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Southern Africa HIV and AIDS Information Dissemination Service

Africa Wins Every Time You Prevent HIV

By Mary Leakey and Cynara Vetch

The Africa Goal 2010 campaign provided an innovative platform for effective HIV information and experience sharing centred around the FIFA World Cup 2010 football matches. Throughout the duration of the FIFA World Cup, the Africa Goal team travelled from Kenya to South Africa, through the region of the world most affected by the HIV epidemic. Every match day the Africa Goal Team screened live World Cup football matches and disseminated HIV information in different localities, sharing not only the excitement of the World Cup but also vital information on HIV with diverse audiences.

Football, the perfect catalyst for bringing people together

The campaign, implemented in a partnership between Africa Goal and SAfAIDS, reached around 25,000 people in sub-Saharan Africa with HIV Information. The team mostly targeted young people, with access to limited resources, and who are located in hard to reach areas with HIV information; this key demographic has often been excluded from HIV information initiatives.

Starting in Kenya, the team travelled through Tanzania, Malawi, Zambia, Zimbabwe, Mozambique, Swaziland and South Africa. The route roughly followed the so-called 'AIDS Highway', through Eastern and southern Africa. This transport and trade route is defined by its high infection rate, caused by a combination of increased mobility and migration.

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EDITORIAL

The FIFA World Cup is over. The momentum of the event brought a renewed spirit to South Africa, as it demonstrated that it is a country that is capable of successfully hosting an international event of this size. In response to the severity of the region's HIV epidemic, many AIDS service organisations (ASOs) took the opportunity to use the spectacle to ensure that clear messages about HIV were there for the public to see and to provide ready supplies of condoms. Several innovative campaigns were developed around the football theme, with vital HIV messages specifically targeted at some hard-to-reach groups.

Our lead story covers one of these - Africa Goal, for which SAfAIDS was proud to provide IEC materials, t-shirts and the ever popular vuvuzelas for distribution. The Canadian Embassy provided much needed financial support, and the team partnered with key ASOs in each of the countries they visited. Africa Goal brought both the FIFA World Cup games, and messages and information on HIV to some of the most remote parts of the sub-Saharan Africa region. The growth of portable technology that allows satellite images of live football to be projected on a manageable film screen virtually anywhere a vehicle can drive has been exploited to the full by Africa Goal and their partners. For those who attended, the messages they delivered will be indelibly linked with the wonder and excitement of watching a World Cup football match as it happened on the African continent.

Africa has called unwanted attention to itself over the last few months with an increase in hostility towards people of different sexualities. The article from amFar highlights this increasing homophobia and its impact on prevention efforts among men who have sex with men. And in News Plus, we carry an important article on emerging issues in gender and sexuality, based on Raewyn Connell's notion of hegemonic masculinities and reflections on emphasised femininities. The authors argue that the goals of HIV prevention and optimising care are best dealt with by addressing gender identities, rather than focussing on individual sexual behaviours.

Two articles from IOM highlight the difficulties presenting in hard-to-reach communities and the problems among increasingly mobile populations crossing borders, as well as working populations whose employment, often in the mining, transport and construction sectors, forces them to be mobile. There is a clear need for employers to take greater responsibility for the situations they put their employees in and to ensure that there are adequate health facilities, as well as safe forms of entertainment available, at places where workers find themselves away from their families, often with only alcohol for company.

The second article highlights the role that gender relations play in increasing women's vulnerability to HIV. This study, carried out recently in Zambia, also revealed that incidences of domestic and sexual abuse may be much higher than previously thought. This report provides valuable evidence on which to base future programming.

As this issue goes to press it seems increasingly likely that donor funding for ARVs will become tighter and tighter. While PEPFAR has recently approved a slight increase in its ARV funding, from US$6.8billion to almost US$7billion, many countries, and international agencies, such as MSF, are already halting new treatment initiations. This brings back the spectres of people in what should be the prime of their lives dying of treatable disease, overburdened health care systems and communities and an increasing number of orphans and children made vulnerable by HIV (see also the article on the plight of children who care for parents with HIV). We believe these cut-backs in funding are a result of fatal short sightedness and failure to recognise the huge impact made by the breakthrough policy of universal access to treatment. The MSF report 'No time to quit', highlighted in this issue, says this better than we can, while the article on the imbalance of treatment availability between rural and urban areas also calls into question the notion that those who need treatment have access to it, even at current funding levels.

Not only is treatment for HIV of inestimable value in high-burden countries, but more evidence is now coming to light that demonstrates that treatment is itself one of the most effective methods of prevention. Thus, several of the articles we present in this edition showcase this research in the hope that policy makers and donors will together realise that this is not the time to reduce access to ARVs. There is need instead to push for greater access to generic ARV treatment and to less expensive diagnostic testing that will allow treatment initiation and monitoring to be easily carried out in low resource countries. And, of course, we must never stop talking 'prevention, prevention and prevention' – even while we recruit treatment as a major prevention method.

Vertical transmission of HIV is the single greatest cause of HIV in people under the age of 15 years and provides the most convincing argument for advocating for treatment as prevention. Are we to return to the days when we gave the mother a short course of ARVs to protect her baby and then left the child to gamble with possible infection through breast milk; or an early death because her mother has succumbed to HIV? But let us also look at the role HIV plays in other ostensibly unconnected areas that are gaining attention – maternal and neonatal mortality. In Zimbabwe, a 2007 study revealed that 25% of maternal mortalities involve HIV as an indirect cause of death. When the mother dies, a newborn's chances of survival are severely reduced.

If there was a single disease called HIV and we would only see resurgence in this particular condition, the reduction in funding for HIV treatment might be understandable. But HIV carries a whole host of co-morbidities, whose death toll will increase incrementally when access to treatment is reduced. Perhaps the disease we should be most concerned about is tuberculosis (TB), which has already increased exponentially, while at the same time breeding both multi-drug resistant (MDR) and extremely drug resistant (XDR) varieties.

These diseases threaten all of us - not just those living with HIV. The TB bacillus is one of the most ubiquitous in humankind, and thrives in conditions of poverty and overcrowding. With increased mobility and international air travel, it is easily spread; making undiagnosed MDR and XDR TB a serious risk for everyone the infected individual comes into contact with. The health care costs of significant epidemics of MDR and XDR TB, not to mention 'ordinary' TB, along with an appalling death toll, will cost humanity a great deal more than continuing to ensure universal access to ARV treatment.

Africa Wins Every Time You Prevent HIV

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Africa Goal crew pitching up a tent, during one of their AIDS Highway campaigns

These factors, alongside rising disposable incomes and the associated escalation of transactional sex, are major contributors to the spread of HIV through the region. In order to maximise impact and ensure relevance and sustainability, the team partnered with local organisations in each of the areas visited. The local experts guided the team on the specific HIV-related issues that were of most relevance to the communities in question.

Regularly, between 1,000 and 2,000 people gathered to attend the HIV events and watch the FIFA World Cup matches – far exceeding expectations. For the first match near Lake Victoria in Kenya, over 1,000 people gathered to watch drama pieces focusing on various HIV issues being performed by local school and youth groups, and to visit information stands representing all the local health organisations which had assembled to promote their HIV related activities, and to share information on the services they provide with those who gathered for the event.

The event was co-ordinated by the District AIDS and STI Coordinator (DASCO) for Mbita, western Kenya, where the match was held. Mr Okomo explained that in partnering with Africa Goal, his organisation "...wanted to take advantage and ride on their back. We know the community loves football and we wanted to deliver to them messages of prevention and management of HIV."

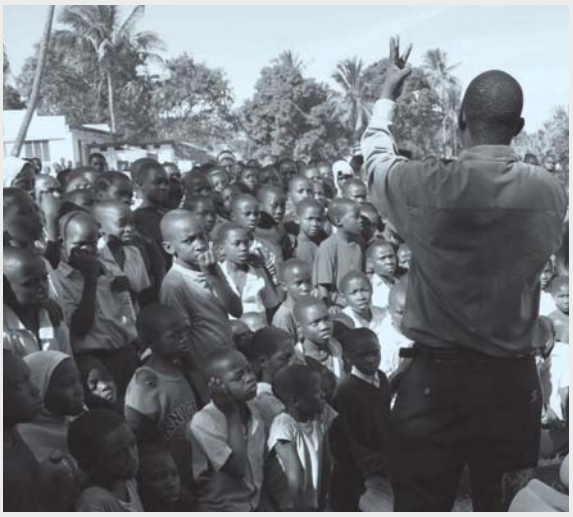
No other sport in the region has the capacity to draw so much attention - football is played and followed in Africa with a passion. In rural, isolated communities such as those visited during the Africa Goal 2010 campaign, football is one of the few sports accessible to all.

At a number of the events, partners arranged for VCT to be conducted on-site. At one memorable event in Lake Baringo, also in Kenya, 28 people were tested during just the second half of the game. Although low compared to the number of people attending the match, the Chief and doctor explained that no one had ever volunteered for testing at previous VCT events that had been conducted in the village. In fact, the doctor almost dismantled his testing site during the interval when only one person had been to see him for testing during the first 45 minutes of the match. However, after identifying a number of youth leaders in the group, and encouraging them to take the opportunity to advise others in the audience of the importance of testing, a steady stream of audience members could be seen heading to the testing site. A number of people actually opted to stand in line for testing rather than watch the second half of the match. As a result of this major breakthrough, it was agreed that the testing site would be made available the following day as well for those who had not had the opportunity to get tested. A further 84 people signed up to attend the following day's VCT.

In Zambia, the events coincided with a National VCT day which would be held a few days after the screening event, on the 30th of June 2010. With this in mind, SAfAIDS and their partners took advantage of the opportunity to mobilise support for the VCT testing drive which would take place throughout the country. A number of HIV related discussions were also held at the Zambia events, as the sense of unity and openness that was cultivated provided a very conducive environment for the discussion of potentially controversial issues, such as the inter-linkages between LGBTI and HIV.

In Mozambique, the team worked with Nweti Trust, a One Love Campaign partner. Magaia, Research Manager with Nweti Trust, explained that about 70% of people in Mozambique are involved in multiple concurrent partnerships (MCPs) and that this is a key reason for the country's 16.1% HIV prevalence rate. After screening a One Love Campaign film, David engaged the audience - made

up mainly of young people in their teens and early twenties - in a lively discussion about relationships; focusing on the HIV risks involved in different types of relationships. Vuvuzelas and T-shirts developed by SAfAIDS and bearing the SAfAIDS slogan 'Africa Wins Every Time You Prevent HIV' were distributed as prizes to audience members who answered questions correctly, or raised key issues in the discussion. David explained why Nweti Trust chose to partner with Africa Goal: "Soccer is one of the events that brings people together - different races, colours and creeds. So many people are involved in this that we can really spread information about HIV. I think it is a wonderful thing and it works because we need to have a mainstreaming of HIV into everything that we do."



HIV information dissemination with school children

Another highlight of the campaign was the event held on the 7th of July in Swaziland. The Minister of Health, Honourable Bennedict Xaba, excited by the concept, mobilised participants through radio and television prior to the event. Through his support and enthusiasm, the occasion became a national event, starting at 9am in the morning and continuing throughout the day.

Africa Goal campaign materials

With around 4,000 people in attendance and a number of local and international organisations represented; the day provided an excellent opportunity to reach people with HIV information as a means to tackle HIV in the country with the highest prevalence in the world. Currently, Swaziland is implementing a major drive to encourage male circumcision, since the Government has pledged a 100% circumcision rate amongst young men. The Africa Goal event provided PSI with an opportunity to counsel hundreds of young men on the benefits of medical male circumcision, as well as signing up over 100 for the procedure. A football and netball tournament was also conducted for all the local schools in the area. At the prize giving ceremony, Mr Xaba spoke to the captains of the football teams and urged them to set up health clubs at their different schools. Showing his personal commitment, Mr Xaba pledged to put up funding for any groups that were established, as well as to assist them in any way that he could. His idea was that these young men would be leaders for their generation and would be instrumental in persuading their friends and classmates to stop the spread of HIV.

Football matches were broadcast live in communities

Throughout the campaign, the SAfAIDS materials, which included packages containing stickers, condoms, post cards, booklets and posters; and slogan branded footballs, as well as the vuvuzelas and T-shirts, proved a huge hit. Often, the audience members were so engrossed in the booklets that had been distributed that they didn't notice goals being scored!

This is not the first Africa Goal expedition - the concept evolved from the 2006 World Cup - during which the team travelled from Kenya to the West Coast of Namibia. Following the huge successes achieved through this year's campaign, it is clear that it will not be the last.

The Africa Goal 2010 campaign is supported by the Government of Canada, The Danish AIDS Foundation, SAfAIDS and PSI Zimbabwe.

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

Regional Training On The Development Information System (DevInfo)

The UNAIDS Regional Support Team for eastern and southern Africa co-facilitated a four-day training on the Development Information System (DevInfo) from February 15th to 19th, 2010 in Johannesburg, South Africa. The training was attended by staff from the Regional Support Team and members of the Regional AIDS Team for Eastern and Southern Africa (RATESA), who learned to use and customise DevInfo to generate statistical data on HIV specific to the region.

The development of a DevInfo database specific to eastern and southern Africa stemmed from the growing demand for sound and accessible statistical data on the trends of the HIV epidemic and nationally and internationally agreed on goals on HIV prevention, treatment, care and support (including the MDGs).

DevInfo is a database system that can be used to organise, store and present data in a uniform way to facilitate data sharing at country, regional and global levels across government departments, the United Nations, civil society organisations and development partners. DevInfo contains simple and user-friendly features that make it easy to produce tables, graphs and maps for inclusion in reports, presentations and advocacy materials.

The software supports both standard indicators (the 48 MDG indicators) as well as user-defined indicators.

Wayne Gill, UNAIDS Regional M&E Advisor for Eastern and Southern Africa, said, "The regional data warehouse is expected to become an essential tool for UNAIDS and members of RATESA to map the ever-changing trends of the HIV epidemic and monitor progress on national and international priorities, such as Universal Access and the Millennium Development Goals. In addition, with the new automated Country Response Information Systems (CRIS) data exchange mechanism, UNGASS indicators will be easily updated".

It is expected that the regional data warehouse will improve the accessibility and availability of data and help all users to generate up-to-date reports, maps, tables, presentations and other materials that are indispensable for sound policy and decision making.

The database was launched on June 4th 2010. For additional information contact Wayne Gill at gillw@unaids.org or +27 11 517 15 59

UNAIDS Executive Director launches the National HIV Counselling and Testing Drive in South Africa

UNAIDS Executive Director Mr Sidibé joined South Africa's President Jacob Zuma, Minster of Health Dr Aaron Motsoaledi and Gauteng Premier Ms Nomvula Mokonyane for the launch of the world's largest HIV testing and counselling campaign at the Natalspruit hospital in Erkuhuleni, east of Johannesburg on April 25th, 2010.

UNAIDS Executive Director Mr Sidibé

The campaign, which hopes to test 15 million people by the end of June 2011, is aimed at providing antiretroviral drugs to 80% of South Africans in need of treatment. The campaign's prevention drive includes an increase in the provision of male condoms from 450 million to more than 1,5 billion condoms.

Mr Sidibé commended President Zuma and Minister Motsoaledi for their leadership and commitment to the HIV response in South Africa, and for the unprecedented mobilisation of South Africans to test for HIV. This campaign "is the biggest national mobilisation in South Africa around any one single issue since the end of apartheid", said Sidibé. "Testing 15 million people by the end of 2011 is the largest programme scale-up in the world we have seen so far. It is historic".

Mr Sidibé and Minister Motsoaledi took an early morning jog and later joined President Zuma, government officials and representatives of civil society in delivering keynote speeches. The launch also included performances by South African artists Choome, Arthur Mofokate and Ihashi Elimhlophe who sang songs carrying messages on the importance of people getting tested.

The launch was opened with songs carrying messages on the importance of people getting tested

In his address, President Zuma disclosed his negative HIV status and encouraged South Africans to test regularly without, however, being obliged to disclose their status. "Anyone's HIV status is private and confidential. Disclosure is an individual decision. We must respect the decisions of those who choose to keep their status confidential, whether positive or negative", he said.

President Zuma said that the testing and counselling drive is aimed at changing attitudes and lifting the stigma attached to HIV. "We have to work harder, together, to fight the perceptions and the stigma, he said. "We have to make all South Africans understand that people living with HIV have not committed any crime, and that they have rights like any other citizen".

South Africa has the world's largest population of people living with HIV; an estimated 5.7 million people in the country are living with HIV, representing nearly one sixth of the global disease burden and approximately 18% of adults in South Africa.

