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TO OUR READERS:
Global AIDSLink editorial pages are a forum for opinions and views on the many issues and controversies raised by HIV/AIDS challenges. We invite you to join in the discussion with short letters to the editor commenting on the articles you have read. What do you think about what you’ve read? What do you agree or disagree with? We also welcome op/ed pieces with a strong voice and/or new take on current HIV/AIDS-related issues; these run from 500-700 words and should be bold, well-researched and original.

International in scope, Global AIDSLink includes HIV/AIDS related conferences and other events as well as new publications and diverse forms of resources. Please send us those as well.

Thank you for your interest in Global AIDSLink.
Sara Ann Friedman, Managing Editor
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Cover Photo: Mike Wessells
Returning girl soldiers in Africa learn to sew, design, construct and develop other marketable skills as part of their rehabilitation and reintegration.

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Dr Margaret Chan of China will be the next Director-General of the World Health Organization (WHO). Dr Chan obtained her medical degree from the University of Western Ontario in Canada and has a degree in public health from the National University of Singapore. She joined the Hong Kong Department of Health in 1978, and was appointed as director of health in 1994 where she launched new services focusing on disease prevention and health promotion. She also introduced new initiatives to improve communicable disease surveillance and response, enhance training for public health professionals, and establish better local and international collaboration. Dr. Chan has effectively managed outbreaks of avian influenza and the world’s first outbreak of severe acute respiratory syndrome (SARS).

The Christian Children’s Fund (CCF) announced the appointment of Anne Lynan Goddard to serve as its eighth president. Goddard brings more than 27 years of development experience to CCF and has worked in international development in five countries – Kenya, Egypt, Indonesia, Bangladesh and Somalia – over an 18-year period.

Ian Askew has been promoted to director of the Population Council’s Frontiers in Reproductive Health Program (FRONTIERS). Askew has more than two decades of experience in reproductive health operations research in some of the world’s poorest settings. Over the past 16 years, he has lived and worked throughout Africa and has conducted studies and provided training in Asia and Latin America. Askew will continue to serve as head of the Population Council office in Nairobi.

Population Services International (PSI) has named Ambassador Karl Hofmann as its new president and CEO, succeeding Richard A. Frank, who retired in August. Hofmann will take office in February 2007 and comes to PSI from a 23-year career at the highest levels of the State Department. He served both Secretaries of State Colin Powell and Condoleezza Rice as executive secretary of the State Department and is currently deputy chief of mission, the senior career diplomat, at the U.S. Embassy in Paris.

President Bill Clinton announced that his foundation has negotiated deeply reduced prices for 19 AIDS drugs to treat children, halving the cost of a treatment that uses three drugs combined into a single pill to less than $60 a year for each child. France, Brazil, Britain, Norway and Chile are putting up $35 million to buy antiretroviral drugs and diagnostic tests to treat 100,000 more children in 40 nations next year. Most of the money was raised through taxes on airline tickets, a revenue source designed to ensure the lifelong treatment of children with AIDS.

PATH has been awarded $6 million from the Bill & Melinda Gates Foundation to expand its Ultra Rice technology program. In addition to increasing the demand for and supply of Ultra Rice in Colombia, Brazil, India and China, the project will transfer the Ultra Rice technology and contribute to global efforts to reduce micronutrient malnutrition.

Interchurch Medical Assistance, Inc. (IMA) has been named as the lead agency for a three-year $40 million program designed to deliver basic health-care services and rebuild the health system in the Democratic Republic of the Congo providing an estimated 8 million adults and children with access to improved health care through the program known as Project AXxes. Project AXxes is funded by the U.S. Agency for International Development (USAID).

Population Services International (PSI) has been selected as a winner in the 4th Annual Fast Company/Monitor Group Social Capitalist Awards. Fast Company, a magazine that highlights best practices in the changing business world, and Monitor Group, a global consulting firm, selected PSI and 42 other organizations from 133 competitors. The program honors nonprofits, or “social entrepreneurs,” who combine creativity and ingenuity with business solutions to address social ills, ranging from poor health care in developing nations to unequal education access, homelessness, unemployment and substance abuse in the United States.

On Nov. 2, 2006, the Baylor–Abbott Fund Children’s Clinical Centre of Excellence-Malawi was opened in Lilongwe. The Center is the first outpatient clinic dedicated to the care and treatment of children living with HIV in Malawi, a country where an estimated 83,000 children (age 0-15) are living with HIV/AIDS. The $2.2 million clinic was funded by the Abbott Fund as part of a greater $100 million commitment to HIV/AIDS programs in the developing world. By the end of 2006, the projection is that 1,300 children will be treated at the new center.
SECRET INGREDIENT TO HIV PREVENTION

Use Kids

By Goldmark Onwolu-Adodo
Executive Director
Live Alive Foundation

Inability to get kids involved is one of the major reasons HIV/AIDS continues to spread like a wild fire. Imagine the disease that started killing men when it was first discovered 25 years ago is now killing people from 25 years downward. If the people concerned had gotten children involved in awareness and education on time, my generation would not even know about HIV/AIDS.

I got to know about HIV/AIDS at the age of four. I knew that I could play with many objects and nobody would talk, but when I picked a blade or needle, the noise that always followed was like that of thunder because my mother or aunties would shout: “AIDS.”

Though nobody in my family is HIV/AIDS positive, in the course of following my mother, who is a journalist and HIV/AIDS educator, to assignments, I developed the interest to start my own NGO. I can still recollect holding small placards and standing in front of large people during rallies.

But when I told my mother the idea, she kicked against me. She believed that you must have a relation at the high level for the Nigerian government to fund your program. She also believed that I was too young to start adult-led work, but when she saw how I touched the lives of people, it persuaded her to let me be.

I started my foundation in 2003, when I was eight, and I saw how people (both kids and adults) received me. They are used to seeing old faces, but for a kid to come out doing what adults are doing is not common. One day at the Nigeria Network of NGOs meeting in Lagos, the usher refused to give me program leaflets. I told her that I was not there to accompany my mother, but came as a member of NNNGO, as well as the executive director and founder of Live Alive Foundation. I don’t really blame the usher. She is not used to see kids at such meetings.

I am in Junior Secondary School 2 (JSS2) and I don’t allow HIV/AIDS awareness to clash with my studies. I use the opportunity to do my homework at school. Most weekends are used for awareness. It is not an everyday affair. I create awareness at any given opportunity. It could be at a party, bus stops, markets, etc.

Goldmark sets out with her megaphone, music, leaflets and stickers.

At bus stops, I raise my megaphone to alert people. There is a musical interlude from my CD player or a siren sound from the megaphone. It always draws people’s attention. I also give out flyers and stickers which Live Alive FOUNDATION is printed on. I then move to speak on HIV/AIDS. At times, I talk on girl-child education and child poverty. If my brothers are not dancing, they will be issuing leaflets to people.

I don’t go into classrooms directly, but I talk to students during break times, in front of the schools when they are about to go home. Many teachers are aware of what I am doing and they are also telling the pupils. Even in my brothers’ school, they have spread the message.

I use my open discussions and bus stop shows to educate everyone, and the issue of girls is on my mind. Poverty to me is the sister to HIV/AIDS. Some people employ girls of 6-12 years as housemaids and treat them like slaves while they pet their own children. It is common to see a girl-child of six years hawking oranges, and the family will depend on whatever she sells.

These girls are either abducted or raped. Here in Nigeria, the law of rape is not strong and rapists get away quickly. Most parents are either too poor to charge them in court or they keep silent because they are afraid. A man of 40 years raped eight girls between five and 11 years old. Whenever they go to him to buy “pure water” (iced water in nylon), he always raped them until he was caught and paraded on television. He blamed the act on the devil.

Per the issue of girl brides, though it is not common in my tribe, (Yoruba, South-West), the northern part of Nigeria is full of girls getting married as early as eight years. And the major problem is that they are forced into early marriages to men not just old enough to be their grandfathers, but men who have more than five or six wives. Most of these men could be HIV positive but the customs and tradition forbids the wives from telling them (the husbands) to go for HIV tests. The government is not helping matters, as it promises free education but never spread it to books and uniforms. Could you believe that many girls go to schools on empty stomachs?

Goldmark’s brothers Adewale, seven years old, and Victor, who turned five in April, are her major staff and part of her volunteer corps.
Some Very Good Ways to Prevent AIDS
There are many ways to prevent HIV/AIDS.

- First of all, educate people in local languages. (When I go to the market, I will first speak English for all to hear. Then when I move closer to them, one on one, I change to the local language.)

- Create awareness using song and drums. Music is like a spirit. Make use of kids. When I mount the stage to talk, people will be attracted by the songs, they will say “what has this child got to say? Let me wait for five minutes.” At the end, they not only spend two hours, they become my volunteers and come for counseling, as well.

- Another way to prevent HIV/AIDS is by going to the most affected places to preach about it. In my city, there is a popular market noted for foodstuffs. Women leave their husbands at home and go to sleep with the sellers of the foodstuffs to get cheaper or free items. I’ve gone there four times. And with the help of some adults, things are changing. Make use of adults through the help of kids.

- Most dentists don’t sterilize their equipment and many nurses are dirty. I have told people loudly about this on a radio program where I was a guest. And the state government is looking into it.

- The issue of parents not discussing HIV/AIDS or sex education should be discouraged. Our leaders should focus on training girls, who will become mothers of tomorrow.

- Never follow a group of boys or an elderly fellow to a corner. And if a man rapes you, tell your parents immediately so that action can be taken.

Personally, I have seen and learned many things, since I watched President Nelson Mandela and Kenneth Kaunda on TV, who wept over the loss of their children who died of AIDS. I know that the disease has no mercy for old age. If AIDS could kill rich people and children, how many more poor people can it kill? That day I was weeping and refused to eat. And because of this, I am working on how to use kings, artists, celebrities, etc. to educate people on my forthcoming TV show.

LIVE ALIVE FOUNDATION, my NGO, is founded to showcase the role of children in HIV/AIDS eradication. And I thank God that I am making an impact in people’s lives. Nigerians are now trooping out to work with me.

Many people who believe the girl-child is nothing compared to boys have openly told me that they are no longer regretting having a girl as a child. Others are ready to rejoice with their wives in case they give birth to girls. And this is unusual in Nigeria.

Funding – A Major Headache
Funding is my major headache. No help from anywhere since I started. I make use of recorded cassettes and a recorder at open shows. My two brothers are my major staff: Adewale, who was seven on Oct. 25, and Victor, who clocked five on April 4. Victor is a good dancer. Adewale is the engineer in charge of music. He also gives leaflets to people. Victor is always ready to go with me to bus stops. He can shout and dance well while Adewale cannot be forced or cajoled. He always follows or partakes when he feels like. He is now telling all that malaria kills faster than HIV/AIDS.

My brothers don’t ask for money or food at the end of the show. Many times, I helped my close relations to do household chores and they give me more than enough to do programs. My pocket money is used for weekend shows. But now, I am expanding as I have about 20 youths who have promised to work for me and there are many volunteers on the ground.

I wish I could organize a rally here in Nigeria where Bill Clinton, Nelson Mandela, Kofi Annan, Mary Robinson, etc. will not just come to raise people’s hope, but lead the rally. Once we kids are carried along, life will be better and problems will be solved easily. If I get a sponsor, I will use my long 2007 holiday to tour the world in order to get more kids involved as well as encourage both parents and world leaders to support us.

