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Sida Regional Conference
on HIV/AIDS in Asia, February 2006

Driving Forces, Issues, Scaling up

Driving forces
Issues
Scaling up

Sida Regional Conference on HIV/AIDS in Asia

PHNOM PENH, CAMBODIA
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Cover photo: Anjali Gopalan, NAZ Foundation, India is demonstrating condom use

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Foreword – The Swedish Response

HIV/AIDS is one of the biggest development obstacles. Therefore HIV/AIDS is a strategic priority for Sida. Sida supports and encourages an integrated approach to face the complex consequences of the epidemic. Sida works with prevention and preparedness also in countries and regions not yet highly affected by HIV/AIDS.

As part of taking on this challenge and scaling up efforts, Sida Civil Society Center initiated a conference for civil society organisations in Asia on HIV/AIDS in Phnom Penh, Cambodia. The conference is part of a long journey officially beginning in 2004 when two regional seminars were held in Africa and one in Härnösand, Sweden.

The purpose of the conference was to enable Swedish and local organisations to meet across organisational boundaries, to create a venue for exchanging new knowledge and exposing one another to new methods and tools. The idea was to offer every participant something to bring home and apply to the local context.

We do not know how the pandemic will develop in Asia, but from the African experience we know potential consequences that can be a reality if we do not take action today. We also know that civil society organisations play an extremely important role struggling against HIV/AIDS.

We learnt that many organisations are already working vigorously to combat the epidemic and an increasing number are looking into how they can intensify their responses. But the experience from these activities also shows that there is a demand from Swedish organisations for activities supporting the implementation of the strategic priority on HIV/AIDS. As a result of our efforts an HIV/AIDS forum has now been established by Swedish civil society organisations (CSOs) and Sida Civil Society Center provides courses in scaling-up and other related topics.

Roland Stenlund,
Head, Sida Civil Society Center

Overview and introduction of HIV/AIDS in Asia

"This is a gathering of sharing. We are here to learn from each other – to help each other learn about structures and development of HIV/AIDS in Asia" Pia Bergman, Sida Regional HIV/AIDS Adviser for South East Asia, said and emphasised the spirit of the conference from the very beginning.

When we talk about Asia, we often hear the *mantra* on low prevalence but instead of this focus on prevalence rates, we should rather think in actual numbers of people. In Asia, we have the largest concentration of people in the world. In India alone, five million people are living with HIV/AIDS, which accounts for almost 13% of the global HIV prevalence. In South Africa, five million people would amount to 22% of the population which is equivalent to the current prevalence rate of 21%, and it took little more than ten years for the prevalence rate to go from 3% to 21% in the country – so we know what can happen if we do not act today.

In Asia the estimated number of infected people is 8.3 million but it could be anywhere between 5.5–12 million. No one really knows. This is a very large number of people that are infected therefore we cannot only say that the prevalence rate is low in Asia and stop there. We need to go further and look at structures in society and risk behaviour. In many countries with low prevalence we see high sub-regional prevalence – within specific groups, regions or areas. Each of these hot spots has the potential to quickly develop into a larger spread of the disease.

The major driving forces of the epidemic in Asia were identified as:

- Injecting drug users (IDUs)
- Un-protected sex with sex workers
- Men who have sex with men (MSM)

Between these three categories there is overlapping but how much and exactly how we do not know. We should be very aware of leakages into

the general population. This is happening now in some countries and poses a big threat to societies and especially vulnerable groups, including youth, are at risk.

Complex risk scenarios and risk behaviour

Compared to Africa, in Asia economic development represents an additional risk factor and spurs the spread of HIV/AIDS. As the current global economic hot spot, Asia's growth is also causing an increase in the concentration of risk factors, including unprotected sex. People follow the money causing large-scale migration. Once in a new place, people can tend to adopt new, often more risky, behaviours. They have to take risks to survive – often sexual risks.

Drug use is increasing in Asia with both the numbers of IDUs and amphetamine users on the rise. It is not only injections and sharing of needles that drive the spread but also how the use of drugs changes peoples' minds. People become more willing to take greater risks: *"why use a condom when you are already on top of the world?!"*

Going into further detail on major differences between the epidemic in Africa and in Asia, Åsa Andersson-Sing, Regional HIV/AIDS Adviser at the Swedish Embassy in India, took her starting point in a recent study by Manitoba University (See www.worldbank.org/saaids). The study found that the most important biological and behavioural factors are how infectious a person is, the number of sexual partners, as well as the nature of the sexual relation – is it serial or concurrent? Concurrent partnerships are less common in Asia and the suggestion is that Asia's epidemics are unlikely to be driven by concurrent sexual networks in the general population. It is rather the nexus of people buying sexual services and injection drug use that plays an important role in igniting and amplifying HIV transmission.

Åsa Andersson-Singh continued to argue that the size of HIV epidemics depends largely on rates and patterns of partner change – inside and outside the commercial sex trade. She described how we can see big regional differences in Africa and how this is also the case in Asia. In countries like Thailand, Cambodia, perhaps Burma and most of India (except North East) the epidemics are sex driven (many men routinely go to sex workers and sex workers have many clients). In countries like Pakistan, Bangladesh, Indonesia, Vietnam and China injecting drug users are the "spark plugs" that ignite the epidemic with sexual transmission and the sex industry as the engines that maintain it.

Speaking on South Asia, Åsa Andersson-Singh asserted that the HIV/AIDS epidemic is severe, but further spread is preventable. The future size of South Asia's epidemics will depend on an effective two-pronged approach: firstly, and most critically, on the scope and effectiveness of HIV prevention programmes for sex workers and their clients, injecting drug users and

their sexual partners, and men having sex with men and their other sexual partners; and secondly, to support these programs which determine the effectiveness of efforts to address underlying socio-economic determinants of the epidemic. And by creating an enabling environment and to reduce stigma and discrimination towards people with high risk behaviours, often marginalized in society, as well as people living with HIV.

Feminization of the epidemic

Women are infected earlier and more easily than men and in most countries the majority of 15–24 year olds who are infected are women. Women tend to know less about the risks than men. Inequity in access to education, economic benefits (property rights) and the whole issue of violence further leads to larger risks for women. Violence is both a cause and consequence of HIV and AIDS: trafficking and rape put women at risk of HIV and if they are detected as HIV positive, they are at risk of domestic violence and being thrown out of their homes. Moreover, faithful women are now being infected by unfaithful partners, a transmission pattern that is a major concern today. Other issues are the lack of negotiating power, early marriages, socio-cultural norms and economic inferiority. All of these are risk factors for transmission. Also, women have only limited access to Sexual and Reproductive Health and Rights (SRHR) services.

Another issue brought up was an issue that would be emphasised throughout the conference: *"it is not prevention or care, it is prevention* and *care, we need to work with both legs."* If not, it will lead to greater vulnerability. Poverty as an accelerating force was pointed out and it was discussed how a vulnerable immune system contributes to the deadliness of HIV. Malnutrition, TB, Malaria, hepatitis and dengue fever affects the poor and puts them at increased risk. Without treatment people are not going to live for very long once they get infected.