RESOURCES

Inter-Agency Standing Committee Addressing HIV in Humanitarian Settings Guidelines

The Inter-Agency Standing Committee (IASC) Guidelines for Addressing HIV in Humanitarian Settings have been finalised and are currently being published and distributed. A training package is being developed for the roll-out of the Guidelines in Zimbabwe (planned for May 2010), the Democratic Republic of Congo, South Sudan and the Central African Republic. These countries were selected by the Global Taskforce on HIV in Humanitarian Settings, which revised the Guidelines during the last three years.

The Regional Inter-Agency Working Groups on HIV in Humanitarian Settings for East and Central Africa and southern Africa selected Malawi and Kenya, respectively, as additional countries for the roll-out this year.

For Guidelines for Addressing HIV in Humanitarian Settings, see: http://www.unaidsrstesa.org/files/u1/IASC_HIV_Guidelines_2009_.pdf

Fomenting a Revolution for HIV

The year 2010 is the year set by the UN to achieve universal access to HIV prevention, treatment, care and support.

Last year, UNAIDS set nine priorities for the Joint Programme with high, but achievable goals. Seven of the goals focus on prevention, collectively underpinning UNAIDS' call for a "prevention revolution" - a revolution that recognises the heterogeneity of HIV epidemics, provides more targeted prevention for most-at-risk groups, and reverses the systematic under-investment in prevention interventions.

Source: The Lancet, Volume 375, Issue 9714, Pages 533 - 535, 13 February 2010, see http://www.unaidsrstesa.org/files/u1/Sidibé_Prevention_Revolution_lancet.pdf

HIV treatment may prevent at least nine out of ten transmissions

By Gus Cairns & Kelly Safreed-Harmon

A study of HIV transmission between long-term, HIV-serodiscordant heterosexual couples in Africa has found that the chance of transmission is reduced by at least 90% if the HIV-positive partner is on antiretroviral therapy.

As a comparison, this is better than the efficacy of 100% attempted condom use, which is in the order of 85% (with a high margin of uncertainty).

There was one transmission from a partner who was taking HIV therapy, however, and presenter Deborah Donnell said that this indicated that the advice to serodiscordant couples that they should maintain safer sex should not change, even when the HIV-positive partner was on treatment.

The proportion of couples who had unprotected sex actually decreased when the HIV-positive partner started treatment, allaying fears about behaviour change, at least in this population and in the short term.

The other important finding from this study was that untreated partners with CD4 counts under 200 cells/mm3 were approximately five times more likely to transmit HIV than those with CD4 counts over 350 cells/mm3, strengthening the case for extending antiretroviral (ARV) provision to all people with low CD4 counts.

The Partners in Prevention study

This was a sub-study in the Partners in Prevention study, a large randomised controlled study designed to see if treatment for the genital herpes virus HSV-2 could reduce HIV transmission. The main study, as reported at last year's IAS Conference in Cape Town, found that herpes treatment was ineffective as HIV prevention.

This sub study was purely observational – it did not randomise people to HIV therapy – so its results can't be regarded as conclusive. Donnell remarked that for that we will have to await the results of the HTPN 052 study, which is currently underway.

Untreated partners were far more likely to transmit HIV if they had low CD4 counts.

In the study, 3,381 serodiscordant couples from seven countries from south and east Africa were included. The average age of women in the study was 29 and men 37, and two-thirds of the HIV-positive partners were women. All the HIV-positive partners had HSV-2.

At baseline about 30% of partners reported having unprotected sex with their main partner in the previous month.

None were on HIV treatment at baseline, and one of the study inclusion criteria was that the positive partner had to have a CD4 count over 250 cells/mm3. The average baseline CD4 count was over 400 cells/mm3.

CD4 counts were taken every six months and HIV status assessed. ARV therapy was ascertained by self-report: there was no independent confirmation that people were indeed on HIV therapy. Women taking short-term therapy for the prevention of mother-to-child transmission (PMTCT) were not counted as being on ARVs, and about one-third of women in fact took ARVs for this purpose at some point.

During the study 349 people, about 10% of the total, initiated HIV treatment. Approximately half of people initiating treatment had CD4 counts under 200 cells/mm3 at initiation and one-third between 200 and 350 cells/mm3.

There were 151 new HIV infections in the study. One important aspect of the study was that human immunodeficiency viruses in transmitting and infected partners were sequenced to show that the new infection had indeed come from the long-term partner, and 108 were thus linked: so 28.5% of infections came from someone who was not the primary partner. Five of these 108 transmissions were excluded because the partner's ARV status was unknown, and one because the positive partner was a woman taking ARVs for PMTCT.

The relative risk of transmission from a partner taking ARVs, when adjusted for time on study and CD4 count, was 0.08; a 92% reduction in HIV transmission.

Only one of the transmissions came from a partner taking ARVs.

When HIV incidence was calculated in terms of person-years of follow-up, antiretroviral users and their partners had a transmission rate of 0.39 per 100 person-years (1 case ÷ 256 person-years) (95% confidence interval [CI], 0.09-2.18). Antiretroviral non-users and their partners had a transmission rate of 2.23 per 100 person-years (102 cases ÷ 4,851 person-years) (95% CI, 1.84-2.70).

This meant the relative risk of transmission from a partner taking ARVs, when adjusted for time on study and CD4 count, was 0.08; a 92% reduction in HIV transmission.

Some significant differences were observed among subsets of study participants. A higher proportion of men (12%) than women (9%) initiated antiretroviral therapy ($p = 0.01$). Men initiated antiretroviral therapy at a median CD4 cell count of 192 cells/mm3, while the median for women was 204 cells/mm^3 ($p = 0.05$).

The single case of transmission involved a man who initiated ARVs 18 days before his 12-month study visit. At this visit his partner tested positive for HIV, having been negative at month 9. His CD4 count was in the 200 to 350 cells/mm^3 range.

Untreated partners were far more likely to transmit HIV if they had low CD4 counts. Annual HIV incidence among HIV-negative partners was 8.79% if their partner had a CD4 count under 200 cells/mm^3, 2.79 for CD4 counts between 200 and 350 cells/mm3, 1.70 between 350 and 500 cells/mm^3, and 1.82 for CD4s over 500 cells/mm^3.

Unprotected sex declined when partners started ARVs. Before ARV treatment, 6.2% of partners reported unprotected sex in the previous month; 3.7% reported it after treatment initiation. There was no change in sexual frequency.

This study had a number of limitations: it was not randomised, ARV status relied on self-report, and transmission and behaviour data were only followed for a maximum of two years. Using a single transmission to calculate the risk of infection by a person on ARVs involves sophisticated statistical analysis and, as noted above, very wide confidence intervals.

Audience members also commented that the incidence of sexually transmitted infections was low (as, of course, were herpes symptoms) and that a similar study needed to be conducted in gay men.

Nonetheless, Donnell commented, ARVs appear to confer a significant prevention benefit across all CD4 ranges, and this study goes some way towards quantifying that more accurately.

It is vital that the evidence produced by research of this kind is highlighted within communities and among those with influence in donor organisations. Universal access to treatment is the most effective way of ensuring that transmission rates and new infections are reduced and it is vital that funds for ARV treatment programmes are not cut, as currently threatened, but instead increased and expanded.

Reference: Donnell D et al. ART and risk of heterosexual HIV-1 transmission in HIV-1 serodiscordant African couples: a multinational prospective study. Seventeenth Conference on Retroviruses and Opportunistic Infections, San Francisco, abstract 136, 2010. Reprinted courtesy of AIDSMAP

http://www.aidsmap.com/en/news/062B2F32-1B29-4CCA-A047-820E21721D9B.asp

A matter of life and death: homophobia threatens HIV prevention work in Africa

By Carolyn Hanson

In February, peer educators at an HIV clinic in Kenya that serves men who have sex with men (MSM) were savagely beaten by an anti-gay mob that doused some of the men with kerosene and tried to set them on fire. In Malawi, a leader of a grassroots group working to stop HIV among MSM went to his local police station to file a report after a break-in at his office — and was arrested for distributing HIV prevention materials the police deemed "pornographic." And in Uganda, the country's legislature is seriously considering anti-gay laws that would make consensual sex among HIV-positive adults punishable by death.

A wave of homophobic rhetoric and violence in some African countries is undermining efforts to combat high rates of HIV among MSM.

Homophobia, of course, is present in every country. But a wave of homophobic rhetoric and violence in some African countries is undermining efforts to combat high rates of HIV among MSM. Human rights activists, AIDS advocates, and grassroots MSM organisations—including a number of groups funded by amfAR's MSM Initiative—say that the progress that had been made over the past several years in reaching African MSM is being threatened by a new climate of fear and repression that is sweeping parts of the continent.

Uganda: "We'll be forced underground"

Same-sex sexual behaviour has long been outlawed in Uganda, but the country's war on homosexuality began to escalate in the spring of 2009, when several evangelical clergymen from the US visited to give a series of talks opposing the 'gay agenda'. Amidst the ensuing anti-gay fervour, in October Member of Parliament David Bahati introduced new anti-homosexuality legislation in Parliament.

The proposed law would impose the death penalty for 'aggravated homosexuality', which includes any same-sex sexual activity by HIV-positive people. It mandates up to life in prison for anyone convicted of homosexuality or attempted homosexuality. It would also imprison anyone who knows of homosexual conduct and fails to report it — effectively criminalising the efforts of anyone providing HIV services to members of the lesbian, gay, bisexual or transsexual (LGBT) community.

Pepe Julian Onziema is the HIV/AIDS Programme Co-ordinator at Sexual Minorities Uganda (SMUG), which received a community award from amfAR's MSM initiative for advocacy and outreach aimed at curbing the spread of HIV among MSM. Over the past several months, Onziema explained, SMUG's vocal opposition to the bill has made it the target of sensational media coverage and has raised fears that anyone associated with the organisation will be subject to violence or arrest.

Providing HIV services has become nearly impossible. "We were referring our clients to doctors who had agreed to help us, but they're finding it difficult to continue because they are afraid something will happen to their jobs", Onziema explained. "One doctor still manages to get us condoms, which we are able to distribute to MSM through our men's organisation. But we are limited in the number of people we are able to reach".

If the Bill passes, Onziema acknowledges, SMUG will be unable to continue working openly with members of the LGBT community. "We'll be forced underground, and that will only increase cases of abuse and HIV infection" .

Malawi: "You can run but you cannot hide"

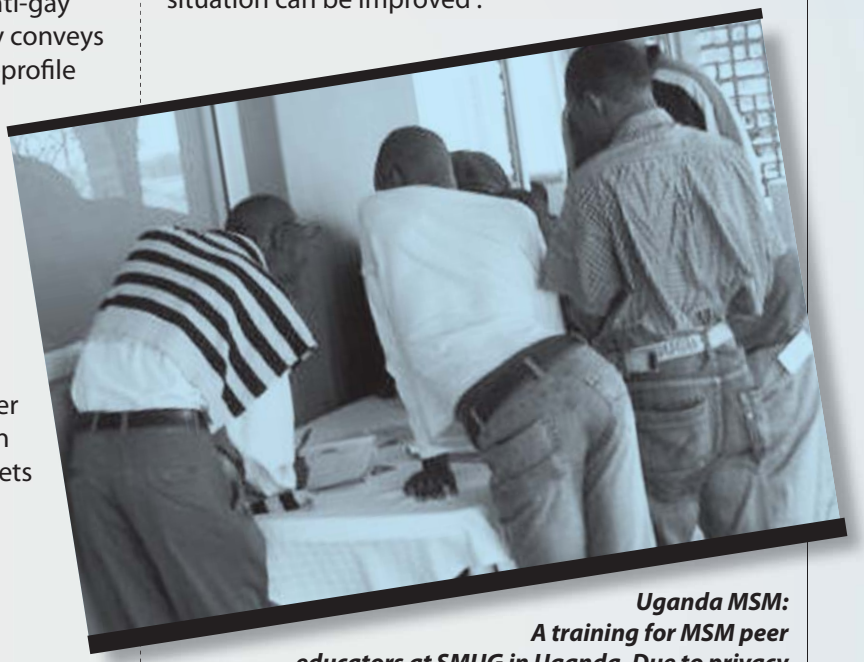
"POLICE HUNT FOR PROMINENT GAYS." This headline in the February 28, 2010 edition of a Malawian newspaper appeared in inch-high block letters above a photo of two men, whose arrest in late December 2009 for holding a traditional engagement ceremony set off a wave of anti-gay hostility in Malawi. The first line of the story conveys a chilling message from police to the 'high-profile homosexuals' they claim are providing encouragement to the engaged men and distributing pornography: "You can run but you cannot hide".

The 'prominent people' described in the article are, in fact, members of an amfAR- supported grassroots group, the Center for the Development of People (CEDEP), which provides HIV testing, counselling, and outreach to MSM and other vulnerable groups. The 'gay pornography' in question? Informational DVDs and pamphlets on HIV prevention.

By the time this inflammatory article appeared, CEDEP's staff had already been forced to close their office in Blantyre and relocate to the capital, Lilongwe, after two health workers from the organisation were arrested.

In Lilongwe, CEDEP has found it impossible to continue its HIV prevention activities. "We were supposed to conduct a big study to determine the size of the MSM population in Malawi. But we can't do that now because people will not agree to be interviewed," explained CEDEP's director, Gift Trapence. "The MSM community can't access testing because they've been driven underground. They are afraid of the police — and the media reports are increasing the threat. They have been publishing statements by the police saying that they have a list of gay people and that they will arrest all of them".

In short, he said, "HIV-related programmes have stopped. We are only doing advocacy to see if this situation can be improved".



Uganda MSM: A training for MSM peer educators at SMUG in Uganda. Due to privacy and safety concerns, the men declined to show their faces in the photograph. *Photo: Pepe Julian Onziema*

Peter Njane (right) and his colleague Solomon Wambua are among those working to raise awareness of HIV/AIDS among Kenya's MSM. *Photo: Kelli Anderson*

[1] In May 2010 a commission appointed by Yowerei Museveni recommended withdrawing the bill - http://en.wikipedia.org/wiki/Uganda_Anti-Homosexuality_Bill#cite_note-

Kenya: "There are no prevention activities [for MSM] going on now."

In Kenya, a February 12 attack on an HIV clinic in the coastal town of Mtwapa, near Mombasa, followed a rumour that two local men were planning a wedding ceremony there. Incited by local radio reports about the alleged wedding and by religious leaders who discussed the issue during Friday prayers, a mob of several hundred attacked the clinic at the Kenya Medical Research Institute (KEMRI), which runs an HIV programme for MSM. The violence spread, as angry mobs attacked the homes of men known or suspected to be MSM.

Police were able to quell the violence—by arresting six of the men who had been attacked by the mob. Peter Njane, director of the amfAR-funded group Ishtar MSM, was involved in efforts to free the men from custody and is now working with other advocates to keep them safe.

HIV services in the area of the attacks have since ground to a halt. "People used to get their antiretrovirals at KEMRI", Njane said. "While it's been closed, there is no provision of condoms and lubricant, no medical services for this community. Some of these things, like lubricant, aren't available anywhere else. There are no prevention activities going on now".

Increased media attention has given Ishtar MSM an unexpected platform for reaching MSM with prevention messages. "More people know about our initiative. After we were mentioned in the media, our website kept jamming. People who need information are coming to us"

Even when the clinic is able to resume HIV services, the lingering fear will not be easily dissipated, making it even harder to reach an already vulnerable population. "Some of the men who were attacked are not sure they will be able to go back to work as peer educators", Njane said.

"And we are hearing from other AIDS organisations in the area that people are afraid to come to their office for meetings".

A Shifting Tide?

Despite the fear and discrimination — even the violence and the threat of prosecution—those working on the front lines in the fight for HIV services for MSM remain determined to continue their struggle. Some can even see the tide shifting — slowly, but surely — in their favour.

"Five years ago, people did not talk about homosexuality, but now I have dialogues about it", said Kenya's Njane. Increased media attention, he explained, has given Ishtar MSM an unexpected platform for reaching MSM with prevention messages. "More people know about our initiative. After we were mentioned in the media, our website kept jamming. People who need information are coming to us".

In Malawi, Trapence and his colleagues remain outspoken advocates for MSM and other minorities, speaking to leaders and activists at home and abroad, and risking their own safety by talking to the media. He has reason to hope that at least some in Malawi's Government will be receptive to their message. Thanks to CEDEP's advocacy efforts, in 2009 MSM were included for the first time in Malawi's national strategic plan on HIV and AIDS.

In Uganda, SMUG is at the forefront of efforts to defeat the anti-homosexuality bill. In early March, SMUG leaders were part of a delegation, including AIDS service providers, human rights activists, and clergy members, who presented a petition signed by more than 450,000 people to the speaker of Uganda's Parliament.

