SECTION IV

LEARNINGS FROM THE WORKSHOPS

LESSONS LEARNT

The two modules discussed in this manual have been field tested over a period of a year. The module entitled "Gender Concerns in HIV and Development" was field tested by the Gender and Development program of the UNDP under its capacity building program and was subsequently used in orientation workshops for UNIFEM and its partners in eight countries namely; India, Vietnam, Senegal, Zimbabwe, Kenya, Nigeria, Mexico, and The Bahamas. The second module entitled "Gender and HIV: A Human Rights Approach", was critiqued by a group of trainers and then field tested in a workshop held in Senegal in which representatives from seven countries were present namely: India, Vietnam, Senegal, Zimbabwe, Kenya, Nigeria, Mexico, and The Bahamas. These experiences have generated a richness of lessons. These lessons are presented below from the perspective of the facilitator and from that of the participants.

I. LESSONS FROM THE PERSPECTIVE OF THE FACILITATOR

a) Location of the workshop

In both the workshops it has been found that it is useful to locate the exercise away from the workplace of the proposed participants. This enables a more complete attendance, which is useful given the method used to envisage the learning process. It was found that when the workshops were held in close proximity to the workplace of the participants, they tended to tie up this commitment along with their obligations, official and personal. As a result attendance in the workshops started to reduce in the post lunch sessions.

It is therefore recommended that either the workshops be organised in locations away from the workplace of the participants or the timings for the agenda be modified so that the workshops commence early and incorporate as many sessions as possible before lunch.

b) Participant Selection

The choice of participants in these workshops is critical to ensure the achievement of the objectives of the workshop. The workshops are meant to develop a new perception towards the epidemic that incorporates the gender dimensions of development. It offers new information for two kinds of participants: **those who have worked on gender but not on HIV, and those who have worked on HIV but not on gender.**

In some countries, a few of the participants had already done extensive work on both gender and HIV, and hence they gained little from their participation in the workshop. For them, as one expressed it, the workshop was "pitched too low".

It is therefore recommended that the participant selection be done carefully so that a synergetic dynamic prevails during the process of the workshop.

c) Module I: Session 3

Both the modules have exercises that promote consensus building through discussion in-groups (refer to pages 43-50). In some workshops it was found that when a group did not reach a consensus the presentation by that group was deferred. However it was found very difficult to place this presentation at some other point in the workshop mainly for two reasons:

- It disrupted the process of the workshop if it was included prior to or after any other exercise.
- It led to a certain amount of frustration by the majority of the members of the group who did agree on the issue but were unable to express their thoughts at plenary due to the difference in opinion of, at times, just one member of the group.

It is therefore recommended that the skill of consensus building be nurtured through this exercise using a certain amount of discretion.

d) Module I: Session 4

The exercise entitled "Demographic Silhouettes" (page 51), is found to be a lively tool that enhances participation in a very effective manner. However, the entire exercise is time consuming and may get a bit tedious in countries with mature epidemics where this information relating to the impact on households may not offer new insights. It was found during the workshops that it was possible to modulate this exercise so that the two stages outlined in this tool could be collapsed into one.

It is therefore recommended that the facilitator assess the knowledge base of the participants, relating to the impact of the epidemic on households, prior to conducting this exercise.

e) Ethical Considerations

In keeping with the principles of partnership and participation, the involvement of people living with HIV/AIDS (PLWHAs) in the workshops has proven to be extremely rewarding. However, ethically it is important that the PLWHAs be briefed thoroughly about the purpose of the workshop.

It is therefore recommended that the organisers of the workshop meet with the PLWHAs prior to the workshop to explain to them the workshop objectives. It is also recommended that an honorarium be provided to the people who come and give their testimonies. They are then respected as a resource person who enriches the knowledge base of the participants through a sharing of their personal testimonies.

f) Time

As seen from the agenda of the two workshops the time slotted for each session leaves little flexibility. The schedule is therefore rather tight and one feedback

that was received from the participants, stated that the workshop should have been spread out over a longer time frame. Whereas this concern is acknowledged and appreciated it is useful to keep in mind that effective participation of key decision-makers is possible only for short periods of time given their overburdened official schedules. The cost implications of an additional day are also worth considering.

