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Medicus Mundi Schweiz

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

AUGUST 2009

CULTURE AND CONDOMS. INTEGRATING APPROACHES TO HIV AND AIDS

Reader zur Tagung von aidsfocus.ch vom 6. Mai 2009 in Bern

IMPRESSUM

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

Bulletin Nr. 113, August 2009
Culture and Condoms.
Integrating approaches to HIV and AIDS

NETZWERK MEDICUS MUNDI SCHWEIZ
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INHALT

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EDITORIAL

Kultur ist nicht primär ein Hindernis in der HIV-Prävention und der Unterstützung aidsbetroffener Menschen, sondern Teil der Lösung. Dies war der Tenor an der Fachtagung von aidsfocus.ch. Mehr noch: Wenn das kulturelle Verständnis fehlt und die Leute mit Botschaften von aussen mobilisiert werden sollen, greifen die internationalen HIV- und Aidsprogramme zu kurz.

Die Fachtagung ging von einem ganzheitlichen Kulturbegriff aus. Kultur ist nicht nur Kunst und Literatur, Kultur umfasst die Lebensweisen, die grundlegenden Menschenrechte, Wertsysteme, Traditionen und Glaubenssätze (UNESCO, 1982). Unterschiedliche Vorstellungen von Gesundheit und Krankheit, von Sexualität und Geschlechterrollen, von richtig und falsch prägen die Verhaltensweisen und so auch den Umgang mit HIV und Aids. Die Gefahr von Missverständnissen ist gross, kulturelle Sensibilität ein Muss.

Kultursensible Ansätze zu HIV und Aids setzen sich mit Werten, Glauben, Traditionen und sozialen Strukturen auseinander, dem kulturellen Kontext und «Bedeutungsgewebe», in dem die Menschen leben. Am sichtbarsten sind kulturelle Ausdrucksformen wie Theater, Tanz, Lieder, traditionelle Riten und Symbole. Beispiele in diesem Bulletin zeigen, wie wirkungsvoll kulturell verankerte Kommunikationsformen sind, da sie die Leute direkt ansprechen, vertraute Bilder nutzen und zum Mitmachen einladen. Weitere Beispiele berichten von der erfolgreichen Zusammenarbeit mit traditionellen HeilerInnen und mit christlichen und muslimischen Geistlichen. Sie sind lokale Respektspersonen, geniessen das Vertrauen der Leute und wirken als kulturelle ÜbersetzerInnen. Bei kultursensiblen Ansätzen müssen die Betroffenen zu Beteiligten werden und sich an der Formulierung und Umsetzung von Präventionsbotschaften und Unterstützungsprogrammen beteiligen.

Kultursensible Ansätze fordern Mitarbeitende in der Entwicklungszusammenarbeit heraus. Kultur ist nicht eine Technik oder ein Instrument, das jeder und jede unbedarft anwenden kann. Kultursensibles Vorgehen verlangt von allen Beteiligten, hinzuhören und sich auf das andere einzulassen – gleichzeitig sich der eigenen kulturellen Identität bewusst zu werden und eigene Bilder zu hinterfragen. In der gemeinsamen Auseinandersetzung und im Dialog können Bedeutungen ausgehandelt und neue Handlungsoptionen entwickelt werden.

Es lohnt sich. Die Erfahrung hat gezeigt, dass dort, wo kultursensitive Ansätze in der Kommunikation zu HIV und Aids gebraucht und die Betroffenen in den Prozess einbezogen wurden, die Programme grössere Wirkung zeigten auf das Bewusstsein, das Verhalten und auf die Reduktion von Stigma.

Helena Zweifel
Geschäftsführerin Netzwerk Medicus Mundi Schweiz,
Koordinatorin aidsfocus.ch

Seiten 5–31 **Über Aids sprechen: Kultursensible Kommunikation und Entwicklungszusammenarbeit**

“If talking publicly and directly about sexuality and HIV/AIDS is so difficult for a man of Mandela’s stature, one can imagine how much more difficult it is for the average citizen.” **Véronique Schoeffel**

AIDS, KULTUR UND TABU: DIE EIGENEN BILDER HINTERFRAGEN

Kultur, Tradition, Religion: Die spannungsvolle Beziehung zwischen lokaler Kultur und der Notwendigkeit, sich und andere vor HIV und Aids zu schützen, stand im Zentrum der Diskussionen an der Fachtagung von aidsfocus.ch vom 6. Mai in Bern. Die TeilnehmerInnen waren sich einig, dass es sowohl Kultur wie Kondome zur Verhinderung der weiteren Ausbreitung von HIV und Aids braucht.

Von Helena Zweifel*

Tagungsbilder: © Marius Schären

«WER HAT GESAGT, dass die Tradition nicht mit Prävention im Einklang ist?» Kunstvoll geschmückte Hände, Symbol muslimischer Tradition, halten ein Kondom. Die marokkanische Aidsorganisation (Association de lutte contre le sida, ALCS), die das Poster geschaffen hatte, knüpfte an Bildern und Botschaften an, die alle kennen und zum Widerspruch und zur Reflektion anregen. Zudem war es eine Antwort an all jene, die predigten, die Tradition schützte vor HIV und Aids und die Jugendlichen sollten auf den Pfad der Tugend zurückkehren. Das provokative Poster fand grosse Beachtung, es traf den Kern der Sache.

HIV UND AIDS FORDERN HERAUS

Ob der Koran oder die Bibel den Gebrauch von Kondomen bejaht oder nicht, darüber streiten und diskutieren auch die geistlichen Würdenträger in den Workshops von Channels of Hope. Reverend Christo Greyling, der internationale Berater von World Vision International zu Fragen von HIV, Aids und Kirche, hatte die Methode von Channels of Hope für die Arbeit mit GlaubensführerInnen zu HIV und Aids im südlichen Afrika entwickelt. An der Fachtagung sprach er sehr engagiert und einfühlsam über die schwierigen Prozesse, welche die Pastoren und Imame im Sensibilisierungsprozess im Rahmen der Ausbildung zu HIV und Aids durchmachen. Die intensive Diskussion und der Dialog mit ihresgleichen ist ein zentrales Element, regt zum Umdenken an und letztlich zu neuem Verhalten. Die Kirchenleute müssen sich mit den eigenen Werten, Einstellungen und Wahrnehmungen auseinandersetzen, müssen Dinge hinterfragen, die sie als gegeben angenommen haben, als Gottes Wille. HIV und Aids fordern heraus. Was den Gesetzen entspricht und als moralisch «richtig» angesehen wird, ist nicht immer sicher und von einer Gesundheitsperspektive her gesehen auch «richtig». Sexualität in der Ehe entspricht Gottes Gesetz, ist aber nicht immer sicher, etwa wenn der Partner oder die Partnerin den HIV-Status nicht kennt oder HIV-positiv ist.

«Die GlaubensführerInnen müssen sich mit den Widersprüchen auseinandersetzen, um ihrer Aufgabe als Seelsorger in ihrer Gemeinde gerecht zu werden», erklärte Christo Greyling. «Als Moderator führe ich sie durch den Prozess, die Lösung muss von ihnen selber kommen.» Immer wieder durfte er positive Erfahrungen machen, etwa mit Pastoren, die Aids als Strafe Gottes sahen und sich jetzt mit den eigenen Unzulänglichkeiten auseinandersetzen. Viele KursabsolventInnen lancierten Präventionsprogramme in der Kirchgemeinde, initiierten Unterstützungsgruppen von und mit HIV-positiven Männern und Frauen oder richteten Zentren für Kinder ein, deren Eltern an Aids gestorben sind.

Anfangs dachte Christo Greyling, dass die Religion und ihre VertreterInnen eines der grössten Hindernisse im Kampf gegen HIV und Aids wären. Doch die Arbeit mit GlaubensführerInnen der verschiedenen Religionen lehrte ihn etwas anderes: Sie sind wichtige TüröffnerInnen im Engagement für und mit aidsbetroffenen Menschen und in der HIV-Prävention.

ZUSAMMENARBEIT VON TRADITIONELLEN UND MODERNEN HEILERINNEN

Die Zusammenarbeit mit religiösen WürdenträgerInnen, aber auch mit traditionellen Führungspersönlichkeiten wie den Ältesten oder HeilerInnen ist ein erfolgversprechender, kultursensibler Ansatz. Sie sind Respektpersonen, deren Wort ernst genommen wird. Die Erkenntnis, dass HIV-Prävention in einem Verständnis der lokalen Kultur verankert und mit lokalen Verbündeten zusammengearbeitet werden soll gewinnt an Bedeutung. Viele internationale HIV-Präventionskampagnen von aussen, die einseitig Verhaltensänderung etwa durch Abstinenz propagieren, erzielten die gewünschten Erfolge nicht.

Über die potentiell zentrale Rolle von traditionellen HeilerInnen, Medizinmännern und Frauen in der Bekämpfung der Epidemie sprach der bangalische Arzt Dr. Shariful Islam. Wie in vielen Ländern des Südens sind in Bangladesch bei gesundheitlichen Problemen die traditionellen HeilerInnen meist die erste Adresse. Traditionelle HeilerInnen wissen, in kulturell angepasster Art und Weise zu kommunizieren und Gehör zu finden. «Wegen ihrer Position in der Gemeinschaft als Vertrauenspersonen haben sie auch die Freiheit, über sensitive Themen wie Sex zu reden», erklärte Dr. Islam. Daher sind sie in der idealen Position, mit den Leuten über HIV-Prävention zu reden, Kondome zu verteilen, zu beraten und zur HIV-Testung zu ermutigen.

Ein Pilotprojekt des Entwicklungsprogramms der Vereinten Natiionen (UNDP) im ländlichen Bangladesch bildete traditionelle HeilerInnen zu HIV und Aids aus. Für die meis-

ten HeilerInnen war dies das erste Mal, dass sie mit medizinischem Personal in Kontakt kamen und erfahren durften, dass sie als Teil des Gesundheitsteams angesehen wurden. Mit einem Handbuch und Kondomen ausgestattet setzten viele der frisch ausgebildeten HeilerInnen das Gelernte in die Praxis um. Sie führten Informationsveranstaltungen mit der Dorfbevölkerung durch, warben für den Gebrauch von Kondomen und wiesen PatientInnen für medizinische Behandlung ins Distriktspital ein. Shariful Islam fordert, dass traditionelle HeilerInnen ins öffentliche Gesundheitssystem integriert, anerkannt und weitergebildet werden und so ihre Rolle als wichtige Akteure in der Gesundheitsvorsorge und Prävention von HIV und Aids spielen zu können.

BREITES VERSTÄNDNIS VON KULTUR

Die englische Konsulentin Clogagh Miskelly hatte im Rahmen des internationalen Netzwerkes für Kultur und Entwicklung «Creative exchange» über 350 lokale Aidsprojekte in Vietnam, Kambodscha, Kenia, Südafrika, Jamaika and Trinidad untersucht. Sie zeigte anhand von Beispielen auf, dass HIV-Programme, die an den kulturellen Besonderheiten und Traditionen anknüpfen, die lokale Bevölkerung einbeziehen, kreative lokale Methoden und Redewendungen nutzen und auch die Gefühlebene und Erfahrungen der Menschen direkt ansprechen, eine grössere Wirkung auf das Bewusstsein und die Haltungen haben als das Propagieren fremder Botschaften von aussen. Bei diesen Formen der Kultur und Kommunikation geht es nicht um künstlerische Glanzleistungen, sondern um den Austausch und das Knüpfen von Beziehungen in Gemeinschaften, in einer Sprache, die alle verstehen. Kultursensibel heisst, zusammen mit den Leuten oder der Gemeinschaft die Fragen anzugehen, auf ihre Bedeutung und Sinngebung einzugehen und sie in der Ausarbeitung von Projekten der HIV-Prävention einzubeziehen. Mit Kultur arbeiten heisst auch mit Gefühlen und Emotionen zu arbeiten – «Kultur geht in den Bauch». Dies kann emotionale und kognitive Lernprozesse auslösen.

Aidsfocus.ch ging an der Fachtagung von einem sehr breiten Verständnis von Kultur aus und stützte sich dabei auf die Definition der UNESCO, welche Kultur als *«the whole complex of distinctive spiritual, material, intellectual and emotional features that characterise a social group»* definierte (UNESCO, 1982). Kultur ist nicht nur Kunst und Literatur, Kultur umfasst die Lebensweisen, die grundlegenden Menschenrechte, Wertsysteme, Traditionen und Glaubenssätze. Kultur und HIV und Aids sind unmittelbar miteinander verknüpft, denn Kultur spielt in der Lebensweise und dem Verhalten der Menschen eine Schlüsselrolle, bestimmt unser Verständnis von richtig und falsch, von gesund und krank, von Sexualität und Geschlecht.

MIT KULTURELLEN SYMBOLEN UND THEATER GEGEN AIDS

Kulturelle Symbole, traditionelle Riten, Tänze, Dramen, Geschichten oder Lieder sind wirkungsvolle, gesellschaftlich verankerte Kommunikationsmethoden in der Aidsarbeit und wirken oft als Eisbrecher für Gespräche über HIV und Aids. Ein Beispiel von der Fachtagung:

Ein Stand auf der Bühne, ein afrikanischer Verkäufer. Eine afrikanische Frau tritt hinzu, der Afrikaner bietet ihr eine Kolanuss an. Eine Kolanuss? Er erzählt ihr von seiner Heimat, erzählt davon, wie bei Besuchen, beim Knüpfen von Freundschaften und vor allem rund um die Heirat Kolanüsse ausgetauscht werden. Sie ist überrascht und interessiert, und die beiden kommen miteinander ins Gespräch. Er schenkt ihr eine Packung Kondome mit dem Kolanussignet. Was?!

Dies war eine Szene aus dem Theater der MediatorInnen von Afrimedia, einem Projekt der Aids-Hilfe Schweiz. Für die Präventionskampagne mit Menschen afrikanischer Herkunft in der Schweiz suchte Afrimedia nach «typisch» afrikanischen Symbolen und Redewendungen – und fand die Kolanuss, ein verbreitetes Symbol für das Knüpfen von Beziehungen und fürs Heiraten. Noel Tshibangu, der Koordinator des Projekts, stellte erstaunt fest, dass viele der in der Schweiz lebenden AfrikanerInnen die kulturelle Bedeutung der Kolanuss nicht kannten. Die Kolanuss wirkte als Eisbrecher, regte das Gespräch an und da das Kondom nicht mehr im Zentrum stand, konnten die Beteiligten offener und mit weniger Scham über diese eher heiklen Themen reden. Viele freuten sich über die Wertschätzung afrikanischer Kultur und die meisten nahmen Kondome mit nach Hause. Wenn auch anders als geplant hat sich die Kolanuss als wirksames, kulturelles Vehikel erwiesen für eine Auseinandersetzung mit HIV und Aids, mit Verantwortung und «safer sex».

KULTUR – TEIL DES PROBLEMS UND DER LÖSUNG

Wenn an der Tagung vor allem die Rede von den Möglichkeiten kultureller Ansätze in der Aidsarbeit war, heisst dies nicht, dass Kultur und Tradition glorifiziert und nicht hinterfragt würden. Oft werden traditionelle und kulturelle Werte und Praktiken als Hindernis erfahren und als Ursache für das Scheitern von Aufklärungs- und Präventionsprogrammen gesehen. Tatsächlich gibt es traditionelle und kulturelle Praktiken, die zur Ausbreitung von HIV und Aids beitragen und Präventionskampagnen unterlaufen. Solche Beispiele sind die Polygamie oder die Tradition der «Witwenvererbung». Im Film «Der Wind und der Baum» aus der Serie «Szenarios from Africa» macht sich Fatim grosse Sorgen um die Gesundheit und das Leben ihrer Tante und vertraut sich der Grossmutter an. Der Onkel war jung gestorben und traditionsgemäss soll seine Witwe mit dem Bruder ihres verstorbenen Mannes verheiratet werden. «Jedoch», fragt Fatim die Grossmutter, «welchen Weg sollen wir einschlagen wenn unsere Traditionen und die Gesundheit miteinander im Widerstreit sind?» Damit ist Aids und Tradition im Gespräch. Letztlich entscheidet der Dorfhäuptling, dass die Tradition befolgt wird, aber das Hochzeitspaar einen HIV-Test machen soll. Falls dieser positiv ausfallen sollte, muss das Paar stets Kondome benutzen. Dies sind sehr «moderne» Ansichten in einem traditionellen Dorf! «Unsere Tradition ist wie ein Baum, der starke Wurzeln hat, aber flexibel sein muss um den Stürmen zu widerstehen», erklärt der Dorfhäuptling im Film.

DIE FRAGE NACH DER WIRKSAMKEIT

Die internationalen Entwicklungs- und Aidsorganisationen sind sich grundsätzlich bewusst, dass Kultur die Umsetzung von Politiken, Strategien und Programmen beeinflusst. Doch der

Zugang zu medizinischer Behandlung und Pflege hat für die mächtigsten internationalen Geldgeber wie dem Globalen Fond zur Bekämpfung von Aids, Malaria und Tuberkulose erste Priorität. Technische Massnahmen scheinen leichter durchführbar zu sein und konkrete, messbare Resultate können vorgezeigt werden. Auch die Institutionen der Entwicklungszusammenarbeit haben ihre eigene Kultur, welche ihre Praktiken und Wahrnehmungen beeinflusst und stark geprägt ist von PlanerInnen und TechnokratInnen.

Verschiedene Organisationen der Vereinten Nationen wie UNESCO, UNFPA und UNAIDS haben wertvolle Studien zur Relevanz kultureller Ansätze in der Aidsarbeit durchgeführt und Politiken, Richtlinien und Instrumente zur Umsetzung kultureller Ansätze in der Entwicklungszusammenarbeit entwickelt. Diese Richtlinien sind bisher weitgehend blosses Papier geblieben.

Unsere Kenntnisse zur Wirksamkeit kultureller Ansätze in der internationalen Aidsarbeit sind sehr limitiert, trotz der Beobachtungen und Erfahrungen von ProjektmitarbeiterInnen, die besagen, dass kulturelle Ansätze wirkungsvoll sind und einen Unterschied machen. Es gibt kaum Monitoring- oder Evaluationsinstrumente zur Wirksamkeit kultureller Ansätze in Projekten der Entwicklungszusammenarbeit, oder sie werden nicht eingesetzt. Das UNDP-Pilotprojekt mit traditionellen HeilerInnen in Bangladesch wird nicht evaluiert und auch nicht weitergeführt, trotz erfolgversprechenden Signalen. UNDP in Bangladesch hat andere, neue Prioritäten, heisst es dazu. Darin widerspiegelt sich die geringe Bedeutung, die kulturellen Ansätzen beigemessen wird.

Eine Ausnahme stellt World Vision International dar. Die Organisation stellte nicht nur für die Entwicklung des Channel of Hope-Programms, sondern auch für Monitoring und Evaluation die notwendigen Ressourcen bereit. Eine Studie kommt zu eindrücklichen Resultaten. Zahlen in Sambia in Bezug auf freiwillige HIV-Test zeigen eine starke Erhöhung bei jenen Kirchenleuten, die an der Ausbildung teilgenommen haben: 85 Prozent der TeilnehmerInnen haben einen HIV-Test gemacht, im Vergleich zu 26 Prozent der anderen.

INTERKULTURELLE KOMPETENZ

Die Fachtagung zu kulturellen Ansätzen in der internationalen Aidsarbeit regte bewusst die Auseinandersetzung mit sich selbst und die Reflektion der eigenen kulturellen Sensibilität an. Im Workshop zu interkultureller Kommunikation schilderte Véronique Schoeffel konkrete Projektsituationen, in denen es im Zusammenhang mit HIV und Aids zu Spannungen und Unverständnis kam. Zu sehr gingen Wahrnehmung und Verständnis der SchweizerInnen und der lokalen PartnerInnen auseinander, etwa zur direkten Kommunikation oder zur Bedeutung der Gemeinschaft im Kontext von HIV und Aids. «Ich musste feststellen, dass auch ich vorgefasste Meinungen habe, beeinflusst durch Kultur, Erziehung und Konvention», reflektierte eine der TeilnehmerInnen selbstkritisch. Die Entwicklung interkultureller Kompetenz ist gefordert, um gemeinsame Bedeutungen auszuhandeln – und Zeit und Energie, sich auf das Fremde einzulassen und eigene Bilder zu hinterfragen.

«Hören, was die Gemeinschaft zu sagen hat», war für die TeilnehmerInnen der Tipp, dem sie von den 24 Tipps für kultursensitive Entwicklungszusammenarbeit der UNFPA am meisten Punkte gaben und den sie in ihrer Arbeit umsetzen möchten. Fast gleichermassen wichtig war das Anliegen, «Zeit zu investieren um die Kultur, in der wir arbeiten, kennenzulernen».

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Ressourcen

UNFPA: Working from Within: 24 Tips for Culturally Sensitive Programming (2004). http://www.unfpa.org/culture/24tips/cover.htm).

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AIDS-HILFE SCHWEIZ
AIDE SUISSE CONTRE LE SIDA
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World Vision

MIGROS
kulturprozent

ENGAGING CULTURE FOR EFFECTIVE RESPONSES TO HIV/AIDS

This paper advocates for engaging culture to enable effective responses to HIV/AIDS in particular it addresses, how culture is being engaged in responses to HIV, why it is important to engage with culture, and points to some of the challenges to engaging with culture.

By Clodagh Miskelly*

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Traditional dancers perform at the airport in Juba, Sudan, September 2007.

THE PAPER draws on examples from HIV/AIDS: the Creative Challenge, an action-research project led by Creative Exchange to develop an evidence base and an international practice and policy network of organisations and practitioners using cultural approaches in Vietnam, Cambodia, Kenya, South Africa, Jamaica and Trinidad. Creative Exchange closed in June 2009 but all the resources for HIV/AIDS are still online. (www.creativexchange.org/hivaids)

WHAT IS CULTURE?

Culture is difficult to define. The Mexico City Declaration on cultural policies, a widely accepted definition, highlights the scope and multi-leveled aspects of culture describing culture as *"the whole complex of distinctive spiritual, material, intellectual and emotional features that characterise a social group (...) not only the arts and letters but also modes of life, fundamental rights of the human being, value systems, traditions and beliefs."* (UNESCO 1982) These features not only characterise social groups but are the resources from which create "webs of significance" within our daily lives. (Geertz, 1993) Culture is dynamic, we make sense of the world and take action based not just on acquired patterns of meaning and practice but also in response to changing social, economic and cultural influences. Culture is closely tied to power relations where, for example, powerful elites draw selectively on cultural traditions to serve current interests. (Vincent, 2008)

The most visible aspect of culture in development is creative, artistic or expressive methods such as drama, music and visual arts which offer a way of building relationships with a local community, of gauging and expressing thoughts and experience of different groups, of building skills and confidence to act, sharing information, combating myths, using established channels of communication, or introducing new forms of expression to enable different reflections and responses.

Different emphasis is placed on participation in this creative practice depending on the context and goal. Some projects use creative processes within a community to address issues of concern to that community while others co-opt local creative practice or introduce methods such as theatre for development as a way of passing their own messages, adapting a message to fit with local references or languages. Some organisations have developed a mix of approaches to suit particular needs or contexts. FilmAid working in Kakuma and Daodab refugee camps in Kenya, moved away from ex-pat led film projects which had limitations in regard to the cultural understandings of different refugee communities and moved toward empowering camp residents to investigate their own issues through participatory video. They use different approaches according to their strengths and weaknesses in different contexts and meeting certain purposes. The organisation continues to use large scale mobile cinema film screenings where audiences see a mix of entertainment, edutainment and educational films, as well as smaller group screenings which are followed by discussion groups. Community video production is used to produce material about issues that are relevant to the different communities in the camps and aim to involve the community at large. (ww.creativexchange.org/hivaids/briefings)

Magic Threes worked in Vietnam with people living with HIV and AIDS (PLWHA) to produce a leaflet for people newly diagnosed as HIV positive for whom there was very little information and support available. Participants used different art forms to share their own experiences and identify information that would be appropriate for the leaflets. This project worked to marry what are sometimes seen as incompatible or opposing approaches, using participatory creative approaches to explore experience in order to identify and develop materials for an information and education communications leaflet. (www.creativexchange.org/hivaids/magicthrees) The use of creative approaches to draw out participants own experiences ensured that the leaflet contained material that was resonant with other Vietnamese and understood cultural sensitivities about addressing sexual matters.