For now, we need laptops, a computer, some money and a bigger office as I plan to establish the foundation at many schools all over Nigeria.

For further information contact: livealivefoundation@yahoo.com
The HIV/AIDS prevalence in Zimbabwe is close to 20 percent, although we have seen some overall declining incidence. While there is no disaggregated data on girls between ages 15 and 18, or younger than 15, formal and informal research suggests a worrying trend. Cultural biases and social norms that plague girls from birth, combined with specific acts of sexual violence such as traditional practices that use girls to appease angry spirits, the unyielding myth that sex with a virgin will prevent or cure AIDS, poverty that drives girls into transactional sex and omnipresent rape and sexual abuse – by fathers, brothers, grandfathers, teachers, classmates, strangers, men of the cloth and employers – are disheartening news for the prevention of HIV and for the overall development of girls into healthy and productive adult women.

As a secondary school teacher in the densely populated Harare suburb of Chitungwiza, I was well acquainted with the abuse of young girls and frustrated by watching how each new school season fewer and fewer would return. In 1998, I put together a girls’ club with nine upper six girls. We met regularly to share stories, ideas, and problems and find solace and solutions as a group. Today, there are 500 girls’ clubs in 49 of Zimbabwe’s 58 districts and a full-blown Girl Child Network (GCN) that serves 30,000 girls, raises community awareness and lobbies government to protect girls. Our goal is to dismantle the link between culture and violence against girls and enable them to take charge of their own destiny.

My own history played a big part in the process. I had been raped at six by a certain man who was in the habit of unabashedly raping minor girls and orphaned at nine by the death of my mother from domestic violence. At age eight, I had stood up and pushed her to report the violence perpetrated on her by my father, but she put a finger to my mouth and said, “Shush,” meaning “Quiet, you don’t say that in public.” So common throughout many societies in Africa, that order is just what I was determined to reject when I grew up. It was not only my mother or I who suffered, but virtually every girl and woman who saw abuse perpetrated against her swept under the carpet. It was the norm.

In March 1999, at Zengeza High School, GCN was officially launched. By then there were 10 clubs, as lady teachers from surrounding schools had picked up on the idea. But the school head at Zengeza became offended by the feminist talk of girls’ rights, so as I sensed problems developing, I resigned from teaching. With only an old typewriter missing the letter ‘e’, and a lot of girls’ stories, I took on the work of Girl Child Network full time.

The first GCN office was in a house also being used as a ‘safe house.’ I slept on the floor with the sexually abused girls during those first months. In October 2000, after careful risk analysis and intense debate on whether it was safe to fund a network with no staff, structure, or office, Oxfam/Novib, the Netherlands took the risk.

Eight Years Later

The girls’ clubs remain the heart of the program and a big heart it is. They create a space for girls all over the country to meet with trained volunteers to break the silence in a safe and supportive environment. The clubs’ flexible structure has five elements: identifying needs; mobilizing and developing strategies to go public on incidents of rape; leadership development of the girls; and developing and empowering the community. As a consequence of empowerment through the girls’ clubs, more and more girls, averaging eight per day, are reporting incidences of rape.

The Information Documentation and Dissemination program collects, analyzes and disseminates relevant and evidence-based information about abuses against the girl child to policy-makers, government, donors and media. It also monitors the media to find how girls and abuse are being portrayed, and to then congratulate or condemn journalists for their work. The media has responded to GCN’s work and continues to increase its reporting of cases of abuse, shaming and naming perpetrators, as well as portraying girls in a more positive light.

The Advocacy and Lobbying department is the mouthpiece of the girl child, successfully lobbying politicians, traditional chiefs, religious leaders, and others in power to change
practices, laws and policies to protect and improve the situation of girl children. It also seeks to harmonize Zimbabwe laws with international and regional legal statutes and human rights instruments.

Enabling and empowering communities to own, support, sustain and even create their own programs to support the girl child is an essential component of GCN’s efforts to change social norms. The Community Development and Empowerment program supports communities to work with the girls clubs through self-help projects that generate income for school fees, and trains volunteers for child abuse monitoring and HIV/AIDS education. This program has mobilized more and more men to work with girls to prevent and report abuse. A group of women in Chitungwiza have become strong supporters of GCN in all its activities and campaigns, participating in marches, protests and celebrations.

The Girls At Risk Support Unit (GARSU) provides 24-hour emergency services to girls who have been abused or are at risk of abuse. GCN accompanies them to the police, social welfare agencies, counseling and other services. To meet the material needs of the girls, so they would not look to would-be perpetrators, it provides school fees to school dropouts and subsistence and humanitarian assistance. To date, the department has assisted 20,000 girls whose cases were reported from as far back as 1998.

Empowerment Villages and PEP
Realizing that empowering girls to break silence on rape in the home, school and community would bring no justice, therapy or rehabilitation if the girl remained in the same abusive environment with her perpetrator, GCN set up three strategically positioned Girls Empowerment Villages. Administered by the GRASU, the villages serve as temporary homes for abused girls, providing shelter, education and support. They provide counseling and basic needs, referral to service providers, and make sure that a girl can take up medical treatment that will attend court sessions and register with a school. In any given month GCN rehabilitates an average of 60- sexaully abused girls, and an estimated 25 percent of girls are HIV positive.

Any form of treatment, for a girl who has been raped, to stop progression of the HIV virus is a critical life saver. In 2002, our girls who reported rape began receiving Post-Exposure Prophylaxis (PEP) after 72 hours; today, based on studies confirming the improved effectiveness after 24 hours, GCN is counseling girls and their parents to seek PEP as soon as possible. The more communities understand and appreciate PEP, the more fresh cases of rape are reported on time. GCN is fully cognizant of the fact that PEP is not available in most parts of the country, and advocacy and lobby efforts targeting relevant government ministries are underway.

Chitoso Empowerment Village in Manicaland, one of three villages to serve as temporary homes for abused girls, providing shelter, education and support.

Small Grants Go a Long Way
GCN is one organization proving the large impact of small grants. Grants ranging from $5,000 to $30,000 from Oxfam/Novib, the Global Fund and American Jewish World Service and Newfield Foundation, which have continued to support us. In addition, donors such as CIDA, the Stephen Lewis Foundation, the Egmont Trust, the British and U.S. Embassies, UNICEF and the EU have also boosted funding of our four administrative centers in seven provinces. GCN has also received three international awards, including the red ribbon in Toronto and raises some of its own income through girl-child music and grinding mills.

The GCN has come a long way since 1998 when it was only me and nine girls. Despite the challenges and the problems faced by the girls of Zimbabwe, their future and that of future generations of girls are beginning to look brighter. The support from communities keeps growing, but most important is the continued support from the girls whose hard and brave work have made the network expand and their own lives improve. This future will include clubs in every school and even in churches, eventually becoming their own organizations. Eventually, Zimbabwean laws will be in line with the needs of girls, and people will recognize the importance of ensuring a good life for the girl child. Communities will work to ensure girls stay in school and are safe abuse will end. Empowerment of girls will prove to be the best prevention of all for HIV.

For further information contact: gcn@zol.co.zw
Laura is a 16-year-old girl from a middle class family in Santiago del Estero, Argentina. The economic crisis of 2002 forced her to drop out of primary school in her last year to care for five younger siblings; her mother worked all day outside of the house to feed the family. Laura’s father and two siblings left home a few years ago and have not been heard from. Last year, at 15, she got pregnant by her 28-year-old boyfriend, Emilio, and now has a son, Rodrigo. She knows that there are ways of avoiding pregnancy, but at the health-care center they told her they could not give her contraceptives because she was under age. When she got pregnant, they gave her an HIV test and that is when she found out she was positive. It had never even occurred to her she would be infected.

Although countries with the most highly affected regions such as those in sub-Saharan Africa have experienced the highest numbers of girls and women, aged 15-24, infected by HIV, the rates of infection in this population have already begun to climb in countries of LAC with far lower overall prevalence rates. It is alarming that in four of Haiti’s most populated counties, a country with one of the world’s largest AIDS epidemics, 4.2 percent of women, aged 15-24, are infected with HIV, whereas males are only 2 percent. In Honduras in 2002, the prevalence in young people was 1.5 percent in women and 1.18 percent in men; and in Guatemala, it was almost equal. In 2001, in Trinidad and Tobago, according to the PanAmerican Health Organization (PAHO), the rate of HIV in adolescent girls and young women, aged 15-19, was five times greater than that for boys. In Argentina since 2004, new infections in the 15-24 age group arose predominantly in women, a figure that increases when considering the even higher rate of increase in the 13-19-year-old female population.

Laura is typical of an adolescent girl in Latin America and the Caribbean (LAC), who is sexually initiated by a boyfriend 10 or more years her senior, and never imagines that she could be infected by having sex with a man she is hoping to marry. If we were to ask her now what she fears most, without a doubt she would say getting pregnant again, not because she is living with HIV, but because she and Emilio have no way of caring for another child. This is the reality of many adolescent and young poor people in Argentina and other countries in Latin America and the Caribbean.

In Argentina due to the sudden increase in poverty at the end of 2001, transactional and intergenerational sex and the rising rate of rape and sexual abuse among girls increased, making them more vulnerable to HIV. In Argentina, 60 percent of sexual abuses in 2002 occurred in girls and adolescents, most of them in the home and perpetrated by a relative or acquaintance. So we must recognize that the home nowadays is no longer a safe place for girls. Like Laura, thousands of adolescent girls in Argentina and other LAC countries became HIV infected by their unique partner. They are unable to protect themselves because they ignored the risks and couldn’t ask to use condoms.

Failure of Sexual and Reproductive Health Education and Services
An increase of poverty together with the promotion of consumerism among adolescents of both sexes and the lack of access to sexual education, family planning services, and condoms created an explosive combination that facilitated an increase in pregnancies and HIV infection of young girls. Adolescent pregnancy in Argentina increased specifically among the 10-14 age group. If we consider ages 13-19, this predominance of female infection in the 15-24 age group is even higher. Also, among AIDS cases we observed the lowest ratio (2.3:1) between men and women in the 15-24 age group, compared to the general population (3:1).

At the end of 2002, a new sexual and reproductive health law was passed in Argentina, creating the National Sexual and Reproductive Health Program. Although this program theoretically provides services to adolescents of both sexes, actual access is still scarce due to the resistance of health-care professionals and the religious and conservative opposition to provide contraceptive methods to adolescents without the permission of an adult. The resistance of health-care personnel is greater in poorer provinces that are usually characterized by a more conservative and religious opposition. The myth that providing contraceptive methods to adolescents will promote their sexual activity and promiscuity persists.

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It is urgent that governments adopt policies and interventions to develop sexuality education for young people in the schools and in non-formal programs that reach those who do not attend, overcoming the resistance by religious and conservative groups.

Young women and mothers attending a workshop on sexual and reproductive health at a healthcare center in a slum area of greater Buenos Aires.
The latest national HIV estimates in China suggest that the HIV epidemic has begun to spread from certain high-risk groups to the general population. The proportion of female to total HIV cases has increased rapidly in the recent years, from 15.3 percent in 1998 to 39 percent in 2004. The combination of several factors – the high level of HIV among injecting drug users (IDUs) and commercial sex workers (CSWs), growing rates among females, as well as the global estimates that 62 percent of 15-to-24-year-olds living with HIV/AIDS are female – have obvious implications for the young female population. However, because there is no age-disaggregated data in China, the rates of young females are unknown and girls remain unseen.