It is recommended that the agenda for the workshops be modified in keeping with the time available for the participants. The time frame that is suggested in this manual is optimally cost effective.

g) Co-facilitation

One facilitator can conduct the workshop. One facilitator tends to keep expenses to a minimum. However, it has been found to be useful (particularly for the two day workshop) to involve a 'national' or 'local' resource person as a co-facilitator. This is a step towards building local capacities in this area. It is therefore, recommended that wherever possible, the workshops encourage the co-facilitation using local resource persons.

h) Evaluation

The nine workshops held before the end of 1999 adopted a method of evaluation that was open and did not follow a specific format. This was done because the workshops aimed at fostering an emotional, cognitive, and reflective experience for the participants which it was felt would be difficult to capture on rigid scales or measurement ranging from unsatisfactory to excellent or from one to five. Participants were asked to record and reflect their feelings in a non-restrictive manner. However, there was one view expressed that a formatted evaluation would have been useful. In some workshops, the evaluation forms are distributed at the beginning of the workshop so that they can record their judgements about the various aspects of each session as the workshop moves on from one session to another. Specific time allocations need to be provided by the facilitator to make this kind of a structured evaluation truly effective.

It is therefore recommended that the facilitator discusses this issue with the participants at the outset of the workshop and respond to the requirement of the group accordingly.

A sample form for evaluation is attached.

i) Strategic Use of the Modules

It was found that these modules are most effective if used as part of a larger process rather than as a one-time endeavour (as the "striking of the match"). After the first workshop three core groups were formed (empowerment through information, empowerment through human rights, and empowerment through capacity building), and the following, illustrate the impact of the workshops.

The work undertaken by the group on Empowerment through information

Currently, we have received community based research reports on the gender dimensions of HIV/AIDS undertaken by groups in various countries such as Mexico, India, Zimbabwe, and Senegal. The following are some of the interesting findings that have been drawn from a few of the reports.

The findings of the community based research reports are path breaking and offer excellent opportunities for advocacy with national governments. For example in Mexico, the research team developed instruments that were used to identify and measure levels of depression, low self-esteem, violence and the impact that these have on women's ability to negotiate safe sex. The report examined the issue of providing access to treatment through policy formulation from a gender perspective. Even though Mexican health policy provides free access to anti-retroviral drugs for PLWHAs, women are still disadvantaged as they are largely in the informal sector whereas access to AZT is possible only through the formal sector.

Another path breaker is the information generated by IWID in India, that knowledge about the protective aspects of condom use became available to women only after they had become infected. This information should help development agencies to re-examine the target of their IEC. The issue of better supplies of affordable medicines for opportunistic infections and the need for more attention to be paid to single women who are bearing the brunt of the epidemic, are also interesting from the policy and programmatic point of view.

In Senegal, the effort was to examine the impact of myths and practices existing in the Senegalese society on the HIV/AIDS epidemic. The findings of the study break stereotyped perceptions, e.g. as far as sexuality and knowledge of one's body is concerned there is not too much difference between the literate and the illiterates. Also, the knowledge of sex workers about their bodies was much lower than that of housewives. The need for promoting a process of unlearning has also been brought out quite categorically. Unlearning of existing sexual myths is critical before new learning on HIV/AIDS can be brought in. For example, the commonly held view in Senegal that "circumcised women cannot be satisfied by just one man", or "that a woman who says no to her husband for sex will never have good children for the mother's behaviour during the sex act is decisive for the future of the child."

The research in Zimbabwe focuses on the socio-economic impact of AIDS on the household and suggests valuable directions for policy modifications and directions for planning for NGO's and the national government. This research has focussed on the area of the adjustments that households and communities make regarding their resource allocation for production and consumption activities in the face of HIV/AIDS and the overall welfare outcome as a result of these adjustments. Very little substantive evidence on this was available in Zimbabwe as the literature search revealed and therefore this kind of exploration helps fill the gap.

For example, one finding showed that the home based care givers require organised educational programmes with a special emphasis on signs and symptoms of HIV/AIDS, shared confidentiality, prognosis of diseases, prevention of cross infection and counselling. Another finding that could contribute to the policy dialogue relates to the need to focus IEC initiatives on "how to cope" rather than "how to prevent", given the maturity of the epidemic in Zimbabwe. The study found that support for PLWHAs even within the family is rather "ambivalent" and not solid and unconditional.

The following are some of the valuable observations from the report: the shift in gender roles as industries that were formerly male dominated (e.g. women are now taking over carpentry as men are getting sick and dying); the fact that women are seen to be more courageous and up front than men as far as disclosing their HIV positive status is concerned – the men prefer to die in silence; and the urge to work harder among PLWHAs so as to leave their children some inheritance. These findings can provide some directions to NGO's in Zimbabwe as to how to respond to the capacity building needs to PLWHAs in the country.

All the findings will be discussed with government decision-makers as well as with the representatives of the civil society through advocacy workshops. The considerable potential for influencing national policy has emerged from the research in all the countries.