Culture may also form an important part of the social fabric that sustains development responses, as can be seen in the way that HIV initiatives in Uganda were able to draw on existing patterns of interpersonal communication and dialogue there, and in South Africa, the tradition of anti-apartheid activism and community mobilization underpinned new campaigns for access to anti-retroviral treatment. (Vincent, 2008)

Kenyan cultural practitioners involved in *HIV/AIDS: the Creative Challenge* emphasised that working with culture is about working with the emotions – "culture gets you in the gut" – and thus engaging culture can enable affective as well as cognitive learning. (Marsh et al, 2008) The emotional character of culture highlights the potential of cultural approaches to manipulate, for example to increase rather than reduce stigma.

Another less commonly acknowledged understanding of culture in development is in the culture of development that shapes the "prac-

tices and assumptions of international development institutions." (Vincent, 2005) *"After fifty years of development assistance, it is clear that policies and projects are not implemented in a vacuum. They are formulated by bureaucrats and planners and implemented by people with a particular mindset in a particular culture, and with particular social norms, reinforced by metaphors, stories, proverbs and film."* Narayan, 1999)

WHY CULTURE?

Culture, as features of a social group, as webs of significance and as creative expression serves as a resource, a means to engage with a community to address different issues related to HIV prevention, treatment and care. Research demonstrates that culture is a factor in the social trends that contribute to infection and HIV/AIDS in turn has an impact on people's lives. (UNESCO/UNAIDS, 2000) This suggests that an engagement with culture is needed to address HIV/AIDS prevention, treatment and care.

The Cross Cultural Foundation of Uganda has produced a case study about The Rakai Counsellors' Association (RACA) strategy of reviving positive local cultural aspects to address the spread of HIV amongst young people. The Association supported *"Ssengas" – paternal aunties – and the Kojjas – uncles –, whose traditional role was to instil moral values especially to adolescents and young married. This community-based cultural referral system had also long existed as a resource in breaking the silence that surrounds sexual matters. RACA has supported Ssengas and Kojjas for the past year, helping communities to select candidates for support, providing up-to-date training, introducing them as a resource to their local areas, and providing them with some inputs to give to their clients. The Ssengas or Kojjas are expected to support their communities, in different ways, according to need and capacity, for instance, individual consultations in private homes or visiting schools. Early signs indicate that this pilot programme is yielding results: the demand for Ssengas' and Kojjas' services is rising, there are stories of behavioural change and the approach, because it is based on an existing voluntary system, promises a good measure of sustainability. RACA feels this intervention can provide useful lessons for other development practitioners, although there is a need to adapt the approach to locality, language and cultural context.* (HIV/AIDS and family resources)

SOCIAL DRIVERS

At policy level there is growing recognition of the need to address the social drivers of HIV/AIDS including human rights, stigma and discrimination, gender inequality and poverty. (DfID, 2007) Culture since it shapes how people live their lives and the social structures within which they live, needs to be recognised as part of the engine of social drivers. Culture contributes to practices, values, and attitudes which create stigma and discrimination, gender and other inequalities. Engaging with culture can help take into account the networks, values and relationships that shape people's lives whether to enrich or constrain them and the factors that affect or limit choices which people, especially women, may be able to make about prevention.

To address inequalities requires approaches which involve people in developing culturally relevant responses which tackle the specifics of their own experience. Local organisations using cultural approaches are well placed to do this. Some cultural practitioners involved in *HIV/AIDS: The Creative Challenge* work with socially vulnerable groups to address a range of concerns, and can therefore address HIV within a community context and in conjunction with other issues of social vulnerability. Other organisations weave HIV/AIDS into the wider themes impacting on their communities, and make use of modes of cultural expression which are well suited to such complexity, for example a drama might weave together a story line addressing a number of social agendas: gender relations, violence against women; the rights of children; poverty and HIV/AIDS.

Organisations already tackling violence against women incorporate HIV prevention into their work. Laphumi'langa (Xhosa for Sunrise) is a project developed by Mothertongue in the Western Cape, South Africa which aims to raise awareness of the link between violence against woman and HIV/AIDS, recognising that broader gender inequalities play a role in the spread of HIV/AIDS. The project trained 28 women who undertook activities including participatory drama techniques to access and creatively express personal stories. These stories were then used to construct plays for forum theatre performances which established dialogues with mixed township audiences in a variety of public venues such as shopping malls. The project explicitly worked within Xhosa culture but in ways which challenged the process of gendering men and women within this culture, in particular the cultural practices which establish men as superior.

Clodagh Miskelly

The value judgements, fears, misconceptions and taboos that contribute to stigma and discrimination are culturally specific and as such require culturally relevant approaches to awareness raising, skills development and dialogue, sensitivity and inclusivity.

Partners in *HIV/AIDS: The Creative Challenge* address lack of awareness, knowledge and misconceptions through a range of cultural strategies to do so taking into consideration beliefs and practices which may contribute to the acceptance or stigmatisation of people living with HIV/AIDS as well as willingness to engage in responses to HIV/AIDS. For example, Abila Creative Centre in Kisumu, Kenya makes use of young peoples debating conventions to address the cultural values and practices at the heart of this community which are perceived to contribute to stigma and discrimination and to the spread of HIV. Through this work, which involves young people talking to older generations and researching aspects of their culture such as widow inheritance, they also open up dialogue and develop resilience and solidarity in addressing inequalities or considering community based approaches.

CULTURE AND PARTICIPATION

The complexity of culture and the variety of modes of communication and locally adapted methods in use challenge assumptions about the possibility of communicating health messages to large numbers of people in relatively uniform ways. Research shows that HIV and AIDS prevention projects have failed where there is a preoccupation with achieving individual behavior change, using communications models based on externally-derived and imposed messages. (Panos, 2006)

Engaging with culture is closely aligned in participatory development methods, since it entails starting where people are, respecting and recognising their ability to decide and act on what changes are important in their lives. En-

gaging with culture means dialogue, working with channels of communication that are favoured and valued within a community, working within the 'cultural logic' of that community, supporting a community to define its own solutions which may be adopted because they work through rather than ignore or confound their understandings of the world. Rather than implying a particular toolkit of participatory methods, which are increasingly invoked in the mainstream of development, culture perhaps returns us to an earlier focus on people developing their own critical consciousness and being empowered to change what they identify as relevant in their lives, which is at the root of the initial turn to participation in development.

EFFECTIVENESS

While the above examples show that it is possible to engage culture productively in development practice, there remains a gap between *"how culture in development processes has been conceptualised and how it is implemented."* (Rao & Walton, 2004) Although increasingly recognised as an integral and important aspect of development, culture remains largely hidden. (Gould & Marsh, 2004)

A study of use of cultural approaches to development by 5 UK development agencies uncovered over 350 projects in 40 countries with an estimated cost of £30 million although none of these organisations had a means of systematically documenting or monitoring cultural approaches in the work they funded or implemented. The study concluded that there is no clear rationale behind the use of cultural approaches by development agencies and that *"the wider role of culture in development is not well understood and there are few systems in place to capture or assess its impact and the possible outcomes, both positive and negative."*

It was noted that there was limited explicit reference to culture in policy documentation. There was a lack of evaluation of integral cultural projects meant that in the majority of cases, there is no assessment of how projects address policy (where it exists). Assessment of whether a cultural approach to local issues is more or less appropriate than other approaches was lacking as was other assessment of impact, so limited evidence exists of the effectiveness of cultural approaches in addressing development communications, education, behavioural change or social/economic development, in spite of the conviction and observations of project staff that these approaches are important and do make a difference.

Both *HIV/AIDS: The Creative Challenge* and recent research from the Ugandan Cross Cultural Foundation point to the effectiveness of participatory cultural approaches citing indications of reduced stigma and discrimination, addressing 'harmful' practices, improved well being, volunteer testing and disclosure and tackling opportunistic infections. Culture needs to be considered as part of a wider social and technical mix. It is clear from these projects that a variety of methods and approaches are working and needed. (Drawing on Culture 2008)

Out of the Routemapping project Creative Exchange developed a conceptual framework as a means to make sense of projects described as cultural and to describe the different intersections between culture and development. The framework provides four different ways of conceptualizing culture:

- *Culture as context:* factors specific to local life: beliefs, value systems, history, geography, social hierarchies, gender, faiths, and concepts of time
- *Culture as content:* languages, practices, objects, traditions, clothing, and heritage
- *Culture as method:* the medium or cultural forms that projects will use to engage/communicate with communities
- *Culture as expression:* the intangible, creative elements of culture that connect with our beliefs, values, attitudes, feelings and ways of viewing the world. (Gould & Marsh, 2004)

The framework serves as a way of identifying different aspects of culture in a project or community and as an aid to preparation when developing a project. It is first step but more evidence is needed to develop a systematic approach to understanding and working with culture that might enable more consistent and effective implementation.

The authors of the Routemapping report point to a three fold impact of the failure to address culture in terms of implementation at policy level:

1) Development agencies are not required to demonstrate how they are considering cultural impacts and therefore there is no system of ensuring their work is culturally sensitive
2) No impetus to evaluate the majority of cultural projects to establish how they affect beneficiaries – no system of quality control
3) No incentive to collect data so role of culture remains invisible (Marsh & Gould, 2003)

There was a consistent call from participants in *HIV/AIDS: the Creative Challenge* for more appropriate and manageable monitoring and evaluation methods to enable them to demonstrate the value of the approaches they adopt as well as to learn from and improve their work. Commonly current reporting and evaluation methods are inconsistent, in some cases they 'screen out' cultural features or activities, or are inappropriate, for example, using purely quantitative measures which address the extent but not the quality of outreach and relate to unrealistic expectations in regard to behaviour change. It is certain that where cultural approaches are one aspect of HIV/AIDS responses in a community then attribution is difficult. Nevertheless monitoring and evaluation methods exist and in some cases what is lacking at project level is training and capacity and what is needed at policy level is understanding and support.

CONCLUSION

In this paper I have for argued for engaging with culture in HIV responses. Culture is dynamic and constitutes a set of resources which may be mobilised as an integral part of any negotiations and power struggles around development. Culture often gives a distinctive twist to development responses, and may play an important part in finding creative and sustainable ways of addressing development challenges.

While the need to engage with culture is increasingly recognised in policy and theory this is not reflected in practice. There is some evidence of the effectiveness of working through culture and of creative cultural approaches in a wide range of local contexts. However, evidence is patchy and there is no systematic approach to ensuring engagement with culture or to evaluating this engagement.

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A street vendor displays a Hindu religious statue in Dhaka, Bangladesh, July 2007.

Engaging culture may be a dimension of participatory approaches that genuinely begin with where people are and work with them to address aspects of their life that they identify as important. Such an engagement however, will often be about creating the space for people to reflect on their situation, and find pathways of change which work in context, rather than the promulgation of particular messages or putting in place particular processes of consensus-based decision-making, which may often be quite "unrepresentative" and subtly coercive.

To recognise culture, reiterates the importance of context, and that people need to be part of driving their own change. It is also to recognise that a technical or 'off-the-shelf' approach will not work. Finding ways to effectively work with culture, may hold the key to a more responsive development that eschews pre-determined solutions, and recognises the need for distributed creativity and initiative in sustainably addressing development challenges.

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THE NEED FOR INTER-CULTURAL COMPETENCY

Working in international cooperation in situation linked to HIV and AIDS, differences in communication styles and cultural values become critical. What are the main dimensions to consider in intercultural communication, the negotiation of shared common meaning? What are the intercultural skills needed to understand each other and to work together?

By Véronique Schoeffel*

THE AIDSFOCUS.CH conference of the 6th of May 2009 reflected on the richness, new opportunities and challenges of a cultural approach for projects related to HIV/AIDS, in terms of prevention, treatment, care and support.

The invitation flyer defined the concept of cultural approach: "a cultural approach allows prevention and care methods and messages to come from within and be appropriate to different cultures. Creative and artistic projects may be the most visible examples. Cultural appropriate projects include working with religious leaders, elders and healers as well as involving people living with HIV and affected by AIDS."

If such an approach seems obvious from the point of view of community development and empowerment, it raises a number of important questions in relation to intercultural communication. How can we make sure that we understand each other, when, due to our different cultural backgrounds, we perceive the disease differently, we talk differently about the same issue, we approach it differently, and we often underestimate the challenges of interacting meaningfully across cultures?

Indeed, most projects in international cooperation are not developed and led only by insiders of the culture of the "beneficiary", but by organisations and partners from various countries and cultures. How can we make sure that we understand each other, when, due to our different cultural backgrounds, we perceive the disease differently, we talk differently about the same issue, we approach it differently, and we often underestimate the challenges of interacting meaningfully across cultures?

If we define intercultural communication not only as an interaction between people of different cultures, but as a *negotiation of shared common meaning* between these people, some dimensions of intercultural communication become critical, in relation to the content and to the process.

This article raises questions relating to three of these dimensions:

- The verbal communication styles, especially the issues related to direct and indirect communication
- The cultural values, especially the issues related to
  - individual orientation and community orientation
  - time orientation and use of money

DIRECT AND INDIRECT COMMUNICATION STYLES

In many countries and cultures of the West, and thus in many of the projects and programs developed in these countries, *direct* communication is considered as more desirable, clear and

Workshops at the aidsfocus.ch conference: shifting identities


Véronique Schoeffel

effective. In direct communication, we "say what we mean and mean what we say", and our words are clear, explicit, expressing exactly what we mean.

In many countries and cultures of the rest of the world, *indirect* communication is considered as more desirable, clear and effective. In indirect communication, the meaning is *not* in the word, but in the context, between the lines, in the implicit. Who says what, when, to whom and how is very coded and regulated. One is especially careful not to hurt or make somebody lose face.

In projects related to HIV/AIDS, this difference becomes critical in the following situations:

- When people are offended by the directness of expatriates who, without being aware of it, use hurtful or offensive words.
- When people prefer not to talk in order to protect their dignity and their families' dignity, but expatriates feel one needs to name things clearly in order to handle them.
- When expatriates find it difficult to cope with the silence, the "not saying" related to HIV/AIDS, and have no other way of communicating.

The following examples illustrate the issues related to direct and indirect communication styles.

The book "28 stories of AIDS in Africa" by Stephanie Nolan dedicates a chapter to Nelson Mandela, one of the most honourable and courageous people on earth. In this chapter, a passage explains why Mandela hardly ever addresses the issue of HIV/AIDS publicly when he was president of South Africa:

"In the period in which he was president of South Africa, the country's HIV infection rate grew from less than 8% of adults to nearly 25%. Yet he (Mandela) almost never addressed the subject, citing the excuse that it was culturally unthinkable for a Xhosa elder to discuss matters related to sexuality in public. "In our part of the world", Graça told me, "everything related to sex is so private. Only aunties and some uncles can speak to the younger ones on sexuality, or those who go to the initiation process" – the traditional rites for young men in many tribes, including Mandela's Xhosa. The spread of a sexually transmitted infection was not viewed as a presidential matter in newly-free South Africa."

If talking publicly and directly about sexuality and HIV/AIDS is so difficult for a man of Mandela's stature, one can imagine how much more difficult it is for the average citizen.

Silvia Noser and Friedwart Storto, who worked as volunteers in the North of Namibia with the organisation Interteam experienced it the following way: *"Sexuality is lived – the many children and the numerous teenage pregnancies show it – yet, one does not talk about it. Sexuality, and thus HIV/AIDS are taboo".* (Newsletter 6, January 2008)

How can one develop and support cultural approaches if our ways of talking about the issue are so fundamentally different? What specific intercultural skills does this require?

INDIVIDUAL ORIENTATION AND COMMUNITY ORIENTATION

If international cooperation is serious about applying a cultural approach, then it needs to accept that many partner organisations and many beneficiaries feel and think in a community oriented way, with implications for the nature and aim of the project.

When some projects have an inclination to want to support the persons living with the virus, many of the latter think in terms of family and community: what are the consequences for my family if I say that I live with the virus? What are the consequences for my extended family, if I can't work anymore?

Lilian Raymund, 18 years old, lives in Tanzania. Her family is affected by AIDS. When Markus Geiger, who works for Interteam in Tanzania interviewed her, he was very surprised by one of her answers. His question was about her future, as an individual, her answer was the answer of a community oriented person:

What do you think for the future?

I think of my family and I hope that my sister will continue working well at school and that my mother will recover from her illness.

I hope that my family will continue caring for one another, and that I can count on the support of my colleagues and neighbours.

And for you personally?

For the time being, I can't imagine anything for myself. My sister and my mom have so many wishes." (Mzungu Gazetti, December 2008)

The book "28 stories of AIDS in Africa" also has a chapter on Tigist Haile Michael, an AIDS orphan from Ethiopia, who lives alone with her young brother Yohannes, in very poor circumstances.

"When they walk down the main road on the way home from school, the children look in all the shop windows. Yohannes tries to catch a few minutes of movies playing on the TV screens, while Tigist likes to look at the clothes and the books. If they had more money, she said practically, she would spend it finding them better housing, and newer clothes, and proper cooking pans. When I put the question to Yohannes, he answered instantly that he would pay for them both to go to the best school in the city. And then he would buy trays and glasses, the things they need in the house. And perhaps, if there were lots of money, a television. When his sister was out of earshot, he confided, "I'd use it to take care of her."

And when Yohannes has gone back out to run with his friends in the street, Tigist watched him from the doorway, her head against one slim-fingered hand, and she said it too. "If we hade more, I would try to take better care of him. I have to take care of him."

The stories of Tigist and Yohannes, as well as the story of Lilian highlight the importance of community oriented thinking in many HIV/AIDS oriented projects.

TIME ORIENTATION AND USE OF MONEY

Multicultural teams involved in HIV/AIDS related projects do often experience tensions because of the culturally different ways of handling time and money.

Western development workers do often find it hard to understand and accept that considerable amounts of money are spent for funerals, when the family does not have the means to pay for schooling of the children or for "decent" housing. They are stunned when their local colleagues ask them to lend them money for funerary rituals. They also find it hard to accept that professional commitments are almost systematically postponed in case of funeral of somebody one knows, even if that person is not in the "close circle" according to western standards.

Local colleagues are, on their side, stunned and shocked that western development workers do not understand the absolute centrality of decent funerals, for the sake of the binding of the community of the living, and for the journey of the soul of the deceased towards ancestry. They are hurt when western colleagues challenge their primary commitment to funerals. For them, dignified funerals guarantee not only their status in the community, but also and even more the journey of the soul of the deceased…and thus their own peace of mind. The tragic story of Mfanimpela Thlabatse, from Swaziland, whose whole family died of AIDS within 5 months, illustrates this central cultural value. It is taken from "28 stories of AIDS in Africa."

"I couldn't bring myself to inquire of Mfanimpela about his wife or the children, but when Siphiwe and I were making our way back down the path, I did ask her."They all died, between April and August," she said baldly. "One after the other."

CINFO AND ITS WORKSHOPS

Further information about cinfo and its services can be found at the following address: www.cinfo.ch.

cinfo offers a number of workshops in relation to intercultural communication and intercultural skills development. More information on the website, under "Formation" (French page) or "Bildung" (german page). The workshops' language is English.

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Ressource

Stephanie Nolen: 28 stories of AIDS in Africa. New York 2007

Sharing different perspectives

Mfanimpela had to give the children paupers' burials, she added, because after he buried his wife there was no money left for more funerals. I understood the shame this must have caused him. Mfanimpela was thirty-four that day we met again — a few months older than I. And he had outlived his entire family."

Let us also listen once more to Silvia Noser and Friedwart Storto's perspective:

"Funerals are more important than any professional commitment or anything else. For funerals, everything else is postponed. Everything. That was also the reason why the key speakers had not attended the teachers' conference. If a colleague dies, whether s/he is in pension or still working, the African understanding of paying respect requests that one attends the funeral. No way out. On one side, we are moved by this unshaken expression of support and condolences in case of bereavement, on the other side, we see that, at the age of HIV/AIDS, the endless number of funerals do not only paralyze schools to some extend, but they also prevent the development of a whole state."

Two situations that highlight the gap between the cultural priorities and the challenge of negotiating shared common meaning.

CONCLUDING THOUGHTS

If some of us give priority to funerals and life after death, whilst some of us give priority to what was planned and committed to; if some of us think as individuals and others as a member of a community, if some of us talk about things in an explicit direct way and others in an implicit indirect way…an important set of intercultural skills is needed to bridge the gap and to try to understand each other. This mutual understanding, result of negotiation of shared common meaning, takes time, but is the key to developing sustainable projects on the base of a cultural approach.

Developing intercultural skills takes curiosity, time, work and energy. It requires knowledge and awareness of one's own cultural identity, relevant knowledge of the other's culture, and knowledge of interaction and skills in it. It also involves the capacity to experience the other's perspective from his or her cultural basis, and the capacity to act in a culturally appropriate way in a given situation.

REACHING COMMON GROUNDS: KULTUR, GESCHLECHT UND MENSCHENRECHTE

Der Zusammenhang zwischen Kultur, Geschlecht und Menschenrechten ist das Thema des jüngsten Berichts «State of world population 2008» des UNO-Weltbevölkerungsfonds UNFPA. In der Arbeit zur Förderung der Menschenrechte und zur Gleichstellung der Geschlechter integriert UNFPA kultursensibles Vorgehen.

Von Susanne Rohner*

Foto: UNFPA

Der «State of World Population Report 2008» arbeitet mit einem umfassenden Kulturbegriff.

OB ZUR FÖRDERUNG der Menschenrechte, der Frauenrechte oder zur Verbesserung der sexuellen und reproduktiven Gesundheit ist ein kultursensibles Vorgehen unerlässlich. Nur wenn der kulturelle Kontext verstanden und einbezogen wird, können in einer Gesellschaft positive Veränderungen herbeigeführt werden, die in den betroffenen Gruppen auch akzeptiert und verankert sind und damit verbunden nachhaltig Wirkung zeigen. Der kultursensible Ansatz ist für den UNO-Weltbevölkerungsfonds UNFPA Programm und zieht sich wie ein roter Faden durch den Bericht «state of world population 2008» (UNFPA State of world population 2008) zum Thema Kultur, Geschlecht und Menschenrechte.

Tsehay war neun Jahre alt, als ihre Eltern sie mit einem 6 Jahre älteren Jungen verheirateten, nichts Ungewöhnliches in ihrem Heimatland Äthiopien. Nach dem Tod ihres Vaters soll das Mädchen zu dem Mann ziehen, mit dem sie verheiratet worden ist. Sie entzieht sich dem, indem sie ohne Nahestehende einzuweihen mit dem Onkel nach Addis reist, wo er sie als Haushaltshilfe in einer Familie unterbringt. Während der folgenden 8 Jahre lebt die junge Frau, die nie zur Schule gegangen ist, völlig isoliert in der Familie, wo sie von morgens bis abends arbeitet, nach eigenen Worten aber immerhin «gut» behandelt wird. Erst über ein Programm, das Frauen wie ihr praktisches Allgemeinwissen vermittelt, lernt sie andere junge Frauen kennen, die ebenfalls auf der Flucht vor Armut und Kinderheirat in Addis gestrandet sind. Tsehay freut sich sehr, ihre Mutter wiederzusehen. Sie kann sich aber nicht vorstellen, in ihre Heimatstadt zurückzukehren, weil es dort unmöglich wäre, ein eigenständiges Leben zu führen. (Generation of Change)

Obwohl Kinderheirat auch in Äthiopien einen Verstoss gegen die Menschenrechte bedeutet, sind solche arrangierten Heiraten mancherorts verbreitet. Die betroffenen Mädchen werden damit nicht nur ihrer Rechte beraubt, sondern solche frühen Heiraten bringen für sie auch beträchtliche Gesundheitsrisiken mit sich. Damit sind sie schon sehr jung einer Ansteckung durch HIV ausgesetzt und riskieren Gesundheit und Leben, wenn sie zu jung schwanger werden. Um erfolgreich gegen Kinderheirat vorzugehen, ist kultursensibles Vorgehen wichtig, weil auch die Gemeinschaft und Familie einbezogen und der kulturelle Kontext berücksichtigt werden muss.

