschäftsführerin Medicus Mundi Schweiz
Kordinatorin aidsfocus.ch



Photo: IAMANEH Suisse

Seiten 5-18

Eigentumsrechte im Zeitalter von HIV/Aids

“Too often, the personal stories of both hardship and resilience in the fact of adversity are lost in the statistics and dry overviews of national policies and epidemiological trends. Excluded from statistics, the women and children become invisible.” Kaori Izumi

DIE LEBENSGRUNDLAGE DER HINTERBLIEBENEN IN FRAGE GESTELLT

Die diesjährige Fachtagung von aidsfocus widmete sich dem Thema «AIDS and Livelihoods – securing property and inheritance rights». Was sehr technisch tönt, umschreibt eine im südlichen Afrika weit verbreitete Praxis: Witwen und Waisen wird der Besitz des verstorbenen Ehemannes und Vaters weggenommen. Angesichts von Aids und Armut ein verheerender Vorgang.

Von Martin Leschhorn Strebel*

DIE FREIWillIGEN MitarbeiterInnen des Kitovu Mobile kennen Gertrud und ihre Familie bereits: Seit 2003 unterstützen sie sie mit Nahrungshilfe und medizinischer Betreuung. Kurz nachdem der Ehemann 2004 an Aids verstorben ist, erklärt Gertrud den Freiwilligen, dass ihr Schwager gekommen sei, um Hab und Gut von ihr zu verlangen. Kitovu Mobile, ein Projekt, das die Deutsche Kinder Nothilfe unterstützt, kann dank der langjährigen Präsenz im Dorf vermitteln. Der Besitz der kleinen Familie bleibt noch unangetastet. Doch dann stirbt auch Gertrud an der Krankheit und der Onkel erscheint wieder bei den Kindern und erneuert seine Forderung. Er setzt sich schliesslich gegenüber den Waisen durch. Kitovu Mobile erreicht wenigstens, dass die Dorfgemeinschaft den Kindern Land für ein neues Häuschen mit Garten übergibt.

Dass die Familie des Verstorbenen von der Ehefrau und den Kindern den Besitz beanspruchen, ist in Afrika ein häufiger Vorgang, der sich auf traditionelles Recht stützt und durchaus in Widerspruch zur modernen staatlichen Gesetzgebung steht. Die diesjährige Fachtagung von aidsfocus in Bern hat sich unter dem Titel «AIDS and Livelihoods – securing property and inheritance rights» diesem vielschichtigen Problem gewidmet.

VERLUST DER LEBENSGRUNDLAGE

Als Schwächste in der Gesellschaft haben Gertrud und nach ihrem Tod ihre Kinder Mühe, sich gegenüber dem Schwager, respektive dem Onkel zu behaupten. Dieser steht als in Armut lebendes Familienoberhaupt selbst unter materiellem Druck. Wäre nicht die anwaltschaftliche Tätigkeit des Kitovu Mobile, drohte den Kindern der Verlust der Existenzgrundlage. Laut Frank Mischo von der Kindernothilfe, der das Schicksal von Gertrud an der Fachtagung vorstellte, ist es kein Zufall, dass viele Waisenkinder als Arbeitskräfte ausgenutzt werden.

«Property grabbing» bezeichnet die Enteignung des Besitzes durch die Herkunftsfamilie des Verstorbenen. Der Verlust der Lebensgrundlage, des kleinen Stückes Land, das zur Ernährung der zurückgebliebene Familie beitragen könnte, verschärft die Armut gerade im Zeitalter von Aids.

Kaori Izumi von der Welternährungsorganisation (FAO) ist aufgrund eigener Reisen im südlichen Afrika auf das Problem und seine Ausmasse aufmerksam geworden. Aids schafft Witwen, die aufgrund der Krankheit stigmatisiert sind und umso mehr Mühe haben ihre Rechte zu verteidigen. Eine FAO Studie zeigt für Namibia, dass durch «property grabbing» 44% der Witwen und Waisen das Vieh, 30%



Aidsfocus Fachtagung 2008

Foto: MMS

das Kleinvieh und 39% die landwirtschaftlichen Ausrüstung verlieren. Damit verschärft «property grabbing» die Not und die Mangelernährung, die Migration und die Prostitution, den vorzeitigen Tod und die Zunahme an Waisen.

TRADITIONELLES UND MODERNES RECHT

Sarah ist Mutter von drei Kindern in Tansania. Als ihr Mann an Aids stirbt, wird sie für dessen Tod verantwortlich gemacht und der Hexerei bezichtigt. Derart stigmatisiert zwingt sie die Familie des Verstorbenen ihr Haus zu verlassen. Sie findet den Weg zur Kivulini Women's Rights Organization, die ein Gerichtsverfahren anstrengt. Maimuna Kanyamala berichtete an der Tagung, dass das Gericht den Fall nicht entschieden hat, sondern zur Beurteilung an die dörfliche Gerichtsinstanz zur Entscheidung zurück gewiesen hat. Damit hat es Sarah die moderne staatliche Gesetzgebung vorenthalten und ihr Schicksal der traditionellen Gerichtspraxis in die Hände gegeben.

Das Beispiel von Sarah wie auch die Ausführungen von Mercy Wahome von der Society of Women and AIDS in Kenya (SWAK) zeigen, wie das an der Fachtagung behandelte Thema des «property grabbing» nicht nur eine Frage nach dem Erbrecht und der materiellen Absicherung der Hinterbliebenen ist. Es zielt

auch auf Ausgrenzung der Schwächsten, der Frauen und Kindern im Zeitalter von Aids. Die ReferentInnen erzählten Geschichten der Stigmatisierung und des Zusammenpralls von sogenannten modernen juristischen Normen mit der alltäglichen oft traditionell ausgerichteten Praxis.

COMMUNITY AWARENESS

Mercy Wahome und Maimuna Kanyamala berichteten auch von ihren Strategien um dem Problem zu begegnen. In Kenya setzt sich SWAK auf nationaler Ebene für die Stärkung von Frauen und Kindern in ihren Eigentumsrechten ein. Empowerment spielt auch für Kanyamalas Arbeit in Tansania eine wichtige Rolle: Frauen werden darin unterstützt Kleinunternehmen zu gründen und diese nach sozialverträglichen Grundsätzen zu führen.

Sowohl in Tansania wie auch in Kenya ist es für die ReferentInnen zentral, auf der Gemeindeebene anzusetzen: Sie bilden Freiwillige aus, die auf kommunaler Ebene die Bevölkerung sensibilisieren und Fälle von «property grabbing» identifizieren können. Ausserdem bieten die beiden Organisationen rechtliche und soziale Unterstützung an.

Nach den Vorträgen der ReferentInnen haben sich TeilnehmerInnen der Fachtagung in drei Arbeitsgruppen mit verschiedenen Dimensionen des «Property Grabbing» auseinandergesetzt. Das Thema wirft Fragen auf, die dazu führen könnten, dass der sektorielle Ansatz überdacht werden müsste, meinte die Arbeitsgruppe, die sich mit der internationalen Politik auseinandergesetzt hatte. Es gebe auch positive Entwicklungen, wie die «Livingstone Declaration», über die sich soziale Sicherheit auch für die betroffenen Frauen und Kinder fruchtbar machen liesse.

BRÜCKEN BAUEN

Im Rahmen der rechtlichen Dimension interessierte insbesondere der Dualismus zwischen traditionellem und dem sogenannten modernen Recht. Die dafür zuständige Arbeitsgruppe

plädierte dafür, die unterschiedlichen Rechtssysteme nicht im Gegensatz zueinander zu sehen, sondern das Wissen über beide zu verbreitern und die Betroffenen im Umgang damit zu stärken.

Die dritte Gruppe diskutierte schliesslich die Bedeutung des Auseinanderbrechens des grösseren Familienzusammenhalts durch Aids und die Traumatisierung von Kindern. Sie sprach sich dafür aus, lokale Netzwerke zu schaffen und zu stärken sowie lokale Initiativen zu unterstützen.

Die ReferentInnen der aidsfocus Fachtagung 2008 brachten den TeilnehmerInnen ein in breiteren Kreisen der Entwicklungspolitik wenig beachtetes Problem näher, das zu zentralen Fragen von Lebensunterhaltssicherung, Stigmatisierung und Ausgrenzung von Frauen und Kindern angesichts von Aids führte. Das Schicksal von Gertrud und Sarah mit ihren Kindern zeigen, wie wichtig ein umfassender, auf die Rechte von Frauen und Kindern zielender Ansatz ist.

* MARTIN LESCHHORN STREBEL ist Mitglied der Geschäftsleitung von Medicus Mundi Schweiz und Redaktor des MMS Bulletins.



DANKE, AIDS-HILFE SCHWEIZ

Aidsfocus.ch und Medicus Mundi Schweiz danken der Aids Hilfe Schweiz für die grosszügige finanzielle Unterstützung der aidsfocus Fachtagung 2008 «Aids and livelihoods. Securing property and inheritance rights» und des vorliegenden Bulletins.

PROPERTY GRABBING FROM WOMEN AND CHILDREN IN THE CONTEXT OF AIDS

Property grabbing we are observing in southern and east Africa today is a symptom of deepening poverty in Africa, which reflects fundamental failures in rural development in Africa in the past. Whereas there are a number of inspiring initiatives with compassion by local communities and grassroots groups to mitigate the devastating impact of property grabbing from women and children, real causes of property grabbing need to be addressed in the context of larger development policies and changing African societies and their cultures.

By Kaori Izumi*

DECLINED INVESTMENT in agriculture and rural development in past 30 years and HIV and AIDS pandemic combined with cut in public expenditure in social service, conflicts and natural disasters have contributed to the deepening poverty and breaking down of social norms in southern and east Africa.

Globally there are 1.2 billion extremely poor. 75% of the world's poor live in rural areas, deriving their livelihoods from agriculture. About 852 million people are under-nourished of which 815 million live in the developing countries. The highest incidence of under-nourishment is found in sub-Saharan Africa where 33% of the total population in the region are under-nourished. In May 2006, 39 countries in the world were facing serious food emergencies of which 25 were found in Africa. Close to half of the world's poor will live in sub-Saharan Africa in 2015. The average annual growth in GDP in sub-Saharan Africa between 1980 and 2000 was negative 1.1% and poverty has increased between 1990 and 1999.

Official foreign development aids (ODA) in agricultural sector declined by 57% in past 30 years from USD 5.14 billion (1983-87) to USD 2.22 billion (1998-2000). The total volume of the lending from International Financial Institutions (IFI) to agriculture declined by 40% in real terms between 1990 and 1999.

HIV AND AIDS PANDEMIC

Today, 33.2 million people are living with HIV and AIDS globally. In sub-Saharan Africa, it is estimated that 1.6 million adults and children died due to AIDS in 2007. Young women account for 76% of new cases in sub-Saharan Africa. In Swaziland, AIDS takes away more than one half of the potential length of life. In Botswana, Central African Republic, Namibia, South Africa and Zimbabwe the loss is 30-40% of years of life expectancy without HIV and AIDS. In Zimbabwe life expectancy dropped from 62 years in 1980 to 37 years in 2006 for both sexes, and for women it was dropped to 34 years. In Malawi, life expectancy declined from 46% in 1987 to 37 years in 2002 according to the World Development Report of the World Bank.



Kaori Izumi

Foto: MMS

The impact of HIV and AIDS pandemic on children is alarming. In 2007 it is estimated that 11.4 million children are orphaned due to HIV and AIDS related diseases (UNAIDS 2007).

Globally, it is estimated that by 2010 over 18 million children will have been orphaned by AIDS.

UNPACKING PROPERTY GRABBING AND POVERTY IN THE CONTEXT OF HIV AND AIDS

In the majority of communities in southern and east Africa, women do not hold land and property rights of their own in customary systems with some exceptions. Land and property rights and inheritance systems differ by gender, the type of property, the type of kinship systems and the residential patterns. It is important to note however that norms and practices of land and property rights are not static but they are evolving. Gendered power relations and customary and cultural norms and practices shape property rights.

HIV and AIDS is a widow and orphans-creating disease. Wives are blamed for having infected the husband, which expose them to domestic violence. Property grabbing from women and children, who are happening in the re-

gion today is a symptom, a cause and a consequence of poverty and breaking down of social norms, family ties and social safety nets. Property grabbing has left women and vulnerable and orphaned children in the situation of distress and poverty but little attention has been given in development agenda.

Targets of psychological and physical harassment, dispossessed of their property, evicted from their homes, these women and children are left destitute. Evicted from their marital and parental homes, most of the evicted women move to urban slums. They live in urban centres as squatters, engaging in informal economic activities. Orphaned children are shared and inherited by their relatives together with deceased parental properties, being separated from their siblings. Other children are left to become child headed households without any care if their shelter is untouched or they move to the streets which become their new homes. Breaking up of families and early marriage of young girls as young as twelve years old is a common phenomenon. It is reported that relatives want to take young girl orphans with a plan to marry them away to earn bride wealth.

Both in rural and urban areas, the living conditions of such women and children are extremely harsh not only physical and material terms but emotionally and mentally. Given that property grabbing usually happens during burial ceremonies and mourning period, the level of mental distress among the victims of property grabbing is high. Many of these evicted women are also HIV positive. Physical and mental distress further leads to their pre-matured deaths before they reach any form of support, leaving more children orphaned.

Several factors have contributed to weakening property rights of women and children that include among others changing role of the extended family, changing patterns of customary property distribution, urbanisation, expansion of market economies, labour migration, social and economic dysfunction associated with AIDS.

Widows are made responsible for deaths of their husbands being blamed by in-laws for having killed their husbands by bringing AIDS from elsewhere or by using witchcraft. Stigmatised people are more likely to be abused and are less capable of defending their rights, and social supports are withdrawn by family, friends and neighbours who fear of being associated with HIV positive and witchcraft. Confiscation of property from widows happens as a measure of punishment (e.g. cutting fruit trees in widows' garden), greed and stigma.

Orphaned children are vulnerable to property grabbing by relatives in absence of any guardian or the guardians themselves confiscate deceased properties from orphaned children.

In absence of clear and appropriate local norms and national policy, laws and effective enforcement mechanisms, children's property and inheritance rights remain vulnerable and are the subject of confiscation, which drives some orphans to destitution, early marriage, breaking down of family, separation of siblings, poverty, food insecurity, lack of education opportunities, sex work, etc. and such vicious cycle continues. As a result disinherited orphans are forced to live under impoverishment not only materially but emotionally. It is important to note that such children are among the future generation of the societies and countries but with minimum opportunities to come out of poverty, food insecurity and human suffering. In other words, poverty, hunger and mis-

ery are inherited unless the vicious cycle is broken up through generations as rightly pointed out in the World Development Report 2008.

THE SCALE OF CONFISCATION OF PROPERTY FROM WOMEN AND CHILDREN

In Ohangwena region in Namibia one FAO study found out that 44% of widows and orphans lost cattle, 30% lost small livestock and 39% lost farm equipment after their husbands and parents had died. In Zambia, 909, 641 and 732 cases of confiscation of property were reported to the Police Victim Support Unit (VSU) in 2001, 2002 and 2003 respectively, which is only a tip of iceberg as commented by Superintendent and the Director of VSU. Another FAO study conducted in Zambia showed that 34% of female headed households with people living with AIDS and orphans experienced property grabbing. This finding was confirmed by the econometric analysis on the data from National Statistics in Zambia over 5000 samples showed that 30% of widows experienced more than 50% of land size reduction after their husbands had died.

In Uganda 90% of intra-familial conflicts which were registered in one of the districts of offices are over women's land rights, of which 70% were cases on threats of eviction from their marital homes.

Seventy percent of orphans surveyed in Copperbelt province in Zambia responded that they had lost their properties when their parents died. A statistical survey on orphans and vulnerable children which was conducted in Manicaland and Chimanimani districts in Zimbabwe showed that 53% of boy orphans and 47% of girl orphans were displaced from their parental homes after their parents had died.

CHANGING SOCIAL NORMS AND PRACTICE

A study in Zimbabwe revealed that customary patterns of distributing inherited property within extended families involve providing for orphans. A problem lies in determining who should provide for orphans needs and how they should do so. In the past, caregivers within extended families assumed control of orphans' parental property and were expected to provide for the orphans needs. Today, poverty and high death rates because of AIDS have exacerbated property grabbing and neglect. Consequently, many orphans, particular older orphans or-

phans heading households are insisting that they be given control of their parents' property and enabled to provide for themselves. Orphans relatives are more likely to get away with property confiscations if they lived far from the orphans, which is common in today's mobile society.

Widow inheritance used to be a common practice in Africa, whereby brothers of deceased husband inherited the widow and her children and provided for them. Even when widows are not inherited, the widows usually remained in marital homes, continuing to live in the deceased's property and working on the land left by the deceased husbands. Today, widow inheritance is gradually disappearing because of HIV and AIDS pandemic for fear of infection. Especially younger widows without established social networks are vulnerable to evictions. They have not many choices but to return to natal homes, move to urban slums or to go on the street for sex work. In this way, the chain of HIV and AIDS, poverty and re-infection continues.

In patrilineal customary societies, a son inherited a piece of land which is sub-divided by his father, when he got married. As it is becoming common that a son die before his father, sub-division and inheritance of land happen only after the father has died. This changing practice of inheritance made young widows vulnerable to eviction and property grabbing.