Faced with intense pressure from around the world, Uganda may remove some of the bill's harshest provisions, including the death penalty. But opponents point out that passing the legislation in any form will cripple efforts to combat HIV among Uganda's MSM. By driving them underground and denying them access to lifesaving prevention and treatment, Uganda will — no matter what the law says — be handing these men a death sentence.

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Access to HIV treatment and care services: Zimbabwean rural areas missing the train

By Vakai Matutu

In 2002, the Government of Zimbabwe declared HIV and AIDS a national emergency. This was followed by the adoption of the scaled up comprehensive multisectoral response to the epidemic co-ordinated by the National AIDS Council. These multisectoral efforts have seen the overall HIV prevalence in Zimbabwe's adult population (15-49 years) dropping from an estimated high of 24.6% in 2003, to 13.7% in 2009. Despite these efforts, the nation has recorded significant negative impacts of the epidemic. Key to note are increasing numbers of AIDS-related orphans and vulnerable children and high morbidity and mortality in all economic and population sectors. The HIV epidemic has caused great strain on budgetary resources in a resource-constrained environment like Zimbabwe, which has seen the national health delivery system being overwhelmed by the demand for its services, at the same time that capacity was diminishing due to limited resources and high attrition among health workers.

The 2009 HIV estimates put the adult HIV prevalence at 13.7%, while HIV prevalence by place of residence is 14.4% for urban and 16.1% for rural areas. For the last two years, rural prevalence (at 16.4% in 2008) has been higher than urban (15.3% in 2008), although the 2009 HIV Estimates Report cautions that this trend could be due to reclassification of census data and the possible overlap of clientele between the rural and urban areas, since historically, prevalence has been higher for urban areas. The estimated number of people living with HIV (PLHIV) in 2009, stood at 1,102,864 down from 1,103,988 in 2008, including adults and children. The proportion of women living with HIV has remained at 60% for both 2008 and 2009.

This paper argues that despite the multisectoral response to HIV and AIDS, men and women, adults and children living in rural areas have not benefitted equally from the multisectoral response to HIV. Rural areas lag behind, especially in access to treatment and care services. Women occupy a complex position - they are the unpaid providers of HIV care services while also being the most infected and affected; above all, they stand on a social, economic and cultural template that disempowers them in all spheres of life.

HIV treatment and care forms the core of the HIV response. Key interventions are: the treatment of opportunistic infections (OIs) and sexually transmitted infections (STIs); prevention of parent-to-child transmission (PPTCT); antiretroviral therapy (ART); counselling, nutrition support; community and home-based care (C& HBC); and HIV testing and counselling. In 2009, the World AIDS Day Campaign theme emphasised the need to scale up treatment and care services. In 2010, the theme is 'Universal Access and Human Rights: Together We Will Make it'. The National AIDS Council's vision is 'No HIV Transmission, Universal Access to HIV and AIDS Services'.

The question is, with all the stress is placed on universal access to HIV services, why has the multisectoral response failed to be inclusive in its reach? It remains exclusive and rural areas, women and children are missing the train of universal access to HIV services.

Access to Treatment and Care Services

Access to treatment is important in reducing morbidity, improving longevity and quality of life for people living with HIV. However, access to ART is dependent on other key services. It thrives on the availability of testing and counselling, PPTCT services and the existence of psychosocial support systems, good nutrition and C&HC. These complement one another and the success or failure of one affects the other.

Access to HIV services is often for people living in rural and peri-urban communites in Africa

Access to treatment is important in reducing morbidity, improving longevity and quality of life for people living with HIV. However, serious gaps exist in the current provision of services.

As HIV testing is the entry point to HIV care and treatment post-test support programmes are essential. When a community sees other community members living with HIV on ART and leading normal, productive lives it motivates people to go for testing. However, rural areas have not had the full package of complementary support services, treatment and care, and treatment and care services continue to be fragmented. Rural areas are under-supported and underfunded in HIV care and treatment compared to urban areas. The question is, why?

The Gaps

Access to ART is key to treatment and care for PLHIV wherever they live. However, serious gaps exist in the current provision of services, with limited collaboration or integration in the continuum of care for PLHIV in rural areas. Conflicting interests have done a great disservice to rural communities. The situation is exacerbated by lack of free CD4 count, liver function and other tests, which are important in initiation of ART and ongoing management, while the critical shortage of trained staff in PPTCT, OI and ART has broken the chain of treatment and care services in rural areas.

Access to treatment

PLHIV living in districts like Gokwe North do not have an ART site dedicated to servicing a population of more than 240,000 people. There isn't a functional district hospital and only two mission hospitals whose catchment and capacity is limited. Districts like Gokwe South, Sanyati and Mhondoro-Ngezi have one ART site each, but are challenged by their capacity to reach out to all their corners.

Research by the Zimbabwe Women's Resource Centre and Network (ZWRCN) found that access to treatment in most rural communities was hindered by lack of money, long distances and poor roads.

- People must travel very long distances by foot or scotch cart and should they have to travel further, they face the serious challenge of finding money for transport, since people living in rural areas have very limited disposable income.
- Rural areas are worst hit by staff attrition in the health delivery system. Poor communications and road networks, and lack of services, are the push factors for staff; this on top of low remuneration and no incentives for work in rural areas.

Women and children

For pregnant mothers, the long distances pose a huge challenge. Many resort to home deliveries with the help of untrained traditional birth attendants. This presents grave risks of vertical transmission of HIV, not to mention the deadly complications which some mothers experience. In Gokwe North, home deliveries are common practice due to limited coverage of health facilities as well as religious and cultural beliefs.

Information

Information is vital for the understanding and uptake of any health service, but in rural areas, there is limited information dissemination to help people to make informed decisions as printed and electronic media often do not reach them. The little information that does reach them is in English, rather than in vernacular languages such as Shona, Nbebele and Tonga. The ZWRCN study found that there was low knowledge of ART in Shurugwi and Gwanda.

Food and nutrition

Nutrition support and coverage of effective comprehensive home-based care have been low, coupled with low incomes. Interventions have been scant, inconsistent and unsustainable due to ad hoc and fragmented implementation.

The *CHBC ATLAS (2008)*, a production of the National AIDS Council, Ministry of Health and Child Welfare with the support of partners such as the Zimbabwe AIDS Network (ZAN) and UNICEF, shows district to district variation in coverage of treatment, home-based care, food and nutrition services with some districts, such as Insiza, Mazowe, Mwenezi and Tsholotsho recording 100% in all services, while others had zero coverage. Uzumba Maramba Pfungwe, Guruve, Gokwe North, Centenary and Zaka had only 3% coverage in the three services.

Women in rural areas are at the centre of production, providing unpaid labour as well as being the caregivers of home-based care, but their heavy workload denies them access to treatment, especially where they have to travel long distances, since most women have no disposable income and are unable to pay for medical attention.

The *Atlas* provides no details on the quality, consistency and comprehensiveness of services being rendered to the community, but explains the variation in coverage among districts as being due to the presence or absence of implementing organisations, with no insight as to why these organisations are absent in some districts. Partnerships among implementing organisations have not been realised due to different sources of funding and the desire of both implementing organisations and their donors to make their names in the community.

The 2006 National Review of C&HBC and access to treatment services found that a lack of information about services and approaches by the various implementing organisations results in C&HBC and ART activities being implemented in a disintegrated manner. Thus poor linkages and programme collaboration have destroyed referral systems and resulted in fragmented programmes with few synergies and poor utilisation of resources, that cost both rural people and the nation.

Women and children

Women remain marginalised, yet they make up the majority of the rural population and remain at the centre of the epidemic due to unequal power relations and socio-cultural values that require silence, submissiveness and conformity. These gender roles make it difficult for women to protect themselves (SAfAIDS, 2004).

Women in rural areas are at the centre of production, providing unpaid labour, as well as being the caregivers of home-based care. Their heavy workload denies them access to treatment, especially where they have to travel long distances, since most women have no disposable income and are unable to pay for medical attention.

The worst manifestation of the gender power imbalance is sexual violence MOHCW/NAC (2004) and general violence against women. Violence exposes women to HIV infection, degrades their self-esteem and affects their ability to seek treatment and care for HIV infection.

The 2006 National C&HBC review notes that C&HBC has paid insufficient attention to the special needs of children on ART. In rural areas, there is a great shortage of staff trained in paediatric ART. Follow-up of babies exposed to HIV is critical if they are to access treatment and care services. There is also low nutritional support for children living with HIV.

The Future

If the gaps highlighted in this paper are to be addressed, a deliberate policy shift is required to ensure that rural areas receive the dividends of the multisectoral response to HIV. The current HIV response must be scaled up, with a special focus on rural areas, women and children. To achieve this, the NAC's co-ordination, planning and monitoring and evaluation roles must be supported. The NAC also needs to be empowered to direct or redirect resources to reduce the current gaps. Failure to provide universal access to treatment and care services and to ensure that women and children in the rural areas have universal access to treatment and care services can be counted as a violation of human rights and must be addressed as soon as possible.

Editor. This article highlights the increasing gap between rural and urban living that occurs on the whole African continent. If we are to genuinely address issues of universal access to treatment, brain drain and rural poverty, then multilateral agencies must be prepared to support the improvement of programmes, by addressing the lack of facilities and basic infrastructure in rural areas.

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HIV testing and treatment to prevent TB

Diagnosing HIV early and starting antiretroviral (ARV) treatment could be the most important weapons in the battle against HIV-associated tuberculosis, but this would need a huge injection of resources in southern Africa, where the dual epidemics of TB and HIV claim the most lives.

The authors of a paper, part of a series on TB in the British medical journal, *The Lancet,* note that the disease accounted for more than a quarter of the two million deaths attributed to AIDS-related diseases in 2008 and is the number one cause of illness and death in people living with HIV in Africa, yet efforts to contain TB-HIV co-infection have been "timid, slow and uncoordinated".

Many people with HIV infection start antiretroviral therapy too late, especially in Africa and have already developed TB by the time that they present to health services for care.

A move towards earlier HIV testing and treatment is already underway. Many countries have adopted the 2009 World Health Organisation (WHO) guidelines, which raised the threshold for starting ARV treatment from a CD4 count of less than 200, to 350.

Earlier ARV treatment as a tool to prevent TB has received less attention, but the reality is that "Many people with HIV infection start ART (antiretroviral therapy) too late, especially in Africa, and have already developed TB by the time that they present to health services for care", the authors said.

Professor Anthony Harries, a senior adviser to the International Union Against Tuberculosis and Lung Disease and lead author of the paper, welcomes the WHO guidelines but supports the more radical approach, yet to undergo field trials, of testing all adults for HIV once a year and immediately starting everyone who tests positive on ARVs.

This strategy, based on findings from a mathematical model published in *The Lancet* in November 2008, could reduce HIV prevalence to less than 1% within 50 years in a country with a generalised epidemic such as South Africa's.

Using the same model, Harries and his co-authors estimated that the incidence of HIV-related TB could be more than halved if ARV treatment were started within five years of infection.

TB materials disseminated at a meeting in Kenya, 2007

Studies to test the efficacy of such an approach still need to be done, but Harries believes it is feasible "if decision-makers are prepared to think and act out of the box".

The upfront costs would be significant and donors appear to be decreasing or flat-lining their support for HIV treatment as a result of the global economic slowdown, but Harries pointed out that a universal test-and-treat approach would result in cost savings in the long term.

"It would not be easy but, if you go back five years, ART scale-up wasn't easy and there was a lot of opposition, but we had good, clear leadership from the WHO," he told IRIN/PlusNews.

The 3Is

In the absence of early HIV diagnosis and treatment, *The Lancet* paper argues that many lives could be saved by better implementation of a policy for preventing HIV-associated TB known as the 3Is: intensified TB case-finding, infection control, and isoniazid preventive therapy.

One of the main difficulties in implementing the 3Is has been diagnosing TB in HIV-positive patients, particularly in low-income countries that lack the equipment to conduct culture testing, the most reliable way to diagnose TB, in which samples are cultivated in a special liquid.

Problematic diagnosis has in turn hampered the use of isoniazid to treat latent TB infection. Fear of creating drug resistance by prescribing it to patients with undetected TB has meant that Botswana is the only country in southern Africa to have incorporated this approach into its national TB policy.

Harries, who has worked as a technical adviser to Malawi's HIV/AIDS department and its TB control programme, said HIV programmes should take responsibility for implementing the 3Is, by ensuring that patients diagnosed with HIV receive regular care before starting ARV treatment.

"In most of poor Africa, you get HIV tested and maybe don't even get a CD4 count, so somebody does a clinical assessment and decides if you're stage three or four (when ARV treatment usually starts). If you're stage one or two (asymptomatic), then basically you're told, "Go away and we'll see you when you're sick," he said.

"We need pre-ART care: a clinic where people would come every three months to be checked and given cotrimoxazole an antibiotic that helps prevent opportunistic infections) or isoniazid."

A more innovative, but as yet untested approach, which Harries and his co-authors propose in The Lancet paper, would be providing TB treatment to all HIV-infected patients who are sick and have low CD4 counts.

"We know it's difficult to diagnose TB in [a low-income] setting," he said, but by putting such patients on TB treatment, "you stop that person transmitting TB every time he comes to the clinic, and if he hasn't got TB, this is a very good preventive therapy."

Harries urged greater collaboration between TB and HIV programmes. "In the HIV/AIDS world, activism has played such a big part; in the TB community we're not good at that. We need to get TB patients who've been cured, who are articulate, and they need to be advocates for TB and work with HIV activists to tackle policy-makers."

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HIV counselling and testing session

Children caring for parents with HIV

By Dr Ruth Evans

This article discusses recent research that explored the experiences and perspectives of children and young people who care for a parent with HIV in the global North and South. It provides unique insights into the similarities and differences in children's and parents' experiences across diverse socio-economic, cultural and welfare contexts.

The aim of the research, led by Professor Saul Becker of the University of Nottingham and Dr Ruth Evans, was to investigate the experiences, needs and resilience of children and young people caring for parents or relatives with HIV and AIDS ('young carers'). They sought to identify some of the key issues and challenges that need to be addressed if policy, services and interventions for children and families affected by HIV are to become more responsive to their needs.

Using evidence from the UK and Tanzania, the research highlighted the experiences of young people caring for a family member with HIV from multiple perspectives (mothers with HIV, young people and service providers), in very different socio-economic, cultural and welfare contexts. The qualitative research involved in-depth interviews with 33 children and young adults (aged 9 – 24) who cared for a parent or relative with HIV; 33 mothers or relatives with HIV; and 27 service providers in England and in Tanzania.

Participatory research methods with young people were used (including life story books, photographs and drawings) to gain insight into different domains of their lives. Most young people in Tanzania and the UK cared for a mother with HIV and sometimes also siblings with HIV in one parent households; the majority of the young carers were girls.

Due to difficulties in recruiting young people from young carer's services, the majority of respondents in the UK sample were recruited via voluntary and community organisations supporting parents living with HIV and their children, based predominantly in London. Since the 1990s, the global HIV epidemic has adversely affected recently-arrived African migrant families in the UK, and most of the UK respondents were from African migrant families. A small number of the families had insecure immigration status which, as other research has shown, compounded their experiences of living with HIV. African refugee families affected by HIV may be particularly marginalised, as they face financial and emotional pressures linked to restrictive immigration and asylum policies, inequalities in access to welfare, health and social care services, racial discrimination and wider processes of social exclusion.

A key message emerging from the research is the need for greater national and global policy recognition of the gendered and age-related caring responsibilities of young people within households affected by HIV.

The research revealed the stigma and discrimination associated with HIV that may confront parents and children in both the UK and Tanzania; the reciprocal and interdependent nature of caring relationships within the family; the ways that young people's caring responsibilities change over time and place; the limitations of existing services and strategies for supporting parents with HIV and their children; and challenges for the future development of policies, services and support at local, national and global levels.

A key message emerging from the research is the need for greater national and global policy recognition of the gendered and age-related caring responsibilities of young people within households affected by HIV and AIDS. The research highlighted the need for greater engagement with children and families and a 'joined up' policy response from the state, voluntary, private and informal service providers, requiring the closer integration of their efforts and services. Rather than targeting support and interventions solely towards young people with caring responsibilities, a holistic family approach to support children and parents affected by HIV should be adopted.

Evidence from the research highlights the fact that caring relationships within households are often characterised by mutual dependence.

Young people often saw their caring responsibilities as 'normal' and part of their everyday responsibilities towards their family. Furthermore, parents with HIV, even those with physical impairments who were cared for in bed for months or, in some cases, years, continued to perform their parenting role, providing love, care, support and guidance to their children.