KULTUR BEEINFLUSST UND WIRD BEEINFLUSST

Als Kultur definiert UNFPA die überlieferten Muster übereinstimmender Sinngebung und das allgemeingültige Verständnis einer Gemeinschaft. Diese beeinflussen den Alltag der Gemeinschaft und das Leben und Denken der Individuen und wirken wie eine Linse, durch die die Leute ihre Umwelt wahrnehmen und interpretieren. Solche überlieferten Sinn- und angelernte Verhaltensmuster wirken zwar langfristig und nachhaltig. Kulturen sind aber nicht statische, sondern dynamische Konstrukte, welche äusseren Einflüssen ausgesetzt und von den Menschen selber gemacht sind und auch verändert werden können. Kulturen setzten sich auch aus verschiedenen Untergruppen zusammen, welche über Geschlecht, Ethnie, Religion, soziale Herkunft definiert werden können. Trotz grundlegenden Übereinstimmungen denken noch lange nicht alle Menschen einer kulturellen Gemeinschaft gleich und die vereinbarten Muster und Interpretationen der Umwelt müssen nicht einstimmig und uniform akzeptiert sein. Sie werden immer wieder von Individuen in Frage gestellt, was Möglichkeiten zu Veränderungen bietet.

Kulturelle Werte sollten gemäss UNFPA in Einklang mit den Menschenrechten stehen, welche universell sind und eine für alle Kulturen allgemeingültige Basis bilden. Die Menschenrechte finden erst Anwendung, wenn sie im kulturellen Kontext umgesetzt werden. Es gibt allerdings überall auf der Welt kulturell begründete Praktiken und Traditionen, welche gegen die Menschenrechte verstossen. Kultursensible Methoden bieten hier eine wirksame Möglichkeit, diese anzufechten: Indem kulturelle Realitäten und der Lebenskontext berücksichtigt und verstanden werden, können erst wirksame Wege gefunden werden, um schädliche Praktiken anzufechten und positive zu stärken. Kultursensibles Vorgehen verhindert auch einen voreingenommenen und wertenden Zugang zu den Gemeinschaften und von aussen hereingebrachten Lösungsansätzen, denen es an Bezug zu lokalen Gegebenheiten fehlt. Sie nehmen Kulturen ernst, ohne schädliche Praktiken zu relativieren und zu verharmlosen.

Erst lokales Wissen und ein Bezugsnetz mit Behörden, lokalen NGOs, Individuen und insbesondere auch Schlüsselpersonen innerhalb der Gemeinschaft bietet die nötige Basis für Dialog und positive Veränderungen. Zu kulturellem Wissen und Verstehen gehören die Ein-

sicht, wie die Leute in ihrem Kontext funktionieren und weshalb sie bestimmte Entscheide treffen. Dazu gehören auch die Kenntnisse geläufiger Kommunikationsformen, das Wissen, über was wie gesprochen werden kann und weshalb. Zudem müssen wirtschaftliche, politische und soziale Kontexte einbezogen werden sowie Fragen nach den Machtstrukturen. Wirksame Veränderungen können herbeigeführt werden, wenn Leute innerhalb der Gruppe unterstützt werden, die sich gegen schädliche Praktiken wehren oder wenn Prominente, einflussreiche Führer und gesellschaftliche Schlüsselpersonen gewonnen werden, die bereit sind, sich für Menschenrechte, Gleichberechtigung der Geschlechter und Ziele wie Prävention von HIV/Aids einzusetzen.

INTERNALISIERTE VERHALTENSMUSTER

Kultursensible Ansätze dringen unter die Oberfläche. Gerade im Bereich Gleichstellung der Geschlechter und Empowerment von Frauen, welche als wichtige Voraussetzungen zur weltweiten Bekämpfung der Armut und einer nachhaltigen Bevölkerungsentwicklung anerkannt sind, ist dies unerlässlich. Geschlechterbeziehungen und Machtstrukturen bauen auf kulturellen Überzeugungen auf. Kultursensitive Fragestellungen gehen weiter als einfach Ungleichheiten zu nennen. Sie zeigen nicht nur auf, wie Geschlechterbeziehungen gesellschaftlich und gesetzlich geregelt sind, sondern sie gehen auch der Frage nach, wie sich Machtstrukturen auf das Private, auf Beziehungen aber auch auf das Selbstverständnis des Einzelnen auswirken. Im Zusammenhang mit Gewalt gegen Frauen suchen kultursensible Ansätze nicht nur nach Tätern und Opfern, sondern auch nach Verhaltensmustern von Männern und Frauen sowie nach versteckten Mechanismen und internalisierten Verhaltensmustern.. Dabei ist es sehr wichtig, Männer einzubeziehen, die sehr wohl auch zu Advokaten von Frauenrechten werden können. Kulturell begründete Rollenbilder und Definitionen von sogenannter Männlichkeit können Machtstrukturen erhalten, Gewalt gegen Frauen relativieren und zum Beispiel Risikoverhalten von Männern fördern, was auch Auswirkungen auf die Prävention einer Übertragung von HIV/Aids hat.

Bei heiklen weil tabuisierten Themen wie Sexualität im allgemeinen und HIV/Aids oder reproduktiver Gesundheit im besonderen ist es besonders wichtig, kultursensibel vorzugehen. Im Zusammenhang mit HIV/Aids weist UNFPA unter anderem auf folgende Vorteile hin: Kultursensibles Vorgehen baut Vertrauen und Engagement auf Gemeindeebene auf, was die Wahrscheinlichkeit von Prävention erhöht. Zudem werden Werte, Vorstellungen, Traditionen und soziale Strukturen, in denen die Menschen leben berücksichtigt. Zudem zeigen kultursensible Programme auch Erfolg bezüglich Abbau der Stigmatisierung Betroffener.

Annie Kaseketi Mwaba aus Sambia hat ihren Mann und vier Kinder verloren. Als sie selber krank wird, muss sie insistieren, bis ihr Arzt sie auf HIV testet. HIV/Aids gilt in ihrem Umfeld als Resultat unmoralischen Verhaltens.

Das positive Testresultat ist für Annie ein Schock, vertrat sie doch selber innerhalb ihrer Kirchgemeinde aktiv die Meinung, «HIV/Aids treffe nur Leute, die nicht in die Kirche gehen.» HIV/Aids wurde leichtfertig als Laster anderer abgehandelt, innerhalb der Gemeinde tabuisiert und Betroffene stigmatisiert.

Als sich herausstellt, dass ihr jüngster und einzig überlebender 9-jähriger Sohn ebenfalls HIV positiv ist, beschliesst Annie Kaeketi Mwaba aktiv zu werden. Ihr «coming-out» in ihrer Kirchgemeinde, in der sie als aktives Mitglied sehr geschätzt wurde, führt dazu, dass heute offen über HIV/Aids gesprochen wird. Es wurde auch sichtbar, dass zahlreiche weitere Gemeindemitglieder HIV positiv sind, dies aber bisher verdrängt und versteckt hatten. Heute steckt Annie Kaseketi Mwaba ihre ganze Energie dafür ein, innerhalb christlicher und islamischer Glaubensgemeinschaften HIV/Aids zu enttabuisieren und über Initiativen Betroffenen und Aidswaisen zu helfen. (UNFPA state of world population 2008)

Präventionskampagne in Marokko

MÄNNLICHKEIT UND WEIBLICHKEIT

Ein kultursensibles Vorgehen ist auch Voraussetzung zur Erreichung des Millenniums-Entwicklungsziels 5, welches die Gesundheit von Schwangeren und Müttern verbessern und die Müttersterblichkeit zwischen 1990 und 2015 um 75% reduzieren will. Trotz Anstrengungen blieben die Zahlen der Frauen, die während der Schwangerschaft oder Geburt sterben, seit 1980 nahezu unverändert: Jährlich sterben rund 500 000 Frauen während der Schwangerschaft oder Geburt, 99,9% davon in Entwicklungsländern. Millionen von Frauen haben nicht nur keinen Zugang zu medizinischer Versorgung, sondern auch nicht die Möglichkeit, zu bestimmen ob und wann sie schwanger werden möchten. Ursachen sind laut UNFPA mangelhafte Gesundheitssysteme wie auch kulturelle Barrieren. In vielen Kulturen bestimmen patriarchale Rahmenbedingungen Männlichkeit und Weiblichkeit, wie auch die Bedeutung von Sexualität und reproduktiven Rechten, mit dem Resultat, dass den Bedürfnissen von Frauen kaum Beachtung geschenkt wird. Deshalb ist es wichtig, die Gesundheit von Frauen in deren sozialen und kulturellen Kontext anzugehen und kultursensible Lösungen zu suchen.

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Ressourcen

UNFPA State of world population 2008 – Reaching Common Ground: Culture, Gender and Human Rights. www.unfpa.org

Generation of Change: Young People and Culture: Youth supplement of UNFPA state of world population report 2008.

Foto: © Manoocher Deghati/IRIN

Kulturelle Werte sollten gemäss UNFPA in Einklang mit den Menschenrechten stehen (Kinderarbeit in Sambia, März 2007).

In einem kulturellen Kontext, in dem Kinderlosigkeit ein Stigma ist, oder die Zahl der Kinder von grosser Bedeutung ist, werden Verhütungsmitteln eher skeptisch beurteilt und nur zurückhaltend verwendet. Erst das Wissen um den kulturellen Kontext ermöglicht es, Widerstand gegen Verhütungsmittel abzubauen und Frauen zu stärken, indem sie ihre Reproduktion selber steuern können.

Junge Menschen und Jugendliche befinden sich oft in besonderem Masse in einem Spannungsfeld zwischen Tradition und Moderne. Gleichzeitig können sie treibende Kraft für Wandel sein.

Der UNFPA-Bericht «state of world population 2008» zeigt Fallbespiele von Jugendlichen auf, welche aufbauend auf ihrem kulturellen Kontext Alternativen zur Elterngeneration finden.

Gritta, eine 22-jährige Frau aus Mocambique, hat als nationale Fussballspielerin Erfolg in einer typischen Männerdomaine. Aufgewachsen in einem von Kriminalität geprägten Viertel in Maputo, ist sie über ihren Zwillingsbruder zum Fussball gestossen. Trotz anfänglichem Widerstand ihres Vaters wurde sie als 1-Jährige in ein Fussballteam aufgenommen. Sie versteht sich aber nicht nur als Fussballspielerin sondern auch als Aktivistin und beteiligt sich an Kampagnen für Kondome. Zur Halbzeit verbreiten sie und ihre Kolleginnen im Gespräch mit anderen Spielerinnen sowie ZuschauerInnen Informationen zu Kondomen, HIV/Aids, sexueller und reproduktiver Gesundheit und Geschlechterfragen. Trotz Erfolg als Fussballspielerin sieht Gritta ihre Zukunft nicht im Sport. Sie möchte sich in einer Gesellschaft, in der Frauen ihrem Urteil nach meist nicht ernst genommen werden, erst mal Unabhängigkeit schaffen und studieren. (Generation of Chang)

24 TIPS FOR DEVELOPMENT PRACTITIONERS

"In our development efforts in poor communities, we need to be able to work with people at their own level and to find common ground. We may not believe in what they do, we may not agree with them, but we need to have the compassion and the commitment to understand them and to support them as they translate universal principles into their own codes, messages and ways of doing things. Human rights is our frame of reference. And we use culturally sensitive approaches to promote human rights in ways that people can identify with and can internalize in the context of their own lives."

Thoraya Ahmed Obaid, UNFPA Executive Director

THE FOLLOWING are excerpted from the UNFPA publication *Working from Within: 24 Tips for Culturally Sensitive Programming.* These guidelines for development practitioners can lead to more effective and efficient implementation of almost any project. http://www.unfpa.org/culture/24tips/cover.htm).

1 INVEST TIME IN KNOWING THE CULTURE IN WHICH YOU ARE OPERATING.
Understanding how values, practices and beliefs affect human behaviour is fundamental to the design of effective programs. Nowhere is this understanding more important than in the area of power relations between men and women.

2 HEAR WHAT THE COMMUNITY HAS TO SAY.
Before designing a project, find out from community members what they hope to achieve. Soliciting their views on different aspects of a project, from the overall strategy to specific advocacy messages, can foster local acceptance and instill a sense of ownership.

3 DEMONSTRATE RESPECT.
Make an effort to show that you understand and respect the roles and functions of community leaders and groups, avoiding attitudes or language that may be perceived as patronizing.

4 SHOW PATIENCE.
A great deal of dialogue and awareness-raising may be needed to persuade others to accept new ways of thinking, especially ones that challenge beliefs closely tied to individual and social identity. Invest as much time as necessary to clarify issues and address any doubts. If questions are not resolved, they may resurface later and derail progress.

5 GAIN THE SUPPORT OF LOCAL POWER STRUCTURES.
Winning over those who wield power in a community, whether they be NGOs, women's groups, religious leaders or tribal elders, can be a crucial first step in gaining acceptance at the grass roots. Make sure your first encounter sends a positive message.

6 BE INCLUSIVE.
The best way to dispel mistrust is through a transparent process of consultation and negotiation involving all parties.

7 PROVIDE SOLID EVIDENCE.
Using evidence-based data, show what program interventions can achieve, such as saving lives. In addition to advocacy, such information can be used to clarify misconceptions and obtain support from policy makers and local power structures, including religious leaders. Credible evidence is especially important when the issues under discussion are controversial.

8 RELY ON THE OBJECTIVITY OF SCIENCE.
Addressing culturally sensitive issues in the context of health can help diffuse the strong emotions that may be associated with them. A technical or scientific perspective can make discussion and acceptance of such issues easier.

9 AVOID VALUE JUDGEMENTS.
Don't make judgments about people's behavior or beliefs. Rather, put your own values aside as you explore other people's thoughts and dreams, and how they think they can best achieve them.

10 USE LANGUAGE SENSITIVELY.
Be cautious in using words or concepts that may offend. Frame issues in the broader context of health and healthy families and communities.

11 WORK THROUGH LOCAL ALLIES.
Rely on local partners that have the legitimacy and capacity to influence and mobilize a community. Such partners have the added advantage of knowing what local people are likely to accept.

12 ASSUME THE ROLE OF FACILITATOR.
Don't presume to have all the answers. Give up control and listen to others express their views, share their experiences and form their own ideas and plans. In an environment charged with ethnic or religious differences, assuming the role of facilitator sends a message of neutrality.

13 HONOUR COMMITMENTS.
Doing what you say you will do is a powerful way to build confidence and trust.

14 KNOW YOUR ADVERSARIES.
Understanding the thinking of those who oppose your views can be key to successful negotiations. Analyze the rationale on which they base their arguments and be ready to engage in an ongoing and constructive dialogue.

15 FIND COMMON GROUND.
Even with seemingly monolithic institutions there are different schools of thought. Look for areas of common interest that can provide entry points for working with nontraditional partners.

16 ACCENTUATE THE POSITIVE.
When addressing harmful traditional practices, emphasize that both harmful and positive practices are found in all societies. This can help diffuse tensions around the challenging issues.

17 USE ADVOCACY TO EFFECT CHANGE.
Well-planned advocacy campaigns are particularly important when project goals are likely to provoke religious or cultural controversy.

18 CREATE OPPORTUNITIES FOR WOMEN.
Give women the opportunity to express themselves and demonstrate their capabilities. This can help diminish false, culture-based beliefs about stereotypical gender roles.

19 BUILD COMMUNITY CAPACITY.
Reinforce a sense of ownership and ensure sustainability by strengthening the skills of community members, including health-care providers and peer educators.

20 REACH OUT THROUGH POPULAR CULTURE.
In many parts of the world, music and dance are popular cultural expressions. Use them to communicate new ideas, and be sure to involve young people in the creative process.

21 LET PEOPLE DO WHAT THEY DO BEST.
Often, an appropriate role for traditional or religious leaders is mobilizing communities or helping to reshape public opinion. Seek their engagement in these areas.

22 NURTURE PARTNERSHIPS.
Cultivating relationships requires an investment of energy, patience, and time. Don't allow them to disappear just because [work] has ended. Sustaining partnership beyond a single [consultation] allows trust to mature, increasing the chances for positive results over the long term.

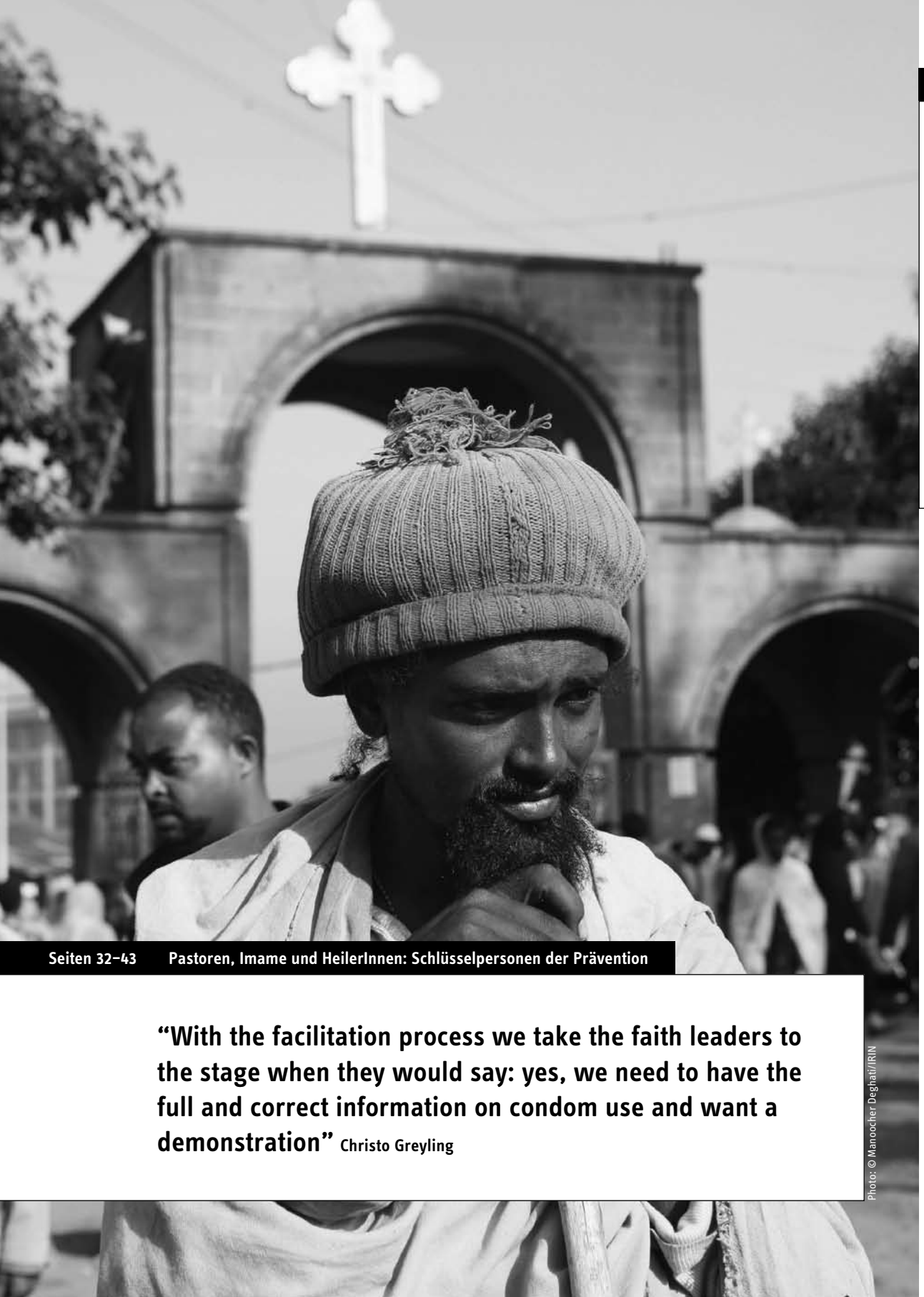
23 CELEBRATE ACHIEVEMENTS.
Bringing accomplishments to the attention of others and publicizing success can create a sense of pride and reinforce community involvement.

24 NEVER GIVE UP.
Changing attitudes and behaviors can be an excruciatingly slow process, especially in closed societies. Don't expect to accomplish everything at once. Even small changes are significant, and may be more enduring over the long term.

STANDING TOGETHER TO FIGHT A COMMON ENEMY

Faith leaders of all religions are very important players in the field of addressing HIV and AIDS. Even Peter Piot, the retiring Executive Director of UNAIDS said at the World AIDS Conference held in Mexico in August 2008: "When I started this job I saw religion as one of the biggest obstacles to our work, but I have seen great examples of treatment and care from the religious community, and lately prevention."

By Christo Greyling*



Seiten 32–43 Pastoren, Imame und HeilerInnen: Schlüsselpersonen der Prävention

"With the facilitation process we take the faith leaders to the stage when they would say: yes, we need to have the full and correct information on condom use and want a demonstration" Christo Greyling

Photo: © Manoocher Deghati/IRIN

THIS CHANGE in attitudes towards faith leaders is echoed in the experience of World Vision International working with faith leaders in its response to HIV and AIDS. Historically, we find that stigma in the context of HIV and AIDS used to be extremely high among faith leaders in high and low prevalence areas. Even today there is still a very strong correlation between HIV and something somebody has done wrongly. People living with HIV/AIDS must have sinned in some way that is why they contracted HIV.

A baseline study done by Word Vision international in rural communities in Zambia and Uganda looked at the prevalence of HIV/AIDS related stigma among Children (10-17 years). The results show, that both in Zambia and Uganda, a high percentage of children agreed that HIV AIDS is a punishment from God. Where would children get this idea from?

The same question was asked to faith leaders from both Christian and Muslim communities. The result showed that 84% of faith leaders in Uganda and 65% of faith leaders in Zambia agreed that HIV is a punishment from God. This is a strong underlying belief still existing in the community and prevents faith leaders from engaging actively in prevention and caring work. Even while caring for dying people or children orphaned by AIDS, they still directly associate HIV with sin.

"THOSE WITH HIV MUST REPENT"

The story of Pastor Thomas Lebiletsa from Lesotho underlines this. He said: "I would tell my congregation almost every Sunday, those with HIV must repent. You will come back to the church when your legs are as thin as the pole holding up this tent and ask for forgiveness… and I will be ready to conduct your funerals."

I am sure that Pastor Thomas did not say this to harm people, but to try to help people not to engage in sexual activity with the risk of getting infected. He actually wanted to prevent HIV. But the language he uses came across in such a stigmatizing way that the people who might have been in the audience would not come to him for support and care.

This underlying judgment apparent in the language used becomes very clear when they talk about "them" versus "us". They are not part of us, not part of the Christian community. Faith leaders talk about innocent victims versus those that guiltily brought it on themselves.

We find a strong tension between theology and practice. In some way faith leaders feel as representatives of God they have to say something to "protect" the values of faith. They do

not think they can encourage the use of condoms as this would lead to an increase of sexual activities. Talking about condoms would make people think the pastor is compromising on this faith.