Impact

The efforts to curb the epidemic should include prevention, care and treatment *and* impact mitigation. Where we can see the impact in Asia today is among children. It is a vicious cycle when HIV enters a family and the children are the most vulnerable. Children are withdrawn from school, the family risks losing the household income and they are discriminated against by society. There is also little support services from health systems which families are otherwise entitled to. In many cases this is a children's problem. It is loss of social and family support, abandonment and increased vulnerability. A large number of children are now caregivers and they take care of their parents and support themselves. These children are robbed of their youth and childhood whilst being heavily discriminated against in society.

The positive message from the opening session was to be discussed in the following sessions: the message that HIV/AIDS in Asia can be stopped. This is, however, not an easy or single-pronged task. It involves meeting the requirements for up-scaling efforts, increasing coverage and interventions, improving the understanding of HIV/AIDS and empowering vulnerable groups to act. And if we can stop risk behaviour (for example, by cleaning needles, increasing safe sex practices and reducing sex partners) we can come a long way.

Currently, according to a study on the Southeast Asia and the Asia-Pacific region but applying to all of Asia, there is low coverage. Interventions are reaching 20% of sex workers, 5–10% of injecting drug users and only 1% of MSM. This leaves a big margin for improvement, both speakers emphasised.

"We know that health systems need to be improved, we need access to health services for many more people. We know that the women's situation has to improve if we are going to stop this epidemic from spreading further. And we know that the human rights situation has to improve along with a lot of other sectors as well. That is the development issue we are facing"

We should encourage participation by all, within each organisation's specific mandate. We should be asking questions like: Where can I improve? Where can I be part of this resistant movement fighting the epidemic?

Which target groups are reached?

20% of Commercial Sex Workers are reached with some sort of intervention

5% of Injecting Drug Users (IDUs)

1% of Men who have sex with men (MSM)

In 2005, some 8.3 million people were living with HIV in Asia, including 1.1 million people who became newly infected in the past year. AIDS claimed some 520,000 lives in 2005. A huge challenge still remains: some 85% of people needing treatment had not yet received it by mid-2005. In 2005, an estimated 1.1 million people in Asia needed antiretroviral treatment, the second highest number in the world.

Source: UNAIDS

Prevention strategy backfires

HIV prevalence rates in Thailand and Cambodia have remained stable in recent years thanks to resolute efforts to hold the epidemic in check. Condom use in commercial sex has increased, men seek the services of sex workers less frequently. However HIV transmission between spouses has become a more prominent cause of new infections—a reminder that **it is inadequate to only target vulnerable groups**.

China

HIV is detected in 48% of China's counties, but is observed in all 31 provinces, autonomous regions and municipalities. The most serious HIV epidemics have been clustered among injecting drug users, sex workers, former plasma donors and their partners, especially in the south and west of the country.

India

India alone is having at least 60% of all people living with HIV in Asia. The future HIV epidemic will depend on the scope and effectiveness of programs for sex workers and clients, for men having sex with men and their other sexual partners, and injection drug users and their sexual partners, the latter particularly in the northeast. Throughout India, it remains vital to tackle stigma and discrimination towards people at risk and people living with HIV.

Pakistan and Bangladesh:

The HIV epidemic is centered within networks of injecting drug users, with evidence of epidemic expansion among MSM and *hijra* communities.

Sri Lanka

HIV remains low even among high risk groups. Early, effective, affordable programs for injection drug users and their sexual partners, sex workers and clients, and for men having sex with men and their other sexual partners, may ensure that HIV remains at very low levels.

Vietnam

An unusually large overlap between injecting drug use and sex work is priming a serious epidemic in Vietnam, where HIV already has spread to all 64 provinces and all cities. Drug injectors are mostly young, commonly using non-sterile needles. The link between HIV and Tuberculosis in Viet Nam is strong.

The government did previously define HIV as a problem of socially marginalized groups. Now, Vietnam is in the process of mobilizing all of society for HIV/AIDS prevention, and to address stigma and discrimination.

Thailand

HIV is generalized in Thailand (1,5%) and general awareness is high, but the epidemic is more diverse than it was a decade ago. Male clients of sex workers are infecting their wives and girlfriends, with the result that as many as half of new HIV infections each year are happening within marriage or regular relationships, where condom use tends to be very low.

Cambodia

Cambodia has the highest HIV prevalence in Asia, but pride itself to have halted further spread. The old prevention strategy of 100% condom use among sex workers is backfiring, since men are turning to indirect sex workers and "sweethearts" for sex – with whom they are less likely to use condoms. 50% of new detected HIV cases are found among (married) women in long-term sexual relationships and 30% among their children. Targeting male cultural norms will pose enormous challenges.

Philippines

National adult HIV prevalence has stayed low, even among at-risk populations, but condom use during commercial sex is infrequent, prevalence of sexually transmitted infections is rising, and high rates of non-sterile needle use among drug injectors has been found in some parts.

Lao PDR,

National adult HIV prevalence has stayed low, two thirds of HIV cases have been occurring in the capital, Vientiane, and Savannakhet. Sexually transmitted infections are increasing along newly built roads and as the economy grows and tourism increases, so will HIV.

Future challenges

Broadening out the base of HIV/AIDS prevention

Engage unconverted political leaders

Convince political leaders that it is possible and necessary to act without losing face or damaging their country's image, and to advocate for increased allocation of the domestic resources needed to prevent the epidemic escalating.

Issues

The HIV/AIDS epidemic is complex and an integrated approach is needed if efforts to combat the disease are to be successful. We saw in the conference which focused on the Asian experience, that the issues raised and reflections made by participants, speakers and moderators covered a broad range of areas, reflecting the diverse group of people gathered in Phnom Penh.

We were public health professionals from Afghanistan and Pakistan, representatives from unions in Malaysia and the Philippines, a gay rights organisation from Vietnam, a family planning organisation from China and government officials from Thailand. Organisations from Sri Lanka and Nepal working for the rights of people with disabilities were there along with several different organisations from India and Bangladesh. Youth representatives from Sri Lanka and Cambodia took part in the discussions as well as a women's rights organisation from Mongolia. Faith based organisations were present as well as general development organisations and many more. All in all, a broad range of Sida's Swedish frame organisations, specialist organisations and their local partners from across Asia were present.

In the following sections, an overview of the discussions during the conference on some of the main issues relating to HIV/AIDS in the region is provided. Much more can, of course, be said and on the conference CD, which was handed out during the conference, you will find a selection of recommended resources. More information is also available on Sida's website (www.sida.se).

Stigmatization

There will always be stigmatization, and as long this is the case, it is hard to fight HIV/AIDS. Stigma and discrimination is one of the greatest barriers to successful efforts dealing with the epidemic. *"And it does not happen just outside this room. It is here!"* stressed moderator Anjali Gopalan in her opening of the discussion on stigma and discrimination. All of us are a part of our environment and we believe in certain things, which create stigmatization.

If we lose our focus on prevention and only focus on care – we will lose the battle. Prevention *and* care must be integrated into our response. One of the reasons that stop us from doing it is the stigma that goes hand in hand with HIV/AIDS. Because of the high level of stigma and discrimination that exists, we are losing the battle against the epidemic.