Hidden in Existing Data

Despite the lack of data, it is not difficult to extrapolate what we know. Among the estimated new HIV cases in 2005, 48.6 percent were associated with injecting drug use. Due to China’s growing consumerism and increased freedom of movement, commercial sex, though illegal, is becoming more and more common in both urban and rural areas. The World Health Organization (WHO) estimates that the number of sex workers in China is around 3 million. The majority of them are poor young women. Condom use among sex workers in China is low due to a combination of poor awareness and a lack of negotiating power for safe sex. The illegal and underground nature of their work creates significant obstacles to effective intervention programs.

Estimates of IDUs in China range from 1 million (registered officially) to 3 million. Drug users in China are largely young and poorly educated. They are often engaged in high risk behaviors including both needle sharing and unprotected sex. Young male drug users tend to seek girls as their sexual partners, and multiple partners are very common among this population. For young female addicts, commercial sex can be a lucrative means to support their habits. Like CSWs, IDUs are deeply hidden due to the illegal nature of drug use in China. Intolerant policies and practices adopted by the Chinese government toward drug abusers and sex workers have created barriers to public health authorities and NGOs seeking to generate group-specific data and to provide health services.

Traditional Values and Changing Ways: A Deadly Combination

A number of common biological and socio-economic factors in many countries make girls and young women especially vulnerable to HIV infection. It is similar in China, keeping in mind the particular Chinese context of high drug use and commercial sex described above, combined with the rapidly changing economic and social mores of the country.

The preference for sons is deeply rooted in Chinese traditions as it is in much of Asia, and is indirectly a factor in HIV vulnerability for girls. Sons are often regarded as a reliable form of social security, especially in poor rural areas where resources are scarce. Although this is changing in urban areas, it remains strong in rural communities where families often prioritize boys’ education and girls remain in their households to provide care for the elderly and the sick. According to UNICEF, an estimated two-thirds of China’s un-enrolled school-aged children are girls. Moreover, girls who are enrolled, as in many other countries, are the first to drop out when economic pressures affect their families. Lack of schooling builds up girls’ vulnerability to HIV/AIDS, leaving them without proper employment skills and unaware of their rights to protection of their health and security. China’s one-child policy has exacerbated the situation by creating a wave of abandoned girls at greater risk of being forced into transactional sex and drug abuse.

A lack of adolescent sex education in school curricula also fuels the growing sex disparity in HIV among young people. Conservative attitudes about sex lead to inadequate and irrelevant sex education for young people. Many Chinese people believe that talking about sex will cause children to engage in sexual activities “too early and too often.” Therefore, school sex education only focuses on physiological changes and often ignores basic knowledge about safe sex and self-protection from sexual abuse. Concurrently, in a rapidly changing Chinese society, adolescents have begun to engage in an exceptionally high level of sexual activities. The lack of knowledge, together with biological differences, makes young girls particularly vulnerable to HIV infection.

Internal migration is a major problem in China compounding these other factors. Since China started the opening and reform policy in 1979, the country has gradually relaxed its system of household registration or hukou. Allured by the flourishing economic opportunities in Chinese cities, millions of rural peasants are flocking to urban areas in search of better jobs and incomes. At present, China has a “floating population” of more than 140 million, the majority of whom are young, male peasants away from home during the most sexually active period of their lives.

Internal migration places adolescent women at high HIV risk in two key ways. On the one hand, young poorly educated male migrant workers are often easy targets of drug sellers and sex workers. Their young wives or partners, who stay in home villages to provide care to the elderly and children, become susceptible to HIV when infected male migrants return home. On the other hand, increasing labor mobility provides young Chinese girls in rural areas with freedom to move to cities to seek better lives. Away from...
Girls: Vulnerable from the Beginning

In the last issue of Global AIDSLink, we discussed the importance of assuring that men and boys take responsibility for their role in preventing the transmission of HIV. Yet we all recognize that at this stage in the global pandemic, it is women and girls who are most at risk for infection. Already, the majority of new infections in Africa are among this group, and we have seen that young women and adolescent girls are most directly in the line of fire. And in other parts of the world where new infections are spreading fast, the rate of growth among women is, for the most part, greater than among men.

This issue of AIDSLink explores many facets of this global challenge. We all recognize that the issues are diverse and complex. Biological vulnerability gives girls and women a higher probability of infection than men for every heterosexual encounter. Societal norms in many places make it more likely that young women’s earliest sexual encounters will be with older men, who are, therefore, more likely to have already been infected. Sexual violence and rape, particularly within the family, are frequently overlooked by legal authorities. Even among adults, gender power-relations often give the woman little say in negotiating sex, making ABCs a hollow strategy for a woman who cannot say “No” to her partner, whose own fidelity is not matched by that of her mate, and who has no say over the use of a condom.

Violence against women, laws concerning property rights and inheritance, substance abuse, and armed civil conflict all expose women to particularly high risks, showing that larger political and legal forces, as well as those that influence intimate interpersonal relations, are important considerations to address.

Perhaps most deeply rooted and neglected is the position of the girl child as a victim of discrimination from the earliest moments. From the time of birth, when the boy child is celebrated and the girl child is seen as a burden, to early schooling, when girl children are often kept out for the purpose of domestic chores, to the enormous challenges faced by girls in the classroom, where they may be subject to sexual predation from their male classmates, teachers and “sugar daddies,” the odds are arrayed against the girl child long before she becomes the target of attention of the health system. Yet we know that early and appropriate sexuality education – for both boys and girls – helps to protect against the likelihood of HIV infection and does not increase the likelihood of sexual activity, as some fear.

Survival and justice make it no longer acceptable that we should neglect the needs of the girl child, and special attention must be directed at girls who have not yet entered adolescence, and strategies devised to address the full spectrum of girls’ status and empowerment, if they are ever to be adequately protected from this plague.

It is relatively easy to identify and decry the injustices underlying these situations. Far more challenging is coming up with workable solutions on the grounds that go beyond the rhetoric. In this issue, we have worked to assemble the voices and experiences of those on the front lines addressing the particular challenges of protecting girls and women.

HIV/AIDS will finally and fully be beaten back when girls are accorded dignity from the earliest age, when women have full rights in the family, the community and in their countries’ political systems. Ironically, what has long had the full force of moral imperative in the universal context of human rights has gained the force of necessity for survival, and it may be that the most significant positive long-term contribution of AIDS is that it made undeniable a clear-eyed view of the central importance of women’s equality and empowerment.
M.C., a 15-year-old South African girl, was asked by a male teacher to come and speak with him in his flat. Shortly after she arrived, he raped her. Following the incident, the teacher persistently tried to convince M.C. to return to his room, promising her higher grades. After M.C. learned that other female classmates had been assaulted by the same teacher, she decided to tell a female teacher and then her mother what had happened. When they went to the principal, M.C. and her family were told to keep quiet, that the matter should be handled internally. But the family chose instead to go to the police. Once the allegations were made, several other students came forward, prompting the accused teacher to take voluntary leave. But facing near constant ridicule from her classmates, M.C., too, has left school. “They say ‘you shagged the teacher,’ but I didn’t, he raped me,” she told Human Rights Watch.

M.C.’s story is all too common. While her family showed courage in reporting the incidents, more often than not the violation of girls by their teachers goes unacknowledged, leaving girls to suffer in isolation and remain invisible. In addition, teachers are not the only source of sexual violence against girls. Many times, assault at the hands of classmates also leads to reduced school performance or drop out. According to A.C., 14, and also from South Africa, “Boys touch your bum, your breasts. You won’t finish your work because they are pestering you the whole time.” Seventeen-year-old M.B. reported that she felt like leaving school after two classmates sexually assaulted her. “Before all this happened,” she said, “they were my friends. How am I going to be the same again?”

Safety in and enroute to school is a fundamental element of the right to education that protects and promotes safety and bodily integrity cannot be overstated. The importance of accurate information delivered in an environment including methods of transmission and protection, and are less likely to seek HIV testing. The impact of fear and trauma on school performance. A 13-year-old girl who was gang-raped by classmates said, “After the school break, my mom asked me if I wanted to go back to school.” She told her mother, “No, as the rapists were still there.”

Sexual Violence at Home
Many children also experience violence at home, which can lead to failure at school and increased vulnerability to HIV/AIDS. Nearly 50 percent of all sexual assaults worldwide are committed against girls aged 15 years or younger, most often at the hands of male family members. Trauma and upheaval at home can prevent children from doing their homework, going to school consistently, or being able to focus in class. UNESCO reports that academic failure such as repeating a grade increases the likelihood that children will ultimately drop out; even those children who try to stay in school may eventually choose to end their education in the face of ongoing failure. When teachers do not recognize signs of trauma and provide support, failure and drop-out are more likely.

Economic and Structural Violence
Poverty is one of the most important risk factors for both school failure and HIV/AIDS. Poor girls are usually the first to leave school early and families without enough money to educate all their children most often keep the girls at home to care for family members, prepare food, gather cooking fuel and water, or supplement the family income. The extra cost of school and uniform fees and the lost opportunity of their daughter’s paid or unpaid labor is an added barrier to successful education for girls.

For these girls, the need to enter the labor force or to exchange sex for money or a school uniform places them at heightened risk of violence and of HIV, and leaves them without time to attend school. Poverty also causes many families to seek marriage for their daughters long before the internationally recognized age of majority, 18 years old. According to the International Center for Research on Women, 51 million girls under age 17 are currently married. These girls are unlikely to begin or continue school and are at heightened risk of violence.

What children learn – or do not learn – also plays a role in their safety, health and success. Many schools do not provide comprehensive, evidence-based health education, particularly related to sexual and reproductive health and HIV/AIDS. Adolescent girls without the knowledge and skills to assess risk, access and learn how to negotiate condoms, say no when they mean no, are more likely to acquire sexually transmitted infections, including HIV, and to become pregnant. In some countries, more than 50 percent of girls under age 19 are already mothers and highly unlikely to attend secondary school, which is recognized as protective against early pregnancy. In addition, studies show that adolescent girls who have been sexually abused are more likely to have misconceptions about HIV, including methods of transmission and protection, and are less likely to seek HIV testing. The importance of accurate information delivered in an environment that protects and promotes safety and bodily integrity cannot be overstated.

The HIV risk and loss of educational opportunity passes from generation to generation. Women with some education are more likely to send their daughters to school than women with no education. According to UNESCO, in some African locations, more than half of all children whose mothers have no education are out of school; in India, 53 percent of children who are not in school have mothers without formal education. This means that the implications

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As HIV and AIDS continue to ravage communities around the world, the role of cultural practices in accelerating the vulnerability of women and girls is coming into sharp focus. While communities need to maintain their values and identity, the HIV and AIDS pandemic demands a fresh review, modification and even the discontinuation of practices that increase the risk of infection.

The Maasai community, which straddles the Tanzanian and Kenyan border, has fiercely guarded and preserved its cultural practices, traditions and norms in the face of modernization. This largely pastoral community has maintained its mode of dressing, food, language and even its traditional manyattas (Maasai homesteads made from cow dung, sand and clay). Until recently, the closed and traditional way of life has insulated the Maasai from the AIDS pandemic. However, trading, mingling and intermarriage with other communities have resulted in a dangerous spread of HIV/AIDS into the community and the Maasai have found themselves at a crossroads: How can they maintain their culture in the face of HIV and AIDS? What do they need to do to modify particular practices and traditions that are so skewed against young girls?