"THEM" AND "US"

The behavior of faith leaders is not so different from the behavior of people in the community. At the workshops with church leaders we usually do a highly confidential exercise in which participants are asked to put codes which apply to their own sexual experience. Be it Muslim or Christian – even high level Bishops – the results regarding their sexual activities are very much the same as in the community. This was a huge shock for the faith leaders. But it is an important process helping to understand that they cannot talk about "them", but only about "us". Pastors and imams are just as vulnerable to HIV infection as the rest of community.

It is surprising how little information and knowledge faith leaders even today have about HIV and AIDS. It is very basic: they know that it can be transmitted sexually, but have little technical knowledge going beyond that. Better knowledge would help them to engage in prevention or in rolling out a care and support programs effectively.

A very strong dualism persists among faith leaders who believe that their main task is spiritual nature. They fear to move outside typical the doctrinal thinking, as they fear to be labeled radical or secular, or that they would seen as compromising and weakening their faith's message.

We experiences that talking with faith leaders on HIV and AIDS opens a lot of possibilities and opportunities for partnership with faith based organisations on HIV prevention, care and support. A faith leader is an extremely good door opener. If the pastor or the imam of the congregation participates in the workshops, he goes through a process and starts to get a new vision. Local faith leaders are the ones that encourage their own congregation and community right at the grassroot level. If a local faith leader is against it, he is a real blocker. That is why it is so important to get the local pastor or imam into the process. We witnesses amazing processes of change: an attitude change and a growing understanding for the need for comprehensive multi-faceted approaches that includes prevention and condoms as well. Local faith leaders become powerful change agents in the community.

CHANNELS OF HOPE

The Channels of Hope (CoH) methodology is one of World Vision's core HIV and AIDS response models. In the first phase, faith leaders from a specific community walk through a three-day workshop where they are challenged to move towards compassionate involvement with HIV and people living with HIV. They start with "HIV and me…" a set of exercises addressing and changing attitudes. Then, the participants receive in-depth HIV and AIDS information. People living with HIV join and share their own experiences, especially people with faith. In a next step, the participants are introduced to a variety of faith responses to HIV prevention, care, and advocacy and are encouraged to link to "communities at work…"

Once faith leaders have been sensitised and mobilised, they develop their own congregational responses by integrating HIV messaging into existing ministry areas, such as worship services, youth, women's and men's ministries. The faith leader needs a team of people to work with him and is encouraged to form a leadership group within the congregation to address HIV in these different areas. It is important to link HIV interventions to existing community interventions, such as the Community Care Coalition. While linking to these processes it really starts to show some promising results.

"… UNLESS MY ATTITUDE CHANGED"

Pastor Thomas Lebiletsa form Lesotho, after going through this sensitizing process, said that he is the one who has to repent: "I realized I hated people with HIV and I knew that those who were suffering because of the pandemic could never come to me for support even though I am a pastor… unless my attitude changed."

Pastor Thomas Lebiletsa now addresses HIV issues in his congregation more openly and in a non-stigmatizing way. He formed a leadership group. When he realized that there are children in the community orphaned by AIDS that stayed without shelter, he rebuilt a shelter and started feeding scheme out of his own kitchen. He later linked it to the Community Care Coalition which produces much better results.

Results from operations research underway in Uganda and Zambia have shown that Channels of Hope leads to significant reductions in stigma among participating faith leaders. In Uganda, faith leaders participating in the programme reported significantly less HIV-related stigma than faith leaders in the control group.

In comparison with faith leaders who have not been involved in the CoH process, the 2nd follow-up survey in Zambia also showed promising results. 100% of the faith leaders said that they now care for orphaned and vulnerable children, as compared to 65% who did not participate in CoH. Out of 78'000 Home visitors for orphaned and vulnerable children and/or chronically ill active, 44'120 are volunteers from Faith Based Organisation.

"LAWFUL AND SAFE"

The prevention messages we often hear are very individualized messages: "God made you special… Choose life!" or "You are responsible for you own sexual health". Though these are good messages, they focus too much on individuals making a choice. However, people are not able to make the choice for his or her own sexual health if the social, political, religious, or economic environment is not conducive. As part of the Channels of Hope process faith leaders are asked to note down social or religious aspects as drivers of HIV. They also identify practices in their own community which could lead to possible infection. As they make this list and include eg. wife inheritance or female genital mutilation, a discussion is raised to identify what makes women vulnerable, what makes children vulnerable, what makes men vulnerable and what this leads to sexual infections. They then realize that they cannot only address these issues on a faith level or spiritual level: "If we do not address these aspects too, we are not doing our job as leaders." That's an aha! moment for them.

Another important aspect we find is important for faith leaders to understand is that there is a difference between practices which are lawful in God's eyes and practices which are safe. Canon Gideon Byamugisha, a church leader from Uganda who became the first African religious leader to openly declare his HIV-positive status, developed this framework. He said that not everything that is lawful according to theological understanding or acceptable is necessarily safe. Or: what is unfaithful or unlawful may not necessarily be unsafe.

The problem is that faith leaders only think about sexual practices as lawful and unlawful according to their theological understanding. But there are aspects in HIV prevention that are lying on the public health side on what is safe and what is unsafe. The ideal situation would be that people have sex in a way that would be lawful in God's eyes and at the same time be safe in term of public health practices. But there are a lot of people who would end up in a situation where their sexual practices would be unlawful und unsafe. It could be that people just don't care, are lacking information or they might be in a situation where they don't have a say. It is not just about a person refusing to listen to God's will or refusing to listen to public health messages. There is a big difference between refusal and failure, and a lot of people might be failing to listen to public health messages or to God's will not out of their own choice.

For a pastor or imam it is hard to understand why people are making a choice that is unlawful in God's eyes. But how could he help them to live a life without infecting others? There might be people engaging in sexual activities outside of marriage, or before marriage, but they use condoms and are saving a life. In this way the sexual practice is unlawful in God's eyes, but it is safe in terms of HIV infection. There might also be people who are legally, lawfully married in a happy relationship, but they are still unsafe or at risk because one of the partners might not know that he is or she is HIV positive.

This exercise helps a faith leader to come to the point that he realizes that he has a role to play in all these different sectors. The outcome is that what is culturally, legally, religiously, or politically correct, acceptable or lawful may not always be safe in terms of HIV infection, transmission and prevention. And to be within God's will, the sexual practice must be lawful; to escape HIV infection the sexual practice must be safe too.

Christo Greyling

SEARCHING FOR ANSWERS TO SIX QUESTIONS

One of the most difficult and challenging tasks is addressing condom use with church leaders. We have to bring in practice versus theology. In the training, we divide the participants in six groups, and each group gets questions which it has to answer with "yes" or "no".

Question 1, "should Christians/Muslims have sex outside or before marriage?" they easily answer with "no". Question 2, "Are Christians/Muslims having sex outside or before marriage?" is mostly answered with yes. Question 3 is more controversial: "Should Christians/Muslims use condoms when having sex outside or before marriage?" The discussions and fight between the participants starts. Question 4, "does condom use fit within the Biblical/Quaranic perspective?" leads to a verbal fight, as some will say "yes", the others "no". Question 5, "should Christians/Muslims use condoms for prevention of HIV infections?" will again raise a lot of "yes" and quite a number of "no". Question 6, "can Christians/Muslims contract HIV when having sex outside, before or within marriage?" is obviously answered with "yes".

This exercise leads to tough discussions – and there are no easy answers. The faith leaders are left with their own discomfort. If this is the reality, shouldn't you know how to help a person who is in need to make a decision whether or how to use a condom or not? With the facilitation process we take them to the stage when they would say: yes, we need to have the full and correct information on condom use and want a demonstration.

It is very important that the faith leaders engage with one another in the discussion processes. Because it is in these discussions that they find out in what way they differ from one another, but also become aware where they themselves need to start to shift in their own thinking.

As a result of the trainings and discussions, there are a growing number of faith leaders who discuss HIV prevention with their congregation, including the use of condoms. During these discussions and activities many faith leaders realized their own risk for HIV and went for HIV-testing. Results from operations research in Zambia have shown increases in voluntary counselling and testing among participating faith leaders: 85% of the participants of Channel of Hope ever had a HIV test, as compared to 26% of other faith leaders.

TOUGH TRIGGERS AND CHANGE

Some of the triggers that lead to tough discussion are linked to cultural issues:

- "If a particular way of doing things is part of our culture, we cannot say it is wrong because it is actually our culture that tells us what is right and what is wrong."
- "It is natural that men should have authority over women and that women are inferior to men."
- "A husband always has a right to have sex with his wife."
- "If it is part of our culture for people (particularly men) to have multiple sexual partners, you cannot say that this is wrong because it is actually our culture that tells us what is right and what is wrong."
- "It is time for the church to talk openly about masturbation as a safe way of releasing sexual energy?"

These are issues that are never talked about, perhaps not even in our Western society within the church community.

ADDRESSING SENSITIVE CULTURAL AND RELIGIOUS ISSUES

An important lesson we learnt is that we need a trained facilitator to engage faith leaders in these process, someone who knows how to facilitate these highly sensitive issues. Not just anyone can pick up a manual and go and do this, as it might harm people in the process in addressing these sensitive cultural and religious issues.

Another important point is the inclusion of people living with HIV to help people shift in their thinking – especially people of faith living with HIV who can share their stories from their own faith perspective.

Another lesson we learnt is that addressing very sensitive cultural issues might require separate sessions by gender. For instance there was a session with a group of Muslims where an respected Sheik from Mali gave important and wise input on Quaranic perspectives on sexuality in a very open and frank way. But in the same group we had people from Ingushetia where people, especially the women, don't talk about sex at all – and the moment this Sheik from Mali started to talk, they left the room. The group had to be split up in by gender to allow discussing things that are so sensitive.

We have to trust the process. Change will happen through the facilitated process and in the exchange with peers. In this process, people discover their personal vulnerability and they grasp the need for a multifaceted approach

EXPERIENCES WITH MUSLIM CHRISTIAN COMBINED TRAININGS

There are many good interfaith HIV programs which uses generalized language instead of faith specific language. We learnt from experience that it is better to speak the language of the specific faith group. People of faith need to tackle the issues from within their own understanding of their faith. In a mixed group they are more sensitive in the discussion on issues they might differ from one another as Christians or Muslims.

Channel of Hope developed some guidelines which are specific to the faith groups. For Christians, they are specific guiding principles taken from the Bible; because that is people believe in. The same is true for the Islamic guiding priciples. Therefore, use the language that the people are familiar with.

Culture and religion are often deeply intertwined. Take for instance the understanding of the position of women or female genital mutilation. Some people in the community will say, it is our religion; we must do it this way. Others would say, no, it is not religion; it is part of a particular culture. It is very challenging to address these cultural issues and show the vulnerabilities without hurting people's feeling and loosing them while addressing it.

The biggest problem in working with Christians and Muslims is that we don't know one another. The lack of contact leads to sustained myths and fear. We often hear Christians say: "All Muslims are like ..." and Muslims "All Christians are like…".

"Interreligious dialogue" is an expression often used, but sometimes leads to focussing on the differences instead of focussing on the issues we share with one another. The differences must be respected in these processes, but more important, what we have in common needs to be celebrated. While addressing a common concern such as HIV and AIDS, the differences becomes less important and we discover how much we share which can enable us to work together towards a common solution.

Dr Iqbal Karbanee, HIV and AIDS coordinator Islamic Relief South Africa, said: "I must honestly say that I had many doubts before this training. But now I am convinced this is the way to go. This approach of Channels of Hope allows people from both faiths to address a common issue. It creates an environment where they can share the common principles while respecting the differences. What I like is the fact that it did not try to make the faiths all the same, but built respect for one another." HIV and AIDS may be an issue that unites, and standing together we can.

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TRADITIONAL HEALERS IN PREVENTING HIV/AIDS: ROLES AND SCOPES

Traditional healers are the preferred and most accessible health care providers in the developing countries. With increasing threat of HIV epidemic and critical shortage of human resources for health it is essential that traditional healers are included in the HIV/AIDS prevention program. This paper presents the roles of traditional healers in HIV/AIDS prevention and scopes for including them in the national AIDS prevention and control program.

By S. M. Shariful Islam and Amadou Moreau*

TRADITIONAL healers play a great role in the health care delivery systems in the developing countries. In some parts of Africa, Asia and Latin America traditional healers are far more in number than the modern medicine practitioners and are widely accepted in the society as the first level of contact and trusted health care providers. The World Health Organization (WHO) (2002) has estimated that up to 80% of Africa's population makes use of traditional healers: for many people it is the only health system available to them. With increasing threat of HIV epidemic and critical shortage of human resources for health it is essential that traditional healers are included in the HIV/AIDS prevention and control program.

TRADITIONAL HEALERS ARE CONSULTED FIRST

In developing world, cultural practices, social attitudes and economic conditions facilitate the spread of HIV/AIDS and complicate prevention. Social stigmas surrounding sexual transmitted diseases (STDs) and AIDS keep many from turning to the public health system for testing and treatment. And as a result many people in developing countries continue to consult traditional healers when afflicted with STDs. Many people still believe that AIDS is due to witchcraft and a fetish conspiracy against the infected person and traditional healers may be one of the principal sources of care utilized by people suffering from HIV/AIDS.

Bangladesh has made significant progress in recent times in many of its social development indicators particularly in health. A major constraint identified towards reaching the MDGs and other national health goals is the issue of shortages in the health workforce and the uneven skill mix. Bangladesh has a pluralistic health system and issue of particular concern is the role of non-state health workforce. Like most transitional societies, a wide range of therapeutic choices are available in Bangladesh, ranging from self care to traditional and western medicine. Traditional healers in Bangladesh are very often the first medical contact, particularly in the rural area and sometimes the only source of treatment. There are several types of healers according to their means of practice, like spiritual healers, faith healers, herbalists, bonesetters, kabiraj, practitioners of folk medicine and traditional birth attendants.

Some herbal practitioners and traditional birth attendants (TBA) are recognized by the government, after receiving training from an approved institution. Other traditional methods are widely practiced in the country, though not acceptable by law. It is estimated that 70-75% population of the country still use traditional medicine for management of their different health problems where there are only 2 doctors for 10 000 population compared to 70 traditional healers (The State of Health in Bangladesh, 2007).

COMMON MISUNDERSTANDINGS AND MYTHS

In Bangladesh, about 30% of STD clients do not have any STD symptoms and perceive themselves as having other Sexual Health problems (Chowdhury et al). The traditional healers in Bangladesh, primarily focuses on treatment of sexual dysfunction and illnesses as due to greater acceptance by the people who believe that traditional healers can help men become sexually stronger and cure impotency. Treatment for both male and female is mainly in the form of traditional and herbal remedies, often combined with homeopathic and other methods, primarily based on common misunderstandings and myths propagated by literature that is used to advertise the services of traditional healers and common beliefs. These messages are widely and freely available in the country, which constructs the perception on STDs among the people of Bangladesh.

Advertisements on different daily newspapers on traditional medicines mostly accounted for the conditions related to sex and sexuality. Claims on increasing sexual power, enlargement of male sexual organs and beautification of female breasts were quite common in most of the advertisements. The most commonly cited medicament in the herbal advertisements was some all-in-one power oil found in various brand names such as Special HP Power Oil, Special SP Genital and Erection power Massage Oil. Other remedies offered in these advertisements include various tablets, creams and lotions prepared from assorted herbs and plants. Many of those manifestations were nothing but common myths or beliefs on sex and sexuality such as nocturnal emission, side effects of masturbation, deformity of penis, thinning of semen and others. Study indicated that the anxiety related to sex and sexuality may be reinforced by ignorant individuals and malpractices of Traditional Healers. Apart from these, choice and use of words in these advertisements were provoking and appealing in most of the cases. One such example from the herbal system can cited for instance as follows:

"A single course (seven days) use of the special massage oil can make the male genitalia as strong as iron rod and as thick as the wrist. It causes instant erection of the genitalia to defeat the sexual partners easily. Even a 60 years old man can be as young as 25 years and will get complete satisfaction in coitus. This power oil provides the stamina for love making several times a day. Both married and unmarried people can apply it. This remedy is tested and appreciated by millions of people. This is entirely devoid of side-effects and makes the skin of genitalia fairer. Success is 100% guaranteed." (Islam/Farah 2008)

Sexual myths abound, but the facts still remain lesser known. As sex continues to be deemed as taboo in the society, not to be talked about overtly, nagging doubts about sex is what makes people inquisitive as they end up picking up myths from random sources. These pervasive myths can act as the biggest wreckers, ruining the fun of a sexual act and leading to traditional healers. While nobody knows where the erroneous beliefs originated from, these myths still make their way into people's bedroom. 7 out of 10 patients with impotency and premature ejaculation issues attribute their problem to the masturbation habits. Most men associate their value with their organ size and also with their macho personality, thus they erroneously believe that the dimensions of their penis are of great importance for sexual techniques and gratification.

The common complaints that bring patients to them are sexually transmitted diseases (STDs) and so called "sexual weakness". Providing correct information about HIV transmission and prevention are the fundamentals for HIV/AIDS prevention. It is not much known about the knowledge among traditional healers concerning STDs and HIV/AIDS although a number of them are involved in advising laboratory investigations and using antibiotics and vitamins for treatment.

UNDP initiated a Health Pilot initiative in the Chittagong Hill Tracts to improve the health status of the people in the region through

Shariful Islam

community health programs, mobile medical teams and partnership building. Although the incidence of HIV/AIDS is low in the region, the high rates of STDs, illiteracy, ignorance, availability of commercial sex workers, injecting drug use and bordering with India and Myanmar posses threat to a raising epidemic in the region. Considering the immense role of the traditional healer within the community, UNDP health unit collaborated with traditional healers for preventing HIV/AIDS in the region.

STUDY ON PERCEPTION AND KNOWLEDGE

Between February-May 2007, 165 traditional healers were interviewed with a semi-structured questionnaire and face-to-face interview to gather information on their perception and knowledge about STDs and HIV/AIDS and prevention. The findings were analyzed using both qualitative and quantitative methods. The findings showed that 68% of traditional healers could mention at least one mode of transmission correctly, 31% answered about symptom of AIDS while 56% mentioned condom as means for prevention of STD/HIV. None of the traditional healers prescribed condoms to clients. However 41% said using herbal also could prevent AIDS. The concern for STDs is diffused by physical and psycho sexual myths. According to the 65% traditional healers all sexual problems are linked with the two most commonly known STDs, i.e. gonorrhea and syphilis, which leads to misconceptions. Interestingly, a few traditional healers could identify HIV/AIDS as a potential threat to human being

Traditional healers

and believed that being faithful and maintaining a monogamous relationship would prevent from getting this deadly disease.

The study concluded that while many people in the region had still faith on the traditional healers, it is important that medical team of UNDP coordinate with the traditional healers for better access to health service and HIV/AIDS prevention program. One possibility is incorporating their influence and skill in the primary health care at community level, after providing orientation on modern medical system.

The project collaborated with the government health departments, hospitals and NGOs to begin the training of Traditional Healers with the goal of harm reduction and improving safety measures within their practice. A consultative meeting was organized at the district level for stakeholders to develop strategies to include the traditional healers within the health systems. With the help of an experienced consultant, UNDP designed a program on HIV/AIDS Prevention.

A three-day residential workshop was organized in collaboration with UNAIDS and Christian Hospital, Chandraghona for 131 traditional healers who participated in the survey. Training program included orientation on STDs and HIV/AIDS, symptoms, safe sex behaviors, prevention methods, health education messages, HIV/AIDS counseling and responsibilities of traditional healers. The health education message was targeted to clear the common myths regarding sexuality and HIV/AIDS and gain better understandings of the real situation which can be conveyed to the patients. Different adult learning methodology was adopted for the training sessions. Participants were provided with a handbook in local language and supply of condoms that they would distribute freely to clients. At the end of the training session, it was noted that a new willingness on the part of traditional healers to demonstrate and offer condoms.

Follow-up meetings were organized quarterly between health professionals and traditional healers at the district hospital. The impact of the training on the Traditional Healers had great impact on their practice. For most of them this was a first time they came in contact with qualified medical practitioners and they felt they were valued and part of the medical team. Most of them had no problem learning from medical practitioners although a fraction of them regarded their practice were safer and more effective. The traditional Healers considered working with the medical doctors as a prestige for them in the society and with the expectation that this would increase their acceptability in the community. It was noted that those who had received training were more likely to have changed their practices and initiated community public health activities. They reported conducting community education, promoting condoms and referring patients to medical treatment to district hospitals.

CONCLUSIONS AND LESSONS LEARNED

The role of traditional healers in the fight against HIV/AIDS is of great importance. Traditional healers, even when illiterate, are vital to disseminating information about the prevention of AIDS. Because of their position in the community as trusted health care providers, they are free to speak about sensitive topics, such as sex. Although there are differences in different tribal societies regarding the religion, the traditional healers practiced in almost a similar fashion. For example, faith healers used different types of prayers to cure diseases and herbal medicine was a common practice. More than 75 % of Traditional Healers were Males compared to females. But, as the traditional healers were mostly (83%) aged more than 40 years and coming from the same community they were at ease to speak on sensitive issues like sex. In a developing country like Bangladesh, many STD patients strongly believe that they can be cured by traditional healers. Due to the limitations of qualified doctors it is important to establish a collaborating mechanism between the traditional practitioners and modern medicine to minimize harm and prevent spread of the epidemic among the vulnerable people. However, there is also a strong desire by traditional healers to access legitimacy and resources that can be achieved through collaboration with modern medicine.

Training of traditional healers on STDs and HIV/AIDS prevention methods including condom promotion is necessary as they are the major service provider to the large number of population. It is important to know about the provider's conception of disease and HIV/AIDS. Training materials should be customized so that the receivers can understand the basic message. Cultural appropriate health education message that deals with common myths should be developed. The take home message is important because this is what they will impose upon the people. We should remember that HIV/AIDS prevention is not solely based on biomedical explanations but require an integrated approach involving the socio-cultural dimension as well. Referral for STD cases is essential in order to incorporate the traditional healers with interventions linking STD/HIV prevention in Bangladesh. Consequently, HIV programs and STD testing and treatment programs should develop stronger linkages with traditional healers providing treatment of STD's, secondary infections, pre and post counseling for the individual and family and referral.

THE WAY FORWARD

With the critical level of health workforce shortage, ineffective health systems and increased threat of emerging and reemerging diseases in the developing countries, bolder thinking is necessary – how can the vast majority of the informal providers be most appropriately used? These providers are deeply rooted in their localities and will not go away. We can not keep pretending that they do not exist but need to think creatively about how to deal with this reality and both the positive and negative aspects of their practice. Traditional healers need to be mainstreamed into the formal health systems, giving them some sort of recognition, training and certification would help to reduce the harmful practice and involve them in providing appropriate level of care to the people who needs it the most.

