



> **Grace Osakue**, guest editor for the thematic section of this magazine on:

Gender-based violence

In this issue of *Exchange* we have selected gender-based violence (GBV) as our main focus of attention. GBV has many forms, including domestic violence, female genital cutting, rape and forced prostitution. An overview article written by guest editor Grace Osakue of Girls' Power Initiative in Nigeria sheds some light on the complexity and pervasiveness of this issue. After describing different types of GBV and its effects, she gives some examples of programmes that have addressed this issue in Nigeria, China and Cambodia. A box on gender-based violence in schools provides some data on the prevalence and persistence of violence against school children and gives UNICEF's definition of a 'child-friendly school'. Other articles and boxes describe programmatic approaches which address trafficking in girls (Nigeria), integrating HIV/AIDS in GBV programmes (South Africa), and involving men in violence-reduction initiatives.

Other issues addressed in this issue are religion, gender and knowledge about HIV and AIDS in Mozambique, and the promotion of the female condom in Burundi.

We wish you pleasant reading and welcome your comments!

Nel van Beelen
Managing editor

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With Women Worldwide: A Compact to End HIV/AIDS p.11



HIV prevention, gender and religion in Mozambique p.14

Violence against women and girls: breaking the culture of silence

"We no longer kill the girl baby with the poisonous sap of the oleander plant as traces of the poison can be detected. We make the death appear natural. For instance, we starve the baby to death or asphyxiate it"

"I had to have an abortion because of pressure from my parents. When they heard I was pregnant, they pressured me to abort for my own well being and that of the family"

"The boys were patient, standing in line and waiting their turn to rape. Their two victims, girls of thirteen [years] were patient as well, never crying out, at least that was what neighbours said, and endured violence and abuse not once but repeatedly over five months"

*"It was in Italy that I discovered that we were in for prostitution of a higher order. Though I resisted at the beginning but there was nothing I could do since I was already committed by the oath I took and the pant the trafficker collected from me"*¹

Whether it is female infanticide, forced abortion, gang rape, human trafficking, or any other form of violence that girls and women suffer, they all share one characteristic. These are actions directed at women and girls simply because of their sex. These acts of violence inflict physical, sexual, psychological and economic harm on women. The Beijing Declaration and Platform for Action defines violence against women as *"any act of gender-based violence that results in or is likely to result in, physical, sexual or psychological harm or suffering to women [and girls], including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in*

public or private life." Perpetrators and victims of violence are, however, of both sexes. Men are also known to suffer from gender-based violence (GBV) but the magnitude is near insignificant as compared to that of women. Women suffer most because of patriarchal values which accord them lower social status. When we talk about GBV, what readily comes to mind is violence perpetrated against women and girls.

GBV violates several recognised human rights such as the right to life, freedom from torture, equal protection before the law, liberty and security of person, the highest attainable standard of physical and mental



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health, and the right to be heard. It also violates women's right to control their sexuality.

Types of GBV

Women and girls suffer from numerous forms of violence and these include acts that cause physical harm such as female genital mutilation. Other forms of violence include stalking, blaming without reason, neglect, and sexual harm such as rape and forced prostitution. Often, these groupings only reflect the nature of the violence and not the effects.

The most pervasive form of GBV women and girls suffer is *domestic violence*. This usually takes place in the home and is perpetrated by family members or relations. Domestic violence includes forced marital sex, incest, honour killings, female infanticide, child beating, etc. Many girls in parts of Africa, Asia and the Middle-East are exposed to female genital mutilation. This type of GBV varies from partial or total removal of the external female genitalia to the narrowing of the vaginal opening through stitching. This practise is part of a concerted effort to make women abide by cultural dictates and control their sexuality.

Sexual violence is also a common form of GBV and this ranges from sexual harassment, insertion of objects into genital openings, sexual intercourse without consent, to child defilement and forced prostitution. Among these forms of sexual violence, rape is most prevalent. The figures for South Africa alone stand at one million cases every year. This simplifies to one incident occurring every minute. According

to the Population Reference Bureau, only one out of every 35 cases of rape is reported. Over 60% of the victims are between the ages of 14 and 19 years. Globally, it has been said that most rapists attack victims that are under the age of 15. The rapists are usually familiar people and not total strangers. Rape is considered as an act of immorality in certain cultures and some families insist on girls marrying the perpetrators to restore family honour.

During wars and conflicts, rape is taken as a symbol of subjugation and humiliation of the enemy. In such contexts, female refugees and street children are more susceptible to rape than during peace times. Children, in general, are vulnerable to sexual abuse because of their ignorance and trustfulness.

GBV occurs everywhere, be it in the home, school, workplace or wider society

GBV occurs everywhere, be it in the home, school, workplace or wider society. The major reason for its widespread nature is embedded in certain patriarchal values that regard women as mere sex objects to be conquered and satisfy the desire of men. Certain myths also see women as accomplices in the rape cases and men as having animalist desires which cannot be controlled. In the absence of limited institutional mechanisms to address GBV and a deliberate culture of silence around issues of sexuality and abuse, GBV will continue to thrive.



KIC

Knowledge Infrastructure with and between Counterparts (KIC)

The KIC Project aims to boost dynamic knowledge sharing, collaborative learning and networking. It is an action-oriented, counterpart-driven pilot project, of which the first phase runs up to the end of 2006. Within the KIC Project Oxfam International and *Exchange* are collaborating to reinforce the learning on HIV/AIDS. The following issues will be about Women living with HIV/AIDS and Sexual & Reproductive Rights Education. Oxfam counterparts are invited to write articles about lessons learned

related to these topics. The articles produced in the framework of this collaboration are accompanied by an Oxfam logo in a green title box. The KIC Project also has an interactive website: www.oxfamkic.org, which enables Oxfam counterparts to share evidenced-based practices and documents, and to participate in online communities. For questions and comments about this edition or about the project, counterparts are encouraged to use the email address aids.kic@oxfamnovib.nl.

HIV/AIDS, conflict, and gender- based violence: some facts

During conflict and flight women and girls may experience violence, forced pregnancy, intentional HIV infection, abduction, sexual abuse and slavery, or rape. In settings of refuge they may continue to face violence, for instance:

- abuses that existed in society previous to the conflict;
- domestic violence that often increases: in many displaced settings, women are separated from family, community members, or other support systems that may formerly have offered a certain amount of protection from abusive partners;
- exploitation and abuse from people with power, even those who control and distribute humanitarian aid.

Factors that contribute to gender-based violence in conflict situations include:

- a general breakdown in law and order, with an increase in all forms of violence;
- erosion in the social structures and the normal mores of society that control acceptable behavior in the community;
- the perception by perpetrators that they will not be brought to justice;
- the polarization of gender roles during armed conflict with the development of an aggressive ideal of masculinity and the idealization of women as bearers of the cultural identity;
- the goal of ethnic cleansing. Rape, forced pregnancy, and other forms of GBV can be weapons of ethnic cleansing directly and by attempting to destroy individuals mentally and the social bonds within a group.

Source: *Gender-based violence in populations affected by armed conflict. A field guide for displaced settings, RHRC Consortium/GBV Global Technical Support Project, www.rhrc.org/pdf/Fact Sheet for the Field.pdf*

Effects of GBV

The effects of GBV on girls are costly, intense and long lasting. These can be physical, psychological, social or economic in nature.