The work undertaken by the group on Empowerment through Human Rights

Recently we have received feedback on work being done by journalists that participated in the module on "Gender, HIV, and Human Rights". The participants took the lessons that they learned at the workshop and incorporated HIV and gender dimensions into their writing. The following interviews and articles illustrate the type of work that has been carried out since the workshop.

Lydia Cacho Speaks

"After working for three years on gender and HIV/AIDS, I was burnt out and tired of the work. The workshop gave me new information that was presented in a very humane manner. I was re-charged after participating and it stirred my desires to work on the issues."

The following profile of Lydia Cacho gives us an insight into the potential impact of the Gender, HIV/AIDS, and Human Rights workshop. Ms. Cacho participated in the workshop organised under the joint initiative entitled "Gender Focussed Responses to Address the Challenges of HIV/AIDS." She attended the workshop as a representative from the Mexican news service, CIMAC. CIMAC is a multimedia new agency that is comprised of 800 female journalists from various countries in Latin America and Caribbean. After attending the workshop in Senegal in October 1999, Ms. Cacho returned to Mexico and has been able to catalyse the following:

- Orchestrated a training on gender focussed journalism using some of the learning tools that were used at the workshop in Senegal. (Ms. Cacho used the role-playing tool at the training because of the impact that it had on her when she was in Senegal. Ms. Cacho had been assigned to be group leader and she decided to have a man play the role of the woman and a woman play the role of a man. Following the session, Ms. Cacho spoke with the man that played the role of the woman and asked him, "How did it feel to be a woman?" With tears in his eyes the man said, "I wish that I could apologise to my mother for the abuse that she suffered.")
- Became a recipient of the National Journalistic Prize for 1999 in Mexico, *Rosario Castellanos*, for her article she wrote for "La Crisis".
- Wrote ten articles on the gender and human rights implications of HIV/AIDS in Africa. The articles have been cross-referenced by over fifteen mainstream dailies via the CIMAC on-line news wire.
- A Mexican weekly political journal entitled "La Crisis", published one of her articles on the epidemic. This was extremely important due to the fact that all Mexican politicians read the journal.
- Wrote an article, "Enfrentarlo o Morir" for *Novedades*, a leading Mexican daily newspaper, on the impact of the epidemic in Africa.
- In Mexico, many people, including the General Secretary of the Governor, the Director of the Social Security Hospital, and the Mayor of Cancun have called Ms. Cacho to congratulate her on her work.
- The most popular radio station in Puebla, Mexico has read all of the articles that Ms. Cacho has written on the epidemic.

Karen Wallace Speaks

Ms. Wallace is a journalist from the Bahamas who has been writing on the lives of those living with HIV/AIDS. The following is an excerpt from an article that she wrote after the workshop on "Alma", a 50-year old mother of four and grandmother of nine. She has been living with HIV for the past four years and is battling to overcome the stigma that has been placed on her.

"*My time with Alma has left me to believe that at present, people living with the HIV/AIDS virus have nothing to look forward to other than death. They are terminated from work, ostracised by persons in the community, feared because of ignorance of the disease and discriminated against because of the stigma placed on them. Although Alma has experienced the many negatives associated with this deadly disease, somehow she struggles to remain positive everyday. This is not the same for all persons living with HIV/AIDS.*

For me, the visit with Alma has truly placed a face on HIV/AIDS and has changed my outlook on people living with the disease. Because of Alma, I have enhanced my commitment to make the public more aware and sensitive through all avenues of the media of the human side of people living with the virus.

The day spent with Alma was a life-moving experience and with her permission excerpts of our discussions will be used in public presentations and planned workshops. Alma can be used as an example to educate the corporate community that people living with HIV/AIDS are still employable if given the chance to be productive citizens.

The time spent with Alma was video-taped and audio-recorded. The interviews are being packaged for news broadcasts and half-hour television and radio programs. The information has been transcribed and will be incorporated with statistics and other data received for national dissemination."

Pamela Philipose Speaks
An innovative way to combine anecdotal evidence with empirical data and linking the macro and micro issues was provided by a workshop participant from India. Pamela Philipose of the *Indian Express* has devised the "AIDS Blackboard" as a means to move discussion on gender, HIV/AIDS, and human rights in India. A few of her articles are appended.

The Demography of a Disease

The Indian Express, 21 October 1999

> **While sub-Saharan Africa accounts for two-thirds of people living with HIV/AIDS, one country – Senegal – has been relatively successful in its battle against the disease.**

Both geography and history have made Senegal something of an enigma. Bound by the Sahara desert on the one side and the South Atlantic Ocean on the other, this tiny republic was colonised by the French for 200 years and is yet overwhelmingly Islamic in belief.