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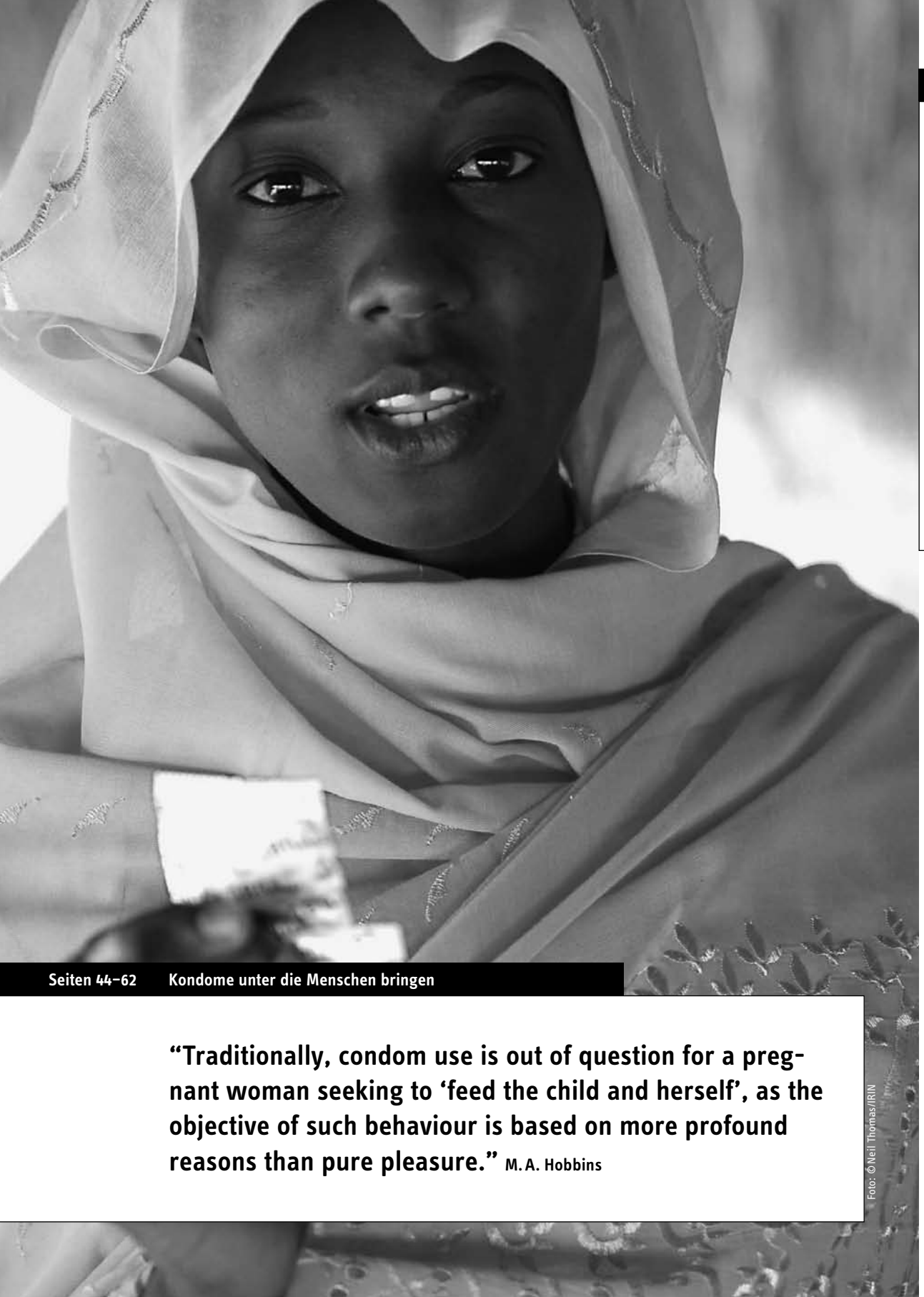
CULTURE AND CONDOM USE

Condom use is one of the elements in ABC-strategy: Abstinence, Be-faithful and Condom use. As the ABC-strategy was implemented, it came clear that it had little regard with local cultures. Despite having much knowledge on HIV and AIDS people still have unprotected sex with partners. This discussion paper found from literature that risk behaviours in any population are shaped by social, structural and cultural factors. Furthermore, it is clear now that cultural norms as well as cultural assumptions about the relations between men and women influence the decision to use condoms.

By Eliudi Eliakimu*



Seiten 44–62 Kondome unter die Menschen bringen

“Traditionally, condom use is out of question for a pregnant woman seeking to ‘feed the child and herself’, as the objective of such behaviour is based on more profound reasons than pure pleasure.” **M. A. Hobbins**

Foto: © Neil Thomas/IRIN

SUB-SAHARAN Africa remains the region most heavily affected by HIV, accounting for 67% of the people living with HIV and AIDS (PLWHIV).(UNAIDS 2008)The HIV infection in the African region is transmitted mostly through heterosexual intercourse and parenteral route. Socio-cultural contexts are important domains of understanding sexual behaviour and pathways of HIV-infection. (Undi et al, 2007) During the 1980s and 1990s the focus of HIV prevention targeted risk-groups such as sex workers, migrants, members of the military, track drivers, injecting drug users (IDU) and risk behaviours such as unprotected sex. (Ramin 2007)

The help of anthropologists has helped to shift the focus from risk groups to vulnerable groups which include women and youths as well as other members of the groups initially referred to as “risk”. (Ramin 2007) The basis for this was that there is no empirically bounded risk-groups but rather the behaviour of unprotected sex that puts people at risk (Ramin 2007) Two strategies abbreviated as “ABC” have been widely used to prevent HIV spread; one advocating for “Abstinence” and “Be-faithful (monogamy)” and another promoting “Condom use”; but both had little regard to local cultures of the people.[3] The purpose of this paper is to discuss condom use and culture basing on available facts and synthesize an outline of the next steps in promoting condom use for prevention of HIV and AIDS.

Literature for building the discussion was obtained from the Bio-Med Central (BMC) citing articles using two key words – condom use and culture. Nine articles were conveniently taken to synthesize the factual discussion and next steps in promoting condom use. The United Nations Joint programme on AIDS (UNAIDS) – 2008 global report on the AIDS epidemic was also cited.

CONDOM USE AND CULTURE

Condom use forms one of the three elements of the ABC-strategy. Even the United Nations Joint programme on AIDS (UNAIDS) declares that condoms are a key to preventing the spread of HIV and AIDS. Studies show that knowledge on HIV and AIDS do not coincide with sexual behaviour (Liverpool et al, 2002). .Several factors have been identified that contribute to “no” or “inconsistent” condom use as shown in table 1.

Ramin, an advocate of the role of anthropology in HIV and AIDS prevention, clearly asserted the value of anthropology in understanding local cultures in the prevention efforts. (Ramin 2007) The complex interplay of social, structural (political and economic), and cultural factors mediate the structure of risk in every population group. Therefore the decision of people on whether to use condoms or not is shaped by the above factors including culture as mentioned.

Table 1: Factors associated with no or inconsistent condom use

Condom use interrupt foreplay and sexual intercourse
Condom makes sex un-enjoyable
Condoms leads to being uncomfortable and inconvenient
Females lack condom negotiation skills
Condom use in trusted or long-term relationships not necessary
Cultural norms such as the need for having children
Marriage
Pregnant women because are not worried about pregnancy
Poor sex communication among partners
Condom use seen as distrust
Reported problems on using condoms
Religion – for example the notion that promoting condom use is to undermine abstinence and that it is equal to telling people that you can't control your sexual urge
Poverty
Cultural practices such as polygamy
Perceiving condoms as ineffective
Feelings that condoms are porous to HIV (it's like golf-ball in basketball loop)
Negative attitudes towards condom such as: condoms are not African; condoms will promote promiscuity and moral lassitude; condoms are ploy to control population size; and condoms kill women.

Table 2: Cultural Norms affecting condom use

Definition of sex (ejaculate into a woman or to receive a man's sperm)
Importance of the notion: flesh-to-flesh in promoting intimacy
Trust to partners (using condom imply that one's partner was a carrier or that one's own sexual behaviour was sordid and risky
Cultural assumptions about relations between men and women
The need for having children

Interesting thing in the efforts to promote condom use is the apparent disparity between people's knowledge and awareness of HIV and AIDS and the extent to which they take measures to protect themselves. (Ramin 2007) It has been further shown that education about risk of infection is not sufficient because cultural determinants of health behaviours serve as important barriers to health behaviour change. Some cultural norms in table 2 have been cited as important barriers to condom use. (Magee et al; Absalom et al)

The use of condoms in HIV prevention is affected by social, cultural, and economic factors. Anthropologists have been even more conclusive by showing that the ultimate barrier to condom use is poverty; not because of its cost-implications but also due to the broader culture of education; risk-taking; and self-preservation. (Ramin 2007)

NEXT STEPS IN CONDOM USE PROMOTION

Proposed next steps in promoting condom use can be divided into five categories:

- **Promoting condom use**
  From the information available on condom use, I propose a framework in figure-1 to guide promotion activities on use of condoms. Importantly, the framework emphasizes on equal promotion of female condoms as is the case with male condoms; also it emphasizes on logistics aspects, monitoring and evaluation and research (basic and operational).
- **Designing and implementing cultural specific interventions**
  Focus on "HIV risk behaviour" alone can not explain the disproportionate HIV rates among certain populations but rather it requires a combined attention to socio-cultural challenges facing the respective population(s). (Williams et al, 2009) Therefore, focus on local cultures of people should guide the advocacy process for condom use.
- **Advocacy and involvement of religious leaders**
  There is a need for more and sustained advocacy and involvement of religious leaders on convincing their followers to use condoms whenever abstinence and be-faithful fails. Here distinction on two lines of thoughts is essential: one is on condom use as contraceptive (example abortion) and the second is on condom use to prevent people dying. (Genrich et al, 2005)
- **More emphasis on risk behaviour prevention**
  Strengthening interventions towards behaviour prevention is extremely important as the success to have effective vaccine and microbicides are far from being reached. A distinguished researcher and psychiatrists at the US National Institute for Mental Health describes "behaviour prevention is today's vaccine". Risk behaviour prevention especially having unprotected sex among the vulnerable groups is important in sustaining prevention efforts.
- **Using a rights-based approach to sexuality education**
  The rights-based Approach (RBA) to sexuality education should take into account the needs of various population groups such as young people and women. (Undie et al, 2007) It entails education on their rights; listening to their views; and exploring methods that allow the target group to express their experiences, aspirations and concerns around sexuality and risk for HIV infection.

CONCLUSION

Although cultures influence the decision of people to use or not to use condoms, it is not the only critical category of factors as political and economic factors are shown to shape much the behaviours of people. In promoting condom use, it is important that structural factors (political and economic) are taken into account on top of the local cultures of people. In this way, the much achieved benefits of the ABC-strategy will be more improved and sustained. Poverty is the ultimate barrier to condom use, hence reducing poverty through a multi-sectoral policy to alleviate policy should be a focus. Lastly, human rights education to young people and women is equally important and hence human rights-based approach to sexuality is an important tool in promoting: safer-sex behaviours (including condom use); rational-decision making; and women empowerment; as well as improving sex communication between partners.

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THE HUMAN SPERM

Ten years ago, the Swiss NGO SolidarMed started to support a "community empowerment in health" programme called "Wiwanana" in the District of Chiure, Northern Mozambique. With this article, we would like to share some experiences related to traditional concepts of health, with important implications for HIV/AIDS prevention in the project area.

By M.A. Hobbins, F. Haupt, J.C. Samuel and J. Ehmer*

Community theatre about traditional healers and HIV

CHIURE IS the District with the highest population in Cabo Delgado Province, with about 260'000 inhabitants of mainly Macua origin living in 140 villages and on 4210 km. There are, on average, 26'000 inhabitants per health centre, one doctor and 51 nurses for the entire district. As in many other African countries, AIDS is a highly prevalent chronic disease in Mozambique, with an estimated 16% of the population (15-49 years) carrying the virus and 10% infected in the Northern part of the country. Chiure District HIV testing centres report a prevalence of 23% (Chiure District Health Data 2008); a minimum of 25'000 persons in the District are infected with HIV. Furthermore, less than half of the population has access to health centres and death registration rate is below 25%.

In such conditions, empowerment of the rural population to prevent and/or manage health issues appears a necessary but long term intervention. Given that – despite a constant increase – a relatively low HIV prevalence still prevails in the Northern region, prevention activities are essential to keep this level down.

COMMUNITY EMPOWERMENT FOR HEALTH

Wiwanana is a Macua word and means "mutual understanding and collaboration". The so-called programme stands at the interface between the state health service providers and the communities, where it acts as mediator, moderator and educator. Such interface is necessary where wide spread and deeply rooted distrust against the state health services exists, as it is the case in this working area *("I did not go to counselling in the VCT for fear that they would give me pills with AIDS",* home based care volunteer, 2008). Local partners support the programme as they recognize the existing communication gap and the importance to approximate the poles. Wiwanana is mainly active in the rural communities, where trained field workers use participatory approaches to initiate learning processes on four health topics: Hygiene and Sanitation, Malaria, Mother and Child Health and HIV/AIDS. At their first community meeting, key community players are identified to later facilitate the organisation of health groups within their community. Such groups then perform house to house visits and speak during community assemblies.

During the many community meetings and discussions on safe sex, HIV/AIDS and family planning held since the start of the programme, the importance of *human sperm* remains paramount and unshakable, and its consequences for HIV/AIDS prevention are worrying.

THE HUMAN SPERM – TRADITIONAL BELIEFS

In Macua culture, men and women are equally convinced that human sperm bears the following qualities and characteristics:

- Energetic value to the woman who receives it during sexual intercourse
- Nutrition for the foetus during pregnancy
- Food to the pregnant woman
- Having polluted colostrum ("first milk")
- Capable of polluting normal breast milk

Whereas the population sees the first three aspects as beneficial, the presence of sperm in the colostrum (sometimes also defined as "sperm which exits in the mother's breast") and breast milk is a negative aspect.

THE HUMAN SPERM – CONSEQUENCES

Following these traditional concepts, single women tend to actively seek casual relationships with men, as they consider sperm as a necessary and nutritious element. The same is true during pregnancy: Frequent sex with the husband or with another man (if there is no husband) is considered beneficial. Married couples may have unprotected sex regularly. However, if the husband is far away, a pregnant woman may actively seek a sexual relationship with another man, to guarantee the best conditions for herself, and for the foetus. This is not always to the pleasure of the family. Sexual escapades often result in conflicts, as it is believed that each man who had a sexual relationship with a pregnant woman shares the development and making of the coming child. If a woman had sexual relationships with more than one man during pregnancy, one speaks of "gravida juntada" (Portuguese for "joint pregnancy").

Whereas sperm is generally considered beneficial to the foetus, it also is commonly accepted that complications during labour indicate extra-marital sex during pregnancy. In this case, the family will investigate who else has "contributed" to the "making" of the child to make him pay child allowances. This potential economic benefit can be torturous to the woman in labour. A pregnant woman with complications during labour will be left to suffer and refrain from seeking help until she admits and tells the name of a second man. Only then will she be sent to the health centre for help. As a consequence, a woman is likely to admit extra marital sex on the basis of saving her and her baby's life. This delay in care-seeking can be of disastrous consequences both for the women and for the child.

In 2008 a head of a clan reported, *"the first-born of my grand child was delivered by Caesarean section, done in Nampula hospital, and we thought it was because she did not tell us the names (of the men with whom she had had sexual relations). When she was pregnant for the second time, our family insisted that she must give birth at home in the village, in presence of the traditional midwife and the family members, not to repeat the same mistake. But then the Safe motherhood group of Wiwanana*

Preparation at initiation rites of girls

Another use of a condom

Photos: Solidar/Med

and the traditional midwife convinced us that she should give birth in the hospital, otherwise she would die."

Once the newborn has arrived, it is deprived from drinking the highly nutritious colostrum (first milk) of the mother. Colostrum is perceived as dirty breast milk, already polluted by sperm from sexual encounters during pregnancy *("we think that the first milk coming from the breast is full of sperm, and therefore we do not recommend to feed it to the newborn as it is dirty milk",* group discussion of various leaders and members of the community, May 09). Instead, the newborn will receive breast milk from another mother until his/her own mother has started to produce breast milk – a dangerous behaviour in areas of high HIV prevalence. Whereas colostrum is considered to be spoiled by sperm from encounters during pregnancy, normal breast milk has the potential to be polluted by sperm from sexual encounters during the lactation period. For this reason, breast-feeding mothers are not allowed to have sex at all for about 2 years. Also, the penis of the man may "frighten" the child, which will consequently fall ill. Many men take this period of abstinence during lactation as an excuse to have sex with other women. Furthermore, it can also have negative consequences for the baby: A breast feeding woman may not take a sick child to the health centre for fear of being accused of extra marital sex – since her husband is supposed to strictly observe the same rule.

In Northern Moçambique, initiation rites are widely held both for young men and women. During these festivities, mostly elderly "initiation rite counsellors" tell the young how to behave in sexual matters. The above named concepts are transmitted and enforced during these rites, which have a very strong sexual component (e.g. girls dancing naked imitating sex with men using a wood phallus etc.). Sometimes, at the end of the initiation rites, girls are encouraged to have sex with many different men, "to try out which fits best" *("from now on you are grown up; you are ready to sleep with any man",* female rite counsellor). Due to their length, price, intensity and strong social dynamic, initiation rites are a key moment in the definition of sexual behaviour for young people in Cabo Delgado. Messages related to the prevention of AIDS and other Sexually Transmitted Diseases are normally not given during these rites.

Cultural norms and the compliance with traditional concepts are a means of social coherence. Today, the same rules increase the spread of HIV, an epidemic likely to affect 20-30% of the population, and already killing thousands.

SOME FINDINGS ON CONDOMS DISTRIBUTION AND USE

Wiwanana applies a condom distribution concept which it calls "intelligent distribution": Local shop keepers are contracted and supplied with somewhat stylish and commercially advertised condoms for sale; religious and political leaders as well as traditional health service providers are supplied with "no-brand" – condoms for free distribution. Shop keepers are also supplied with balloons for sale to children, to prevent them from playing with condoms.

Despite the cultural barriers indicated above, the general demand for condoms appears to be on the rise. In 2008, the programme was not able to meet the demand due to a complete condom stock rupture at District level during several months.

Complementing national efforts, Wiwanana provides about 1-2 condom per man per year in the District. The sales of condoms in local community shops are stagnant and sellers are not interested to sell them anymore due to low demand (up to 6 condoms sold per month). Women appear to be especially reluctant to buy condoms at open shops. A woman publicly seeking and receiving condoms may be accused to be a prostitute by members of the community.

In addition – but probably more for curiosity than eagerness to use it – female condoms are frequently asked for in community meetings. The Ministry of Health has now launched the introduction of these on a pilot basis. Wiwanana will support the District Health Directorate in its efforts and closely monitor the reactions of the communities.

Traditionally, condom use is out of question for a pregnant woman seeking to "feed the child and herself", as the objective of such behaviour is based on more profound reasons than pure pleasure. The man, on the other hand, may not use condoms for other reasons *("it needs to be flesh and bone, that is what I pay for",* man, community reunion, 2009).

During a recent group discussion with young men (n=23) and women (n=12), reasons for young men to not use condoms were:

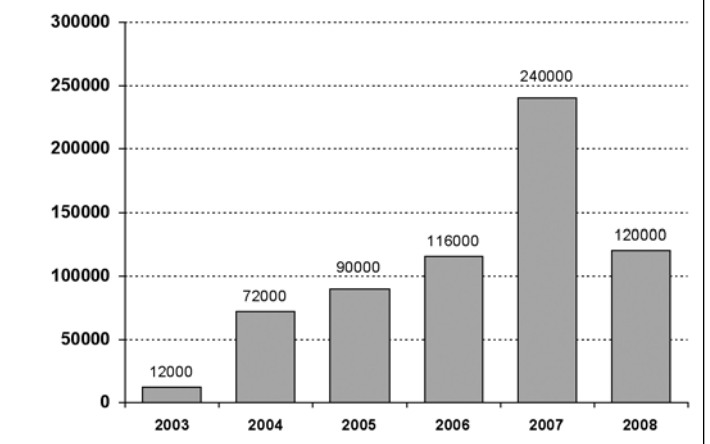
- want "flesh-to-flesh" contact
- irrigate the woman
- want value for money

Reasons for young women not to use condoms were:

- suspect HIV/AIDS to be in the condom
- need of vitamins (sperm)
- need to have children
- fear that the condom stays in the womb

These reflections may indicate a certain gender imbalance regarding awareness and knowledge on the subject. They also confirm the deep roots of cultural concepts around human sperm, especially its nutritive value to the receiver. Whereas the concept of "human sperm" is an important influencing factor, sexual decisions and condom use are affected by other aspects also: *"My husband told me to use condoms such as I could finish my studies, but I refused. I got pregnant, had the child, my husband left, the child is not registered as it needs the father to be there",* young woman, focus group discussion 2009.

Condom distribution by Wiwanana in the last 6 years



"When I asked a young woman for sex, she wanted to use a condom, but I refused and told her I will ejaculate outside. I convinced her as she wanted the money and I got some sexually transmitted illness from this relationship", young man, focus group discussion 2009.

THE INTERVENTION

Wiwanana has a broad, participatory, community-near approach covering many, but not all, influential factors, such as promotion, formal and informal information, education and communication. Most important, the project gained trust among the population – an essential base for introducing change *("in the beginning I did not want to participate in Wiwanana meetings; I thought they were spreading cholera and AIDS",* male farmer, 2008). Methodologies and topics changed and were added during the last ten years; they were constantly adapted to experiences.

HIV prevention efforts were included in the programme since 2003, with the following strategic objectives: Consistent use of condoms, reduction of concurrent relationships, delayed onset of sexual activity, prompt care seeking in case of illness (STI, HIV), use of sterilized instruments during traditional treatment (needles, blades), improved referral between traditional healers and formal healthcare providers, increase of male circumcision, better use of mother-and-child services (PMTCT).

Main target groups are young people (especially young girls), high risk individuals such as casual sex workers or truck drivers (which play a paramount role especially in evolving epidemics), but also "normal" women and men.

To attain the objectives and to increase its impacts, Wiwanana works with relevant peer leaders, such as initiation rite counsellors, traditional healers, elders, religious leaders, informal community drug injectors, village health workers or shebeen (bar)-girls. An enabling and consistent framework is provided by strong local Government stewardship.

In 2008, Wiwanana has been working with 248 village health groups, organized 222 meetings with traditional healers and initiation rite counsellors; 69 encounters with young people, 22 at local schools and 83 meetings in bars, discos and other public high risk places. It has realized 42 radio emissions on AIDS, 24 film and 15 theatre presentations. A spot to promote Voluntary Counselling and Testing (VCT) was broadcasted 560 times. About 100'000 believers have been reached through Christian and Islamic church leaders. Wiwanana also works with 17 female sex workers, 23 advisors in 10 shebeens (local bars), as well as youth groups in 9 schools. Strongly committed to HIV prevention, Wiwanana closely works together with another SolidarMed programme called SMART. SMART supports state HIV services such as voluntary counselling and testing, antiretroviral treatment, the prevention of opportunistic infections, the prevention of mother to child transmission, home based care and STI clinics. With an additional "technical assistance to the health sector" component at District level, the base for integrated health system strengthening is also provided.

DISCUSSION

Individual health-related behaviour is influenced by many factors, including political, socio-cultural, economical, educational, personal and environmental. Each factor depends on various underlying variables, of which some weigh more and some weigh less. The collusion of all these variables will, at the end, result in a certain behaviour of a specific individual at a specific time point.

Understanding these variables, weighing their relevance for specific health related problems and assessing their interdependency with other variables is necessary for the design of successful interventions aiming at behaviour change. With its programme, Wiwanana intends to influence some of the key factors of health related behaviour.

Having sought to understand the key cultural barriers to HIV prevention, Wiwanana has subsequently made various efforts to address these obstacles. Its peer education concept and its strong collaboration with initiation rite counsellors, traditional healers and village elders are examples for strategies to overcome them.

However, isolated NGO efforts to act on traditional health related concepts are not sufficient to provoke change. Messages and stimuli must come from multiple sources, be consistent in content, ongoing in time, adapted to local culture and embedded in an enabling framework. Changing traditional concepts is a long term effort (probably over generations) involving various inputs through different channels and at different levels. Wiwanana's experience, confirmed by community members, is that messages are adopted more easily when reaching the individual from different sources, such as radio, peers, leaders, pamphlets, theatre, traditional healers, affected relatives, initiation rite counsellors etc.

A female farmer in 2009: *"…before, I was a prostitute…I once assisted a Wiwanana meeting talking about AIDS and its prevention, but I did not believe it…then, one day I assisted a theatre play about AIDS, and I started wondering whether it was true or not…finally when I saw a man dying of AIDS here in the village, then I started thinking and changed my behaviour."*

New behaviour appears to be easier adopted than a complete change of habits and concepts. For instance, the acceptance of – not harmful – traditional medicines as a complementary treatment is the basis to motivate people to search help at health centres in high risk situations.