METHODS FOR GRABBING ORPHANS PARENTAL PROPERTY

There are several methods to confiscate orphans parental property, some of them cruel such as taking parental property when the parents were sick and unable to protest. Absorbing parental property while also taking in orphans is another common method applied. When orphans are absorbed by relatives with intention to take in parental property, there are high possibilities of lack of care and abusive treatment by guardians as their prime motive was not to care and provide for the orphans. Calculated and cruel methods of property confiscation from orphans include

- take moveable property when parent is sick
- take moveable property after death of parent but before bereavement rituals
- obtain burial order and death certificate of parent and gain access to moveable and immoveable property such as pensions and bank accounts
- assume guardianship of orphans and dispose of moveable and/or immovable property

HIV and AIDS related dysfunction within families are observed and translated by relatives into an opportunity for themselves. As a result orphans lose their shelters, households and source of livelihoods at the same time when they lose their parents.

EXAMPLE OF TARGETED MULTIPLE APPROACH FOR POVERTY REDUCTION, FOOD SECURITY AND PREVENTION OF HIV AND AIDS

Multiple interventions are necessary to tackle complex issues of AIDS, property rights, food security, livelihoods and such interventions could potentially increase food security, reduce risky sexual behaviour and gender-based violence, thus reducing poverty.

HIV and AIDS and food insufficiency are two leading cause of morbidity and mortality in sub-Saharan Africa and are thought to be inextricably linked. Women in some of the countries with high HIV prevalence in sub-Saharan Africa, such as Botswana and Swaziland, lack of control over resources, including food supply at home, while taking the responsibility for caring for children, elders and the sick. A demographic and behavioural characteristic of 1050 women and 999 men conducted in Botswana and Swaziland, 32% of women and 22% of men reported not having enough food to eat over the previous 12 months. Among women, food insufficiency was associated with approximately 70% higher odds of inconsistent condom use with a non-primary partners, women who reported food insufficiency had over 80% higher odds of reporting intergenerational sex, women who reported food insufficiency had over two times the odds of reporting lack of control in sexual relationships.

Furthermore, poverty and food insufficiency significantly influenced the decision of whether to use condoms among female sex workers. The same survey revealed that African women who had experienced sexual violence and who lacked control over sexual decision-making were more likely to engage in unprotected sex, to exchange sex for money or resources, to have multiple partners, and to be HIV positive. Poverty focused microfinance initiative combined with a gender and HIV training curriculum led to a 55% reduction in levels of intimate-partner violence.

The report concluded that use of targeted food supplementation and food production strategies could help address some of the gender and economic disparities that drive unsafe sexual behaviours and should be considered as a way of reduce HIV transmission behaviours.

MULTIPLE APPROACHES ON INVISIBLE POVERTY
I discussed that the majority of victims of property grabbing are invisible as they have no households and livelihoods, and they do not appear in statistics. First step is to make these invisible poor visible. Second is to provide shelters to those without shelters and households. Third is to provide them secure property rights on which their livelihoods could be built on.

Fourth is to provide livelihoods opportunities to those without livelihoods with training, starting capital, etc. The most important is to assist the losers and the invisible poor to gain self esteem so that they could believe that they have a value, future and capability to take the responsibilities for their own lives. Inclusive agriculture that target not only those who can compete in global market, but also those who may not capture global market but capable of providing themselves through agriculture and other forms of livelihoods opportunities.

Swazi Positive Living (SWAPOL) has 1003 women members of 30 groups who live with HIV and AIDS. In Swaziland, women are legal minors, who are not able to own property of their own. Therefore, the SWAPOL members did not have any piece of land to grow their food and many of them were evicted from their marital homes when their HIV status was known to the family in-law or their husband died of AIDS. After extensive negotiation with traditional leaders, SWAPOL finally managed to acquire eleven hectares of land by 2002 for their group members. In the 2003 and 2004 season, one of the groups produced 300 bags of maize, of which 50 bags were put for storage for emergencies, five bags were donated to neighbouring care points to feed orphans and vulnerable children in the communities, ten bags were donated to child-headed AIDS orphans households. The rest of the maize was sold for USD 3883.

CONCLUSION

Development is about people and their capability of taking initiatives to improve their livelihoods with aspiration, self esteem and responsibilities. Extreme poverty deprives people of their aspirations and self-esteem. Millions of children and youths in southern and east Africa have grown up with extreme poverty under three decades of disinvestment in agriculture and rural development, cut in public expend-

Voices of Poverty

Impact of property grabbing

Here are the voices of poverty

"These things... suitcases and mattresses belonged to my boys. And these remains decay... even my memories..."

"When I do not have anything to cook at home, I simply put water into boiling. And we all sleep listening to water boiling... (as if we are cooking)."

(Interviews with grandmothers with orphans, November 2005, FAO Junior Farmers Field and Life Schools, Bondo, Kenya)



Aidsfocus Fachtagung 2008: Kaori Izumi und Mercy Wahome diskutieren mit dem Publikum.

iture in health and education, and devastating impact of HIV and AIDS pandemic for past 30 years. The extreme poverty and changing fabric and norms of local communities made it difficult for children and youth to have a role model, hopes and dreams for the future. Lack of governance, justice and democracy, not least lack of property rights further demoralised such children and youths.

It is the time to focus not only on material needs but emotional and mental needs of the people living within poverty. How does the future for Africa look like when the children who have lost parents, experienced hunger, property grabbing, abuse and violence as well lack of justice have grown up? Investment in agriculture and alleviation of poverty is important but limited in scope for future generation in Africa and elsewhere. Healing of neglected and abandoned young souls are important yet forgotten issues in development agenda of halving the world hunger by 2015.

Too often, the personal stories of both hardship and resilience in the fact of adversity are lost in the statistics and dry overviews of na-

tional policies and epidemiological trends. Excluded from statistics, the women and children become invisible.

Poverty can not be measured by monetary terms, but in order to understand poverty and what poverty does to people and their mind, poverty and human suffering must be heard, seen, touched and felt with one's hands.

With new emerging challenges such as climate change, bio fuel, increasing food prices, we may be at the corner of paradigm change. Perhaps it is the time to revisit an overall development policy because property grabbing is only one of the symptoms of poverty, cultural change and development failure.

*KAORI IZUMI, is HIV/Rural Development Officer at the Food and Agriculture Organization of the United Nations (FAO). This paper does not represent the views of FAO, but all the views expressed in the paper are solely those of the authors alone. Contact: Kaori.Izumi@fao.org

References

- Gustavo Anriquez and Kostas Stamoulis: Rural Development and Poverty Reduction: Is agriculture still the key? Edited by FAO, ESA/07-02, Rome 2007
- Agenda Prabhu Pingali, Kostas Stamoulis, and Randy Stringer FAO: Eradicating Extreme Poverty and Hunger: Towards a Coherent Policy. Edited by FAO, ESA/06-01. Rome 2006
- The Global Coalition on Women (Ed.): Keeping the Promise: And Agenda for Action on Women and AIDS. 2006
- The World Bank (Ed): The World Development Report - Agriculture for Development, Washington, D.C. 2007
- Kaori Izumi: Reclaiming Our Lives - HIV and AIDS and Women's Land and Property Rights and Livelihoods in southern and East Africa, HSRC Press 2006
- Children's Property Rights and Inheritance Rights, HIV and AIDS, and Social Protection in Southern and Eastern Africa. Edited by FAO, Rome 2007
- Children's Property and Inheritance in the Context of HIV and AIDS in Zimbabwe. Edited by FAO, Rome 2008
- HIV/AIDS and Agriculture: Impacts and Response - Case studies from Namibia, Uganda and Zambia. Integrated Support to Sustainable Development and Food Security Programme (IP). Edited by FAO, Rome 2003
- Chapoto, A., Jayne, T.S. & Mason, N.: Security of Widows Access To Land In The Era Of Hiv/Aids: Panel Survey Evidence From Zambia, International Development Collaborative Policy Briefs ZM-FSRP-PB-22, Department of Agricultural Economics, Michigan State University 2007
- Mari aili Tripp: Women's Movements, Customary Law, and Land Rights in Africa: The Case of Uganda. African Quarterly. Vol. 7, Issue 4, 2004 (<http://www.africa.ufl.edu/asq/v7/v7i4a1.htm>)
- Sheri D Weiser, Karen Leiter, David R Bangsberg, Lisa M Butler, Fiona Percy-de Korte, Zakhe Hlanze, Nthabiseng Phaladze, Vincent Iacopino, and Michele Heisler: Food Insufficiency is associated with high-risk sexual behavior among women in Botswana and Swaziland. In: PloS Med., 2007, 4(10), pp. 1589-1598

THE BONANZA IS OVER

By Kidan Felomon*

MY NAME is Kidan Felomon. I am a 47-year old widow and I live in Asmara, the capital of Eritrea. I have nine children. The oldest is 20 and the youngest 7. My husband died of AIDS in 1999. He was a well-to-do merchant who traveled between Eritrea and Ethiopia. He did not tell me that he was infected with AIDS. Three years before his death I asked the doctor who was looking after him to tell her the cause of his sickness and he told me that my husband was suffering from liver cancer. But later, one of the nurses who were coming to my house weekly told me that my husband was infected with the virus. When I heard that, I was shocked and cried until my husband died. When I found out that I was HIV-positive too, I felt like killing my children and myself, but the nurse helped me to accept the problem and to look after my children.

... DESPITE OUR EFFORTS, OUR FAMILY IS UNDERFED

I told my eldest son and daughter that I was HIV-positive. At first it was so difficult for the children to accept it. They cried for three days and nights. But slowly they started to support their mother. My daughter undertakes all activities that involve sharp instruments and I do everything that is done with water, like washing clothes, cleaning the house, etc. The eldest boy undertakes income-generating activities. I sometimes participate in the informal sector, selling vegetables, soap, and matches. But, despite our efforts, our family is underfed. Recently, we started receiving food aid from the government.

The illness of my husband totally impoverished our family. I sold all our furniture and jewelry to support my family and pay for my husband's medical expenses. I had 70-80 grams of gold, which my husband had bought for me, but I had to sell that, too. There were times when I could not give food to my children. Once, my children went without food for the whole day. In the evening I gave the last plate of pasta to my husband and did not know what to give to the children. I was going in and out of the house the whole evening, until finally a neighbor realised my situation and left me five pieces of bread, which I divided among her eight children. The eldest shared his piece of bread with me and then we all went to sleep.

I am a member of the association of people living with HIV and AIDS. However, I am not an active member, because most of the members are commercial sex workers and I do not want to be associated with them. I thus fail to get the benefits that I could get from the Association.

Before my husband got sick, people used to come to our house and spend the night with us and enjoy the bonanza we used to have. But after he became ill, people started refraining from coming to our house. One day my husband vomited and asked his mother to help him. Instead of helping him, however, his mother called me, because she was afraid of getting infected. Then my husband told his mother to leave the house for good. She went back to her natal village.

I have some friends who have similar problems. Among them is a woman whose husband died in 1998. The family depends on farming for a living. They had a plot of land on which they used to plant barley, maize and potatoes. As she could not plough her land, she used to give out the land to sharecroppers who were ploughing the land for her. She was responsible for weeding and harvesting. The sharecroppers used to give her half of the produce but later, as she became weak, she could not weed, so the sharecroppers gave her only a quarter of the produce and, since this could not support her, she decided not to have her land ploughed and she now depends on food aid. In Eritrea, women do not plough land. Traditionally, ploughing is a male task and ploughing for women is an unacceptable task that has a stigma attached to it.

*KIDAN FELOMON is a pseudonym. The woman was interviewed by Worku Zerai, Ethiopian Women Lawyers Association

Source

Reclaiming our lives: HIV and AIDS, women's land and property rights and livelihoods in southern and East Africa. Narratives and responses. Edited by Katori Izumi. Cape Town 2006

RESSOURCES AND TOOLS

TO HAVE AND TO HOLD: WOMEN'S PROPERTY AND INHERITANCE RIGHTS IN THE CONTEXT OF HIV/AIDS IN SUB-SAHARAN AFRICA

This paper of the International Center for Research on Women (ICRW) seeks to examine the link between HIV/AIDS and women's property rights – if women's lack of rights increases household poverty and women's own vulnerability to infection, and if securing these rights can mitigate the impoverishing impact of the epidemic. The first section of this report explores the relationship between HIV/AIDS and women's property and inheritance rights, and how women may be better able to prevent infection or mitigate its consequences if these rights are protected. The second section discusses the ways that women can obtain access to and control over property and how these rights are often denied in practice, and then provides several country examples. The third section explains de jure and de facto rights to ownership and inheritance and discusses how to bridge the gap when the two differ. The fourth section highlights some "best practices" in efforts to ensure women's property and inheritance rights. The report concludes with lessons learned and suggested next steps. (2004)

www.icrw.org/docs/2004_paper_haveandhold.pdf

WOMEN'S PROPERTY RIGHTS AS AN AIDS RESPONSE: EMERGING EFFORTS IN SOUTH ASIA

This report by the International Center for Research on Women (ICRW) is highlighting programs that work through legal and cultural mechanisms to help women from being dispossessed and impoverished because of HIV and AIDS. "Our research takes us one step closer to understanding how secure property rights might help women protect themselves and their households from

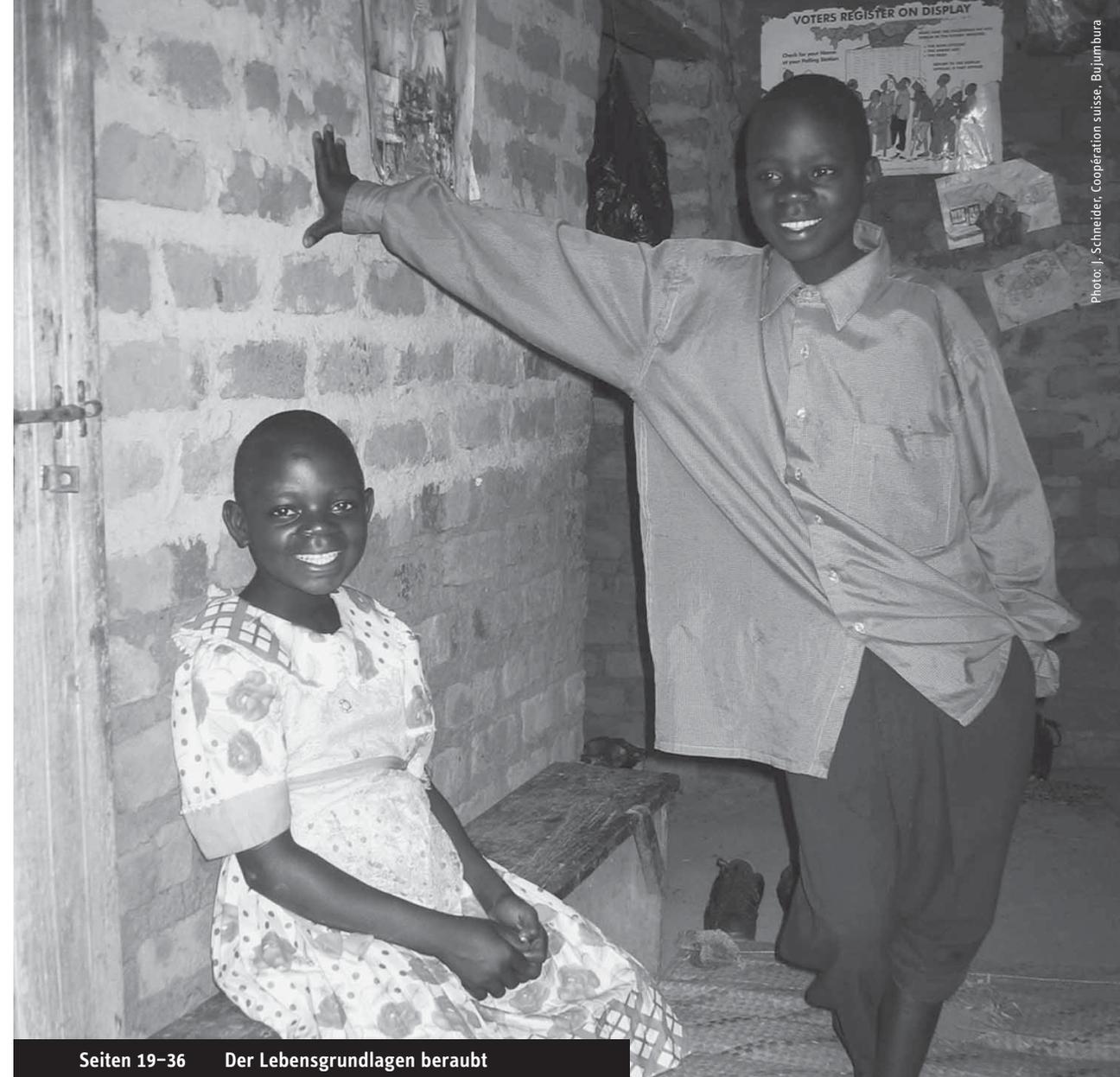
adverse consequences related to HIV, including stigma, poverty and property dispossession," says ICRW lead researcher Hema Swaminathan. The report shows that a complex, comprehensive strategy is needed to link women's property rights with HIV/AIDS prevention, treatment, counseling and care services. (July 2007)

www.icrw.org/docs/2007-property-rights-south-asia.pdf

REPORT OF THE REGIONAL WORKSHOP ON HIV AND AIDS AND CHILDREN'S PROPERTY RIGHTS AND LIVELIHOODS IN SOUTHERN AND EAST AFRICA

This workshop report by the Food and Agriculture Organisation Sub-Regional office for Southern and East Africa gives details of HIV and AIDS and children's property and inheritance rights project planning. As a contribution to the UNICEF/UNAIDS initiated Global Campaign on HIV and AIDS and Children, FAO initiated new activities on HIV and AIDS and children's property and inheritance rights. This regional workshop on HIV and AIDS, and Children's Property Rights and Livelihoods in Southern and East Africa was dominated by the voices of children sharing experiences, and concerns on issues of property rights in the face of HIV and AIDS. The development of child-friendly tools emerged as the key to addressing children's vulnerabilities. (2006)

www.ovcsupport.net/graphics/OVC/documents/0000810e00.pdf



Seiten 19–36 Der Lebensgrundlagen beraubt

“Furthermore, a new developing trend that increases the vulnerability of women in land ownership is the policy of economic liberalization and the official policy to attract private investors, particularly foreign investors.” Maimuna Kanyamala

SASA!