Since it is perched on the brow of Africa's Northwest coast – the closest Africa comes to the North American mainland – Senegal has been the site of one of humanity's darkest moments. Visit the island of Goree, which lies three kilometres from Senegal's capital, the harbour city of Dakar, and you will be taken to the Maison des Esclaves, or the Slave House. It is a monstrous vestige of the slave trade that saw some 15 to 20 million Africans captured and sold over three centuries – from 1536 to 1848. An estimated six million died in the process.

Today the slave trade is thankfully just an ugly memory but modernity has brought with it fresh threats. One of the biggest social and medical challenges facing Senegal today is dealing with the HIV/AIDS pandemic, which has cut a swathe across the African continent. Approximately two thirds of the people living with AIDS world-wide live in sub-Saharan Africa.

The disease has wrought immense havoc in countries like Uganda, where whole villages have been wiped off the map, where a quarter of the children have at least one parent stricken by AIDS. Here fields lie untended because of the lack of able adult labour and old women are left to nurture the numerous children orphaned by the disease.

And in not just sub-Saharan Africa, Eunice Mafuabikwa, a senior activist/writer from Harare, Zimbabwe, revealed that it is very rare in her country to come across a family that has not experienced a death caused by AIDS.

What disturbs her the most about the situation is that despite Zimbabwe being poised to become the country with the largest number if AIDS cases in the African continent, there has been little or no change in social behaviour. "The general attitude seems to be that 'everyone has to die some day anyway.' Men continue to pride themselves on their promiscuity. There is even a local saying that just as a bull is known by its scars, so is a man by the sexually transmitted diseases he has experienced!"

It is heartening therefore to learn of Senegal's conspicuous success in grappling with the spectre of the dread disease, as a workshop hosted by UNIFEM in Dakar earlier this month revealed. The workshop was part of UNIFEM's two-year pilot project on gender focused interventions in HIV/AIDS involving six countries – Zimbabwe, Senegal, Mexico, Bahamas, India and Vietnam.

Senegal's attempts to address the problem become crucially important – not just for the African continent but for the rest of the world, which is still largely clueless about the social impact of the disease.

According to Dr. Ibrahima Ndoye, co-ordinator of Senegal's national programme on HIV/AIDS, who had addressed the workshop, the country which had a prevalence rate of one percent in '91-'92 now has to contend with a prevalence rate of 10 to 20 percent among high risk groups. "But this is a low figure considering the fact that in many countries of the region the figure is more than 50 percent," says Ndoye.

Data collection was perceived as a crucial input in managing HIV/AIDS. "We have stepped up the monitoring of the disease through scientific, medical and epidemiological surveys – today Senegal, along with Thailand and Uganda, has an extremely good data bank, which helps to provide some focus to the programme," says Ndoye.

Along with the data bank, care has also been taken to clean up blood banks. While many sub-Saharan nations just don't have the health infrastructure to guarantee safe blood, in Senegal strict screening for HIV has been made mandatory.

Interestingly, spiritual leaders have been encouraged to get involved in the nation's AIDS control programme. As Ndoye puts it, "We are 95 percent Muslim and 5 percent Catholic, and we have involved our religious leaders in our campaign. They have helped especially in fighting the stigma traditionally associated with the disease."

But while the men of God promote the values of abstinence and fidelity, Ndoye himself takes no chances. "They preach abstinence. We preach condom use," he remarks dryly.

The national HIV/AIDS programme consciously tries to reach the youth. According to Ndoye, it is crucial that over the next 10 years, young people from the ages of 10 to 25 in all developing nations must be sensitised to the problem.

Senegal has also discovered that no HIV/AIDS control programme can be successful without involving and empowering women. Being a polygamous society, women often find themselves sexually powerless.

Aster Zaoude, Regional Programme Advisor, UNIFEM, Senegal, pointed out that the husband plays an inordinately powerful role in social relations here. "We find that the biggest problem seems to be that while most women know about the dangers of the epidemic, they don't know how to negotiate safe sex," says Zaoude.

This is where recent experiments with the female condom have added a new dimension in the struggle against AIDS in Senegal. Dr. Penda Ndiaye of the Social Hygiene Institute, Dakar, conducted a study on female condom use by local women including sex workers. They were found to be well accepted, indeed even in great demand. According to the study, the female condom seemed to help women gain some control over their sexuality in a society that had always considered them as passive partners in the sexual act.