Working closely with the communities in rural areas, Wiwanana has generated a rich bouquet of experiences with the local culture and traditional health beliefs. In this example, the deeply rooted concept of the importance of sperm for women and foetuses has been identified as an important cause for sexual high risk behaviour. Taking it into account for the design of its interventions, Wiwanana is able to contribute to awareness building in young men and women, who think, debate and act on the AIDS pandemic and prevention measures in the District. A few years ago it would have been shocking and seriously offending to publicly talk about sex. This time however, is now over *("some values of our tradition are braking away for the sake of our health",* female farmer, 28y).

This felt progress is comforting. Yet, whereas behaviour change is possible, the process may be slow – a mixed acknowledgment given the high human toll and emergency of the situation. For the moment, constant presence will be necessary to keep up the momentum and to avoid fall backs into previous structures.

The Wiwanana programme is now in the phase to become a National organisation with a strong knowledge management component. As such, it hopes to secure a more permanent position, act long term, disseminate its experience and counsel other local organisations and institutions on cultural and community empowerment aspects in health and health promotion.

HIV is a complex disease, resonating far beyond health dimensions. For this reason, SolidarMed has chosen a comprehensive approach and interventions now cover all main areas from prevention over treatment to care. One of the most important variables, however, remains the individual and its beliefs buried in a network of external inputs.

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MIT HUMOR DIE GRENZEN SPRENGEN

Mit dem Mitmachparcours zu Aids, Liebe und Sexualität versucht das Schweizerische Rote Kreuz (SRK) in Tibet die breite Bevölkerung erreichen. Der Parcours informiert die BesucherInnen über sexuell übertragbare Krankheiten und Methoden der Familienplanung. Dazu gehört auch eine praktische Anleitung zur Kondombenutzung und ein Frage- und Antwort-Spiel zu Liebe und Beziehungen.

Von Monika Christofori-Khadka*

GESPANNT beobachtet der Schafhirte Tenzing aus Gyang Gar was sich am Dorfrand abspielt: auf einer kleinen Ebene stehen sechs bunte Zelte. Ein Jahrmarkt? Ein Fest? Händler aus dem benachbarten Nepal? Neugierig geworden, will er sich die Zelte von innen ansehen und entdeckt dabei etwas ganz und gar Unerwartetes: In der Mitte des Zeltes steht ein Gruppe von Frauen aus dem Dorf, die mit sichtlicher Faszination zuschauen, wie eine von ihnen ein Kondom über einen hölzernen Phallus rollt. Einige kichern verlegen, als Tenzing den Kopf ins Zelt steckt. Doch schon wird er gefragt, ob er auch mitmachen wolle? Im Nachbarzelt gebe es eine Männergruppe.

Schon seit 2002 setzt das Schweizerische Rote Kreuz (SRK) in Tibet auf HIV-Prävention, obwohl zu dieser Zeit gemäss den lokalen Gesundheitsbehörden «HIV in der Präfektur Shigatse und Tibet kein Problem» darstellte. Eine der Zielgruppen sind seit Beginn der SRK-Intervention die Sexarbeiterinnen und deren Klienten in Shigatse und sieben weiteren Städten. Das Projektteam besucht Bars und sogenannte Friseursalons, dort klärt es die jungen Mädchen und deren Klienten über HIV/Aids auf. Zudem hat das SRK als erste Organisation in Tibet ein «Youth Peer Education Programme» in Berufsschulen und höheren Mittelschulen in Shigatse Stadt lanciert, das sich an die jungen Erwachsenen richtet. Zu Beginn des Aufklärungsprogrammes glaubten noch 49% der Studenten, es gebe keine HIV-Fälle in Tibet und «unsafe sex» stelle deshalb auch kein Risiko dar. Nach Abschluss des Trainings in 50 Klassen waren nur noch 7% dieser Meinung. (Jahresbericht 2008)

HIV/AIDS IN TIBET

Obwohl China mit 0,1% als «low-prevalence country» gilt, gibt es «high-prevalence» Nischen bei bestimmten Bevölkerungsgruppen wie Drogenabhängigen, Migranten, homosexuellen Männern und Sexarbeiterinnen. Das Gesetz schreibt vor, dass Individuen vor einem Test ihre volle Identität angeben müssen. Aus Angst vor Stigmatisierung und Diskriminierung melden sich viele nicht. (HIV infection in Giangdong Province, 2009) Es ist davon auszugehen, dass die Dunkelziffer hoch ist.

Lokale Statistiken und Informationen der tibetischen Gesundheitsbehörden erhält das SRK durch das Tibetische Rote Kreuz. Sie besagen, dass von 1993 bis 2008 in Tibet 70 HIV-positive Personen registriert wurden. Allein im Jahr 2008 wurden 25 Neuinfektionen gemeldet, davon erstmals eine Mutter-zu-Kind-Übertragung. Der Anteil an Geschlechtskrankheiten

Foto: © SRK; Bruno Gremion

Durch Humor und eine lockere Atmosphäre fallen viele Barrieren.

in Stadt und Land wird als hoch eingeschätzt. Die noch oft praktizierte Polyandrie auf dem Land erhöht das Übertragungsrisiko.

Die Arbeitsmigration von Landbewohnern in die Stadt ist hoch. Auch steigt der Anteil an Han-Chinesen in Tibet. Weit entfernt von der Familie suchen diese Männer oftmals Barmädchen und Sexarbeiterinnen auf. Der zunehmende Tourismus, bedingt durch den Ausbau der Zugverbindung von Lhasa ins Binnenland Chinas, erhöht die Nachfrage nach Prostituierten weiter. Immer mehr junge Mädchen ziehen in die Städte, um das Einkommen für ihre Familien auf dem Land zu sichern.

Für diese Zielgruppe führt das SRK Aufklärungskampagnen durch. Dabei hat sich gezeigt, dass die tibetischen Mädchen viel schlechter informiert sind als ihre chinesischen Kolleginnen. Beim jährlich durchgeführten «Knowledge, Attitude and Practise» (KAP) Survey des SRK wurde 2008 bei 308 Sexarbeiterinnen in Shigatse Stadt festgestellt, dass 82% der Tibeterinnen zwar schon von HIV gehört hatten, aber nur 12% Kondome benutzten. Dagegen hatten 95% der chinesischen Kolleginnen schon davon gehört und 92% verwendeten Kondome. (Jahresbericht 2008) Durch die hohe Fluktuation ist es nicht möglich die Verhaltensänderung der einzelnen jungen Frauen festzustellen. Die Ergebnisse der Vorjahre zeigen jedoch, dass immer mehr chinesische und tibetische Sexarbeiterinnen über HIV Bescheid wissen. Kondome, die kostenlos beim Eingangstor des SRK-Lokalbüro abgegeben werden, sind beliebt. 2008 wurden 27 500 Kondome dort bezogen.

DER HIV MITMACHPARCOURS

Doch auch ausserhalb der bekannten Risikogruppen nimmt die Zahl der Infektionen zu. Um die breite Bevölkerung besser zu erreichen, hat das SRK das von der deutschen Bundeszentrale für gesundheitliche Aufklärung (BzgA) entwickelte Konzept des Mitmachparcours zu Aids, Liebe und Sexualität übernommen. (www.gib-aids-keine-chance.de/aktionen/mp-

aids/index.php) Dieser Parcours wurde für die HIV-Aufklärung von Jugendlichen an Schulen konzipiert, um sie spielerisch an diese Themen heranzuführen. Die Gesellschaft für technische Zusammenarbeit (GTZ) hat den Parcours zur HIV-Aufklärung für einige Länder Afrikas und Zentralasien adaptiert. Schliesslich hat das SRK das Konzept in den tibetischen Kontext übertragen. Der Parcours besteht aus verschiedenen «Stationen», wo die Besucher/innen über die Übertragungswege des HI-Virus, sexuell übertragbare Krankheiten und Methoden der Familienplanung informiert werden, eine praktische Anleitung zur Kondombenutzung erhalten und schliesslich an einem Frage- und Antwort-Spiel zu Liebe und Beziehungen mitmachen können. Die Stationen lassen sich nach Bedarf erweitern. Jede wird von einer Person moderiert, die durch Fragen und Demonstrationen die Besucher zum Mitmachen animiert.

Die Entwicklung des Parcours für Tibet erfolgte in intensiver Zusammenarbeit mit dem lokalen Rotkreuz-Team und den staatlichen Gesundheitsbehörden. Um ihn möglichst ansprechend zu gestalten, wurden in typisch tibetischem Design Zelte hergestellt, die die einzelnen Stationen beherbergen. Die farbigen Zelte, die Raum für 10 bis 15 Personen bieten, heben sich gut von der kargen Landschaft ab und sind allein schon optisch eine Attraktion.

In jedem Zelt wird ein Lernziel verfolgt, das durch ein passendes Logo und einem Text am Zelteingang beschrieben wird. Der aus dem Tibetischen übersetzte 'Beschützer im Schneeland' und seine 'Familie' führen die Besucher anschaulich in jedes Thema ein.

Die Lehrmethoden sind kulturell angepasst. So wird zum Beispiel in einem Lernspiel der Gebrauch von Kondomen mit dem Erklimmen des Heiligen Berges Chomolungma (Mount Everest) verglichen.

FRAUEN UND MÄNNER SEPARAT

Ob Stadt- oder Landleute, Jung oder Alt: der Mitmachparcours ist bei allen beliebt. Selbst religiöse Führer, traditionelle Heiler und Mitarbeiter der staatlichen Gesundheitsposten beteiligen sich freiwillig daran. Weil ein Lernzyklus 120 Minuten dauert, können pro Tag höchstens drei Parcours durchgeführt werden. In grossen Dörfern wählt deshalb jede Familie zwei Mitglieder (einen Mann und eine Frau) zwischen 16 und 45 Jahren zur Teilnahme aus. Es wird darauf geachtet, dass nahe Verwandte nicht in derselben Gruppe eingeteilt sind, auch Männer und Frauen durchlaufen die Posten separat. Zuletzt erhalten alle Teilnehmer/innen eine Schachtel Kondome und eine Broschüre zur HIV-Prävention mit der Bitte, das Gelernte an ihre Familienmitglieder weiterzugeben.

Es ist erstaunlich wie offen sich viele Teilnehmer in der Gruppe äussern. Der Lernerfolg ist gross: während nur 15% der Teilnehmenden vorher je von HIV gehört haben, können nach dem Parcours alle die Krankheit beschreiben. Ob dieses Wissen nachhaltig ist und zu verändertem Verhalten führt, wird allerdings erst ein KAP Survey in zwei Jahren zeigen.

POSITIVES ECHO

Die Pilotphase, bei welcher der Mitmachparcours nicht nur auf dem Land, sondern auch bei Regierungsmitarbeitern, Polizei, Feuerwehr, Militär und Schülern in der Stadt Shigatse zur Anwendung kam, wurde von allen Beteiligten sehr positiv bewertet. Die staatlichen Gesundheitsbehörden wünschen eine Ausweitung des Programmes.

Das SRK versucht nicht nur im Mitmachparcours, sondern auch bei den Barbesuchen und der Peer Education die kulturellen Gegebenheiten in die HIV-Aufklärung zu integrieren. Dabei ist es immer wieder spannend zu sehen, wie kulturelle Tabus spielerisch thematisiert werden können. Mit Humor und einer lockeren Atmosphäre lassen sich Grenzen sprengen.

Auch Tenzing hat mit sichtlichem Spass etwas Neues gelernt. «Mir war nicht klar, wie wichtig ein Kondom ist. Das probiere ich beim nächsten Mal aus», sagt der junge Mann.

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APPROCHE RÉGIONALE DE LA RÉPONSE FACE AU SIDA EN AFRIQUE CENTRALE

Depuis 2005 la coopération financière allemande (KfW) appuie une initiative régionale, le "Projet Prévention de lutte contre le VIH/SIDA en Afrique Centrale", qui couvre le Cameroun, le Tchad et la République Centre Africaine. Le projet a pu contribuer à l'augmentation de l'utilisation des condoms masculins et féminins qui sont promus à travers des associations nationales de marketing social.

Par Emmanuel Gbaguidi et Kaspar Wyss*

L'AVANCÉE de la pandémie du VIH-SIDA dans les pays de la Communauté Economique et Monétaire de l'Afrique Centrale (CEMAC) et l'urgente nécessité d'harmoniser la réponse face au mal du siècle à l'échelle régionale, ont conduit à l'établissement d'un partenariat entre la CEMAC et le Gouvernement de la République Fédérale d'Allemagne pour la mise en œuvre du Projet de Prévention du VIH-SIDA en Afrique Centrale (PPSAC). L'Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale (OCEAC) et la KfW (Banque Allemande de Développement) sont mandatées pour sa concrétisation. Pour la réalisation des activités, l'OCEAC est appuyée par un Consultant Régional, l'Institut Tropical Suisse (ITS) qui anime un bureau de Coordination régionale du Projet basé à son siège à Yaoundé au Cameroun.

PPSAC est fondé sur le développement d'une approche régionale avec pour but principal d'assurer une meilleure disponibilité des préservatifs et un changement positif des comportements des groupes cibles concernés en vue de contribuer à la réduction de la propagation du VIH-SIDA et des méfaits de la stigmatisation et de la discrimination envers les PVVIH.

Au niveau opérationnel de chaque pays concerné, l'exécution incombe aux Associations de Marketing Social (AMS) d'envergure nationale de ces pays membres. Ces AMS établissent à l'échelle pays un large partenariat avec d'autres ONG et Associations de compétence avérée en vue d'une action synergique pour une large couverture des cibles et du territoire national.

L'harmonisation de la réponse tant à l'échelle pays qu'à l'échelle régionale se fait grâce à deux organes. L'un technique dénommé la Réunion de Concertation Inter-Pays (RCIP) de périodicité 2 fois par an regroupe les acteurs de premiers plans des pays concernés, et l'autre d'orientation stratégique, le Groupe Consultatif Régional de Suivi de PPSAC (GCRS) qui se réunit une fois par an et qui regroupe en plus de ces acteurs de premiers plans, la plupart des organisations bi et multilatérales et autres partenaires de développement en lutte contre le SIDA des pays concernés.

Le bien fondé de l'approche régionale repose sur le large partenariat, la concertation avec les autres partenaires techniques et financiers, mais aussi sur l'intégration de tous les acteurs. Le Projet, à travers ses organes au niveau régio-

nal et national joue le rôle de facilitateur, d'interface entre les différents acteurs stratégiques et opérationnels. Ce faisant, il contribue à l'instauration et à l'animation d'un cadre de coresponsabilité et de cogestion des problèmes liés à la protection des populations contre les IST/VIH/SIDA à travers des prestations de qua-lité et accessibles aussi bien financièrement que géographiquement.

Ces prestations s'inscrivent dans une approche globale intégrant toutes les particularités socioculturelles telles que, l'ignorance, la multiplicité des partenaires sexuels, le statut défavora-ble de la femme, la faible utilisation des préservatifs, la précocité des rapports sexuels, le poids des us et coutumes.

VALEUR AJOUTÉE D'UNE APPROCHE RÉGIONALE

Comme mentionné plus haut, le programme vise une meilleure disponibilité des préservatifs et un changement positif de comportement du groupe cible sont réalisés en Afrique Centrale. Depuis 2006, la mise en œuvre des activités a permis le développement de plusieurs approches régionales, le partage des acquis, toutes choses qui ont contribué à asseoir dans les pays couverts un standard minimum commun pour la riposte contre les IST-VIH-SIDA.

La commande groupée des préservatifs masculins à l'échelle régionale a permis d'obtenir une économie de 22% sur le coût de revient des commandes. La vitesse de progression de la vente est de 1,38 sur la situation d'avant avec une réalisation de 87% des objectifs de vente attendue pour le condom masculin. La disponibilité permanente de préservatifs masculins de qualité et à coût accessible est une réalité avec 1,21 Points de vente disponibles pour 1000 h réalisés en fin 2008 contre un niveau d'avant phase régionale de 0,83 Points de vente pour 1000 h. Ce dispositif a permis d'atteindre un niveau moyen de 1,37 préservatifs consommés par tête d'habitant avec pic de 2,05 préservatifs masculins consommés par tête d'habitant constaté en République Centrafricaine.

Malgré le poids des us et coutumes et aussi la réticence de certaines cibles féminines la promotion de l'utilisation du préservatif féminin est rendue systématique au niveau des trois pays et a atteint un niveau de vente en 2008 de 335 mille préservatifs féminins contre une attente de 220 mille unités.

En plus des marques existantes de préservatifs que promeut le Projet, il est envisagé le développement et la promotion d'une marque régionale de préservatif qui avec la participation de tous les acteurs y compris ceux du monde religieux contribuera à réduire les barrières socio-culturelles, les ventes transfrontalières etc. L'approche régionale de l'accès universel aux préservatifs (ARAUP) offre l'opportunité à ces différents acteurs d'harmoniser leurs points de vue sur les différents goulots d'étranglement qui font obstacle à l'acceptabilité, à la promotion et à l'utilisation des préservatifs et aussi d'autres méthodes alternatives.

Le développement d'activités synergiques transfrontalières a permis de toucher les populations migrantes, les déplacés, les travailleuses de sexe, les filles libres y compris les populations riveraines des deux côtés des frontières. Dans un contexte marqué par le boum économique et dès fois par des troubles sociopolitiques engendrant des déplacements de populations sur fonds de désintégration sociale, de forte promiscuité sexuelle, de violences de toute nature y compris les viols, le commerce du sexe, ces activités en stratégie avancée complètent les actions menées par les structures traditionnelles. L'accent y est mis sur les campagnes de masse pour un changement de comportement, le dépistage volontaire et gratuit du VIH et des Infections sexuellement transmissibles (IST), la prise en charge de ces IST et la lutte contre la stigmatisation et la discrimination envers les PPVIH. En partenariat avec les Associations des Personnes vivants avec le VIH les cas dépistés positifs pour le VIH sont aussitôt pris en compte. Un impact sensible est noté quant au taux de retrait des résultats de dépistage du VIH qui avoisine les 90% contre un taux de retrait de 10% environ relevé lors des stratégies en poste fixe.

Le Forum Régional des Jeunes en lutte contre le SIDA (FREJES) offre l'opportunité aux jeunes et adolescents d'apporter leur réponse spécifique à la lutte à travers la systématisation du développement par les jeunes et pour les jeunes entre autres de la pair éducation en milieu scolaire et extrascolaire, l'édition de magazine 100% Jeune, l'animation de site web, etc. L'année 2008 a connu la vente d'environs 400 000 magazines 100% Jeunes édités par les jeunes et pour les jeunes.

Le développement en approche régionale des enquêtes CAP (Comportement Attitude Pratique) conduite sur la base d'une harmonisation des procédures méthodologiques, des outils de collectes des données avec l'implication de tous les acteurs concernés pose les fondements d'une meilleure synergie régionale dans les efforts de lutte contre les IST-VIH-SIDA. Cette enquête CAP réalisée en 2007 a confirmé certaines performances réalisées, notamment avec 85% des jeunes de 15 à 24 ans qui trouvent que le condom est toujours disponible quand ils en ont besoin, en moyenne 1 jeune sur 2 en 2007 contre 1 jeune sur 4 en 2005 ont adopté un comportement sexuel à moindres risques, on compte encore moins de 30% des jeunes qui ont adopté une attitude positive envers les PVVIH.

CONCLUSIONS

La promotion d'une approche régionale intégrée aux réponses nationales pour la prévention du VIH/SIDA au Cameroun, Tchad et en République Afrique Centrale est un choix stratégique bénéfique pour les pays et offre des opportunités. Les avantages se situent au niveau des économies d'échelle dans l'achat des condoms, dans le partenariat et collaboration approfondie entre les ONGs, les programmes nationaux de lutte contre le VIH/SIDA, les bailleurs et institutions régionales. Ceci résulte dans une meilleure efficacité et efficience de la lutte contre la maladie. Les acquis sont encore fragiles et méritent d'être approfondis et développés. Le dynamisme et la performance des AMS ont permis une amélioration substantielle de la disponibilité et jusqu´à un certain égard l´accessibilité au préservatif.

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ENTRE CIEL ET TERRE DANS LA LUTTE CONTRE LE SIDA AU CAMEROUN

Dans un contexte où les barrières sociales élevées par les traditions et la religion considère le préservatif comme un incitateur aux rapports sexuels de tous ordres, allant jusqu'à bafoué une éthique sociale construite autour de la fidélité dans le mariage, et particulièrement dans une optique de procréation, la promotion de l'utilisation du préservatif au Cameroun demeure un défi. Le présent article témoigne des activités et résultats de l'Association Camerounaise pour le Marketing Social et fait ressortir quelques actions.

Par Bertrand Dimody et Inès Tchomago*

SELON ONUSIDA, 60 millions d'adultes et 15 millions d'enfants vont succombé du Sida en 2025. Au vu de la montée fulgurante de la propagation de l'épidémie VIH dans le monde et particulièrement en Afrique, des efforts considérables sont entrepris par les autorités à la fois gouvernementales, locales et internationales, dans la mise à disposition des populations à risques du préservatif masculin et féminin. ONUSIDA nous indique aussi que les préservatifs masculins et féminins, s'ils sont utilisés correctement et de façon systématique, peuvent réduire le risque de transmission par voie sexuelle de 80 à 90%. Car en fait, les préservatifs sont les seuls produits qui offrent une protection efficace contre le VIH et les autres infections sexuellement transmissibles.

UN GRAND PAS DANS L'ACCOMPAGNEMENT INSTITUTIONNEL

Au Cameroun notamment et ce depuis plus d'une dizaine d'années, des programmes multiples s'attèlent à rendre disponibles et accessibles les préservatifs auprès des populations vulnérables au travers des techniques de marketing social. C'est le cas de l'Association Camerounaise pour le Marketing Social (ACMS), lancé en 1996 et qui reprenait les activités de marketing social du préservatif masculin lancées au Cameroun par l'ONG internationale Population Services International (PSI) depuis 1989. Ses activités consistaient à mettre à la disposition des populations vulnérables et à faible revenu, le préservatif de qualité comme moyen de protection à la fois, des grossesses non désirées, des infections sexuellement transmissibles et du VIH. Diverses campagnes de promotion des préservatifs de l'ACMS ont reçu le soutien du Comité National de Lutte contre le Sida (CNLS), organe technique du Ministère de la Santé Publique en charge de la lutte contre le Sida. Le CNLS a dans son plan stratégique 2006-2010 consacré dans son axe premier l'accès universel à la prévention à travers différentes méthodes, notamment le préservatif. Ceci illustre le fort engagement politique des institutions et de l'Etat.

Plus de 26 et 28 millions de préservatifs ont été utilisés par les groupes cibles respectivement en 2007 et 2008, grâce à l'effort de promotion de l'Association Camerounaise pour le Marketing Social (ACMS) avec le financement de la Banque Allemande de Développement (KfW) à travers le Projet de Prévention du VIH-SIDA en Afrique Centrale (PPSAC) de l'Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale (OCEAC). Ces chiffres, ne font pas état de la distribution du secteur privé pharmaceutique et de la Centrale Nationale d'Approvisionnement en Médicaments et consommables Médicaux Essentiels (CENAME).

BARRIÈRES SOCIO CULTURELLES POUR L'UTILISATION DES PRÉSERVATIFS

Cependant, cette promotion du préservatif se heurte aux barrières socioculturelles d'un environnement dans lequel, parler de sexe est encore tabou. Comment faire alors pour favoriser l'utilisation du préservatif que les traditions et les religions considèrent comme un incitateur aux rapports sexuels de tous ordres bafouant une éthique sociale construite autour de la fidélité dans son mariage, et particulièrement dans une optique de procréation?

