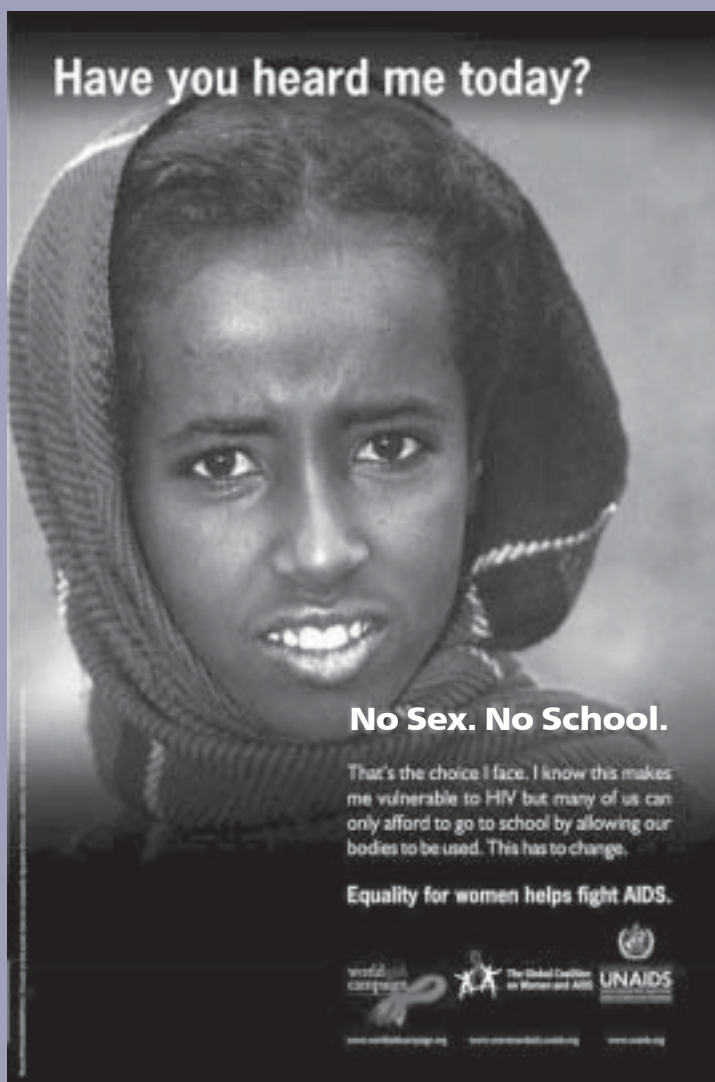


# Sexuality in Africa

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## Silence, Sexuality and HIV/AIDS in South African Schools

Robert Morrell

## HIV/AIDS and Sexuality in Africa

Mervat M. Mohammed

## Women, Sexuality and HIV/AIDS

Cesnabmihilo D. Aken'Ova



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## 1

## Feature

## Silence, Sexuality and HIV/AIDS in South African Schools

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### Introduction

For nearly ten years, the slogan 'Break the Silence' has been a feature of AIDS prevention work in South Africa. The slogan is a response to the reluctance of individuals who are

HIV positive either to test or to disclose their status. 'Breaking the Silence' is a campaign that seeks to promote acceptance for people living with AIDS and, as a direct consequence, seeks to encourage people to be medically tested for HIV.

The silence around HIV status is not the only silence that bedevils efforts to limit HIV transmission. In many schools there is a culture of silence. Certain subjects are taboo for discussion and teachers and learners are guarded, unable or unwilling to reflect personally on issues of gender and sexuality. Such school cultures seriously undermine AIDS prevention initiatives and place learners and teachers at risk of sexually transmitted diseases and HIV/AIDS.

In this article, I examine some of the gendered causes and consequences of silence, particularly in school settings. I argue that work which, firstly, acknowledges the importance of silence in blocking prevention messages and, secondly, seeks to break this silence has the potential to impact dramatically on life choices, gender equality and HIV prevention.