Experts are now increasingly coming around to the view that the most significant risk factor for HIV/AIDS is not sexual activity or drug use as much as socio-economic helplessness. Since the infection is preventable, people who are literate and have access to information usually take the necessary precautions. Women, given their lack of both economic and sexual independence, are thus more vulnerable to the disease.

Madhu Bala Nath, HIV and Gender Adviser to UNIFEM, and the woman who anchored the Dakar workshop, believes that given the fact that an increasing number of women are affected by HIV/AIDS – approximately 43 percent of adults living with HIV/AIDS are women – the gender dimension of the battle against the disease cannot be emphasised enough.

Says Nath, "On the one hand the campaign against AIDS has not sufficiently focused on women, on the other, the women's movement has just not adequately addressed issues of sexuality or perceived HIV/AIDS as a women's issue."

The AIDS Blackboard

- According to UNAIDS, out of 33.4 million living with AIDS world-wide, 22.5 million live in Sub-Saharan Africa – about half of them women.
- Life expectancy in some severely affected countries in Africa has been reduced by 10 years because of the disease.
- In Uganda, a quarter of the children live in families in which at least one parent has AIDS.
- Situations of social strife have only increased the rapidity of the spread of the disease. In Rwanda, before the war, only two percent of the population was HIV/AIDS affected. The figure now is thirty percent.
- Of the $2 billion allocated to HIV/AIDS world-wide, an overwhelming ninety- percent goes into research and testing.

Irrational complacency, Irrational fears

The Indian Express, 22 October 1999

> ***The HIV/AIDS epidemic in India is largely hidden because society is not prepared to confront the disease***.

"No HIV/AIDS please, we're Indian. We also love our wives." Somewhere, Indian society seems to have internalised the received wisdom that while Africans are promiscuous, Indians are not. Therefore, while AIDS may be a problem for them lot, we really have nothing to worry about.

International data, however, belies such easy complacency. According to the evidence at hand, South and Southeast Asia is the epicentre of the HIV epidemic, the majority of new infections are said to be occurring in this region. In fact, the impact of the disease on Asia could be worse than it was in sub-Saharan Africa because it seems to be spreading at a faster pace. Since 1994, almost every country in the region has seen HIV prevalence rates more than double.

Today, some 6.4 million are believed to be affected by the disease in a region where 60 percent of the population is sexually active. India is estimated to be particularly vulnerable with some 3 to 5 million HIV infections. Officially, by the end of July 1998, the country had 78,904 HIV infections and 6,386 AIDS cases, but the actual figures could be much higher.

Says Madhu Bala Nath, advisor on HIV and gender to UNIFEM, "We are looking at a country where there is a high prevalence of the disease in at least four regions – the Northeast, Tamil Nadu, Maharashtra and Andhra Pradesh. We are looking at a country where a large percentage of the population is in the sexually active category."

Nath is also critical of the view that India should concentrate on fighting malaria and tuberculosis instead of AIDS. "These distinctions are breaking down. Last year, 30 per cent of the TB cases world-wide were AIDS-related,' she says.

Nath finds African societies more pragmatic about the issue. "While we assume that our cultural and social factors will prevent AIDS from acquiring pandemic proportions Africa, I find it far more realistic about such matters."

It is a realism that India can certainly learn from. The ugly and brutish brush with AIDS deaths through the late eighties and nineties have forced countries like Uganda and Tanzania to install systems that could, in the long run, check the rampant spread of the disease. The first signs of an HIV turnaround are surfacing. The prevalence rates among pregnant women in Uganda and those among young people in Tanzania have fallen by 40 and 60 per cent.

Changing social attitudes and government policy towards HIV/AIDS, in a culture where widespread stigma is attached to the disease, is certainly a difficult enterprise. But somewhere along the way, the realisation seems to have dawned in many of these African

nations that without a human rights-based approach to the disease, it would be impossible to challenge its reign.

The Uganda Network on Law, Ethics and HIV/AIDS initiated a legal review process to safeguard the human rights of people living with the condition and recommended that ethical norms govern biomedical research and drug and vaccine trials in the country. It argued that the testing, counselling and treatment of the AIDS-affected must be done with sensitivity and professionalism.

Similarly, the Zimbabwean Intersectoral Committee on AIDS and Employment came up with a national code on AIDS and security, as well as training and employment benefits for the affected.

India, in sharp contrast, has remained supremely indifferent to such issues. As Anand Grover of the Lawyers Collective observed in a recent article, "The number of cases of mandatory testing, isolation of people living with HIV/AIDS, breaches of confidentiality, discrimination and harassment is increasing rapidly throughout the country." He argued that there is an urgent need for law reform, for new laws and for the training of lawyers, legal activist and paralegals on key issues. As he put it, "Thus far the Indian government has failed to develop a sensitive and supportive legal environment to deal with the epidemic."