Dès lors, la nécessité du changement de comportements des populations fortement ressentie est prise en compte ipso facto par les pouvoirs publics et les associations locales. Plusieurs campagnes et projets de sensibilisation ont vu le jour. Parmi eux, le projet de l'ACMS dénommé 100% Jeune à travers un magazine mensuel, des émissions radiodiffusées hebdomadaires, l'éducation par les pairs et un site web. De même que les campagnes de sensibilisation du CNLS telles que Vacances Sans Sida et les autres initiatives de la société civile en direction des jeunes de 15-24 ans.

Par ailleurs, des campagnes de promotion de l'usage correct du préservatif «Pincez déroulez» qui cible la population générale, notamment les travailleuses de sexe, a laissé voir le gap qui se trouve entre la connaissance de l'existence du préservatif et son utilisation par la population cible. Car, si près de 98% des personnes ont entendu parler du VIH selon l'enquête de santé et de démographie (EDS 2004), les chiffres baissent quant à ceux qui utilisent correctement les préservatifs. Il est à noter qu'à peine 78% des personnes citent le condom comme moyen de prévention. De surcroît, les chiffres entre la connaissance théorique de l'utilisation du préservatif, la citation orale des principales étapes de l'usage correct et la démonstration du port correct du préservatif baissent sensiblement à chaque niveau; les chiffres passent ainsi et respectivement de 78,7% à 52,7% et à 32,2%, selon la même étude de PPSAC en 2006. Ces statistiques couvrent essentiellement les préservatifs masculins, car les préservatifs féminins sont encore en cours d'introduction au Cameroun. Ceci justifie l'effort de distribution massive des préservatifs et l'intensification de la communication en vu de son usage correct et systématique pour une meilleure prévention du Sida. La campagne «Pincez déroulez» phase II avec ses composantes mass média et interpersonnelles; les différentes activités telles que «les tirs groupées» (technique couplant dans une zone la distribution de masse des préservatifs auprès d'un réseau de vente – pour doper l'offre- aux causeries éducatives massives en direction de la population – pour stimuler la demande) par les promoteurs spécialement formés aux techniques de communication par l'ACMS, vient contribuer à combler ce gap.

CONDOM POURTANT TOUJOURS TRÈS CONTROVERSÉ

Pourtant, l'on n'est pas sorti de l'auberge devant la guerre socioculturelle qui oppose l'utilisation du préservatif aux traditions et à la religion; bien plus, à la remise en cause de son efficacité dans la lutte contre le SIDA au Cameroun.

Le récent passage du Pape Benoît XVI au Cameroun à travers ses propos contre l'utilisation du préservatif, a soulevé l'épineuse question de l'efficacité du préservatif dans la lutte contre le SIDA. Si la plupart des études démontrent que les préservatifs sont aussi essentiels aux efforts de prévention du VIH, offrant à la fois une protection contre les IST et contre la réinfection, et protégeant les partenaires sexuels, certains organismes et politiques gouvernementales, notamment le droit à la santé, constituent un véritable frein à la vulgarisation du préservatif. En effet, plusieurs facteurs entrent en droite ligne dans les obstacles liés à l'accès du préservatif. Entres autres, l'absence d'autonomisation des femmes notamment dans la prise de décision quant à la possibilité d'utiliser le condom pendant les rapports sexuels; la religion et l'éthique sociale qui voient en l'utilisation du préservatif le développement de la

promiscuité sexuelle; la promotion de la fameuse formule ABC – Abstinence, monogamie et utilisation des préservatifs – avec une incidence forte quant à la stigmatisation des personnes utilisant le préservatif; les croyances personnelles et les questions liées au plaisir…

Malgré tout cela, d'années en années, les campagnes de communication sur la nécessité de se protéger du VIH, des IST et des grossesses non désirées, ont connu un impact positif dans la promotion et l'acceptation du préservatif par les populations et notamment au sein des communautés rigides. D'ailleurs selon les statistiques de l'ACMS, 28 992 945 préservatifs masculins et 148 993 préservatifs féminins ont été distribués sur l'ensemble du territoire camerounais en 2008. Soit une consommation moyenne par tête d'habitant d'environ 1,8 préservatifs pour une population d'environs 16 000 000 d'habitants. Alors qu'en 1993 les ventes atteignaient difficilement les 3 millions d'unités.

Le préservatif malgré tout, rentre progressivement dans les mœurs. Et si la tendance en terme de vulgarisation et de capacitation de la population à l'usage correct de ce dernier est maintenue, la fédération des efforts avec les différents mouvements socio- politico- religieux, le scénario catastrophe de l'an 2025 à défaut d'être évité sera réduit et l'incidence du VIH sur la population et l'économie mondiale ramenée à la valeur la plus faible.

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Seiten 63–70 Theater und Festivals: Wege der Kommunikation

"Processions and rallies with people dressed like condoms and carrying placards, puppet shows, street theatre are attractive awareness raising instruments" **Bharat Rijal**

Photo: Kamal Baral, SRK

USING ARTS TO TACKLE VIOLENCE AGAINST WOMEN AND HIV AND AIDS

The Mothertongue Project is a collective of women artists, facilitators and healing practitioners who, inspired by Forum Theater, employed participatory arts methodologies to explore the intersections between violence against women and HIV/AIDS. The plays opened up vibrant discussions on socio-cultural issues, which are at the heart of the twin issues of violence against women and HIV, and on the traditional roles of women and men.

By Awino Okech*

Plays adress taboo issues

Photos: The Mothertongue Project

A member of the audience acts her ideas out on the stage.

KHAYELITSHA, a black township, is located some 30 minutes drive from Cape Town. Home to half a million people, it is the third largest township in South Africa and the largest black township in Cape Town. The ethnic makeup of Khayelitsha is approximately 90 per cent African with IsiXhosa as the predominant language. A creation of the former apartheid regime, Khayelitsha emerged out of the relocation in the early 1980s of all "legal" Africans from other townships to this new site. There are high rates of sexrelated violence particularly rape of women, including a range of hate crimes against lesbians. Most cases are not reported.

Most organisations in South Africa work either on HIV and AIDS as a specific area of focus or deal with violence against women. The groups work largely around rape. Research findings point to the intrinsic link between HIV and AIDS and violence against women.

In 2006, Mothertongue Project initiated discussions with groups in Khayelitsha on the best way a feminist theatre collective could contribute to activism at community level on HIV and AIDS and violence against women. Mothertongue Project is a Cape Town-based collective of women artists who explore keys to empowerment of women by developing practical processes of healing and transformation. We spent two months during which we consulted with a range of community-based organisations that work either in the field of HIV and AIDS or respond to rape or other forms of violence against women. The result was the pilot project Laphumilanga (IsiXhosa for sunrise), whose first phase was implemented in 2006 with Phase II continuing in 2007. The pilot project was supported by UNIFEM's trust fund on violence against women and the second phase by Action Aid South Africa.

ROLE OF DRAMA IN FOSTERING CHANGE

The pilot phase of this project had a number of objectives. We wanted to create awareness in the community around the intersections between violence against women and HIV and AIDS. One cannot focus on HIV and AIDS in isolation because broader gender inequities also contribute to the situation. Through the work, we wanted to articulate the value of drama in fostering change with emphasis on the infected and affected as critical voices. In the process, we trained a pilot group of 28 women to use drama to advocate around HIV and AIDS and violence against women. We created the space for an assessment of their personal narratives in relation to the intersections.

Since our work focuses on healing and transformation, it was important that the pilot group we worked with be empowered by the process and in turn make informed choices around situations of violence in their own lives as well as their HIV status (whether HIV-positive or negative).

Our project was inspired specifically by Forum Theatre, an interactive participatory theatre form developed in Latin America in the 1960s by theatre director Augusto Boal. This is a performance where the distinction between reality and theatre is lifted by inviting the audience to act their ideas on stage. The pilot group had 28 women aged between 25 and 50 years and included support group members, counsellors and volunteers within community and national organisations working around either HIV or gender violence in Khayelitsha. Within the 10 days of the workshop, participants brought to our attention three cases of women who had been raped and murdered. They were either neighbours or friends of the participants. In addition, there were at least 10 other similar reports in local community newspapers and cases before the local magistrate's court.

GENDERING WOMEN AND MEN

The theatre workshop was an important component of the project. We engaged in an analysis of the gendered dynamics of HIV and AIDS through participants' experiences. Through a variety of arts-based exercises that included creative writing, photography and role plays, we initiated discussions on the participants' perceptions about the causes of violence against women in their community. The participants pointed to the predominance of culture in informing the processes of gendering women and men. This was exemplified in reference to the initiation process for young amaXhosa men. This practice is known as "ulwaluko", which is a traditional custom marking the transition from boyhood to manhood. Participants argued that when boys are taught 'philosophies of manhood' in the bush, the idea that men are heads of families and that they are stronger than women are emphasised and internalised by the initiates. However, as part of similar processes for young women during "ntonjane" (the rite of

LESSONS LEARNED

1 It is important to recognise the complexity of the environment, the issues being dealt with and the broader environment (national and international) that shows increasing 'hostility' to women's rights work.

2 The role the workshop and the resultant community of support played in the lives of the plays' participants was critical. These frameworks provided the necessary safety and motivation that is easily sustained during a project.

3 Translating an experience into a theatrical narrative in a workshop space and subsequently into a play for the community involves a complex process of reflection, release and healing.

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passage for young women amongst the amaXhosa) they are socialised to accept that a married woman must submit to the will of the man of the house.

The role of socialisation and its subsequent impact on power relations between women and men were some of the key areas that were later explored through the plays. The workshop provided a safe space that allowed participants to interact with other women, and share their stories and strategies about common problems. Using these stories, they created storylines that were used to develop the plays that were later taken into the community. The play-building process for most of the women, therefore, became a therapeutic way to process their experiences.

Twelve open-ended pieces were created and performed in Khayelitsha. Each Laphumilanga performance attracted audiences of about 200 people. A total of 3200 people were reached through 16 performances. The performances were conducted at a range of advocacy events held by partner organisations in the area. Other performance venues included the Magistrate's court, churches, schools and public spaces such as malls, taxi ranks and bus stations. Most spectators were women, with the youth coming in second, followed by men. The audience composition differed depending on the nature of the event and the location.

The plays dealt with numerous issues including the popular perception that sex is better without a condom; early childhood marriages, why young girls are married off at a younger age to older men; and the challenge of disclosing one's HIV status to a partner.

The goal of these plays was to get the community to unpack some of the popular sociocultural perceptions surrounding these issues and challenge these dominant perceptions. A range of opinions emerged while addressing reasons for men's reluctance to use condoms and most women's inability to successfully negotiate for this option. Community members and participants said this was reinforced by the culturallyendorsed notion that it is a man's role to initiate sex, and to reverse the practice would cause friction within the relationship. They noted that men are quick to mistrust and feel insecure if a woman initiates or suggests new styles of having sex. In addition, insisting on using a condom was also attributed to one's knowledge of their HIV status. Insistence would also raise a lot of questions that may lead to disclosure that could in turn result in being ostracised as well as being verbally or physically abused.

UNINTENTIONAL PEER COUNSELLORS

Through reports written after every performance and during monthly reflection workshops, the participants indicated that after their performances, spectators approached them with queries on their next performance, showed interest in being part of the project and, on occasion, sought help from the women on problems they were facing. Unintentionally, they became peer counsellors. As a spectator said, "I see myself taking the work that I have done here to my support group so that we too can go out and show people how to be independent, because we will be protecting those who think they know when they know nothing."

After performances and during the impact assessment, many community members indicated that the plays addressed important issues that people are not always willing to talk about. The plays opened up vibrant discussions on socio-cultural issues, which we believe, are at the heart of the twin issues of violence against women and HIV. The discussions questioned the traditional roles of women particularly within the amaXhosa tradition. The plays provided the "safety" required for women to actively challenge these positions. We believe this is the first step in social transformation.

Based on an impact assessment conducted at the end of the first year, the reception and impact of this work has exceeded our expectations. Achievements have been recorded on the number of women who chose to leave abusive relationships, those who found the strength to disclose their HIV status to their partners and family and in the number of community members who begun to actively use counselling support centres in the area. The project promoted the participants' ability to actualise their dreams of acting and to re-enact moments of their lives through the plays Translating an experience into a theatrical narrative in a workshop space and subsequently into a play for the community involves a complex process of reflection, release and healing that was realised by most of the women, like the one who said: "I have gone through big changes in my life since performing the plays. I used to drink a lot before, and as an HIV-positive person, this is not good for my health. During the period of making the plays for the outreach performances, I realised that it was hypocritical of me to preach and educate others when I did not apply these lessons to my own life.

Since finding work as an HIV counsellor, I now try to live by example to clients that look up to me due to my acting work and as a HIV survivor."

CREATING "SAFETY NETS"

Despite these gains, it would be premature to celebrate without recognising the complexity of the environment, the issues we are dealing with and the broader environment (national and international) that shows increasing "hostility" to women's rights work. Considering how these factors impact on our work, its successes and sustainability is critical to any practitioner's planning. There are questions around the responsibility that we have to the communities within which we work. The role the workshop and the resultant community of support played in the lives of the plays' participants cannot be underestimated. These frameworks provided the necessary safety and motivation that is easily sustained during a project. The question remains as to how these can be sustained when they "return" to a community where everyday occurrences of violence and abuse of women are disenfranchising.

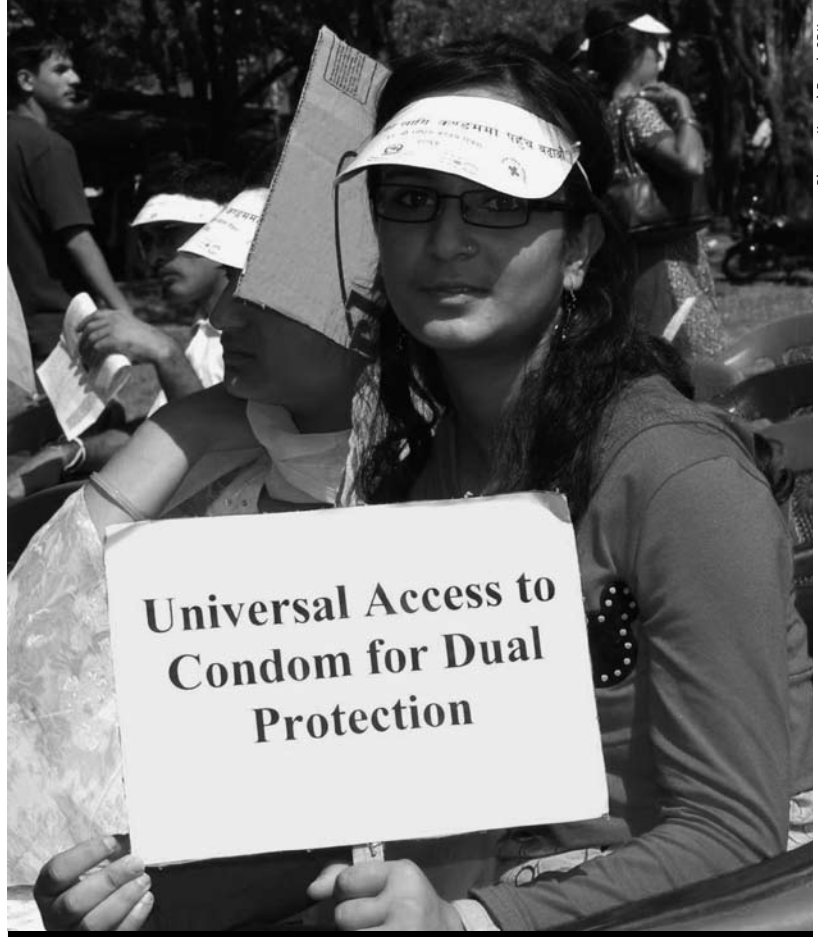
It is necessary to create "safety nets" for the participants as means of ensuring that the impact is more sustainable. This involves building stronger partnerships and networks with local organisations already working jointly or separately on the intersections, to ensure that they incorporate the same message and language into their work. The strategy adopted through the project to work with women already involved with community-based institutions and support groups is a mechanism to ensure that the work is sustained through these structures. As a result, performances such as the ones we conducted and resultant discussions are viewed as central to achieving their goals and would be integrated into programmatic content and strategies within these organisations. We, therefore, propose consolidated efforts towards programmatic intervention instead of parallel processes.

In going forward we intend to provide drama therapy training to counsellors and to infuse elements of gender training for community organisations that have been working solely around HIV and AIDS. The outreach work continues to be integral to strategic development for they provide an opportunity to engage with current community concerns and perceptions.

CONDOM DAY CELEBRATION

Have you ever celebrated “National Condom Day”? Won the condom-blow competition? Visit Nepal during the main festival season and participate in this yearly fun event organised nationwide by the Nepal Red Cross Society. A whole day is dedicated to the condom, breaking the taboos of HIV. And this happens already since more than 14 years.

By Bharat Rijal*



Photos: Kamal Baral, SRK

A volunteer getting ready for the street parade.

IN THE TRADITIONAL Hindu society of Nepal people are not open to talk about sex, sexuality and reproductive health issues. Only behind closed doors women would talk to each other about their contraceptives and reproductive rights. Information about sex is mainly passed on among peers, prone to transmitting wrong information and fostering superstition. Even though reproductive health is included in the school curriculum of health and physical science, embarrassed teachers skim over those subjects or only superficially deal with them.

Condoms were introduced and promoted in Nepal since 1978 as one of the family planning devices. Even though they are available in health clinics, pharmaceutical outlets and retail shops, the public awareness and use of condom is still low. In a study conducted by the Swiss Red Cross’ supported “Community Eye Care and Health Project” of the Nepal Red Cross Society (NRCS) only 29% of the respondents stated to have used a condom when last time having sex. (Annual Report 2008)The main reason is the difficulty of wives to negotiate on condoms in the male dominated society like Nepal. Another important barrier is the misconception that condoms are to be used only for extramarital relationships. Thus purchasing and marketing of condoms has not been an easy task in most areas of Nepal.

THE ORIGIN OF CONDOM DAY

In 1993, during the tenure of the “Reproductive Health Project”, the NRCS staff working in Udaipur district decided to hold an exclusive event on the condom, in order to disseminate information of contraceptives in 5 districts. When organized for the first time, people were shocked about the open discussion and display of condoms. However, despite all personal hesitation and shyness, the local people showed a huge interest to know more. Inspired by its success and in the light of the growing HIV epidemic in Nepal, NRCS decided to launch this event nation-wide. Since 1995, every first Saturday after the Hindu festival Dashain, the time when family members and migrants from within Nepal and abroad return to their homes for the holidays, is set as the National Condom Day. This special event, originally targeting male and female community members for family planning purposes, is meanwhile focusing on the importance of condoms in prevention of HIV and AIDS. Thus the day is particularly designed to reach migrants, youth and risk groups but also the general public.

GAMES AND FUN

Nowadays the celebrations not only involve the Nepal Red Cross, but all stakeholders in the area of health and HIV prevention participate. National Condom Day is used as a kick-off to many more events and campaigns throughout the month. The Ministry of Health, Non-Government-Organizations, school children, positive people, sex workers and other groups organize different activities allowing people to learn more about HIV and AIDS, stigma, positive living, and reproductive health issues in a playful way. Processions and rallies with people dressed like condoms and carrying placards, puppet shows, street theatre, films around the theme of HIV and AIDS, concerts, dances, fairs, posters and pamphlets, games and competitions with packets of condoms as prizes, are attractive awareness raising instruments.

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Red Cross volunteers wearing special tags, caps and T-Shirts displaying the years particular theme, are ready to answer questions during the events and at special information stalls. The stalls at the border to India are open for the whole month targeting the returning migrants from India before reaching their home villages.

BREAKING BARRIERS AND TABOOS

An estimated 2’500’000 people are directly reached every year through this unique event and many more through media transmission. Whereas in the past parents would forbid their children to be part of the celebrations, the participation of young girls has increased every year. (Statistics of the National Centre for AIDS and STDs Control, December 2008) Dealing with the sensitive issue of condoms so openly has helped to break barriers even within generations. Due to the enhanced awareness and publicity, also accessibility of condoms has im-

Red Cross volunteers are informing migrant workers at the border to India about the importance of condom use.

Facts on HIV and AIDS in Nepal

According to the data of the National Centre for AIDS and STD control, by December 2008 12'933 cases of HIV were reported, among which 2151 persons are living with AIDS. 187 cases of HIV and 48 cases of AIDS were newly registered in December. The second highest case detection rate is among housewives, giving evidence that HIV has spread far beyond the traditional risk groups of injecting drug users and clients of sex workers, and manifests itself in the general population. Given the hidden nature of the problem, the actual size of the infected population is likely to be considerably larger. It is estimated that 72'000 of people of Nepal living with HIV and AIDS.

proved. A grocery shop keeper in Jumla reported that in the past he would insist that the customers who asked for condoms disclose their marital status. "I refused to sell condoms to unmarried persons. Now I have completely changed my attitude. I am aware now that condoms protect lives from the deadly disease of HIV&AIDS, so I do not care any more whether my customers are married or not. I just want to save their lives."

The increased condom promotion and awareness has also influenced the policy level. Only in 2002 the National Guidelines for Family Planning Service stated that adolescents, irrespective of their marital status, are granted access to family planning services and free condoms. (Adolescent Youth and Reproductive Health in Nepal, Status, Issues, Policies and Programmes, January 2003) Over the years of observing Condom Day, discussing sex, sexuality and HIV and AIDS openly in Nepal's society has become much less a taboo.

DEBATTE

WAS TUN, WENN NICHT STEHLEN?

Zur Rolle Reicher Länder in der Migration von Gesundheitsfachkräften

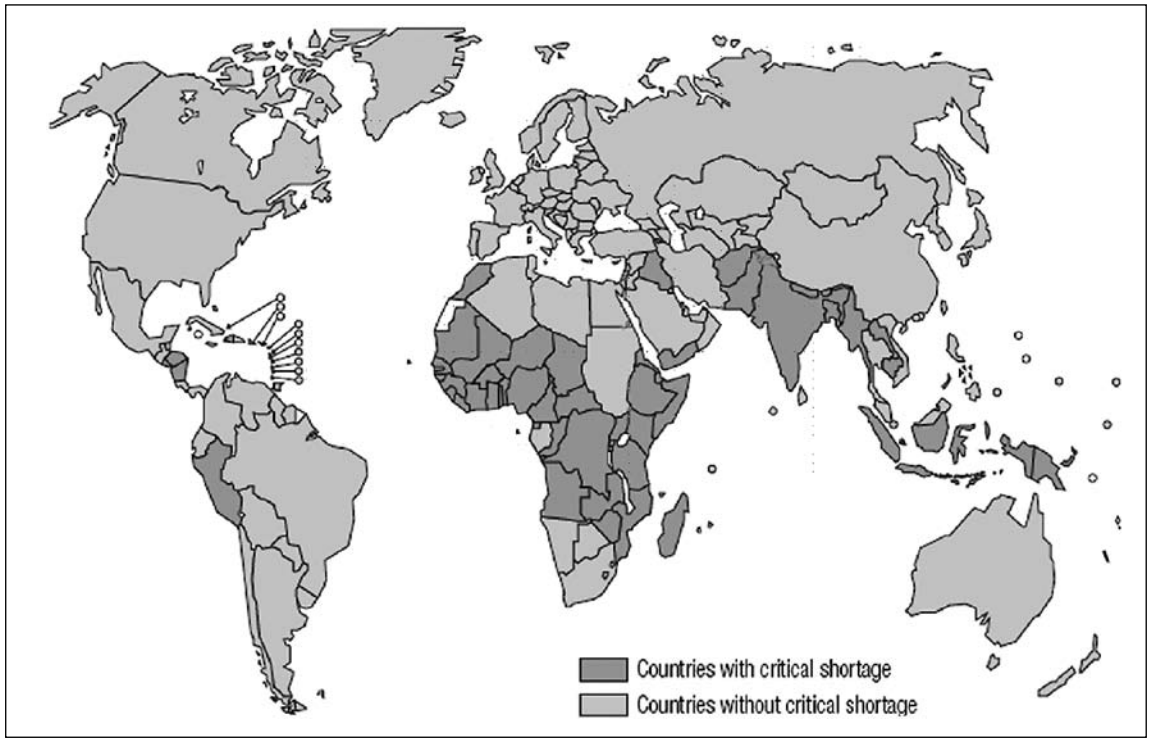
Die Migration von gut ausgebildetem Gesundheitspersonal aus ärmeren in reiche Länder mag für die einzelne Fachkraft zu einem höheren Verdienst führen. In ihrem Herkunftsland verschärft ihre Auswanderung aber die Gesundheitskrise. Die WHO will mit einem Verhaltenskodex für etwas Ordnung sorgen – ein nicht unumstrittenes Unterfangen, schreibt **THOMAS SCHWARZ***.