- **Physical effects** – According to the UNHCR, physical effects of sexual violence include pain, contracting of STIs and HIV in cases where the assailant is infected, mutilated genitalia, unintended pregnancy, abortion or infanticide, unwanted children, and even death.
- **Psychological effects** – Psychological trauma is also known to result from GBV and this ranges from paralysis and terror to emotional pain; sense of denial, depression, mental disorder, and sometimes suicide. The victim can also experience nightmares and be haunted by fear and feelings of shame or guilt.
- **Social effects** – Social costs to survivors of GBV include rejection, stigmatization, further sexual exploitation and severe punishment. The development and well-being of children and families is also affected. Boys who witness battery are likely to be of violent disposition while girls grow into victims. GBV inhibits girls' access to schooling, may result in poor performance at school and deprives society of the full participation of women in development. Research confirms that: *“Early sexual victimisation may leave*

women less skilled in protecting themselves, less sure of their worth and their personal boundaries, and more apt to accept victimisation as part of being female, these may increase the chances of future victimisation like battery, rape, domestic violence, high risk behaviour in adolescence and adulthood like unprotected sex with multiple partners, alcohol and substance abuse, teen pregnancy, prostitution.”²

Efforts to address GBV will remain reactive and less successful if we continue to keep silent about it and believe that equality of the sexes is a myth

- **Economic effects** – Victims bear enormous financial costs in accessing justice and health services. States also bear costs when they commit resources to provision of legal and health services to survivors.

What is being done?

Some government institutions and many non-governmental organizations have started conducting awareness raising campaigns, legal reforms and providing services for survivors of GBV. For example, in Lagos, Nigeria, *Project Alert*



Photo: Armando Waak, PAHO

(www.kabissa.org/prolet) provides information on violence against women and renders support services to female victims of violence. It has actively campaigned to raise awareness on violence against girls in parts of Nigeria, brought about and pursued litigation and law reform on the issue, published several research reports on the subject and mobilized support for health-care services to victims.

Research, advocacy and hotline management are strategies that have been combined successfully by the *Maple Women's Psychological Counselling Centre* in Beijing, China (www.maple.org.cn). The centre opened the first women's hotline in China in 1992 and has since then added special anti-domestic violence hotlines, carried out researches and public awareness activities that have led to law reform, e.g., prohibition of domestic violence and legal responsibility of the

concerned government department in the 2001 Revised Marriage law.

An example of successful adoption of a holistic approach is that of the *Project against Domestic Violence* in Cambodia (www.padv.org.kh). It is a pioneer organization in that country dealing with issues of domestic violence through law reform, research and publication, collaboration with government and other

sectors, workshops and trainings, community mobilization, direct services to victims and a male involvement project.

Other strategies that have been recommended to address GBV include:

- comprehensive education on sexuality to demystify the subject, build life skills in adolescents to recognise and combat GBV and become gender sensitive;
- strengthening women's economic

opportunities in order to improve their options and negotiating power within and outside the homes;

- involving survivors in programming;
- eradication of structural inequality against women through promotion of equal access to opportunities, assets, resources and rights;
- integrating statistics on GBV into data collection, planning and training projects to increase the visibility and recognition of GBV as obstacle to development;
- implementation of the Beijing Platform for Action by governments, especially the elimination of all forms of discrimination against girls in policies, statutes, bills and laws.

Gender-based violence in schools

- In an educational setting in Ecuador, 22% of adolescent girls reported being sexually abused at school.¹ A Human Rights Watch study of violence in eight South African schools found that sexual abuse and harassment of girls were rampant in many schools. Girls were raped in school lavatories, dormitories and empty classrooms.²
- Perpetrators of gender-based school violence are generally older male classmates, but teachers are also offenders. A 2003 study in Dodowa, Ghana, found that teachers were responsible for 5% of these assaults on students. Additionally, one third of the 50 teachers interviewed said that they knew of at least one teacher who had sex with students.³

Education is an important tool in the fight against HIV and AIDS. However, some schools fail to provide the necessary protection for children and may expose young people – especially girls – to violence. School cultures can contribute to gender violence. Often, gender stereotypes and inequities abound in the classroom, where different behaviours and roles are expected from girls and boys. Gender-based violence in schools takes many forms, e.g., sexual harassment, aggressive or unsolicited sexual advances, touching, groping, intimidation, verbal abuse or sexual assaults. Schools that are not safe or that promote gender disparity breed the inequality that lasts a lifetime. HIV-prevention education is undermined in these hostile environments because the curriculum teaches one thing and the atmosphere models the opposite.

While access to, and the availability of, life skills classes are important to stopping the spread of HIV, so too is a school environment that is child-friendly, and protects the rights of all children. According to UNICEF, a child-friendly school:

- is gender-sensitive for both girls and boys;
- protects children (there is no corporal punishment, no child labour and no physical, sexual or mental harassment);
- involves children in active and participatory learning;
- involves all children, families and communities (and is particularly sensitive to and protective of the most vulnerable children);
- is healthy; has safe water and adequate sanitation, with separate toilet facilities for girls and boys;
- teaches children about life skills and HIV/AIDS.

Adapted from: Girls, HIV/AIDS and education, UNICEF, 2004 (32 p.):
www.unicef.org/publications/index_25047.html (English/French/Spanish)

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Conclusion

That GBV is pervasive is well known. Efforts to address it will remain reactive and less successful if we continue to keep silent about it and believe that equality of the sexes is a myth. All those who are concerned about GBV should therefore seek ways to be proactive and more effective by addressing the gender issues in their settings and programming to break the culture of silence on the issue. ■

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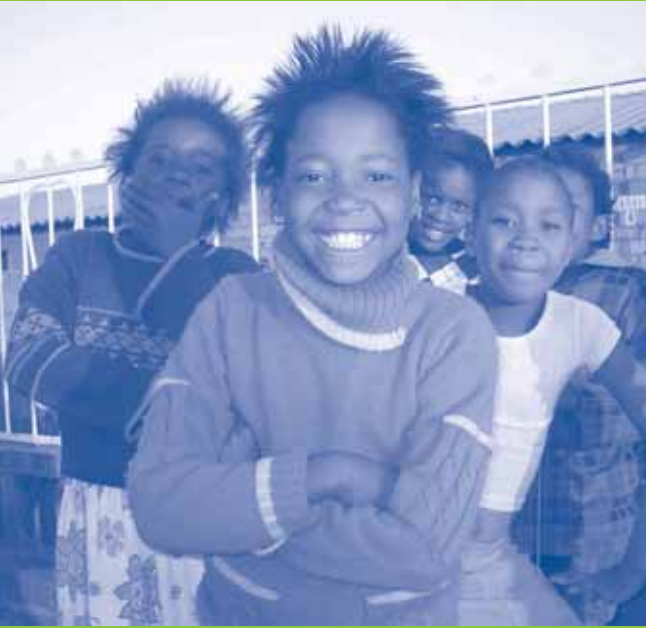
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1. For reasons of space, we have omitted the references. They can be found in the online version of this article: www.kit.nl/ils/exchange_content/html/2006-2_contents.asp.
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Photo: Francisco Almendra, 2005 (chico.carriaca@pobox.com)



Raising awareness on the interface between gender-based violence and HIV/AIDS in South Africa

The experiences of Zubeda Dangor of Nisaa

Article produced as part of the KIC Project

South Africa is reported to have one of the highest rates of sexual violence in the world, with adolescent girls being particularly at risk. In response, both the South African government and women's rights organizations are working to improve the response to domestic and sexual violence. In 1994, the same year that Apartheid officially ended, the Nisaa Institute for Women's Development was founded by a group of committed women activists. Nisaa is an NGO focusing on the abuse of women and their children (who are secondary victims of abuse). At the time, according to a Human Rights Watch report, South African women's organizations estimated that as many as one in every three South African women had been raped whilst one in six South African women had been in an abusive domestic relationship.

