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Village Refl ection and Dialogue on Gender and HIV/AIDS using Human Rights-Based and Visionary Approaches to Development in a Ugandan Context

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Village Reflection and Dialogue on Gender and HIV/AIDS using Human Rights-Based and Visionary Approaches to Development in a Ugandan Context

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Abstract

The article argues that people and communities perceive and deal with HIV/AIDS as only of the many problems and tensions they experience as affecting their well being rather than perceiving and dealing with it as the single most significant problem. Thus, the intervention for the control of HIV/AIDS through the creative rather than the responsive orientation in the development process is being proposed. It is also noted that the discussion of the issues related to HIV/AIDS and sexuality is blocked by deeply held views that men have about women and sex. This is the reason why the issue of gender is central when discussing with the people to determine the health they truly want including how to manage the HIV/AIDS problem. Using participatory research methodologies that empower and give voice to participants of different perspectives, the study team formed partnership with four villages in Kibaale District, Uganda. The team brought together rural youth of 13-25 years and men and women of 26-45 years to discuss issues regarding gender and HIV/AIDS. The discussions helped the participants to reflect and exchange information, knowledge and skills on the issues related to gender and HIV/AIDS. This empowering knowledge was useful for launching advocacy for attitude and behaviour change towards risky sexual behaviours and for supporting communities in developing visions of healthy communities the people truly cherish. The study process generated information, which was used to develop the content for a facilitator's guide on Gender and HIV/AIDS. It is, therefore, recommended that the activities the participants were involved in should be scaled-up for use in many communities in Uganda, which are still grappling with the HIV/AIDS problem.

INTRODUCTION

HIV/AIDS has received much international and national attention and in some cases has been presented as a security, political, medical and economic priority by some governments, and as the major cause of increasing morbidity and mortality in countries in Africa. From the beginning, when the disease was discovered, it was predicted that the fear of AIDS would tame an African sexuality perceived to be responsible for the high rate of fertility and the spread of AIDS (Caldwell and Caldwell, 1988: 19-28). Yet, more than two decades into the epidemic there is still conflicting evidence that these predictions have been realised and fertility, mortality and sexual behaviour change remain outstanding issues. There is moreover growing evidence that people and communities perceive and deal with AIDS as only one of the many problems and tensions they experience as affecting their well-being (World Bank, 2000). Therefore, over the years, a lot of experience in regard to the spread of HIV/AIDS has been gained and hence the intervention for the control of HIV/AIDS through the creative other than responsive orientation in the development process is being proposed. The adoption of a holistic approach and taking community participation and involvement are very crucial in helping the people to determine the health that they truly want. It is also noted that the discussion of the issues related to HIV/AIDS and sexuality is blocked by deeply held views that men have about women and sex, though; at times such views are also stronger in women themselves. Dialogue and shared learning stops when men are blaming women and vice versa about such issues such as who is or not using a condom and whose behaviour is causing the spread of HIV/AIDS. This is the reason why the issue of gender has been brought into the discussion. The study, therefore, aims to explore how individuals and community members make sense of the epidemic, the discourses and the preventive programmes, and identify capacities, resources and energies to promote well-being and cope with ill-health.

The village reflection and dialogue on gender and HIV/AIDS using human rights-based and visionary approaches to development is well buttressed

in today's understanding of enabling people to create for themselves peace, health, prosperity, freedom and happiness and this understanding is linked to people's health. This study is part of the author's post-doctoral fellowship in Development Studies that among other things includes the establishment of a university called the African Rural University (ARU) for only women, which wants to provide critical leadership using visionary and creative leadership to rebuild communities, nation-states and the entire African continent. It wants to enhance productive human and social capital in a participatory way to enable the people of Africa to question themselves as to where the development process faltered, how to avoid repeating old mistakes and chart a new course for the future. Further, we see an emerging need for All Women Rural Universities in Africa, and we aim at ARU to set an example others can follow.

The study's purpose was to bring together the rural youth of 13-25 years and men and women of 30-45 years to discuss issues regarding gender and HIV/AIDS. Sexuality matters were discussed in order for the participants to have an in-depth discussion of the problem of HIV/AIDS in the broader context. The broader context handles issues of healthy living, gender and rights-based perspectives. The loss of productivity and production caused by the HIV/AIDS and the strategies for its mitigation/prevention, care and treatment of HIV/AIDS patients were also discussed.

The study was conducted in five major phases. The first phase was the formation of Village Reflection and Dialogue on Gender and HIV/AIDS Capacity Building Team.

The second phase involved the identification of partners in the communities. The purpose of this phase was to identify people that would continue with the interventions to handle the issues of gender and HIV/AIDS that would be identified. It was aimed at creating a sense of belonging and ownership of the study process among the communities and support from the local leaders and the district officials.

The third phase was aimed at building capacity of the identified partners in the issues of gender and HIV/AIDS and matters of sexuality so that they can train or build capacities of people in the communities in order for the people to be knowledgeable in gender and HIV/AIDS.

The fourth phase focused on the development of the facilitator's guide, which was developed by the partners together with the study team. The purpose of this phase was to have a harmonised message/information that would be shared with other members of the communities in the targeted area and beyond. This phase was supposed to ensure that the facilitator's guide is translated from English into Runyakitara languages so that it is given a wide publication. Radio programmes were to be cross cutting in all the four phases.

Phase five, though not the concern of this publication, handles the dissemination of the facilitator's guide. This involves the delivery of information/message and distribution of the facilitator's guide to the communities and other constituents.

Study Objectives

The overall aim of the study is to undertake an inquiry on how communities in Uganda conceptualise good health and well being and make sense of gender and HIV/AIDS and related discourses using interactive and collaborative methods to create enabling environment for expression, dialogue and reflection. This, in turn, generates relevant knowledge that is acted on by the communities and the policy makers as the knowledge creation proceeds.

The study, specifically, aimed at:

- Enabling the people to create for themselves an understanding of good health and well being using criteria they would have developed in their local areas and also identify community structures that support well being, in order to accurately define what are healthy communities;

- Enabling the people of the four villages reflect and exchange information, knowledge and skills in handling issues regarding gender and HIV/AIDS;
- Enabling people of the four villages have a thinking of how they can sustain and continue with gender and HIV/AIDS programme in their communities;
- Increasing willingness to discuss and consider at the village level preventive measures for HIV infection, such as sex education and the use of condoms (issues in reproductive health);
- Increasing advocacy by community leaders and youth role models for attitude and behaviour change towards risky sexual behaviours, which are responsible for the transmission of HIV/AIDS;
- Encouraging and supporting village communities in developing action plans to decrease the spread of HIV/AIDS, especially among the risky group of young women (aged 13 to 25 years) and linking them to the sub-county authorities so that they can be integrated in the sub-county plans for support and sustainability of the programme; and
- Developing, conducting training sessions on how to use and disseminate a Gender and HIV/AIDS facilitator's guide in English and Runyakitara languages.
- Creating an innovative infrastructure for monitoring and prevention of gender related violence and HIV/AIDS and for healthy communities given the poverty trap and tensions around them and how can capacities, energies and resources be unleashed to sustain improved well being.

The study addresses the following questions:

- How do local communities wish and look upon well-being and what criteria do they use in their local areas when talking of healthy communities?

- What are the main community structures supporting well-being?
- How do people make sense of gender, HIV/AIDS, HIV test, drug testing, discourses and controversies in their health aspirations?
- In what ways, other than the expected or assumed sexual behaviour change, have people changed their behaviours that support good health? What are the views, experiences and practices with regard to fertility and reproduction?
- How can an innovative infrastructure be created for effective monitoring and prevention of gender related violence and HIV/AIDS and for healthy communities given the poverty trap and tensions around them and how can capacities, energies and resources be unleashed to sustain improved well being?

CONTEXTUALISING HIV/AIDS DEBATE IN THE VISIONARY APPROACH TO DEVELOPMENT

AIDS is a relatively new epidemic in Uganda. There are older epidemics not yet under control in the country, for example, malaria and tuberculosis. Moreover, the country lacks capacity to handle these epidemics, for example, a recent assessment of infectious disease surveillance found that only 35% of health facilities had the official standardised case definition booklet and an adequate supply of reporting forms. Only 51% had the laboratory capacity to confirm a diagnosis of malaria and 44% to confirm tuberculosis (Morbidity and Mortality Weekly Report, 2000): the major epidemics associated with HIV/AIDS. AIDS is complex because it is not one disease. A recent UNAIDS report made the point that HIV does not cause a single, specific fatal disease and individuals whose immune system has been weakened by the virus fall prey to already common infections and ailments. These common infections and ailments, tuberculosis being one of them, are more likely to spread in conditions of overcrowding and malnutrition under which large numbers of people in Uganda live. Distinguishing increasing morbidity and mortality caused by AIDS from the effects of poverty and gender related violence and other infectious diseases are therefore problematic and little has been done to that effect. Under such conditions even if an effective vaccine against HIV became available its effectiveness and efficacy would be compromised by these living conditions and the epidemics not yet under control. Research in South Africa elaborates this pointing out that worm infestations, a common phenomenon in most of Africa, could for example render HIV vaccine ineffective, if worms are not treated (Daily Mail and Guardian, 2001). Addressing the fundamental causes of ill-health-poor nutrition, housing, sanitation, and gender related violence-would seem essential if morbidity from AIDS were to be well understood and reduced.

With no vaccine or effective cure for AIDS, health education has been the main strategy to combat the epidemic, though largely scare-biased, i.e.,

reacting to the situation that the disease causes rather than creating the end results that a healthy person would truly want. Interventions focusing on measures to prevent the spread of HIV, predominantly through encouraging condom use, reduction in the number of sexual partners and prolonging the age of sexual debut have been proposed for the society. The impact of AIDS education campaigns has been assessed by behavioural studies using knowledge, attitude, practice and behaviour (KAPB) surveys as the main evaluating tool although KAPB surveys have well recognised limitations in their assumptions, conceptualisation and design as will be indicated later (Warwick, 1993; Choldin, Kahn and Ara, 1993; Hauser, 1993). Changes in sexual behaviour have been monitored in two population-based surveys in 1989 and 1995 which found that while knowledge about HIV/AIDS transmission and preventive options has increased behaviour change was reportedly modest (UNAIDS, 1998).

The underlying assumption of this health education model is that individuals execute their preferences or rational choices once information about health risks is provided to them: an assumption that ignores local contexts and societal dynamics and pressures. Moreover, the HIV/AIDS education message globally has been inconsistent. Roffman describes the opposing views contained in the policy in the United States by those advocating comprehensive sex education for young people and those advocating abstinence (Roffman, 2001). In Africa, these inconsistencies are further confounded as African systems that regulated sex behaviour in young people were disrupted by colonialism and colonial education systems that assumed that African sexuality was savage and unrestrained. These assumptions continue to resonate through some aid agencies similarly professing contradictory moral perspectives. Additionally, a stigmatising process has been ingrained in the assumptions, discourses and globalised practices in ways, which have debilitated the people and seems no wonder that over two decades in the epidemic very basic questions are still being asked (Pharma-Brief, 2000).

Outside the biomedical reference framework, little has been sought, as to whether people perceive AIDS as the major threat to their well-being, or whether the health interventions have improved the quality of their lives. There is increasing evidence that people do not define their well being solely using disease entities, but issues of overwhelming insecurities, for example, loss of employment, loss of social worth and inability to educate and make provisions for children are more important. A World Bank funded study seems to be giving this message (Deepa, et. al., 2000).. Anecdotal evidence seems to suggest that hypertension, stroke and other chronic illnesses and disabilities, alcoholism and drug abuse are increasing in the developing countries as a result of mass retrenchment or threat of loss of employment. Whitehead and colleagues describe the poverty trap, that includes untreated morbidity, reduced access to care, long-term impoverishment and irrational use of drugs arising from the health reforms including privatisation of health service provision, private financing via user fees and out-of-pocket expenses for private service, as most significant as compared to the AIDS epidemic (Whitehead, et. al, 2001).

In spite of the complex context described above it is also clear that communities have wisdom, resources, aspirations and infrastructure, which research and development as currently practised rarely tap or mobilise for action and change. This study is concerned with creating a process or environment that facilitates dialogue or space for dialogue thus enabling people to collectively make sense of the gender and HIV/AIDS and its complex dimensions and to reflect on their experiences and actions to improve their well being.

STUDY METHODOLOGY

Selection and Training of the Study Team

During the first week of September 2005, there was a selection of study team members and this consisted of 5 females and 2 males. This was a team considered to be conversant with HIV/AIDS and gender issues because its members had attended training in this area and it was able to relate directly to the local community. In addition, three youth members were selected: 2 females and 1 male because during the study we were going to interact with the youth. To know what gaps members had about the issues regarding gender and HIV/AIDS, they answered questions set for them about these issues. According to the needs assessment outcome, team members identified capacity building areas in HIV/AIDS, Gender, Human Rights, Life Skills and Reproductive Health. Capacity and team building workshops were conducted in the above areas, emphasising in the area of HIV/AIDS voluntary counselling and testing, stigma and discrimination, treatment of opportunistic infections, positive living, mother-to-child transmission and condom use. In the area of gender, gender roles, families and girl child, girl children's education movement and bride wealth, health, sexuality and sexual life were handled. Other areas that required training in included human rights, documentation, radio for rural transformation, computer training, monitoring and evaluation, drama for rural transformation, layout and design of appropriate media and community action planning. The author and other two facilitators facilitated the training and 10 team members of whom 7 were females and 3 males attended the training. Out of curiosity, members of the community also attended the training, mainly as observers; because of the work we do with communities it is not prudent to send away community members even when this raises some questions about the effectiveness of the training. The capacity building was conducted in the month of September 2005. The evaluation, done by the facilitators of the training, of the capacity and team building workshops concluded that team members had acquired adequate skills, knowledge and information to

enable them implement the village reflection and dialogue on gender and HIV/AIDS effectively.