Caring is not just a one-way process between a young person as the 'care-giver' and their parent as the 'care-receiver'. Rather, it is embedded in social relations between children, parents, relatives and members of the wider community.

Community based volunteers listen during a community dialogue, in Zimbabwe, 2008

SAfAIDS NEWS plus

Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention

Rachel Jewkes[1]*, Robert Morrell[2]

Abstract

Research shows that gender power inequity in relationships and intimate partner violence places women at enhanced risk of HIV infection. Men who have been violent towards their partners are more likely to have HIV. Men's behaviours show a clustering of violent and risky sexual practices, suggesting important connections. This paper draws on Raewyn Connell's notion of hegemonic masculinity and reflections on emphasized femininities to argue that these sexual, and male violent, practices are rooted in and flow from cultural ideals of gender identities. The latter enables us to understand why men and women behave as they do, and the emotional and material context within which sexual behaviours are enacted. In South Africa, while gender identities show diversity, the dominant ideal of black African manhood emphasizes toughness, strength and expression of prodigious sexual success. It is a masculinity women desire; yet it is sexually risky and a barrier to men engaging with HIV treatment. Hegemonically masculine men are expected to be in control of women, and violence may be used to establish this control. Instead of resisting this, the dominant ideal of femininity embraces compliance and tolerance of violent and hurtful behaviour, including infidelity. The women partners of hegemonically masculine men are at risk of HIV because they lack control of the circumstances of sex during particularly risky encounters. They often present their acquiescence to their partners' behaviour as a trade off made to secure social or material rewards, for this ideal of femininity is upheld, not by violence per se, by a cultural system of sanctions and rewards. Thus, men and women who adopt these gender identities are following ideals with deep roots in social and cultural processes, and thus, they are models of behaviour that may be hard for individuals to critique and in which to exercise choice. Women who are materially and emotionally vulnerable are least able to risk experiencing sanctions or foregoing these rewards and thus are most vulnerable to their men folk. We argue that the goals of HIV prevention and optimising of care can best be achieved through change in gender identities, rather than through a focus on individual sexual behaviours.

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Introduction

Intersections of HIV, gender power inequity in relationships and violence: evidence from epidemiology

In countries of sub-Saharan Africa with a predominantly heterosexual HIV epidemic, the prevalence in women climbs steeply in the late teens, which is five years before this occurs in men. Overall, a much greater proportion of the adult female population become infected [1,2]. Understanding this difference between women and men is critical for HIV prevention. While there are sex differences in susceptibility to HIV, which, like all sex differences, are rooted in biology [3], the patterns of prevalence have more complex origins. It is not biology, but gender differences in sexual socialization that are more important in influencing who women and men partner, when and in which circumstances.

Key here are differences in the way in which men and women position themselves and act as social beings, i.e., differences in socially defined and constructed ways of being a man or woman, and the power and possibilities so entailed. For it is gender, not sex, that is more influential in determining behaviour. In a given relationship, for example, a man may expect to lead and control sexual relations and his woman partner to comply, and he may feel entitled to have sex with other women, but expect her to remain faithful. Gender differences take many different forms in different settings, but an area of commonality lies in diffentials in power. There is strong evidence that gender power inequity in relationships, which is a cause of intimate partner violence, places women at enhanced risk of HIV infection.

South Africa is a country which exemplifies the dual epidemics of HIV and gender-based violence. It presently has 5.5 million people living with HIV, out of a population of about 47 million [1], the largest HIV epi-demic in the world.

The society is strongly patriarchal, and violence against women is widespread. South Africa's rate of rape has been found to be the highest of any INTERPOL member country [4], with more than 55,000 rapes reported to the police annually [5].

Intimate partner violence is also common. Research has found that between 25% and 55% of women have experienced physical intimate partner violence [6-8], and the rate of female homicide by an intimate partner is six times the global average [9]. In interviews, 42% of men disclose perpetration of intimate partner violence [10,11] and 28% disclose rape of a woman or girl [10].

These two epidemics have provided an important impetus for research into the nexus of gender and HIV, and the country provides an important opportunity to understand these problems and the implications of them for responses to HIV.

A decade of cross-sectional research from African countries, including Rwanda, Tanzania, South Africa and more recently, India, has consistently found women who have experienced partner violence to be more likely to be infected with HIV [12-15]. Two studies have shown that women who have been sexually coerced by male partners in Rwanda (n = 914) and Tanzania (n = 245) had a higher prevalence of HIV, with an adjusted odds ratio (aOR) of 1.89 (1.20, 2.96) in Rwanda, and 2.39 (1.21, 4.73) in Tanzania [12,13]. The Tanzanian study was conducted among women in a clinic offering voluntary testing and counselling, and it also showed that those aged under 30 who had ever experienced physical intimate partner violence were significantly more likely to have HIV [13].

In South Africa, among women (n = 1366) in antenatal care having HIV testing as part of treatment for prevention of mother to child transmission, those experiencing the greatest gender power inequity in rela-tionships when compared with the most power equitable of three categories [aOR 1.56 (1.15, 2.11)], as well as those experiencing physical or sexual violence [aOR 1.53 (1.10, 2.04)] were more likely to be HIV seropositive [14]. Emerging evidence from yet unpublished longitudinal data from South Africa shows that women who have experienced intimate partner violence and have greater gender power inequity in relationships are at elevated risk of acquiring HIV. In both cases, there is a close response relationship [16].

Research from India, analysing data from husband-wife dyads (n = 20,425) that provided both intimate partner violence (IPV) exposure and HIV sero status has shown that abused wives face increased HIV risk, based both on the greater likelihood of HIV infection among abusive husbands and elevated HIV transmission within abusive relationships. This suggests that IPV functions both as a risk marker and as a risk factor for HIV among women [15].

In an effort to explain why partner violence and relationship gender power inequity should place women at risk of HIV, research has been conducted with men. This has shown that like their Indian counterparts, South African men who have been physically violent towards partners are more likely to be infected with HIV [10,15]. Some indications of why men who have been violent are more likely to be HIV infected can be seen in analyses that focus on the inter-relationship of gender-based violence perpetration and a range of risky sexual practices.

South African research shows an apparent clustering of violent, anti-social and risky sexual practices, suggesting that these are connected. Thus, men who have been violent towards intimate partners are more likely to rape, have large numbers of partners, drink heavily, not use condoms, have sex with prostitutes and engage in transactional sex [17]. Men who rape are more likely to have had transactional sex, be physically violent to partners, have large numbers of partners, drink heavily and engage in transactional sex [18]. Men who engage in transactional sex are more likely to be physically violent to partners, have large number of partners, drink heavily and rape [19]. In essence, men who are violent are more likely to be sexually risky, and vice versa. A key question is: what is the basis and nature of this connection? And what are the implications of these for HIV risk, prevention and care?

This paper seeks to move beyond the epidemiology and the measurement of behaviours and associations and enable us to understand these empirical findings. In so doing, we draw on theoretical resources from the area of critical men's studies, and in particular, the notion of hegemonic masculinity, initially developed and expounded by Raewyn Connell [20,21], and related discussion of femininities. We will describe the theoretical framework, discuss its relevance in terms of findings of South African research on hegemonic masculinity and femininities and their relation to HIV risk, and relate it to broader concerns in HIV prevention and care.

Theoretical perspectives on men and gender

Feminist studies of sex and gender have historically foregrounded the oppression of women. Debates about the causes of, particularly, sexual oppression have fre-quently invoked a nature/nurture binary to explain global patterns of men's dominance over women. The former approach, which focuses on the genetic or physical to explain gender inequalities, has the major disadvantages of failing to explain diversity among men and among women and of lacking a model of how to make things better. Models that focus on how gender is a learned behaviour make more allowance for diversity and provide conceptual clarity about the forms that inequality take and how inequalities occur. Such analysis also can suggest gender equity interventions.

The focus on the social construction of gender has in the past quarter of a century generated a sophisticated literature on the gender identities of men and women, masculinities and femininities. This has permitted the conceptual inclusion of men within the ambit of gender studies, an initiative strongly associated with the theoretical work of Raewyn Connell [20,21].

Connell [20,21] describes the existence of multiple configurations of masculinity that are hierarchically organised and structured along lines of gendered domination (of men over women, of powerful men over less powerful men, of adult men over younger men). She identifies one masculine position that is dominant and refers to this as "hegemonic masculinity". It is this position that is generally associated with the subordination and oppression of women.

The concept of hegemony, drawn from Antonio Gramsci's work, refers to the exercise of power by creating consent through the establishment of accepted ideas or values. The concept is generally used descriptively to identify that form of masculinity that legitimates the subordination of women. It is in this sense that the framework enables an analysis of gender power while also allowing for the existence of divergent forms of male expression that may, for example, challenge the unques-tioned right of men to this power.

There have been several interpretations of hegemonic masculinity by Connell herself [22] and others. Some focus on the fluidity and contested nature of the concept, while others stress the organising, structured and structuring nature of hegemony. In this latter sense, hegemonic masculinity represents the dominant cultural model of idealised manhood. It is a frame used by individual men to judge their "success" as men. In a highly gender-inequitable country like South Africa, hegemonic masculinity mobilises and legitimates the subordination and control of women by men. Conceived in this way, hegemonic masculinity is a necessary and integral element of patriarchy, the social organization that allocates, distributes and secures the power of men over women.

Hegemonic masculinity is characterised by a set of practices that both expresses men's power within the social

system and serves to bolster this power. In essence, the practices flow from the hegemonic ideal. Implicit in the idea of "hegemony" is recognition that social ascendancy of this ideal of masculinity is not achieved through brute force, although violence may be used by men to bolster this ideal, but through a complex web of processes that extend into the organisation of private life and cultural arrangements [21]. Thus, tenets of culture and religion and, for example, the operation of the legal system, may work to preserve the ascendancy of a particular cultural ideal of manhood.

Connell [21] argues that there is no equivalent notion of "hegemonic femininity" because there is more diversity in feminine ideals, although women are globally subordinated to men. She describes a form, or forms, of "emphasised femininity" that is characterised by compliance with women's subordination and an orientation towards accommodating the interests and desires of men. In other words, women "agree" with the unequal structuring of relations, do not challenge these relations, and ultimately collude in the unequal distribution of gender power with men. Other forms of femininity are shaped around strategies of resistance, and some combine compliance, resistance and cooperation [21].

Just as hegemonic masculinity is given power as a "cultural norm", forms of femininity that either in whole or in part emphasise compliance with this are expressed as cultural ideals of femininity, and are usually in some way socially rewarded. Women who adopt femininities based on resistance, or indeed engage in acts of resistance, can be marginalised and stigmatised. Patriarchal societies are heteronormative, that is, they require men and women to demonstrate their gender by actively participating in heterosex or affirming heterosexual desire [23].

While there are societally different ways in which this might be done, transgressions of heteronormativity are punished, and in South Africa, often violently so. The gang rape of African lesbian women and other instances of homophobic violence are particularly horrifying examples of this [24,25]. Having said this, it is important to note that gender identities change over time and that under particular circumstances, may change rapidly, for example, when legal or material contexts change dramatically. In South Africa, there is evidence that gender identities are indeed changing, although for our purposes, the persistence of gender violence remains a worrying continuity that shapes and binds forms of femininity and masculinity.

While hegemonic masculinity, and emphasised femininity, encompass practices that extend far beyond the arena of domestic, sexual and otherwise intimate relations with women (and men), it is the expression of these practices in these domains that is particularly pertinent to consideration of the intersections of gender power inequity and intimate partner violence and HIV risk. A lens of gender identity provides a frame through which we can begin to understand why men and women behave in the way that they do. It provides a way of reflecting on the emotional and material context within which sexual behaviours are enacted, in particular, the broader struggles, aspirations, desires and needs that motivate men and women's behaviour. It follows that only when we understand this, will we be able to change sexual behaviours (and thereby reduce the risk of HIV infection).

Shape of masculinities and femininities among black Africans in South Africa

The gender order in South Africa under colonialism and apartheid was strongly racialised [26]. Two major features are relevant here. The first is that racial integration occurred to a very limited extent and this ensured that black African and white South Africans lived largely separate lives, connecting in the work place under conditions of inequality (whites dominating professional and business positions, and black Africans overwhelmingly limited to positions as labourers or subsistence farmers). This arrangement allowed for quite distinct racialised gender arrangements to persist, with perhaps the most notable feature being the retention of traditional forms of (male-dominated) authority (for example, chiefs). The second important feature was the emer-gence of distinctive gendered ideals for black and white men and women.

The material inequalities and associated spatial demography (with black Africans prohibited for a long period from living in cities unless in the service of white-owned industry, and therefore confined to increasingly impoverished rural areas), which are a feature of South African life to this day, impacted on constructions of masculinity and femininity. Offering a broad brush stroke description of gender topography always runs risks, but for our purposes, we will venture some generalisations. We do so even as we acknowledge that the changes unleashed by national political developments (especially the assumption of power by the African National Congress in 1994) and global economic forces have effected significant alterations to the stark picture that we paint here.

Until 1994, white men and women had the vote, had ready access to economic power or, at least, stable employment, and to forms of social and public status [26]. This influenced the ideals to which both white men and women aspired. White men were heavily invested in material achievement, public position and embodiment that found particular expression in sporting achievement. White women, on the other hand, were less vested in professional autonomy, even though they benefitted from free schooling in well-resourced institutions. Their identities were primarily built around children and the home.

For black African men and women, the material challenges of life were dominant. Men were generally employed in menial, poorly paid positions, and many found only seasonal, insecure ways of securing a liveli-hood or spent much of their time without any form of paid work [26]. This has made it difficult for the major-ity of black African men to vest their masculinity in material or professional achievement, and has increased the likelihood of finding masculine affirmation in homo-social (sometimes criminal) settings and in their relations with black women. Black African women, generally without the means to be economically independent, have often been dependent on black African men and this, together with cultural practices of respect, has promoted obedience and passivity as hallmarks of African femininity. With South Africa'shistory of colonialism and apartheid, all gender identities are in some ways marked by violence. We return to this theme shortly.

Historical perspectives on sex in South Africa reveal two competing discourses on sexuality. In one, rooted in Christianity, sex is located in marriage for procreation. The other reflects traditional black African ideas that sex is a normal and healthy and an essential feature of life for all ages, and something about which there should be openness and communication [26]. This latter discourse normalises sex play in childhood and presents sexual exploration as a natural activity, including during adolescence. Historically, pre-marital penetrative sex was prohibited, but it is now the norm and, indeed, half of all black women have had a child by the age of 21, mostly outside marriage [27]. Within the frame of sexual openness, African women are constructed as sexual beings and sex is seen not just as normal in relationships, but as essential for their success [27,28]. Furthermore, in the domain of healing, sex is seen as a process of cleaning, and is commonly advised by traditional healers (and nurses) for a range of maladies [29].

For our purposes, it is important to make some statements specifically about gender in South Africa since

1994, when the country formally entered a period of transition, dismantling apartheid's edifice and constructing a new legal and policy framework for a non-racial democracy. This period has seen greater public diversity and fluidity in gender identities. The most obvious indication of this is the emergence of a public gay movement in the wake of the constitutional protection afforded to sexual orientation in the Bill of Rights in the Constitution in 1996, although the gay movement per se long preceded this [30].

For women, there has been a conspicuous emergence, primarily in urban settings, of "modern girl" femininities, associated with the exercise of independence, the use of specific fashion commodities and "explicit eroticism" [31]. This is an ideal of womanhood that is chiefly the domain of those women with access to (at least some) material resources. Whether these girls and young women seek political emancipation, or economic or sexual independence, the emergence of this phenomenon has drawn attention to the question of feminine agency.

Despite this diversity, there are clear patterns of power and dominance. While there is not one, single, domi-nant masculine form that serves as a model for all men, it is empirically clear that various racialised forms of masculinity are dominant. It is these masculinities that prescribe particular ways of being a man and legitimate gender-inequitable practices. One example of a black African hegemonic masculinity is found in the Zulu concept of isoka, an idealised heterosexual, virile man, who is desired by women, and whose prodigious sexual successes are the envy of other men [32]. Ethnographic research in the Eastern Cape province has shown that a key element of successful African manhood is heterosexual success and this is proved by being able to "win" desirable women, keep them (and thus prevent them from being seduced by others), and show evidence of being a man in control (of others) [33].

While the power of men is by no means established through the use of force, indeed the cultural foundations of patriarchy and processes through which it is maintained are broad and deep, and the use of violence, within limits and in particular contexts, is viewed by many, but not all, men as legitimate in pursuit of their goals [34]. This applies both in the public (for example, men resolving differences between one another using physical violence [35]) and private domains (where domestic violence, including femicide, is common).