Wife inheritance is a serious violation of women's human rights. In Tanzania, it is a widely practiced tradition among the 120 tribes. This practice is generally used when the deceased was living in accordance to the tradition and customs of his tribe. When the husband dies the wife is inherited by an elder or younger brother as a mean of protecting the widow, children and property of the deceased. However, in recent times the pattern of inheriting the wife is changing. This may be a result of HIV/AIDS.

By Maimuna Kanyamala*

THERE have been many cases where the widow and children of a man dieing of HIV/AIDS have been left with very little or nothing after the relatives have grabbed away all the assets of the family. In other cases women have found themselves disinherited because they refused to "go with" the male relative of their deceased husband. Even though, in Tanzania, the government has facilitated legal empowerment through several progressive laws, Customary Laws are particularly powerful in over-riding statutory law. There is an urgent need to challenge the Customary Law Declaration Orders of 1963 that inhibits the right to own property particularly by women. Furthermore, women need to be informed on their legal rights.

Currently, there is an increasing focus internationally on the strengthening of women's property and inheritance rights as a possible strategy to reduce their exposure to gender based violence and HIV/AIDS. Furthermore, it is also recognized that wife inheritance increases the risk of HIV-transmission. Therefore, as development issues, wife inheritance and HIV/AIDS share many other common behavioral change, sexuality and gender, marriage and control over women's bodies, gender discrimination and violence against women.

In Tanzania, the right of equality is enshrined in Article 12 of the Constitution, which states that "all human beings are born free, and

are all equal". Moreover, Article 13 of the Constitution states that "all persons are equal before the law and are entitled, without any discrimination to protection and equality before the law". At its fifth paragraph, this disposition defines the expression "discriminate" as meaning: "to satisfy the needs, rights or other requirements of different persons on the basis of their nationality, tribe, place of origin, political opinion, color, religion or station in life such that certain categories of people are regarded as weak or inferior and subjected to restrictions or conditions whereas persons of other categories are treated differently or are accorded opportunities or advantages outside the specified conditions or the prescribed necessary qualifications".

Therefore, the Constitution prohibits discrimination based on nationality, tribe, origin, color or religion. Furthermore, article 24 of the Constitution of Tanzania guarantees the right to own property. The said provision stipulates that every person has the right to own or hold property lawfully acquired and shall not be arbitrarily deprived of his property without fair and adequate compensation according to the law.

MODERN AND CUSTOMARY LAW

Even though it would therefore appear that women's property and inheritance rights are in theory relatively protected in Tanzania, there are some areas where there is still cause for

concern. For instance discrimination based on sex, age or disability is not specifically prohibited by law. Significantly, Article 24 of the Constitution of Tanzania is highly violated while practicing Customary Law. Customary Law, (Declaration) Order, 1963 excludes the possibility for a widow to inherit land from their deceased husband. This means, women are not allowed to inherit property from their husbands. However, sons, uncles and other male relatives are given preference over women in matters of inheritance. Additionally, women are restricted from disposing clan land and are therefore restricted in where they may live and how they choose to live their lives.

As of to date, in Tanzania, the greater part of society stays traditionalist. Thus, when it comes to gender issues and application of customary laws in certain domains like inheritance (with the application of the Local Customary Law (Declaration) Order, 1963) illustrates well the strength of traditions in the country. For instance, according to Anna Makerere (not her real name) after the death of her husband, the brother of her husband took farms and 60 cows which were the properties of this woman's late husband. When she asked for her rights, along with those of her 6 children, she was given only 6 cows (one for each of the children). She was worried about asking for more of her inheritance because she is a woman.

Another woman, after the funeral of her husband, relatives of his deceased husband told her she had to go with her children to her home in the village where they would send her all property. Initially, she had been living in Mwanza with her husband. She went to the village with her children but the relatives did not send any of her property. She went to make a follow up and found everything was sold and the money used by those relatives. She couldn't do anything. She just left and came back to her village. Yet, even where the deceased husband has written a will, this was not a guarantee that the widow and children will not be facing a counter claim by relatives.

At, Nkome Ward, Geita District in Mwanza one respondent said that when her husband was seriously sick he wrote a note that his properties must be inherited by his wife and four children. These properties included money, cows, a house, farms, a plot of land and building materials. But after the death of her husband, the

relatives of her husband are still debating, up to now, on those properties. Therefore, even though there is a written note, the relatives are still trying to claim them.

MODERN DAY WIFE INHERITANCE

Originally, this practice of wife inheritance was designed to protect the wife and any children of a deceased man. Traditionally the elder or younger brother of the deceased takes on the responsibility for all properties including his wife and children. However, in more recent times, the responsibilities for the wife and children – which are meant to go hand in hand with the inheritance, have sometimes been put aside in the rush to grab the more valued land, animals, tools, furniture or houses. Therefore, the pattern of wife inheritance is changing to "Modern Day Wife Inheritance". In a study conducted by Kivulini Women's Rights Organization (Kivulini) in collaboration with Catholic Relief Services (CRS) in 2002 in Mwanza, it was revealed that in more recent times this may be as a result of HIV/AIDS. If it is suspected that the man died of AIDS, there is less motivation to take a wife who may herself be infected and may infect the new 'husband' and/or leave him with children from her first marriage if she dies. Thus there have been many cases where the widow and children have been left with very little or nothing after the relatives have carried away all the assets of that family. In other cases women have found themselves disinherited because they refused to "go with" the male relative of their deceased husband.

In 2006, this was unsuccessfully challenged in Court by two widows. A civil society organization named Women Legal Aid Clinic (WLAC) represented the two widows from Shinyanga region to challenge the Customary Law on the grounds that it discriminates against women and violates the country's Constitution. In this landmark case, the High Court threw out a petition against the customary law that bars women from inheriting the estimates of their deceased husbands on the basis that the custom violated the Constitution, saying that "it would be dangerous to make changes through judicial declarations on the societal laws which have been in practice for many years". Therefore, in Tanzania, given the fact that the livelihood of about 80 percent out of 34.4 million of the population depends on land, and that



Maimuna Kanyamala

Foto: MMS

women peasants are more predominately using the land than men, land is an essential resource and asset to women. It could be argued that, in Tanzania, women are excluded from accessing and owning land thus exposing women to gender based violence and HIV/AIDS.

ATTRACTING FOREIGN INVESTORS

Furthermore, a new developing trend that increases the vulnerability of women in land ownership is the policy of economic liberalization and the official policy to attract private investors, particularly foreign investors. This has often resulted in large tracts of land being allocated for private investment and both women and men losing their rights to land to which they had usufruct and customary rights with no title deeds. This increases the vulnerability of the relatively poorer men and women especial-

ly the latter who are already marginalized due to cultural practices related to land ownership. The continuation of this practice of wife inheritance and control of resources is in complete violation of the principles of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in which the signatories including the Tanzanian government agreed to eliminate all forms of discrimination against women and to remove all laws, customs and practices that are discriminatory.

Article 2(f) of CEDAW address this specific issue and request from the Parties "to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women". In spite of this, Tanzanian women's civil rights are often limited by the existence of several factors, such

as the dual legal system which includes statutory, religious and customary laws, the presence of discriminatory laws as well as some remaining traditions and practices. As a result, although the law provides for equality of women their rights are in practice often disregarded. Perhaps, the question is, how could we use our power to bring change?

Experience has taught us in Tanzania that, one of the major difficulties in advocating for widow inheritance rights is the existence of Local Customary Law. The Customary Law has reinforced the experiences of so many widowed women in Tanzania who have internalized the oppression of male dominated power of ownership of resources. As a result, lack of access to, and use of, property such as land, leaves many women extremely vulnerable and trapped in an ever-deepening cycle of poverty and powerlessness.

A second problematic area is that of women do not know their rights and do not have adequate access to legal advice. Thus, the conflict between the customary and statutory law and other violations of the laws could have been resolved if the victims had better access to information about their rights and legal services. Many women particularly in the rural areas are not aware that they can appeal to higher courts when violence happens. The CEDAW and other laws that provide for equitable rights for women and men are not well disseminated.

"SASA" MEANS "NOW"

Where, then, to begin? A recent study by the International Centre for Research on Women (ICRW 2007) on the links between poverty, inheritance rights, HIV/AIDS and gender-based violence suggests that "strengthening women's property and inheritance rights is seen as a possible strategy to reduce their exposure to gender-based violence and HIV/AIDS. Therefore, we need to take urgent steps to challenge the Customary Law (Declaration) Order, 1963 that excludes the possibility for a widow to inherit land from her deceased husband. In Tanzania, Women Legal Aid Clinic has remained persistent to continue challenging the law.

In terms of violence and HIV/AIDS, the time is SASA. In Kiswahili, SASA means "NOW". Now is the time to prevent violence and HIV/AIDS. SASA! Means

Start: Start thinking about violence and HIV/AIDS as interconnected issues and foster power within yourself to address these issues.

Awareness: Raise awareness about how our communities accept men's use of power over women, fueling the dual pandemics of violence and HIV/AIDS.

Support: Support the women, men and activists directly affected by or involved in these interconnected issues, by joining your power with others.

Action: Take action. Use your power to prevent violence and HIV/AIDS.

What is Kivulini doing? As Kivulini experience has taught us that women need to understand what is happening to them, to stop denying and find the support which will help to break the cycle of violence. Therefore, Kivulini is using a holistic approach in reaching out to women. Under the main strategy of community mobilization, Kivulini strives to engage the whole community women, men, youth and children at the grassroots to community leaders and professionals within local institutions. Kivulini addresses violence, HIV/AIDS and women's rights as a community responsibility instead of making it a women's issue in order to reach out to all sectors in society.

CREATING DIALOGUE AND ACTION

In the community: Kivulini works closely with women and young people through community action groups, community volunteers, and end violence groups. These groups are at the forefront of the efforts and play a key role in 'getting the word out' to other women, men, community leaders, and children. There are over 300 members who take the lead in organizing and conducting community dialogues, public events, community theatre, video shows, impromptu discussions, etc. within their own streets and communities. This means that the activities have incredible reach and all the organizing and planning comes from community members themselves. These community members also track cases of violence, help women experiencing violence, conduct family mediation and refer clients to Kivulini or other relevant institutions when additional support is needed. Their goal is to create dialogue about, and action against domestic violence. The representatives of all the groups meet month-

ly with Kivulini staff to plan, review, discuss challenges, problem solve and get further training. These representatives then train and support other members in the groups.

Furthermore for the last three years, Kivulini started working on the link between violence and HIV/AIDS as an urgent step on addressing violence against women. Women's vulnerability to HIV infection is clearly related to their autonomy and status in their intimate relationships, their ability to negotiate safer sex with their partners, and the level of communi-

cation, respect and mutuality in their partnership. Therefore, women's vulnerability to both violence and HIV is a result of a core set of issues including gender inequity, imbalance of power in their personal relationships and their low status in their community.

In the institution: Kivulini works with local institutions and local government because they hold considerable influence in the community and community members rely on them for support and assistance. They also greatly influence how an issue is thought about in the community and are "opinion" leaders within the community. These representatives from local institutions include: community leaders (at the street and ward level), police, social welfare officers, health care providers, religious leaders and journalists. Through seminars, policy review committees, training and community dialogues Kivulini aims to increase their conceptual understanding of violence against women and women's rights and strengthen the capacity to better address these issues within their own workplaces. Kivulini works with the same groups over a long period of time and sees this as an important step toward creating an environment in the community that is supportive of women's rights.

At the Centre: Recognizing that prevention efforts are not successful overnight, Kivulini also responds to the practical needs of women and families in the community through life skill training, counseling and mediation. Women access legal aid if they opt to pursue their cases in a court of law. Referrals are made to health care centers, police or social welfare department, if needed. Importantly, the work of Kivulini is not only giving services, but making sure clients are informed on their rights and are able to demand them. Therefore, in the community Kivulini facilitate legal literacy sessions mainly focusing on Marriage Act, Inheritance Act, Writing wills, Land Act, etc.

CHALLENGES FACING CIVIL SOCIETY ORGANIZATIONS IN GRASSROOTS ACTIVISM

The civil society has a catalytic role to play in mobilizing communities, promoting women's rights, building the bridge between policy and practice and facilitating change at the grassroots. However, in Tanzania there is lack of adequate support for civil society efforts to enhance the organizing capacity of grassroots

women to increase their power and control over basic resources at all levels. To this regard the Tanzania Gender Networking Programme (2007, p. 87) wrote

"Many civil society organizations are ready to carry out their mandate and responsibilities, but lack adequate support from both the government of Tanzania and the donor agencies. This has been compounded by the adoption of the 'new financial architecture' associated with General Budget Support and Joint Assistance Strategy. In many European countries, for example, foreign assistance to Tanzania is channeled in two ways: direct from government to government (the largest share) and through their own civil society organizations."

Convulsively, widows encounter problems in regard to inheritance rights that include: she might be forced to marry a relative of her dead husband; she might not be granted custody of her children and she might be denied inheritance rights. Nevertheless, in Tanzania it has been noted that recently many widows have resisted widow inheritance, even at the cost of their rights to the land and other property that they have accumulated together with their husbands. A growing number of widows have also been able to attain a higher level of autonomy and have been able to provide their children with adequate material support, as a result of their new independent status. However, more research is needed to investigate the extent to which this is true for widows in all income groups and urban-rural locations.

* **MAIMUNA KANYAMALA** is the Executive Director and Founder of Kivulini Women's Rights Organization based in Mwanza Tanzania. Kivulini was established in 1999 by six women who felt compelled to take action to prevent the violence happening against women in their community. It is a registered non government organization that advocates for women's rights in Tanzania. Kivulini specifically mobilizes community (men, women and young) to prevent domestic violence. Kivulini is a partner of terre des hommes schweiz: [www/http://kivulini.org](http://www.kivulini.org). Contact: maimunakanyamala@hotmail.com

References

- Gender Based Violence Network et al. (2006) Strengthening Work on Gender Based Violence: A meeting of Activists, Practitioners and Researchers from the Horn, East and Southern Africa, Kampala.
- Gender Based Violence Network (2007) Perspectives on Prevention, November 2007/Issue No. 6
- Kivulini Women's Rights Organization (2002) A Situation Analysis of Orphans and Other vulnerable Children In Mwanza Region, Tanzania, unpublished report
- Legal and Human Rights Centre (2007) Tanzania Human Rights Report 2006: With Zanzibar Chapter, Dar es Salaam.
- Norwegian Church Aid (undated) Norwegian Church Aid: Life Without Violence, Women and Men Together, Oslo.
- Raising Voices (undated) SASA! A Film about Women, Violence and HIV/AIDS, Kampala.
- Raising Voices and Safer Cities (2004) Preventing Gender-Based Violence in the Horn, East and Southern Africa: A Regional Dialogue, Nairobi.
- Tanzania Gender Networking Programme and Swedish International Development Corporation Agency (2007) Gender Profile of Tanzania: Enhancing Gender Equity, E & D Limited, Dar es Salaam.
- Ugwu S. N. (undated) The Agony Of A Woman, Dalwa Press Ltd, Nigeria.

DOUBLE TRAUMA: LAND GRABBING FROM AIDS ORPHANS WHEN THE PARENTS PASS AWAY

A double traumatic experience: Aids orphans lose their homes just after the parents have passed away. Community based support for Aids orphans and vulnerable children focus on mediation as prevention of land and property grabbing. The article reports from field experiences of an HIV/Aids-project with a holistic approach in the rural context of the Masaka and Rakai districts in South-West-Uganda.

By Frank Mischo*

GERTRUD NAMAGANDA and her family are typical for a lot of personal stories collected by the non-governmental organisation (NGO) Kitovu Mobile. The family got medical and food support from Kitovu Mobile since 2003. Gertrud's husband passed away 2004. Since then, her husband's family threatens to drive the family out of their home.