Selection of Study Villages

Kagadi Sub-County was initially proposed but on advice of the District Director of Health Services, Kibaale and the District Focal Person in Charge of HIV/AIDS activities, Nalweeyo and Kisiita Sub-counties were selected. Kagadi Sub-county was preferred because it was considered more knowledgeable in matters of HIV/AIDS than the other two sub-counties. SWOT analysis, i.e., strengths, weaknesses, opportunities and threats of the above sub-counties in relation to the capacity to handle the HIV/AIDS problem, was the criterion used to select them in comparison to other sub-counties in Kibaale District.

The team visited 12 villages that make up Nalweeyo and Kisiita sub-counties out of which 4 partnership villages, i.e., Nyamirama, Nyabirungi, Kyempungu and Kiriisa, for village reflection and dialogue on gender and HIV/AIDS were selected using the SWOT method. The following were considered as strong points for the partnership villages:

- There was some work being done in Nalweeyo and Kisiita regarding roads, rights and justice. Therefore the combination of the roads, human rights and justice activities and gender and HIV-AIDS would be a good entry point for the study team.
- The above villages were very active during the health programme sponsored by the Uganda Rural Development and Training Programme (URDT): an organisation that supported this study, from 1998 to 2002 and they were willing and ready to continue with the gender and HIV/AIDS study, which again falls in the area of health.
- The organisation that sponsored this study has an outreach office and residence in Nalweeyo. Therefore, this would decrease on accommodation and transport costs for the team because initial costs were based on proximity of transport and accommodation.

- The existence of active formal structures at village levels such as local councils and the committees of health, education and agriculture were helpful in mobilisation.
- Willingness of the villages to participate in the different activities of the village reflection and dialogue on gender and HIV/AIDS.

Then, on the other side, the following were the weaknesses of the above selected areas, which were put into consideration:

- There is no any NGO/CBO that had ever operated in the selected villages especially in the area of training to address issues of gender and HIV/AIDS.
- During the exercise, it was discovered that some people are not fully informed as far as gender and HIVAIDS issues are concerned. For example, people revealed that in most cases, a good number of them are involved in risky sexual behaviours like unprotected sex, having multiple partners, unfaithfulness among married couples and condom use is very minimal.

Study Research Methods

Participatory action-oriented methods that included Focus Group Discussions (FGDs), brainstorming, information sharing, role-plays, songs and drama presentations by the groups were used. The groups were three: adult male, adult female and the youth groups that discussed the issues. Out of these groups, participants from each group identified their own facilitator, observer and recorder. Communities have a record of the process, which they can use to facilitate further dialogues and for future reference. The following guiding questions were given to them and discussed amongst themselves:

- What is Gender and HIV/AIDS,
- What are the risky sexual behaviours in this community,
- Who are the vulnerable categories of people to HIV/AIDS in this community, and

- Among those vulnerable categories, who are the most vulnerable?

The plenary sessions were organised because they bring clarity to the groups and some assumptions are openly discussed. Interestingly, no major discrepancy on the issues of gender and HIV/AIDS was observed between the three groups.

Each village had two days for capacity building. The study had targeted participants of 13 –25 years of age. However, when the discussions began people of more than 25 years did not want to be left out. They were all invited to participate and their contributions enriched the discussion. Below, we show the members of different groups that attended the capacity building workshops and the reasons why. These capacity building workshops were meant for the study participants not the training that the study team attended.

Study Participants

Traditional Birth Attendants (TBAs): because they handle delivery of babies at the village level where health centres are very scarce or lack maternity wards and/or facilities. They also collaborate with community health workers. TBAs require knowledge of HIV/AIDS because when they are handling the delivery of the babies they need to take extra caution so that prevention of infection to the baby, mother and to themselves happens. This is done by encouraging the TBAs to put on gloves, use the instruments they employ to cut the umbilical cord once and refer complicated cases to health units.

Community Health Workers were selected from the four partnership villages because they mobilise, train and monitor people on issues of health at the local level. No female health workers were available in the communities at the time of the team's visit.

Youth Representatives: the youth are very susceptible to the disease and yet the most productive members of the community. These can mobilise and sensitise fellow youth on the subject of gender, women's vulnerability and HIV/AIDS.

Local Council 1 Chairpersons and their Secretaries: they are the government representatives at the village level and influential in decision making and bringing the attention of the village to the issues during council meetings. All members of the village are councillors and hence key to the success of the programme.

Religious Leaders: These are influential in the communities as they deal with issues of faith and religious practice. The church and some Islamic practices run counter the arguments that are being raised in the fight against HIV/AIDS and it is claimed, in some quarters, without sufficient evidence that these practices have led to the escalation of the spread of the disease. By involving the religious people in the project would help in reducing the number of counter accusations and also mobilising them to talk about these issues in their pastoral activities.

Youth Drama Groups: to carry out the sensitisation and promote dialogue within the villages about gender and HIV/AIDS. Two groups in Kisiita Village, Ngoma Drama Actors and Nyabirungi Brain Trust Singers were helped to actively integrate gender and HIV/AIDS in their activities.

Community Based Organisations: Nalweeyo Nkooko Kisiita United Farmers Association and Bakyala Kweterena Women's Credit Scheme had their members taking part in the capacity building process in order to help them mainstream gender and HIV/AIDS issues in their work.

Educators: These were got from each primary school, secondary school and other institutions of learning in the four villages where the study was conducted since these are responsible for the youth when they are at school. The educators use their teaching to pass on information related with gender and HIV/AIDS.

223 participants participated in the capacity building phase, 143 males and 80 females.

The identified partners were trained on how they can facilitate the process of reflection on Gender and HIV/AIDS in their communities. The partners

mobilised 800 members of the communities in the four partnership villages to participate in the gender and HIV/AIDS dialogues. The topics discussed in these community dialogues concentrated on risky sexual behaviours and prevention, positive living, human rights in relation to gender and HIV/AIDS, male-female relationships and consciousness raising on gender and HIV/AIDS with the focus on power relations.

Radio Programmes

Broadcasting of the issues discussed with the communities was done on Kagadi-Kibaale Community Radio (KKCR) in order to reach a wider audience. The topics broadcast included: positive living, prevention, care and treatment of HIV/AIDS, male-female relationships and vulnerability to HIV/AIDS. Some of the radio programmes were presented by the people living positively with HIV/AIDS. People responded and showed enthusiasm when someone living positively with HIV/AIDS talked to them whether physically or phone in sessions on talk shows.

According to the work plan of Village Reflection and Dialogue on Gender and HIV/AIDS, the activities carried out in October 2005 fall under the capacity building phase of the study. During this month, a series of workshops were carried out in the villages of Nyabirungi, Nyamirama, Kyempungu and Kiriisa. These workshops were organised by the study team on Gender and HIV/AIDS with the help of local leaders of the above villages. The team noted with satisfaction that the turn up of the participants was good (working with more than 100 members of the village in question) as expected and most of the planned topics (more than 80%) were covered. Secondly, there was active participation and sharing, which was manifested through asking questions, sharing ideas and experiences and making presentations by both females and males and finally, women and men were actively sharing, they formed focus groups, discussed their ideas and experiences and hence dialogue was realised.. The team was enabled to carry out its activities because of financial and material support provided by URDT and the Australian High Commission and the effective mobilisation

of local people by local leaders. Thirdly, the willingness to learn by participants through interactions among themselves and the team learning between facilitators and participants contributed to the success of the study. Fourthly, the active participation, that involved both facilitators and participants, was manifested through focus group discussions, and finally, people were co-operative and eager to learn. However, in Nyabirungi the workshop did not take place on the date planned due to the visitation of the area Bishop and the workshop was postponed and conducted on another date. In Kiriisa, poor time management led to not covering all that was planned. One topic about the effects of HIV/AIDS was not covered due to late coming of participants. Lessons were learnt from carrying out this study and included, among others, the following:

- Most people like the methods that make them get wholly involved in different discussions such as focus groups and brainstorming.
- Some people still have negative attitudes towards condoms, for example, one participant in Kiriisa stated that 'People who manufacture condoms are the ones who brought HIV/AIDS."
- Through dialogue and reflection people were able to understand more the status of their village in relation to HIV/AIDS.
- Participants want practical work, for example, they want to learn how the condom is used.
- People want to concentrate on the programme they drew during community action planning

The study team made sure that the communities built consensus on issues raised about gender, HIV/AIDS and human rights. The communities came up with their own strategies to address those issues by use of visionary approach and applying the elements of a learning community. These elements combine to form what has been described as systems thinking, which encompasses a large and fairly amorphous body of methods, tools and principles, all oriented to looking at the interconnectedness of forces, and seeing them as part of a common process (Senge, et. al, 1994: 89).

The study team requested each village to identify one person to document the community learning process in one of the Runyakitara (Runyoro, Rutoro, Runyankore and Rukiga) languages and used this as a basis of coming up with a facilitator's guide to be used when the facilitators hand over the process to the identified partners. The person identified was given a file in which all documents were kept.

The study team made a follow up to find out if the action plans made by the communities were done according to what was agreed and then to advise accordingly as part of creating an innovative infrastructure for monitoring and prevention of gender related violence and HIV/AIDS and for healthy communities given the poverty trap and tensions around them and how can capacities, energies and resources be unleashed to sustain improved well being.

The research methodologies employed in the study are informed by the theoretical underpinnings entailed in participatory action research (Freire, 1970; Fals Borda, 2001) and constructivist inquiry (Lincoln, 2001; Denzin, 2000; Guba and Lincoln, 1989) arguing for strategies that uncover realities not often recognised in the conventional research. In their *Fourth Generation Evaluation*, Guba and Lincoln advocate for new methods of evaluation, which aim to empower and give voice to 'stakeholders' of different perspectives. They criticised traditional means of evaluation for often allowing some perspectives to be viewed as more legitimate than others thus empowering some stakeholders by recognising their experiences as reality and disenfranchising others. The proponents of participatory inquiry are concerned with issues of empowerment and justice, bridging the gaps between academic science and popular knowledge, the voice of the disenfranchised and dialogue (Farls Borda, 2001) in the belief that the best way to test a theory is through practice. The methodologies we employed in the study help *create an enabling environment for dialogue, reflection and reflexivity* (Cant and Sharma, 1998: 244-263; Fetterman, Kaftarian and Wanderman, 1995; Hertz, 1997). Reflexivity is a process that

enables different stakeholders whether lay people, policy makers, health professionals or researchers to monitor, contest and revise what is believed or thought to be assumptions underlying the knowledge leading in this case to what Freire refers to as critical awareness. This process aims to produce what Obi calls emancipatory epistemologies or moving from studies to understand Africa to studies that revitalise and transform the continent (Obi, 2001: 1-2). In this sense the study process entailed research and development with micro-level analysis as entry point for understanding the macro-level scenario in the gender and HIV/AIDS discourses.

STUDY FINDINGS AND ANALYSIS

The study team formulated a number of questions that guided the process and whose answers formed the basis of which areas to cover in a facilitator's guide. These questions are listed below:

- How has HIV/AIDS affected the human rights of women, men, girls and boys?
- What will you do to address those issues?
- How has HIV/AIDS affected the relationship between male and females?
- What have you done to address gender and HIV/AIDS related issues?
- How has the social behaviours of male and female influenced the spread of HIV/AIDS.
- What strategies have you put in place to mitigate the spread of HIV/AIDS?
- What are sexual issues you discuss in your communities?
- As families and communities, how, when and where do you discuss sexual issues?
- What makes people become susceptible to HIV/AIDS?

Understanding the Concepts: Gender, HIV/AIDS and Human Rights

Combining all the questions that we identified to guide the study we developed gender and HIV/AIDS areas that the community members should be knowledgeable about in order to mobilise them for action and change. The first included understanding of the concepts such as gender, HIV/AIDS and human rights, and the spread of HIV/AIDS and vulnerability to HIV/AIDS. The second area tackled the relationship between gender and HIV/AIDS. The third area treated the socio-economic and political effects of HIV/AIDS on the individual, household, community and the nation. Introducing visioning in the field of health and well being was the fourth area that we treated. The whole concept and practice of a healthy living

was handled. The fifth area managed information regarding the available treatment options of HIV/AIDS.

Through brainstorming and focus group discussions and with the facilitator's guidance the participants were able to come up with the meaning of gender and HIV/AIDS.

Gender: this is the social contractual relationship between male and female. It is a broad term that refers to the socially defined masculine and feminine roles and characteristics of men and women. Gender also relates to the different identities assigned by society rather than by nature/biology to men and women namely the masculine identity and feminine identity. The question put to them was what comes to their minds when the words man and woman are told to them. Their responses were sorted to see those that fell under social norms and those that fell under the nature of man and woman. From this categorization, the concept gender was then clarified. The details of this discussion will be seen later under what to consider as the content of the facilitator guide.