In a group exercise on stigmatization, each table was given a statement to discuss and try to reach consensus on. The statements initiated lively discussions around the 14 tables and the following are just a few out of many viewpoints:

STATEMENT: MEN WHO HAVE SEX WITH MEN INDULGE IN ABNORMAL BEHAVIOUR

What is normal and abnormal, and who decides this? Sex is a question of individual choice!

STATEMENT: PEOPLE WHO CONTRACT HIV HAVE ONLY THEMSELVES TO BLAME

What about faithful women who get infected by unfaithful partners? We cannot blame them. Or women who don't have a choice to refuse – especially wives? They are not to blame either. Or how about girls who are victims of rape and/or trafficking? We cannot blame them. It is about education – people who know the dangers, maybe they can blame themselves. Do we hold people responsible for getting infected? The idea is for us to think about the lengths to which society blames people.

STATEMENT: TALKING TO WOMEN ABOUT CONDOMS MAKES NO SENSE

Male domination is there in this statement. In everything, husband and wife must communicate with and respect each other.

STATEMENT: WOMEN WITH HIV SHOULD NOT HAVE KIDS

A mother does not have the right to give HIV to her child. However, we must also recognize that every woman has the right to bear a child. Modern techniques can do a lot to prevent transmission therefore programmes that prevent mother to child transmission (PMTCT) are key interventions.

STATEMENT: IS IT ALRIGHT FOR MEN TO HAVE SEX BEFORE MARRIAGE?

A sensitive topic – in some countries in the region you cannot talk about sex before marriage. Also, some cultures do not allow sex before marriage but allow men to go to prostitutes. This statement is about reducing the responsibility of spreading the infection, which is wrong. Instead of focusing on how not to get infected and not infect others it is introducing gender biases and ethical standards of marriage. Do we focus enough on the whole demand side within the sex industry?

The facilitator, Anjali Gopalan, commented on this statement and argued that: *"it's about marriage. I've worked with 10,000 women – they all say that there is no need to educate their daughters about sex because their husbands will tell them about it! So where do the husbands learn? There is an implicit acceptance that it is ok for men to have sex before marriage. It brings us back to the weak link of trust."* She further emphasized that *"information about condoms can demystify sex so we must try to eroticize condoms and we must empower women. HIV prevention challenges the institution of marriage – it challenges the trust."*

After having been confronted with their own stigmatization and discriminatory thinking, participants heard from Family Health International. FHI works against discrimination and stigma in its many activities and projects. One project, called Living Again, is run by both people living with HIV and AIDS (PLHA) and non-infected people and involves working with PLHA to promote adherence to care and support; stimulate discussion and sharing of experiences between PLHA and their families; and strengthen the facilitation skills of PLHA support group leaders.

Some keywords of the presentation: dignity, respect and inclusiveness.

The message was clear: break the stigmatization and involve PLHA in your work. The last point was underscored by Ou Him from the provincial town of Battambang in Cambodia who is HIV positive and a volunteer actor in a video against stigma produced by FHI as part of the Living Again project. She again and again emphasised the importance of people living with HIV and AIDS standing up and ending self-discrimination. It is about attitude change – within the community and within the individual. In Ou Him's words: *"I volunteered because I wanted people with HIV to know how to stay healthy, stop their children from being infected, use health care centers, know how to participate in community and society and not discriminate against themselves".*

"Silhouettes" is an exercise encouraging the participants to challenge the normal view of a family and of who are at risk.

The participants were asked to create an imaginary family with the silhouettes they had been given. First after they had formed a family, they were informed about the persons who were HIV positive. From this point they developed a history and identified needs. Some key questions: What interventions are possible? What interventions are needed?

Some key outputs: Multi sectoral response needed; Information is very important; Financial support to affected families, either directly or indirectly; Importance of linking with a number of institutions and government agencies to get things moving! How can we actually put it into place?

Rainbow of Genders

In the debate that followed the drag queen show, an important message that emerged was the need to address the vulnerability of transgender, gay and MSM groups and provide real and substantial means to do so. During the debate there were presentations by Meas Chanthal from Urban Sector Group, Cambodia, Le Hao Dung from Blue Sky Club, Vietnam and Jonas Tillberg from the Swedish Association for Sexuality Education (RFSU).

Jonas Tillberg used the term LGBT – that is: Lesbians, Gays, Bisexual or Trans-gendered people – and argued that LGBT are victims of discrimination, social marginalising and violence, assaults, rapes and executions in many countries. To have these people's fundamental human rights respected, and to contribute to development generally, their situation and vulnerability must be made visible.

In the future many things can be done in ongoing as well as new projects. Mainstreaming LGBT in Sexual and Reproductive Health and Rights (SRHR) is a first step. Other steps might include targeting and empowering local initiatives and building alliances with LGBT movements. Not only for support and empowerment but for the sheer effectiveness in having an accepted transmitter for your messages and having the question owned by the community itself. And in doing so, we must keep ourselves and our messages realistic, non-judgmental and even affirmative to the sexual behaviour and identity chosen.

Meas Chanthal stressed that it is not always easy to work with the transgender group. When you yourself, are not a part of the group, you can be seen as an outsider which makes it difficult to be accepted and thus create good well-targeted interventions. He also described how it can be difficult to get the transgender people he works with to attend meetings and also to get female sex workers to join meetings with transgender people present.

Again, it was emphasised during the debate that only 1% of the target group is being reached by HIV/AIDS interventions and this in a group where the prevalence often is considerably higher than in the general population. Some progress really could and should be made.

In the end, the first steps are not that hard, argued Jonas Tillberg. As formulated by the Swedish government, it is to understand that everybody is not heterosexual. It is about understanding that our target group in SRHR is not one, but many. It is about leaving our own culturally inherited presumptions behind and not being hetero-normative. We should, by now, have understood that human sexuality includes far more than marriage between husband and wife. And that this neither can nor should be questioned.

Working for LGBT is a question of rights. RFSU, Sida and the Swedish government share this perspective. But it is also a question of public health. Numerous reports show a lower health in LGBT than in the general population and in many regions, an overwhelming overrepresentation of HIV is found in the MSM group.

Jonas Tillberg continued to link the health perspective with the rights perspective and argued that one could identify some rights for MSM in relation to HIV, and let them be a guideline in policies and implementations. These would include the rights to:

- Know ways of transmission and their relative risks of transmitting the virus
- Know how to minimise these risks
- Know how to test and have the possibility to do free and easy testing
- Have free antiretroviral treatment (ART) in case of being positive
- Not be discriminated against, by state or society
- Not to be excluded or marginalised
- Live worthy healthy lives, including having a dignified sexual life with minimised risks of transmitting HIV

And with these rights respected, there will be health achieved.

Moreover, Meas Chanthal discussed the work done by USG in Cambodia and the 'ABC' approach (Abstinence, Be faithful, use Condoms) and Le Cao Dung focused on the specific interventions done by Blue Sky in Ho Chi Minh City. One important issue mentioned during the debate is that we are not inventing the wheel. We have 20 years experience to draw upon. What is vital is political will and advocacy supported by broad alliances between civil society and governments.