Nisaa provides temporary emergency accommodation and counselling services to abused women and children. Through campaigns, media presentations, talks, seminars, trainings, workshops and conferences, we promote public awareness and education on violence against women. Also, there is a resource centre available at Nisaa where the community can access information.

We became formally involved in HIV and AIDS work in 2003 when we started mainstreaming HIV/AIDS into all our programmes. Before then, general workshops on the subject were conducted for staff. The mainstreaming process went a step further when HIV/AIDS was included in our 2003-2005 Strategic Plan. The decision to mainstream HIV and AIDS was prompted largely because of the experiences we had with abused and HIV-positive women clients who were accessing our services. At that time, AIDS service organizations were not focusing on the intersection of gender-based violence and HIV. Neither were gender-based organizations focusing on HIV/AIDS.

It was easy to start discussing HIV/AIDS with our staff because they had already started mentioning this issue prior to the strategic planning sessions. HIV/AIDS was seen as both an internal and external threat to the organization in the coming years and could, therefore, not be ignored. The staff also welcomed discussions on HIV and AIDS because it also meant the creation of an environment where both infected and affected members could have open discussions in the workplace. Everybody was, thus, involved in the development of the organizational policy as well as the shelter policy on HIV and AIDS. Today, most of Nisaa's programmes have an HIV/AIDS component.

Most women believe that when they experience abuse in relationships, it must be their fault

Different levels of understanding

At the shelter, there are programmes for both mothers and children on HIV/AIDS awareness, prevention and care. The staff is also trained on how to deal with HIV/AIDS issues within the shelter. Usually the issue of HIV is introduced when exploring the different types of abuse that clients experience. HIV is mentioned as one of the dangers a woman may face when she is in a sexually abusive relationship and does not have power and control over her own sexuality. It is hard for women to grasp this reality as many of them still do not understand that being married or having a single partner does not mean one is safe from HIV. The level of understanding of the linkages between HIV/AIDS and gender-based violence differs from one client to the other. Some women come with an understanding of how much they are at risk of contracting the virus when in abusive relationships, while others do not think about that at all. Most women believe that when they experience abuse in relation-

Gender violence in South Africa: some data

Domestic violence – Research at three prenatal clinics in Soweto, a township in South Africa’s richest province Gauteng, on the relationship between HIV/AIDS and violence showed that over half of the 1395 pregnant women interviewed had been subjected to some sort of assault by their husbands or partners.¹ This finding is supported by studies from the Medical Research Council. The Council further reported that a woman is killed every six hours by her intimate partner in South Africa and only one third of people arrested for femicide were convicted. Researchers of the Medical Research Council found a high correlation between witnessing violence against mothers in childhood on South African men’s use of violence in a range of settings in adulthood. About a quarter of nearly 1400 Cape Town municipal workers interviewed witnessed their mothers being abused. Some 42% of these reported using physical violence against a partner in the last 10 years, and 9% reported physical violence in the past year.²

Forced sex and rape – According to the Deputy Minister of Health, there was an increase in sexual crimes in 2004/2005. Rape cases escalated by 4% and indecent assault by 8%. In a recent national cross-sectional study conducted in 1418 South African schools, about 11% of the boys and 4% girls claimed to have forced someone else to have sex. Around two-thirds of the pupils had been sexually abused.³ In another study involving adolescent boys and girls between the ages of 14 and 16 years, researchers found a relationship between rape-supportive attitudes and the existence of traditional notions of masculinity, normalization of inter-personal violence as well as poverty, and the commodification of sex. Adults and the community did not offer much protection to potential rape victims.⁴

1. K. Dunkle, R. Jewkes, H. Brown, et al., Prevalence and patterns of gender-based violence and victimization among women attending antenatal clinics in Soweto, South Africa. *American Journal of Epidemiology*, 2004, 160 (3), p 230-239.
2. N. Abrahams, R. Jewkes, R Laubscher & M. Hoffman, Intimate partner violence: prevalence and risk factors for men in Cape Town, South Africa. *Violence and victims*, 2006, 21 (2), p. 247-264.
3. N. Anderson, A. Ho-Foster, J. Matthias, et al., National cross sectional study of views on sexual violence and risk of HIV infection and AIDS among South African school pupils. *British Medical Journal*, 2004, 329 (7472), p. 952.
4. I. Petersen, A. Bhana & M. McKay, Sexual violence and youth in South Africa: the need for community-based prevention interventions. *Child Abuse & Neglect*, 2005, 29 (11), p. 1233-1248.

ships, it must be their fault. This problem is also compounded by cultural and religious beliefs that equates abuse with a part of marriage.

Nisaa includes HIV/AIDS as an integrated topic in school- or community-based presentations on GBV prevention. At a public awareness level, we initiated the Red & White Ribbon Campaign where we distribute pamphlets and ribbons and conduct talks on the link between HIV/AIDS and GBV. Training programmes are also conducted for communities or organizations which highlight the intersection between HIV/AIDS and GBV, illustrating how this happens and initiating discussions around the issues. For schools, discussions and presentations around issues of date rape inevitably raises the issue of HIV/AIDS and GBV.



With young women learners, the situation is tricky. Some are informed about the linkages while others believe that HIV will only infect those who are seriously engaged in sexual relationships and that those in casual sexual relationships stand a chance of escaping infection. Some young women measure progressiveness by having a sexual encounter by the age of 14. This puts them at high risk of infection from HIV. Young men, on the other hand, record sexual encounters around the same age as a sign of conquest, which also puts them at high risk of contracting the virus.

It takes a long time for people to understand and deal with HIV and GBV as a result of the stigma attached to both issues

Explaining the link

The following hypotheses are usually put forward to explain the link between HIV/AIDS and gender violence:¹

1. Rape may directly increase women and girls’ risk of contracting HIV. The violent nature of rape creates a higher risk of genital injury and bleeding (increasing the risk of HIV transmission), while, in cases of gang rape, exposure to multiple assailants may also contribute to the risk of transmission. Studies in South Africa suggest that there are high levels of sexual violence and harassment against children, girls and women, and that significant numbers of young women report coercion in their first and subsequent sexual relationships.
2. Abusive relationships (including other forms of abuse besides that of a physical nature) may limit women’s ability to negotiate safer sex. Similarly, numerous studies have shown that women in violent and abusive relationships are at greater risk of becoming HIV positive, possibly because they are more fearful of negotiating condom use with their partners and are abused when discussing condom use. They are also less likely to be able to limit the number of sexual partners that their primary partner can have. Certain cultures promote multiple sexual partners for males thus placing the women at risk of contracting the virus.

3. Women who experience sexual abuse in their childhood may engage in riskier sexual behaviour as adolescents or adults, thus increasing their risk of HIV infection.
4. Women who receive HIV counselling and testing may be at risk of partner violence should they disclose their HIV status.

In the light of the above, it is imperative that HIV and AIDS are addressed in the context of gender-based violence programmes.