World Vision has a long history of working with this community. In the presence of HIV/AIDS, we recognize the need for a fresh approach that is sensitive to the community’s culture, traditions and values. The traditional prevention approach, such as ABC (abstinence until marriage, be faithful, and correct and continuous use of condoms) is inadequate to protect girls in the Maasai community as it does nothing to address the systemic factors that put them at high risk. It is difficult for girls to abstain from sex while the Maasai custom allows betrothal of girls even at birth. The practice of polygamy, allows a man to have more than one wife at the same time, sanctioning multiple partners. One young girl, esoto, quipped, “It is not a must, but if a morani wants sex there is no option.”

Comparative research was conducted among the Maasai and Lozi communities of Tanzania and Zambia respectively. It consisted of qualitative and quantitative data, using structured questions for face-to-face interviews, focus group discussions, and interviews with key informants. A total of 374 adults and 1,100 children and youths, aged 8-24 years, answered a wide range of questions from their knowledge of HIV to sexual behavior. This article discusses the results among the Maasai community in Tanzania.

The study unearthed a number of traditional and cultural practices and norms that compare and go beyond other African societies. Asked who arranges marriage in the family, the majority of the young respondents answered that it is their father alone. More than 90 percent said that women do not hold positions of leadership in the Maasai community.

Early sexual initiation – Respondents pointed out that sexual practices lead to the girl child engaging in sex as young as eight or nine. In accordance with Maasai customs, her sexual debut, and often most active sexual period, is during the pre-pubescent period, prior to initiation into womanhood that often takes place in early adolescence. Pre-pubescent girls are expected to provide domestic help to adolescent boys who have undergone their circumcision rites. Known as morani, the initiates reside in designated residences called esoto. The young girls frequently reside at the same esoto where they are introduced – sometimes forced – into sexual activities by the morani.

Early sexual debut increases the vulnerability of girls to HIV due to their biological immaturity that allows tearing and bleeding more easily. In addition, one young girl, asked whether it is mandatory to have sex in esoto, quipped, “It is not a must, but if a morani wants sex there is no option.”

Female Circumcision – More than 80 percent of those interviewed confirmed that female circumcision is a common practice that is regarded as an important aspect of cultural identity and essential to facilitating girls’ social and spiritual transition into womanhood. One respondent said that a girl “won’t be regarded as a woman until she is circumcised.” This practice creates a clear risk of HIV due to cross-transmission during the cutting ceremonies when the same razor blade is used to circumcise different girls. Since this initiation defines a girl as an “adult,” it also contributes to early marriage.

Early marriage – Early betrothal and marriage is another cultural practice contributing to girls’ increasing vulnerability to HIV. The arrangement includes a bride price paid by the groom to the girl’s family, which may occur when a girl is very young and long before the actual marriage. The practice undermines the girl’s capacity to determine her own

**By Timothy Mbugua**

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In 2004, World Vision undertook an action-oriented research project to identify the key cultural values that make girls vulnerable to HIV. A key strategy of the study was to involve boys and girls – as well as communities – building their awareness and capacity as agents of change and creating a sense of ownership in programs and policy interventions.
partner and limits her access to education, thus excluding her from the empowerment that education can facilitate, as well as important HIV prevention messages. The Maasai prefer to admit boys more than girls to school, said one respondent, “because they are used to sending the girls to the husband in exchange for dowry.” The husband is often twice or even triple the age of his wife, leaving her in a weak position to demand or suggest safe sex, and further contributing to the biological vulnerability of her age.

Polygamy – Commonplace among Maasai, polygamy is another practice placing girls at high risk. According to respondents, the number of wives range from two to 16. The risk is determined not only by the sexual behavior of the husband, but of his co-wives, who may also have multiple partners, creating a complex network of potential risk of HIV infection. Respondents also pointed out that the polygamous structure facilitates competition among co-wives over limited resources. As the husband is solely responsible for distributing resources, he may often have “favored wives,” leaving the others struggling to meet their needs and those of their children, often forcing girls to drop out of school and get married early.

Age-mates – In Maasai tradition, males and females circumcised on the same day are age-mates and are expected to form a very close bond. When a male visits a married age-mate, the host is expected to leave his house and provide total access to the visitor, leaving his wife to provide food, drink and a place to sleep. Many young married girls believe that they are obliged to have sex with age-mate visitors or would be cursed if they refused. One girl explained the issue this way: “You might have a guest; you’ve prepared water for a bath, a bed and food, but still, during the night, you will be much disturbed. He will wake you up with the purpose of sex with you, and when you ignore him, you will be cursed.” The research found that in more than 80 percent of females who reported a problem with visiting age-mates, sexual advances were the cause of the problem.

Education – One of the most negative outcomes of these cultural practices is the denial of education for girls, whether forcing them to drop out early or forego attendance altogether. Despite the incontrovertible evidence that educating girls is a major key to reducing their vulnerability to HIV, many Maasai parents fail to see the need while regarding girls as property to be sold off with a bride price.

Finding Solutions through Community Conversation
Emerging from the linked conclusions of the research was finding a way to protect girls that would allow the Maasai to preserve their positive traditions and change the practices that contribute most heavily to the spread of HIV.

The World Vision study proposed a community approach that was developed by the United Nations Development Program (UNDP), the Salvation Army and the Rockefeller Foundation as the most appropriate method to address girls’ vulnerability. This approach stimulates the community to generate insights on the underlying factors fueling the spread of HIV and AIDS, and to find solutions within the context of their culture. It is expected that this process will lead to the community adapting, modifying or discontinuing traditional practices that have existed for ages but have been identified as harmful in the context of HIV/AIDS. Still at the beginning, the approach is expected to help the community open up and discuss issues that have been hitherto taboo subjects. The community will take responsibility for its own prevention by organizing visits to Voluntary Counseling Testing (VCT) centers. An idea proposed by one of the respondents is to construct a separate visitors’ hut for visiting age-mates. Community conversations could identify an alternative rites passage to female circumcision, agreed upon and respected by the community. Discussions can generate community appreciation of the importance of education to both boys and girls and the need to allow girls to remain in school to reduce early marriages and protect them from HIV infection.

The study also recognized that creating programs focusing solely on girls will not achieve the desired results. Creating an enabling environment for girls must include full community participation and a broad range of actors that includes the full involvement of mothers, fathers, husbands, boys, religious leaders, initiators, traditional healers and other community leaders. Using local power structures, individual members of the society will become powerful allies in initiating community change.

The Maasai community is respected in many places because of its unique culture in an increasingly homogenized world. However, HIV/AIDS, if left unchecked, could devastate the community and wipe out an entire generation – and ultimately an entire culture. This study suggests that even a stringent and seemingly culturally complex community is willing to change as long as it is allowed to identify, explore, reflect and make decisions in its own community conversations.

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Community conversations with the Maasai help to preserve their positive traditions while changing practices that contribute to the spread of HIV among girls.

Photos by L-r: rAcheL woLff (1,3,5), MichAeL ArunGA (2), John kisiMer (4) courtesy of worLd vision cAnAdA
By Judith Bruce
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As the new HIV data from sub-Saharan Africa roll in, it is increasingly clear that the epidemic is heading toward a poor, young and highly neglected segment of society – adolescent girls. With case ratios reaching 8:1 (female: male among those aged 15-24) in South Africa, 5:1 in Kenya, and an overall prevalence ratio of 3:1 in sub-Saharan Africa, young women – often adolescent girls – are the new face of the epidemic. Even in the most economically advanced Western societies, their relative vulnerabilities are reflected in higher HIV rates: African-American adolescent girls in the southern states of the United States have the highest prevalence (6.4 per 1,000), relative to their white, Hispanic, or male African-American peers from other parts of the United States.

However, most of these girls are currently outside the paradigms of conventional HIV prevention that remain stuck in the strategies of the first epidemics and confined by Western middle-class assumptions: unmarried girls are in school, with reliable family support, have access to media, and operate with sufficient agency to make consensual and protective decisions about sexual relations. Although we now know otherwise, marriage regardless of age or conditions of consent is still viewed as voluntary and relatively protected.

The most disadvantaged adolescent girls are neither among the commonly-defined high-risk populations (a girl of 15 can hardly be referred to as a sex worker) nor the voluntarily sexually active. The majority are under the age of consent, excluding them from reliable access to reproductive health services or risk-mitigating social and economic supports. Increasing attention to gender equality has not been accompanied by sufficient attention to the conjunction of age and gender.

Pressures of Young Adolescence
As we understand more about adolescent development, our attention turns to the time just around puberty. For boys, this takes place closer to 14; for girls, their lives begin to change often critically and irrevocably around age 12. Sexual maturity brings noticeable changes in a girl’s appearance, which, in turn, affects the way she regards herself, how she is treated by her family, and her value and security in the wider world. The percentage of girls leaving school may increase during the transition from primary to secondary school, which typically coincides with puberty when the risks and pressures of gender norms intensify.

Poor Young Girls beyond Reach of Prevention
In terms of effective HIV prevention, age 12 maybe the last moment at which to reach the poorest and most vulnerable girls in many communities before poverty-linked mobility pressures for marriage and unsafe liaisons set in.

A 12-year-old girl from a poor family may be essentially asset-less, and use as a basic livelihood strategy “marriage” in rural areas and liaisons in urban areas. Many countries with generalized HIV epidemics have high levels of child marriages or substantial proportion of girls 10-14 who are living with one or neither parent. The proportion of girls 10-14 in PEPFAR sub-Saharan African countries living apart from both parents and out of school reaches a level of 23 percent in Cote d’Ivoire, with 9 percent as a median value.

While poor girls across the millennia have faced forced sex, child marriage, social isolation, exploitation of their bodies for hard labor, domestic service and income, and poverty-driven exchanges of sex for gifts, money or shelter, HIV now serves as a sad biological tracer of girls’ disadvantage. The conditions under which they live make them out of reach of current debates over abstinence and sexual health as they have insufficient agency to choose either.

Poverty Alleviation Programs
HIV-prevention strategies that emphasize poverty alleviation, without specifically empowering girls, are inadequate. Living in the same poor communities as poor boys (and the older men who are more likely their partners), girls are relatively, and sometimes dramatically, more deprived. To a much greater degree, they lack friendship networks and safe and supportive spaces.

A recent study in Kibera, Kenya, the largest slum in Africa, found that of the 96,000 adolescent girls aged 10-19 (in a community of 800,000), less than 1 percent had access once a week to a two-hour girl-only space where they could safely meet friends. Their negligible access to girl-
A lack of school safety is one reason that many girls are not there, and there is no reason why schools can’t create girl-only spaces and adopt girl-friendly practices, while continuing efforts to get girls to school and keep them there. Further, it is past time to revise curricula that will realistically prepare marginal girls and boys for safe and decent work.

There are many moments when boys and girls can be reached together, but girls need special structures and safe spaces of their own for youth safety nets to be effective.