HIV/AIDS: Human Immuno-Deficiency Virus (HIV)/ Acquired Immuno-Deficiency Syndrome (AIDS). HIV is the virus and once inside a human being' s body it attacks the immune system so that a person can become very ill or die from a disease that others are capable of fighting. HIV is passed from person to person through blood or other bodily fluids, either through transfusion of infected blood, to a baby from its mother, through use of contaminated hypodermic needles, or through sexual contact with a person who has the disease. Participants were asked what HIV/AIDS is or what came to their minds when HIV/AIDS is mentioned. Their responses are indicated in Tables 1, 2, 3 and 4 below. Surprisingly, they mentioned a substantial amount of information about HIV/AIDS, which indicated, as earlier noted, that the people are knowledgeable about the disease despite the behaviour change being really modest.

Table 1: Nyamirama Participants Responses

Responses	Female	Male	Total
▪ It is faithfulness between man and woman	10	15	25
▪ Condom use	2	7	9
▪ Taking care of person living with HIV/AIDS	5	5	10
▪ People should go for HIV testing	7	11	18
▪ Harmony in homes	4	7	11
▪ Educating children about AIDS	6	9	15
▪ Going for prayers every Sunday	5	8	13
▪ Avoiding to share sharp instruments	-	2	2
▪ Dialogue between husband, wife and children	5	7	12
▪ Women should always be loving and submissive to their husbands	2	4	6
▪ Woman and man should provide for each other	3	5	8
▪ Good nutrition in homes	2	4	6
▪ People should avoid going for strip dancing	3	5	8

Table 2: Kiriisa Participants Responses

Responses	Females	Males	Total
▪ Misunderstandings	4	5	9
▪ Over drinking alcohol	12	17	29
▪ Indecent dressing	4	7	11
▪ Poverty in homes	16	17	33
▪ Working together as a family	11	8	19
▪ Witchcraft	5	7	12
▪ Sharing sharp instruments	5	7	12
▪ Having unprotected sex with an infected person	-	-	-

Table 3: Kyempungu Participants Responses

Responses	Females	Male	Total
▪ Having faith in each other	7	11	18
▪ Dialogue in families	2	7	9
▪ Being truthful to your partners	12	6	18
▪ We have to look after the affected	9	10	19
▪ We have to avoid catching HIV	5	5	10
▪ Its mostly men who bring HIV/AIDS	3	3	6
▪ There should be understanding between husband and wife in homes	6	3	9
▪ Husband and wife should go for HIV/ AIDS check up to know their status	6	12	18
▪ Positive couples should eat nutritious foods	3	7	10
▪ Parents should give their children condoms	4	5	9

Table 4: Nyabirungi Participants' Responses

Responses	Female	Males	Total
▪ This is brought by having sex	3	8	12
▪ Not going outside to have other partners	5	5	10
▪ HIV/AIDS is got if one plays sex with an uninfected person	6	6	12
▪ This a virus got through unprotected sex	6	3	9

Human Rights: are those basic standards without which people cannot live in dignity. To violate someone's human rights is to treat that person as though she or he were not a human being. To advocate human rights is to demand that the human dignity of all people be respected.

Human rights are the basics to which people are entitled simply because they are human beings, regardless of their nationality, race, ethnicity, gender or religion.

The rapid spread of HIV/AIDS epidemic has lead to an infringement of human rights of men, women and children affected by the disease. In relation to gender and HIV/AIDS, the starting point is to understand the examples of human rights violated. Some of the examples of human rights are: the right to liberty, the right to security, the right to freedom of movement, the right to dignity, the right to work, and the right to education. Other examples of rights include the right to social security and services, the right to equality–equal protection before the law, the right to marriage and family life, and the right to health.

How does HIV/AIDS affect the Rights of Women, Men, Girls and Boys?

Participants in the four villages were asked how HIV/AIDS affects the rights of women, men, girls and boys. Below are their responses.

- The right to dignity for men in their homes is affected when the wife stigmatises the husband pin-pointing that he is the one who brought the HIV/AIDS in the family.
- The right to marriage is also affected in a way that a girl cannot get married unless she has gone for HIV/AIDS testing.
- Men and women have a right to sex but due to the prevalence of HIV/AIDS they cannot have sex without using a condom.
- The right to education for children is so much affected and children are diverted to look after the sick person in the family due to HIV/AIDS leading to dropping out of school.

When participants were asked what actions should be taken to address the rights violated they gave the following responses:

- Engage in HIV/AIDS mitigation programmes.
- Engage in dialogue (as members of the community and engage other stakeholders in the local government, particularly those dealing with health) on the issue of HIV/AIDS

- Insist that no marriage should take place unless a man and a woman have undergone HIV counselling and testing.
- Raise the consciousness of the people.
- Initiate and establish income-generating activities to raise funds to support the education of the children and the people living with HIV/AIDS in the family.

Of the issues the participants raised could not fit into rights violated or the actions taken to address the violations.

- They want HIV testing services to be brought nearer to them.
- They doubted whether or not the condom is 100% safe.
- Is it possible for a husband and wife all infected with HIV/AIDS to be able to produce a child who is HIV negative?

The facilitator responded to these issues and there were to be followed up in the facilitator's guide that was to be developed after the study.

The Spread and Vulnerability to HIV/AIDS

A combination of brainstorming, focus group discussion, plenary presentation and lecture methods was used to handle the topic on the spread of HIV/AIDS and vulnerability to HIV/AIDS. The participants were able to generate information that could be used in the fight against HIV/AIDS spread. Among the ways through which HIV/AIDS is spread they mentioned:

Improved transport infrastructure like new roads: opening channels of communication like new roads contribute to the enormous potential for the rapid spread of HIV. This could be via carriers such as workmen and women moving to previously isolated areas to build roads, or via the increased truck drivers, businessmen and women and other individuals using the roads.

Mobility: travel between districts, towns and villages due to growing trade and tourism may contribute to the spread of the disease. Relaxation

of requirements for travel documents within the country in recent years, including people settling in new places without many obstacles and the fact that individuals do not move with partners, especially men, creates an unusually high demand for commercial sex.

Lack of substantial information about HIV/AIDS prevention measures: a substantial number of people, for example, many women still lack enough information about the necessity and use of condoms since most awareness education programmes focus on male condoms. Demonstration on how to use a condom is probably done with a banana and yet even the women have to know about the female condoms, which are even very few. So the decision to use a condom and how to use it still lies with the men.

Unprotected Sex: practising unprotected sex is still a reason for the spread of HIV/AIDS because some women are more conscious of becoming pregnant rather than preventing themselves from sexually transmitted diseases such as AIDS (playing unprotected sex during the safe period). Condoms are used, sometimes, entirely at the discretion of the man for the social norms still groom a woman never to reject or demand for sex. This is the role of the man.

Vulnerability to HIV/AIDS refers to the underlying factors that cause easier acquisition of HIV/AIDS by an individual than another one. These factors are discussed below.

Biological vulnerability: women are biologically more vulnerable than men to HIV infection and other sexually transmitted diseases. Women are two to four times more likely to become infected with HIV virus after intercourse with their male partners because:

- Their genital organs provide a larger surface area to the virus.
- The amount of the virus present in semen is greater than in vaginal secretions.
- Semen may remain in the vagina for hours after intercourse.

- Women are more likely to have an untreated sexually transmitted disease (STD) since the area of injection is hidden and often unnoticed. Having an untreated STD puts women at a greater risk of contracting the HIV infection from an infected partner.
- Women are more likely to be the recipients of blood transfusion due to anaemia and complications during child-birth.

Gender related vulnerability: gender related social norms can also increase women's vulnerability to HIV/AIDS, for example, women are expected to have only one life time partner, whereas men are encouraged to have more. This double standard puts women in a more vulnerable position.

What is increasing the spread of HIV in girls and young women is age mixing. If the girls' sole sex partners were boys of their own age they would run little risk of becoming infected as there are few HIV infections among boys before the late teens. However, girls have older partners compared to boys, who are physically and/or financially powerful. Men often believe that young girls are free of HIV infection.

The high social value placed on virginity in unmarried girls may also pressure parents and the community to ensure girls are kept ignorant about sexual matters. Female ignorance of sexual matters is often viewed as a sign of purity and innocence. The emphasis on 'innocence' prevents young women from seeking information about sex or services relating to their sexual health.

Economic vulnerability: in many situations, women are economically dependent on men. More than two-thirds of world's women are illiterate and 70% live in poverty. Due to their socio-economic status, some women do not have autonomy or resources of their own. Their fear that their husbands may abandon them makes it difficult for many women to negotiate safe sex. For many women, sexual intercourse is not a question of choice but rather a question of survival. As a result women have very little control over how and when they have sex.

Participants were asked what the vulnerable groups to HIV/AIDS are and among these groups who is most vulnerable to HIV/AIDS. The mentions are indicated in the Tables 5, 6 and 7 below. The most vulnerable groups to HIV/AIDS mentioned by the participants are the youth and women and a lot of attention should be paid to them.

Table 5: Vulnerable Groups in Nyamirama

Responses	**Female**	**Male**	**Total**
▪ Youth	17	13	30
▪ Men and women	5	10	15
▪ Children	12	9	21
▪ Old people	-	5	5
▪ Drunkards	4	7	11
▪ Business people	4	5	9
▪ Drivers	8	6	14
▪ Soldiers	4	6	10
▪ Motor cycle riders	4	6	10
▪ Doctors	6	5	11
▪ Disco goers	4	8	12
▪ Women and men who have unprotected sex	10	4	14
▪ Bachelors and spinsters	10	4	14

Table 6: Vulnerable Groups in Kyempugu

Responses	**Females**	**Males**	**Total**
▪ Youth	14	10	24
▪ Drivers	10	4	14
▪ Business people	10	4	14

Table 7: Vulnerable Groups to in Kiriisa

Responses	Females	Males	Total
▪ Drunkards	3	3	6
▪ Youth			
▪ Rich people who don't protect themselves			
▪ Lazy women			
▪ Soldiers			
▪ Students			
▪ Mad people			
▪ Bar attendants	3	3	6
▪ Disco goers	5	5	10
▪ Teachers			
▪ People who attend night prayers			
▪ Witch doctors			
▪ Prostitutes	3	3	6
▪ People taking care of AIDS patients			

The most vulnerable groups to HIV/AIDS in Nyamirama and Kyempugu are the youth and women (see Tables 5 and 6). There was no agreement in other villages on which groups were the most vulnerable to HIV/AIDS. The figures that are lacking in the tables is because the study team recorder did not pay attention and missed counting the members that had responded thus (this is the same explanation that is offered for other tables in the whole text).

The Linkage between Gender and HIV/AIDS

In order to establish the linkage between gender and HIV/AIDS, participants were asked to brainstorm on the linkage between these concepts (gender and HIV/AIDS) and presented their findings in the plenary. Information generated is presented below.

The gender perspective on the spread of HIV/AIDS in Uganda and Africa as a whole insists that the key to fighting HIV/AIDS pandemic is discussing or dialoguing women's sexual rights outside the production, violence and morality framework. However, it was difficult and complex to dialogue on the crucial issues of sexuality. Dialogue and shared learning stops when men are blaming women and vice versa about such issues as who is or is not using condoms and whose behaviour is causing the spread of HIV/AIDS. It has been discovered that the epidemic is now conclusively a ferocious assault on women and girls' rights.

Gender is a mutual relationship between men, women, and children in a family. Gender roles and relationships powerfully influence the course and impact of HIV/AIDS epidemic. Gender related factors shape the extent to which men and women, boys and girls are vulnerable to HIV/AIDS infection. The way in which HIV affects them and the kind of responses that are feasible in different communities and societies are based on their gender.

Gender inequalities overlap with other social, cultural, political and economic inequalities that affect men and women of all ages.

A variety of factors increase the vulnerability of women and girls to AIDS. They include social norms that deny women sexual health knowledge and practices, which prevent them from controlling or deciding when they should have sex.

Men and young boys are vulnerable too. Social norms reinforce their lack of understanding of social health issues and at the same time make them celebrate promiscuity. This vulnerability is further increased by the likelihood of engaging in abuse [violence] such as alcohol and other drugs that can lead men and young boys abandon their families causing family disruption.

There is growing violence that a large share of new cases of HIV infection is due to gender based violence in homes, schools, workplaces, and other

social spheres. In settings of civil disorder and war, women and girls are often systematically targeted for sexual abuse. This increases their odds of acquiring HIV and other sexually transmitted diseases and unwanted pregnancies. Research has shown that up to 80% of cases of women in long-term relationships who are HIV positive have acquired it within marriage.

The burden of caring for ill family member (s) is placed on the heads of women and girls. As the impact of AIDS epidemic grows girls drop out of school in order to cope up with the task of caring for ill family members.

Experience shows that controlling the epidemic in communities and families demands confronting the gender driven behaviours that increase the chances of infection for girls and boys. This in turn calls for strong and coherent national policies, strategies and plans. CEDAW (Convention on the Elimination of all forms of Discrimination against Women) is a key basis for legal reforms and other steps aimed at countering the violation of women's human rights and protecting women who are infected and affected and those not yet infected or affected by HIV/ AIDS.