Experiences and learnings

I believe Nisaa has made significant progress in raising awareness on the interface between HIV/AIDS and GBV at a national level especially as evidenced by the launch of the Red & White Ribbon Campaign in 2003. The ultimate result of this was the production of a single ribbon with colours that represented both gender violence and HIV/AIDS aspects. We have also successfully come up with both an organizational policy on HIV/AIDS and a shelter policy for those affected by GBV and AIDS. In keeping with the policy, a fund has been started to assist HIV-positive staff and volunteers who do not have medical benefits.

Experience indicates that it takes a long time for people to understand and deal with HIV and GBV as a result of the stigma attached to both issues. GBV happens behind closed doors and is surrounded by shame and guilt. HIV cannot be seen by the naked eye until the later stages. People have learned to live in denial until it is too late to deal with or rectify the situation. Programmes like those at Nisaa are assisting communities to initiate discussions on the intersectionality between HIV/AIDS and GBV in the public arena to deal with the stigma and discrimination associated with being HIV positive and abused.

Everyone is vulnerable to HIV and GBV and it is therefore critical for everyone to take responsibility for their lives. There is need for behaviour change in both men and women, clear information on HIV/AIDS, care, innovative communication and networking. We need to author new stories of hope around HIV and have fresh discussions and interaction on these topics. Last but not least, our leaders should show a much greater commitment and a greater sense of responsibility towards the information they disseminate regarding HIV and AIDS. ■

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Mobilizing men against gender-based violence

Men as Partners (MAP) is a programme by EngenderHealth in South Africa which involves community-based workshops with men and mixed-sex audiences, in settings such as workplaces, trade unions, prisons and faith-based institutions. Based on the premise that gender inequity contributes to both AIDS and violence against women in South Africa, MAP promotes discussions of gender issues, power dynamics and gender stereotypes. A preliminary evaluation suggested that – compared to control groups – a higher percentage of participants believed that women and men should have the same rights and that wife-beating was wrong. Adolescent boys appeared more open to changing their view of masculinity than older men.

Similar work has been carried out by *CANTERA* (Population Education and Communication Centre, Nicaragua) and by Brazil-based *Instituto Promundo* in various countries in Latin America. *CANTERA* runs workshops for men in Nicaragua, Costa Rica, El Salvador, and Guatemala on masculinities, gender, power, and violence. *Instituto Promundo* conducts a programme called Program H in Brazil, Bolivia, Colombia, Jamaica, Peru and Mexico. Program H (The H stands for homens = men) focuses on gender equity promotion among young men. A quasi-experimental study conducted in Rio de Janeiro showed that the programme had a positive impact on the prevention of gender violence and the reduction of youth vulnerability to STIs, including HIV. After extensive testing, Program H is now being expanded to several countries in Asia, Africa and the Americas.

Sources and more information:

- *Preventing and responding to gender-based violence in middle and low-income countries: a global review and analysis*, World Bank Policy Research Working Paper 3618, June 2005: www.preventgbv africa.org/Downloads/WorldBank.EllsBottMorr.june05.pdf
- *Men as Partners website*: www.engenderhealth.org/ia/www (English)
- *Promundo website*: www.promundo.org.br/330 (English, Portuguese, Spanish)
- *CANTERA website*: www.canteranicaragua.org/eng.htm (English and Spanish)

Combating trafficking in girls



Girls doing a role play on trafficking and its effects in one of GPI's fora organized for parents and guardians

The learnings of Girls' Power Initiative (GPI), Nigeria

Article produced as part of the KIC Project

Ehita Ikoghode-Aikpitanyi

Human trafficking is recognized everywhere as the transfer of persons by fraudulent means for exploitative purposes. The working definition used in our work is the same as contained in the United Nation's Protocol on Human Trafficking which recognizes trafficking as *"the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation."* In the case of child trafficking, it is not necessary that fraudulent means be used for a situation to be classified as trafficking.

GPI's interventions to reduce human trafficking dates back to 1997. We have carried out public awareness campaigns on the issue. This was after a research on trafficking by Grace Osakue and Bisi Olateru-Olagbegi revealed that human trafficking in boys and girls existed in the region but awareness on it was still very low. In 2000, GPI commenced a research into the incidence of trafficking in four of the six States that make up the Niger Delta region of Nigeria to validate existing data on the issue as well as to provide a basis for interventions by both GPI and other organizations and the government. The study set out to answer three questions: 1) what makes girls susceptible to trafficking, 2) what can be done to enable girls to resist trafficking, and 3) what services should be put in place for girls who do not desire to be trafficked.

The following conclusions were drawn from the study:

- While national and international attention is focused on external trafficking, there is a very visible internal trafficking in girls and boys in the region. Victims are recruited from villages and brought to the cities to be used as house helps, shop attendants, waitresses, sex workers in hotels etc. In external trafficking, victims are transported abroad and used mainly as sex workers by their 'sponsors' (traffickers) until such a time as they gain their freedom.
- Whether internal or external, girls between ages 13-25 years form the majority of victims.
- Persons trafficked are never fully aware of the nature of work in their final destinations. Some are forced, some go willingly, many take oaths and most are bonded until full payments are made to the trafficker.
- Trafficking is thriving because of notions that it leads to affluence.
- Despite the many economic gains

identified by many, most of the victims loath to go back or allow their relations to go through the same experiences.

Susceptibility to trafficking

Traffickers (sponsors) and agents go out of their way to convince girls, parents, boyfriends or other family members. Some parents actively look for sponsors for their daughters and some girls look for sponsors by themselves with/without the knowledge of their families. Some victims are even trafficked by their close friends and relations who live abroad and visit or send messages back home for such girls to join them.

Although boys are being trafficked as well, Nigerian girls are more susceptible to trafficking for various reasons. There is parental pressure on girls to rescue their families from poverty. Son preference and low value placed on girls makes the family choose a girl if one of the children has to risk his/her life to aid the others. From the point of view of traffickers, girls are highly 'marketable' because there is a high demand for them in the sex sector abroad.

The research also identified what can be done against trafficking:

- Girls need to be well educated and given personal empowerment skills so that they will be able to make healthy decisions on issues affecting them.

- Gainful employment or skills acquisition opportunities should be provided for girls to learn trades and meaningful grants to set up their own businesses when they finish training.
- Crisis centres should be set up to attend to reports of forced trafficking for the traffickers or their agents to be apprehended.
- Girls that are under pressure from parents to work abroad should be given the opportunity to achieve their career aspirations, if necessary, out of parental custody.
- Enlightenment programmes are needed for girls and parents to broaden their scope of knowledge on trafficking especially the hazards involved.
- Social Welfare departments of relevant government ministries have to be more functional in meeting the needs of girls who do not desire to be trafficked.

Lessons learned

- The incidence of trafficking in girls is directly related to the low status of the girl child in the society, it is fuelled by poverty and has adverse effects on the struggle for gender equality.
- To be able to say no to agents of traffickers, or their parents, girls need to be confident and knowledgeable on sexuality-related issues; sexuality education should therefore be part of the school curriculum.
- The sensitization of lawmakers, heads of government institutions, heads of schools and the general public on the issue of trafficking is necessary to reduce the incidence.
- The best strategy is one that includes the benefiting group in every step and draws on the strengths of as many other organizations as possible. As most organizations have limited resources, networking with and referral to like-minded organizations offering complementary services is a productive approach.
- The fight against trafficking will remain a lost battle until either the traffickers and their agents find an alternative lucrative means of income, or children have the wisdom and the voice to say no without dire consequences.