Youth

Young people are at the centre of the epidemic in terms of transmission, impact and potential for change. During the conference it was repeatedly emphasised that youth are a vulnerable group that need special attention and special efforts. Several youth organisations from Sweden and from around Asia were present at the conference and the potentially important role of young peer educators and role models were highlighted.

In a specific session on youth, three speakers took their starting point in the debate on how to communicate with and reach young people in HIV/AIDS work.

First, David Wood from BBC World Service Trust gave an entertaining performance and presentation on communication methods and the *edutainment* genre. Then Nicky Harrington from Friends International went into further details and discussed specific examples on how it is possible to reach young people and children living on the streets. Finally, Carl Heath from Swedish Centre for International Youth Exchange (CIU) discussed role-playing as a tool to reach young people.

BBC World Service Trust

This agency works with educating the public through innovative uses of media and has communication projects on a range of issues including HIV/AIDS. Youth is not the only target group for their work but an important one.

A main point made by David Wood was the importance of using research and analysis before implementing projects – and being

willing to make changes. Without research and pre-testing of programmes you are walking in blind *"If you have no research, you're just hoping and I do not think that is a very good use of people's money"*. It was further emphasised that organisations should engage in dialogue with potential partners and target groups. During the presentation, David Wood gave illustrative examples of BBC World Service Trust's work in Cambodia on HIV/AIDS in the form of general mass media campaigns, information spots and a long running TV series. Their TV drama series *Taste for Life* includes well-known actors who are HIV positive and this contributes to breaking down stigmatization. *Taste for Life* is highly popular and reaches a broad spectrum of people including young people. Young people are also targeted through a radio call-in show that takes up issues of sexuality. David Wood argued that when it comes to communicating with youth, one should consider that the audience really is far more advanced than what we are told. Listen to and respect your audiences.

Lessons learned include:

- Research is *key*
- If you have time, be flexible
- Think about how you are going to measure impact from the very start
- Use HIV positive people – take advice from the experts
- Learn from others and use others expertise

Friends-International

In her presentation on FI's work, Nicky Harrington dealt with a range of relevant issues for everyone working with vulnerable groups. FI interventions are directed towards street kids and youth and they have many different activities. She also questioned the official prevalence rate of 1.9% in Cambodia and pointed to estimates that are from 1.5% to 4.4%. 50% of Cambodian population is under 18 year old and there are up to 300,000 AIDS orphans. Approximately 40% of FI's target group is affected by AIDS (their parent(s) are infected) and approximately 11% of these kids are themselves infected. FI takes a holistic approach and has both direct and indirect HIV/AIDS interventions. For more information: www.friends-international.org

Swedish Centre for International Youth Exchange (CIU)

CIU works with young people and facilitates a youth exchange programme where young people from Sweden and from countries in the South (e.g. Cambodia, Sri Lanka and Costa Rica) travel to each others country and live within the different community for a period of time. Carl Heath

Education is about giving people a positive experience

talked about a variety of educational methods using the entire body as an effective way of communicating a message – especially to young people. One method is to use something which catches the eye and the attention of the individual. Because we often deal with large populations under 18 in HIV/AIDS work, a youth perspective is critical when communicating the message.

Using different types of drama and role-playing activities can be very effective to get young people thinking about their situation and daily life, Carl Heath argued. For western countries, getting people to do role-plays is quite difficult whereas in countries in the South, it is easier because people's attitude to use their own body is different, which makes it a very valuable tool here.

The use of peer educators is quite effective, but the problem is educating the peer in the first place. Working with peer-to-peer issues is crucial and for NGOs. The challenge is to figure out how to include young people in the work; if *only* adults work on materials targeted for young people, it is difficult to get the message across.

You must use your target group in the design process

Drugs

Drugs are a major driving force behind the spread of HIV/AIDS in Asia and the use of drugs is increasing in the region. Graham Shaw from WHO Cambodia presented a thorough overview of the different kinds of drugs – including a practical description on how people use them and how drug use is linked to HIV/AIDS.

Drug use is a major route of HIV transmission, so we have all the reasons to include drug related efforts into our programmes. Sharing needles and syringes is an easy way to transmit HIV, with a 50% chance of contracting HIV virus through contaminated syringe. Moreover, studies have found that drug injectors are disproportionately likely to be involved in the sex industry and hereby accelerate the spread of the disease into the general population through sexual contacts with non-injectors. It was also stressed that drug use leads to high-risk unsafe sexual practices.

Youth especially at risk

Graham Shaw talked at length on the socio-economic impact of drug use and argued that the impact of drugs is negative both for the individual and society. The negative impact on the individual is well known and ranges from behavioural change, societal dislocation and poor health. Drug use can drive poverty and dependency.

The impact on society can be seen in many places and as an example, Graham Shaw talked about the huge profit generated from drug sales which can be used to buy off the courts, law enforcement agencies and relevant senior elite. It is very difficult to stop this from happening. If the government has accepted HIV as a public health is-

sue, drug use can be added on as a "back-door" issue because it is part of the problem.

In his presentation, Graham Shaw included a thorough examination of drug use around the world and the different types of drugs, with a focus on Asia. He described four main drugs: opium/heroin, cannabis, cocaine and amphetamine-type stimulants.

Heroin: *"Because of the impact that this drug has on the body and mind, it can lead to behaviour change including unsafe sexual practices and other activities that one wouldn't do unless taking the substance."*

Cocaine: Use in Cambodia is very limited. For any country where a large number of the population lives near or below the poverty line, cocaine use is unlikely because it is too expensive. In these countries, cost is a safe-guard to some extent.

Amphetamine Type Stimulants: Quickly becoming a major drug used worldwide. With correct chemicals and knowledge it can be made relatively easily in a bathroom or back of a car. Another form, which is of more direct concern, is "ice" crystals. It is easily smoked and can be injected. Injection use is increasing around the world, especially in Asia. Occurrence is accelerating in virtually every country of the world. It is cheap, easy to make and produced from legal chemicals. In Southeast Asia and India it is a "big mess" – the level of increase is astonishing. In Cambodia it is rapidly taking over in urban areas and sex workers are given the drug to induce sexual stimulation or help numb them from the sexual acts.

Another issue raised in the session on drugs was one brought up in many discussions during the conference – the importance of including target groups in all programmes. In India, Pakistan, Afghanistan and Bangladesh where there is long history of use of opium, heroin and cannabis, former drug users should be part of programmes. They can share experience and knowledge with existing users or people at risk. And because they have had personal experience, they are believable and can put across realistically, the social and health impacts of using the substances.

A final point made by Graham Shaw was that anyone can become a drug user or drug addict. Nobody wants to be addicted. Keep this in mind and treat drug users with dignity and respect, he argued, and emphasised to the participants that many people, at or below the poverty line, do not care about the future. They want to get through today and maybe tomorrow, but do not think about next week, next month or next year. How do you work with this issue in drug related programmes?

Drug Use among Cambodian street youth and kids

According to research by Friends International, 50% of street children use drugs. 1/3 of injecting drug using street children reported HIV+.