South African masculinities all valorize the martial attributes of physical strength, courage, toughness and an acceptance of hierarchical authority, but most of all, they demand that men are able to exercise control (over women and other men) [36]. Within relationships with women, the expectations of establishing control provide space for the use of physical and sexual violence against women, in efforts both to achieve this and to demonstrate it. While men are not expected to injure women, and acts of extreme cruelty often incur familial and community wrath [34], the use of moderate violence by men (and in other circumstances, by women) is toleratedand generally is not viewed as evidence of weakness or lack of self-control.

With sex viewed as a need, particularly of men, but within context, also of women, wooing women with gifts, or exchanging money or other services for sex are seen as largely culturally acceptable practices [19]. Historically, sexual relationships between individuals were part of (subsumed) socially negotiated relationships between families, with marriages formalised through payment by men of lobola, the bridewealth. Nowadays, marriage occurs relatively late in adult life (at a mean age of 28 years for women [27]), if at all, and sex mostly happens outside marriage, and "serious" intent is demonstrated by gift giving. In this cultural milieu, it is easy for men to assume some form of patriarchal ownership over women and to establish or demonstrate this with physical violence. In this way, hegemonic masculinity inextricably links having multiple sexual partners with the subordination of women to male control, if necessary with the use of violence.

Other practices which flow from hegemonic masculinity involve sexual and other forms of risk taking. These include driving cars fast and dangerously, and heavy alcohol consumption; indeed, social norms around alcohol drinking are such that South Africa has the highest level of consumption per drinker of any country in the world [26,37]. Derision is cast on those who "fail" in navigating these risks without losing control or showing weakness, whether shown by their lives being destroyed by alcoholism or by becoming infected with HIV. Thus, blame is framed in terms of individual weakness, rather than being placed on the overarching gender order that provided the context within which these practices were and are encouraged [38,39].

In this way, hegemonic masculinity can be seen as a cultural ideal that links risky sexual practices and the use of violence and other controlling behaviours against women, particularly women partners. It is masculine-gendered identities, and the processes through which they are constructed, enacted and reproduced, that explain the clustering of violence and risky sexual practices seen in the epidemiological studies (discussed above). Viewed through this lens, these practices are seen as having meaning that extends well beyond the motives and rewards of the individual act.

With young black African women in the forefront of the HIV epidemic in South Africa, it is appropriate that we apply ourselves in the same way to young black African femininities. Our understanding of women's sexuality can be considerably advanced by reflecting in a similar manner on gender identity and the entailed meaning of practices. Emerging, yet unpublished research by the authors, based on extended qualitative interviews and participant observation over 10 months with women from the Eastern Cape, shows that the dominant idea of successful young womanhood is one where success is proven through being desirable to men. This is clearly complicit with hegemonic masculinity as it is framed in a way that encourages resonance, rather than discordance, with those ideas.

With worth of women assessed by men, women who wish to be "successful" are under massive pressure to conform to the dominant social order, including accepting the control by men. But there are other powerful forces at play. In a resource-poor setting, flirting and meeting with boyfriends provides hours of affordable entertainment. Thus, women have fun, compete and measure their desirability through flirting and encoura-ging proposals from men, while remembering that this is ultimately "proven" through having a boyfriend. Given the threat of being single to social status and self-esteem, and the risk of boredom, many women prefer to have more than one boyfriend (referred to as "walking on two legs") lest they split with one of them. The terms in Sotho and isiXhosa of nyatsi and khwapheni refer to secret concurrent partners, which is culturally accepted for women, as well as men, providing relation-ships are conducted in a manner respectful of the main partner, i.e., covertly [14,40].

With sex viewed as "natural", women's sexual desire is acknowledged, as is an expectation that sex should be pleasurable, preferably "flesh-to-flesh" sex and thus with no condom use [41]. While there has been a suggestion in literature on sexuality that it is a male requirement, authors have also found that women often oppose condom use because of concerns about their sexual pleasure, as well as a lingering suspicion that their chances of keeping their partners in the competitive world of multiple concurrency are greater with flesh-to-flesh sex [41]. The emphasis on the heterosexual prerogative of men in a context of great gender inequalities has

often led to treating women as sexually passive, simply waiting for men to propose and then acquiescing [42]. In some contrast to this, having multiple partners is on one level an expression of resistance to dependence on, and even control by, one man; yet the cultural acceptability of the practice allows women to do so without perceiving themselves as engaging in resistance to the gender order as a whole.

While the dominant ideal of femininity is fundamentally subordinate, women do not all experience controlling behaviour by their male partners to the same extent. Archetypically controlling boyfriends, however, expect to know where their partners are at all times, stop them seeing other men, expect to find them at home when they call, and to have them willing to free themselves from whatever they are engaged in and be ready for sex on demand [33]. It is hardly surprising that women with violent and controlling partners have been shown both to have more frequent sex and to use condoms less often [8,43-45]. Women are expected to avoid behaving in a way that threatens men's sense of control, failing which they are expected to endure and accept their physical punishment [33].

For African women, excusing male behaviour is an integral part of dominant femininity and essential for keeping the right man. In a practical sense that entails tolerance of violence (if he is violent), tolerance of his other partners (or when this fails, direction of aggression against them, rather than him), and ensuring that sex with the right man is "the best" (i.e., no condoms). This is supported by cultural wisdom, such as the saying that "beating is a sign of love". This dominant form of femininity thus requires women to be strong, and able to accept and cope with the stresses life brings, including those caused by women's subordinate position in their relationships.

Acquiescent femininity and hegemonic masculinity are both cultural ideals and are upheld by a system of sanctions and rewards. Women who do not comply, or express resistance, suffer marginalization and stigmatiza-tion. For example, divorce is an ultimate act of non-compliance, and for women in African culture, is strongly stigmatised and happens infrequently. In 2007, more white South Africans divorced than Africans (9,935 versus 9,055), despite the fact that the former represent only 9% of the population, compared to the latter group's 80% [46]. The position of these women was recently described by one older Xhosa woman politician, when she said, "In our language [isiXhosa] we have iin-tombi (unmarried girls) and iintombazana (married women). We have no word for women who divorce, we do not know where to put them." [47]

This is not to say that there is no social space in South Africa for gender difference. There are many men from across the social spectrum who adopt masculinities that incorporate counter hegemonic practices, such as engagement in childcare and caring for sick and dis-abled relatives, or support for gender equality and opposition to against violence against women [48,49]. There are also many women who are single mothers and economically independent of men [27]. But equally, it is important to read these behaviours through a historical and cultural lens.

In South Africa, the gendered division of labour has constantly evolved and shifted. Women historically have engaged in domestic work and caring [50]. They have adopted gender positions as "wives" in single-sex institutional settings [51-53], and women have run households that are economically independent of men [54]. The long historical trajectory shows the dynamism and fluidity of gender relations, but it does not show that these women and men resist the fundamental gender order that subordinates women to men [48]. It is possible to occupy apparently dissident gender positions without mounting an outright challenge to the gender order or supporting an alternative, gender-equitable vision of society.

Compliance with the dominant acquiescent femininity is rewarded, not just by men, but by other women. Women with desirable partners are admired by their peers, and respected in families and communities. Just as hegemonically masculine men seek amenable female partners so that their relationships can be relatively harmonious, rather than characterised by strong resistance, successful women desire hegemonic men [55]. Viewed as "real men", their displays of hegemonic masculinity are interpreted by many women as sexually and socially desirable, and research by the authors, and others, shows that men who practice more gender-equitable masculinities are often marginalised by women.

Discussion

It is important for this argument not to be read in a way that is either culturally deterministic or victim blaming. We argue that in pursuit of hegemonic masculinity, as well as the dominant emphasised femininity, men and women are following ideals that have deep cultural roots and thus, models of behaviour that may be hard for individuals to critique and exercise real choices around. Indeed, we invoke a notion of choice for women with considerable caution, given the huge constraints on the power of young, impoverished women in a patriarchal society that has a marked age hierarchy.

Nonetheless, there is considerable diversity in the actual practices of men, choices of partners by women, and degrees of complicity, cooperation and resistance. There are women from across the social spectrum who resist gender inequality, and there is a proud history of women's movements in South Africa and of role models of women who have asserted considerable power of different forms within communities [56,57]. When interpreting women's decision making around partners and responses to male violence and controlling practices, it is apparent that women differ in the degree to which they accept and excuse these. While in some cases this is a product of social and financial circumstances that leave no options, the visibility of this in the dating relationships of girls who are supported financially in their families reveals that the picture is more complex.

Women who experience more marked gender inequity in relationships and violence are placed at risk of HIV because they lack control of the circumstances of sex during particularly risky encounters, but their exposure to such gender inequity and violence is often related to complicity with an ideal of hegemonic masculinity.

When women are acquiescent and accept male control and violence, their behaviour is considered as a trade off made from an expectation of social (or financial) reward. The degree to which women feel able to risk loss (or non-acquisition) of these rewards differs according to other dimensions of their material and emotional vulnerability. Thus, the poorest and most marginalised women, and those who have been rendered vulnerable in other ways, such as by abuse in childhood, may be least able to take the risk of displaying signs of non-conformity and resistance and of bucking the patriarchal trend of passively subordinating themselves to men.

What are the implications for prevention and care?

Thus far, we have argued that sexual practices are rooted in and flow from (although not always in a consistent and linear way) gender identities, and therefore we need to address our attention to changing the bigger picture, rather than the individual behaviours. In real terms, this means focusing attention on building more gender-equitable and caring masculinities, and less acquiescent femininities. In so doing, interventions are needed at policy, service and community levels, as well as individual levels [58]. This needs to include, for example, investment in education, change to the national legal

and policy framework related to gender equity, policy support for women's economic empowerment and property and inheritance rights, and strengthening the school curriculum and institutional environment so that it can promote gender equity and protect girl learners from violence and harassment in schools.

Both policy changes and service strengthening are needed to effectively enforce legislation that protects women and girls from gender-based violence and enables effective care and legal redress and protection for survivors. There is a need for initiatives at all levels to promote men's involvement in the care economy, including in South Africa, promoting the involvement of men as fathers, both financially and socially, in the lives of their children.

Interventions at an individual level and those that address community norms around gender and HIV have been developed in many settings. Some of these are gender sensitive, in that they recognise the specific needs and realities of men based on the social construction of gender roles. The better ones are "gender transformative" in that they seek to transform gender roles and promote more gender equity and thus address them-selves to changing how men come to view themselves, and thus behave, as men [59].

Examples are interventions that have focused on chan-ging harmful gender norms away from attitudes and behaviours that negatively impact on women's health and HIV risk through initiatives such as the Better Life Options for Boys that was implemented across 11 Indian states in schools with more than 8000 boys [60]. There are also examples of major national mass media initia-tives, such as the Sexto Sentido campaign in Nicaragua, the Brothers for Life campaign in South Africa that seeks to change societal norms around masculinity, and the White Ribbon campaigns (initiated in Canada) that have focused on raising awareness about and changing norms on gender-based violence in many countries.

Sexto Sentido has been very extensively evaluated and shown to be effective in building gender-equitable attitudes, communication about HIV and condom use [61]. Other examples include the Program H group education intervention and social marketing campaign, developed in Brazil, that focused on improving sexual health and reducing HIV risk through changing gender norms and reducing violence. Its evaluation showed impact on gender attitudes and the prevalence of self-reported sexually transmitted infections [62]. Evaluation suggests that gen-der-transformative interventions are more effective than those that merely acknowledge or mention gender norms and roles.

The small, but emerging, body of literature on evaluations of HIV prevention behavioural interventions in sub-Saharan Africa has shown these to be generally unsuccessful, especially when using biological markers of sexual risk [63,64]. An exception is Stepping Stones. This intervention, first developed by Alice Welbourn for Uganda and now used in more than 40 countries, seeks to be gender transformative. Stepping Stones involves a participatory approach that includes critical reflection to encourage safer sexual practices through building more gender-equitable relationships. Evaluation of its effectiveness in a randomised controlled trial showed that it was successful in achieving a reduction both in a biological indicator (HSV-2 infections) in men and women and in perpetration of intimate partner violence over two years of follow up [65]. In the first year, changes in other male sexual practices were observed. It is appropriate to speculate whether Stepping Stones' success was a product of its engagement with gender identities, most conspicuously seen in a qualitative evaluation of its impact on those of men [66].

Interestingly, Stepping Stones had impact on women's HSV-2 incident infections, but measured change in sexual practices was not observed [65]. It is hard to know whether the changes in HSV-2 were a product of change in behaviours not measured as secondary out-comes, but the intervention did not impact on the most HIV-risky women as it did not reduce their likelihood of new HIV infection.

Qualitative research showed that the intervention was generally empowering for women and seemed to empower women in their minor sexual relationships (with khwapheni, secret concurrent partners), but there was more limited evidence of empowerment with their main sexual partner [66]. The evidence suggests that within the prevailing gender order, women perceived themselves to be unable to influence their partners' behaviour; they perceived that had they asserted them-selves, the price would have been relationship break down. Some women accepted this, but given that so many of their short-term, and long-term, aspirations and sense of value were embedded in that relationship and there has often been uncertainty about whether the next partner would be different this was, for most, a price that was too high to pay.

This highlights the value of interventions in resource-poor settings that combine a focus on gender equity and broader structural interventions, such as seen in the IMAGE study, which combined microfinance with a programme on gender-based violence and related community action [67].

Ideas of masculinity and femininity also impact on HIV testing and thus access to treatment in different ways. Ideals of hegemonic masculinity that are predicated on toughness and being in control give little room for men to acknowledge vulnerability by testing for HIV and using health services. Their reluctance to do this has been well described. In South Africa, the 2008 National AIDS Survey showed that 43% of men and 57% of women had ever tested for HIV, and 20% of men and 29% of women said they had done so in the previous year [2].

There is evidence from services in multiple settings, and even global regions, that men enter antiretroviral treatment at lower CD4 counts than women and have a higher mortality on treatment [68,69]. The dominant model of femininity, in these respects, benefits women as they are diagnosed with HIV earlier and are more likely to get into and do well on treatment. Changing constructions of masculinity are essential for encouraging men to engage with productive health seeking in an era of HIV.

Discussion of gender and HIV should not be concluded without reflecting on how HIV creates possibili-ties for gender transformation. The imperative for building safer sexual practices provides the possibilities of engagement with change in the gender order and encouraging more gender-equitable men [70]. Research also suggests that for men, the experience of having HIV can be part of the process of gender transformation [71]. For many men, being diagnosed with HIV is a life-changing event that shifts the way in which they position themselves with respect to their families and partners. Thus, faced with their own vulnerabilities, there are multiple accounts of men who engage in caring and support for their partners and extended families [48]. Similarly in his accounts of change to the Zulu ideal of isoka (the desirable heterosexual man, personified by men who had multiple sexual partners), Mark Hunter described how some men have come to realise that their very survival is predicted on their engagement with new ways of being men [72].

Conclusions

There is a growing body of evidence showing that women who have experienced more gender power inequity in their relationship and gender violence are at greater risk of HIV. Since men who have been violent are more likely to be infected, it seems that women are least able to protect themselves when in relationships with men who pose the greatest risk for them.

Reflecting on the clustering of male violent and risky sexual practices, we have argued that these flow from dominant ideals of masculinity. Women's exposure to these is related to their adoption of femininities that forgive and accommodate male gender-inequitable and anti-social behaviour. These ideals of femininities are embedded in cultural processes that reward compliance. Women who are most vulnerable materially and emo-tionally are least able to reject them, and thus, most vulnerable to male violence and control, and consequently HIV.

Understanding sexual practices as flowing from gender identities helps us to understand why they are so hard to change, as well as how change should be approached. Evidence is suggesting that it is the underlying gender identities that must be changed to advance AIDS prevention and care.

Our understanding of how to change gender identities and build the gender equity to prevent HIV infections is still in its infancy; yet the experience of many countries teaches us that it is possible to move towards gender equity. Aligning the agendas of HIV prevention and building gender equity will help to extend human rights globally, as well as make HIV prevention more effective. However, resources for this work remain severely and disproportionately limited. It is essential that funders and politicians, researchers and activists work to ensure resources are available for the developing and testing of strategies to build more gender-equitable masculinities and femininities and to implement effective strategies to address the inseparably entwined problems of gender inequality, violence and HIV.

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Authors' contributions

This paper was written by both authors.

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This was of paramount importance in protecting young people from the emotional impacts of HIV on the family and many young people felt that they had become closer to their parent or relative as a result of their caring responsibilities.