The above findings were widely disseminated and GPI actions on trafficking have been guided by them. Since the release of the research results in 2001, we have opened up two new centres in two of the states with high incidence of trafficking in girls in an effort to address the problem more closely. We have dedicated some editions of our quarterly newsletter to public awareness raising on the issue. Our strategy for addressing the problem of trafficking in girls focuses on empowerment of the girl child, enlightenment of parents on the issue, and advocating appropriate laws:

- *Preventive education and personal empowerment skills building for children*
 - Realizing the need for girls to be able to say no to traffickers or their parents, we have added the issue to our curriculum on sexuality education and have been in the forefront of advocating for the implementation of comprehensive sexuality education in schools, so that girls acquire the confidence and ability to make and insist on healthy choices for themselves. The three-year curriculum has modules on personal skills development, human development, relationships, sexual health, gender, society and culture, violence against women, legal protection, youth activism and economic skills development. This curriculum is not only in use in the training programmes for girls in the GPI centres but it is also used in our school outreach activities and for the training of programme beneficiaries of other organizations.
- *Public awareness raising* – Awareness-raising programmes such as the annual marking of the 16 Days of Activism against Gender-based Violence with activities on one of these days addressing human trafficking; dedication of several slots of our weekly television programme to the issue of trafficking in girls; production and airing of radio and television jingles with messages to dissuade the practice; airing of radio drama serials on trafficking; campaign visits to markets, parks and rural communities with films, dance, drama and talks on the issue. As a



Ehita Aikpitanyi and Grace Osakue of Girls' Power Initiative

result of our programmes many parents are now aware of the dangers of trafficking in persons. We have had testimonies of parents who through our seminars and sensitization have resisted the lures of so-called 'Good Samaritans' who promise to end their poverty by trafficking their daughters.

- *Interventions to assist vulnerable persons*
 - GPI is into direct service provision and referrals for victims of trafficking as well as girls who are vulnerable to being trafficked. These girls have on many occasions been linked with resources, given scholarships for schooling, or reunited with their parents. One girl was supported to prosecute her trafficker though unsuccessfully, 20 were given scholarships to complete their secondary school education and over 40 were trained on self-esteem building under the TAMPEP ALNIMA project for returned victims and vulnerable girls.¹
- *Networking* – Networking with other civil society and government agencies has been a very productive strategy and GPI has used it effectively in its public awareness efforts and in ensuring that a multifaceted approach is used to address the problem. Whereas we emphasize prevention through awareness raising and personal skills building, other members of our coalition against trafficking specialize in the provision of other services both to vulnerable and trafficked girls such as economic skills building, micro finance, shelters, counselling and legal aid.
- *Advocacy campaigns to implement sexuality education* – We not only belong

to a national coalition against trafficking but co-ordinate local coalitions on the issue in all the States where we have centres. Efforts at law reform and legislation on trafficking and sexuality education have been very time-consuming and are yet to produce expected laws at the local levels because of the red-tapism in our legislative houses and near non-responsiveness of legislators to the issue. However, they have so far produced a better understanding and closer working relationship among the civil society groups and government agencies involved; the sensitization of lawmakers, heads of

government institutions, heads of schools and the general public on the issue of trafficking and how personal empowerment skills training in our schools can help reduce the incidence.

In Nigeria, GPI has become well known as an organization with capacity for addressing the issue of trafficking especially as it relates to the girl child. In conjunction with others, we have successfully raised knowledge levels on the issue, carried out actions to support victims and vulnerable girls. We believe that within the next two years, our advocacy on effective preventive education will yield more results. ■

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1. The ALNIMA Project is aimed at providing girls who had been trafficked to Italy (from Albania, Nigeria and Morocco) with the necessary assistance that will enable them to be reintegrated back into their home countries.

Resources on gender-based violence

Gender-Based Violence Network website

The website of the GBV Prevention Network is filled with the experiences, innovations and knowledge of over 100 member organizations in Africa. It is a place where often hard to find regional and international resources about gender-based violence prevention can be accessed.



www.preventgbvafrica.org/home.html

Violence against girls and women

Implications for HIV and AIDS in Africa

B. Makinwa & B. Kinfegebriel, The African Child Policy Forum/UNAIDS, 2006 (22 p.)

This paper identifies links between gender-based violence and the higher rates of HIV infection among African girls than among their male counterparts. It further identifies strategies to reduce HIV prevalence among girls in Africa through tackling the violence they experience in their homes, at school and in the community. The paper was prepared for the Second International Policy Conference on the African Child: Violence against girls in Africa, which took place in May 2006 in Addis Ababa, Ethiopia. Several other papers on violence against girls can be found on the ACPF website.

www.africanchildforum.org/publications.asp



Violence against women and HIV/AIDS: Critical intersections

Intimate partner violence and HIV/AIDS

WHO, Information Bulletin Series, number 1 (9 p.)

This WHO bulletin highlights that there is a compelling case to end intimate partner violence both in its own right as well as to reduce women and girls vulnerability to HIV/AIDS. The evidence on the linkages between violence against women and HIV/AIDS highlights that there are direct and indirect mechanisms by which the two interact.

www.who.int/gender/violence/en/vawinformationbrief.pdf

HIV & AIDS – Stigma and Violence Reduction Intervention Manual

N. Duvvury, N. Prasad & N. Kishore,
International Centre for Research on
Women (ICRW), 2006 (130 p.)



This manual is a guide for community-based organizations to facilitate a community-led and -owned process that addresses stigma and gender-based violence in HIV prevention efforts. It is based on findings from the Stigma and Violence Reduction Intervention (SVRI) project, conducted in Andhra Pradesh, India from 2003 to 2005. The SVRI project explored and described the origins and manifestations of stigma and intimate partner violence, including sexual violence experienced by mobile and mobility-affected sex workers, truckers' helpers and truckers' spouses.

www.icrw.org/docs/2006_SVRI-Manual.pdf

With Women Worldwide – A Compact to End HIV/AIDS



Photo: WHO/PIR-Virat

The International Women's Health Coalition (IWHC) has called 2006 a critical year to determine the international community's future response to the global HIV/AIDS pandemic. In the beginning of June, governments and civil society met at the High-Level Meeting on AIDS ('UNGASS+5') to review the implementation of the 2001 Declaration of Commitment on AIDS. In August, the biennial International AIDS Conference (IAC) in Toronto provided an opportunity to reshape dialogue and decisions with an even wider range of leaders. In preparation for these critical discussions, IWHC convened a group of women advocates in Bangkok in November 2005. They developed *With Women Worldwide – A Compact to End HIV/AIDS* as a tool for use in 2006 and beyond. The main goal of the authors was to mobilize extensive support for the Compact Agenda to ensure that it was incorporated into discussions and decisions at the UNGASS+5 and the IAC.

WITH WOMEN WORLDWIDE — A COMPACT TO END HIV/AIDS

Sexual and reproductive rights are a pivotal neglected priority in HIV/AIDS policy, programming and resource allocation. Failure to protect the human rights of girls and women, including their right to health and their right to live free of sexual coercion and violence, fuels the pandemic. Universal access to sexual and reproductive health services and education, and protection of sexual and reproductive rights, are essential to ending it.

It is widely acknowledged that rates of HIV infection are increasing in women in every region in the world, and that these rates are often higher for girls and women than for men. Women, especially young women and girls, are vulnerable because of denial and neglect of their rights, gender inequality, social, cultural and economic factors, pervasive violence, and biology.