THE STORY OF GERTRUD NAMAGANDA AND HER FAMILY

Gertrud Namaganda married her husband Joseph in the year 1998. In that time he was already severely sick, but nobody diagnosed his illness. Gertrud also started to get the same disease. From a community member, who works as a volunteer for Kitovu Mobile, she heard that she can get testing, counselling and medical support from Kitovu mobile. That was in 2003. She went to the next church community, where the Car of Kitovu Mobile comes by every week with a nurse and a social worker. After her first meeting, Gertrud gets medicine and she was invited for an HIV-test. Her test results were HIV-positive and since then, she

went regularly to the meeting point. Immediately after her test, her husband passed away, probably because of Aids. Since then Gertrud had to work alone for the family, even when her illness got more difficult to work regularly. Another problem started by the elder brother of her husband. He blamed her for bringing the disease in the family and accused her for letting her husband die. Then he demanded to get her house. Gertrud managed to defend herself to stay in the house, but the uncle kept on threatening the family since then. Gertrud has four children. Winton, the eldest son, is from her first husband. When Gertrud is severely sick, Winton takes over her responsibilities for the family and misses school.

COUNSELING OF GERTRUD

Gertrude's physical condition got worse and worse. When she talked to the social worker of Kitovu Mobile she was looking for support for the struggle against her husband's brother. When Gertrud passed away in 2007, her husband's uncle immediately chased the children away from their home. The children stayed



Frank Mischo

Foto: MMS

with another neighbour and informed Kitovu Mobile. Kitovu Mobile tried to mediate within the family.

WINTON'S NEW HOME AND WORK

Even after 3 months Kitovu Mobile didn't manage to get back the home for the children, but they organised a new house with the help of the community. And Winton goes now to the farm school of Kitovu Mobile and has an income by the fruits of his new garden for the children headed family.

This is one case of the growing need of mediation and support for orphans and vulnerable children (OVC) out of a small survey of Kitovu Mobile, one Ugandan partner of the children's relief organisation Kindernothilfe. Kindernothilfe aims to reach with its partners a world, where children and adolescents have the chance for a life in dignity, to be able to make use of their potentials and to take their development together with their families in their own hands. Principles of Kindernothilfe are participation, self help- and child rights

approach. Kindernothilfe cooperates with local partners, like Kitovu Mobile in South-West Uganda.

Since 21 years Kitovu Mobile is a Partner of Kindernothilfe. Both organisations experienced the Aids pandemic from the beginning till now. Kitovu Mobile started as an organisation taking care in the improvement of health care. Since 1987 Kitovu Mobile faces the Aids pandemic, in the beginning as the unknown disease with illness and deadly end, after a time, as the burden on the family structures increased, by caring for the ill and taking care for the children of the weakened parents. Kitovu Mobile concentrated itself on people with Aids since then. Counselling, testing and medical support is an increasing part of the work. Today a rapidly growing number of patients receive antiretroviral drugs (ARV).

KITOVU'S MOTTO IS "WE CARE"

Kitovu Mobile's vision is to see an empowered community with the ability to cope with HIV/Aids and its impacts. The aim of the work is to improve the quality of life of people living with

HIV/Aids through working with communities in the area of prevention, care, support and capacity building.

Kitovu Mobile started with caring for people living with HIV/AIDS in their homes. Counselling and HIV-related prevention programs were added. Kitovu Mobiles concentrates also on motivating volunteers. Now there are more than 700 volunteers active for Aids orphans. Educational support for orphans became increasingly important. Thousands of orphans have received support with school fees, uniforms, and scholastic materials. Kitovu Mobile also supported the community's construction and rehabilitation of school buildings, teacher trainings, and income-generating activities. To minimize both the short and long term psychological problems, Kitovu Mobile provides individual, group and family trauma counselling. Community participation and involvement in orphan care and support through regular community meetings with the beneficiaries is one important part of the work.

In 1998 Kitovu Mobile introduced Mobile Farm Schools to train teenage school drop outs in modern, sustainable and integrated organic farming skills. Till today more than 2.000 teenagers have benefited directly with approximately 12.000 indirect beneficiaries in their families. The children learn to sustain themselves and by giving their knowledge to their

neighbours it works against discrimination and isolation of Aids orphans. Additional Self Help Groups have been formed. Home Care and Palliative Care are a component of Kitovu Mobile, where people affected by HIV/Aids are visited in 121 small centres in 4 districts by nurses and social workers every fortnight for counselling and medical support.

In the Beginning of the Aids pandemic the families could take care for the children of the missing parents. Today 1 million Aids orphans live only in Uganda. The most productive generation between the ages of 15 to 49 years is mainly affected by HIV/Aids.

STRENGTHENING COMMUNITIES AND FAMILIES

In 2007 12,1 millions of children in Sub-Saharan Africa lost one or both of their parents. The Number of Aids orphans and vulnerable children (OVC) is rapidly growing. Often when one parent is passing away, the other is already sick. It is important to strengthen communities and families, whose role is crucial to every aspect of a child centred approach to Aids. The health, education and social welfare systems have to be reinforced to ready to make effective key interventions to support children with HIV and Aids.

Aids orphans often have to take over the home based care of the parents and they try to find any small income for the family. In that time the children often miss the opportunity to go to school. When the parents pass away, it is always a shock and a traumatic experience for the children. Many of the children stop schooling from that time on. Some mainly work for living others are so traumatised that they just don't know what to do best next. If there is a helpful family, children manage often to go back to school. But if not the children families are extremely vulnerable for abuses.

The example of land and property grabbing shows that there is a need of support and protection of Aids orphans. Aids orphans experience more often an extreme double trauma: Directly after the Parents have past away, mainly the family and sometimes neighbours grab the land or the property of the orphaned children.

The Ugandan Project Partner Kitovu Mobile of Kindernothilfe works on this issue. Another case of the survey shows how important it is to include the prevention of land grabbing in the work of supporting Aids orphans.



Kitovu Mobile's Farm Schools

Photo: Kindernothilfe

*FRANK MISCHO is Political Scientist and works in the Department for Awareness Raising in the German Kindernothilfe. He is responsible for the HIV/Aids-Project and lobby work and additionally he is one of the speakers of the Uganda Forum in Germany. He has worked in Uganda on field studies f.e. on the issue of HIV/Aids. Contact: frank.mischo@knh.de, www.kindernothilfe.org

References

Kitovu Mobile 2007: Survey about Land Grabbing from Aids-Orphans in Masaka-Rakai, Masaka
UNICEF 2008: Children and Aids. New York. The Second stocktaking report is a review of progress on how AIDS affects children and young people. Unite for Children, Unite against AIDS, which was launched in October 2005 by the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF and other partners, was a call to action around the impact of HIV and AIDS on children.

SECOND CASE STUDY: SIMON AND JESSICA

Both parents of Simon and Jessica passed away in 2005 by Aids. Kitovu Mobile heard of the 7 and 10 year old orphans. A nearby neighbour reported regularly to Kitovu Mobile and helped the children in the garden or to go to school. One day in 2006, the landlord, an uncle of Simon and Jessica, came and asked for all properties and that the children have to leave the house. He said, he would need the house for his sister who is also in need now.

KITOVU MOBILE'S INTERVENTION

Kitovu Mobile heard from the helpful neighbour about the problem and a social worker talked to the landlord. A mediator of the Community who was elected by the community organised a meeting with the landlord, his sister, Kitovu Mobile, the neighbour and the children.

The result of the meeting: the children can stay in their home! The uncle has to take care for the needs of the children and the sister gets another house from the Landlord. The neighbour monitors that everything is all right for the children.

CHANGING LAND LAWS

Traditionally children would live within extended families instead of living as child headed households. Caregivers assumed control of orphans parental properties and were expected to provide for the orphans needs. Today the increase of property- and land grabbing and neglected children are the result of the growing poverty and the high death rates in the families. Children living alone are more vulnerable for exploitation and different kind of abuses. The Government of Uganda tries to establish local authorities to protect the children and to adjust by law the inheritance rights, that children can keep their homes and the belongings of the family.

MEDIATION AS PREVENTION

For Kitovu Mobile the main focus of the work will be home based care, medical support, counselling and testing. The main methods of property grabbing are taking away moveable property already when a parent is sick or after the death of the parents. The family gains access to all moveable and immovable property



Photo: Kindemohilfe

Gertrud with Kitovu Mobile's social worker

by burial order. Also guardianship for orphans is used to get the property of the children. Because of the growing problem mediation will play a bigger part in future than today.

Kitovu Mobile has developed a four steps approach to minimize the land and property grabbing:

1. A lawyer is hired part-times.
2. All volunteers are sensitised on looking after the children and if people threatens to chase them away. In case they go immediately to Kitovu Mobile or a responsible and cooperative person from the local government.
3. Teachers are trained to ask for which reason pupils are missing in school and also to report it directly to Kitovu Mobile.
4. A small fund was established to buy a piece of land for child headed households who were chased away for example. Because of the very few resources for the fund, it is used only for the worst cases, when no other solution is possible.

PERSPECTIVES OF MEDIATION

In cooperation with organisations like Kitovu Mobile the Government of Uganda also supports the mediation against land and property grabbing. But it is still a growing problem because of the vicious circle of poverty and Aids:

Anyone becoming ill with immune deficiency cannot continue to work without undergoing expensive treatment. Children have to take over the work of ill parents and look after the whole family. That means they have to stop going to school where they would receive instructions on the dangers of HIV and how to avoid infection. The lack of knowledge leads to a situation where the number of people, which are HIV positive, is continuously growing.

Kitovu Mobile reacted on the changing main problems of the families. It started a programme with self help groups and volunteers to reorganise the support for the affected families.

Farm schools for adolescents from 14 years on were there from the beginning. But now they are one main tool to reach the Aids orphans who missed schooling and who need educational support and life skills. Often children headed families miss the knowledge to work effectively in the own gardens. An increased income strengthens the child headed families and they start to manage their life themselves in working together with other farm school participants.

A story from Rwanda

STEP BY STEP – THE ROAD TO RECOVERY

By Rose Mukabalisa*

MY NAME is Mukabalisa born in 1959 in Shyorongi – Rwahi in Kigali rural Province. I am a survivor of the 1994 genocide living at the Village of Hope, Kagugu Sector, Gisozi District in Kigali Urban Province. I am a woman living with HIV/AIDS with one daughter and five sons, my first husband died in 1987 and I separated with my second husband before the 1994 genocide because of ethnic tensions at that time. He took all the property and cash we had and left me with the children.

After seeing the problems I was going through, a friend of mine (a widow) living in another province gave me one house among three houses she had on a plot in Kigali city. I used to manage her property, collect the rent and then send the money to her. The 1994 genocide took place when I was living in this situation. I was found in this house and gang-raped by Interahamwe militia while my children watched. This went on for like one month until I sought refuge in a nearby church. On the way to the church at night I was stopped on a road block and beaten. At the end of the 1994 genocide, I returned to my house and came to learn that my friend, who had given me the house, was killed in the genocide. I went to visit her children and resumed my responsibility of delivering the money for rent to them.

POLYCLINIC OF HOPE

It was at this time that, due to the horrific experiences I went through – gang rape, beatings, the fear and trauma – I joined the Polyclinic of Hope Centre, a Rwanda Women Network (RWN) project for victims of rape and violent crimes. The Polyclinic of Hope started in 1995 and I was one of its first members. The Clinic is a space for interaction, provides free medical care for members and their families, trauma and

HIV and AIDS counselling, care and support for people living with HIV/AIDS, micro-credit, information on human rights and legal aid, and education and awareness on different issues.

In 1998, because my house had been destroyed during the genocide, the RWN assisted me to rehabilitate it. I was offered materials including sand, stones, cement, paint, timber and iron sheets, as well as the labour to help in the repairs that needed to be done.

In 2000, I started receiving people claiming to be brothers to the husband of my friend demanding that I move out of their house because the house was not mine. I refused to move out because I believed the house to be mine, although I had no documents showing that my friend had given me the house. Her children were aware of this situation and also the family of her husband had not contributed anything in the property's acquisition. The problem continued and I was reported to the local authorities. The claimants' main strength was that I had no official document showing the house was given to me. They reported me, saying I had refused to give them their property.

...SAYING I HAD REFUSED TO GIVE THEM THEIR PROPERTY

I was accompanied and advised by RWN on the day our case was to be heard and through the whole process. The authorities were not ready to believe my statement without any written document. It was only when my friend's children came forward that matters improved. They testified that they were aware of their mother having given me the house and that I was helping them manage the rest of the property in their absence. Hearing this, the local authorities decided I should stay in the house and gave me a document testifying to this decision.

The claimants were not satisfied with this decision and resolved to use other means to get me out of the house. In collaboration with my neighbours and the surrounding community involved in my genocide case, they started harassing me and my family. At night they would throw stones on the roof of my house; they would attack, beat and harass me as I came from the market where I was working. When I reported the different harassment incidents to the police, the people involved were arrested but after about a week they were released.

After this, they were determined to do worse. They came at night with pangas and knives, started hitting on my door saying they would kill me. They were heard by some of the neighbours, one of whom was a policeman. He came with a gun and shot in the air and the assailants ran off. I reported again to the police, investigations were carried out and arrests were made.

I was traumatised and living in fear for my life and family, so the police advised me and the RWN to find a way to relocate me for security reasons. At that time, beneficiaries for a shelter programme among women victims of violent crimes at Polyclinic of Hope Centre were being identified, so I was included.

A NEW HOUSE IN THE VILLAGE OF HOPE

At the end of the construction of the 20 houses that make up the Village of Hope, I moved to my new home, the police department even provided transport. The Village of Hope was constructed by the RWN for women victims of rape and other violent crimes who had no shelter at the end of the 1994 genocide.

When I decided to rent out the house I had been staying in, the different tenants were harassed the same way I had been harassed – with stones and other objects being thrown on the

roof at night. When the last tenant moved out, the house remained empty for two months and then the same people who had reported me before reported again to the local authorities. They claimed that I had moved out of the house, left it empty and that the person who had given it to me without any written document had left orphans who were suffering and could use the income from the same house to improve their welfare.

WOMEN NEED TO BE SENSITISED

Considering the case history – no written document to show that the house was given to me, lack of security and income from the house due to the tenants being harassed out of it, the fact that I had a home to stay now, and in consideration of my health (a woman survivor who had been gang raped and was living with HIV/AIDS because of this) – the RWN advised me to claim for the funds invested in renovation and then allow the house to revert to the children of my friend. This is the decision the local authorities passed and the money used for rehabilitation was given back to me.

Concurrently with the above, I was following up a case with my second husband for having deserted us, and not having provided any support to our two children. Because we were not married legally under Rwandan law, I first of all took him to court in 2002 in order that he acknowledges the children as his. Upon the decision of the court in favour of the aforementioned, my former husband was supposed to provide child support and the children would have a right to inherit their father's property. He did not fulfil his responsibilities as a father and I reported him to the local authorities. After hearing our case, the court requested my former husband to give me RWF 15'000 per month for child support.

In conclusion, I would say that in order for women's rights to be protected, women need to be sensitised. They also need to be determined to demand that their rights be respected. Women also need support and reinforcement because I would have found it very difficult to follow up my cases and demand for redress without the assistance of RWN and the Polyclinic of Hope. Also, for the existing laws and structures that protect women's rights to work, women have the responsibility of coming forward.

*ROSE MUKABALISA is Member of Polyclinic of Hope – Rwanda Women Network (RWN). Interview by RWN, March 2005

Source

Reclaiming our lives: HIV and AIDS, women's land and property rights and livelihoods in southern and East Africa. Narratives and responses. Edited by Kaori Izumi. Cape Town 2006

GAPS, VIOLATIONS AND BARRIERS TO WOMEN'S RIGHTS

1.27 million Kenyans are infected by HIV. The worst impact of this epidemic is felt by women and girls with over 600'000 living with the virus. Many of these are widows in their 20s and 40s, young girls and grandmothers. Women who are known or suspected of being HIV positive are frequently ejected from their homes by their husband's family resulting in loss of property.

By Mercy Wahome*

WHEN RUTH MUTHONI lost her father she knew that she and her siblings would be well taken care of by her grandparents in Nakuru. Her mother had succumbed to HIV a year earlier, leaving them under the care of their father who would soon follow.

By then, the family was living in Naivasha, where Ruth's father had built a big house in addition to acquiring land and other property in the town. Now that the parents were gone Ruth was confident that under her grandmother's and uncles' care in Nakuru, education and other needs for her siblings and herself would be taken care of with what would be accrued from regular income gained from the family property in Naivasha.

This was not to be, however. As soon as the orphans were installed in their grandmother's home, the uncles started plotting how to disinherit the young children of their family property. Any income from it ended up in their pocket, with none going to help the children.

Having greatly suffered after several years of taking care of her siblings, Ruth finally contacted the Society of Women and AIDS in Kenya (SWAK) where she is now a beneficiary of the SWAK Paralegal Program.

SWAK'S PARALEGAL PROGRAM

Established in 2002, the Paralegal Program came about as an intervention measure with the realization of the many cases of human rights abuse at the hands of relatives, and especially property disinheritance, resulting from Aids deaths of spouses (mainly husbands) and parents. The program offers paralegal training for SWAK members to work with their communities and refer legal cases such as that of Ruth to the professionals. A legal network therefore exists that works with local lawyers, who offer their services for free.

In Ruth's case, the land and estate of her parents is being followed under succession regulations so that she can have the properties registered on behalf of the children under trusteeship to be able to benefit them.

Ruth's case however only illustrates the situation of Aids orphans and vulnerable children. The other most affected are Aids widows and women living with HIV. Currently, 934'000 people are infected with HIV nationally, with the vast majority of these being women. Women known or suspected to be HIV positive are frequently ejected from their homes by their husband or husband's family resulting in loss of property.