**Needed: An Ecological Approach**

There is sufficient data to locate concentrations of girls at risk in communities with severe HIV epidemics. Using an ecological approach and the same focused energy with which we discovered truckers’ routes, we can track the migration routes of girls, as well as the communities in which migrant girls, girls in domestic service, girl-headed households, and girls at risk of child marriage live.

Further, intensifying resources to girls in circumstances that are direct social precursors of HIV may be a strategic middle path between a narrow emphasis on reaching conventionally defined “high-risk” or “core transmitter” groups and more generalized socio-economic empowerment strategies for poor girls and women.

Happily, we do not begin at zero in finding effective responses. Information collection, prevention, care and support, social, economic and health initiatives are already in place that could be reoriented to meet the needs of these girls.

**Child and community health initiatives:** Child and community health initiatives often make large investments in house-to-house contact and targeting out-of-school young adolescents. It would be practical and cost effective to identify vulnerable girls (those out of school, in unsafe work, “engaged” or already married) in the course of such contacts. Further, in urban areas it may be feasible to establish rescue and/or health stations in places where vulnerable girls transit through or congregate in (such as bus stations).

**Making schools safer for girls:** A lack of school safety is one reason that many girls are not there, and there is no reason why schools can’t create girl-only spaces and adopt girl-friendly practices, while continuing efforts to get girls to school and keep them there. Further, it is past time to revise curricula that will realistically prepare marginal girls and boys for safe and decent work.

**More youth centers serving girls:** Current youth-serving initiatives, many of which have redefined their mission to be explicitly HIV prevention (including youth centers, peer education, and school-based family life education) typically disproportionately benefit school-going and/or urban populations, favor boys’ participation, and commonly serve high proportions of non-youth males. Rural and/or non-school-going populations, very young adolescent girls and boys living apart from parents, and married girls are grossly underserved or totally absent from these programs. A recent study in Addis Ababa, Ethiopia, where 37 percent of girls aged 10-14 are living without either parent, found that less than half a percent of all program contacts were with girls 10-14 living apart from parents.

**Girl-specific youth initiatives:** It is urgent from a health-equity as well as an HIV-prevention perspective to create age and gender-specific spaces in these burgeoning youth initiatives. There are, of course, moments when boys and girls can be reached together, but the prevailing evidence is that without special structures, girls – especially out-of-school girls – are not being reached by the very efforts meant to offer the poorest youth a social safety net. All sorts of facilities – youth centers, churches, schools after hours, community centers, friendly beauty parlors – could all be reoriented to offer secure gathering places and appropriate programs for girls.

**Youth media:** Youth media promotes protective behaviors, but its penetration is very limited when it comes to rural areas and poor communities, particularly in sub-Saharan Africa, and is limited as well in its reach to vulnerable girls, such as those living apart from parents, married or in domestic service. Youth media can provide more supportive messages by drawing attention to the life situation of these girls and providing linkages to HIV information, testing and services specifically designed to meet their needs.

**Livelihood activities:** Livelihood activities that claim to reach youth have largely bypassed younger, unmarried, rural, indigenous and poor girls. These girls are enormously interested in developing livelihood skills and express interest in group affiliation, savings and financial literacy targeted to their age, gender and context. Program venues created for girls and young women could be the basis of savings clubs and ideal vehicles for the delivery of health information, providing a needed bridge to voluntary testing, counseling and other services.

**Child marriage:** Finally we must address child marriage. Married girls form the vast majority of sexually-active adolescent girls in most countries with generalized HIV epidemics, and yet they have been dramatically neglected by programs. The effort must have four parts: to delay marriage until at least age 18; communicate to girls and their parental and community gatekeepers that marriage is not a sexual “safety zone”; force an examination of the safety of prospective partners, including age; and promote voluntary testing and counseling of both partners before marriage. We must also support newly married girls by offering catch-up schooling initiatives and meeting venues in which they can receive functional literacy, life skills, livelihood training, effective support for a safe pregnancy and birth and crucial access to HIV testing, services and treatment.

All this adds up to a central message: We must make ‘visible’ the girls living in the reservoirs of social and economic disadvantage; strongly encourage the reorientation of social, health, development and youth initiatives to build up their protective and productive assets; and, assure their access to the best prevention, care and treatment services. If we fail in this, a substantial proportion of vulnerable girls will be ‘left behind’ and as a result will carry a rising and disproportionate share of HIV infection in the decades to come.

This article draws on material from The Girls Left Behind (edited by Judith Bruce and Amy Joyce), with original contributions and research by Annabel Erulkar, Kelly Hallman, Naomi Rutenberg, Nicole Haberland, Erica Chong and the Binti Pamoja Center.

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BEATING DEATH IN COMBAT GIRL SOLDIERS FACE DANGER FROM HIV/AIDS

By Mike Wessells
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In 2002, visiting a dusty rural village in Sierra Leone, ravaged by the country’s 10-year war, I talked with Fatmata, who asked me use her real name and to tell her story to the world so that other girls would not have to endure what she had.

Abducted by the Revolutionary United Front (RUF) at age 12, she had become a “wife” of her captor and was forced to provide sex on demand or else suffer brutal beatings. Having worked within the group as a porter, she was also a mother to a two-year-old child. She had contracted HIV/AIDS and her baby was also HIV positive. Then 15 years old, but without an education or livelihood and feeling stigmatized by her community after the war, she asked, “How will I be able to feed my baby and buy the medicines we need?”

Among the approximately 300,000 children worldwide who are inside the lines of the fighting forces, nearly 40 percent are believed to be girls under 18 and as young as 11 years. They have joined the government forces and rebel factions – in wars ranging from Colombia to Sri Lanka, Nepal and the Philippines – in a number of ways and for a number of reasons: willingly and unwillingly, to escape a forced marriage, for money, to avenge the murder of their families, to fight oppression, and by abduction and force. Girls also carry out multiple and diverse roles, including domestic, porter, spy, cook, combatants and ‘wives’ – sometimes all of the above. Their treatment varies, depending on the conflict and context, but often includes simultaneously being victim to, witnessing, and even committing unspeakable atrocities. They carry heavy burdens, travel long distances without food, and serve as sexual slaves to their commander or a whole group.

Girl Soldiers in Africa
In Africa, girls have served in the fighting forces in 13 countries between 2001 and 2004. On a continent where rape and sexual abuse are widely reported and girls who have reached puberty are likely to be viewed as potential “wives,” they are often recruited through abduction and controlled through forced sex and other forms of gender-based violence.
A heightened risk of sexually-transmitted infections, including HIV/AIDS, and a host of maternal-child health problems are their constant companions. As armed groups roam widely, attacking and raping women and girls (and also boys) along the way, the chances are high that each man has had multiple sex partners and spreads the infection in multiple ways. Many girls, who have already contracted HIV/AIDS, give birth, risking transmission of HIV/AIDS to their babies. In a conflict zone, however, there are no data and it is very difficult to know the depth and breadth of HIV/AIDS.

**Girls Keep Out!**

Unfortunately, the international community has long paid scant attention to girls associated with fighting forces and to their children. Until recently, the world has referred to them as “camp followers” or “soldiers’ wives,” but more recently, the girls are acknowledged to be “victims” and “sex slaves.” Reintegration efforts have discriminated against girls in Sierra Leone, Liberia and Angola, for example, where they were deemed ineligible for reintegration programs because they did not carry or use automatic weapons and were told that the release process was for boys only. Returning girls also face major stigma from their communities by being harassed and called “kolonko” or “prostitute” by the villagers. In the northern province, the girls were told they had “unsteady minds,” which in the local idiom meant spiritual impurities as a result of their sexual violation in the bush. Local people said “they cannot eat off the same plate” and viewed the girls as unmarried and “damaged goods,” largely because they have STIs and HIV/AIDS. In Sierra Leone, girls like Fatmata, and nearly half the formerly abducted girls, are mothers, who want nothing more than to be good mothers. But without a livelihood and with villagers’ label of “rebels,” whom no man would want to care for, they held little hope.

Although health screening and basic treatment by the local health post were established for HIV infection and other diseases, health support remains a large unanswered challenge. The lack of data about the assumed high rates of HIV positive girls and their children, compounded by damaged and dysfunctional or non-existent health infrastructure, makes the availability of essential health support problematic and urgent.

**Seal the Past and Face the Future**

Improved health care alone will not protect girls from the intersecting ravages of war and HIV/AIDS. It is vital to end the discrimination visible in most DDR (demilitarization, demobilization and reintegration) processes and to ensure girls full access to reintegration supports that respect the resilience and strengths they showed in surviving horrific circumstances.

Recently, NGOs, UNICEF and other agencies have developed support for girls’ reintegration. Christian Children’s Fund/Sierra Leone, for example, has developed a community-based program called “Sealing the Past, Facing the Future” to support girls such as Fatmata and many others. Currently conducted in both the northern and eastern provinces, the program integrates community sensitization and mobilization, healing rituals, health support and livelihood programs, and self esteem and a sense of accomplishment.

Before girls like Fatmata returned, local staff worked with villagers, who initially feared the girls and viewed them as perpetrators, to help them understand that the girls had suffered and had been forced to commit atrocities. Using song, dance, story-telling and proverbs, the communities explored its own role in the peace process and discussed how to support the returning girls (separate but linked programs were conducted to support boys’ reintegration). As one elder said, “Before, we had not known that they, too, had suffered because of the war.”

CCF worked with local healers to conduct cleansing rituals, including such practices as washing the girls with black ash soap to expunge the impurities, having them inhale the vapors of boiling herbs believed to have purgative powers, sacrificing animals to appease the angry spirits, and dressing girls in white dresses with the red waist-sashes characteristic of the northern region. These rituals helped to reduce stigma, “cleared the heads of the girls,” and enabled villagers to say that the girls “can eat off the same plate with us.” Villagers formed Girls’ Well-Being Committees that imposed fines for mistreatment, ending both the verbal and the physical abuse.

The willingness of girl mothers to work multiple jobs to earn money to help meet their children’s needs is exceptional. In reality, however, many girl mothers are unable to support themselves and their children, and they turn to prostitution, increasing their risk of HIV infection. Livelihood support and training is a key aspect of the program. Working in solidarity groups of 10, each girl receives training in marketable skills and a small loan (US $50), enabling her both to earn money and to change her social status, assert her own strengths, and fulfill her maternal role. “Now I have money in my cash box and people respect me,” said one former soldier. Others reported that they received numerous marriage proposals following their success in business or that they were now able to support their child. For many, money meant that they don’t have to work all day and can go to school. Education is a very high priority since it helps them be like other girls, reclaim the education they had been robbed of by the war, and develop hope for the future.

**Respecting Strength and Resilience of Girls**

In establishing programs, it is essential to avoid the common tendency to treat sexual violence as the sum total of girls’ experience inside armed groups. Their varied experience shatters simplistic stereotypes of girls as passive victims – they are also agents and political actors in which they often negotiate their roles to the extent permitted by the situation. In Sierra Leone, a girl commander who had a reputation for toughness said she had never been violated because “They [men] know that if they try to attack me, I’ll kill them.” Another girl, whom the RUF had abducted, maneuvered herself into the role of “Mommy Queen” in which she took care of the many children who had been captured following raids on villages.

African girls also talk with pride of the skills of organizing and decision making that they learned inside armed groups. And contrary to the stereotype of being “damaged goods,” most girls like Fatmata do successfully transition into civilian life and exhibit remarkable resilience after all they have been through.