Children and parents also developed informal and formal support networks among relatives, friends, neighbours, NGO workers and other members of the local community, which mitigated the material and emotional impacts of HIV on the family and helped to alleviate young people's care work. Caring is therefore not just a one-way process between a young person as the 'care-giver' and their parent as the 'care-receiver', but rather is embedded in social relations between children, parents, relatives and members of the wider community.

This research suggests the need to provide both targeted support for young people with caring responsibilities and parents with HIV, as well as universal services. Specialist services for young people affected by HIV were highly valued by the young people interviewed in the UK and Tanzania, for providing opportunities for social activities and emotional and peer support with others in similar situations. However, differences of age, gender, race, ethnicity, class, disability and other characteristics crucially affected young people's experiences and responsibilities within the family. Targeted support needs to remain sensitive to these differences to ensure that services are responsive to the diverse needs of young people and their families.

Most of the young people interviewed in the UK regularly attended at least one specialist youth group targeted towards young people affected by HIV or young people from African communities (and in a small number of instances, young carers' groups). However, the majority of these projects were concentrated in London and specialist support was unevenly developed outside the capital. Furthermore, there was considerable apprehension among parents and service providers about the accessibility of young carers' projects for young people caring for a family member with HIV, because of concerns about stigma, confidentiality and the cultural appropriateness of services, particularly for African refugee families. This suggests that, where specialist family-focused HIV services do not exist, there is a need for more inclusive young carers' projects and other mainstream services that are sensitive to the culturally diverse support needs of young people and parents living with HIV.

Although specialist youth-focused support for young people affected by HIV was not widely available in Tanzania, the few young people interviewed who had been able to attend memory clubs or other therapeutic opportunities highly valued the opportunity to learn more about HIV, to develop life skills and share their feelings with other young people in similar situations.

In addition to targeted support, the research highlights the need to increase the capacity of mainstream services to provide culturally appropriate support for children, young people and parents affected by HIV that is sensitive to stigma and the need for confidentiality. Service providers in the UK and Tanzania suggested that professionals in mainstream services may have limited understanding and expertise in supporting families with HIV-related issues. They also revealed the need for greater engagement between, on the one hand, mainstream providers and welfare institutions and, on the other, specialist HIV organisations and community groups that are currently supporting these families. This would help to improve the accessibility and cultural appropriateness of universal services, building the capacity of professionals to deal with the complexity of issues surrounding HIV within the family, in addition to young care-giving.

The experiences of service providers, young people and parents raise a number of important challenges in developing services and support for this hidden group of young carers and their families. Policies, services and interventions which start from an understanding of the diverse gendered and age-related dynamics of caring roles and responsibilities within households affected by HIV, and that offer support to children, parents, relatives and communities in these roles will help to promote the welfare, well-being, resilience and caring capacity of families and communities in both the global North and South.

Editor. while this useful research highlights some very significant gaps in the support needed by and provided to young carers, there is an urgent need for replication of the research in southern Africa, where the majority of those infected and affected by HIV live. The challenges in terms of available services are bound to be even greater for young people, who often find themselves socially isolated and without sufficient financial resources. Nonetheless, the information presented here provides important guidelines for those involved in policy development and should stimulate new and more comprehensive programme implementation.

Dr Ruth Evans is a Lecturer in Social and Cultural Geography at the University of Reading. *This research was funded by the ESRC and has recently been published in a book by Ruth Evans and Saul Becker entitled: Children caring for parents with HIV and AIDS: global issues and policy responses, 2009 The Policy Press, UK.*

The relationship between gender, concurrent partnerships, migration and HIV in Zambia

By Oda Shor Gilleberg

"You cannot talk about HIV without talking about gender. Where there is gender inequality there is HIV. Everything is interrelated," said Mercy Halwiindi, one of the participants at a recent Gender, Migration and HIV training workshop organised by the International Organisation for Migration (IOM) in Zambia.

Gender roles and norms make it difficult for women to protect themselves against HIV and abuse. Social and cultural definitions of masculinity and femininity mean that men generally hold the power to initiate and dictate the terms of sex. Gender inequality and the low status of women can impede human and social development and exacerbate the impacts of HIV and AIDS. Cultural norms influence sexual behaviour, including the occurrence of concurrent partnerships which, along with migration, is one of the six key drivers of the HIV epidemic in Zambia.

Recent research[1] conducted by Family Health International (FHI), in partnership with IOM, the National AIDS Council (NAC) and the Joint United Nations Programme on HIV/AIDS in Zambia, indicates that concurrent partnerships are widespread. The final results of the research are due to be published in late 2010 but early findings – which were presented at the bi-annual AIDS conference in Vienna in July 2010 - indicate that overlapping concurrent partnerships are frequent among both men and women in stable relationships[2].

More than two-thirds of men (70.7%) and almost half of women (46.3%) interviewed reported having had overlapping concurrent relationships in the past 12 months. Almost all of those who reported having more than one sexual partner in the past 12 months had concurrent, rather than sequential, partners.

"Most of the mine workers say they are allowed to have as many girlfriends as they want. The psychological abuse is the worst for Zambian women today and the normalisation of concurrent sexual partnerships is part of that. It's impossible to keep it a secret, and women are taught to persevere. There is nothing the wife can do about it."

[1] The research was conducted by a team from Tropical Diseases Research Centre (TDRC) with scientific and technical leadership provided by Family Health International (FHI) and funding and technical support from the National Aids Council (NAC), United Nations (IOM, UNAIDS, UNICEF, UNFPA, WHO), and the United States Agency for International Development (USAID), 2010.

[2] The study aimed to produce context-specific information on the practice of concurrent sexual partnerships in the context of stable relationships. Researchers used a purposive (non-random) sampling strategy to enroll men and women who perceived themselves to be in stable relationships and who agreed to participate in in-depth interviews. In-depth interviews were conducted with 301 men and women between the ages of 16 and 49, from seven different sites in Zambia. The study sought to highlight community perceptions and understanding of HIV risk; to strengthen evidence-based community dialogue on HIV prevention within stable relationships; and to strengthen the monitoring systems that track behavioural trend data that influence the HIV epidemic in Zambia

Findings indicate that normative explanations of concurrent sexual partnerships centred on money and gender power dynamics, mobility and the use of alcohol as a disinhibitor. Over half (51%) of males interviewed and a quarter (26%) of female participants who were in concurrent sexual partnerships said they had one or more partners whose primary residence was different from their own.

Participants reporting overlapping concurrency reported inconsistent condom use and noted a variety of reasons for not using condoms including: lack of pleasure, medical or health reasons and a distrust of condoms. About half the women and men who said they were in monogamous relationships indicated 'no condom use' while one-quarter reported inconsistent condom use.

Mercy Halwiindi who works with NGO Comprehensive HIV/AIDS Management Programme (CHAMP) in Zambia's copper mining region, implementing HIV and gender social change programmes with mine workers, confirms the findings of the study: "Most of the mine workers say they are allowed to have as many girlfriends as they want. The psychological abuse is the worst for Zambian women today and the normalisation of concurrent sexual partnerships is part of that. It's impossible to keep it a secret, and women are taught to persevere. There is nothing the wife can do about it".

Thousands migrate out of Zambia each year

To respond to some of these gender-related challenges IOM Zambia, in partnership with CHAMP and the Global Development Alliance (GDA), is rolling out a series of Gender, Migration and HIV trainings for up-and-coming Change Agents in workplaces across the country. As the programme moves forward, the trainings will be implemented with workers in several of the biggest mining and agri-business companies in Zambia; including Zambia Sugar, First Quantum Mining Limited, Mopani Mines and Dunavant Cotton Limited.

"Gender training is a key component of IOM Zambia's HIV programmes which aim to reduce the HIV-related vulnerabilities of migrants and host communities in Zambia", says Katy Barwise, Programme Officer for Migration Health at IOM Zambia. "As it is today, in parts of southern Africa, a female farm worker could lose her job - and livelihood - if she refuses to have sex with her supervisor," Barwise continues.

According to a survey on gender-based violence (GBV) conducted by the Zambian Central Statistical Office (CSO) in 2006, 4% of Zambian men and women aged 15-49 years were said to have experienced sexual abuse, with more women reporting abuse in both rural and urban areas. However, according to community-based participants at IOM's gender trainings, domestic sexual abuse is much more common than this number indicates.

"The domestic physical and sexual abuse that is reported may be only the tip of the iceberg", says David Kabati, the HIV/AIDS CARES Co-ordinator for Dunavant Cotton. "Wives do not report domestic rape, because 'such a thing does not exist'. Everybody is taught that a husband can have sex with his wife when he wants it, and she must persevere".

But despite this, both men and women play a role in perpetuating the gender norms that encourage domestic abuse and concurrent partnerships: "Gender roles are defended by women who perceive them as moral and African", says Sgidi Sibeko, Gender, Migration and HIV consultant at the International Organisation for Migration. Sibeko emphasises that women should not support traditional practices and values that further marginalise them.

These rigid gender norms where men can behave freely, with the collusion of women, are sometimes defended by religious arguments. At IOM workshops with mine workers in Solwezi (in the copper mining region), male participants expressed the belief that 'biblically, men are more intelligent than women', and 'biblically, the woman was created just to help the man. Initially all the jobs were meant for the man to do alone'.

[3]Gender Based Violence (GBV) Survey 2006 Summary Report: http://www.zamstats.gov.zm/media/gender_based_violence.pdf

That being said, however, men also suffer under inflexible gender expectations. Men's health and well-being are jeopardised by traditional gender roles. In some cases men are encouraged to associate violence, alcohol and substance use, the pursuit of multiple partners, and domination over women with 'manliness'. Contemporary gender roles leave both men and women vulnerable to HIV infection and reduce the likelihood that men will seek HIV testing services, or access medical services until they are already very ill. For this reason IOM's gender training programme focuses on the role of men as agents of change, and at its heart is the One Man Can approach.

The One Man Can Campaign was launched in 2006 by Sonke Gender Justice Network in South Africa. The campaign has been implemented in Burundi, Kenya, Malawi, Mozambique, Namibia and Uganda, and is currently being integrated into IOM Zambia health programmes. The ideology behind it is that every single one of us can make a difference, and men are especially encouraged to advocate singly and collectively for gender equality.

Behavioural change is gradual and does not happen overnight. "We know that the system of patriarchy grants men power over women. As a result, men enjoy certain privileges in society. Nothing should be seen to threaten or erode that power. Should that happen, the man may respond with violence to restore or abuse to ensure that it is well entrenched", explains Sibeko.

On the other hand, female participants at one of the gender trainings said that they had experienced being controlled by men. One female participant recounted her experience: "Not long ago I received a text message from a number I did not know. My boyfriend demanded to read the text and beat me up afterwards. I continued to receive these messages and every time my boyfriend would beat me up, even though I never responded to them. One day I found a sim card in our bedroom and discovered that it was my boyfriend who had sent me those texts in the first place."

Gender roles can change though, and according to Sibeko, both men and women need constant engagement in order to change their behaviour. Despite the challenges, he emphasises that gender roles and behaviour do change over time. Addressing gender inequality is an essential part of the HIV response, "gender imbalance is one of the drivers of HIV, and we need to engage all sectors of the society".

Participants at these gender trainings, all of whom work at grassroots level and witness gender inequalities daily, believe that gender equity can be achieved in Zambia. "It can take a decade. But what is important is to begin somewhere, and we have begun," concludes Kabati.

Oda Shor Gilleberg works for IOM Zambia

Contemporary gender roles leave both men and women vulnerable to HIV infection and reduce the likelihood that men will seek HIV testing services, or access medical services until they are already very ill.

Mineworkers often live away from home for long periods of time

HIV prevention studies for young people in Africa often of poor quality and show limited effect

By Michael Carter

The quality of research examining HIV prevention programmes targeted at young people in Africa is poor, according to the authors of a systematic review and meta-analysis published in the online edition of *AIDS*. Moreover, evidence that such prevention programmes had an effect was limited and confined to sub-groups. "Surprisingly little information was available on youth interventions in sub-Saharan Africa: only 28 studies were identified, with as few as two studies collecting biological endpoints, and many studies had suboptimal design", write the investigators.

Young people are one of the focuses of the HIV epidemic. In South Africa, 4% of young women aged between 15 and 24 are HIV-positive, with 2% of men in this age group also having HIV infection.

A large number of prevention programmes are targeted at younger people, with the aim of reducing their sexual risk behaviour. It's important to know if these interventions work. Therefore investigators conducted a systematic review and meta-analysis to assess the effectiveness of prevention programmes for the young. They noted, "...this is the first meta-analysis of the impact of behaviour interventions for youth in sub-Saharan Africa".

To be included in the review, the studies had to have a control group, focus on young people (ages 10 to 25), have been undertaken after 1990, and report on the behavioural interventions aimed at preventing HIV transmission by reducing sexual risk taking. The investigators' search identified 758 articles. However, only 31 studies reporting on 28 interventions met the investigators' inclusion criteria.

Eleven of these studies were randomised trials, 15 used a cross-sectional design, and 13 were cohort studies. Most (16) were conducted in schools; eight were undertaken in the community, and four in both schools and the community. The duration of interventions ranged from one hour to three years. Outcome measures included condom use, behavioural change, and biological outcomes such as infection with HIV or a sexually transmitted infection.

Condom use

A total of 18 studies measured condom use. Their results were highly variable. Generally, the interventions had a greater impact on condom use by males than females. In the meta-analysis, condom use was 46% higher during last sex among the males who received the intervention than those who did not. Interventions also increased general condom use amongst young men (RR = 1.32; 95% CI, 1.25 to 1.40). Three studies examined participants' intention to use condoms. One study had a positive effect, one had negative results, and the intervention in the third study had no impact at all.

Sexual behaviour

The most common measure of sexual behaviour (eleven studies) was ever having sex. Generally, there was no evidence that participation in HIV prevention programmes increased sexual activity.

Sexual abstinence was examined in three studies. Reported rates increased in two of these, but fell in the third. Recent sexual activity was evaluated in seven studies. One study found a reduction, whereas three identified an increase.

Information on nine studies was available on their effects on multiple sexual partnerships. Once again, there was little evidence that these increased amongst those who received the HIV prevention intervention. In the five studies where the intervention was successful, in three the effects were more pronounced in young men than young women.

There is a paucity of high quality studies examining the effectiveness of HIV prevention interventions for young people in Africa. This is particularly concerning given the extent of the vulnerability of HIV infection faced by the 125 million young people in sub-Saharan Africa, and the presence of numerous HIV prevention initiatives and funding opportunities in the region.

Biological outcomes

Only two studies examined biological outcomes. Rates of HSV-2 were lower in the intervention group in a South African study, but the intervention had no impact on the incidence of HIV or pregnancy. A Tanzanian study also showed that the intervention had no impact on rates of HIV or pregnancy.

The investigators express their surprise and concern about the paucity of high quality studies examining the effectiveness of HIV prevention interventions for young people in Africa. They write, "...this is particularly concerning given the extent of the vulnerability of HIV infection faced by the 125 million young people in sub-Saharan Africa, and the presence of numerous HIV prevention initiatives and funding opportunities in the region".

Moreover, the investigators note that there was little consistency in the prevention approaches of the studies they identified and that few "have built upon previous knowledge in a linear fashion. In addition, no two studies used the same methods of analysing or reporting data, and outcome indicators very markedly diverse ".

They therefore recommend that "there should be more studies that use a strong evaluation design and measure biological outcomes". As regards the outcome of the studies, the investigators found it 'encouraging' that interventions did not increase sexual risk-taking. They comment, "the effectiveness of HIV prevention interventions on sexual behaviour overall, to date, however, appears relatively small".

Young people are disproportionately infected with HIV and need targetted responses

Reference
Michielsen K et al. Effectiveness of HIV prevention for youth in sub-Saharan Africa: systematic review and meta-analysis of randomized and nonrandomized trials. AIDS, online edition, DOI: 10.1097/ http://www.aidsmap.com/en/news/BB8BF6B1-81F2-4EC5-80A2-5E935FB2942C.asp

Survey highlights HIV prevalence and vulnerability of farm workers

By Nosipho Theyise

The International Organisation for Migration (IOM), with partner Hoedspruit Training Trust (HTT), implemented an Integrated Biological and Behavioural Survey (IBBS) on ten farms in the Hoedspruit area in the Limpopo Province, South Africa in2008.

The survey involved 1,500 farm workers and management who all volunteered to participate. The study found that farm workers are highly vulnerable to HIV: 28.5% of farm workers surveyed were infected with HIV. Female workers were significantly more at risk than male workers at 32.5% versus 20.9% respectively. The anonymous HIV prevalence survey was linked to a questionnaire to better understand the relationship between HIV and various social, economic, mobility and behavioural factors that are prevalent on commercial agricultural estates.