Foto: MMS

Mercy Wahome

There are also cultural and other dimensions. Social, cultural, economic and occasionally legal frameworks in which most Kenyans live allow men significant control over women's lives. Land ownership, access and control is central to the sustenance of the livelihood system in Kenya. It is the key asset at the centre of the right to own and inherit property.

SOCIAL AND CULTURAL, ECONOMICAL AND LEGAL DIMENSIONS

Most communities do not give land ownership rights to women, as land is mostly passed from father to son. A woman's right to land is only through marriage, but that does not confer to her security of tenure on the same land. The Law of Succession does not give a widow any land inheritance rights, although she can hold the land in trust for the children resulting from the marriage.

Widows' right to continue living on a husband's ancestral land is in some cultures (such as the Luo and Luhya) guaranteed by her acceptance of cultural practices like "wife inheritance" which may also spread HIV. Traditionally, indigenous land tenure systems protected

the access rights of all members of the community including women and children, who are now being disinherited rather than protected. Under the outdated 1882 Married Women's Property Act, division of property is not clearly defined. However, landmark cases have established that women are entitled to half of the family property in cases of death or divorce, but only if they can prove that they contributed to the household's welfare.

Whereas legislation may avail remedies, it does not stop abuse from happening. The invisible power of culture, beliefs and socialization is more deeply rooted than the visible power of the statutes, courts and Parliament. There is also indifference towards will writing, leaving widows and children vulnerable when it comes to inheritance of property.

Another barrier is lack of access to legal assistance due to lack of information and poor economic status of women. It is in this regard that SWAK comes to the aid of the affected through the paralegal program.

HUMAN RIGHTS AND HIV/AIDS

SWAK is an affiliate of Society for Women and AIDS in Africa (SWAA), which other than Kenya supports human rights projects in eleven West and Central African countries: Cameroon, Chad, Nigeria, Gambia, Ghana, Benin, Mali, Mauritania and Guinea, Liberia and Sierra Leone.

SWAA's main objective is to work towards finding out how best to get governments to adopt the model law on human rights and HIV/AIDS, which has been identified as a promising tool to reducing the pandemic's related stigma and discrimination.

Nationally, SWAK's mission is "to mobilise and empower women, girls and the greater community to reduce their vulnerability to HIV/AIDS through advocacy, networking and strengthening capacity within the community." The organisation has a branch and focal persons in each province, and boasts over 8000 members countrywide.

ADVOCACY

SWAK has been involved in Kenya's constitutional reform process, where it has submitted on issues of women's rights and HIV/AIDS and contributed to the UNAIDS 2006 report on Women and Property Rights in Kenya. The organisation has also participated in the development of the Kenya National HIV/AIDS Strategic Plan 2005-2010. Other efforts have included working with Human Rights Watch to highlight cases of property disinheritance in Kenya.

At the community level, nearly 400 paralegals have been trained up to date. The paralegals identify cases of human rights abuse and refer them for appropriate legal redress, as above illustrated with the case of Ruth. So far 108 cases of property disinheritance have been handled. Additionally, 25 community leaders were trained on Human Rights in 2006 and over 5000 community members reached through community outreaches.

* **MERCY WAHOME** is National Coordinator of the Society for Women & Aids in Kenya, SWAK. Contact: mwahome@swakenya.org. Website: www.swakenya.org/

The concept of community mediators has also been introduced. To this end 30 women and men were trained in 2007 to mediate on the numerous cases of property disinheritance to avoid having them end up in court. 10 cases have successfully been resolved using this method.

DIFFERENT LEVELS OF INTERVENTION

To complement the paralegal program, SWAK is involved in other interventions such as the Memory book program which assists parents living with HIV/AIDS to acquire knowledge and skills to develop supportive strategies that enable their children cope with the effects of Aids. This program includes training on will writing. SWAK has trained many of its members and built the capacity of other organisations as trainers of trainers (ToTs). 205 ToTs have been trained on the memory book, with an additional 2,500 parents trained by SWAK and other NGOs.

Another complementary intervention is the Male initiative, which advocates for the involvement of men to enhance HIV/AIDS activities including protection of women's right to property ownership. The initiative aims to foster greater awareness on the relationship between men's behaviour and HIV/AIDS, stimulate public debate on men and HIV/AIDS prevention, care and support, and encourage men to adopt safer sex practices to reduce the risk of infection among men and women. SWAK supports over 70 organisations for greater involvement of men.

The Ambassadors of Hope (AoH) program encourages and gives skills to HIV positive people to speak out in public and put a human face to AIDS. This contributes greatly to public education on the pandemic and reduction on stigma and discrimination. SWAK has trained over 1000 people living with Aids as ambassadors of hope on public speaking. Through public forums, schools and religious meetings AoH have reached over 2 million people advocating for the rights of people living with Aids.

NO BOY CHILD, NO LAND

By Zawadi Kaatano*

MY NAME is Zawadi Kaatano. I am 42 years old and a mother of four daughters who have borne three grandsons. In 1994, I went for a blood test to establish my health status after being attacked by a series of illness. The doctors told me that I had contracted the deadly HIV virus. In 1999 my beloved husband died, leaving me with four daughters. I was the second wife to my husband. The first wife was blessed to have six children, five males and one female. According to the traditions and cultures of Kagera people, each male was given a piece of land to own as an inheritance and was given responsibility to take care of one of his sisters. As I had no male child I was not considered in this process of land distribution together with my children. Due to this fact I was forced to leave my house to my father's house and leave my children to be taken care of by their brothers. But this was not possible. First of all, their brothers were too young to be able to take care to them. Therefore it was not possible to leave my children behind without any help. As I was not on good terms with the first wife, it was not possible for her to let her sons take care of my children. Additionally, the house in which I was married was given to one male child. Therefore, I had to leave with my children and go to my father's house where I was born.

... I HAD NOWHERE TO GO

My brothers welcomed me home, but with very difficult conditions. They claimed that, they

only know me as their sister, but I'm no longer of the "same blood" with them. I felt terribly bad and angry. But since I had nowhere to go, I stayed with them for only one week, then I left for a nearby town. There I met with a friend of mine whom we last met nine years ago. I managed to arrive at her place by asking several individuals on the way.

BEING A GRANDMOTHER BEFORE MY TIME

My friend welcomed me so warmly that I felt as if I was at home. She was living alone due to the fact that she was barren. She was kicked away by husband simply because she didn't conceive. She was earning a living through selling local brew. Through her help I managed to engage myself in casual labor in farms near the town. My friend helped me also to secure a room where I stayed with my children. During the evening, after my farm work, I joined my friend in selling local brews. I brought up my kids in this kind of situation. I believe the environment we live in contributed very much to the present situation. As a result of this environment, all of my children have been made pregnant by unknown men, without getting married. This is too much for me because I don't even know fathers of my grandsons. I hear that they were pregnant by married men who cannot marry them. I found myself being a grandmother before my time, and this is only because I didn't have opportunity to inherit a piece of land.

When I started attending counseling sessions with the World Vision in Kagera, I was very much encouraged. I came to realise that there are a lot of women who were in a situation like mine, but who still struggled to overcome and live on. We are desperate and hopeless simply because the society thinks that we have no right to own the land. Our own future and that of our kids have dashed into a crash and nobody seems to care.

*ZAWADI KAATANO was interviewed by Pelagia Katunzi, Kagera, 2001

Source

Reclaiming our lives: HIV and AIDS, women's land and property rights and livelihoods in southern and East Africa. Narratives and responses. Edited by Kaori Izumi. Cape Town 2006



Foto: SRK

Seiten 37-52

Prävention, Frauenrechte und Community Health

“At the same time, organizations should realize that the community led child care responses to the HIV and AIDS crisis provides a unique opportunity for a paradigm shift in the balance of power in communities in favor of children.”

Stefan Germann et al.

«ES DREHT SICH ALLES UM AIDS»

Was tun, wenn HIV und Aids eine ganze Gesellschaft bedrohen? Das Schweizerische Rote Kreuz (SRK) begegnet der dramatischen Situation im kleinen Königreich Swasiland mit einem innovativen Programm. Die Geschichte einer Pionierleistung.

Von Annette Godinez*

IN DEM IM SÜDLICHEN Afrika gelegenen Kleinstaat Swasiland mit rund einer Million Einwohnerinnen und Einwohnern hat sich Aids zur bedrohlichen Pandemie ausgeweitet: Insgesamt ist jeder dritte Erwachsene mit dem HI-Virus infiziert. Aids als gesellschaftliches Tabu und die Stigmatisierung der Kranken haben die hohe Verbreitung der Epidemie wesentlich begünstigt. Erst 1999 erklärte der König von Swasiland, Mswati III, die Krankheit zum «nationalen Desaster».

Dieser Schritt ermöglichte es dem SRK, seine Anstrengungen gegen die Krankheit zu verstärken. Angesichts der menschlichen Tragödien, die sich täglich abspielen, und der drohenden Gefahr eines Zerfalls der Gesellschaft war dies dringend notwendig. «Alles dreht sich um Aids», sagt Lilly Pulver, die bei der Internationalen Zusammenarbeit des SRK für Swasiland zuständig ist. «Jeder hat ein krankes Familienmitglied oder bereits einen engen Verwandten verloren. Die Krankheit ist allgegenwärtig. Es geht um die Rettung einer ganzen Nation.» Die Dauerbelastung der Menschen ist kaum vorstellbar. Welche Wege geht man im Umgang mit einer traumatisierten Gesellschaft?

VERTRAUEN SCHAFFT LICHTBLICKE IN DER KRISE Gemeinsam mit dem lokalen Roten Kreuz und den Gesundheitsbehörden von Swasiland setzt das SRK auf eine umfassende Eindämmung der Krankheit: Prävention, Heimpflege, psychologische Unterstützung und medizinische

Behandlung sind gleichermassen Teile des Programms. Die Weltgesundheitsorganisation (WHO) bezeichnete diesen Ansatz als vorbildliche, «optimale Strategie». Dank unermüdlischen, langfristigen Anstrengungen auf allen Ebenen sei das Vertrauen der Bevölkerung in die Arbeit des Roten Kreuzes langsam aber stetig gewachsen, sagt Lilly Pulver. Trotz der Krise, in der sich das Land befindet, schafft dieses Vertrauen Lichtblicke: «Die Betroffenen akzeptieren die antiretrovirale Therapie normalerweise gut und befolgen die strengen Regeln für die Einnahme der Medikamente», berichtet die Fachfrau. Alles andere wäre fatal: Die Bildung von Resistenzen gegen die Medikamente ist eine der grössten Gefahren im Kampf gegen Aids.

BAHNBRECHENDE THERAPIE AUCH FÜR LÄNDLICHE GEBIETE

Die Einführung der antiretroviralen Therapie 2004 in der Rotkreuz-Klinik von Sigombeni war einzigartig im ganzen Land und ein wichtiger Markstein in der Arbeit des SRK. Dabei geht es aber um weit mehr als «nur» um medizinische Hilfe: Das SRK schult Begleitpersonen zur psychologischen Unterstützung der Aidskranken und um zu gewährleisten, dass sie die Medikamente regelmässig und richtig dosiert einnehmen. In intensiven Vorgesprächen und mit offener Information werden den Patientinnen und Patienten alle Facetten der Krankheit und der Therapie aufgezeigt. Mit



Aids ist allgegenwärtig. Ein Rotkreuz-Pfleger hilft einer aidskranken Frau.

Erfolg: Heute sind rund 400 Menschen in Behandlung – 400 Menschenleben, die gerettet wurden und deren Kinder nicht als Waisen zurückblieben. Besonders wichtig ist die Therapie für werdende, HIV-infizierte Mütter: Dank den Medikamenten kann die Übertragung auf das ungeborene Kind verhindert werden. Inzwischen konnte das Rote Kreuz seine Tätigkeit auf weitere zwei Kliniken in Silele und Mahwalale ausweiten.

INVESTITION IN DIE HEIMPFLEGE

Mit der Pflege zu Hause und der Unterstützung der Kranken im Bereich der Ernährung trägt das SRK viel zum Wohl der Betroffenen und ihrer Angehörigen bei. So besuchen in Swasiland Freiwillige des Roten Kreuzes Aidskran-

ke, um sie im täglichen Leben zu unterstützen und zu pflegen. Für viele Kranke bildet die Hauspflege den einzigen Kontakt zur Aussenwelt und ist für ihre Angehörigen eine grosse Entlastung. Im Endstadium der Krankheit bedeutet die Heimpflege auch eine Sterbebegleitung. Der Einbezug des familiären Umfeldes ist auch deshalb wichtig, weil dadurch der Isolation der Patienten und der Stigmatisierung der Krankheit Aids entgegengewirkt werden kann.

Auch die Kinder von aidskranken Eltern schliesst das Rote Kreuz in seine Arbeit ein. Es gibt Nahrungsmittel für die ganze Familie ab und übernimmt die Schulgebühren von Aids-waisen. Diese schreiben ein besonders trauriges Kapitel: Rund 70000 Kinder haben bereits ihre Eltern verloren. Wer keine nahen Verwand-



Foto: SRK

Ein 10-jähriges Mädchen holt in der Rotkreuz-Klinik die monatliche Ration seiner Aids-Medikamente ab. Jedes Mal bespricht der Pfleger mit ihm die richtige Einnahme.

ten mehr hat, fristet auf der Strasse ein würdeloses Dasein. Oftmals springen die Grossmütter ein und übernehmen in aller Stille und ohne Hilfe die Verantwortung für die heranwachsende Generation.

PROSTITUTION FÜR EINEN LITER ÖL

Eine weiteres tragisches Schicksal betrifft die Frauen: Sie sind wesentlich häufiger mit dem Virus infiziert als die Männer. Die Verletzlichkeit der Frauen in dem stark patriarchalisch geprägten Land ist gross. Ihre gesellschaftlich schwache Stellung macht sie finanziell abhängig von ihrem Mann. Der Missbrauch in Form von Unterdrückung und Ausbeutung ist häufig.

«Manchmal prostituieren sich Frauen für einen Liter Öl», sagt Lilly Pulver. Der Weg in die Verelendung ist nicht weit. Und es entsteht ein Klima, in dem die Krankheit ungehindert grassieren kann.

Umso wichtiger ist die Präventionsarbeit an breiter Front, insbesondere bei der jungen Generation. Dabei setzt das SRK auch auf innovative Ideen: Clowns informieren auf spielerische Weise in Form von Mimik und Schauspiel über die Krankheit und ermutigen alle, sich testen zu lassen. «Jugendliche wollen eine Perspektive für die Zukunft», so Lilly Pulver. Im Engagement für sie schöpfen Lilly Pulver und ihr Team die grosse Kraft, die sie für ihre Arbeit brauchen: «Wir wollen Jugendliche fördern und aufbauen. Jede Förderung eines Individuums ist für uns ein Beitrag an das Gesundheitssystem im Land.» Und sie fügt an: «Welche Alternative haben wir? Nur wer vorwärts geht, kann überleben.»

*ANNETTE GODINEZ arbeitet als Redaktorin beim Schweizerischen Roten Kreuz, Internationale Zusammenarbeit. Kontakt: annette.godinez@redcross.ch

MOBILIZING AND STRENGTHENING COMMUNITY-LED CHILDCARE

This article presents findings from a study, involving over 778 respondents from 24 communities in 4 countries, where World Vision (WV) has supported community-led childcare initiatives. WV conducted the study from August to November 2006 with the aim of identifying the strengths and weaknesses of different types of community care groups (CCG), which are directly involved in child care, and community care coalitions (CCC) within different contexts in order to inform and guide World Vision (WV) and its partners' future programs to mobilize and strengthen community-led care for orphans and vulnerable children.

By S. Germann, F. Ngoma, R. Wamimbi, A. Clatxton, M. Gaudrault and the CCC Study Country Teams*

THE COMMUNITY CARE

coalition (CCC) is a foundational feature of World Vision's programming model for mobilizing and strengthening community-led care for orphans and vulnerable children (OVC), and people chronically/terminally ill. To date, WV facilitates and supports over 3700 such community care mechanism with over 934'500 orphans and vulnerable children being supported by those groups in 20 African countries. Findings indicate, that community led-child care established through strong community mobilization processes, well horizontally and vertically networked, are sustainable mechanisms for enhanced child well being at the community level. However, the quality of care depends largely on the quality of home visitors and the frequency of ongoing home visits. Home visitors have limited capacities in areas such as HIV and AIDS information, psychosocial care, local level service access advocacy, as well as child rights and protection. There is a need to enhance investment in training and strengthening the skill sets of home visitors. Organizational capacity build-

ing is an important step towards full ownership and sustainability of CCCs. Stronger, well established CCCs should start to mentor less established CCCs in the same geographical areas. WV needs to see such community-led child care initiatives not "just" as HIV and AIDS projects but as the foundation for long-term sustained and community owned child care and support institutions. Child participation in existing CCCs is either weak or absent. This general lack of children's participation in CCC processes provides significant challenges and opportunities for program innovation and development that have the potential to shift the balance of power in communities in favor of children. Children need to be seen by CCCs and home visitors as active participants and not just beneficiaries. It is important for CCCs to develop strong participation capacities to ensure full and meaningful child participation towards enhanced and sustained quality of life for all children in communities where CCCs exist.