Many girls, who had been supported in 2002, continue with their businesses and education, and they report that they feel accepted by their communities. These successes in selected areas need to be scaled up and applied throughout the region and in other parts of Africa. Empowering these girls and supporting their strengths is ultimately the best HIV prevention.

And equally or more important is the task of ending the exploitation of girls and all children by preventing their recruitment and use by armed groups.

For **[For further information contact: MGWessells@ccfusa.org](mailto:MGWessells@ccfusa.org)**
of violence in schools go far beyond current risk of drop-out and subsequent HIV vulnerability; it affects future generations, as well.

**New Programs Promoting School Safety**

The good news is that there are a growing number of programs addressing the vulnerability to violence in schools and subsequent risk of drop-out and HIV/AIDS. For example, programs in Mexico, Nigeria and Cambodia work to promote gender sensitivity and violence awareness and prevention among bus and taxi drivers, and to modify school buildings and grounds to promote safety. The World Bank reports that South African school girls feel most unsafe at school gates, where students are able to congregate in large groups, at latrines or toilet areas in the absence of private latrines, and in male teachers' staff rooms and dormitories. This research has led to programs that emphasize building private latrines and training and hiring an increased number of female faculty and staff members.

Other efforts at creating a safe school environment take a more systemic approach. In Tanzania, the government has established a Mlezi (Guardian) system in which one teacher in each of the 185 primary schools is designated to support girls who have been sexually abused, need advice or seek to report an incident. Girls in schools with a mlezi state that they are much more likely to report harassment than girls in schools without such a guardian.

Plan Togo has implemented a national program to train teachers and increase accountability, modify curriculum to include violence, health and equity; improve school infrastructure; advocate for appropriate government support and resource provision; and engage parents and the community in preventing violence, all while simultaneously working to ensure that all children receive a successful basic education.

Similarly, the U.S. Agency for International Development (USAID) has launched a Safe Schools Program (SSP), that has begun pilot projects in Ghana and Malawi and conducted needs assessments in Jamaica and Ethiopia. SSP will take a similarly holistic approach to developing violence-free schools, and will provide adaptable training manuals on life skills and violence prevention, power dynamics in the classroom, and psychosocial support for survivors of violence. SSP is still quite small-scale and appears to be moving rather slowly, with needs assessments having begun in 2003 and programs still reaching only around 50 schools.

The Global AIDS Alliance, Global Action for Children, and other partners in campaigning for universal access to free basic education are now incorporating a safe schools agenda into all of our education work. Education is one of the greatest HIV prevention strategies available, yet when we send girls to unsafe schools, their chances of succeeding in school, and of subsequently breaking the cycle of poverty that puts them at risk of both violence and HIV are severely threatened. It is essential that our work focus simultaneously on advocating for the scale-up of successful models for preventing school violence and on continuing our efforts to secure education for all.

For further information contact: lschechtman@globalaidsalliance.org

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**China – Continued from page 9**

the social constraints of home, commercial sex work can become a temptation for an easy and lucrative means of income.

China’s shift to a free-market system has also increasingly put the burden of health care on individuals, resulting in a failing public health system. A recent report released by China’s State Council Development Research Center indicates that China’s medical insurance system currently covers less than half of urban and only 10 percent of rural residents. Due to the lack of medical insurance and social welfare programs, it has become exceedingly difficult for young girls to access affordable, quality adolescent health care and counseling, especially in China’s poverty-stricken countryside. Young girls again bear the brunt under a failing health-care system.

**Keeping Open the Window of Opportunity**

There is a narrowing window of opportunity to prevent a new generation of young females living with HIV/AIDS. It is time to learn from the experience in other regions. Many interventions are on a reasonable wish list, including sex education, expanded access to schooling, and quality health care, particularly in rural China, as well as programs to enhance HIV awareness and life skills among migrant workers. To do so, public health authorities and NGOs should work with the whole society to alleviate repressive attitudes toward drug use and commercial sex work to provide better outreach and health services.

Yet, it is the need for adequate data on the impact of HIV on the young female population in China that is perhaps most immediate and urgent. If we are to avoid a new generation of AIDS in China, the existence of young girls as valuable human beings and their intensifying vulnerability to HIV infection must first be seen and fully recognized in the society.

For further information contact: xln@csis.org

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**Argentina – Continued from page 8**

Only in October 2006, after many attempts, a national law was finally passed in Argentina that established sexual education at all levels without permission of students’ parents. Educating girls about sexuality and safe sex are crucial ways of decreasing the rate of infection. In the words of one Argentine AIDS activists, without this knowledge, “we are sending them into battle without arms.”

Also, young people must be reached by campaigns and messages in the mass media as well as face-to-face training to achieve a better rate of condom use, which is currently low and non-existent in stable relationships. It is necessary to continue strengthening interventions to promote the use of condoms among young people, particularly women, including free distribution. The bottom line is that young women must perceive their vulnerability to HIV/AIDS and they must have access to prevention methods, to confidential/voluntary testing and counseling, and access to “friendly” health-care services, including HIV/AIDS care and treatment provision.

There must also be cultural change to eliminate sexual inequality. Abstinence only and fidelity programs are not effective for girls and women in the LAC context of poverty and gender imbalance. Also, girls and women need to increase the generation of income to be economically independent, an important factor in controlling the epidemic.

Finally, policies to decrease poverty to improve the economic income of girls and women and access to education are the best ways to slow the spread of HIV. Religious and conservative opposition as well as economic constraints must be defeated by governments in LAC to succeed in the fight against HIV/AIDS and to avoid the suffering of girls and adolescents.

For further information contact: feim@ciudad.com.ar
The Office of the U.S. Global AIDS Coordinator (OGAC) launched www.PEPFAR.gov – a new online resource for the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). The website features comprehensive information on PEPFAR’s work around the world. The issue brief series provides an overview of each PEPFAR intervention area, examples of PEPFAR-supported work, information about results, and lists of key resources. Briefs are currently available on adult treatment, gender, and HIV counseling and testing. Information is updated frequently.

The Center for Public Integrity released Divine Intervention, a report on its year-long investigation into how President Bush’s $15 billion HIV/AIDS initiative has failed countries struggling with the pandemic. Reporters found that faith-based ideology often trumps science in the guise of federal rules and regulations and the support of organizations receiving taxpayer money. They found that after three years of PEPFAR, about $8.3 billion was spent with less than $1 billion going to prevention. During their investigations, reporters encountered PEPFAR officials who couldn’t answer basic questions about the programs they oversaw, PEPFAR recipients who were reluctant to criticize their donor out of fear of losing funding and Freedom of Information Act requests that were stalled for months. The report also features extensive in-country interviews, profiles of all 15 focus countries and a sampling of organizations that have received funding, as well as a PEPFAR glossary. For more information on the report, visit the website at www.publicintegrity.org/about/release.aspx?aid=78 and contact Steve Carpinelli at 202-481-1225.

Media coverage of HIV/AIDS worldwide leaves much to be desired in both quality and quantity according to the new report, Voice and Visibility: Frontline perspectives on how the global news media reports on HIV/AIDS published by Internews. The report points out that 25 years since the first news stories on HIV surfaced, reporters and editors still tend to stigmatize HIV/AIDS and people living with HIV/AIDS. The report is a collaboration between the Global Network of People Living with HIV/AIDS (GNP+) and the International Council of AIDS Service Organizations (ICASO). It analyzes responses from people living with HIV and frontline AIDS care and service providers from 44 countries. For copies, go to www.internews.org/press/2006/20061129_health.stx.

Left Coast Press, Inc. has published Witches, Westerners and HIV: AIDS and Cultures of Blame in Africa by Alexander Rödlach, PhD. Drawing on 10 years of work and research in Zimbabwe, Rödlach has written the first in-depth study of African theories about where HIV/AIDS comes from, who gets it, and who dies. He describes the complex cultural and political dynamics that underlie widespread beliefs about conspiracy theories and witchcraft. He also shows how these beliefs influence African people’s interactions with Western biomedical and health programs, explaining how cultural misunderstandings are contributing to the failure of many well-intentioned efforts. Contact the publisher for additional information: Jennifer Collier, 509-962-6364; Jennifer@LCoastPress.com.

The Center for Women’s Global Leadership has launched the online version of its new human rights report, Strengthening Resistance: Confronting Violence Against Women and HIV/AIDS that focuses on the social, political and public health crises of violence against women (VAW) and HIV/AIDS. The report highlights nine creative advocacy initiatives from different countries and regions, including South Africa, Haiti, Vietnam, Spain and India. It offers recommendations to governments, UN bodies and NGOs, and contains a resource section for further study. A full PDF version is available at www.cwgl.rutgers.edu/globalcenter/publications/strengthening.

Sonke Gender Justice has launched its new One Man Can Initiative. Timed to coincide with the 2006 16 Days of Activism to End Violence Against Women Campaign, the initiative is an ongoing campaign developed in partnership with the South African government and many national and international organizations. Visit the campaign website to download action sheets, fact sheets, workshop activities and a resource directory at www.genderjustice.org.za/oneman.ck.

Faces and Voices of Recovery – South Africa (FAVORSA) is a new website that provides “one stop” alcohol and drug abuse information, education and daily international news in Southern Africa. It is the only website to link the serious dangers and consequences of drug abuse and the spread of HIV/AIDS, particularly among the youth in South Africa. The designers of FAVORSA have brought together the best researched and accredited websites on Substance Misuse from around the world. To learn more about their work visit www.favor.org.za.

A South African Medical Research Council study found that one in five men between the ages of 15 and 26 years had raped a woman at least once in their lives, and most of them did so for the first time at 17 years of age. The authors said the destructive effect of apartheid policies on families made children vulnerable to sexual and emotional abuse and they concluded that there was considerable overlap between rape-associated factors and known HIV risk factors, suggesting a need for further research. Visit www.thethelancet.com/journals/lamin/article/PIIS147309906706429/fulltext for more information.

The Ark Foundation of Africa released a new book, Africa, AIDS Orphans and their Grandparents: Benefits and Preventable Hidden Dangers by Rhoi Wangila and Dr. Chinua Akukwe. The book documents the crisis and struggle of aging African grandparents caring for AIDS orphans. The result of a 15-year study, it reports on the troubling neglect and lack of global awareness on the safety of orphaned children under the care of grandparents. For more information on this topic or to see excerpts from the book, visit www.arkafrica.org.

SANIYA
ONE OF UGANDA’S YOUNGEST CAREGIVERS

BY PAUL MAYENDE
CHRISTIAN CHILDREN’S FUND – UGANDA

Eight-year-old Saniya is a shy, smiling, soft-spoken girl. But she is also a strong-willed, mature and courageous young lady. Little did Saniya know that at such an early age she would be in charge of the household and playing the role of care-giver. Her grandmother, Jaja, whom she often refers to as ‘mummy,’ is HIV/AIDS-positive. When Jaja’s condition deteriorated, Saniya was put in charge of the household.

Saniya is among the many young HIV/AIDS caregivers in Uganda. She was sent to live with her grandmother Jaja, at the age of two. Her father went to another town to look for work. “Saniya did all the housework, cleaning, cooking, fetching water and taking care of me,” said Jaja. “I taught her how to use gloves while nursing me, but the gloves were too big for her.”