Dr Clive Evian, who conducted the survey, characterised the results as a "serious epidemic" and highlighted the need to strengthen current HIV testing, care and support services. The key findings suggest that:

- Female employees, especially those under 30 years old appear to be particularly vulnerable to infection. Young female employees (in the 18 – 24 year age group) are three times more likely to be infected than males of the same age.
- Female employees who travel daily for more than one hour to work are more likely to be infected with HIV than their male counterparts - and women spent more time travelling to work than men.
- Unmarried women and married men appear to be more vulnerable to HIV infection.
- The majority (60% of all employees and 53% of HIV positive employees) do not know their HIV status.
- A quarter (25%) of HIV positive employees who reported knowing their status do not use condoms.
- Male circumcision seems to provide only partial protection. 71% of all HIV positive males reported having been circumcised either as adults or as children. However, HIV prevalence is significantly lower among men who reported having been circumcised as children (under 15 years).

Dr Evian emphasised that since the farming community comprises a high percentage of young, female employees "addressing issues affecting young women is critical and of the highest priority".

This survey highlighted areas that needed immediate focus, especially in terms of the vulnerability of young women. It also encouraged farmers and farm workers to go for testing and informed all workers about HIV workplace policies that will support them, as well as other services, including antiretroviral medicines that are available to those that need them.

Farm workers at a farm in Limpopo, South Africa

- *Female employees aged 18 – 24 are three times more likely to be infected than males of the same age*
- *Female employees who travel to work daily for more than one hour are more likely to be infected with HIV than their male counterparts*
- *Unmarried women and married men appear to be more vulnerable to HIV infection*
- *60% of all employees and 53% of HIV positive employees do not know their HIV status*
- *A quarter (25%) of HIV positive employees who reported knowing their status do not use condoms*
- *Male circumcision seems to provide only partial protection. 71% of all HIV positive males reported having been circumcised either as adults or as children.*

The survey will provide employees, employers, as well as policy makers, with a more accurate appreciation of the epidemic in the agricultural sector and will thus assist in better programme design as well as monitoring. The survey was implemented as part of IOM's Partnership on Mobility and HIV in southern Africa (PHAMSA) that aims to reduce the HIV incidence and impact of AIDS among migrant and mobile workers and their families.

About PHAMSA: *The International Organisation for Migration (IOM)regional programme, Partnership on HIV and Mobility in southern Africa (PHAMSA) aims to reduce the HIV incidence and impact of AIDS among migrant and mobile workers and their families in the Southern African Development Community (SADC) region. Active since 2004, PHAMSA implements HIV prevention projects in sectors that are characterised by high levels of population mobility. These sectors include construction, transport, commercial agriculture, fisheries, mining as well as mobile and migrant populations living and working around border sites, such as customs and immigration officials as well as informal cross border traders. Nosipho Theyise email: ntheyise@iom.int*

Home Based Care vegetable farmer in Chiredzi, Zimbabwe

HIV prevention and treatment not accessible to migrant workers in southern Africa

By Nosipho Theyise

A recent International Organisation for Migration (IOM) study has found that migrant workers in southern Africa have relatively limited and inadequate access to HIV prevention and treatment services, although they face increased vulnerability to infection. The findings are based on a regional assessment of the HIV vulnerabilities of migrants and mobile workers in the southern Africa region commissioned by the U.S. Agency for International Development (USAID) and funded by the Southern Africa Prevention Initiative of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

Conducted in eight countries (Angola, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland and Zambia) over a five-month period from July to November 2009, the assessment focused primarily on labour migrants employed in the commercial agriculture, mining, transport, construction, domestic work, informal cross border trade and maritime sectors. Irregular migrants were a secondary focus.

The study found that numerous factors contribute to the increased HIV vulnerability of migrant workers, mobile populations (and the communities that they interact with), including:

- Boredom and loneliness resulting from the long periods of time spent away from home;
- Poor social environments in which alcohol and sex are the only forms of entertainment;
- Multiple and concurrent sexual partnerships, including commercial and transactional sex;
- Low HIV knowledge and inconsistent condom use;
- Limited access to HIV prevention services;
- Low coverage of social and behaviour change communication programmes

Additionally, the study found that irregular and undocumented migrants face special health vulnerabilities as they often avoid accessing public health services, citing reasons such as high cost; fear of being deported; language barriers and possible xenophobic attitudes of healthcare service providers.

Sector-specific findings and recommendations:

Commercial Agriculture Sector

Poor living conditions, seasonal mobility, boredom and loneliness, lack of access to health services and gender inequalities amongst other things, contribute to the increased vulnerability of farm workers to HIV. In some cases, because farm workers work on a 'no-work-no pay' system, they do not take time off work to seek medical attention for otherwise treatable conditions, until it is too late.

It is recommended that agricultural businesses conduct periodical onsite medical checkups which include voluntary screening for sexually transmitted infections and HIV. NGOs are also encouraged to support governments in reaching isolated agricultural settlements with adequate basic healthcare, including HIV prevention services.

Construction Work

Construction workers typically live in temporary accommodation on construction sites and often in remote areas. This separation from families, coupled with limited recreational activities or entertainment on remote sites makes them vulnerable, as they may engage in transactional sex with members of the communities around them. They also lack access to healthcare services because of the often remote location of construction sites.

Recommendations for this sector are that, in cases where local healthcare services are not available, all construction workers should be given access to on-site mobile health services. Additionally, all new construction projects should conduct social impact assessments on how proposed construction developments will affect the social dynamics of nearby communities in both the short and long term.

Domestic Work

Domestic workers are vulnerable to HIV often because of their poor living and working conditions;

possible unlawful labour practices by employers; time spent away from home; possible sexual and gender based violence; and general lack of access to healthcare services.

Recommendations for the domestic work sector include the formalisation of domestic work by governments to limit unlawful labour practices; greater enforcement of regulations over individual employers and providing them with incentives to enable regular access to HIV prevention information and services for employees.

Fisheries

Seafarers spend most of their time at sea, which limits their access to healthcare services. Like all other sectors mentioned, the time spent away from home makes them vulnerable and they may abuse alcohol and engage in high risk sexual behaviour with sex workers when they are on shore leave.

The report recommends that in addition to the provision of health services in HIV 'hot spots' like harbours and ports, onboard health services should also be provided to all workers.

Mining Sector

Some of the factors influencing the HIV vulnerabilities of mine workers are dangerous working conditions and masculine identities; living away from families; limited access to healthcare; mine settlements being in isolated and often deserted and inhospitable places; and impoverished mineworker-sending communities.

Recommendations made for this sector include: HIV workplace programmes should be available to all mine-workers, regardless of their contractual status (permanent or non-permanent); development and implementation of evidence-based and culturally sound social and behaviour change communication interventions; and the introduction of mine worker-friendly healthcare services that are accessible after hours.

Transport Sector

The job of a truck driver is a lonely one. They often experience long delays at ports and border posts where they can spend up to five days waiting for documentation. Some truck drivers go to nearby bars to kill time, and may engage in transactional sex. Additionally, because they are always on the road with expensive cargo to protect, they are reluctant to leave their trucks unattended for more than a few minutes. This means that truck drivers seldom seek healthcare while on the road, which contributes to their HIV vulnerability.

Scores of people wait inside the departure terminal at Road Port in Harare, Zimbabwe. A station for buses arriving from or headed to South Africa and Botswana. Many Zimbabweans have resorted to travelling to neighbouring countries to buy diffent products for resale at home. *Tsvangirayi Mukwazhi*

The report recommends amongst other things, the standardisation of customs clearance procedures at border posts in the region in order to reduce waiting time; and greater coordination amongst SADC countries to provide accessible health facilities and HIV prevention services in all countries in the region.

Informal Cross-border Trade

Like truck drivers, informal cross-border traders spend long periods of time at border posts. They spend limited time with their families because of their frequent cross border movements, and due to their restricted financial situation they may not be able to afford accommodation and healthcare in destination countries. This makes them vulnerable to HIV infection, as they may engage in transactional sex in exchange for such things as accommodation, transportation or even food.

Recommendations are made that NGOs and governments should introduce HIV-prevention service centres and health clinics that are open after hours in high-risk areas where informal cross border traders are found.

On the whole, the assessment revealed that despite an increase in HIV prevention services provided by governments and NGOs, access to

HIV-prevention services and treatment for migrant workers, their families and the communities around them remains inadequate.

The report makes a number of comprehensive recommendations to help reduce the HIV vulnerability of migrant workers and mobile populations, such as the need to look at migrants within a public health context, and the development of programmes for migrants and the communities with whom they interact, in particular "spaces of vulnerability", such as border posts and transport corridor hot spots; the need for further research to examine sexual behavioural patterns within the migration process; and the need for governments to introduce comprehensive HIV policies that cover the specific vulnerabilities faced by migrants; in particular, access to healthcare at their work place and along major transit corridors.

The report also encourages governments to enforce stiffer regulations to ensure that all companies, including smaller companies, provide workplace policies and regular access to HIV prevention services for all employees, regardless of their contractual status.

USAID's Southern Africa Mission Director, Mr. Jeff Borns, said, "USAID supported this valuable research to find out how susceptible the migrant workers are to HIV and AIDS, and to gain valuable guidance for those seeking to address the needs of such a vulnerable and underserved group."

Editor: This survey helps fill a very large gap in prevention activities around HIV and mobile and vulnerable populations, by pointing out the gaps that others can surely fill. Certainly there is scope here for public/private partnerships that will allow private sector support for public sector prevention efforts at border posts and elsewhere. Simple solutions such as the provision of cinema facilities that can provide safe entertainment to while away long hours, as well as showing educational videos and other materials on prevention and safer sex, can be implemented through such partnerships. Who knows, they might even start generating their own funds instead of requiring constant donor support. At the very least, heads of industry in each of the sectors highlighted should be given free copies of this report.

The complete report titled *Regional Assessment on HIV-prevention needs of Migrant and Mobile Populations in Southern Africa 2009* can be downloaded from:*http://iom.org.za/site/index.php?option=com_docman&task=cat_view&gid=22&Itemid=238*

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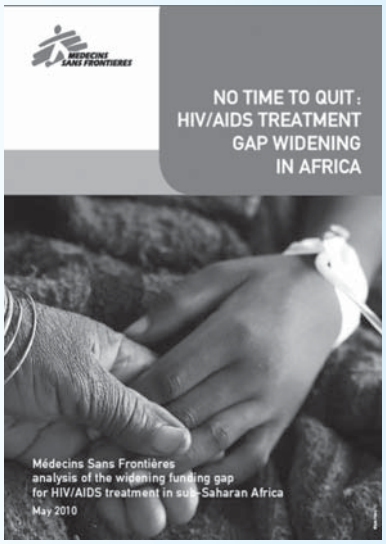
Truck drivers at a border post between Zambia and Zimbabwe. Drivers spend a lot of time on the roads with no access to health care

No Time to Quit: treatment gap widening in Africa

Special Report by MSF



At the end of the 90's, Médecins Sans Frontières (MSF) got involved in HIV because they viewed it as an emergency. Today MSF still believes this is a crisis requiring an exceptional response. Since the start of the epidemic, HIV has created an acute public health crisis in many countries requiring an emergency response to the resulting high mortality and the spread of the disease. To date, much has been done to tackle HIV, but the urgency of the situation still calls for a sustained and expanded response over a long period of time — the battle is not over yet.

Through its medical humanitarian work in the majority of the worst-affected countries in sub-Saharan Africa, MSF has recently started to observe a worrisome turn-around among the donor community. After years of political willingness and financial commitment to combat HIV, donors now seem to be disengaging from the fight, leaving behind people who are still in dire need of life-saving treatment. In 2009-2010, MSF carried out in-depth field analyses in eight key countries – Democratic Republic of Congo (DRC), Kenya, Lesotho, Malawi, Mozambique, South Africa, Uganda, and Zimbabwe - where we have been providing HIV care and treatment for several years. The findings confirm our concerns in terms of donor backtracking on commitments to scale-up the fight against the HIV epidemic. Today, this disengagement is becoming visible in the field and the level of HIV care is beginning to deteriorate.

Uncertainty and unreliability of donor funding has stalled the enrolment of new patients and put the supply of antiretroviral medicines (ARVs) at risk in the medium to long term. Donors have also diluted their initial emergency approach and shifted funding toward other health issues, disregarding the proven cross-benefits of effective HIV intervention on healthcare in general. Ironically, at the same time as the level and sources of funding decline, donors expect the money dedicated to combat HIV to fund increasingly comprehensive packages extending to other priorities within the health sector.

A possible donor retreat not only hampers HIV treatment scale-up but threatens to undermine all the positive effects and future perspectives that high ART coverage brings, in terms of community-wide reduction of mortality, morbidity and transmission.

Any retreat from the current efforts toward ART scale up will have far-reaching and very real negative consequences for patients and front-line workers in HIV care.

Combined with the effects of the economic crisis in low income countries and in particular on vulnerable people, donor fatigue on HIV will further widen the HIV treatment gap in sub-Saharan Africa.

In concrete terms, reducing funding for HIV treatment and ART means:

- Patients will have to wait longer to start ART and may die before they can access life-saving medication.
- Patients left untreated risk succumbing to opportunistic and contagious infections such as TB.
- Implementation of WHO guidelines that give patients the benefits of earlier treatment will cease.
- Knock-on effects on already fragile antiretroviral supplies, meaning more stock-outs and disruptions and additional strains on patients' adherence and health facilities' workload.

- Further reductions in affected countries' ambitions for tangible results and inclusion of specific vulnerable groups.

From the field perspective, donor retreat will change the character of the epidemic, with increasing numbers of patients seeking care, more ill patients and rising mortality in the community — echoing the early 2000s when ART was rationed to a few.

If funding for treatment continues to shrink:

- *Patients with lower CD4-counts will be most affected. Those starting with lower CD4-counts require more frequent, more intensive and more costly care. At the same time, they have lower chances of survival and take longer to recuperate.*
- *Health facilities' patient loads will increase and health workers will be discouraged by the worsening results in the patients to whom they provide care.*
- *Patients may start sharing their pills, effectively lowering their dosage and increasing risks of both virus transmission and resistance and tensions will rise between those on treatment and those who are not.*
- *Tuberculosis rates will increase, presenting an additional burden on already busy health services.*
- *Mortality among adults in the prime of their lives and the number of orphans will rise further.*
- *A proportional slowing down of testing and counselling activities will be needed.*

A brief survey of donors' plans for the next years illustrates the challenge.

One key donor, **PEPFAR**, has flat lined it's funding for 2009-2014, and since 2008-2009, has further decreased its annual budget allocations by extending the period of cover with the same amount of money. Funding for ARV purchases will also be reduced, translating into less people starting ART, as seen in South Africa and Uganda.

The World Bank currently prioritises investment in health system strengthening and capacity-building in planning and management over HIV dedicated funding. However, without funding for ARV drugs and related costs, the impact of such capacity to support HIV care will remain very limited.

UNITAID is phasing out its funding. By 2012, the drug and other medical commodity procurement organised by the Clinton Foundation for HIV and funded by UNITAID for second line ARVs and paediatric commodities should end in DRC, Malawi Mozambique and Zimbabwe.

The **Global Fund** faces a serious funding shortfall. Donors have requested the Global Fund to lower its financial ambitions. Current funding scenarios are already inadequate as they do not include the additional resources required to implement the new WHO guidelines. With very few exceptions, **other health actors** do not fund HIV treatment directly and hardly ever finance ARV supplies, besides through their contribution to the Global Fund. They are unlikely to fill the gap created by the current shortfall, yet remain reluctant to increase their support to the Global Fund.

While the resource mobilisation since 2001 has allowed us to fight effectively against the HIV epidemic over the past years, a sense of denial has set in among the donor community about this ongoing crisis. For the past year and a half, donors have increasingly voiced concern regarding the cost, sustainability and the relative priority of HIV, against the background of an ostensible lack of funds. This belies the evidence of global long-term gains from engaging decisively in the fight against HIV today.

Patients in need of life-saving treatment will not go away; the numbers of people in urgent need of care will incr http://www.zamoya.net/project/ratn/images/index_r5_c3.jpg ease and negatively impact their families, communities and the health care system. The cost of inaction will be far higher than that of action.

Our collective responsibility toward people living with HIV in the hardest-hit countries should remain steadfast. This is a historical opportunity for the international community to renew its commitment to fight the HIV epidemic and stand by the people and countries that face the challenge of providing lifesaving treatment to those in need. This depends critically on continued financial support by donor agencies such as PEPFAR, UNITAID and the Global Fund and calls for expansion of commitment of those donor countries whose support has so far been limited.