Every person stricken with HIV/AIDS is literally driven underground by the stigma and discrimination that comes his or her way. In her recent study on 'HIV/AIDS discrimination, stigmatisation and denial,' Shalini Bharat of the Tata Institute of Social Sciences, Mumbai, relates instance after instance of patients being subjected to the treatment that the leprosy-afflicted had experienced in Biblical times.

Bharat cites the case where the dead body of a man who died of AIDS was not allowed to be brought into his village near Bangalore. Within a few days the local community had hounded the man's widow out of the village, accusing her of being an 'AIDS carrier."

It's not just rural India that displays such cruel and uninformed behaviour. According to Bharat, prejudice and stigma are manifest at every level of society. In hospitals, patients are routinely refused treatment and access to common facilities like toilets. Even in death, they are not spared. The bodies of IDS patients are routinely covered with a plastic sheet.

The situation in the workplace is not much better. Summary dismissal and the withdrawal of health and insurance facilities are the norm. Within the family, relationships break down, desertion and separation follow. As Bharat notes, the fear of social opprobrium, guilt, and desperation often keep infected members from accessing help and support. She writes: "HIV/AIDS related discrimination and stigmatisation and denial is pervasive and extensive, affecting people's will to fight and survive AIDS." This, in turn, renders the disease a hidden one and adds to the silent spread of HIV/AIDS in the country.

Much of the popular response to the disease is an irrational fear based on inadequate knowledge and culture of silence about sexuality. Indeed, this fear and silence would first have to be addressed if HIV/AIDS in India is to be defeated.

As Nath say, "Our focus thus far has been on prevention rather than care. If you make care your entry point, you get people sensitised to the disease. Care is, in any case, essential when it comes to managing a disease such as this, which is so closely linked to human behaviour."

The AIDS Blackboard

- Of the 33.4 million living with HIV/AIDS world-wide, 6.4 million live in Asia. Since 1994, almost every country in the region has seen HIV prevalence rates more than double.
- A survey in Tamil Nadu shows that 82 percent of men afflicted with STDs had had sexual intercourse with multiple partners within the last 12 months and only 12 percent had used a condom.
- Another study in India revealed that 90 percent of male clients of male sex workers were married.
- Mahrashtra, Tamil Nadu, and Manipur account for almost 77 percent of total HIV infections in the country.
- Some 75 percent of infections were contracted sexually, while blood and blood products accounted for seven percent and needle-sharing another seven percent.
- The spread of the disease from urban to rural areas is growing thanks to high population mobility. The urban-rural ratio was 4:1. Over the last five years, the rural proportion has registered an increase in North India.

The work undertaken by the group on Empowerment through Capacity Building
A resource guide for NGO's on how to empower women to negotiate safe sex has been prepared drawing on the first hand experiences of women in the field. This resource guide has been endorsed by women's groups in the participating countries and will then be shared with a number of NGO's. The case study below can be found in the resource guide.

The SHIP project in Sonagachi

The SHIP project was an experimental public health intervention, focusing on the transmission of STD/HIV among communities in Calcutta. The project was launched by WHO in 1992 in close collaboration with the Indian Institute of Hygiene and Public Health. It set up a STD clinic for sex workers in Sonagachi, to promote disease control and condom distribution, in line with the then-popular approach of targeting HIV prevention to particular groups who were particularly at risk. However, during the course of the project, the focus broadened considerably beyond disease control, to address the structural issues of gender, class and sexuality. As mentioned above, Sonagachi is a community where constant negotiations are going on, and it was perhaps this aspect of life that inspired work to control HIV through addressing sexuality and gender power relations.

The focus on using `insiders' to work with their peers to motivate them reflects the ideology on which the project is based. At the start of the SHIP project, members of the sex workers' community were invited to act as peer educators, clinic assistants, and clinic attendants in the project's STD clinics. Since that start, SHIP has aimed to build sex workers' capacity to question the cultural stereotypes of their society, and build awareness of power and who possesses it. It seeks to do this in a way, which is democratic and challenging, yet non-confrontational.