How does HIV/AIDS affect the Relationship between Male and Female in the Communities?

- HIV/AIDS has caused separation/divorce of spouses in their communities. One member of the community revealed that when a man/woman is alleged to be involved in adultery they start becoming suspicious of each other. This can result into a quarrel that may lead to separation or divorce.
- They also reported that when a person in a family is HIV positive he or she needs careful attention or special treatment. This special treatment goes with high resource utilisation.
- A lot of time is spent caring for one person and when one dies a lot of time is required to carry out funeral rites.
- Funds to buy food and medicine for the infected person deplete the family resources and hence affecting other members of the family.

For example, the children drop out of school followed by early marriage and dishonest people in the communities rob the orphans of their property and as a result they are not well supported resulting in some becoming street children.

- They also reported that productivity and production are negatively affected. The family members, due to illness, will not have energy to work and will not engage in farming activities and as a result there is food insecurity and low income for families. Such families pick quarrels amongst themselves from time to time leading to family instability or violence.
- They shared that when one partner dies because of HIV/AIDS, more especially the husband, some members of that family can decide to chase away the widow and deny her ownership/accessibility of the property of the deceased.

When participants were asked **how they want to manage the above problems** they gave the following responses:

- The Gender and HIV/AIDS Reflection and Dialogue partners should begin to carry out awareness activities about these issues.
- Promoting continuous dialogue on gender and HIV/AIDS in the community members' families.
- To engage in income generating activities at family level in order to have sufficient funds to meet their domestic needs.
- Consciousness raising on human rights to commence so that members of the communities can understand their rights and make informed decision, for example, writing a will before one dies in order to minimise chaos or disharmony after death.

Attitudes and Practices related to Gender and HIV/AIDS

Participants were asked to mention those attitudes and practices that relate to gender and HIV/AIDS. They responded as follows:

Unprotected Sex

Some people are not yet fully informed or sensitised as far as HIV/AIDS is concerned. For example, during the study, people revealed that in their communities condom use is very minimal especially among the youth. And on the other hand adults have a negative attitude towards condom use. Most people think that condoms are supposed to be used by unmarried men and women; people living with HIV/AIDS and those condoms encourage irresponsible sexual activities among the youth.

Unfaithfulness among married couples

This was pointed out strongly in Kyempungu village by local leaders that some men in the village are involved in extra-marital affairs and this seems to put their wives at risk since they practice unprotected sex. Moreover, they do not go for HIV/AIDS testing before being involved in such relationships. After observing this trend it was decided that condoms should be procured and distributed through the local councillors. St. Ambrose Charity Health Centre, Kagadi, donated these condoms. This gave the team the opportunity to educate the members of the community on the usage of condoms in the capacity building workshops.

Polygamous families

From the research findings, it was discovered that around 60% of the married couples in the 4 villages are involved in polygamous marriages. And the challenge is that, at times, these people are not faithful to each other. One of these people can be involved in irresponsible sexual activity and thus ends up affecting other members of the family.

Early marriages/forced marriages

According to the findings, many young girls in these villages drop out of

school and get married to rich and polygamous old men. Parents make arrangements by accepting bride-wealth in exchange of their daughters. They are married to such men without testing for HIV/AIDS and thus put their children at risk of acquiring the disease.

Abuse of women and children's rights

Poverty leads many women and girls to have unprotected sex in exchange for goods and services they could otherwise not afford. Condom use is almost invariably a male decision. Despite increasing condom use, many men remain reluctant to use them. Many women lack the power to negotiate for safer sexual practices and may be forced or expected to have unprotected sex. Thus, it was discovered that some people are not informed on the importance of condom use since there are hardly any non-governmental organisation, community based organisation or government health unit (within a distance of 10 kilometres) operating in the selected villages to address issues of gender and HIV/AIDS.

Also social norms deny women sexual health knowledge and practices that prevent them from controlling their bodies or deciding the terms on which they have sex. Girls and women are often systematically targeted by men and boys for sexual abuse such as rape and defilement. It came out strongly in Kyempungu where they accused the teachers as having sexual relationships with their students and primary kids. This dramatically increases girls' chances of acquiring HIV/AIDS and other sexually transmitted infections and of becoming pregnant.

Negative attitude towards Condom use

People still have the age-old fear that talking about condoms to the youth will lead to greater sexual activities and that those who manufacture condoms are the ones who brought HIV/AIDS to Africa and Uganda in particular. Having realised that people have negative attitude towards condom use participants were asked to mention the risky sexual behaviours people involve themselves in so that planning is initiated to mobilise the people for action. Tables 8 and 9 below indicate their responses. Interestingly, some

people mention the causes of risky sexual behaviour as if they are risky sexual behaviour showing that the HIV/AIDS problem at the community level is located in the entire development process.

Table 8: Risky Sexual Behaviours in Nyamirama

Responses	Females	Males	Total
▪ Failure to work together as family members, particularly of husband and wife	4	2	6
▪ Drunkardness in homes	10	8	18
▪ Not fearing God	3	3	6
▪ Having unprotected sex	4	10	14
▪ Having more than one sexual partner	10	13	23
▪ Lack of knowledge about condom use	5	3	8
▪ Poverty in homes	4	7	11
▪ Sharing sharp instruments	3	8	11

Table 9: Risky Sexual Behaviours in Kiriisa

Responses	Females	Males	Total
▪ Misunderstanding between husband and wife	-	-	-
▪ If there is no respect for each other	-	-	-
▪ Neglecting each other	-	-	-
▪ Over drinking alcohol	4	3	7
▪ Laziness			
▪ Ignoring the prevention of HIV/AIDS			
▪ Poverty			
▪ Not believing in God			
▪ Having sex before going for HIV/AIDS			
▪ Check up of the health status	5	8	13
▪ Lack of trust between man and woman	3	7	10
▪ Marrying widows	3	7	10
▪ Lack of sensitisation on HIV/AIDS	3	7	10
▪ Having unprotected sex	6	9	15
▪ Going for discos	3	7	10

EFFECTS OF HIV/AIDS ON THE INDIVIDUAL, HOUSEHOLD, COMMUNITY AND NATION

Using focus group discussion, observation in all target groups, story telling and music, dance and drama, the participants were made to respond to the question: "What are effects of HIV/AIDS on an individual, household, community, and the nation?"

Effects on an Individual

Madness: When one is infected with HIV/AIDS and it goes out of control it can lead to madness. Very often we have seen victims of HIV/AIDS running mad. This is sometimes a sign that HIV/AIDS virus has reached in the brain.

Poverty: in many cases, when people discover that they are HIV/AIDS positive they become reckless and careless and think that the end of the world has come and that they are to die the next day. Because of this they even stop working since they know that they are to die the next morning. Yet they do not die as expected and they just find themselves still alive even in the next 10 years and this has caused them to live in poverty.

Death: this is self-evident because it is said that AIDS has no cure and that the best medicine is the 'spade and the hoe'. Therefore we should avoid HIV/AIDS.

Early marriages: when children are left as orphans and nobody is concerned about them they resort to early marriages as a way of looking for survival.

Committing suicide: some people commit suicide after discovering that they are HIV positive. This is because of worries and loss of hope, which make them feel as if they no longer fit in the society.

Single parenthood: AIDS has increased single parenthood especially men dying and leaving widows behind who cannot give enough care to the family. This has led to the family members especially children to grow up in poor conditions.

Other effects of HIV/AIDS on the individual include *discrimination* arising from stigmatisation by self, members of the family and community. The HIV virus attacks the white blood cells, which form the immune system of the individual, thereby reducing their number and making an *individual vulnerable to many diseases and ailments*.

Effects at the Household Level

Children out of the wedlock: This happens especially when men get children outside the wedlock. In case a mother of a certain child dies before the father of the child the father sometimes fears to take care of children of the dead mother and children remain with no one to support them.

Poor standards of living in a home: of course, when the family loses a bread winner who is the father of the home, the widow and orphans and other people in a home will live under poor standards of living. They will not afford to build a good house for themselves, to have good food and adequate health care.

Low levels or no education of orphans: due to the fact that AIDS has left children as orphans they have nobody to cater for them by giving them support to go to school. You find a child cannot afford the basic necessities of school such as school fees, books, and, etc. This leads children to drop out of school at early stages and in most cases at the elementary level.

Some parents use their daughters as traps: many people, today, after discovering that they are HIV/AIDS positive, force their daughters to marry and apprehend their husbands that they have defiled them. They take them to courts of law as a way of getting money from them.

Effects at the Community and National Level

Low agricultural production: it has been noted that most of the agricultural productive group is the youth and at the same time they are the ones who are most affected by HIV/AIDS. This eventually results into low agricultural production.

Retardation in the economic progress: for example, if someone is constructing a commercial house, after knowing that he/she is HIV positive, will lose hope and start saying for whom am I working? And that will make him/her consume all the money he/she is getting. In such a case the community will be losing. But at times the disease can make people work hard to leave behind investments to help their families because those infected do not die suddenly.

Increase of street (needy) children: most of the children who are found on streets are orphans. After losing their parents and relatives and nobody is looking after them they go to streets looking for survival.

High increase of crime rates: that is, boys resort to crimes like high way robbery and girls resorting to early marriages and commercial sex as means of survival. Other crimes involved in are rape and defilement, which again increase the rate of spread of HIV/AIDS.

Increase of government expenditure: if people are infected with HIV/AIDS the government expenditure will increase especially on health facilities. The government will also be responsible for orphans' health and education and the budget for these two goes up.

Other effects of HIV/AIDS on the community and nation include loss of prominent people and decrease in the tax base.

What is Healthy Living?

Focus group discussions, testimonies of those living positively with AIDS, brainstorming and demonstration were employed as methods of study to enable the participants handle the meaning of a health living. The information that was obtained from the participants was guided by these questions: What is healthy living? How is healthy living related to human rights? What should be done to live positively with AIDS?

Participants were asked to state what they understood by healthy living in the context of HIV/AIDS and they mentioned the following:

- Health living is a state where people with HIV/AIDS infection prolong their life by making good choices to care for their own mental, physical and spiritual health.
- Everybody has a right to life and this means that a person with HIV/AIDS has this right to live a healthy life.
- It also means living responsibly with HIV/AIDS.

What are the ways through which one can live a healthy life even when infected with HIV/AIDS? To this question the participants mentioned what we present below.

Physical Care

Medical Care: a person with illnesses due to HIV infection needs to seek for prompt medical attention. Most opportunistic infections that affect people with HIV are treatable. Prompt treatment of opportunistic infections reduces the severity of the illness. Early diagnosis and treatment of infections retards the multiplication of HIV in the body. When a person's health is controlled she/he is in position to continue with work, which will in turn help the person to plan better for the future, for self and family. A person with HIV infection can get treatment from all established TASO centres and most government and mission hospitals in Uganda and any other health facility.

Proper Nutrition: having a balanced diet is an essential part of living positively with HIV/AIDS. A person with HIV infection needs to feed on foods with essential nutrients required by the body. These include:

- Proteins (both vegetable and animal protein), which help to rebuild cells in the body.
- Vitamins derived from fresh fruits and vegetables, which repair body cells and protect the body from diseases.

- Carbohydrates from foods like maize, rice, cassava and potatoes etc., which are important in providing energy. The energy strengthens the body and enables the body's capacity to fight infections.
- Taking a lot of fluids to keep the body cells supple, for example, water, fruit juice etc.

Resting: people with HIV infection need to take enough rest and sleep when they are tired. Resting and sleeping helps to reduce the fatigue and strain on the already weakened body.

It is healthy for a person to have at least 8 hours of sleep daily. You can listen to music, or read a newspaper, holy books, novels, or other favourite books as part of resting.

Light physical Exercise

- Exercising the body regularly keeps the body strong and enables the body systems to work well, enabling proper circulation of blood and oxygen to different parts of the body, regulating body temperature, and getting rid of unnecessary waste products.
- If the body does not exercise regularly, the body muscles tend to retract and stiffen which results into unnecessary pains and aches and deformation of joints.
- Exercising the body causes sufficient body exhaustion, which helps the person to sleep comfortably. Exercising helps the person to concentrate on whatever he/she is doing which, in turn, diverts the persons mind off the thoughts and worries of AIDS.
- People with HIV can exercise by performing slight domestic work like sweeping the compound, cooking, washing gardening, etc. They can also consider physical game exercise.

Avoid Taking Alcohol and smoking Cigarettes

- People with HIV infection should try to avoid habits that endanger their health status. Taking alcohol and smoking cigarettes/drugs weakens the body generally and exposes the body to various

infections like respiratory complications, liver complications, and brain cell damage.

- Alcohol and drugs claim a substantial amount of one's income and also intoxicate the person's mind, which prohibits the person from making rational decisions leading a person into accidents and immoral behaviour.
- Alcohol and certain drugs reduce an individual's appetite for food, which denies the body certain nutrients. It also enhances peptic ulcers and diarrhoea.

General Hygiene: people with HIV infection should maintain hygiene of the body and environment. Body hygiene includes the following:

- Hair should be kept short and clean to avoid lice.
- The mouth and teeth should be cleaned regularly with a soft toothbrush, cotton or piece of cloth to avoid oral infection.
- The skin should be washed regularly and oiled to avoid cracks.
- Nails should be kept short and clean to avoid germs and bruising of the skin if scratched.
- Clothes and beddings should be kept clean and free from fleas to avoid skin problem.