We must never forget why we started the fight against HIV. We were reacting to needless illness and excessive loss of life among young people, communities losing valuable energy and experience, profound wounds inflicted on the social fabric, and above all, the injustice of unnecessary suffering and death.

RESEARCH BRIEFS

RESEARCH HIGHLIGHTS

HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana

Sexual networks and social capital: multiple and concurrent sexual partnerships as a rational response to unstable social networks

Access to HIV/AIDS care for mothers and children in sub-Saharan Africa: adherence to the postnatal PMTCT programme

Yield of HIV-associated tuberculosis during intensified case finding in resource-limited settings: a systematic review and meta-analysis

HIV prevention in young people in sub-Saharan Africa: a systematic review

HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana

Authors: Baral S; Trapence G; Motimedi F; Umar E; Iipinge S; Dausab F; Beyrer C
Source: PLoS One 26 Mar 2009; 4(3): e4997.

BACKGROUND: In the generalised epidemics of HIV in southern sub-Saharan Africa, men who have sex with men have been largely excluded from HIV surveillance and research. Epidemiologic data for MSM in southern Africa are among the sparsest globally, and HIV risk among these men has yet to be characterised in the majority of countries.

METHODOLOGY: A cross-sectional anonymous probe of 537 men recruited with non-probability sampling among men who reported ever having had sex with another man in Malawi, Namibia, and Botswana using a structured survey instrument and HIV screening with the OraQuick(c) rapid test kit.

PRINCIPAL FINDINGS: The HIV prevalence among those between the ages of 18 and 23 was 8.3% (20/241); 20.0% (42/210) among those 24-29; and 35.7% (30/84) among those older than 30 for an overall prevalence of 17.4% (95% CI 14.4-20.8). In multivariate logistic regressions, being older than 25 (aOR 4.0, 95% CI 2.0-8.0), and not always wearing condoms during sex (aOR 2.6, 95% CI 1.3-4.9) were significantly associated with being HIV-positive. Sexual concurrency was common; with 16.6% having ongoing concurrent stable relationships with a man and a woman, and 53.7% had both male and female sexual partners in the preceding six months. Unprotected anal intercourse was common and the use of petroleum-based lubricants was also common when using condoms. Human rights abuses, including blackmail and denial of housing and health care was prevalent with 42.1% (222/527) reporting at least one abuse.

CONCLUSIONS: MSM are a high-risk group for HIV infection and human rights abuses in Malawi, Namibia, and Botswana. Concurrency of sexual partnerships with partners of both genders may play important roles in HIV spread in these populations. Further epidemiologic and evaluative research is needed to assess the contribution of MSM to southern Africa's HIV epidemics and how best to mitigate this. These countries should initiate and adequately fund evidence-based and targeted HIV prevention programmes for MSM.

Sexual networks and social capital: multiple and concurrent sexual partnerships as a rational response to unstable social networks

Author: Robert Thornton
Source: African Journal of AIDS Research Oct 2009; 8(4): 413–421.

Multiple and concurrent sexual partnerships (MCP) are prevalent in southern Africa and have been identified as a primary cause of high HIV prevalence in this region. Sexual liaisons with multiple partners serve to increase the size and diversity of an individual's sexual and social network, and therefore to increase their social capital. This maximisation of social capital may minimise the risk to relationship(s) at the cost of maximising the biological risk of HIV infection. Many sexually active individuals appear to neglect their biological risk of HIV infection in order to maximise their 'social capital.' This would seem to be irrational from the perspective of any individual actor, but on a larger social scale, may give individuals better access to some social and economic goods. This article argues that people in unstable and less-connected parts of the sexual network are those most active in building their sexual networks, even where they are not especially promiscuous. However, such strategies may increase exposure to HIV infection in particular populations, such as intravenous drug users, sex workers, and men having sex with men, as well as in the general population of heterosexual southern Africans. What these high HIV-prevalence populations have in common is their participation in sexual–social networks in which individuals try to maximise their social capital by extending the diversity and density of their sexual networks. The discussion shifts analytic attention away from the notion of higher-risk sexual practices of individuals towards consideration of the structure and dynamics of social and sexual networks at a societal level.

Access to HIV/AIDS care for mothers and children in sub-Saharan Africa: adherence to the postnatal PMTCT programme

Authors: Mercy Nassali; Damalie Nakanjako; Daniel Kyabayinze; Jolly Beyeza; Anthony Okoth; Twaha Mutyaba
Source: AIDS Care, Volume 21, Issue 9 September 2009, pages 1124 - 1131.

Despite scale-up of perinatal prevention of mother-to-child transmission (PMTCT) of HIV interventions, postnatal continuity of comprehensive HIV care for both mother and baby remains a challenge in developing countries. We determined adherence to the postnatal PMTCT programme (PN-PMTCT) and the associated factors among mothers at a public urban hospital in Uganda. We interviewed HIV-positive postnatal mothers on discharge and determined adherence to PN-PMTCT by the proportion of mothers that honoured their return appointments by the end of eight weeks postpartum. We held focus group discussions to assess factors that influence adherence to PN-PMTCT. Of 289 mothers, only 110 (38%) adhered to PN-PMTCT. Previous attendance at a routine postnatal review and having access to a phone were significantly associated with adherence to PMTCT among mothers older than 25 years (odds ratio (OR) 3.6 (95% confidence interval (CI); 1.2-10.4)) and (OR 3.1 (95% CI; 1.3-7.1)), respectively. On the other hand, Christianity (OR 3.2 (95% CI; 1.1-9.0)) was significantly associated with adherence to PN-PMTCT among mothers below 25 years of age. Mothers' perceived benefits of the PN-PMTCT programme, easy access to the programme, and social support from a spouse were important motivators for mothers to adhere to PN-PMTCT. Even with improved antenatal and intra-partum PMTCT services, only a third of the HIV-infected mothers adhered to the PN-PMTCT programme. Mothers who previously attended a routine postnatal care were 3.6 fold more likely to adhere to PN-PMTCT. We recommend strategies to increase mothers' adherence to PN-PMTCT interventions in order to increase access to HIV care for mothers and children in sub-Saharan Africa.

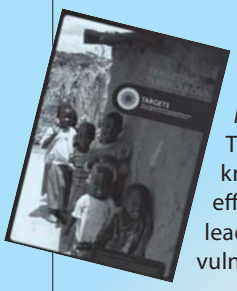
Yield of HIV-associated tuberculosis during intensified case finding in resource-limited settings: a systematic review and meta-analysis

Source: The Lancet Infectious Diseases, Volume 10, Issue 2, Pages 93 - 102, February 2010. Open access through free registration with The Lancet
Authors: Katharina Kranzer, Rein MGJ Houben, Judith R Glynn, Linda-Gail Bekker, Robin Wood Stephen D Lawn
Intensified case finding is the regular screening for evidence of tuberculosis in people infected with HIV, at high risk of HIV, or living in congregate settings. We systematically reviewed studies of intensified case finding published between January, 1994, and April, 2009. In 78 eligible studies, the number of people with tuberculosis detected during intensified case finding varied substantially between countries and target groups of patients. Median prevalence of newly diagnosed tuberculosis was 0·7% in population-based surveys, 2·2% in contact-tracing studies, 2·3% in mines, 2·3% in programmes preventing mother-to-child transmission of HIV, 2·5% in prisons, 8·2% in medical and antiretroviral treatment clinics, and 8·5% in voluntary counselling and testing services. Metaregression analysis of studies that included only people with HIV showed that for each increment in national prevalence of tuberculosis of 100 cases per 100,000 population, intensified case finding identified an additional one case per 100 screened individuals (p=0·03). Microbiological sputum examination of all individuals without prior selection by symptom screening yielded an additional four cases per 100 individuals screened (p=0·05). Data on the use of serial screening, treatment outcomes in actively identified cases of tuberculosis, and cost-effectiveness, however, were lacking. Concerted action is needed to develop intensified case finding as an important method for control of tuberculosis.

HIV prevention in young people in sub-Saharan Africa: A systematic review

Source:http://www.aidsportal.org/Article_Details.aspx?id=12769&nex=30
Due to social, cultural, economic and biological easons, young people are particularly vulnerable to HIV infection. Global goals to reduce vulnerability and prevent HIV in young people highlight the growing consensus that HIV prevention efforts must include a focus on young people. Resources for HIV prevention in all countries are limited, and therefore it is imperative that resources be used effectively. A compelling case can be made for the need for focused interventions to prevent HIV among young people, but it is less clear how precisely this should be done. This report presents an update of the first Steady, Ready, Go! systematic review, adding evaluations of interventions in sub-Saharan Africa in schools, health services, or geographically-defined communities with results released between January 2005 and December 2008. The results of the limited number of studies which reported the impact on HIV and/or other biological outcomes have been presented separately. An initial screening of nearly 1,200 citations resulted in 23 studies which met the criteria for inclusion. This relatively large number of studies reported in the recent four year period reflects an increasing recognition of the importance of HIV prevention among young people, and the need for studies to assess the effectiveness of interventions that aim to achieve that. The review utilised a methodology known as the Steady, Ready, Go! approach, where different types of HIV interventions for young people in different settings were systematically reviewed alongside each other using a similar methodology and graded for their effectiveness. A major focus of this methodology is to use the implications of the results to generate clear recommendations for policies and programming.

New publications at SAfAIDS Resource Centre Network



1. Targeting Tuberculosis. Porter, John; Leth van Frank. *London: Joint Clinical Research Centre, 2009.*
This document aims to develop new knowledge, tools and approaches for more effective communicable disease control, leading to better health for the poor and vulnerable.

2. No More People Living With HIV Dying of TB. World Health Organisation. *New York: WHO, 2009*
Infection control involves introducing measures to curb the spread of TB in places where people with TB and HIV gather, such as in clinics, hospitals, prisons or military barracks.

3. A Cut Above The Rest: A Progress Report On The Promotion Of Adult Male Circumcision As An HIV Prevention Strategy. *Grund, Jonathan. Atlantia, IAVI,2010*
It has been two years since TIME magazine voted male circumcision for HIV prevention the top medical breakthrough of the year. This followed results from three clinical trials in Kenya, Uganda, and South Africa which showed that circumcised men are approximately 60% less likely to acquire HIV from heterosexual sex.

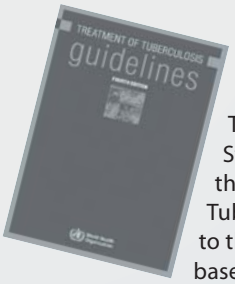
4. Emerging Issues from Policy Dialogues: Exploring Links Between GBV, HIV and Culture. SAfAIDS. *Harare: SAfAIDS, 2009*
Policy primer exploring the links between gender-based violence, HIV and culture. The book presents issues raised during policy dialogues that SAfAIDS conducted in Zimbabwe.

5. Roadmap To Equality: Lessons Learned In The Campaign For SADC Protocol On Gender And Development. Made, Pat; Morna, Lowe Colleen. *Johannesburg: Southern Africa Gender Protocol Alliance, 2009*
The Southern African Gender Protocol Alliance vision is of a region in which women and men are equal in all spheres.

6. Antibodies Beyond Neutralisation: Nipping HIV In The Bud. Kresge, Jill Kristen. *New York: IAVI, 2010*
Ever since HIV was discovered, researchers have been probing the life cycle of the retrovirus. Some of their recent progress was highlighted during the annual Keystone Symposia on HIV Biology.

7. World Health Statistics. Boerma, Ties, AbouZahr. *Geneva: WHO,2010*
The World Health Statistics series is WHO's annual compilation of health-related data for its 193 Member States, and includes a summary of the progress made towards achieving the health-related Millennium Development Goals and associated targets.

8. Caring forthe Environment and for People. Baya, Stanley. *London: Tearfund, 2010*
The Arabuko-Sokoke Forest in Kenya is what remains of an East African coastal forest which used to extend from Somalia to Mozambique. It is now only 40km long and needs urgent international protection.



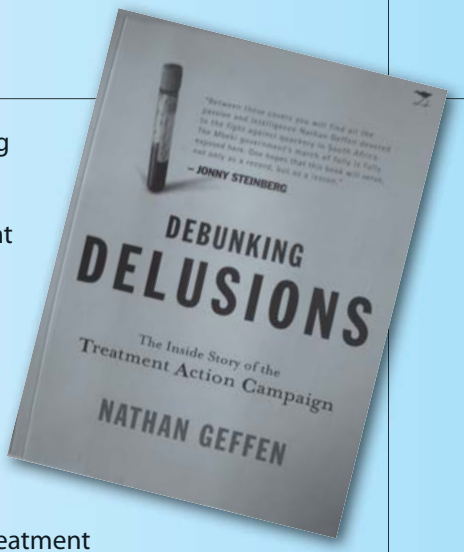
9. Treatment of Tuberculosis Guidelines. WHO. *Geneva: WHO, 2010*
The World Health Organisation's Stop TB Department has prepared this fourth edition of Treatment of Tuberculosis: Guidelines, adhering fully to the new WHO process for evidence-based guidelines.

10. Lung Health Consequences of Exposure to Smoke from Domestic Use of Solid Fuels: A Guide for Low-Income Countries on What It is and What To Do About It. Enarson, Donald; Ait-Khaled, Chen-Yuan Chiang. *Paris: The Union, 2009*
The "cause" of disease is now recognised to be much more complex than was previously understood. We can no longer rely on the idea that single agent determines the presence or effects of disease.

Book review

Debunking delusions: the inside story of the Treatment Action Campaign (2010)

By Nathan Geffen
Published by Jacana Media (Pty) Ltd in 2010
ISBN 978-1-77009-781-0



This 'passionately-written' book by Nathan Geffen outlines the history of the Treatment Action Campaign's struggle against AIDS denialism which has been described as "one of the great iconic struggles for social justice in the 21st century in South Africa". Geffen places the blame and responsibility for hundreds of thousands of AIDS deaths squarely on the shoulders of Thabo Mbeki and his former Minister of Health, Dr Manto Tshabalala-Msimang. He argues that Mbeki and Tshabalala-Msimang actively obstructed policies to roll out life-saving medicines to people living with HIV, created doubt among the populace by not speaking out clearly about HIV and AIDS, and promoted and protected untested remedies.

As one of the leaders of the Treatment Action Campaign since 2000, and editor of TAC's magazine Equal Treatment, Geffen describes his experiences and documents TAC's campaign to change the state's response to HIV. Using case studies and testimonials, Geffen outlines the struggle against ongoing AIDS denialism and state-sponsored quackery (defined as support for ignorant/dishonest practitioners, and ineffective or untested treatments). Drawing on real-life experiences, such as Andile Madondile's story, he brings to light the impact of 'quackery' and denialism on the lives of people living with HIV.

Since Mbeki's initial statements questioning the link between HIV and AIDS, (and although he later retracted this), the health structures and policies under his Government created fertile ground for ongoing denialism and the flourishing of unproven treatments. Debacles such as the Virodene affair saw the erosion of the Medical Control Council (MCC)'s authority to decide which medicines are effective or safe for clinical trials on humans. Geffen also recounts the stories of Tine van der Maas, Matthias Rath and Zeblon Gwala, who each sold their untested 'treatments' for HIV to unsuspecting and vulnerable people, who often experienced fatal consequences.

Geffen highlights that while TAC's media advocacy and litigation have been effective, a key strategy for countering state-sponsored denialism, was their emphasis on treatment literacy education. Grassroots education and information sessions were given within the communities for people living with HIV, often by people living with HIV. "It was through treatment literacy that TAC developed a membership that could explain, discuss and debate HIV." More than just advocating for the provision of ARVs, it was essential that people had the information and skills to understand the science between the disease and the medicines used to treat it. With a critical mass of people in communities who were able to discuss the science of HIV, a 'consensus that Mbeki's policies were wrong', was created.

With the departure of Mbeki, the South African government's response to HIV has changed. The new Government has placed a greater emphasis on addressing HIV, and providing treatment services. However, using current investigations from 'e-Health' and '3rd degree' (investigative journalism TV programmes in South Africa) Geffen highlights that 'quacks' in the form of ignorant or dishonest practitioners, and/or AIDS denialists, continue to emerge and promote treatments which are untested, and potentially harmful to people living with HIV. These treatments rob people of money, time and often their health.

Treatment literacy and evidence-based information about HIV and its treatment are essential. People living with HIV need to remain vigilant and to advocate for policies and services which protect their rights and their health, as enshrined in South Africa's Constitution.

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Website: www.safaids.net The Editor welcomes views, comments and any other helpful feedback that will make *SAfAIDS News* a better publication.