Girls' and women's empowerment must be at the centre of a multi-sectoral response to the global pandemic. Regarding sexual and reproductive rights and health in particular, we call on HIV/AIDS decision makers at all levels to:

- 1. Redefine 'High Risk':** Recognize that women, especially young women and girls, are at serious risk, and that all women have the right to have access to confidential, voluntary counselling and testing (VCT), treatment, care and support as part of comprehensive sexual and reproductive health services.
- 2. Expand Decision-making:** Ensure that women infected and affected by HIV/AIDS, and women's health and rights advocates, are full participants in decision making, especially at the highest levels, so that decisions reflect the realities and needs of women.
- 3. Exercise Leadership:** Prioritize in words and concrete actions reducing the risk and the burden of HIV/AIDS for women and girls, through protection of their sexual and reproductive rights and health, including

the promotion of policies and laws against discrimination and sexual violence.

4. Invest HIV-targeted Funds: Allocate and monitor the use of significant HIV/AIDS resources for health services and education that protect and empower women and girls, including:

- Comprehensive sexual and reproductive health services accessible to all women with capacity to deliver HIV/AIDS and other STI prevention, counselling, testing, care, and treatment (or referral) services;
- Universal access to subsidized female condoms as well as male condoms, and development and dissemination of microbicides and other women-initiated prevention technologies, and vaccines;
- Comprehensive sexuality education that promotes sexual and reproductive rights, gender equality and skills development, as well as full and accurate information, for all children and youth in and out of school.

5. Strengthen HIV/AIDS Programmes: Protect all women's health and rights through HIV/AIDS programmes:

- Ensure women's access to confidential VCT, including support for the choice not to be tested; provide protection from violence, stigma, and discrimination that may result from disclosure of status;
- Ensure equitable, sustained access to treatment for AIDS and opportunistic infections for all women and girls, appropriate to their age, health and nutritional status, with full protection of their human rights including their sexual and reproductive rights; increase research on and development of appropriate treatment for various ages; and track access to treatment by age, sex, and continuity of care;
- Increase and utilize funds for care and support to reduce women's disproportionate burden of care;
- Provide support for women's economic empowerment in order to reduce their vulnerability.

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e-mail: withwomenworldwide@iwhc.org; web: www.withwomenworldwide.org

Promoting the female condom in Burundi

Mireille Munyana



In Burundi, several years ago, informal discussions during consultations in various associations and health centres led to a number of women raising the problem of men who were unwilling to use condoms, even when their partners asked them to. This situation was worrying for these women, more because the education they received put emphasis on the submission of women in case of sexual relations even if they knew their husbands were unfaithful. As a response, since 2002, SWAA-Burundi has included the promotion of the female condom, or Femidom, in its HIV prevention action plan. SWAA-Burundi is a Burundian not-for-profit organization created in 1992. It is a branch of the international SWAA (Society for Women Against AIDS in Africa), a pan-African NGO of women facing HIV and AIDS.

An acceptability study on the female condom in Burundi was done in 2001 by SWAA-Burundi with financial support from UNFPA.¹ Some 320 women participated in this study. At the time, the female condom was not available in the country. Respondents were, therefore, given two female condoms each to try with their partners. Of the 320 women that participated in the study, 267 (83%) used the condom, 36 (11%) did not and 17 (5%) did not return to disclose their opinions.

The results of the investigation revealed both positive and negative results. On the positive side, the female condom was seen as having the following advantages:

- It was comfortable and soft.
- It did not rob the partners of sexual satisfaction during intercourse. The lubrication and the soft texture of the material probably accounted for this.
- It collected the sperm properly, as compared to the male condom.
- It did not feel bad. The Femidom was perceived to be an additional protective method that presented evident qualities and that assured women their autonomy.

On the negative side, it was noted that the condom was difficult to insert. Some women were also of the opinion that it caused anxiety

and worked poorly. The Femidom was seen as incompatible with the technique 'Ruganga' (a sexual practice done by Rwandan and Burundi men which focuses on the clitoris). The production of noise during sexual intercourse was cited as another area of discomfort.

The work of SWAA

Since its introduction in Burundi, the demand for female condoms by women has been high as shown by the increasing number of Femidoms distributed since 2002 by the branches of SWAA. SWAA distributed 3741 condoms in 2002; 13,521 in 2003; and 30,103 by 2004. About 18,000 Femidoms were distributed in 2005. With the support of UNFPA, the National Reproductive Health Programme (PNRS) receives condoms and guards them in store. SWAA distributes them to the health centres, organizations involved in HIV/AIDS work and to national and international NGOs for free.

Promotion of the female condom was necessary in Burundi because it was a new product and most women had not seen or heard about it before. Since 2001, SWAA conducted a wide range of activities to promote the female condom and many participants received information on the condom. Some of the activities include:

- Awareness raising campaigns and education of participants at all levels: health care facilities, the counsellors, media personnel, administrative staff, NGOs in the fight against AIDS, CBOs, faith-based organizations, etc.

The female condom responds to the need for security expressed by women who feel dominated by men in their sexual lives

- Information dissemination to the population (women and men) on the existence of the female condom.
- Identification of pilot centres for the promotion of the female condom (testing ways of distribution, evaluating before scaling up, adaptation of the messages and tools, etc.).
- Increase of the number of participants that receive and pass on education on the female condom.
- Distribution of the female condom through health facilities, organizations working on HIV/AIDS and reproductive health,

- schools, cafés, hotels, restaurants, military camps and prisons.
- Production of posters, radio and TV spots, and leaflets on the usage and promotion of the preservative.

Since the introduction of the female condom in Burundi, SWAA conducts workshops and awareness meetings each year on the use and promotion of male and female condoms at different levels. At these workshops, demonstrations on the proper use of condoms are conducted using models of penises and vaginas. From ongoing investigations, it was noted that not all women were comfortable with the use of the female condom. Nevertheless, certain categories of women could try and adopt it, even though this method has disadvantages. As a strategy, SWAA targets women whose husbands or partners do not accept the use of male condoms but do not object to female condoms, as well as women who cannot use other contraceptive or protective methods. These groups of women are sensitized on the benefits of the female condom.

The female condom responds to the need for security expressed by women who feel dominated by men in their sexual lives, and women who are dependent on men for the choice of the means of protection. However, the use of the female condom still requires

negotiation between both partners before intercourse and this limits the decision power that women have in matters of sexual relations. In addition, the price of the female condom is relatively higher and the condom is not as available as the male condom. Nevertheless, women in Burundi and elsewhere can delight in the fact that the range of prevention methods is wider now and that the female condom is one such method they can control themselves. ■

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1. *Etude sur l'acceptabilité du Femidom au Burundi. Rapport final.* SWAA, 2002: www.web-africa.org/swaa-burundi/fichiers/femidon_rapport.htm

About the female condom

The female condom was first designed and manufactured by the Female Health Company. The World Health Organization (WHO) and UNAIDS encourage the introduction of the female condom as a method of prevention and as an additional tool.