Hygiene of the environment includes the following:

- Food /eating utensils should be kept clean; free from flies to avoid diarrhoea.
- The house should be kept clean and free from fleas to avoid skin problems.
- The grass should be trimmed and the compound kept clean and free from stagnant water to keep off mosquitoes in order to avoid attacks of malaria.

Avoid having unprotected sex: having unprotected sex leads to:

- Re-infection, which can quickly spread up the disease in one's body. It is also risky because one can be exposed to other sexually transmitted diseases.
- Pregnancy which weakens the health of the mother and causes HIV infection in babies. So if one wants to become pregnant should first seek advice from a health care worker.
- Infecting others. One can avoid infecting others by using a condom every time you have sex. Proper use of condoms can reduce the risk of passing on HIV or getting other sexually transmitted diseases.

Mental Care

Counselling: the person infected with HIV/AIDS should seek counselling to discuss any worries and problems that may arise. Counselling involves the person sharing out his/her worries with another person he/she confides in. Usually a problem shared is a problem halved. Ventilating certain feelings, for example, anger and fear, calms down the person and has a healing effect on the person. Counselling services are offered in centres that look after AIDS patients, for instance TASO, AIDS Information Centre, some government and mission hospitals.

Spiritual Care: many people with HIV/AIDS get great strength from spiritual beliefs, counselling and care. They realise that in their struggle they are not alone. They find that their fears are diminished. They should feel free to go to their religious leaders. All religions have special prayers and ceremonies for people who are sick. Your religious leader can help you to cope with many of the problems posed by HIV/AIDS. Religious support can strengthen your spiritual beliefs and can help you to accept yourself and others. It can help you to get rid of bad feelings and to live positively.

Keeping Busy: the person takes on leisure activities like watching football, listening to music, visiting friends, relatives, watching films, reading

novels, newspapers, etc. This helps the person to keep busy and therefore keeps off stressing thoughts.

A part from leisure activities it is important for a person to engage in activities that will bring income. This helps the person to plan for the future and to sustain himself/herself. Over depending on others for survival is problematic. Keep to your job and only stop when you are completely unable to do so.

Fellowshipping: this involves engaging oneself in constructive social gatherings like attending church groups, women clubs, choir and drama clubs, day centres, etc. Apart from keeping the person active, fellowshipping helps the person to be allocated certain roles, which if performed well, will arouse appreciation from others. A person with HIV/AIDS learns certain coping mechanisms from other persons living with HIV/AIDS.

Develop a Positive Attitude: it is important to accept the fact of being infected with HIV. Have the will to live and look at the future with hope. Blaming oneself or others for the situation will not solve anything. Grieving the situation renders one helpless and lowers one's self esteem. It is good to maintain hope for the rest life.

Creation of a Healthy Community People Truly Cherish

Treatment of HIV/AIDS was handled by treating topics on voluntary counselling and testing, prevention of mother to child transmission and anti-retroviral drugs by the facilitators. Using the visionary approach the participants were made to define the end result they want (a healthy living) and describe in truthful terms their current reality. When they did this they were able to define the gap that exists between their current reality and the end result they truly wanted. This created a momentum in them and their energies were mobilised for action towards the end result they truly cherished. The whole process generated information that we discuss below.

Counselling and Testing for HIV/AIDS

Voluntary Counselling and Testing (VCT) is a combination of two activities, i.e., counselling and testing. Fear of stigma and discrimination discourages people from seeking VCT services and this increases the likelihood that infection will be passed on to others.

Importance of Testing and Counselling: to make significant progress in the fight against this pandemic VCT is necessary because:

- Knowing one's HIV status empowers one to make informed decision about his/her sexual lifestyle that would enable people to prolong and improve the quality of their life.
- Counselling and Testing decreases the anxiety, stigma and sense of hopelessness. Those who learn their HIV status and receive specific counselling based on their test results report an increased sense of hope in facing their situation openly and with adequate information.
- Also if one is HIV negative the information and counselling they receive can be a powerful catalyst for behaviour change so that one can remain uninfected.
- VCT services help people make informed decisions about marriage, pregnancy and sexual relationships.
- They also provide the opportunity for receiving additional services, such as legal assistance, family planning and detecting and treating other sexually transmitted diseases and opportunistic infections such as fever, cough, flu and herpes zoster.

Who should receive VCT?

- Any one serious about his/her life and behaviour change.
- Those with more than one sexual partner.
- Those diagnosed with a sexually transmitted disease and/or TB.
- Any Adult.

- Couples before marriage, those starting a relationship or those planning for pregnancy.
- A person whose partner has more than one sexual partner.
- A person working away from a spouse.
- A person who has had a blood transfusion of unknown quality.
- Youth between 15-18 and some minors already engaged in risky sexual behaviours.
- Children under 15 can be served but only with parental consent but only if there is clear benefit to the child.

Types of Counselling in the area of HIV/AIDS: there are two types of counselling and these are:

Pre–test Counselling: issues discussed in the pre–test session include:

- Basic facts about HIV infection and AIDS
- Meaning of a HIV test
- Reasons why the client is requesting counselling and testing.
- Procedures to expect while undergoing the test
- Since rapid tests give results immediately a prevention counselling session is held while the test is being carried out.
- Basic HIV prevention
- Determining whether one is ready to learn about his/her HIV status.
- Client's intentions after finding out the results.
- Exploration of what the client might do if the test is positive/ negative.
- If HIV positive the way of coping should be discussed and if HIV negative the ways of remaining uninfected should be explored.

*Post–Testing: b*efore disclosing the test result the counsellor makes sure that the client is truly willing and ready to receive the results and understands what negative and positive test results mean. The counsellor gives the

test results calmly and in a quiet private setting. One is also given every opportunity to express his or her feelings about the test results as well as any other personal issues. By visiting a VCT centre you will be playing an active part in the fight against HIV/AIDS. By knowing your status you will be empowered to make the right decision concerning one's health.

The participants asked the team where people could go for HIV testing. Kagadi Hospital was the place where HIV testing could be carried out but it was found out it was far from where they were residing. In order to show participants that HIV/AIDS was among the serious diseases in the area we gave statistics that have been collected from Kagadi Hospital since 2000. According to Ondoga Jimmy, a laboratory attendant and Amongin Florence, a Clinical Officer, In Charge of HIV/AIDS Voluntary Counselling and Testing, Kagadi Hospital, who were part of the study team, reported that out of 6122 clients who visited Kagadi Hospital from 2000 to 2004, 702 clients were confirmed to be HIV positive (see the Table 10 below). There is need to lobby medical officials to take HIV/AIDS voluntary counselling and testing services nearer to the people.

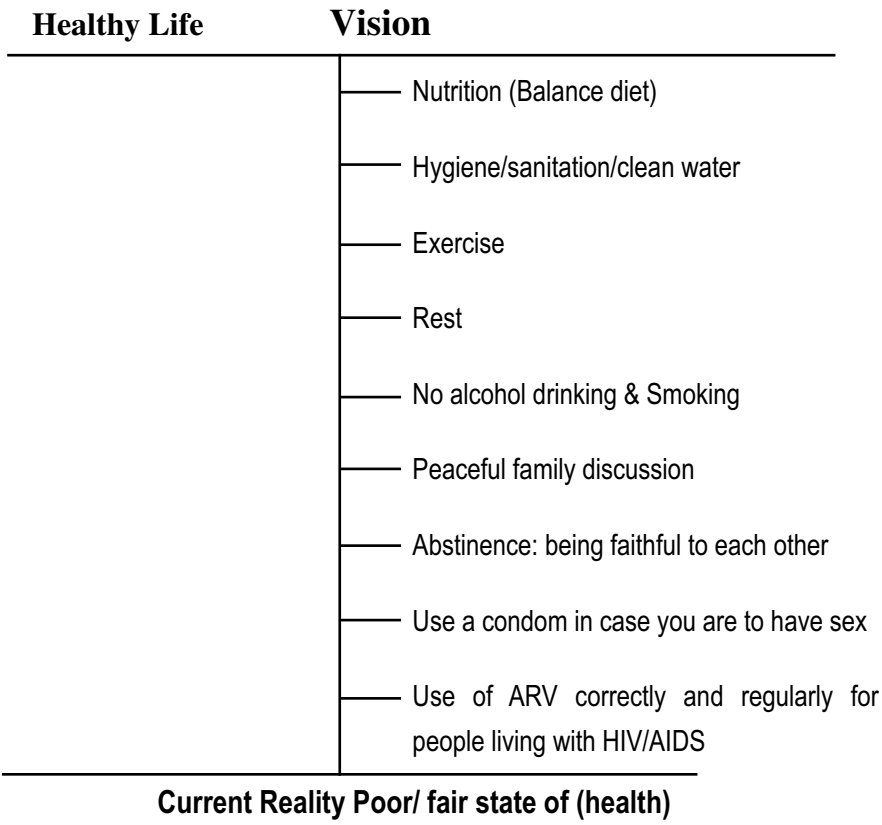
Table 10: Clients have been Visiting Kagadi Hospital for HIV Testing in Kibaale District

YEARS	**CLIENTS**
2000	82
2001	624
2002	1670
2003	1198
2004	2468
TOTAL	**6122**

Treatment of HIV/AIDS is an Aspect of Community Well Being and Healthy Being

The participants were asked where the treatment of HIV/AIDS lies in the creative process/visionary approach. Using the visioning technique

the participants were asked to close their eyes and think about the health they want to be living. Again, the participants were asked to close their eyes and to reflect on the health they are living in now in their homes. The participants were enabled to see the gap between **Healthy Living** (the vision they uphold) and their **Current Reality**. A structural tension is created as a result of the gap between their vision of healthy living and the state of their health. This tension created seeks resolution. The resolution can be towards the vision so that the achievement of healthy living is attained or it can be towards the current reality where energy and momentum is lost and people stay where they are. To bridge the gap between healthy living, therefore, there should be actionable steps. Treatment of HIV/AIDS is an actionable step towards the attainment of a healthy living (see the figure below).



Anti-Retroviral Drugs (ARVs)

Participants wanted to know the type of treatment that the HIV/AIDS patients receive. Since today, the most common drugs for the treatment of HIV/AIDS are the anti-retroviral drugs (ARVs), we decided to give the information we present below to the participants.

ARVs are the main types of treatment for HIV/AIDS. They are not a cure but they stop early onset of illness. They are taken for life.

ARVs slow down the reproduction of HIV in the body. HIV is a virus, which combines with the cells in the body and produces new copies of itself and thus the rapid spread of the virus throughout the body. ARVs inhibit the HIV virus to make its new copies by interfering with HIV enzyme reverse *transcriptase*.

When to start the therapy?

*Know your HIV status first: i*f one is found HIV positive one needs to be examined and counselled for treatment from a trained health worker. If found HIV negative repeat test after 3 months and ensure that you remain negative by abstaining from sex, being faithful to your an uninfected partner and using condoms correctly and consistently.

If the doctor decides that you need to start with ARVs you will be educated and counselled and start on treatment. Remember to go with a family member, relative or a friend for moral support. If the doctor decides that you do not need to start treatment go for regular check up as directed and learn to live positively with HIV and if possible join a post-test club

Five **As,** namely: assess, advise, agree, arrange and adhere, must be followed in order for one to start the ARV therapy. **Assessing** involves the CD4 count and should be less than 200 for one to start accessing ARVs. CD4 are T lymphocytes. These are cells on which HIV virus attaches. Haemoglobin level of one's blood – for men it should be 13 grams per decilitre and for women 12 grams per decilitre. Lymphocyte cells are

immunity cells and should always be above 500 micro units per litre of blood. Kidney function and liver function tests are carried out in order to determine their effectiveness with respect to the functions they perform, that is, secreting of the drug out of the body and regulating toxicity of the blood respectively. **Advise** accordingly for those whose CD4 count is less than 200 to start on ARVs and for those ones who are HIV negative to abstain, be faithful to their partners or use a condom. **Agree** with the client if he/she has agreed to follow the advice or not. **Arrange** for those ones who are HIV positive and their CD4 count is less than 200 to receive ARVs regularly. The client, then, should **Adhere** to taking the ARVs correctly and regularly for rest of his or her life.

The information that we generated and discussed above is an outcome of the questions that participants were asking and also responses of the participants to the questions we put to them. We found out that this information should be used in formulating development programmes to handle issues related to gender and HIV/AIDS using the human rights-based and visionary approaches to development. One such development programme should emphasise that this empowering information should be shared amongst the people. It was for this reason that it was decided that a facilitator's guide on Gender and HIV/AIDS be developed for use in organising training for the communities in Uganda and mobilising their energies for action. It is to the content of this guide that we now turn.