Street children and the evolution of drug use:
1998: Glue (remains most common for younger children). 200 riel (5 cents) for a tube of glue which lasts about half a day.
2003: Amphetamines (ATS or candy) overtook glue as main substance of choice especially amongst adolescents. Heightens sexual awareness. Communal drug. Leads to more vigorous sex and more stamina. Promoted by pimps.

HEROIN. Approx $3 for ¼ gram, lasts two people for a day.
2000: First appeared in Cambodia. Smoking as method of intake.
2001: Youth started injecting. Raw injecting popular.
2005: Injecting overtakes smoking as preferred method of intake.

Trafficking & HIV/AIDS

Roma Debabrata from STOP-India gave a brief presentation on the organisation's work to fight trafficking of women and girls for sexual purposes and the linkages to HIV/AIDS. Some main points from the presentations were:

- What makes India vulnerable is that causes of HIV/AIDS are the same vulnerabilities that cause trafficking.
- There is a need to strengthen and consolidate action on migration, trafficking and HIV/AIDS.
- Youth are most at risk and this group needs special attention and support.

Roma Debabrata also discussed how to treat a victim of trafficking and argued that the recovery process is the start and that victims should be seen as a resource with potential to change their lives. Young women and children that are victims of trafficking are not prostitutes and should not be looked down upon. They are simply young people who have been forced into this situation. The discussion returned to the issue of stigma and discrimination and it was argued that if victims of trafficking have been infected with HIV, they are not to blame. They should be treated with dignity and respect and we should do everything to help them recover from their painful experiences.

Roma Debabrata's presentation, and many other discussions during the conference, focused on the supply side and on how we can help empower the sex workers, and by this stop the spread of HIV/AIDS. Many

argued that interventions should focus on improving conditions for sex workers and their safe sex practices. Others highlighted the need to also address the demand side. What is being done to prevent men from going to sex workers in the first place? Or at least to secure that they are using safe sex practices? Do we focus too much on empowering the sex workers but miss out on the demand side?

In his presentation, David Wood from BBC World Service Trust described a campaign targeted to men who have several sexual partners. He argued that in Cambodia buying sex or having many sexual partners is not a moral issue. Thus BBC WST approached the campaign with health arguments and communicated a message on how to protect yourself rather than one that argued for change of sexual behaviour. By using this approach they reached a big audience and according to their research, the message came through.

Some participants argued that we need to make a distinction between trafficking and sex work. That not all sex workers have been trafficked and thus need acknowledgement and assistance in their work. Sex workers have the right to do what they are doing and we can help them only by recognizing sex work and by making this distinction. Selling sex is like selling labour – as long as they know what they are doing – it is ok. This line of argument is contrasting to the viewpoint of the Swedish government, which sees all forms of prostitution as a violation against women and argues for a strong link between all forms of prostitution and trafficking. Without prostitution markets, there would be no trafficking for sexual purposes. Since 1999, Sweden has a gender based law saying it is illegal to buy sexual services, but being a sex worker is not criminalised. According to this law, the sex workers are perceived as victims.

STOP India works with reintegration of victims and includes support to HIV positive women and girls. This aspect to their work has developed over time as an increasing number of girls are being found to be HIV positive when they come into contact with the organisation. In this way, STOP India has been ready to change and has mainstreamed a HIV/AIDS element into their work, based on the needs of their target group.

Men in Uniform

It is well known that men in uniform are a group at risk which requires specifically targeted interventions. The fact that men in uniform are away from home for long periods of time and often placed in different locations, in combination with a tradition of acceptance of buying sex, result in risky behaviour. This was acknowledged by Cambodia as early as 1995 when the Ministry of National Defense initiated the formation of a unit responsible for HIV/AIDS prevention. In 1997, 7% of the military personnel were HIV positive, a substantially higher number than the general population in Cambodia.

Tan Sokhey from the Cambodian Ministry of National Defense is responsible for implementing the HIV/AIDS prevention programme within the military and he reported that the results have been good so far. In his presentation, he stressed the importance of cooperation with civil society and his open mindedness and engaging personality showed the participants that such cooperation is indeed possible.

The programme works with the promotion of condom use and uses dramas about alcohol consumption to illustrate its influence on risk behaviour. HIV/AIDS education is included in the military training and is an action-based programme run according to a model that is not in line with the ordinary top down methods employed in the military.

The challenge of the programme is to change the image of the military – not at least, the soldiers' own perception, and it includes training on "how to be a model man". Condom use has now increased to above 85% when men go to sex workers. It is, however, a problem that *extra* girlfriends and beer girls are not seen as sex workers by men in uniform, which result in a continuation of unsafe sex practices.

When it comes to HIV prevention – juniors can educate seniors

Mainstreaming

When talking about HIV/AIDS, as in many other areas today, the concept of mainstreaming is frequently used. What does this concept mean in practice and why are we discussing it? There is a common understanding between stakeholders working with HIV/AIDS that in order to be successful, the response to HIV and AIDS needs to be multidimensional and cover all sectors. Mainstreaming means that HIV/AIDS is understood as a development issue and that HIV/AIDS activities are integrated into all strategic planning and day-to-day operations, both inside the organisation and within its relationships with others.

An important element of the conference was to inspire organisations to scale up HIV/AIDS activities, and in scaling up, mainstreaming is a key concept. Eva-Charlotte Roos from the Sida HIV Secretariat discussed mainstreaming and explained the 3x3 model, a step-by-step analysis which organisations can use in their efforts to mainstream HIV/AIDS activities into all programmes.

According to the model, the first step of an HIV/AIDS analysis is to get an increased understanding of the current HIV/AIDS situation as it varies in each country and context. Before defining the level of activity, there needs to be an understanding of the impact of HIV/AIDS in the sector where the programme shall be implemented. The analysis phase involves looking at the prevalence rate among target groups and analysing attitudes and perceptions of rights and sexuality as well as peoples' patterns of behaviour. The analysis should be gender sensitive and also include major policies and the existing legal framework. Another important element is that we should learn from previous and ongoing interventions. What are the lessons learned? Often studies and analyses are already available – make use of them.

The next step is to determine if HIV/AIDS affects the programme and to include an element of impact analysis. In doing this, the method operates with an internal and external sphere.

The internal sphere is within the institution or organisation and deals with issues like how HIV/AIDS has affected staff and their families. Is there a work-place policy and if so, what does it say about services and rights etc.? It is important to find out if the staff are aware of risks. The external sphere is related to programme and field activities. One example could be an agricultural project working with impact mitigation for families affected by HIV/AIDS. Another is to include an analysis of the extent to which staff at ministries and collaborating partners are affected. An important part of the analysis is to determine the impact of a programme including its possible negative side effects. This means that before implementing a project, it should be assessed whether planned activities will do any harm, increase vulnerability or increase risk behaviour among target groups, staff or partners.

Problems to consider include:

- Will the programme generate income which is likely to be spent on sexual services?
- Will the programme lead to further gender inequalities?
- Will the programme lead to increased mobility? Can you do anything to mitigate the increased risk involved with mobility?