Negotiating with the self
The respect and recognition that was provided by the project to these peer educators transformed their lives (personal communication, Calcutta 1999). From the very beginning, the project made it very clear to the sex workers that in no way would a 'rehabilitation' approach be adopted. The project had not been established to 'save' 'fallen women'. The peer educators acquired a uniform of green coats, and staff identity cards, which gave them social recognition. A series of training activities were organised, with the aim of promoting self-reliance and confidence, and respect for them in the community. Comments from peer educators are on record in a project report. One reported: 'The project has enabled me to face society with confidence' (report by the Durbar Mahila Samanwaya Committee, 1998), and another said 'This apron has changed my life, my identity. Now I can tell others that I am a social worker, a health worker' (ibid.).

Once the sex workers saw the results of the discussions and the survey statistics, they could see their vulnerability to structural problems, and those who had previously seen themselves as 'sinners' and `loose women' changed their perspectives. In focus group discussions, peer educators said, "For us, this trade is also an employment. Why wouldn't the government recognise it? Who says we are loose women?"

This awakening is a very significant transformation that the project has achieved. The sex workers of Calcutta have begun to challenge the age-old notions of sin and blame, and are trying to reconstruct their identity. This perhaps, is the first stage of negotiations towards safer sexual practices – a negotiation with the self.

Negotiating with peers

Although the SHIP project had started well, the empowerment of 65 peer educators was not adequate to protect the 5,000 sex workers who lived in Sonagachi alone from this abuse of their rights. How could the project keep a focus on promoting safer-sex practices with this wider issue of political rights going unaddressed? From negotiations with the self, they moved to a new level: negotiations with their peers.

The peer educators began their work, going from house to house in the red light areas, equipped with information on STDs/HIV prevention, AIDS and how to access medical care, and material which suggested ways of questioning power structures that promoted violence. House-to-house work took three hours each morning. Each day, every group of peer educators (4 in each group) contacted between 40 and 50 sex workers, and 10 to 15 brothel owners. They encouraged the sex workers to attend the clinic for regular health check ups; they used flip charts and leaflets for effective dissemination of information on STDs/HIV; they carried condoms with them to distribute to the sex workers.

As these activities got underway, awareness grew in the community about the project. While the project had begun as a targeted intervention to prevent the spread of HIV/AIDS, using a strategy of promoting behavioural change, it had become clear to all involved that the main obstacles facing the successful implementation of the project were not just behavioural. They were to do with the way sexuality is seen in society, the lack of a social acceptance of sex work, the legal ambiguities relating to sex work. All these were now being increasingly recognised by the community as elements to be confronted and battled against and overcome. Sex work was an occupation, and not a moral condition. And because sex work was an occupation, the occupational hazards of STDs/HIV, violence and sexual exploitation had to be acknowledged as such, and overcome.

Building alliances with the clients

In 1993, early in the life of the project, a survey was conducted by the peer educators with babus (long-term, regular clients) (All India Institute of Hygiene and Public Health, 1997). The survey revealed that only 51.5 percent of the clients had heard of HIV/AIDS, but even this group lacked awareness regarding the use of condoms. Only 1.5 percent regularly used condoms, and 72.7 percent had never used a condom (ibid.). After the survey, a meeting was organised, to begin to build alliances between sex workers and their regular clients in the interest of promoting safer sexual practice. About 300 clients attended. The discussions that began at this meeting led to the opening of evening clinics for the clients, where they could receive free treatment, counselling and access to condoms. Socio-cultural programmes were organised to introduce safer sex and HIV/AIDS messages targeting the clients. Today, the clients have come together in a support group called the ‘Sathi Sangha (‘Group of Friends’). This group supports the sex workers in motivating new clients to use the condoms, and supports the sex workers’ efforts to eliminate sexual violence in the area.

The Sonagachi movement has also successfully intervened in stopping child trafficking in West Bengal. The self-regulatory Boards set up in 1999 are the mechanism that enforces this. A number of children trafficked have been returned to their homes, and in this way the organisation is reducing vice and violence in the larger society.

By 1996, research from SHIP showed indicators that were different (All India Institute of Hygiene and Public Health 1997; DMSC 1998). The knowledge of STDs in Sonagachi improved from 69 percent in 1992 to 97.4 percent in 1996; the knowledge of HIV/AIDS rose from 30.7 percent in 1992 to 96.2 percent in 1996. Condom usage shot from 2.7 percent in 1992 to 81.7 percent in 1996. HIV/AIDS prevalence levels plateaued at five percent, when other red light areas the country were recording a rate of 55 percent. In fact, the Telegraph, a leading daily newspaper, hailed Sonagachi as the `biggest brothel in Asia' which had a negative growth rate of HIV/AIDS (Telegraph, 18 September 1995).

II. LESSONS FROM THE PERSPECTIVE OF THE PARTICIPANTS

The responses and evaluations from the participants at the end of the training highlighted the various achievements and failures of the workshops. The responses of the participants have been grouped below in relation to the workshop objective.