WHAT TO CONSIDER IN THE FACILITATOR'S GUIDE ON GENDER AND HIV/AIDS

Today, in the Third World, what should engage development practitioners is human and rural development where issues of health are very fundamental. It is documented that the health status of the population determines its productivity hence its development. Integral development programmes should take health as a central concern. To this end the availability of clean safe water, environmental sanitation, home improvement and consciousness raising in HIV/AIDS epidemic should form part of integral development programmes. Over the years, development workers in communities have accumulated a lot of insights in regard to the spread of HIV/AIDS and hence the interventions for the control of the scourge using the creative other than reactive- responsive orientation. Community participation and involvement has been taken very crucial in helping the people to determine the health that they truly want, i.e., when people choose to be healthy they work towards achieving that vision by having safe sex, good nutrition, etc. The participants identified traditional prejudices which pause social stratification barriers to development and the need to address issues of perception, deception and truth regarding HIV/AIDS, for example, attitude towards condom use, stigmatisation and discrimination of those infected with HIV/AIDS and the prevalence of spread. They believe a lot has been done in awareness raising and support regarding the epidemic but still realises a gap in the interventions to curb the spread. Much as HIV/AIDS infection rate nationally has dropped from 35% to 5% (Hanley, 2005: 268), a lot still needs to be done to completely stop the spread if people choose to stay healthy and work towards achieving this vision.

Through the process of the study it was noted that the discussion on issues related to HIV/AIDS and sexuality is blocked by deeply held views that men have about women and sex. Dialogue and shared learning stops when men are blaming women and vice versa about such issues as who is or is not using condoms and whose behaviour is causing the spread of HIV/AIDS. Therefore, there is a need to empower women to negotiate for safe sex and

men to take the responsibility in preventing the spread of HIV/AIDS. There is also a need to recognise that we are all human beings and that life is a human right and a value we need to cherish and a need to reflect and share experiences and help each other make proper choices.

Through discussion and careful listening, the content of the facilitator's guide on gender and HIV/AIDS was put together and it is our hope that is used by all those people involved in rights-based and visionary development.

However, the content of the guide is not a blueprint, but rather the focus should be more on the process. The guide is meant to share processes with facilitators and civic leaders who intend to promote health at community level. They can adapt it to their own situations deemed appropriate to cause dialogue on gender and HIV/AIDS for reducing on the high infection rate. The guide helps communities to develop a common purpose on health and generate enough action to create the life they desire (in particular healthy and prosperous life with respect to gender, HIV/AIDS and human rights).

After extensive interactions and participation with the communities (community leaders and groups) the study team created the Village Reflection and Dialogue on Gender and HIV/AIDS to fill a particular gap (there was an absence of any infrastructure at the village level to handle HIV/AIDS issues). We have, therefore, drawn extensively on information and workshop experiences from villages in creating the content of this guide.

This guide is for facilitators, people who can engage others for discussion and reflection to cause action. It is designed for leaders in various capacities, for example, school teachers, religious leaders, health workers, social workers, community leaders and local councillors in the case of Uganda.

This facilitator's guide is a by-product of a four-phased approach to community participation in gender and HIV/AIDS dialogue. Phase one looked at Community Mobilisation. Phase two looked at Community Action Planning in which the collective understanding of the vision about

peoples' development and the importance of healthy being were discussed. Participants were led to reflect on the health status of the people in the communities, which visibly brought out a discrepancy or gap between what the people aspired for and the condition they were living in. The second phase was to narrow the information gap in which families and community members participated in workshops on health but with emphasis on gender and HIV/AIDS. This was to enable the people look critically at the power relationships in matters of sexuality and socio-economic situations in gender terms. The third phase was to help the communities, household members and individuals to develop strategic plans for follow up interventions. The fourth phase was to call forth commitment and responsibility from community members and to discover the power of one's own commitment in stopping the spread of HIV/AIDS.

The facilitator's guide has been designed specifically to meet the following goals:

- Community Action Planning at village level. Enabling people articulate their aspirations and their current situations regarding their healthy being.
- Community mobilisation at the village level to discuss gender and HIV/AIDS using community leaders as role models and initiators.
- Creating space for reflection and dialogue in village communities about the relationship between male- female power relations, sexuality and the transmission of HIV/AIDS.
- Documentation of the process at village level for reflection and dialogue about attitude and behaviour change related to gender and the transmission of HIV/AIDS through risky sexual behaviours.
- Increasing community awareness of the risk of HIV infection among community members.
- Increasing willingness to discuss and consider at the village level preventive measures for HIV infection, such as sex education and the use of condoms.

- Increasing awareness of and participation in Uganda government sponsored programmes such as prevention of mother to child transmission of HIV/AIDS.
- Increasing advocacy by community leaders and youth role models for attitude and behaviour change towards risky sexual behaviours, which are responsible for the transmission of HIV/AIDS.
- Provide community based resources to help communities understand and plan for activities to decrease the transmission of HIV/AIDS especially among the risky group of young people aged 13 to 25 years.

Guiding the Process: General Information for the Facilitators

Participatory approach to training should be used to reflect the content of this guide. Among the multiplicity of terms used for trainer, educator, etc, we have chosen to use facilitator, which indicates a person who promotes and supports the process of participatory approach to acquisition of knowledge.

As a facilitator of the process remember the following guidelines to create full participation from the participants and to help them come up with their own thinking and making them to reflect and take action.

- Listen to and respect the experiences, ideas and opinions that each participant brings to the discussion.
- Promote sharing and conversation between participants.
- Discussions facilitate the shared interpretation of concepts and promote the development of consciousness about gender and HIV/AIDS.
- Prepare and encourage participants to develop new approaches to situations in which they live and work, i.e., the visionary approach rather than problem solving, to create for themselves what they truly want and make proper choices to achieve their goals.

- Activities that motivate participants to reflect on their own experiences and ideas are designed to lead each individual to evaluate and question his or her everyday practices and beliefs.

Phase l: Community Mobilisation

The Team (group of people facilitating the process) meets with the Chairperson LC I of each village, creates an understanding with him/her by reminding him/her about its work with gender, HIV/AIDS, human rights and other interventions. The Team then introduces the project, i.e., Village Reflection and Dialogue on Gender and HIV/AIDS and its objectives. If the Chairperson accepts to work with the team and pledges to mobilize other partners and the community as a whole, he/she declares that he/she is willing to participate given that HIV/AIDS is a grave problem in his/her community. However, people do lack knowledge and information about the disease, the HIV/AIDS counselling services are far from them, though, they have a health centre and any other issues that he/she feels are of concern in his/her village. He/she promises to talk to Local Council members who in turn will go out to mobilize others.

The Team, then, begins to work with partners identified earlier, i.e., the Traditional Birth Attendants, Religious Leaders, Local Leaders, School Teachers, Drama Groups, Members of Community Based Organisations and Community Health Workers. Invitations to partners are done by radio announcements, invitation letters, and visiting them at their homes.

The team meets with the above to:

- Explain the overall objectives of the project
- Explain the role of the identified partners.
- Determine what other activities regarding Gender and HIV/AIDS are going on in the communities (villages). This is done by discussing the following questions:

1. Do we have any activities on Gender and HIV/AIDS going on in your communities?
2. If yes, what are the challenges experienced in carrying out those activities?
3. If no, why are they not there?
4. Do we have any Community Based and Non Governmental Organisations carrying out activities on Gender and HIV/AIDS?
5. What have we done and what do you think we can do differently in this project.

There is a possibility that the community may not agree to work with the project team. If this happens it requires going back to the drawing board to establish the reasons for the community's refusal. However, there should be no difficulty if all the principles that should be followed for community entry are adhered to. Do not force the community to partner with you in case it maintains that it does not want to work with you. Seek partnership with neighbouring communities and if the project becomes successfully either this community will demand that you come back and partner with it or it will adopt the changes introduced in the neighbouring communities.

Information Gap Assessment

It is essential to carry out an information gap assessment before community action planning because it is the basis for capacity building for the identified partners.

Conducting an initial assessment on the information gap and willingness to work with the team is achieved through a series of interactions or conversations that identify key issues:

(1) To what extent does this community have the skills, knowledge and abilities to implement a plan to address the issues of gender and HIV/AIDS?

0 –Not at all: participants do not have the skills, knowledge and abilities and cannot implement the plan.

1 – Somehow: community members have some skills, knowledge and abilities but can not use them collectively to solve the problem.

2 – Pretty well: members have the skills, knowledge and abilities, and the community can implement the plan.

3 – Very well: members have all the skills, knowledge and abilities and the community can implement the plan.

(2) Does your community feel more, the some how or less confident than you did a few years ago in tackling the problem of gender and HIV/AIDS?

0 – Less confident

1 – Some how confident

2 – More confident.

(3) Have you had any training on Gender and HIV/AIDS? (1) Yes (2) No

(4) (a) If yes, what did you learn?

(b) If No, why?

Introduce the concept of dialogue and reflection to the communities and also help villages organise their discussions on Gender and HIV/AIDS. Leaders organise discussions with various communities on reproductive rights, gender equality and HIV/AIDS. In the conversation, these are some of the questions that should be added:

- What is the situation with regard to HIV/AIDS in our homes/ families/communities?
- Is there any relation between Gender and HIV/AIDS?
- How are you tackling the issues of gender inequality in your communities?
- Do you think we can change your approach towards issues of Gender and HIV/AIDS?

- How often do you meet to discuss issues of Gender and HIV/AIDS?
- During our discussions, do we discuss the issue of human rights in relation to Gender and HIV/AIDS?
- How do men and women's role contribute to enhancing the spread of HIV/AIDS in the community? For example, what happens in our community when one deliberately infects another with HIV/AIDS?
- Do men and women discuss issues of sexuality freely?
- What happens when women are not in position to discuss matters of sexuality freely?
- What kind of community do we want?
- How can we all participate in creating this community?

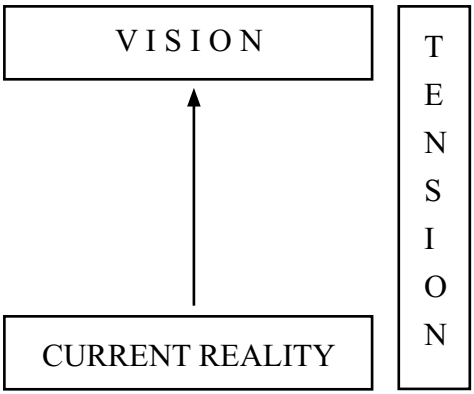
The Team also works with various groups of the identified partners independently and later organises general meetings in participating villages where all members of the community, i.e., the youth, women and men, and community leaders are invited to attend. These meetings describe the Gender and HIV/AIDS Reflection and Dialogue programme to all community members and present a plan for discussion.

Phase 2: Community Action Planning

This is the entry point to community workshops. It may take 2-3 days. People are guided to recognise the kind of society they want, articulate where they want to be, and look at their current situation. They start to see the community they are in and their aspiration of the community they want to be. The community they want to be is defined by many elements and health, in most cases, is looked at as a strategic condition.

Participants are divided into focus groups and helped to analyse their current situation, the vision they hold for their communities and what actionable steps they should take to achieve their aspirations. This is done in three days as follows:

- **Day 1**: Visioning (see illustration below)-helps participants to describe their current situation and the vision they hold.
- **Day 2**: Participants are facilitated to appreciate the relationship between their vision and current reality.
- **Day 3**: After participants have known the relationship between their current reality and vision they are then facilitated to come up with actionable steps towards their vision



The creative/visionary approach encourages people to begin at the end result they truly want as a first step. The facilitator, then, explains to the participants that when one describes clearly his/her compelling mental picture of the future and analyses his/her current situation he/she creates a structure that results into a force. This force is called structural tension. Tension seeks resolution and therefore the need to have actionable steps towards the articulated vision.

Phase 3: Capacity Building

At this stage, facilitators deal with knowledge and consciousness, community perceptions, fear and truth.

After the community members have committed themselves to work with the Team, the Team then organises capacity building workshops. The workshops are meant to help members increase awareness of the risk of HIV infection among young women, increase willingness to discuss and consider preventive measures of HIV infection such as sex education and use of condoms. They also aim at increasing awareness and participation in the prevention of mother to child transmission of HIV and also increase advocacy by community leaders and youth role models for change in attitude and sexual behaviour which is responsible for the transmission of HIV/AIDS.

The youth, women, men and community leaders are invited to attend and participate through discussion groups based on age and gender and other social categories, for example, married or not married and the elected members of the community. Through these discussions, the women, youth and other individuals who are normally excluded from community decision making are given chance to have direct say on critical issues and each group gives its feedback based on gender and HIV/AIDS related concerns.

The facilitator acknowledges participation of participants and summarises all the issues that came out of the discussions. Some of the identified issues in the workshops should be taken up to high levels for advocacy or lobbying for services that are required to handle the challenges, for example, voluntary counselling and testing services at nearby health centres.

SECTION 1 - CAPACITY BUILDING: HIV/AIDS

Objectives

- Participants have information about HIV/AIDS and whether there is a cure for AIDS.
- Participants have knowledge, skills and information on how HIV/AIDS is spread, its signs and symptoms and ways of preventing its spread.
- Participants have knowledge on the effects of HIV/AIDS in our homes, villages and community and how people can live positively with it.
- Participants know the different effects of HIV/AIDS for men and women and share their experiences
- Participants have knowledge and information on HIV/AIDS, VCT and PMCT and where to get these services.

These objectives are derived from the expectations of the participants. In one of the villages that the study team partnered with the following were the expectations. The expectations are given as an example and therefore do not be confused that results are being presented again.

- Where to go for testing HIV/AIDS?
- How to prevent myself from contracting HIV?
- How to use a condom and how to choose the right type of condom?
- How to live with an infected person?
- What a person with HIV/AIDS eats, does and does not do?
- How can I know if I have HIV/AIDS?