The third step of the analysis is to look at how the programme can contribute to combating HIV/AIDS. In low prevalence countries, it can be more strategic to focus on prevention initiatives among at-risk groups. One priority can be to target vulnerable groups (e.g. MSM, IDUs, youth, and persons with disabilities) and to look into the possibilities of mainstreaming interventions in the health and education sectors. A programme could also focus on integrating activities into advocacy work and in the dialogue with partners.

In high prevalence countries the focus must be to target everybody, because the reality is that everyone is at risk. All the intervention areas are highly relevant – prevention, care and support, and impact mitigation.

After the introduction with various inputs of elements of an HIV analysis, Åsa Andersson-Singh took over and moved on to a discussion on how a programme can assist in scaling up the response to HIV/AIDS. Sida's ambition is to do much more, in terms of scaling up, to combat the epidemic. This very much involves all participating civil society organisations in the conference, Åsa Andersson-Singh emphasised. It is important to remember that this is a complex process and that there are many different needs. To address the needs we must work at all levels: the community level, national, regional and international levels and with different partners and mandates.

Sida is trying to simplify the process of identifying how to work with these issues by using *the 3 x 3 model* (model on page 29):

– The vertical scale indicates *how* to work and the horizontal shows *what* can be done

Types of intervention areas include: prevention, care and treatment, and impact mitigation as well as underlying factors such as trafficking and migration. The challenge is to find suitable interventions, keeping in mind the specific HIV/AIDS situation in your target area and amongst your target group.

As an example on how to scale-up, Åsa Andersson-Singh discussed the issue of *dialogue* and argued that everyone should engage in dialogue – with partners, communities, in national forums etc. The dialogues should be based on your HIV analysis and the comparative advantage of your organisation. A key question to ask before starting a project: *What can I contribute with?*

Everybody needs to integrate HIV components in their programmes and one example out of many discussed was how a faith based organisation can scale up. Faith based organisations can acknowledge and make use of the fact that many religious leaders have strong positions in their communities and therefore great potential to play pivotal roles in the work against stigma and discrimination. In their work, faith based organisations can try to inspire them to engage in dialogue within their communities.

Direct support – can involve you or your partners working in areas where there is a need to set up specific programmes on prevention or care and treatment. For example, youth organisations can include HIV/AIDS education in their activities. Or organisations working with health related programmes can add on an IDU element or work with prevention among migrant populations. This is a process that may also mean re-focusing your priorities and an organisation might have to leave something out to focus on something else; it is a question of prioritising.

What is possible? Take the opportunities!

In relation to *mainstreaming-integration,* it was mentioned how non-specialist organisations, set-up with no direct purpose of combating HIV and AIDS in their daily work, realise that it is necessary to incorporate a HIV/AIDS element into their programmes. One example is an organisation working with trafficking that recognized they needed to address the fact that many of the victims of trafficking were HIV positive. Another example is a transport workers union that implements a programme for truck drivers. This is a group known for a higher prevalence rate than the general population and a group often engaging in risk behaviour. Åsa Andersson-Singh also argued that any comprehensive SRHR agenda, of course, needs to include

an HIV/AIDS element and that youth SRHR programmes should comprise HIV/AIDS education.

"Up-scaling doesn't necessary mean only more money, but also expansion of target groups, working areas, re-focusing of activities and improving the quality of existing programmes"

After this input from the Sida experts, the participants engaged in a group exercise mapping their own organisations' strengths and weaknesses. Using the models described, the exercise initiated many interesting analyses and discussions when participants examined what they are doing today, making a quick inventory of their current efforts. They also assessed to what extent they had carried out a HIV/AIDS analysis before implementing their ongoing projects. Moreover, the exercise worked as a basis for an exercise the following day about identifying opportunities for scaling up and major challenges ahead.

Further reading: **www.deza.ch**, a manual on mainstreaming developed by the Swiss Agency for Development and Cooperation.

3 x 3 model/Scaling Up

The boxes are not isolated. For instance, mother to child transmission could fit under prevention as well as treatment – to prevent the child from transmission as at the same time the mother undergoes treatment by taking ARV.

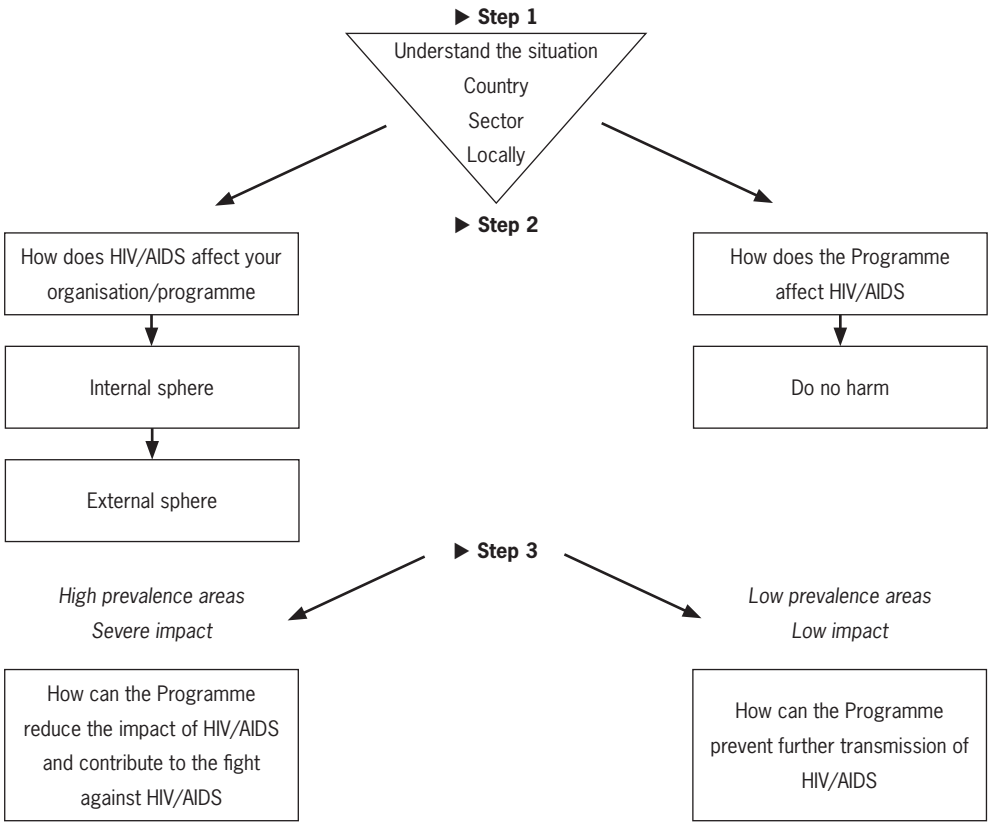
Prevention is directly related to the immediate causes – in other words the modes of transmission of HIV (unprotected sex, transmission from mother to child, contaminated blood, sharing needles etc.)

Care & Treatment interventions can include psycho social support, counselling, nutrition, positive living, the whole treatment agenda – access to ARV, capacity building etc.