Use and effectiveness – The female condom is strong, soft, transparent, and has a sheath that is 17 centimetres long with a flexible ring at each end. The condom is inserted into the vagina prior to sexual intercourse and provides protection against both pregnancy and STIs, including HIV/AIDS. The inner ring at the closed end of the condom aids the insertion process and secures the device in place during intercourse while the softer ring remains outside the vagina. A systematic review of articles that examined the effectiveness of this female-controlled barrier method as a method of disease prevention showed that there is evidence that female condoms confer as much protection from STIs as male ones.¹

Access – Since 1997, the female condom has been introduced into over 100 countries. However, the number of condoms distributed annually is still low. According to the initiators of the Prevention Now! Campaign, access to female condoms has been limited in part due to myths and misconceptions that have restricted investment by governments and international donors. This lack of investment has, in turn, kept the per-unit cost of female condoms unnecessarily high. The Prevention Now! Campaign, an international advocacy effort carried out by the Center for Health and Gender Equity, the International Women's Health Coalition, the World YWCA and Action Aid Uganda, was launched in June 2006 on the occasion of the UN High-Level Meeting on AIDS ('UNGASS +5'). Its goal is to dramatically increase access to female condoms and other existing prevention methods by demanding increased investment by governments and international donor agencies.²

Successful implementation – A review of introduction programmes developed by Ministries of Health and NGOs in four countries (Brazil, Ghana, Zimbabwe and South Africa)³ showed that successful programmes have several key similarities: 1) a focus on training for providers and peer educators, 2) face-to-face communication with potential users to equip them with information and skills, 3) an identified target audience, 4) a consistent supply of the product, 5) a long assessment period to measure actual use beyond the initial novelty phase, and 6) a mix of public and private sector distribution. Finally, in order to ensure successful introduction of the female condom it is crucial to involve a range of decision-makers, programme managers, service providers, community leaders and women's and youth groups.

1. A. Minnis & N. Padian, Effectiveness of female controlled barrier methods in preventing sexually transmitted infections and HIV: current evidence and future research directions. *Sexually Transmitted Infections*, 2005, 81 (3): p. 193-200: <http://sti.bmjournals.com/cgi/reprint/81/3/193>

2. More information: change@genderhealth.org

3. M. Warren & A. Philpott, Expanding safer sex options: introducing the female condom into national programmes. *Reproductive Health Matters*, 2003, 11 (21): p. 130-139.

Religious organizations and HIV prevention in Mozambique

Victor Agadjanian



Photo: Rufus de Vries

The role of religion in the fight against HIV and AIDS is frequently talked about. It is often argued that religion discourages risky behaviour and therefore serves as a barrier to HIV infection. In particular, it is said that religious people are less likely to have multiple or casual sexual partners. Religious organizations can also make an important contribution to raising public awareness of HIV and AIDS by using their institutional channels and mechanisms. In poor areas, where secular institutions are relatively weak and ineffective, the role of religious organizations, with their social mobilization potential and networks of committed activists, can be especially important. At the same time, religious leaders may disagree with the secular authorities on approaches to HIV prevention. Religious leaders may be particularly reluctant to directly accept (not to mention to promote) the notions of safer sex and condom use on the grounds that this encourages extramarital and casual sex.

To examine the potential benefits and barriers of involving religious organizations in prevention activities, our research team carried out a study in urban and rural areas of southern Mozambique, a region where the adult HIV prevalence at the time was estimated at about 15 percent. The study, funded by the National Institute of Child Health and Human Development (USA) and conducted in 2003-4 by a team from Arizona State University (USA) and Eduardo Mondlane University (Mozambique), included a survey and qualitative interviews in congregations representing the most prominent religious denominations (mostly Christian) in that part of the country. The survey sample included 731 respondents, with an almost equal number of men and women. About eight percent of the respondents also participated in semi-structured interviews. Another series of in-depth interviews with members of the same congregations were conducted a year after the survey. In addition, we interviewed the leaders of the congregations. It is important to note that all study participants were recruited from respective congregations and

were more or less actively involved in congregation life.

The data show that HIV and AIDS were a matter of great concern and a common subject of conversations among congregation members. However, while most respondents were well informed about HIV/AIDS – through formal educational events or informal exchanges – they had little practical exposure to the disease (measured by knowledge of concrete AIDS cases). The low level of practical knowledge on HIV/AIDS, particularly surprising if we take into account the rather advanced stage of the HIV/AIDS epidemic in the area, was probably due to the stigma and secrecy still surrounding the disease. The survey data also indicated that condoms have gained considerable acceptance in church circles. Condoms were frequently mentioned by study participants as the best form of HIV prevention and almost one-third of the respondents were using them for that purpose. Of course, hardly any church leader is keen on promoting condom use.

Yet the condom message makes its way into the religious teachings and discourse – directly and especially indirectly. In our study, church leaders and churchgoers alike used the expression ‘prevention’ (or some-times ‘protection’) as a euphemism for condom use. Such condom-centred ‘prevention’ becomes a standard – even if not explicitly expressed – addition to the churches’ favourite repertoire of premarital abstinence and marital faithfulness.

Exposure to HIV-related messages

Our study also detected considerable differences among congregations. The most pronounced differences seem to exist between what can be defined as mainline churches (in our study represented by the Roman Catholic Church and the Presbyterian Church) and those that are often defined as ‘African-initiated’ churches (AICs)¹. The results suggest that members of mainline churches, which are typically larger and interact more with the world outside church walls, are generally better positioned when it comes to exposure to HIV-related information than members of African-initiated churches. The former also reported slightly higher attendance of public HIV/AIDS-related lectures or events than did the latter. The gap between the two types of denominations was even wider when it came to exposure to HIV/AIDS-related messages within the church. Interestingly, whereas members of African-initiated churches were slightly more likely to practice faithfulness and abstinence as a way of HIV prevention, members of mainline churches were relatively more inclined to opt for condom use.

These denominational patterns could be partly explained by educational differences. Members of mainline churches are typically better educated than members of African-initiated churches. However, education could not fully account for these patterns and I suggest that they reflect the already noted greater connectedness of mainline churches with the secular institutions and ideas. The differences in exposure to HIV-related information, as the survey showed, manifest themselves in a rather subtle way, largely because the leaders of all denominations condemn promiscuity and promote chastity and faithfulness.

While the *religious* discourse on HIV/AIDS does not seem to differ much between mainline and African-initiated churches, members of larger mainline congregations are more exposed to HIV prevention information because of the following main reasons:

1. Mainline congregations frequently coordinate activities and exchange visits with sister congregations that are of different social settings. Visits by delegations from urban congregations may be particularly beneficial for members of peri-urban and rural congregations.
2. The membership of these congregations encompasses professionals such as nurses who are knowledgeable about HIV/AIDS. Some of the members also interact with both governmental and non-governmental health agencies and these resources can be easily tapped when it comes to HIV/AIDS.
3. Mainline congregations are, in general, more ideologically tolerant and accommodating than the African-initiated ones. Although the core social values that they champion may not differ much from those promoted by African-initiated church leaders, they are typically more lenient when it comes to enforcing their members' compliance with those values.

As a result, members of mainline churches get more consistent, direct, and continuous exposure to HIV prevention messages, especially coming from outside of the churches. Even if mainline church leaders

themselves do not openly raise the controversial issues of condoms and safer sex, they allow – willingly or not – much more discussion on these issues within their congregations than those from African-initiated churches.