Participants are divided into focus groups basing on age, sex, married or not married to discuss the effects of HIV/AIDS in their homes, villages and communities and give possible solutions. Table 11 shows how it was done in one of the villages the study team visited and this also should not be confused as presenting results but should be taken as an example.

Table 11: Effects of HIV/AIDS in Homes, Villages and Communities and Possible Solutions

Category	Effects	Possible Solutions
Married men	• Increasing divorce • Poverty • Girls are not in for marriage for fear of contracting HIV/AIDS • Men involve young girls into early marriages thinking that the girls are free from HIV/AIDS • Children do not go to school after their parents have died	• People should be educated about HIV/AIDS • People should go for blood tests • People should welcome orphans and look after them • Educate people on the condom use
Married women	• Orphans are not well looked after • Women are denied the right to sex • Men do not want to stay with their wives after realising they are HIV positive • Women do not decide on how, where and when to have sex • Some men do not give medical care to the women	• There should be dialogue in the homes • Accept and care for each other • After testing for HIV and whatever the results insist on safe sex and join post-testing counselling clubs.
The youth	• Education is affected • No love in the family • Child school drop outs • Orphans are left suffering • Children are left unhappy • Bad feeding • Causes early marriages • Children may grow up badly behaved	• Free education from government • We should fight against stigma and discrimination • Train people in vocational skills • Teach people to have balanced diet • Go for HIV testing • Talk to children above 18 years for behaviour change or protective measures.

Once the groups have discussed and shared, then, the facilitator uses the following notes to react or supplement to the participants' responses.

What is AIDS?

AIDS is a condition called Acquired Immune Deficiency Syndrome (AIDS). AIDS makes peoples' bodies unable to fight against other diseases. People without AIDS are better able to recover from other diseases by resting and with medicines. AIDS takes that ability away from people. Anyone can get AIDS. AIDS is not caused by poverty (although the spread of the disease is made worse because of poverty). AIDS is not a punishment from God: it is a disease. AIDS is deadly and it is an ongoing constant condition like heart disease that ends in death. AIDS is infectious and can be spread from one person to another.

Is there a Cure for AIDS?

- There is no known cure for AIDS
- Traditional healers do not have a cure for AIDS
- There are no drugs in the "West" that can cure AIDS
- Having sex with a virgin does not cure AIDS
- Any myth that claims to cure AIDS is untrue

This list is not exhaustive of all the facts about the answers to the question "is there a cure for AIDS?"

What causes AIDS?

AIDS is caused by a virus called Human Immune Deficiency Virus (HIV) which stays in the blood and other fluids in the body of an infected person. Examples of other diseases caused by viruses are polio and meningitis. You cannot see (detect) HIV unless you have special medical equipment.

Where did AIDS come from?

No one knows where AIDS came from. Sometimes people blame other people or animals for 'starting' or causing AIDS. These accusations have not been scientifically validated.

How do people get HIV/AIDS?

There are a number of ways through which people can contract HIV. However scientific evidence shows that HIV is almost always spread

through unsafe sex, that is, sexual contact without the protection of a condom, with a man or woman who is already infected with HIV. 9 out of 10 people with HIV got the virus through unsafe sex. Unsafe sex includes virginal, anal and oral sex without the use of a condom.

HIV is also spread in two other ways

1. HIV can be spread through **contact with blood** of an infected person. Examples include spread through **blood transfusion** of infected blood. This is a very rare way of getting AIDS because blood can now be tested for safety. Being **cut with a knife or any other sharp object** that has cut another person who is infected with HIV. Any knife or sharp object that will be used on more than one person must be washed thoroughly with soap and water and dried completely after each time it is used. Sharp objects include **shaving razors**: if a person gets even a small cut while using a razor and it is used on another person he could also get a small cut. The spread of HIV through **infected knives** includes any traditional practice that involves cutting any part of the body causing any bleeding and then using the same knife on more than one person. Examples of these **traditional practices** are tattooing and circumcision. Being **injected with a needle** that was used to inject an infected person. Sharing infected needles is the main reason that drug users are frequently infected. Touching **blood from a cut of an infected person** if you have a cut or even a small scrape on your hands.

   People, like medical staff, who are likely to be touching wounds or cuts on other people should always wear latex (rubber) gloves to make sure that the other person's blood does not touch their hands. A person could have a small cut or scrape on their hands and not even know it.

   People with other sexually transmitted diseases (STDs), such as gonorrhoea and genital herpes are even more vulnerable to HIV because of symptoms such as open sores and wounds that can lead to transmission of the virus.

2. HIV can be spread from mother to child through childbirth and/or breast-feeding, when the mother is infected. If a woman has HIV

when giving birth or breast-feeding the baby may or may not be infected with HIV. 25% to 40% of babies born to HIV positive mothers in Africa are infected with HIV.

HIV is not spread in any of the following ways:

- HIV is not spread by drinking from the same glass or sharing the same plate of food with a person who is infected with HIV/AIDS.
- HIV is not spread by being near or living with a person who has HIV/AIDS, or even sleeping in the same bed.
- HIV is not spread by sharing a bathroom with a person who is infected with HIV/AIDS.
- HIV is not spread through the tears or saliva of a person who is infected with HIV/AIDS. AIDS cannot, therefore, be spread by a person who has the virus when he coughs or cries near someone.
- HIV is not spread by shaking hands with a person who is infected with HIV/AIDS.
- HIV is not spread by kissing persons who have HIV/AIDS or by hugging them.
- HIV is not spread by the sweat of a person who has HIV/AIDS and therefore working together and playing sports with people who are infected is not dangerous.
- HIV is not spread by mosquito bites.

Can I tell if I or someone else has HIV?

There is no way by looking at someone if one is infected with HIV. People with HIV look healthy for a period of time before they start to get "sick". Even if a person looks and feels healthy it does not mean that they do not have HIV. After a period of time, when a person starts to get sick, a person with HIV will start to show the following signs: continual weight loss and stomach problems, fevers and/or coughing that keeps coming back.

Remember that AIDS makes people **less able to fight against normal diseases** that healthy people are more able to fight. Therefore, when people with HIV get sick they have the same symptoms as anyone else with the same "ordinary" disease. However, they get sick more frequently and take longer to get better.

The only way to know if you are infected with HIV is to have **a blood test**. Testing for HIV/AIDS using eyes or depending on one's history does not work.

What can I do If I am already infected with HIV?

- People with HIV can live many years with good nutrition and access to primary health care.
- All across Uganda, people are leading rich and productive lives with HIV.
- There is no cure for HIV, but there are treatments available which cure the sicknesses associated with HIV, such as diarrhoea, coughs, fevers and other infections.
- Many communities have groups of people that travel to homes giving basic health care and food to people who have become sick from HIV.
- There are also medicines called anti-retroviral drugs that allow people to live for many years with HIV. Although prices are decreasing these medications are still very expensive.
- If you have HIV, it is critical to inform your most recent partners and use a condom each and every time there is sexual contact.
- People living with HIV/AIDS in Uganda have been at the forefront of stopping the spread of the disease and speaking out for the rights of people living with HIV/AIDS.

Many people, in our villages, especially young people, also travel to other areas in Uganda for work: ask participants to name places, villages, counties and towns they know of that people travel to for work. Then, point out these villages, counties and towns whether they have higher, lower or the same infections rate as your own.

The effects of AIDS on our society in Uganda

Effects of HIV/AIDS are dimensional, some are social, economic, cultural and physical and mental and are represented at family, community and the national levels.

- AIDS causes the death of many people, mostly between 20 to 45 years old.
- People between 20 to 45 years old are in the prime of their lives. This is usually the time when a person contributes most to their community by earning money, growing food, taking care of children and old people and carrying on the culture of a community including the history, music and traditions of the people.
- Losing so many of these people means that the economy of every village and the whole country suffers
- Every person who dies of AIDS represents a loss to the family, the village and the country
- Less food is grown and less money is earned
- Children are orphaned, and create a burden on their extended family
- Old people lose the children that they expected to take care of them when they are no longer able to take care of themselves
- When so many people are sick with AIDS, other healthier people must take care of them. Healthier people are therefore also unable to earn as much money, grow as much food, or carry on all the traditions important to culture.

Are Men and Women, Girls and Boys equally affected by AIDS?

In Africa, more women have HIV/AIDS than men. Out of 100 people with HIV/AIDS in Africa, 55 of them are women. Women and girls are more likely than men to be infected with HIV during a single act of unprotected sex. Because women's sexual organs are more fragile than men's women are infected more easily if they have sex with a man who has HIV. For young people, girls are infected with HIV more frequently than boys of their age. This is because girls frequently marry or have relationships with older men who have more sexual experience and are therefore more likely to be infected with HIV.

In many countries, for every one teenage boy who has HIV/AIDS, there are more than five teenage girls who are infected. Men are polygamous and therefore women are more vulnerable to HIV/AIDS. Because men are more likely to have multiple sexual partners than women, persuading 10 men with

several partners to engage in safe sex has far greater impact than enabling a thousand women to protect themselves from their only partner. Therefore, it is very important to educate men of the risks of AIDS and to make sure that they have access to condoms and practice safe sex every time.

Can AIDS be prevented? If so how?

YES! AIDS is 100% preventable through the following ways:

- **Abstinence** is the only way to protect oneself (100%) from being infected but taking into account other modes of transmission such as blood transfusion and usage of contaminated sharp instruments is equally important.
- **Be faithful** with one's sexual partner. Even if the relationship is currently monogamous, one person could have been infected from a previous relationship without knowing it, and without showing any signs of sickness. The only way to know your HIV status is to get a blood test.
- **Using latex (rubber) condoms** correctly and consistently during every sexual act is another most effective way to protect yourself and your partner.
- **Develop consciousness** for positive healthy living. Instead of one's life being ruled by don'ts one creates the end result (good health) one truly cherishes. It is this end result that motivates one's actions towards living a good healthy life, including avoiding contracting HIV/AIDS as one of the actionable steps.

The facilitator should talk about the most effective and practical way to protect people against AIDS, particularly those who are or will become sexually active. This most effective and practical way to protect people from AIDS is by using condoms correctly every time they have sexual contact.

- In the workshop room, post the demonstration picture cards on a visible place on the wall showing the steps that should be followed when putting on a condom.
- If the attendees are literate, pass out the papers with one of the eight steps written on each or the facilitator should ask the participants to read each card aloud.

- Pass around wooden sticks and condoms to each pair.
- The facilitator should demonstrate the eight steps of using a male condom while asking for advice from the participants.
- Have each pair demonstrate to one another how to put on the condom correctly based on the previously identified steps.
- Ask participants to come back and ask for people to volunteer to discuss any difficulties that they had.

The facilitator emphasises to everyone in the workshop that the above steps must be done every time someone has sex and that there should not be any sexual contact before the man puts on the condom. Also to emphasise is that women should initiate putting condoms on their partners.

The facilitator should handle the discussion on the female condom and bring some samples so that people can see what they look like.

Where available, the female condom is an important option to assist women in protecting themselves and their partners from HIV, unwanted pregnancy and other sexually transmitted infections.

The female condom is a strong, soft, and transparent piece of special plastic. It is designed to fit the inside of the vagina.

The female condom is inserted in the vagina before vaginal sex and provides protection against HIV, pregnancy and other sexually transmitted infections. The inner ring of the female condom is used to insert the condom and helps to keep it in place. The inner ring slides into place behind the pubic bone inside a woman. The outer ring is soft and remains on the outside of the vagina during vaginal sex. This ring covers the area around the opening of the vagina. The female condom forms a barrier between the penis and the vagina. Benefits of the female condom include:

- The female condom is a method that gives women some control over protecting themselves against HIV, unwanted pregnancy and other sexually transmitted infections.
- It is stronger than a male latex condom.
- The female condom does not have to be removed immediately after ejaculation.
- The female condom has no known side effects or risks.

SECTION 2 - CAPACITY BUILDING: GENDER AND HIV/AIDS

Objectives

- Understand gender roles and the difference between sex and gender.
- List some of the gender roles expected of men and women in their communities.
- Recognise that society expects certain behaviours and roles from men and women, some of which are harmful.
- Understand that certain social norms and expectations leave women and men unable to protect themselves against HIV/AIDS

Gender roles that put women and men at risk

Reminding ourselves about the previous sessions we note:

- What we learned in the previous sessions that HIV/AIDS is primarily spread because people have unsafe sex.
- However, given all these facts and knowing the dangers involved people continue to have unsafe sex.
- We now need to confront why this is the case.

Why do people have unsafe Sex?

- People lack correct information on HIV/AIDS
- People refuse to believe the reality of AIDS
- People may lack information on HIV/AIDS prevention and protection.
- People lack the resources, such as condoms, to protect themselves
- People may think that “it can not happen to me”
- People, especially women, may engage in risky sexual behaviour because of hunger or poverty (commercial sex work)

If the facilitator finds a lot of cultural issues arising from the discussions let him/her take time to discuss culture and HIV/AIDS and determine the way for a healthy and prosperous life. In summary, people have unsafe sex for one of the three main reasons.

- They do not know the consequences or do not take responsibility for the consequences of their behaviour.
- They do not have the resources to protect themselves.
- They do not have the power to determine where, when, how and at times even with whom to have sex.