Objective I: Working on enhancing the understanding about gender concerns in HIV development.

- "Before attending this workshop, I was of the opinion that HIV/AIDS was only a health issue and if there was any social impact it was gender independent. Why talk about women only when more men were suffering? My impressions have been modified." (Dakar, Senegal)
- "The meeting put HIV/AIDS gender concerns in perspective. The tool used to analyse gender issues in HIV/AIDS is excellent. It can be used at policy level, mid-managerial level and community level." (Nairobi, Kenya)
- "The workshop clearly brought out the impact of the epidemic on men and women, hence the need for gender based institutions to be more productive." (Nairobi, Kenya)
- "What I mainly learnt from the workshop was the necessity and urgency to focus on the gender perspective of AIDS." (New Delhi, India)
- "I see a platform being built to see the problem of women and HIV in an integrated system perspective and not only as a health issue." (New Delhi, India)
- "The issue of gender in HIV/AIDS has become clearer to me – it is like a cycle. It expresses the fact that women are still on the receiving end in this issue – the statistics are alarming. It creates a desire in me to do more research and ensure the dissemination of the results of those already done." (Lagos, Nigeria)
- "Many eye-opening and alarming data has touched me to the core. I feel more responsive in all the programmes of community mobilisation and gender sensitisation camps." (New Delhi, India)

Objective II: To understand the complex dimensions of the challenges being posed by HIV/AIDS within a framework of human rights with a gender lens.

- "I was sensitised to the gender and human rights issue of persons living with HIV/AIDS particularly as it relates to women." (Nassau, Bahamas)
- "Was able to gain greater insight and understanding about gender, HIV/AIDS, and human rights from the global perspective." (Dakar, Senegal)
- "This is the first workshop I have attended that has left me with motivation and limitless energy to do my part in sensitising persons in the Bahamas about gender, HIV/AIDS, and human rights." (Dakar, Senegal)
- "The gender aspects are now clearer in my mind. I am now armed to know what to say, who to say it to, how to say it, and why." (Dakar, Senegal)

Objective III: To identify strategies that can address the challenges of HIV/AIDS from a gender and human rights perspective.

- "The workshop has served as a moment of coming face to face with the realities of HIV/AIDS. As a researcher I can see that I have a critical part to play in helping such victims, the society at large and women in particular." (Lagos, Nigeria)
- "There is a need to intervene through aggressive campaigns, building capacity of all citizens to avoid and prevent the disease." (Lagos, Nigeria)
- "I want the Broadcasting Corporation of Bahamas to play an integral role in helping to make a change in the perception of people living with HIV/AIDS." (Nassau, Bahamas)
- "I am leaving here further energised and committed to continue to educated, network, share, and grow." (Dakar, Senegal)
- "Many eye-opening and alarming data has touched me to the core. I feel more responsive and committed to include the issue of women and HIV in all the programmes of community mobilisation and gender realisation camps." (New Delhi, India)
- "I leave inspired to do more articles, better informed on gender and HIV/AIDS." (Dakar, Senegal)

The following were some suggestions to improve the workshop:

- "Good workshop but I felt it was pitched too low." (New Delhi, India)
- "Unhappy that there were less men/government people participating in the workshop." (New Delhi, India)
- "I only missed the participation of more males." (Harare, Zimbabwe)
- "More time needed for the workshop. Need to include PLWHAs as participants." (Dakar, Senegal)
- "Would have liked more reading/reference material." (Dakar, Senegal)
- "How are we going to get men more actively involved in these human issues? It is still very difficult and was not touched deeply in the workshop." (Dakar, Senegal)

EVALUATION FORM

1. What happened in the workshop?

2. Key issues included in this workshop were:
   - A gender analysis of the prevalence, causes, and consequences of HIV/AIDS.
   - A review of the gender based construction of sexuality.
   - An analysis of the impact of HIV/AIDS on the household.
   - A discussion on the gender based impact of the epidemic on national economies.
   - An insight into the life of people living with HIV/AIDS.

   Indicate those which were of most interest to you and explain how they are relevant to your work.

   What other issues would you have liked to discuss at this workshop?

3. Did the workshop contribute towards the building of any skills?

4. How do you think you will use the outcomes of the workshop?

5. In what aspects of the follow-up activities would you like to participate in?

6. How has your understanding of the epidemic changed after participating in this workshop?

7. If a similar training format were used again, what would you suggest to do differently?

8. What aspect of the workshop did you most appreciate? Why?

9. Additional comments.