Saniya was forced to leave school for three months to stay at home and take care of Jaja. “Jaja could not sleep at night; she wanted to be changed and be cleaned,” said Saniya. When Jaja started vomiting blood in the late hours of the night, Saniya ran to call in the neighbors for help. They took Jaja to the national hospital HIV/AIDS unit. There, Saniya sent the doctors out of the room crying when they realized she was the only person available to sign forms so that her grandmother could start using antiretroviral treatment for AIDS.

The doctors told Saniya of a CCF-Uganda Wakisso program, where community volunteers offer motherly care to HIV/AIDS clients. The volunteers took on Saniya’s role at home during the day so that she could attend school. They visited the family daily for more than five hours until Saniya’s grandmother was strong again.

Now Saniya is back in school and very relieved. Her major task is watching the clock and reminding Jaja to take her medicine early in the morning and at 8 pm before she goes to bed. “The drugs have to be taken two times a day and when Jaja forgets, I remind her at the exact time.”

For further information contact pmayenda@ccf.org

Saniya and her grandmother Jaja
AFRICA

High Number of Rapes in Zambia
Statistics released by the Young Women’s Christian Association (YWCA) of Zambia revealed eight cases of rape of young girls every week at its center in Lusaka. The report cited 15 women and girls being battered or physically abused by their husbands, and 53 percent of women overall as experiencing physical violence. The report said that the number of cases was high because girls and women are now more prepared to report the abuse and that alcohol and substance abuse was often a contributory factor. The Zambian government, in collaboration with civil society, has started consultations on a gender-based violence bill, and the YWCA said an amendment to the penal code providing stiffer sentences of rapists was before parliament.
– IRIN PlusNews, Dec 1

Condom Use Increasing Among Young African Women
Condom use among young women in Africa has been increasing, according to the journal, The Lancet. The researchers found that condom use increased more than threefold from 5.3 percent to 18.8 percent, with a median annual increase of 1.4 percent. Rates of abstinence changed little.
– AP/Philadelphia Inquirer, Nov 17

Ex-Fighters in DRC’s War Face High HIV Prevalence
Former combatants in the civil war in the Democratic Republic of the Congo are coming to terms with the unseen danger of HIV as they reintegrate into society. Roughly 180,000 former fighters are expected to enter disarmament, demobilization and reintegration (DDR) programs that include HIV/AIDS education. But there are fears that the short instruction period will be of little benefit and HIV cases will increase as combatants return to rural areas.
– IRIN News, Nov 14

Fish Sellers in Kenya Risk HIV
Hundreds of women in Kenya, who live along Lake Victoria, put themselves at risk of HIV by engaging in sex with fishermen in exchange for fish to sell. Some sellers also engage in sex with drivers of public vans so their fish can be transported more rapidly. Activists are mobilizing the community to form a theater group using participatory educational theater to perform skits, dances and songs related to HIV/AIDS.
– East African Standard, Nov 11

ASIA

India’s Criminalization of Homosexuality Undermines HIV Prevention
UNAIDS India coordinator Dennis Broun said that India’s law criminalizing homosexuality is undermining the fight against HIV/AIDS and violates the human rights of men who have sex with men. The law makes “carnal intercourse against the order of nature with man, woman or animal” punishable by up to 10 years in prison and, when strictly interpreted, makes it illegal to distribute condoms to gay men and men in prison. As the law is used to arrest offenders of sexual abuse of children, some people warn that if repealed, efforts to prosecute pedophiles and sex offenders could be negatively affected. The statute is being challenged under a 2001 lawsuit brought by the Naz Foundation India Trust. The Delhi High Court initially threw out the case, but the Supreme Court of India instructed the high court to review the case again.
– Reuters UK, Dec 1

HIV/AIDS in China Increases 28 Percent
According to China’s health ministry, the number of reported HIV/AIDS cases in China increased by 28 percent in the first 10 months of 2006, and the virus appears to be spreading to a broader population. However, health experts from the UN and the health ministry estimate that undocumented cases could be as high as 650,000. According to the report, injection drug use accounts for 37 percent of the new cases, unprotected sex for 28 percent, the illegal selling of contaminated blood from hospitals for 5.1 percent, and mother-to-child HIV transmission for 1 percent. Commercial sex workers accounted for 1 percent of new HIV/AIDS cases, and 1-4 percent of new cases occurred among men who have sex with men.
– International Herald Tribune, Nov 22

India to Adopt Policy Reducing Stigma
The Indian state of Maharashtra announced the country’s first policy to reduce discrimination against HIV positive people in the workplace. The policy, covering recruitment, transfers and promotions, will first be implemented in state government offices after which private firms will be asked to adopt the policy keeping the employee’s status confidential. Maharashtra, the wealthiest Indian state, has approximately 650,000 HIV positive people.
– Reuters, Nov 20

Rising Illicit Injection Drug Use in Afghanistan
The increasing use of illicit injection drugs in Afghanistan might be fueling the spread of HIV, according to the Afghan health ministry. There are 61 confirmed HIV/AIDS cases in the country, compared with eight in 2001, 18 of which are among women and 15 among illicit injection drug users. In addition, there are between 1,500 and 2,000 suspected HIV/AIDS cases, mostly among IDUs. To address the issue, three NGOs and a public hospital run programs to help IDUs overcome their addiction, and health authorities have encouraged an ABC model of HIV prevention.
– AFP/Yahoo! News, Nov 19

Chinese Tackle Rise in Injection Drug Use
In China’s mostly Muslim region of Xinjiang, public health officials are struggling to combat an increase in intravenous drug use and rising HIV infection. Roughly 60,000 of Xinjiang’s 20 million people are living with HIV/AIDS, and the region has one-tenth of China’s AIDS cases and the highest HIV prevalence nationwide. High resistance to treating drug use is a public health threat in China. Since 2005, health authorities in the region have used different strategies, including needle-exchange programs, drug substitution programs, community outreach programs, and briefings targeted toward imams and mullahs to tackle the situation.

Taiwanese Doubles Funding for HIV/AIDS Awareness
In 2007, the Taiwanese government plans to double funding for HIV/AIDS awareness programs, in response to the rising number of HIV cases among injection drug users. The campaign will receive $8.5 million compared with $4.3 million last year. Arthur Chen, director of the AIDS prevention and research center at National Yang Ming University, said surveys conducted among Taiwan’s prison population and drug users in the country indicate that the total number of HIV positive people in Taiwan could be as high as 30,000 – almost three times the official number.
– Bloomberg News, Nov 13
Risk Behaviors of Pakistani Truck Drivers

Truck drivers in Pakistan, soliciting commercial sex workers and using drugs on long-distance travel, are among the most vulnerable for HIV transmission. Although most associate condoms with contraception, many do not see them as an HIV prevention method. Many truck drivers view sex with commercial sex workers and injection drug use as part of their way of life. In addition, some receive treatment for sexually transmitted infections from traditional healers rather than doctors.

– IRIN News, Nov 14

CENTRAL AND EASTERN EUROPE

HIV Rising in Czech Republic

Due largely to low levels of awareness among young people who are not concerned about the disease because of the availability of newer drugs, the Czech Republic is recording an increasing number of HIV/AIDS cases, according to a new report from the National Institute of Public Health. A total of 899 HIV/AIDS cases were reported this year, compared with about 500 in 2000. The report found that more than 20 percent of HIV-positive people in the Czech Republic are women.

– Prague Daily Monitor, Nov 14

LATIN AMERICA AND THE CARIBBEAN

Chilean Condom Campaign Provokes Church Response

In an effort to reduce the spread of HIV in Chile, a new government-sponsored campaign in promoting condom use among youth has “provoked the ire” of the Roman Catholic Church and some conservative political parties. The $1 million campaign exclusively focuses on condom use and “makes no mention of abstinence” as an HIV prevention method. According to a 2004 government survey, most Chileans become sexually active at ages 16 or 17. About 35 percent of young people reported using a condom during their first sexual encounter and 52 percent reported never having used a condom. Official figures indicate that 14,820 people in Chile are HIV positive, but health officials say as many as 50,000 Chileans could be living with the virus.

– Miami Herald, Nov 10

MIDDLE EAST AND NORTH AFRICA

Stigma Complicates Prevention in Saudi Arabia

Social stigma associated with HIV/AIDS is complicating HIV awareness and prevention efforts in Saudi Arabia. The ministry of health announced in June that more than 10,000 people were HIV positive, although some physicians say the real number is much higher. Although the government recently has begun to address the spread of the virus, HIV prevention efforts often do not include discussions of condoms or safer-sex practices but instead focus on abstinence and the “fear of God.” People often link the disease to premarital sex, adultery and men who have sex with men— which are acts forbidden by their religion and sometimes punishable by death.

– AP/Houston Chronicle, Nov 27

Pan-Arabic Project to Address HIV/AIDS

Religious and political leaders from 20 Arab countries at a meeting of the League of Arab States announced a pan-Arab project to address HIV/AIDS in the Middle East. The project will aim to reduce HIV/AIDS in Arab countries and to provide medical treatment and counseling to HIV positive individuals and their families. The project will develop steps to promote abstinence, prevent commercial sex work, and provide health services and counseling. The project, called “Chahama,” meaning “magnanimity” in Arabic, will be funded through donations from individuals, mosques, NGOs and international groups. According to UNAIDS, there were more than 67,000 new HIV cases in the Middle East and North Africa in 2005. About 510,000 HIV positive people live in the region.

– Associated Press, Nov 10

NORTH AMERICA

Christian Conservatives Urge U.S. to Cut Global Fund

Claiming that the Global Fund does not allocate adequate resources to faith-based programs, that it promotes condom use, and doesn’t give abstinence messages, Christian Conservatives are calling for a reduction of U.S. money to the Fund. Peter Brandt, of the Christian group Focus on the Family, said that the U.S. could continue to support the Global Fund’s TB and malaria programs. Global Fund Executive Director Richard Feachem said that the battle against the pandemic “will only succeed if the great faiths of the world become totally mobilized.”

– The Boston Globe, Dec 1

Bush to ease rule limiting HIV-positive foreign visitors

President Bush announced plans to issue an executive order to ease a long-standing rule barring HIV-positive people from entering the United States without a special waiver, a ban long criticized by human rights groups. Because of the rule, organizers of the biannual International AIDS Conferences have not held a gathering in the United States since 1990, when San Francisco hosted the event. “Activists, taken by surprise by the announcement, generally praised Bush’s decision but said all restrictions on immigrants with HIV should be lifted. “It’s a step away from a terribly discriminatory and inappropriate policy, but it doesn’t go far enough,” said Leonard Rubenstein, executive director of Physicians for Human Rights, in Washington. “This is a treatable disease. If you want to remove stigma from AIDS, you have to go the whole distance, and eliminate all restrictions on entry to the United States for people with HIV.”

– San Francisco Chronicle – Dec 2

PEPFAR to Increase Generic Drugs

The U.S. government has dramatically increased the amount of generic antiretroviral drugs distributed under PEPFAR. According to data from the first three months of FY 2006, generics will account for more than 70 percent of antiretrovirals distributed in Nigeria, Haiti and Zambia—a sevenfold increase in one year and a “direct result” of FDA finding that 29 generic drugs are safe. Mark Dybul, U.S. Global AIDS Coordinator, said that the FDA process is vital for PEPFAR’s long-term sustainability and safety. He added that the U.S. government “always has wanted the lowest-cost product as long as it was safe and effective.