Impact mitigation is to deal with the consequences of the epidemic. For example, support for orphans and elderly, legal assistance to PLHA, coping activities within the agricultural sector (tools/equipment that require less work force), recruitment of teachers and health staff etc.

Eva-Charlotte Roos, Sida

Step by step analysis



	PREV	CARE TREATM	IMPACT MITIGATION
DIALOGUE	X	X	X
DIRECT SUPPORT	XXX	XX	XX
MAINSTREAMING/ INTEGRATION	**XXX**	**XX**	**XX**

PREV	CARE & TREATM	IMPACT
X	X	
X		
XXX		

Monitoring & Evaluation

Scaling up

	Prevention	Care&Treatment	Impact Mitigation
Dialogue			
Direct Support			
Mainstreaming/ Integration			

Challenges Ahead & Conclusions

During the three conference days, major issues concerning the HIV/AIDS epidemic in Asia were discussed in a participatory and lively way. At the closing session, many participants expressed that they were delighted to have been a part of an event that provided opportunities to network and engage in relevant discussions with like-minded people. It is always difficult to create a suitable level for everyone – some participants have years of experience in the fight against HIV/AIDS, others are just beginning to look into the possibilities of working within the area; but it was the general impression that the conference had been pitched at a level and within a format that allowed everyone to participate and gain new insight. According to participants an important outcome of the conference was that everyone was inspired to take on the challenge to intensify the fight against HIV/AIDS.

It is a huge task to stop the spread of HIV/AIDS, but it *is* possible if everyone takes action now. However, this requires all stakeholders including donors, governments and civil society organisations to join hands and work together. This conference showed us all that many organisations are involved in the fight against HIV/AIDS, and that organisations with both long running and limited experience in HIV/AIDS work, are committed to scale up activities in order to try even harder to make use of the window of opportunity that still exists in Asia to eradicate the disease.

In the group exercises on the final day of the conference, the participants continued to use the 3x3 model to map out their current HIV/AIDS efforts and to identify potentials for scaling-up activities. The participants were enthusiastic about this exercise and many stressed the usefulness of having time for these types of specific action-oriented group exercises during the conference. The participants were divided into groups with people from the same region or country and groups of Swedish organi-

sations and their Asian partners. The output was creative flipcharts, full of yellow post-its with notes on programmes, projects, possibilities and needs. Like a spider web, current and future efforts were mapped out. Many new contacts were established during these exercises and the opportunities to network were appreciated. The participants also used the exercises to highlight and discuss major future challenges and it became clear that many challenges lie ahead.

A main topic in the discussion was that all organisations should focus on working together and limit competition. There are many organisations working on HIV/AIDS but if all work together, there is much greater potential to reach further, be more efficient and create more effective responses. Individual organisations and the donors have a responsibility to create an environment enabling networking and cooperation.

A related issue brought up was how to sustain HIV/AIDS on the agenda as it helps attract donor funding and creates opportunities for change. Without substantial and sustained funding there is an inherent risk that many ideas and initiatives will never materialise into action. Sustained funding would also recognise the need for new actors, without prior expertise in HIV/AIDS work, to engage in a learning process where they are allowed to fail and try again.

Moreover, three other key issues were pointed out:

1. Target groups including vulnerable groups like youth, persons with disabilities and PLHA need to be involved in HIV/AIDS work. Without involvement from target groups, interventions can never be as relevant or effective.

2. Youth remain at the centre of the combat against HIV/AIDS as a vulnerable group where impact is visible and measurable but also as an important resource in fighting the disease.
3. Women are increasingly at risk. In several countries in Asia, the spread has moved from high risk groups like IDUs into the general population, and the transmission pattern is now increasingly from unfaithful partners (husbands) to faithful partners (wives). There is an increasing feminization of the epidemic, which also affects interventions towards sex workers.

The issue of mainstreaming was a central part of the conference and in the concluding discussions, it was pointed out that the development community has been working on mainstreaming the combat against HIV/AIDS for twenty years. During this time, there have been many successes and improvements but much more still remains to be done. The HIV/AIDS epidemic is like an earthquake in slow motion thus not always getting the attention it should. This affects the opportunities for mainstreaming, however, sustained mainstreaming efforts are about creating preparedness so that governments and societies can meet the challenges that lie ahead. That is the central message that must be communicated. The response to the epidemic demands continued and strengthened mainstreaming by all, and the ambition of this conference was to inspire organisations to scale up and mainstream HIV/AIDS into their work according to their expertise and mandates.

Sida emphasised that all participating organisations should highlight elements of HIV/AIDS in applications to Sida and reports to their Swedish partners so that they can properly communicate on the ac-

tivities to Sida. Sida needs to know what is going on in order to know how to assist organisations' work and to strengthen the Swedish response.

HIV/AIDS in Asia can be stopped; but only if everyone scales up activities and integrates and mainstream HIV/AIDS in all programmes at all levels. A starting point is to actively participate in existing networks to learn from each other. This conference showed that already many activities are being carried out by a large number of organisations at different levels and in many countries in the region, and that national action plans are in place. Only by close cooperation between governments and civil society organisations (CSOs) will an actual implementation of national action plans be possible. CSOs play a crucial role in the fight against HIV/AIDS and their sustained efforts, supported by governments and donors, are needed if we are going to win the battle against this disease in Asia.

For the Swedish government and for Sida, it is a strategic priority to assist these efforts in order to minimise the global spread and impact of HIV and AIDS.

- Rivalry no, networking yes
- Mainstreaming & preparedness
- Funding – sustaining HIV/AIDS on agenda
- See Youth as a resource
- Women are increasingly at risk

Day to Day – A Brief Overview of the Conference

Welcome

The 90 participants representing 70 organisations and 14 countries arrived in Phnom Penh and gathered at Sunway Hotel for an informal welcome dinner. This was a pleasant way to start the conference and an opportunity for cultural exchange. A highlight during the dinner was a performance by orphaned former street children who danced traditional Cambodian dances.

Day 1

The conference kicked-off with welcoming speeches and practical information then moved on to an overview of the HIV/AIDS epidemic in Asia and was followed by a presentation and group exercise on stigmatization. In general, this first day of deliberations and debate centred on introducing some major characteristics of HIV/AIDS in Asia and some practical tools.

Within the introductory session on HIV/AIDS in Asia, the major driving forces of the epidemic were presented and the differences between Africa and Asia were discussed. It was emphasised that here in Asia we have a window of opportunity – if all actors scale-up their efforts the spread of HIV/AIDS in the region can be stopped.

In the discussion on stigmatization, Anjali Gopalan from NAZ Foundation in India led a group exercise which challenged all participants to think about common discrimination and misunderstandings. Family Health International (FHI) gave an introduction to their work against stigma and discrimination and Ou Him, a woman living with HIV/AIDS, told the participants about her participation in a FHI video and encouraged other HIV positive people to stand up and stop discriminating against themselves.

After lunch, the participants found their seats, the lights were dimmed, music turned on and two Cambodian drag queens took center stage,

opening the session on rainbow of genders in Asia with a few songs.