Gender differences

The study also identified important gender differences in HIV/AIDS-related knowledge, perceptions, and practices reported by study participants. Female participants in general had lesser knowledge of HIV/AIDS-related issues and reported less exposure to either formal or informal information exchanges on HIV and AIDS than did men. Fewer women than men had attended public HIV/AIDS educational events. The number of women who talked about HIV prevention in congregational circles was also lower than that of men. Men's knowledge on HIV and STIs was more advanced than that of women as well. For instance, while 81% of men thought that a healthy-looking person could be HIV positive, only 54% of women held that view. Almost all men reported practicing some form of HIV prevention, whilst slightly above half of women did so. Roughly one in every five women was using condoms with either regular or occasional partners but almost half of the male respondents admitted having used condoms. In fact, women were less likely than men to report practicing any form of prevention, including abstinence and faithfulness promoted by churches.

Finally, the study produced intriguing insights into the *interaction* of gender and religious affiliation, especially in matters of HIV prevention. Most interestingly, while overall women were less likely to report condom use than men, this gender gap appeared more pronounced in African-initiated churches than in mainline churches. While 28% of female and 48% of male respondents from mainline congregations reported using condoms for HIV prevention the corresponding percentages were 11 and 47 among African-initiated church members. Women in the latter congregations were also much less exposed to secular HIV/AIDS information than women in

mainline churches: only 37% of women belonging to African-initiated churches attended HIV/AIDS educational events as compared to 57% of those from mainline churches. As the public discourse on HIV/AIDS stresses safer sex, there appears to be a connection between the limited exposure of women from African-initiated churches to secular HIV/AIDS education and their low use of the condom.

Policy-makers and programme designers who intend to involve religious organizations in HIV and AIDS-focused interventions should pay attention to how different types of these organizations differently position their members, women and men, with respect to prevention information and resources. The predominance of women among active church members is also a factor to be taken into account. For most women, especially those in rural areas, the church membership may be the only form of non-kin association and possibly the only reliable source of spiritual, psychological, social, and even material support. ■

Interested readers can get a more detailed account of the study from V. Agadjanian, Gender, religious involvement, and HIV prevention in Mozambique, in Social Science & Medicine 61 (7): 1529-1539, 2005.

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1. AICs are predominantly protestant churches that were founded by Africans and function independently from western missions or churches. The initials can also stand for African Independent Churches or African Indigenous Churches. The main categories are Ethiopian, Zionist, Apostolic and Messianic churches. More information: http://en.wikipedia.org/wiki/African_Initiated_Church

→ Manuals & Guidelines

CBO/FBO capacity analysis: A tool for assessing and building capacities for high quality responses to HIV/AIDS. CORE Initiative, 2005 (22 p.)

Pdf: www.coreinitiative.org/Resources/Publications/Capacity_Analysis

Print copy: International HIV/AIDS Alliance, Queensberry House, 104-106 Queens Road, Brighton BN1 3XF, United Kingdom; www.aidsalliance.org/sw31738.asp
e-mail: publications@aidalliance.org

The CORE Initiative developed this tool to enable community and faith-based organizations (CBOs/FBOs) to analyse levels of capacity in different organizational and technical areas. It is based on an existing toolkit for NGOs developed by the International HIV/AIDS Alliance. This tool can be used with community organizations to identify capacity-building needs, plan any technical support needed by the organization, and monitor and evaluate the impact of capacity-building support.

Theatre-based techniques for youth peer education: A training manual. UNFPA, 2005 (100 p.)

Pdf: www.fhi.org/en/Youth/YouthNet/Publications/peerredtoolkit or www.unfpa.org/adolescents/docs/ypeer_theatre.pdf

Print copy (free): youthnetpubs@fhi.org

This manual developed in the framework of the Youth Peer Education Network programme is intended for programme managers and youth peer educators who are interested in adding a theatre component to their reproductive health and HIV prevention activities or in strengthening a theatre component that is already part of a programme. It contains four peer theatre training workshops, a series of theatre games and exercises that can be used in trainings, and information on developing and building a peer theatre programme.

Keep the promise. A teaching resource on advocacy and HIV and AIDS. Ecumenical Advocacy Alliance, 2006 (20 p.)

Pdf or print copy (free)
www.e-alliance.ch/hiv_curriculum.jsp



A new teaching resource was launched in February 2006 to encourage young people to call on national and world leaders to keep their promises with regards to HIV/AIDS. This curriculum can be used by schools, church groups, and community and faith-based organizations to support them in their advocacy efforts. Available in English, French, Spanish, Portuguese and Russian.

Investing when it counts. Generating the evidence base for policies and programmes for very young adolescents. Population Council/UNFPA, 2006 (75 p.)

Pdf: www.popcouncil.org/pdfs/InvestingWhenItCounts.pdf
Print copy (free): Ms Corazon Gallardo; UNFPA, 220 East 42nd St., New York, NY 10017 USA
fax: +1 212 5576416, e-mail: gallardo@unfpa.org

This guidance document and toolkit begins to address the lack of research and attention to very young adolescents (ages 10-14) by compiling new data-gathering approaches, tools, and methodologies. The methodologies described in the guide are useful primarily for discovering which very young adolescents are most vulnerable, what are their needs, and whether they are being reached by existing programmes.



→ Research reports & Reviews



Living on the outside – Key findings and recommendations on the nature and impact of HIV/AIDS-related stigma. HDN, 2006 (60 p.)

Pdf: www.hdnet.org/library/stigma/Stigma-Primer-final.pdf
Print copy: publications@hdnet.org

Living on the outside is a summary and synthesis of four individual publications on HIV-related stigma. This primer provides a brief overview of the discussions that took place as part of the HIV Stigma Project (www.healthdev.org/eforums/stigma-AIDS) and gives recommendations about how HIV stigma can be tackled.

→ Factsheets & Issues briefs

HIV prevention for men who have sex with men.

amfAR Issue Brief no. 4, 2006 (4 p.)

Pdf: www.amfar.org/binary-data/AMFAR_PUBLICATION/download_file/46.pdf

Recent evidence indicates that HIV infection is re-emerging in new cohorts of MSM in developed countries and is an emerging epidemic in MSM in developing countries. This Issue Brief gives information on current trends in HIV infection in MSM and on the status of effective and promising interventions.

→ CD-ROMs and other Resources

CD Rom: Orphans and other vulnerable children support toolkit. International HIV/AIDS Alliance, 2005

Order (free): www.aidsalliance.org/sw31925.asp
e-mail: publications@aidalliance.org
or access online: www.ovcsupport.net

This CD-ROM contains an electronic library of over 600 resources on supporting orphans and vulnerable children. The toolkit is for use by NGOs, CBOs, governmental organizations and individuals working with orphans and other vulnerable children. The on-line toolkit is regularly updated with new information and resources. The CD-ROM and many of the documents it contains are in English, however there are also documents in French, Spanish, Portuguese and Russian.

Women's Treatment Literacy Toolkit. SAfAIDS, 2005

Pdf: www.safaid.org.zw/viewpublications.cfm?linkid=47 (English only)
Print copy (US\$ 25): SAfAIDS, 17 Beveridge Road, Avondale, Harare, Zimbabwe; fax: +263 4 336195
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SAfAIDS in conjunction with the American Jewish World Service (AJWS) and ActionAid International launched a Women's Treatment Literacy Toolkit, giving practical information on antiretroviral treatment to women, girls and those supporting them. The tools include: fact sheets, posters, activity cards, a calendar, a brochure, an audio-cassette and lists of additional resource materials. The audiocassette aims to support women with low literacy levels and/or visual impairment. Available in English, Shona and Ndebele, available in Portuguese soon.

Exchange

on HIV/AIDS, sexuality and gender

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