– Boston Globe, Nov 12

Male Circumcision Should Be ‘Central Strategy’ To Fighting HIV/AIDS

After two NIH studies “removed any doubt” that male circumcision helps protect men from HIV infection, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the President’s Emergency Plan for AIDS Relief “should make circumcision a central strategy as soon as possible,” a Boston Globe editorial said. The studies from Kenya and Uganda found that routine male circumcision could reduce a man’s HIV infection risk through heterosexual sex by about 50 percent. The results of the studies were so overwhelming that NIH stopped the trials early and offered circumcision to all participants. The researchers also found no evidence that the circumcised men in the studies adopted higher-risk sexual behaviors, including sex with multiple partners and unprotected sex. A procedure such as circumcision, which could be administered by trained non-physicians for relatively low cost and provide close to that level of protection, would save millions of lives.

– Boston Globe, Dec 17

Southern African Leaders Discuss HIV/AIDS Among Sex Workers, MSM

Leaders from 14 member nations of the Southern African Development Community gathered in Blantyre, Malawi, for the third annual forum of national AIDS authorities to discuss ways to reach out to commercial sex workers and men who have sex with men to help control the spread of HIV. Malawi’s Health Minister Marjorie Nguenje said that Southern African countries must break the silence surrounding HIV/AIDS in vulnerable populations. “To make advances in prevention, we must begin to tackle honestly the difficult questions that the epidemic raises ... addressing positively the needs of sex workers and of men who have sex with men.” Commercial sex work “is not officially accepted in Malawi and other countries, but the truth is that it happens, and let’s open up, and we need to start talking about these issues,”

– Mponda, SAPA/Independent Online, Dec. 12

Global AIDSLink | 21
Jan. 13-19
Vital Voices Pan-African Leadership Summit & Initiative for Women and Girls
Location: Cape Town, South Africa
Organized by: Vital Voices Global Partnership/African and International Partners
The African Leadership Initiative for Women and Girls will build the capacity of more than 200 emerging women leaders and girls throughout Africa and build a powerful new network across sectors, while shining a spotlight on the advancements of African women leaders. For more information visit www.vitalvoices.org

Jan. 17-19
10th Bangkok Symposium on HIV Medicine
Location: Bangkok, Thailand
Organized by: HIVNAT, the Netherlands, Australia, Thailand
For more information visit www.hivnat.org17 and contact Chris Duncombe.

Jan. 22-25
HIV/AIDS and the Impact on Business in Africa
Location: Sandton Convention Centre, Sandton, South Africa
Organized by: IQPC SA
Distinguished speakers seek solutions to minimize the effect of HIV/AIDS on business, including an increase in loss of skills and absenteeism. For more information contact Cheryl Smith at: www.aidsafricaconference.com.

February 2007
Feb. 4-6
International AIDS Conference: Strategies and Challenges for AIDS Management
Location: Varanasi, Uttar Pradesh, India
Organized by: M.G. Kashi Vidyapith University, Varanasi in collaboration with UPSACS and supported by UNICEF
The conference will comprise keynote address, guest lectures, free paper presentations, symposia, workshops. Avenue for updating knowledge and skills for those working in the field of HIV/AIDS research, treatment, prevention. For more information contact Prof. Anand at profananda@yahoo.com or call 9415202167.

March 2007
March 8-11
The 2nd World Conference on Gender-Specific Medicine
Location: Rome, Italy
This Congress will present new frontiers in health care based on the biological, physiological, pathological and therapeutic differences between women and men. For more information contact Michal Pink at www.gendermedicine.org.

April 14-15
Best Practices to Achieve Global Goals – A Unite for Sight Conference
Organized by: Unite For Sight
Location: Palo Alto, CA
Unite for Sight’s Fourth Annual International Health Conference will convene more than 1,500 people interested in international service, global health, public health, international development, eye care, health policy and advocacy, entrepreneurship, microfinance, bioethics and medicine. It brings together students, doctors, nurses, Peace Corps volunteers, public health, business and nonprofit professionals, anthropologists, policy-makers, and others. The goal is to exchange ideas across disciplines about best practices to achieve global goals in health and development. For more information visit http://uniteforsight.org/2007_annual_conference.php and contact Jennifer Staples.

April 16-18
8th International Workshop on Clinical Pharmacology of HIV Therapy
Organized by: Virology Education
This abstract-driven workshop will have invited lectures, roundtables, poster sessions and oral abstract presentations. Full information and online registration can be found on www.virology-education.com. Deadline for abstracts and proposals is March 5, 2007.

May 2007
May 4-5
HIV Management 2007: The New York Course
Location: New York, NY
This advanced continuing medical education activity will provide participants with the latest information and practical guidance from nationally and internationally recognized AIDS experts on pathogenesis, resistance and treatment of HIV. For more information visit www.newyorkcourse.com.

May 13-17
18th International Conference on the Reduction of Drug-Related Harm
Location: Warsaw, Poland
Organized by: International Harm Reduction Association/Conference Consortium
This annual international conference is a key forum for the dissemination of harm reduction ideas and practice, attended by more than 1,000 people from over 60 countries. It brings together frontline workers, researchers and policy-makers. For more information visit www.harmreduction2007.org or send an e-mail to management@harmreduction2007.org.

May 23–25
Crucial Issues in HIV Diagnosis and Management in South-East Europe
Location: Belgrade, Serbia
Organized by: The Training Initiative of the Royal Free Centre for HIV Medicine
The goal of this free training is to improve current HIV/AIDS care and prepare for the future health-care needs throughout southeast Europe with quality education, sharing of clinical experience and regional cooperation. Visit home_AT_partners-services.co.uk for more details.

May 29-June 1
Partnerships Working Together 2007
Location: Washington, D.C.
Organized by: The Global Health Council
The Global Health Council’s 34th Annual International Conference is dedicated to partnerships: how they are built, what they have and can deliver, and how those living in poverty and disease can best benefit. For information visit: www.globalhealth.org/conference/.

June 2007
June 7-9
3rd International Workshop on HIV and Hepatitis Co-infection
Location: Paris, France
Organized by: Virology Education
Online registration and abstract submission are possible from Feb. 15, 2007, via website www.virologyeducation.com. For more information visit Website: www.virology-education.com and contact Jo-Els van der Woude.

June 25-28
International Union against TB and Lung Disease – Eastern Region
Organized by: Ministry of Health Malaysia, Malaysian Association for the Prevention of Tuberculosis, International Union against Tuberculosis & Lung Disease
Location: Kuala Lumpur, Malaysia
The conference is designed to address the growing trend of HIV/TB co-infections in Asian countries. Emphasis will also be placed on the other core challenges of the TB control program such as DOTS. For more information visit www.tubi2007.com and contact Grace Chong.

July 2007
July 4-7
International Women’s Summit – Changing Lives, Changing Communities (Women’s Leadership on HIV/AIDS)
Organized by: WorldYWCA, International Women’s Summit and International Community of Women Living with HIV/AIDS
Location: Nairobi, Kenya
The conference will bring together some 1,500 women leaders of all ages and HIV statuses, including representatives of national, regional and international non-governmental and faith-based organisations, researchers, advocates and other stakeholders. The summit will build skills, help strengthen existing networks, and create new partnerships to mobilize needed change and address the global HIV and AIDS pandemic and its impact on women and girls at all levels. For more information contact Clarissa Balan at clarissa.balan@worldywca.org.
The Sky’s the Limit

BY RUDO MOYO
spoken to and translated from Shona by Francisca Nyamukoro

My name is Rudo Moyo and I am 17 years old from Zimbabwe. My mother passed away and left behind three children. I am the third born. When she died we were left under the guardianship of my aunt, who herself passed away later. Following her death, we went to stay with our maternal grandmother in the communal lands at Mashonaland East Province. And then our uncle came to take us to live in town.

The first days with our uncle were good, but as time passed it became more and more unbearable. My uncle mistreated me and took me out of school to do his bidding. Two of my boy cousins raped and beat me but nobody took me to the hospital for treatment. And then my uncle sent my older sister Nicole to the communal lands and told her never to come back again. When I was in Form III, she moved back to town and took me out of my uncle’s house to live with her. She sent me back to school and paid my fees.

In 2005 Nicole told me about Girl Child Network. They took me up and I was placed in one of their empowerment villages in Chihota. The matron at Chihota empowerment Village, Mrs. Gumbere, then took me to Chitungwiza Central Hospital.

I was tested for HIV and the results revealed that I was positive. No words can describe exactly how I felt at that moment, but I remember wishing that the ground would just open up and suck me in. But I knew that I had to be strong and go on with life.

I was released from the empowerment village after going through a rehabilitation process to regain my self-esteem. I went to stay with my mother’s sister. She often shouts at me for no apparent reason. I often wish that my mother were alive so I would not be facing all these trials and tribulations.

I have faced so many challenges because of my HIV status. The community that I live in still has a lot to learn about HIV and AIDS. Being HIV positive at 17 when every girl in the village is still expected to be a virgin has left most people wondering what my story is exactly. It is not easy to open up to every one about being raped by your cousin brothers.

Now it has been a number of years living with the virus and I take good care of myself and live positively. I am glad that I have managed to fight both self-stigma and discrimination. I have realized that I can do anything and everything that any girl my age does. I am open about my status because I realized that it is good therapy. At the empowerment village I was taught that it can help one overcome the stress and anxiety associated with HIV. People no longer whisper when I am around or gossip about me because they know that I am fine with talking about my status. Also, I was taught that sometimes people die of the virus, but more often they die of loneliness.

My aunt is still a hard nut to crack but I don’t take what she says to heart. My friends have accepted me the way I am. My status has made me very popular at school and I actually use this as an opportunity to educate other girls about the disease. I tell them that it can catch anyone no matter how clever they might try to be.

Our village is full of child-headed families who have lost one or both parents to HIV/AIDS. I am aware of their plight and it is very unfortunate that at school most of these kids face a lot of discrimination and don’t know how to fight it. Some drop out of school, because of the stigma or because they may have to take care of a sick parent at home. Girls have special needs, which when ignored, can make them more vulnerable to many things like diseases and abuse.

Now I am able to help other girls who are HIV positive by providing peer to peer counseling. I use every opportunity to share the knowledge I got when I was at the empowerment village. I also take part in activities at our Girl Child Network club at school. I could call our club a support group because we are made to feel at home and we discuss all issues that affect us as young girls with the support of our club coordinator. It feels good to have a platform to discuss issues as girls. I am able to conscientise and sensitize girls who are HIV positive on where and how to get help, also on the dos and don’ts.

I am on ARVs and managing quite well. The Girl Child Network gives me transport money to come to Chitungwiza General Hospital for my check-ups and whenever I fall ill I can easily access treatment. They are also paying for my education, food, uniforms and most importantly by providing money to buy antiretroviral drugs on a monthly basis.

I am quite aware of the diet that will keep me healthy and that is what I stick to. I eat whole and natural foods. These are almost always readily available in the village. We also have indigenous foods and they are healthy as well. At the empowerment village we were always encouraged to stay away from fatty diets and junk food.

My experiences have helped me grow. I am now much stronger and I feel that I am ready to tackle any challenge that comes my way. What is left is for me to plough back what I got. I can see a bright future ahead of me and I definitely will swim against the tide and remain above my situation. I would want to encourage all the girls out there to remain firm, for the sky is the limit!

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