Wenn wenigstens 2,3 gut ausgebildete Gesundheitsfachkräfte pro 1000 Menschen zur Verfügung stehen, können 80 Prozent oder mehr der Bevölkerung mit qualifizierter Geburtshilfe und Impfungen für Kinder erreicht werden. Gemäss WHO erreichen aber 57 Länder diese Quote nicht; ihnen wird deshalb im Weltgesundheitsbericht 2006 ein «akuter Arbeitskräftemangel im Gesundheitswesen» bescheinigt. Am schlimmsten ist die Lage in Afrika südlich der Sahara, wo der Mangel an gut ausgebildeten Fachkräften die ohnehin schon geschwächten Gesundheitssysteme noch zusätzlich belastet.

Der Arbeitskräftemangel ist ein weltweites Phänomen, auch in reichen Ländern. Weltweit werden mehr als vier Millionen zusätzliche ÄrztInnen, Krankenschwestern, Hebammen, Manager und Public Health Worker dringend gebraucht. Anderseits ist die Welt in den letzten Jahren kleiner geworden, auch der Fachkräfte-Personalmarkt ist nun «globalisiert». Die grenzüberschreitende Anwerbung von Gesundheitsfachkräften ist deshalb eine gängige Praxis geworden.

VERSCHÄRFUNG DER GESUNDHEITSKRISE

Wenn eine Gesundheitsfachkraft eine Stelle in einem anderen Land findet, macht sie zunächst ganz einfach von ihrem Recht auf Bewegungsfreiheit Gebrauch. Ihr Einkommen mag dem Wohlstand ihrer Familie und – wenn sie Geld nach Hause schickt – auch dem Volkseinkommen ihres Herkunftslandes förderlich sein. In Ländern mit einem akuten Arbeitskräftemangel im Gesundheitswesen aber trägt die Abwanderung von Fachkräften auch ganz direkt zur Verschärfung der Gesundheitskrise bei. Und auch volkswirtschaftlich betrachtet, ist die Sache nicht ganz so einfach: Die Entwicklungsländer verlieren die Erträge auf die Investition, die sie in die Ausbildung der Fachkraft gemacht haben. Viele arme Länder unterstützen heute faktisch reiche Länder, die zu wenig Fachkräfte ausbilden – oder die aufgrund der niedrigen Löhne, gerade im Pflegebereich, auf ihrem Binnenarbeitsmarkt nicht genügend Personal finden.

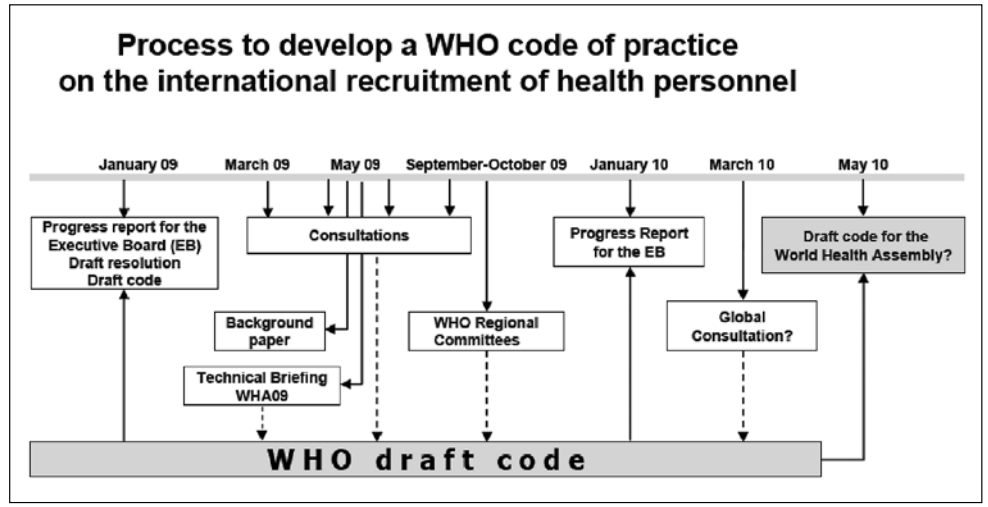


Zahlen zu Migration von Gesundheitspersonal sind allerdings schwer zu finden sind, da es bislang wenig systematische Übersichten und Statistiken gibt. Die bereits vorhandenen Studien haben je verschiedene Parameter und sind daher schwer zu vergleichen. Im Januar 2008 wurden Daten einer ersten systematischen Untersuchung zu diesem Thema veröffentlicht. Sie beruhen auf Erhebungen aus dem Jahr 2000. Danach arbeiteten zu jenem Zeitpunkt ungefähr 65 000 ÄrztInnen und 70 000 Krankenschwestern, die in Afrika geboren wurden, in einem Industrieland. Das entspricht etwa einem Fünftel der afrikanischen ÄrztInnen und einem Zehntel der afrikanischen Krankenschwestern. Die Rate der afrikanischen Gesundheitsfachkräfte, die nicht in ihrem Herkunftsland arbeiten, variiert je nach Land zwischen 1 und 70 Prozent.

UMSTRITTENER «CODE OF PRACTICE»

Angesichts dieser Situation haben die Mitgliedstaaten der Weltgesundheitsorganisation in den Jahren 2004 und 2005 den Generaldirektor der WHO aufgefordert, in Abstimmung mit den Mitgliedstaaten und allen massgeblichen Partnern die Federführung bei der Ausarbeitung und Umsetzung eines Verhaltenskodex für die grenzüberschreitende Rekrutierung von Gesundheitsfachkräften zu übernehmen.

Ein erster Entwurf des «WHO code of practice on the international recruitment of health personnel» liegt bereits seit einiger Zeit vor. Die am Zustandekommen des Verhaltenskodex interessierten Organisationen, darunter das Netzwerk Medicus Mundi International, sind eigentlich davon ausgegangen, dass der Kodex durch die



diesjährige Weltgesundheitsversammlung im Mai 2009 verabschiedet würde. Doch hat der Vorstand der Weltgesundheitsorganisation an seiner Januarsitzung die Bereinigung der Vorlage auf das nächste Jahr vertagt und zuvor eine Reihe von nationalen und internationalen Konsultationen angesetzt.

Das Thema ist ganz offensichtlich politisch «sensibel» und Gegenstand eines Interessenkonfliktes und wohl auch Machtkampfs zwischen Ziel- und Herkunftsländern der Migration von Gesundheitspersonal. Dies zeigt auch ein im Mai von der WHO veröffentlichtes, an die Mitgliedstaaten der WHO gerichtetes Hintergrundpapier. Die in diesem Dokument aufgeworfenen Schlüsselbereiche und Fragestellungen sind ein «offenes Buch» der politischen Debatte. Sie umfassen neben den allgemeinen Zielsetzungen und Grundsätzen des Verhaltenskodes unter anderem auch die Praktiken der grenzüberschreitenden Rekrutierung, die Nutzbarmachung der Migration für alle Beteiligten und die nationalen Arbeitsmarktpolitiken im Gesundheitsbereich. Die einzelnen Fragen sind brisant, zum Beispiel: «Soll der Kodex eine Empfehlung zur finanziellen Entschädigung der Herkunftsländer durch die Zielländer der Migration enthalten?» «Soll das Konzept einer nachhaltigen nationalen Arbeitsmarktpolitik im Gesundheitsbereich in den Kodex aufgenommen werden?» Diesen Fragen nachzugehen und die eigene Rolle als Zielland von Fachkräftemigration im Gesundheitsbereich kritisch zu hinterfragen, lohnt sich bestimmt auch für die Schweiz.

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Allgemeine Quellen

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MAGAZIN

MMS WORKSHOP

MEDIENARBEIT FÜR KLEINERE UND MITTLERE ORGANISATIONEN

GESUNDHEITSZUSAMMENARBEIT IN DIE ÖFFENTLICHKEIT TRAGEN

Von Martin Leschhorn Strebel

Für kleinere und mittlere Organisationen erweist es sich oft als schwierig, ihre Projekte über die Medien einer breiteren Öffentlichkeit bekannt zu machen. Ein Workshop des Netzwerkes Medicus Mundi Schweiz vermittelte Tipps und Tricks.

Eine Erfahrung die kleinere und mittelgrosse Nonprofitorganisationen immer wieder machen: Sie schreiben gehaltvolle Medienmitteilungen oder verschicken ansprechende Einladungen zu Jahresversammlungen an JournalistInnen, doch kein einziger Bericht erscheint. Das erzeugt Frustrationen, möchten sich die Organisationen doch mit ihren Projekten einer breiteren Öffentlichkeit präsentieren.

KEIN PFLICHTSTOFF DER REDAKTION

Gerade kleinere und mittlere Organisationen, deren Medienmitteilungen nicht zum Pflichtstoff der Redaktionen gehören, haben es oft schwer über den kleinen Kreis involvierter Personen hinaus gehört zu werden. Für sie hat das Netzwerk Medicus Mundi Schweiz im Juni einen Workshop zum Thema «Tue Gutes und sprich darüber – Medienarbeit in der internationalen Gesundheitszusammenarbeit» organisiert. Die Journalistin, Buchautorin und Erwachsenenbildnerin Barbara Lukesch vermittelte den vierzehn TeilnehmerInnen Tipps und Fallstricke im Umgang mit den Medien.

Zentral für eine erfolgreiche Medienarbeit, die nicht auf grosse finanziellen und personellen Ressourcen basiert, ist der sorgsam Aufbau und die kontinuierliche Pflege von Kontakten zu Medienschaffenden. Vorstandsmitglieder, Freiwillige oder allenfalls die Geschäftsstelle können eine Liste mit Kontakten zu Medienschaffenden erstellen, die sie bereits aus anderem Zusammenhang kennen. Weiter gehören JournalistInnen auf die Liste, die bereits einmal über die Organisationen und ihre Tätigkeiten geschrieben haben. Damit entsteht eine erste Liste von JournalistInnen, die bereits in irgendwelcher Weise einen Bezug zur Organisation und der dort engagierten Personen haben. Diese werden nun in die relevante Informationstätigkeit der eigenen Organisation einbezogen.

MEDIENKONTAKTE AUFBAUEN UND PFLEGEN

Verfügt die Organisation nun über eine Thema oder eine Geschichte, mit der sie an eine weitere Öffentlichkeit will, muss zuerst geprüft werden, für wen diese relevant ist. Eignet sich die Präsenz eines Projektmitarbeiters aus Malawi wirklich auf für eine Zeitungsgeschichte oder interessiert das nicht einfach nur die Mitglieder der Organisation? Vielleicht interessiert seine Reise in die Schweiz nicht gerade «10 vor 10», aber die Lokalzeitung aus der Region, in welcher der Projektmitarbeiter aufgewachsen ist – oder aber eine Auslandsredaktorin, die sich regelmässig mit Afrika beschäftigt.

Foto: © Julius Mwelu/IRIN

Solche Überlegungen stehen am Anfang der Entscheidung, ob und wie eine Organisation mit einer Geschichte an die Öffentlichkeit möchte. Eine Medienmitteilung kann durchaus breit gestreut werden, dabei müssen die AutorInnen aber achten, dass sie kurz, prägnant auf den Punkt geschrieben ist und auf ein nur InsiderInnen bekanntes Vokabular verzichtet. Wichtig ist nun aber, dass diejenigen JournalistInnen, die auf der Medienkontaktliste stehen, persönlich und am besten per Telefon direkt auf die Geschichte und ihre Möglichkeiten angesprochen werden.

Eine Analyse verschiedener Zeitungsartikel, die in den letzten Monaten über Mitgliedorganisationen des Netzwerkes Medicus Mundi Schweiz erschienen sind verdeutlichen, was für die Redaktionen berichtenswert ist: lokale Bezüge oder die Involvierung von Prominenten sind erfolgversprechende Herangehensweisen. Gut ist immer auch das Anknüpfen an laufende Debatten. Die Geschäftsstelle von MMS nutzte etwa die Abstimmungsdebatte über die «Zukunft der Komplementärmedizin», um in der Basler Zeitung über den komplementären Ansatz im internationalen Kontext zu berichten.

Grundsätzlich machte Barbara Lukesch deutlich, dass die Ausgangslage für Organisationen der Gesundheitszusammenarbeit gut ist, um von einer breiteren Öffentlichkeit wahrgenommen zu werden. Denn Gesundheit ist ganz grundsätzliche ein Thema, das auf Interesse stösst.

THE GLOBAL HEALTH PROGRAMME AT THE GRADUATE INSTITUTE OF INTERNATIONAL AND DEVELOPMENT STUDIES

INNOVATION IN GLOBAL HEALTH GOVERNANCE

By Ilona Kickbusch and Michaela Told*

The Global Health Programme at the Graduate Institute of International and Development Studies (IHEID) in Geneva was established after the merger of the former Institut de Hautes Etudes Internationales (HEI) and the Institut Universitaire d'Etudes du Développement (IUED). Since 2009, IHEID is replacing IUED as a member of Medicus Mundi Switzerland, the Network Health for all.

The policy landscape of global health governance is changing rapidly. A wide range of approaches crowd the field: global health as foreign policy, global health as security, global health as charity, global health as investment, and global health as public health (Stuckler/McKee, 2008). But at least two major approaches are missing from this analysis: global health as a market and global health as social justice. Yet these have probably been the most important driving forces of the 21st century global health agenda.

INCREASING INFLUENCE OF NON-STATE ACTORS

Much of the debate has focused on the *first seminal power shift* in global health: the increasing influence of non-state actors in many spheres of global policy-making driven by discourse based and resource based power. Strong non-governmental organizations had the ability and means to shape the issues at stake and benefited from the historically unique availability of significant new funds through foundations, private sector contributions, as well as new commitments by nation-states and regional organizations such as the European Union. One result of this shift has been the emergence of a new form of governance best described as *market multilateralism* (Bull/McNeill, 2007)which combines multilateralism and the approaches of market actors. Health is the global policy arena in which this form of collaboration is found to be most advanced: it has led to a redefinition of the role of international organizations, the political strategies of transnational corporations and the engagement rules of non- governmental organizations. But while it has led to a wide range of diverse approaches and solutions to global health challenges and included a continuously growing set of actors it has not fundamentally changed the asymmetry of power between the North and the South. The new "shopping mall" of global health does not provide the recipient "customers" in the South a real choice.

NEW CONSTELLATIONS

But another – less discussed – *second seminal power shift* is under way. Increasingly nation states are returning in new constellations to establish their spheres of influence on a global scale in what Parag Khanna has analysed as a new geopolitical marketplace (Khanna 2008). Today the global health arena is marked by the growing influence of the emerging economies such as China, India, Brazil, South Africa and Indonesia and of regional organizations such as the European Union. These are all undergoing many transitions at home and in the regional and global sphere. Many of these states have moved health higher on their political agendas in many different spheres of policy recognizing its role in overall economic development; poverty reduction and social stability. The emerging economies are increasingly using both the decision- making power and the legal power provided to them in the global arena through the universalistic and legal structures of the multilateral organizations for their national health interest and for the health interests of the South, including their participation in the global health market. Many of them practice sophisticated forms of multi alignment and diplomacy and in consequence they are redefining the global health priorities.

These two powershifts are a defining feature of global health governance at present. They open up new alliances and make for tougher negotiations than in the past. The key trend in global health governance at this point is the expansion of health into many areas of policy and politics – it is clearly gaining a strategic place in the international agenda. In consequence, many global health issues move out of the purely technical arena of global public health and have become highly politicized.

The Global Health Programme addresses these dynamics through its three key research areas:

- Innovation in global health diplomacy and governance
- The powershift in global health
- The role of Switzerland in global health governance

The Global Health Programme within the Graduate Institute of International and Development Studies as one of the first research programmes of its kind in an institute devoted to international relations and development. It examines which characteristics and mechanisms define successful global health governance. Since its inception, the Global Health Programme has built a wide-range of partnerships with different actors at international, regional and national levels and engages closely with the World Health Organisation.
Indeed, this positions the Global Health Programme uniquely to act as applied policy research centre, to analyse trends in various key research areas and to provide reform proposals for global health governance, to regularly organize executive education in global health diplomacy, to prepare in-depths case studies, to publish research findings, and to organise conference and debates.

UPCOMING

SAVE THE DATE
of the third high-level symposium
to be held on 15 October 2009
at the Graduate Institute Geneva entitled

NEGOTIATING HEALTH IN THE 21ST CENTURY: REGIONAL VOICES IN GLOBAL HEALTH GOVERNANCE

For more information, please check the website under: www.graduateinstitute.ch/globalhealth

* **PROF DR ILONA KICKBUSCH** is Director of the Global Health Programme and Michaela Told is the Programme coordinator. For more information on the programme, please contact: globalhealth@graduateinstitute.ch, www.graduateinstitute.ch/globalhealth

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HERAUSFORDERUNGEN UND PROBLEME BEI DER BEHINDERTENINTEGRATION IN KAMERUN

PROFESSIONELLE DIENSTLEISTUNG – EHRENAMTLICHE FÜHRUNG

Auch behinderte Kinder brauchen eine Zukunft. Seit elf Jahren unterstützt der Verein Freunde Behindertenintegration Kamerun (FBK) das orthopädische Zentrum Obala (OZO) in Kamerun.

(hz) Es ist ein eindrückliches kleines Projekt, welches mit bescheidenen finanziellen Mitteln effizient und haushälterisch umgeht und eine wichtige Lücke füllt: die orthopädische Behandlung behinderter Kinder und Jugendlicher mit dem Ziel, sie zu möglichst grosser Selbständigkeit zu führen und in die Gesellschaft zu integrieren. Das Projekt wird offiziell von einem kleinen einheimischen Verein JHAR (Association d'aide a la réintégration des Jeunes Handicapés au Cameroun) getragen, der aber zu 90% von externen Spenden abhängt, relativ isoliert dasteht und stark vom Engagement des schweizerisch-französischen Gründers und Leiters des Zentrums geprägt ist. Der Verein FBK in der Schweiz besteht aus einem unermüdlichen Kreis von Gleichgesinnten, die in ehrenamtlicher Arbeit die Finanzen beschaffen, logistische Unterstützung suchen und die Arbeit im OZO von Ferne begleiten. Die externe Evaluation von 2008 lobte die Wirksamkeit und Notwendigkeit der Arbeit des orthopädischen Zentrums, sorgte sich um dessen Stabilität und forderte vermehrte Anstrengungen zur Sicherung der Lebensfähigkeit und Nachhaltigkeit.
Aufgrund eines Inputs von Dr. ing. Markus Oelhafen, Co-Präsident, Dr. med. Eva Erdmann, Co-Präsidentin FBK und Dr. phil. Friedrich Oelhafen, Vorstand FBK, werden am Meeting Point folgende Fragen diskutiert:

- Wie kann die Nachhaltigkeit des Projektes gesichert werden, finanziell und personell?
- Wie kann ein Nachfolger gefunden werden für den Gründer und Präsidenten des kamerunischen Vereins JHAR, und was sind die notwendigen Qualifikationen?
- Wie kann der ehrenamtlich arbeitende Vorstand, der zugleich Projektberater, Finanzverantwortlicher und Fundraiser ist, das Projekt in Kamerun gut begleiten und die Qualität langfristig sichern?

Der Meeting Point ist ein Forum, welches vor allem Mitwirkende von kleinen und mittleren Organisationen die Möglichkeit gibt, auszutauschen, voneinander zu lernen, sich gegenseitig zu beraten und ein arbeitsbezogenes Netzwerk aufzubauen. Alle sind dabei Beratende wie auch Lernende. Der Meeting Point ist zudem eine praxisorientierte Form der Weiterbildung in Fragen des Projektmanagements für kleine und mittlere Organisationen der internationalen Gesundheitszusammenarbeit.

Der Meeting Point richtet sich an Mitwirkende von kleinen und mittleren Organisationen der internationalen Gesundheitszusammenarbeit, an Ehrenamtliche, Freiwillige und bezahlte MitarbeiterInnen.

MEETING POINT FÜR KLEINE UND MITTLERE ORGANISATIONEN

15. September 2009,
13.45–16.45 in Bern

Informationen und Anmeldung:
hzweifel@medicusmundi.ch,
www.medicusmundi.ch

MAGAZIN

SYMPOSIUM 2009

CHRONISCHE KRANKHEITEN IN ENTWICKLUNGS- UND SCHWELLENLÄNDERN

GLOBALE GESUNDHEIT VOR NEUER HERAUSFORDERUNG

8. Symposium der schweizerischen Gesundheitszusammenarbeit
Basel, 10. November 2009

Chronische Krankheiten haben die Todesraten der Infektionskrankheiten auf allen Kontinenten ausser im südlichen Afrika überholt. Sie können nicht mehr als ausschliessliches Problem der reichen Länder angesehen werden.

(ml) Chronische Krankheiten wie Diabetes, Krebs oder Herz-Kreislauferkrankungen werden in der Schweiz von vielen als Wohlstandskrankheiten angesehen. Dass zunehmend auch Entwicklungs- und Schwellenländer damit konfrontiert sind, wird nicht nur von einer breiteren Öffentlichkeit, sondern auch in der Entwicklungszusammenarbeit selbst ausgeblendet.

Die chronischen Krankheiten stellen eine grosse Herausforderung für Entwicklungs- und Schwellenländer dar – und sie werden immer stärker zu einer Belastung für die dortigen Gesundheitssysteme. Doch diese sind vorwiegend auf die Bekämpfung von Krankheiten wie Malaria, Tuberkulose oder HIV/Aids ausgerichtet.

In Asien, Lateinamerika, den Tranisitionsländern Europas sowie im urbanen Afrika sind die chronischen Krankheiten bereits die häufigste Todesursache. Es sind immer mehr junge Menschen davon betroffen – auch Kinder, die als Folge von Mangelernährung und Bewegungsmangel unter verschiedenen, chronischen Folgekrankheiten leiden.

Nicht nur die betroffenen Länder sondern auch die internationale Gesundheitspolitik und die in der Gesundheitszusammenarbeit tätigen Nichtregierungsorganisationen stehen vor grossen Herausforderungen.

Grund genug das Thema mit Fachleuten aus nichtstaatlichen Entwicklungsorganisationen, aus der Verwaltung und der Forschung sowie mit Vertreterinnen und Vertretern internationaler Organisationen zu debattieren, Erfahrungen auszutauschen und Lösungsansätze zu kennen zu lernen. Eröffnen wird das Symposium Martin Dahinden, Direktor der Direktion für Entwicklung und Zusammenarbeit.

Programm und Anmeldung:
www.medicusmundi.ch

Maladies chroniques dans les pays
en développement et les pays émergents:

LA SANTÉ MONDIALE FACE À DE NOUVEAUX DÉFIS

Symposium annuel de la coopération suisse en matière de santé

Bâle, 10 novembre 2009

Programme et inscription:
www.medicusmundi.ch