INTRODUCTION

Life expectancy in many countries in East & Southern Africa has declined as a result of AIDS. This development has reduced the number of caregivers of optimum age. This shortage of prime-age adults has consequences for the next generation. Increasingly, instead of being cared for by uncles and aunts, many orphans and vulnerable children will grow up in households headed by elderly or adolescent caregivers. In most of Africa the extended family system was the traditional social security system. Family members were responsible for the protection and care of the vulnerable. Although the combined impact of urbanization, HIV/AIDS and poverty has weakened this social safety system, the extended family remains the predominant care giving unit for orphans in communities with severe epidemics. But the extended family is not a “social sponge” (see Figure 1) with unlimited capacity to care for an ever-increasing number of vulnerable children and orphans (Foster 2000).

Community-led care for vulnerable children, in the context of poverty, HIV and AIDS and other factors that negatively impact the ability of vulnerable families to adequately support their children, is a primary safety net in providing essential support for those children who have “slipped” through the safety net of

the extended family. Reinforcing the capacity of communities to provide care, support and protection is the basis of a response in support of children that will match the scale and long term impact of the compounding crisis of poverty, HIV and AIDS. The global multi-agency framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS, recognizes the importance of community care, one of the five key strategic response areas, in mobilizing and supporting community-led responses (UNICEF & UNAIDS 2004).

The Community Care Coalition (CCC) is a foundational feature of World Vision’s programming model for mobilizing and strengthening community-led care for orphans and vulnerable children (OVC), and people chronically/terminally ill. CCCs may have different names in different countries depending on the local context and what national OVC policies use to describe such care groups. CCCs are groups of individuals and/or organizations at the local level that join together for the common purpose of expanding and enhancing care for the most vulnerable children in communities. Those groups who provide care directly are called Community Care Groups; those who have mainly a coordination role are called Community Care Coalitions. CCCs typically

include representatives of churches and other faith-based organizations, the government, businesses, and other local NGOs/CBOs in the community. They support volunteer home visitors who provide ongoing care and support to OVC through regular home visits.

World Vision has worked to mobilize and build the capacity of over 3700 CCCs in 20 high prevalence countries across east and southern Africa. By the end of 2007, over 59’000 home visitors operating in these CCCs will jointly monitor and support over 934’500 vulnerable children (CHARMS 2006). As the CCC structure is intended to be flexible and adaptable to local contexts, the CCC has taken a variety of different forms. More than three years after the development of CCCs began, there was a need to conduct an in-depth study of the resulting strengths and weaknesses of the CCC structure as it has been implemented in various contexts. The findings of this study will substantially inform and guide WV and its partners’ future facilitation role of community-led care across Africa.

FOCUS OF THE STUDY

The main aim of this four country study was to identify the strengths and weaknesses of different types of community care groups (CCG) – directly involved in child care – and community care coalitions (CCC) –focused on coordination and networking – within different contexts in order to inform and guide World Vision (WV) and its partners’ future programs to mobilize and strengthen community-led care for orphans and vulnerable children in 20 African countries.

RESEARCH METHODOLOGY

The study had a qualitative nature and the information collected was analyzed under five domains of inquiry, namely:

- 1) Operational context and linkages,
- 2) WV inputs to community care groups and coalitions,
- 3) CCC structure, composition, organization and leadership,
- 4) CCC ownership and sustainability,
- 5) Enhanced orphans and vulnerable children’s well-being.

Two main sources of data were used: i) secondary documentation (National Plan of Action for

OVC, project outlines and reports) and ii) the views and opinions of a range of stakeholders, gathered through focus groups and key informant interviews using standard interviewing instruments. The instrument for use with children and youth involved a drawing activity as a supplemental means of understanding their perspectives. All interviews were digitally recorded.

The study sites were selected using random approaches from purposely-selected lists of CCC to include both community care groups and community care coalitions as well as different operational contexts such as grant funded vs. private funded, rural vs. urban / peri-urban and predominantly literate vs. predominantly non-literate.

The study involved a total of 24 CCCs/CCGs with a distribution of 6 sites in each of the four selected countries (Ethiopia, Mozambique, Uganda and Zambia). The study was led by a study coordinator and each country formed a study team that involved at least one independent researcher, staff from WV Africa’s regional HIV and AIDS team and staff from the respective country’s office. Fieldwork in each country consisted of at least 10 days of interviews and focus group discussions. Over 105 Focus Group Discussions (FGD) and 62 Key Informant Interviews (KII) with a total number of 778 study participants (716 in FGD / 62 KII) were involved in the study over the period of August to November 2006. 23 FGD involved orphans and vulnerable children.

STUDY RESULTS AND DISCUSSION

Results of the study are presented following the same five domains (see above) that were used for the data collection process.

DOMAIN 1

CCC MOBILIZATION, STRUCTURE AND CAPACITY

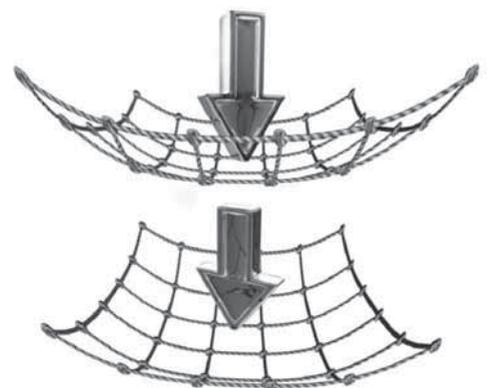
Mobilization: Results indicate that the quality of the CCC depends to a large degree on the inclusiveness and effectiveness of the initial community mobilization efforts. Good investment in the mobilization process in the beginning is critical for future ownership and understanding. The participation of traditional leaders in the CCC is also important in fostering and maintaining positive relationships with all stakeholders in the community. In most CCCs the research teams found that there was not suf-

Extended family safety net for orphans in Africa

Traditional Safety Net:
Aunts and Uncles

Alternate Safety Net:
Grandparents and other relatives

Children who slip through the Safety Net:



Child headed households

Street children

Domestic workers or other work

Source: Germann 2005 (Adapted from Foster 2000)

ficient participation of government representatives in CCCs. In CCCs where there was good, broad government stakeholder representation, the leverage of such CCCs was much stronger. Further, it was discovered that CCCs with a more diverse membership tended to show greater innovation in assisting children in the community. Participation of vulnerable children and youth was absent in almost all CCCs. This might be partly as a result of the language used in *The CCC Guide*, which refers to orphans and vulnerable children as *beneficiaries* rather than as *active participants*.

Structure: Local communities are adapting resource materials such as *The CCC Guide* (WVI 2003) to set up CCC structures that fit well into the local operational context. The local level implementing community care groups (CCGs) appear to enhance the participation and empowerment of less literate stakeholders, such as grandparents, and vulnerable community members, who seem to be intimidated by a higher-level coalition set up. There was also a risk of CCCs usurping the role of their member organizations because the CCC is often the most visible and powerful organization, receiving more support from WV than its members. This is not problematic when the CCC is only engaged in networking and coordination, however, when CCCs are mixing implementation and coordination, this situation has adverse effect on the CCC and its member organizations.

Capacity: CCCs and home visitors of CCGs demonstrate good capacity in the areas of broad child care and support, however in other areas such as HIV and AIDS information, psychosocial care, and child rights & protection, their capacities are much weaker due to insufficient training and capacity building at the level of volunteer home visitors. To date, CCCs only received very limited organizational capacity building support and formed part of the CCC guide that deals with community mobilization. There is broad consensus among all CCCs, national and other stakeholders that it is critical to strengthen CCCs with structured, ongoing organizational capacity building support. The capacity area of “beneficiary” participation, ensuring that orphans and vulnerable children, chronically ill, and others who benefit from CCC support, are fully engaged in planning, governance and implementation of the CCC, is weak.

DOMAIN 2 WORLD VISION INPUTS IN CCC PROCESS

Resource materials: Existing training resources and manuals such as *The CCC Guide* seem to be comprehensive and of good quality. There is a need to enhance the role of the psychosocial material *Journey of Life* as home visitors identified this as a major capacity gap. To strengthen the organizational capacity of CCCs, the draft Organizational Capacity Building manual needs to be made available.

Material support (Gift in Kind) & Grants: In Ethiopia and Zambia, WV is supporting some CCCs with materials in the form of Gift in Kind. Such material support ranges from seeds, fertilizers, home based care materials to clothing and food. Although such support meets certain needs of households, it has proven problematic within communities and among guardians in many cases. It appears that small grant support (piloted in Ethiopia and Mozambique) to CCCs that have sufficient organizational capacity, especially in the areas of project and financial management, is a more useful approach than for WV to provide material support. This enables CCCs to support partners and their home visitors with locally identified specific household needs at a specific time. Most households with orphans and vulnerable children found in the study are extremely poor and in need of material and/or cash support in addition to the benefits of home visits. In every study location both volunteers and guardians expressed frustration at the lack of material support at the household level. The area of how best to provide material support requires further study that includes a review of programs that use cash transfer as a means to address this important issue. Gift in Kind that focuses mainly on home based care materials, such as soap, gloves etc. are useful and seem not to create tensions within communities and households. Further, in settings where Gift in Kind support was carefully used as incentives for volunteers, it can be beneficial. This contributes to volunteer motivation but creates the risk that the number of volunteers will be predetermined by WV’s ability to budget and support these inputs, resulting in undermining the growth of CCG volunteer membership of home visitors.



Home Visit, 2007

Training: Many home visitors have only received 2-3 days, of the *CCC Guide* recommended 5-10 days, training. In most cases, there has been insufficient training provided by CCCs to home visitors. The cascading approach to training assists in scaling up the response of CCCs with the flip side that the content becomes diluted by the time the training finally reaches CCC members.

DOMAIN 3 LINKAGES

Horizontal: The strength of horizontal linkages depends largely on the quality of the initial community mobilization process. The better the mobilization and the more inclusive the membership, the better the links will be between all community stakeholders. Where links with government structures are weak, this usually represents missed opportunities for the CCC to access government services and sup-

port for members in supporting OVC. In many situations, CCCs are not well integrated into other WV developmental activities in the same community as CCCs are still often seen by the community and WV local staff as an “HIV and AIDS” response, rather than as a critical community platform for care and support regardless of cause.

Vertical: Vertical links (District level) have generally proven difficult. Most existing CCCs presently do not have the size, capacity or budgets to engage effectively with district-level bodies. To date most CCCs are usually dependent on WV to facilitate these links. Those CCCs that have successfully established vertical linkages have experienced positive results. As an example, some CCCs are now accessing government grants that are available at the district level for care and support. Such funds are either from the World Bank or the Global Fund.

**DOMAIN 4
IMPACT OF CCC ACTIVITIES**

Community/Volunteer level: Across all CCCs in the study, there is evidence of improved community sensitization to the needs of orphans and vulnerable children in the community. There is also an increasing perception that the challenge of orphans and vulnerable children requires a concerted community effort and should not be left to individual struggling households. CCCs and communities that were involved in the *Channels of Hope* program (a participative process to work with faith-based communities for a transformed understanding of HIV and AIDS) seem to have a transformed understanding especially in the areas of stigma and discrimination. It appears beneficial to include in the community mobilization elements of the *Channels of Hope* program.

All CCCs have been successful in mobilizing volunteers. As indicated, in over 3700 CCCs in 20 countries in Africa, over 59'000 volunteers operate as home visitors. The frequency of their visits vary, the consensus seems to be that weekly or bi-weekly visits are reasonable depending on distances between homes to visit. More frequent visits would be a burden on volunteer home visitors. Personal faith and the desire to make a difference in the community and the lives of vulnerable children were stated as the key motivating factors for carrying on the home visitations for years to come.

Child level: The importance, value and impact of home visits cannot be overstated. All children participating in the study stated that even when home visitors are unable to provide any form of material support that they greatly value the visits. It is however important to them to receive such visits at least twice per month and in a sustained manner. The quality and integrity of the home visitors was important to the children and affected their ability to share their concerns with home visitors. One of the most significant findings of the study is related to the impact of CCCs on children. In almost all interviews at the community level (home visitors, children, CCC members, local government) across all four countries, respondents stated that since the CCC or CCG started operation in the community, they have experienced a general increase of orphans and vulnerable children accessing education, health services, birth registration and other services and

rights that had previously been denied or were out of reach for vulnerable children in the community. This is important and indicates that despite many shortcomings in quality of mobilization, training and capacity building, coordinated community-led care responses have a positive impact on perceived child-well being at the community level.

**DOMAIN 5
OWNERSHIP & SUSTAINABILITY**

Ownership: Despite WV and *The CCC guide's* special attention and efforts to ensure and encourage community ownership, many CCCs struggle to experience and communicate an identity independent of WV, and have not yet developed a full sense of ownership by the community. It is evident that the strength of community ownership is linked with the degree and effectiveness of community mobilization and the quality of WV staff to facilitate that process. When staff is sensitive to the "small pitfalls and traps" that undermine ownership and carefully negotiate through this process in a manner that from the beginning lets the community own the process and outcomes, level of ownership is high. When staff is mainly focusing on "getting the job done" and establishing a CCC that reports upwards on results based performance, then shortcuts in mobilization are more likely and this reduces the level of ownership experienced by the CCC. The area of monitoring data collection is an additional sphere where ownership of CCCs can be easily undermined. In some settings, CCCs were using monitoring forms for home visitation that had the WV logo on them. Albeit a detail, such a factor can easily undermine ownership. The area of monitoring is a challenge. On one hand, WV, as a facilitator of the process requires some limited reporting data for national level performance and for grant and private donor reporting. On the other hand, the moment WV "demands" from the CCC monitoring data, the issue of ownership is put in question. It requires experienced, quality WV staff at the local level, to be able to manage such tensions in a manner that does not undermine ownership of the often still-nascent CCC and CCG organizations.

Sustainability: While voluntarism appears to be genuine and is seen as the key sustainability factor for CCCs, there are various additional

**IMPACT OF COMMUNITY CARE COALITIONS
ON IMPROVED CHILD WELL BEING AND ACHIEVEMENTS
OF CHILD RIGHTS IMPLEMENTATION**

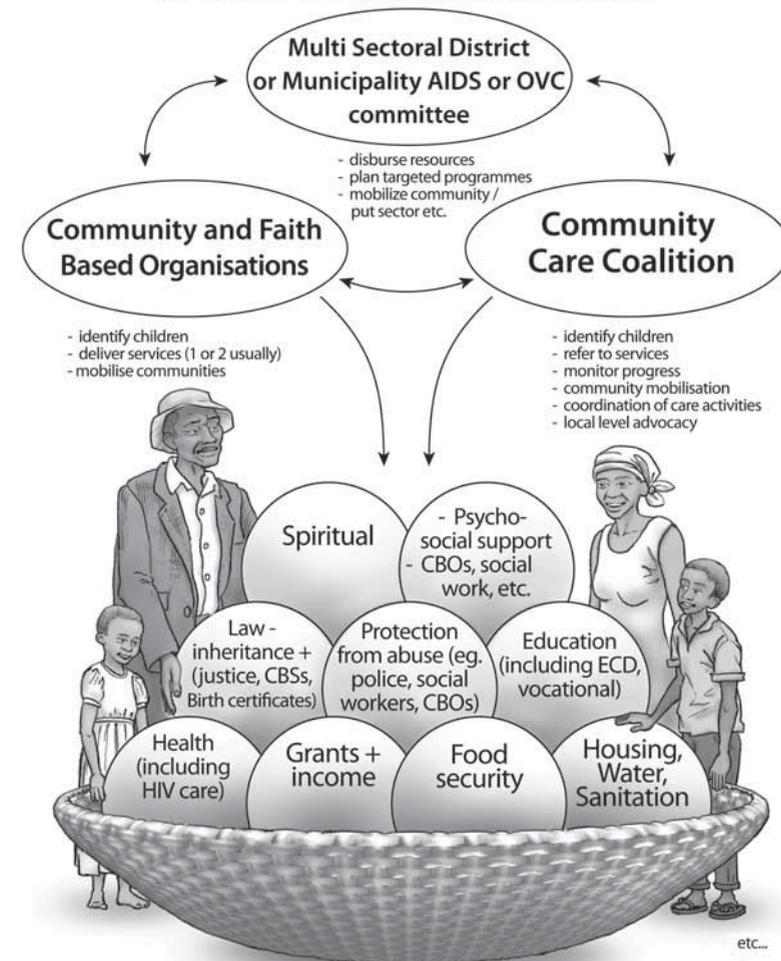


Diagram © 2007 Stanley Watt/World Vision

factors that contribute to the sustainability of CCCs. These are

- 1) improved vertical linkages to government district structures,
- 2) the involvement of community leadership (in rural context, traditional leadership) combined with the strong community demand for the CCC/CCG and home visitor services and support,
- 3) increased investment in home visitor training and organizational capacity building at the CCC and CCG level and

4) as the organizational capacity of CCC increases, their ability to access funding through local, district (decentralized funding from World Bank, Global Fund and others), national and even international fundraising, income generating activities, government sub-contracting of care and support and expanding social protection schemes.

PROGRAM IMPLICATION AND CONCLUSION

The level of investment and quality of the initial community mobilization process is critical to ensure a strong foundation for the CCC to operate as a sustainable, community-owned child and community care entity. CCC membership should be as multi-sectoral as possible and needs to include participation of orphans and vulnerable children and people living with HIV. It is suggested that CCCs set up program advisory sub-groups that include children and PLWH,

and provide monitoring support of home visitor quality and are part of home visitor recruiting / vetting panels at the community level.