"I am beautiful no matter what they say, words can't bring me down" sang one queen and with these lyrics, the message was quite clear: stand up for who you are; stand up against discrimination. In the following debate on "Rainbow of Genders", an important message was the need to address the vulnerability of both transgender people and men who have sex with men (MSM) and to provide the real and substantial means to do so. Currently it is estimated that 1% of men who have sex with men are reached by interventions.

The last session on the first day included three diverse presentations on communication tools and specific approaches to communicating with youth. David Wood from BBC World Service Trust gave great examples of how to use TV and radio media as a tool for reaching large audiences. Nicky Harrington from Friends-International (FI) discussed their outreach activities and emphasised that they take a holistic approach to working with street youth and children. Carl Heath from CIU started out with some group stretching to shake off the tiredness and then continued with an introduction to the concept of role-playing as a communication tool explaining that this is especially useful in communicating with youth.

In the evening after dinner, a smaller group had the voluntary opportunity to visit a karaoke bar. In Cambodia, karaoke bars are closely related to the sex trade and are places for both brothel based and occasional sex workers to do business. The small group of participants gained some insight in the Phnom Penh sex industry, having a chance to ask questions and talk with some of the girls working in the karaoke bar.

Day 2

The use of drugs is increasing in Asia and is a major driving force behind the spread of HIV/AIDS in the region. Graham Shaw from WHO Cambodia presented a thorough overview of the different kind of drugs – including a practical description of how people use them and how to identify a drug user. Drug use is linked to HIV/AIDS through its spread by injecting drug users (IDUS) but also from drug induced changes in sexual behaviour.

Mainstreaming, what does this concept mean in practice and why are we discussing it? The mainstreaming session dealt with these two

questions, giving an overview of mainstreaming and introducing the 3x3 or scaling-up model, which the participants then used in group exercises to identify the areas where they are working and where they have opportunities to scale-up.

Mainstreaming is about identifying needs and impacts, and analysing how it is possible to scale up your activities. It is about understanding the context in which you are working – is it a high or low prevalence country/region? What are the characteristics of the community and target groups? What are the attitudes and perceptions of rights and sexual behaviour, and what are the patterns of behaviour? Many different factors are important to understand in order to have well targeted interventions and be able to identify potential for mainstreaming.

"Up-scaling doesn't necessarily mean only more money, but also expansion of target groups, working areas, re-focusing of activities and improving the quality of existing programmes"

After lunch, the participants divided into groups and went on field study visits around Phnom Penh to see organisations working with HIV/AIDS prevention, care, treatment and impact mitigation. One group visited a faith-based organisation (FBO) working with communities in the poorest neighbourhoods. Another observed a training session of workers at a garment factory outside Phnom Penh producing for the Swedish retailer H&M. Another group visited a shelter for sex workers and here discussed survival strategies with them. Other participants visited a youth organisation where they watched a forum theatre and an open discussion on condom use. Finally, a group visited Friends International and saw and discussed how FI works with street children and youth to empower them and give them a chance of improving their lives.

The participants were very satisfied with the field study visits as these allowed them to exchange further ideas, feel motivated and gain a more hands-on perspective on what is Cambodia's experience. As expressed by one participant, *"exposure to other organisation's work is an important part of*

gaining new inspiration and ideas and it was great to get outside the conference room and talk to people in our target groups."

After an afternoon out and about in Phnom Penh, the evening was spent indoors at the hotel though with the offer of an around the world journey on the big screen through the film *Transit*. An MTV production sponsored by Sida, *Transit* illustrates how randomly HIV/AIDS can strike and discusses common prejudices by telling interlinking stories of young individuals from different parts of the world.

Day 3

Tan Sokhey from the Cambodian National Ministry of Defense took over the show after the day had begun with discussions on the film, Transit, and the field study visits. He explained how the military works with civil society to promote condom use among its soldiers. Tan Sokhey showed us all that it is very much possible to engage in a dialogue with the military, and that such a dialogue is needed if prevention work is going to reach men in uniform.

Before participants broke into groups to do exercises on how to move forward, STOP India told about the relation between trafficking and HIV/AIDS and SHAI spoke about HIV/AIDS in Sweden.

The last part of the conference was dedicated to group exercises where the participants had to map out their strengths and weaknesses and identify potential for mainstreaming activities. There were also sessions on practical networking, identifying specific actions and discussing challenges ahead. These sessions were lively and essential as the participants here got the opportunity to engage in practical dialogue with both their Swedish partner organisations and colleagues from the same country or region.

"HIV/AIDS networked us" was one conclusion from a participant after four days of deliberations and debates. The participants left the conference, inspired to intensify their work, understanding that a lot remains to be done but also knowing that they are not alone. There are many others, including potential partners, working on combating the spread and the impact of HIV/AIDS in Asia.

Participating Organisations

Church of Sweden
Lutheran World Service India
Rangpur Dinajpur Rural Service
Lutheran World Service
Center for International Youth Exchange CIU
Women's Education for Liberation
Khmer Youth Association
Community Development Department
Diakonia
Mahila Vikas India
CSDA Cambodia
Christian Conference of Asia (CCA)
IOGT NTO
Swedish HIV/AIDS Info (SHAI)
Adoptionscentrum
Praina India
Healthy Way of Living Vietnam
Swedish Committee for Afghanistan
Comfrel
Cambodian Defenders Project (CDP)
Forum Syd
Skaraborg Hospital
Xinjiang Medical University
LO-TCO
PSI – Public Services International AP
ITGLWF-TWARO Phillippines
Education International (A-P)
International Transport Workers Federation (ITF)
Swedish Scout Movement

YCC Cambodia
Khmer Youth Association
Democratic Youth Leadership Program, DYLP; Sri Lanka
Noaks Ark-Red Cross Foundation
Kids Ark, Thailand
Lahunetwork
House of Hope Thailand
Olof Palme Center
Stop Trafficking and Oppression of Children and Women (Stop-India)
Labor Education, Advocacy and Research Center (Learn-Philippines)
Union Aid Abroad ADHEDA
Women's Union of Hai Duong
PMU InterLife
Light of Life, Yunnan, China
The Full Gospel Trust of India
Fridsro
RFSU
China Family Planning Association, CFPA
Marie Stopes China (MSC)
National Centre against Domestic Violence (NCAV)
Save the Children Sweden
SDR – Swedish Association of the Deaf
NDA – Nepal Disabiled Association
AKASA – Association of Women with Disabilities
SHIA Sri Lanka
Sida
Erikshjälpen
Hosea
Thalita Kumi Welfare Center
Hindustani Covenant Church
Pakpingjai Home Development Project
Swedish Red Cross
Cambodian Red Cross
Chinese Red Cross
Nepal Red Cross Society
NAZ Foundation
Blue Sky Club, HCMC
WHO, Cambodia
Cambodian Ministry of National Defense
Family Health International
BBC World Service Trust
Cambodian Human Rights and Development Organisation (ADHOC)
Friends International, Mith Samlanh


Sida
Regional HIV/AIDS Conference, February 20-23, 2006

For more information visit:

www.sida.se/scsc

www.sida.se/ngodatabase

www.towards2015.org

Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.

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