Gender roles versus Biological Sex

Fundamentally, once there is awareness about how to protect oneself and once condoms are available, the reason that HIV/AIDS continues to be spread in almost every area of Africa is because of the way women and men relate to one another. We have all grown up thinking about women and men in certain ways. Society has assigned specific roles for men and women.

The participants are given an exercise to better understand how we relate to one another as women and men and how a person's gender roles are different from his or her biological sex. In one of the villages the study team visited the participants were asked to say the first words or phrases that come to their minds when the word WOMAN is said. Their responses include the following words or phrases: pregnancy, serving others, fetching water, producing an egg, chopping firewood, cooking, raising children, love, powerless, helpless, strong, beautiful, caring for the sick, active in church, vagina, strength, teacher, nurse, and breast-feeding. When the same exercise was repeated for the word MAN the responses were: leadership, decision-making, education, authority, money, work, power, sperm, intelligence, penis, violence, sports, politics, family decisions, driving vehicle, active in religion, and strength.

By looking at the list of words and phrases given in the exercise the facilitator asks the participants to choose words or phrases which show whether they are social norms or not. If they are social norms, give examples that the participants came up with and ask if these words can apply to both men and women. Point out that there is no strong reason why social norms must not apply to both men and women. Physically, both men and women can do all of them.

Defining "Sex"

- As we have discussed some traits of men and women are biological: the ones that are part of our nature such as women being pregnant.
- Other traits we mentioned such as leadership, decision-making, driving a vehicle, active in religion, etc, are not biological in nature but rather have been taught by society.
- Sex is whether you are male or a female. It is the biological fact of being born a boy or a girl.

A person's SEX refers to "physical traits that identify someone as male or female such as male and female reproductive organs."

Defining "Gender"

Participants are led through the process of defining gender by asking them these questions: what does the term "gender" mean? What made you place certain words under MAN and other words under WOMAN?

Participants are, then, assisted to mention the roles of a person based on what society or culture expects from him/her based on whether one is a man or a woman.

The ideas generated by participants in one of the villages that we partnered with are presented below. Do not confuse these ideas as the presentation of results but they are presented as an example.

- Unlike sex, gender is determined by culture: it is how the community wants you to behave and think based on whether you are a man or a woman.
- As we have seen, every society has certain ideas and expectations concerning women and men and how women and men should behave in various situations. These ideas and expectations are learned from families, friends, leaders, religious and cultural institutions, school, the media, etc.
- Because of roles and behaviours that we are taught, women and men may experience different inequalities (based also on age, class, ethnicity, race, and religion).

- Both women and men have accepted and reinforced these gender roles and stereotypes.

These shared ideas about how men and women should behave and interact with each other influence people's ability to protect themselves against HIV/AIDS.

Some harmful roles expected of men and women create an environment in which women lack the power to make sexual decisions that are safe and men lack responsibility for the consequences of their sexual behaviour. When these two are put together the ingredients for an epidemic that threatens the future of the village, the country and the continent are created.

How do Women's Gender Roles put them at Risk?

The participants are asked to give some examples how men and women reinforce gender roles that put them at risk of being infected with HIV/AIDS. In order to do this we need to examine why women lack power to negotiate for one of the most intimate acts: why, when and with whom to have sex. Why do they lack control over their own bodies? The reasons why this happens are presented below:

- Women have been taught for generations to be subservient and dependent.
- A woman's father or husband or brother usually makes major decisions in her life
- Women are taught by society that they are not permitted to refuse sex from their husbands.
- If a woman says no to sex, she may be threatened with violence by her boyfriend or husband.
- Women are dependent on men economically and socially, as men are the heads of the family and control land, money and other resources.
- Women frequently cannot choose whom they marry because their male parents decide for them.
- Women frequently cannot choose the age at which they marry because their male parents decide for them when to marry.

- As sex is considered taboo, women lack access to information on sex.
- As a result of poverty, women may be forced to trade sex for money, food or favours. Even in marriage, women may not determine when and how to have sex because they are economically dependent on their spouses.

How do men's gender roles put them at risk?

We also need to understand why men lack responsibility for the consequences of their (sexual) behaviour. Why do men engage in risky sexual behaviour?

- Men are expected to make all decisions relating to sex.
- Men frequently view women as objects to fulfil their sexual desires, instead of being individuals with their own needs and desires.
- Men are expected to be experienced and knowledgeable about sex.
- Society allows men to beat their wives or girlfriends if they disobey.

All of these attitudes and expected roles for men and women are not God-given. They were assigned by societies many years ago and are no longer useful for the development of the nation and its people

Impact of Gender Equality on Society

We have just discussed some of society's harmful roles and expectations for men and women that contribute to the spread of AIDS. We also know that the AIDS epidemic is a symptom of gender inequality in society. We are now going to talk about gender equality. Gender equality means that women are valued as much as men and are able to achieve equivalent levels of education, health and nutrition, income, access to land and agricultural inputs and decision-making roles in the public life of their village, their district and their country.

Let us look at how a village can improve once we achieve greater gender equality. The impact of gender equality on society is discussed below:

- When power relations between men and women are more equal, the health of a village not only improves but there is also more economic growth, more children in school, more food produced and better democratic governance. For example, when women are **more educated**: they are more likely to survive pregnancy and childbirth than their less educated sisters and the chance that their children attend to school increases.
- Fewer people get HIV/AIDS because there is more respect for each other.
- When women have better health and nutrition: their children are healthier, and their family's income increases.
- When women earn **more income**: they are more likely than men to spend their money on the health and education of their children and their family's income and standard of living increases.
- When women have access to land and agricultural inputs: their family has more food, their children are healthier and more likely to attend school and the community's agricultural production increases.
- When women play a **greater role in public life**: they take a stand for issues critical to village life, such as better nutrition, health, sanitation, safe drinking water and education and there is less corruption in government.

Overall, when women have more basic rights, including having education, better health, and greater opportunities for employment, a country's overall standard of living and well being increases for everybody. Furthermore, literate women are more likely to know how to protect themselves, have access to resources and be more empowered to negotiate safe sex.

SECTION 3 - CAPACITY BUILDING: HUMAN RIGHTS

We now know that AIDS is a deadly disease, which has no cure but it can be prevented. It is primarily spread by unsafe sex. Unsafe sex happens mainly because women lack the power to say "no" and men lack the responsibility to practice safe sex. This is because of gender inequality: unfair and harmful gender roles we have adopted from society.

Redefining what it means to be a Woman

Earlier, we saw that society defines women to be subservient, passive, dependent and obedient within their family and to their husbands. Participants are then asked how they want to define a woman such that people are protected against the spread of HIV/AIDS. In one of the villages as a form of example participants responded that a woman should be redefined to assume the following traits: strong, independent minded, economically self–reliant, and educated. Other traits are: speaking out on important issues: women's rights, family well–being and harmful practices, responsible for making own decisions in society, willing to stand up for own rights and the rights of her fellow women and committed to refuse unsafe sex.

Redefining what it means to be a Man

Similarly, if men are to become responsible for stopping the spread of HIV/AIDS in their community what new roles do they need to have?

- See women – including my sister, my mother, my daughter, my wife – equal human beings, with the same rights as men.
- Stop seeing women as "property"
- No longer giving "commands" to women – be willing to share decision making
- Committed to respect the equality of women
- Committed to abstain from unsafe sex
- Willing to share household responsibilities with female family members

Who are we as human beings?

It is now time for us to have a new understanding of who we are as human beings. We need to rethink who we are. We need to change ourselves if we are going to reach where we want to go. In addition, these changes we are proposing are stated in some of the laws of Uganda. In the Uganda Constitution (1995), women are given equal rights with men. These rights include the rights:

- To life, liberty and the security of person
- To equality and dignity
- To information, health, and the opportunity to work
- To education and to participate in the cultural life of the community
- To own property, to peaceful assembly and association
- To choose who and when to marry and to equal rights during marriage and divorce
- To equal protection of the law and access to courts
- To freedom of thought, conscience and religion
- To take part in government and equal access to public services
- To rest and leisure

To be a human being means to be committed to our own human rights and to the human rights of all.

Phase 4 OF CAPACITY BUILDING: COMMITMENT AND ACTION

The purpose of this section is to call forth commitment and responsibility from every person in the workshop and to discover the power of their own commitment in stopping the spread of HIV/AIDS. After achieving commitment, you will then lead the participants to create a concrete "plan of action." We now know that stopping the spread of AIDS and achieving better education, health and standard of living we need to create new ways to relate to one another as women and men based on equality and human rights. This knowledge alone, however, will not stop AIDS. We must commit ourselves to take action that matches this understanding.

Declaration of Commitment of the Participants

Because HIV/AIDS or the threat of HIV/AIDS is one of the greatest challenges that is confronting society it requires everyone to declare what he/she personally and individually is going to do. Participants are invited to declare three of their own personal commitments to stop the spread of HIV/AIDS and to create new ways of relating to one another as men and women. As each person speaks, his/her commitments are written on the board or flip chart. The responses of the participants in all the villages the study team visited fell under the following four broad commitments.

- I promise to take action to stop the spread of HIV/AIDS.
- I promise to oppose any unsafe sexual practices.
- I promise to respect and defend the rights of every woman and treat her as an equal and independent human being.
- I promise to change the harmful attitudes and behaviours of men and women, including myself, that threaten our health, and hold us back from creating a better future.

The Declaration of Commitment based on the participants' discussion above is written and read to the participants. They are then asked to repeat it.

Program of Action for Workshop Participants for the next 9 months

Now that the participants are committed they are made to plan the actions they will take in the next 9 months. The participants are asked what are some ideas of next steps they need to take. This question is asked primarily

to stimulate participation. All ideas should be heard and acknowledged. However, the facilitator should fully develop the following points and any other ideas where consensus has been built:

How can women protect themselves against the consequences of demanding that condoms be used (i.e. against violence or rejection)?

Suggestion: Formation of Women's Support Groups so that women can stand up for each other and become their own advocates for equality.

How can men take responsibility to create a society of equality and support other men in being responsible for their behaviour?

Suggestion: Formation of Men's groups who bring their leadership to creating a society of equality and who will challenge men who are abusive of women, both verbally and physically.

These two suggestions demand that the questions presented below are adequately answered:

- How will these men and women's groups be set up? Who will be responsible? How many are to be established in the next 9months?
- How can we make it as safe and easy for women to get information? For men to get information?
- How should we teach our children about AIDS and safe sex? At what age should we begin? It should be noted that some people say that sex education encourages young people to have sex. This is, indeed, false. Instead, it enables the youth to delay having sex and to protect themselves when they do decide to have sex.
- What shall we do here? Who will be responsible? By when will this start?
- Are there any particular places you want to educate on priority basis, places where people are most likely to come into contact with AIDS? (i.e., army bases, community centres, markets, truck routes)
- What people and resources (such as traditional structures, religious and spiritual leaders, and local officials) do we already have in our community that we should partner with to stop the spread of AIDS?
- How should we reach out to the surrounding villages?

Structure for Reinforcing Behaviour Change

We have now created an action plan to transform the attitudes and behaviour that contribute to the spread of HIV/AIDS. We need to know that this problem will not disappear overnight. As we take these actions we put in place permanent structures in the community to strengthen people's resolve and reinforce the changes they intend to make. Below are the structures that are created and left behind to deal with all the issues related to gender and HIV/AIDS.

1) We have a Co-ordinating Committee on Village Reflection and Dialogue on Gender and HIV/AIDS in the area, which is responsible for ensuring that the health, education, livelihood and public safety of the community are taken care of. (Have the Committee members stand for recognition.) If you do not know where to go with a problem, you can turn to any of the member of the committee.
2) We have a Health Sub-Committee in the area that is totally committed to the health of the community and is responsible for ensuring that condoms and accurate information are always available. (Have the health committee members to stand up for recognition). Always consult the health committee in case of any information that is not clear to you on matters dealing with gender and HIV/AIDS.
3) We have a health clinic where both women and men can go privately and with confidence to get any questions answered and basic health treatment.
4) We now have women and men's groups. For example, if a woman suffers violence or other violations of her rights she can turn to these groups for moral support and providing advice on what steps to take.
5) We now have programmes in the schools so that youth can learn the facts and have where to turn to if they are pressured to have unsafe sex.
6) We have economic empowerment programmes for women in this area. When women are economically strong they have more voice and more respect.

CONCLUSION

The study has ably shown that the problem of HIV/AIDS cannot be treated in isolation. For its management it requires the inclusion of all the issues that relate to the creation of well being and healthy being of communities. Therefore, the people's capacities need to be developed so that they can take roles of community action planning. It was for this reason that the study team decided to develop the content for the facilitator's guide on Gender and HIV/AIDS to allow the development of people's capacities happen. The guide is an initiative that must be scaled up for use by many communities in Uganda that still grapple with the HIV/AIDS problem. Capacities of people will further be developed if we put in place structures that are totally committed to the health of the community. Facilitating the process of forming men and women's groups to which members can turn to in case they get problems related with gender and HIV/AIDS is another way of building people's capacities. In addition, designing school programmes that treat issues dealt with in the study in order to empower teachers and children. Finally, developing women's empowerment programmes that would enable them to be autonomous so that they can begin conversations with men on the possibility of creating an end result that they truly cherish.

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