World Vision successfully managed to scale up across 20 countries over 3700 CCC/CCGs. However, it is important to maintain the balance of scale-up with quality implementation. Organizations involved in scale-up need to enhance investment in training and capacity building of volunteer home visitors. This requires sufficient quality field staff with adequate time to facilitate mobilization efforts, provide quality training and hands-on local level capacity building with CCCs, CCGs and home visitors. For some organizations this may require a shift in focus, mainly from seeing the work with CCCs not as a HIV and AIDS project, but as a key programmatic focus, towards achieving sustained quality of life for children.

Therefore, an important programming area for the future is to resource and facilitate a long-term process of organizational capacity building with CCCs. There should be a special focus on enhancing ownership and the ability of CCCs to manage small grants. Once a CCC has grant management capacity, support organizations such as World Vision, should link the CCC to existing grant makers and/or set up grant making mechanisms at the national level for CCCs to access small grants.

CCCs have an important role to ensure horizontal and vertical networking of all stakeholders that need to be engaged in community and child care issues. Whilst CCCs presently operate well on the horizontal level of linking and networking, there is a need to strengthen the capacity of CCCs to link vertically with district and national structures.

The quality of home visitors is the main determining factor for how community-led child care impacts the quality of life of orphans and vulnerable children. Children have contextual preferences to the type of person they would like as home visitors. It is therefore imperative that children are consulted about the selection and allocation of particular home visitors. The general lack of children's participation in CCC processes provides significant challenges and opportunities for program innovations and developments that have the potential to shift the balance of power in communities in favor of children. According to Lena Dominelli: "It is critical pursuing the objective of em-

powering children because these can make caring for children a responsibility that can be discharged by a large group of people which are not necessarily related to children through kinship ties, but who, nonetheless, accept that they have a duty of care towards them. These people are those living in the same community as them and who share with them a number of attributes and social links rooted in interdependence, reciprocity and citizenship. For adults to share a reciprocated interdependent citizenship with children requires the empowerment of children, that is, their being treated as citizens from birth." (Dominelli 1999)

In conclusion, community-led childcare in the form of community care coalitions and care groups is a powerful, sustainable mechanism to match the scale and long-term impact of the HIV and AIDS crisis. At the same time, organizations should realize that the community led child care responses to the HIV and AIDS crisis provides a unique opportunity for a paradigm shift in the balance of power in communities in favor of children. However, for this shift to take place, it is critical for CCCs to develop strong participation capacities to ensure full and meaningful child participation towards enhanced and sustained quality of life for all children in communities where CCCs exist.

***DR. S. GERMANN** teaches at the Nelson Mandela Metropolitan University, Port Elizabeth and is Director for Learning and Partnerships at World Vision International Global in Geneva. Contact: stefan_Germann@wvi.org

F. NGOMA, R. WAMIMBI AND ANN CLAXTON are World Vision Africa Regional HIV AND AIDS Team Advisor for OV in, Lusaka Zambia

M. GAUDRAULT is consultant in Mozambique.

References

- Ankrah, E.M. (1993). The impact of HIV and AIDS on the family and other significant relationships: the African clan revisited. In: *AIDS Care* 5:5-22.
- Charms (2006). Core HIV and AIDS Response Monitoring System. Database to track WVI. HIV AND AIDS key indicators. Federal Way: World Vision International.
- Dominelli, L. (1999). Empowering children: The end-point for community approaches to child welfare. In Dominelli, L. (Eds.), *Community Approaches to Child Welfare*. Aldershot: Ashgate.
- Donahue, J & Mwewa (2006). Community action and the test of time: Learning from community experiences and perceptions. Case studies of mobilization and capacity building to benefit vulnerable children in Malawi and Zambia. Washington: USAID.
- Foster, G. (2000). The capacity of the extended family safety net for orphans in Africa. In: *Psychology, Health and Medicine* 5(1):55-62.
- Foster, G & Germann, S. (2002). The orphan crisis, in *AIDS in Africa*, edited by M Essex. New York: Kluwer Academic & Plenum Publishers.
- Foster, G, Shakespear, R, Chinemana, F, Jackson, H, Gregson, S, Marange & Masumba, S. 1995. Orphan prevalence and extended family care in a peri-urban community in Zimbabwe. In: *AIDS Care* 7:3-17.
- Gaudrault, M. (2006). *Community Care Coalition Study Guide*. Port Elizabeth: World Vision International Models of Learning.
- Germann, S. (2006). An exploratory study of quality of life and coping strategies of orphans living in child-headed households in the high HIV AND AIDS prevalent city of Bulawayo, Zimbabwe. Pretoria: University of South Africa.
- Ntozi, JPM. 1997. AIDS morbidity and the role of the family in patient care in Uganda. In: *HealthTransit Review* 7(suppl):1-22.
- Piot, P & Bartos, M. (2002). The epidemiology of HIV and AIDS, in *AIDS in Africa*, edited by M Essex. New York: Kluwer Academic & Plenum Publishers.
- Unicef & UNAIDS (2004). *The Framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS*. New York: UNICEF.

PROGRÈS MÉDICAUX ET DIFFICULTÉS SOCIALES

Sous le titre «si les mères vont bien, les enfants vont également bien», IAMANEH Suisse apporte son soutien à des actions visant à améliorer la santé des femmes et des enfants. Au Burkina Faso, elle collabore depuis 2000 avec l'association AMMIE (Appui Moral, Matériel et Intellectuel à l'Enfant) dans le cadre d'un projet permettant d'améliorer les conditions de vie et donner des perspectives à des filles mères et leurs enfants.

De Diallo Djénèba, Traore Arouna et Viviane Fischer*

MALGRÉ UNE ÉVOLUTION positive de la prévalence du VIH/SIDA au Burkina Faso, la majorité des personnes touchées par l'infection sont des femmes. Dans ce contexte, les filles mères représentent un groupe particulièrement vulnérable. En effet, une fille mère infectée souffre d'une double stigmatisation: de part l'infection du VIH/sida et de par son statut de fille mère. Une prise en charge globale est nécessaire, qui prenne aussi en compte la (re)valorisation du rôle de la femme, au sein de sa famille et de la société.

ÉVOLUTION DE LA LUTTE CONTRE LA PANDÉMIE DU VIH/SIDA AU BURKINA FASO

Depuis 1996, les progrès dans le domaine de la thérapeutique antiretrovirale (ARV) se sont traduits par un changement clinique majeur et très rapidement perceptible avec une réduction de près de 80% du nombre des décès, du nombre de cas de sida et de l'incidence des infections opportunistes. Les HAART (Highly Active Antiretroviral therapy) ont radicalement transformé le pronostic d'une infection rétrovirale, dont l'histoire «naturelle» était létale chez plus de 90% des malades, en une infection chronique n'entraînant pas un déficit immunitaire significatif. L'accès à la trithérapie est une réalité aujourd'hui dans les pays à faible revenu de-

puis la Session extraordinaire de 2001. L'Organisation mondiale de la santé (OMS) estime ainsi que l'extension de l'accès aux traitements a permis d'éviter entre 250 000 et 300 000 décès entre 2003 et 2005 dans ces pays.

Le Burkina Faso compte parmi les pays où on assiste à une baisse de la prévalence avec une stabilisation de l'infection de 2001 à nos jours. La prévalence était estimée à 6,5% en 2001 et est de 2% depuis 2006. Ces progrès sont à l'actif de l'implication effective des autorités politiques à travers le conseil national de lutte contre le sida et les IST (CNLS/IST) et la forte mobilisation communautaire.

Plus de 50 structures de santé, réparties sur toute l'étendue du territoire, font la prise en charge médicale avec dispensation des ARV. De plus, une centaine d'associations et ONG de lutte contre le SIDA interviennent dans la prévention et certaines mêmes offrent la prise en charge globale des patients, avec prescription d'ARV.

VULNÉRABILITÉ SOCIALE ET ÉCONOMIQUE DES FEMMES PORTEUSES DU VIH/SIDA

Les femmes sont les premières à faire le dépistage du VIH/Sida et la majorité des malades dans le pays est constituée de femme (67,8%). Ces femmes sont pour la plupart très jeunes,

avec un âge moyen de 26 ans et sont régulièrement confrontées à des problèmes de stigmatisation. Plus de la moitié est veuve ou célibataire, posant le problème de procréation et d'intégration dans la vie sociale (mariage, épanouissement économique). La plupart désirent se marier ou se remarier et avoir des enfants pour satisfaire à ce devoir social mais malheureusement, du fait de leur statut, aucun partenaire ne veut s'engager avec elles. Certaines ont été rejetées par leurs propres parents, d'autres par leurs conjoints car accusées d'être la source de contamination. Elles sont donc répudiées soient de la famille paternelle ou du domicile conjugal, souvent dépossédées de tous les biens au décès du conjoint. Sur le plan économique, elles sont également très vulnérables. Nombreuses sont celles qui n'ont aucun revenu et donc éprouvent d'énormes difficultés pour s'alimenter, se soigner et subvenir aux besoins de bases.

LES FILLES MÈRES: UN GROUPE PARTICULIÈREMENT VULNÉRABLE

La stigmatisation ne concerne cependant pas uniquement les femmes porteuses du VIH/Sida. En Afrique, avoir des enfants hors mariage est perçu par la communauté comme une honte et une fille qui tombe enceinte est généralement rejetée par sa famille. «Si tu as un enfant sans être mariée, les gens te considèrent comme une personne de mauvais caractère; une vaurienne; tu peux plus avoir un foyer,» explique Mariam, jeune fille mère qui fait partie du projet AMMIE (*). Le nombre de filles mères est cependant élevé et s'explique par l'environnement économique et social: la grande pauvreté et le manque de connaissances et d'information, surtout en ce qui concerne la planification familiale et la sexualité. Dans cette lutte pour la survie, les jeunes filles cherchent par tous les moyens à subvenir à leurs besoins fondamentaux et les relations sexuelles sont souvent perçues comme une opportunité. Les conséquences sont cependant dramatiques pour leur santé: maladies sexuellement transmissibles (MST), VIH/sida, avortements clandestins dans de mauvaises conditions, avec de graves séquelles ou aboutissant parfois à la mort. Celles qui n'ont pas pu avorter se retrouvent sans assistance, souvent rejetées par leurs familles, avec des enfants non désirés et dont la paternité est souvent contestée. Elles se re-

trouvent dans des situations encore plus précaires et leurs enfants sont à leurs tours exposés à la malnutrition, aux maladies, à la sous-scolarisation et à la délinquance. Mariam constate: «Il y a des gens qui regardent les filles mères comme des poubelles et ils ont raison; tu es dans la souffrance, tu n'as pas à manger, tu t'habilles mal, les gens ne peuvent pas te respecter.»

La pandémie du sida contribue à assombrir davantage ce tableau et fragilise d'autant cette couche de la population très vulnérable: une fille mère qui est aussi infectée par le VIH/sida souffre d'une double stigmatisation: de par la maladie et son statut social.

UNE PRISE EN CHARGE GLOBALE DES FILLES MÈRES

A Ouahigouya, au nord du Burkina Faso, l'association AMMIE est leader dans la lutte contre ce fléau et la prise en charge des personnes infectées par le VIH (PVVIH). Elle dispose d'un centre de dépistage volontaire anonyme et d'un centre médical de prise en charge des PVVIH. Le nombre total de malades suivis était de 1168 à la fin du premier trimestre 2008, avec 445 sous traitement ARV.

À côté du centre de dépistage volontaire anonyme et de prise en charge médicale des PVVIH, l'association AMMIE a mis en place en collaboration avec IAMANEH Suisse un projet spécifiquement destiné aux filles mères. Ce dernier contribue à travers différentes activités à l'amélioration de la situation de vie des filles mères et de leurs enfants, ainsi qu'à la prévention de telles situations. 50 filles mères participent pendant 3 à 5 ans au programme qui s'appuie sur 3 volets: la prévention et prise en charge médicale, la formation (élémentaire et professionnelle) et l'intégration économique. L'objectif est d'amener ces filles en situations difficiles et exposées à se protéger contre les maladies sexuellement transmissibles (MST) et le VIH/sida et leur donner des perspectives pour l'avenir par la mise en place d'activités génératrices de revenus et d'un suivi professionnel. Un appui important revient aussi à leurs enfants pour la scolarisation et l'alimentation. «Moi, avant, je voulais faire du commerce mais je n'avais pas d'argent, mais grâce à AMMIE, je le fais maintenant. Je n'avais pas les moyens pour m'occuper de mes enfants...»

LA VALORISATION SOCIALE DES FEMMES: LA CLÉ DE LA RÉINTÉGRATION

L'autonomie financière des participantes par l'acquisition d'un revenu joue un rôle important dans la valorisation sociale mais n'est cependant pas suffisante pour une réintégration sociale. La revalorisation du rôle de la femme passe aussi par une amélioration de son statut, aussi bien dans la société que dans la famille. Une part importante du projet concerne ainsi aussi des activités de sensibilisation destinées à un public élargi sur la problématique des filles mères et des personnes vivant avec le VIH/SIDA.

Au-delà des connaissances, attitudes et pratiques dans le domaine de la santé de la reproduction et des activités génératrices de revenu, le projet a d'autres effets sur les bénéficiaires et sur la communauté dans laquelle elles vivent. Il permet de modifier non seulement le regard et la perception que les autres ont sur les filles avant leur prise en charge mais également la vision qu'elles ont d'elles-mêmes. De participer à un projet au sein d'un groupe vivant des problèmes similaires renforce aussi la solidarité entre ses membres. L'estime de soi et la confiance en soi sont améliorées et la vision de l'avenir change de façon positive. «Grâce à AMMIE, ce n'est pas la peine de quitter la ville. Ce projet nous aide beaucoup et nous avons eu un changement dans nos vies. C'est les hommes même qui vont courir derrière nous,» déclare Fanta.

(*) Toutes les citations sont tirées d'interviews réalisés avec des filles mères dans le cadre d'une évaluation externe

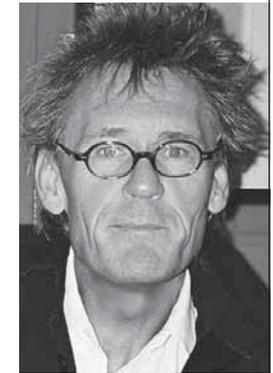
* **MME DIALLO DJÉNÈBA** est la coordinatrice du projet «Filles – mère» mis en place par AMMIE en collaboration avec IAMANEH Suisse à Ouahigouya. Contact: ammie@fasonet.bf

* **DR TRAORE AROUNA** est le médecin responsable du centre de dépistage et de prise en charge médicale des PVVIH d'AMMIE à Ouahigouya. Contact: ammie_ohg@yahoo.fr

* **VIVIANE FISCHER** est chargée de programmes d'IAMANEH Suisse à Bâle. Contact: vfischer@iamaneh.ch

DOWN WITH UNAIDS, UP WITH HEALTH

Why do we have a UN agency for HIV and not for pneumonia or diabetes, each of which kills more people? UNAIDS should be dismantled rapidly, because its single-issue campaigning is distorting global health spending and betraying the world's poor, writes **ROGER ENGLAND*** for the MMS Bulletin.



As the biennial international AIDS industry conference gathers 25,000 delegates in Mexico, a wind of change is blowing. UNAIDS, the UN's AIDS advocacy body, stands accused of exaggerating the threat of AIDS, wasting billions on "preventing" epidemics that were never going to happen and undermining basic healthcare in Africa by diverting ever-larger funds to HIV/AIDS.

The impending change of leadership of UNAIDS provides an opportunity for fresh thinking. That is why I am a candidate for the position. My platform is to dismantle the organisation constructively, to help ensure that HIV spending is balanced with that on other equally pressing diseases through stronger primary health care.

No one is denying that HIV/AIDS is a serious problem: it has hit some sub-Saharan African countries hard, particularly South Africa. Globally, however, its impact is less severe. The number of the annual two million deaths from HIV is about the same as the number of under-fives who die in India from easily preventable diseases like pneumonia.

But while HIV causes only 3.7% of global mortality, it receives 25% of all health aid plus a big chunk of domestic expenditure. At its worst, in sub-Saharan Africa, HIV/AIDS constitutes less than 20% of the disease burden, an average that is skewed upwards by South Africa's high prevalence. Yet globally HIV/AIDS receives 40% of health aid – US-\$ 4.6bn in 2006, and rising. HIV/AIDS aid now often exceeds total domestic health budgets.

For years, activists have justified this disproportionate spending by claiming that HIV/AIDS is exceptional: a disease of poverty, a developmental catastrophe and an emergency demanding wide-ranging UN intervention.

These claims have now been demolished. New data from Africa show that prevalence is highest among the middle classes and more educated. Although HIV can tip households into poverty and constrain national development, so can all serious diseases and accidents. Prevalence in Africa has peaked and rates in Asia are far lower than projected by UNAIDS.

The UNAIDS claim that HIV is a "potential threat to the survival and well-being of people worldwide" is sensationalist. As the World Health Organisation's head of HIV stated last month, "it is very unlikely there will be a heterosexual epidemic" outside sub-Saharan Africa.

A MEDICAL APARTHEID

The success of UNAIDS advocacy is constraining improvement in basic health services in the poorest countries. Excessive HIV funding has created two-tier health systems, a kind of medical apartheid in which HIV patients receive treatment free, while non-HIV patients pay for sub-standard services.

HIV funding also by-passes countries' institutions, creating parallel financing, employment and systems, thus entrenching bad management and creating duplication and waste.

The USA in particular is at fault: its HIV programme PEPFAR has flooded 15 countries with HIV-dedicated resources, attracting staff and skills away from other needs. And the Global Fund to Fight AIDS, TB and Malaria is not far behind.

Although UNAIDS has now reduced world HIV estimates from 39.5 million to 33.2 million, it is still calling for huge increases in annual spending, from US-\$ 9 billion today to US-\$ 42 billion by 2010 and US-\$ 54 billion by 2015.

Flooding the world's poorest countries with foreign currency on this scale would cause inflation and push up interest rates – a de facto tax on the poor. As an advocacy body, it is hardly surprising that UNAIDS wants more money but its demands look increasingly absurd.

CRISIS OF PRIMARY HEALTH CARE

While the AIDS industry grows fatter, primary healthcare in the poorest countries is in crisis. As Mozambique's health minister Paulo Ivo Garrido wrote last year: "The reality in many countries is that funds are not needed specifically for AIDS, tuberculosis or malaria. Funds are firstly and mostly needed to strengthen national health systems so that a range of diseases and health conditions can be managed effectively."

Time is up for UNAIDS. Why do we have a UN agency for HIV and not for pneumonia or diabetes, each of which kills more people? UNAIDS should be dismantled rapidly, because its single-issue campaigning is distorting global health spending and betraying the world's poor. Its useful monitoring function can be transferred to the World Health Organization.

This will be resisted strongly. The world-wide HIV industry has become a monster with too many vested interests and reputations at stake, too many single-issue NGOs and too many rock stars with AIDS support as a fashion accessory. In Mozambique, there are 100 times more NGOs devoted to HIV/AIDS than to maternal and child health.

With UNAIDS dismantled, international donors can concentrate on strengthening health systems by providing sustained and predictable funding. This will be good for all poor people, not just those with HIV/AIDS.

* **ROGER ENGLAND** is Chairman of the Health Systems Workshop, an independent think-tank promoting health systems reform and strengthening in poor and middle-income countries. He has worked for several international agencies including secondments to the World Bank and the World Health Organization. Contact: roger.england@healthsystemsworkshop.org

PLEASE COMMENT

What do you think about Roger England's point of view? Send your opinion to Medicus Mundi Switzerland: martin.leschhorn@medicusmundi.ch.

MAGAZIN

MEDICUS MUNDI SCHWEIZ

MMS MITGLIEDERVERSAMMLUNG 2008 IM MUSEUM NEUHAUS IN BIEL

STRATEGISCH LUFT HOLEN

Martin Leschhorn Strebel

Am 29. Mai versammelten sich die Mitglieder von Medicus Mundi Schweiz (MMS) zu ihrer jährlichen Versammlung. Eine Gelegenheit, zurück und voraus zu blicken und viele Bekannte wieder zu sehen, die das Netzwerk Gesundheit für alle lebendig erhalten.

Die diesjährige Mitgliederversammlung fand in einer für das Netzwerk wichtigen Zwischenphase statt. MMS steht mitten in einer Selbstevaluation, welche die Grundlage einer neuen Mittelfriststrategie für die Jahre 2009–2011 bildet. Zudem stehen wichtige Vertragsverhandlungen mit der Direktion für Entwicklung und Zusammenarbeit (DEZA) bevor. In diesem Zusammenhang prüft der Vorstand auch die Schaffung einer zweiten Fachplattform. Im Rückblick auf fünf Jahre aidsfocus.ch, der bereits bestehenden, erfolgreichen Plattform zu HIV/Aids und internationaler Zusammenarbeit, zeigte die MMS Geschäftsführerin Helena Zweifel die Möglichkeiten und Grenzen dieser Form des Austausches auf.

Ein wichtiger Schritt war die Aufnahme der operativen Tätigkeit der Geschäftsführung von Medicus Mundi International (MMI) auf dem Sekretariat in Basel. Der MMS Präsident, Thomas Vogel, stellte fest, dass die Übernahme der MMI Geschäftsstelle durch MMS bereits zu einer deutlichen Belebung des internationalen Netzwerkes geführt habe. An der Mitgliederversammlung vermittelte Thomas Schwarz als MMI Geschäftsführer den neuen Wind gleich selbst und berich-

tet über die primären Aktionsfelder, auf welchen MMI zurzeit aktiv ist: Human Resources for Health, Positionsbestimmung unter nicht-staatlichen Organisationen in Gesundheitssystemen, angepasste Technologie und das Zusammenspiel von Wissenschaft und NGOs. Thomas Vogel verspricht sich von der Arbeit der Geschäftsstelle, die MMS als Mandat führt, einen Mehrwert für die Schweizer Mitgliedorganisationen.

Nachdem die Mitglieder an der letztjährigen Versammlung verschiedene Modelle für die finanziellen Beiträge ans Netzwerk diskutiert hatten, schlug der Vorstand der diesjährigen Mitgliederversammlung eine moderate Erhöhung der Beiträge um 100 Franken vor. Die vertretenen Organisationen nahmen den Vorschlag ohne grössere Diskussionen an. Mehr zu reden gab der zweite Vorschlag, die neue Beitragsstruktur für die Einzelmitglieder. Nicht in Frage gestellt



Foto: MMS

MMS Vize-Präsident Edgar Widmer im Gespräch.

RÜCKBLICK AUF DEN MMS WORKSHOP «BEZAHLT ODER UNBEZAHLT – WIR ALLE ARBEITEN PROFESSIONELL»
VOM 29. MAI 2008

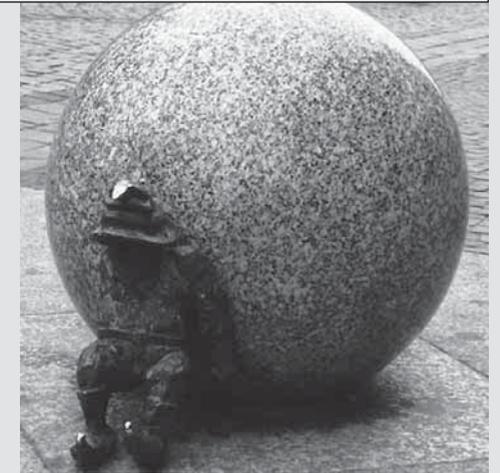
«EXPERTINNEN» DER ZUSAMMENARBEIT

Helena Zweifel

Angeregte Diskussionen und Gespräche zeichneten den Workshop von Medicus Mundi Schweiz aus. Herausforderungen, Freuden und Probleme der Zusammenarbeit von ehrenamtlichen/freiwilligen und angestellten MitarbeiterInnen – bei diesem Thema sind alle «ExpertInnen».

Meist stehen bei Diskussionen über die Zusammenarbeit von Ehrenamtlichen und Angestellten die Probleme, Konfliktpunkte und Frustrationen im Zentrum. Der Workshop von Medicus Mundi Schweiz packte das Thema anders an. Der Moderator Dominique Steiner forderte die zwölf TeilnehmerInnen auf, von den Erfolgserlebnissen in der Zusammenarbeit – den «Juwelen» – zu berichten. Und deren gab es viele. Eine Teilnehmerin erzählte von der Organisation eines Solidaritätsfestes, an der viele Freiwillige mitwirkten und tolle Ideen einbrachten. Ein anderer sprach von Momenten der Zusammenarbeit zwischen ehrenamtlichem Vorstand und den MitarbeiterInnen, welche von gegenseitigem Vertrauen und der Freude am gemeinsam Erreichten geprägt waren. Die Zusammenarbeit wurde zum Erfolg, da die Verantwortlichkeiten klar waren und auch eingehalten wurden.

Klarheit, zwischenmenschliche Beziehungen und Anerkennung kristallisierten sich als die zentralen Elemente des Erfolgs heraus. Diese drei Kernthemen gingen die TeilnehmerInnen in drei Arbeitsgruppen vertieft an, in welchen sie Wissen, Erfahrungen und Wahrnehmungen miteinander teilten, darüber reflektierten und



zu geteilten Einsichten und gemeinsamer Analyse verfestigten. Alle Beteiligten brachten viele Kenntnisse und Erfahrungen in diesem Gebiet der Zusammenarbeit ein – sie waren selbst die «ExpertInnen». Die erarbeiteten Poster können als Checklisten für die Arbeit in der eigenen Organisation dienen.

In der Evaluation fragte der Moderator nach den Früchten, die die TeilnehmerInnen mit nach Hause nehmen, den Sprossen, die noch etwas reifen sollten, und den welken Blättern, die sie nicht mehr brauchen würden. Ein sehr bunter, fruchtbarer Baum entstand. Eine der TeilnehmerInnen, voll mit neuen Ideen und Anregungen, wünschte sich mehr Zeit, um die Erkenntnisse zu sortieren und für die Umsetzung in der eigenen Organisation zu konkretisieren. Eine kleine Organisation, die gleich mit vier Leuten aus Vorstand und Team vertreten war, nahm die Gelegenheit wahr, in der abschliessenden Gruppenarbeit die nächsten Schritte festzulegen.



wurde die grundsätzliche Idee, den individuellen UnterstützerInnen eine abgestufte Form der Unterstützung anzubieten. Sollen StudentInnen nun aber weniger oder Verdienende mehr bezahlen? Schliesslich stimmte die Mitgliederversammlung dem vorgeschlagenen Modell deutlich zu.

Die Mitglieder liessen sich von Charles Sennesse die Organisation African-European Medical and Research Network (AEMRN) vorstellen. AEMRN wurde als 47. Organisation im Netzwerk herzlich willkommen geheissen. Die vor allem von AfrikanerInnen geprägte Organisation wird eine afrikanische Sichtweise auf die internationale Gesundheitszusammenarbeit einbringen.

Alle zwei Jahre wählen die Mitglieder den Vorstand. Ausser Andrea Isenegger, die sich mit Médecins Sans Frontières für einen mehrjährigen Einsatz in Kirgistan befindet, liessen sich alle in ihrem Amt bestätigen. Dies sind: Thomas Vogel (Präsident), Edgar Widmer (Vizepräsident), Vreni Wenger (Quästorin), Anna Beck, Beat Stoll, Bettina Schwethelm und Carlo Santarelli.

Der statutarische Teil ist wichtig – doch was wäre die Mitgliederversammlung ohne den Apéro im schönen Garten des Museum Neuhaus' und ohne das gemeinsame Nachtessen im Anschluss an die Versammlung? Eine trockenere Gelegenheit, ohne die Momente der Begegnung, des Austauschs und des Netzwerkelns – dafür ist MMS ja da.

AFRO-EUROPEAN MEDICAL AND RESEARCH NETWORK: A NEW MEMBER OF MMS

“TOGETHER WE CAN MAKE IT HAPPEN”

By Charles Senessie*

The Afro-European Medical and Research Network, a non-governmental and not for profit Organisation was founded in Switzerland in May 2006, with a strong vision of helping to improve the quality of life for people from resource limited settings. Since 29th May 2008 it is a new member of Medicus Mundi Switzerland – Network “Health for all”.

The founding members came from five different African countries of Congo DRC, Ghana, Sierra Leone, Nigeria, Cameroon and Liberia together with Swiss and American citizens. Bern-Switzerland is the overall and European headquarters and the Africa Regional headquarter is in Liberia. Projects have been initiated in various resource-limited countries especially in Sub-Saharan Africa.

PLATFORM FOR PROFESSIONALS FROM DIFFERENT DISCIPLINES

Its members strive to contribute to the medical, mental, social, educational and every sound well-being of mankind irrespective of race, creed, beliefs, faith and social affiliation. It serves as a platform wherein active professionals from different disciplines as education, medicine, engineering or nursing can interact at various levels of self-initiated conferences, seminars, workshops, exchange programmes and voluntary workcamps including medical camps with mobile clinics.

Members shall endeavour to share ideas and knowledge for the betterment of the less fortunate human sectors of the world from poor-resourced settings. As a team, we will reach out to needy communities; offer them our services and at the same time fostering and promoting cross-cultural exchange and global peace. This will benefit both our own multinational and multi-professional team as well as the people we will be interacting with.

We continue to collaborate with local and international organisations such as WHO, UNAIDS, International AIDS Society, International Organisation for Migration, British HIV Association, Inter-

AEMRN will organise its first annual Strategic Planning Symposium on the theme:

Knowledge Management, Resource Mobilisation and sustained HIV/AIDS Research in Low-income Countries – Case of Sub-Saharan Africa

Friday 19th September, 2008
Universal Postal Union Complex (UPU)
Weltpoststrasse 4, Bern

Working language will be English but simultaneous translations into German and French will be done during the Symposium

Informations: contact@aemrnetwork.ch



national Association of Physicians in AIDS Care in Chicago USA, World Dental Federation in France, aidsfocus in Switzerland or Swiss African Forum as well as African AIDS Research Network.

AEMRN BRANCHES IN OTHER COUNTRIES

The AEMRN has up to date travelled to several countries and has set up active branches with members in African countries such as Liberia, Sierra Leone, Nigeria, Cameroon, Ghana, Democratic Republic of Congo, Kenya, South Africa. We also have branches in France, Germany, The Netherlands, Great Britain, Portugal, Sweden, USA and in Canada.

The aim of setting up these branches is to mobilise the diasporas in these countries to contribute their skills to low income countries especially Sub-Saharan Africa and hence help to develop the human and infrastructural capacity building and to minimise brain drain and brain waste and assist in brain gain.

PROJECTS AND INITIATIVES IN AFRICA

We have initiated several projects in Sub-Saharan Africa: health projects in Liberia, Kenya, Sierra Leone and educational projects in Liberia, Cameroon and Congo Democratic Republic. There are other projects in the planning stage for South Africa and Karella in Southern India. We have recently concluded the running of mobile clinics together with local and international organisations in North-Western town of Kitale in Kenya.

* **CHARLES SENESSIE** is the President of AEMRN, contact: csenessie@aemrnetwork.ch, www.aemrnetwork.ch

7. SYMPOSIUM DER SCHWEIZERISCHEN GESUNDHEITZUSAMMENARBEIT
BASEL, 11. NOVEMBER 2008

30 JAHRE NACH ALMA ATA: DIE ZUKUNFT VON COMMUNITY HEALTH

Die internationale Konferenz über Primary Health Care (PHC), die vom 6.–12. September 1978 in Alma Ata stattgefunden hat, gilt als Meilenstein der Gesundheitszusammenarbeit.

Die verabschiedete Deklaration propagierte umfassende Massnahmen, mit welchen Gesundheit für alle Völker der Erde erreicht werden sollte.

Wo steht die internationale Gesundheitszusammenarbeit 30 Jahre nach Alma Ata? Bald nach der Konferenz stellten VertreterInnen neoliberaler Ideen den durch die Deklaration von Alma Ata proklamierten Ansatz in Frage. Die sog. «Selective Primary Health Care» wurde als sinnvoller propagiert: Einerseits sollten einzelne Krankheiten gezielt angegangen werden. Diese durch die Weltbank vertretene Position dominierte in der Folge die internationale Gesundheitszusammenarbeit.

VERTIKAL VERSUS HORIZONTAL?

Das an der Alma Ata Konferenz entwickelte PHC-Konzept propagiert die Basisgemeinschaften, die Communities, als zentrales Element, um Gesundheit für alle zu erreichen. Die Gesundheitsversorgung muss so nahe wie möglich dorthin gebracht werden, wo die Menschen leben und arbeiten. Dieses Verständnis und dieser Ansatz prägen noch immer viele Projekte der internationalen Gesundheitszusammenarbeit und erlebt sogar in letzter Zeit auch in Zusammenhang mit den Millennium Development Goals ein Wiederaufblühen.

Es stellt sich aber angesichts der auf einem selektiven Ansatz beruhenden, globalen Programme auch die Frage, ob die Entwicklung von Community Health nicht gebremst wird. Das geringere Prestige von basisnaher Gesundheitsvorsorge ausserhalb der wirtschaftlichen Zentren, aber auch ausserhalb der von finanzkräftigen, global agierenden Stiftungen lancierten Gesundheitsprogramme, hat die Abwanderung von gut ausgebildetem Gesundheitspersonal gefördert. Vom weltweiten Gesundheitspersonalmangel sind basisnahe Gesundheitseinrichtungen besonders betroffen.

Mit dem Symposium 2008 leistet Medicus Mundi Schweiz einen Beitrag, um die Erfahrungen mit Community Health zusammenzutragen, zu diskutieren und die Ergebnisse für die internationale Gesundheitszusammenarbeit fruchtbar zu machen.

Das Symposium der schweizerischen Gesundheitszusammenarbeit richtet sich an ein breites Spektrum von TeilnehmerInnen, die auf nationalem oder internationalem Gebiet tätig sind. Veranstalterin des Symposiums ist Medicus Mundi Schweiz, das Netzwerk Gesundheit für alle. Das Symposium wird von der DEZA mit einem Beitrag unterstützt und inhaltlich begleitet.

Programm und Anmeldung:
martin.leschhorn@medicusmundi.ch