### AIDS and Schools

South Africa has a demographic profile characteristic of developing countries – 33 per cent of the population is under the age of 19 years. Put another way, a very large proportion of the population is either in school or will shortly be of school-going age. In 1999, over 22 per cent of the population was HIV positive in South Africa [1]. Infection disproportionately affects the young – the highest incidence of full-blown AIDS is recorded in the 20–24 age group, where females are much more likely to be the sufferers. Since AIDS normally only presents after 6–8 years, one can extrapolate that it is while at school that many people become infected [1].

Most of South Africa's school population is black, working class and attends public school. We do not know how many learners are HIV positive. The only reliable sources of such details are State-run antenatal clinics where blood tests are routinely conducted. These figures are generally used in calculating the extent of the pandemic but are not translated into school settings. In schools, male and female learners show little inclination to test or to discover their status. A recent World Bank Report suggests that 12 per cent of the country's teachers are HIV positive [2].



*Adolescents participate in a DramAidE forum theatre performance at a high school in Kwazulu Natal, a province in South Africa with the highest HIV/AIDS prevalence.*

*Credit: © 2000 Patrick Coleman/CCP, Courtesy of Photoshare*



AIDS is already considered a serious problem for schools, teachers and learners. Many different types of intervention conducted by the State and non-government organisations are underway. These concentrate on prevention. AIDS and sexuality are handled in the Life Skills section of the school curriculum. Although gender is formally included in these lessons and in the curriculum, it is often omitted, neglected or taught from a medical perspective that focuses, for example, on the mechanics of reproduction or sexual intercourse [3]. This may be one of the reasons why levels of transmission continue to be very high. KwaZulu-Natal has the highest rates of new infections in the world [1]

#### **Definitions of Silence**

In the course of research work in public schools in Durban, KwaZulu-Natal's most populous city, I was confronted by a silence about AIDS and its personal impact. Direct questions to groups big and small yielded the same order of answer. AIDS was a problem, but it was a problem for somebody else. It was not a problem in the school, for any of its learners or teachers. The reluctance to talk about AIDS was my initial experience of silence. I understood that one of the reasons for this silence was the stigma attached to being HIV positive or dying of AIDS [4]. But I was also very much aware that silence reached into many other areas.

#### **Suppressed Discourse**

What is silence? In this article it has two meanings. In the first instance it is a social phenomenon experienced collectively. The language of discourse offers a useful way to explain silence. Silence is a result of prohibition and policing [5]. Understood in this way, silence is a suppressed discourse. It is thus an effect of power. Dominant discourses permit and legitimate certain vocabularies and values while marginalising or silencing others.

The second meaning which silence takes in this article involves the personal. A person who either feels unable to talk about certain subjects or emotions or is unaware of certain aspects of his or her history suffers from silence. Although the two ways in which I use silence cannot actually be separated because they fuel one another, it is nevertheless helpful to begin by distinguishing them.

#### **Unequal Power**

Silence is an effect of unequal power. Dominant discourses deprive certain acts and phenomena of names. Without names, these 'things' are not recognised [6]. Carrie Herbert argued in the context of sexual harassment that normalising discourses ensured that certain types of discrimination and abuse could not be named and hence were not recognised [7]. Where such discourses operate, victims believe that they are themselves responsible for their misfortune. In cases of rape, for example, women may feel that they provoked the assault by wearing provocative clothes. They therefore elect not to talk about their experience.

Silence is not a problem for women alone. For men, the inability to access difficult emotions has long been identified

publicly revealing her status. Many women now remain silent (about rape, about being HIV positive) for fear of such consequences.

In South Africa, stern Calvinist traditions compounded by the authoritarianism of Apartheid produced a silenced society for the majority of black and white people. Racial and gender inequalities underpinned the silence. Black people were silent before whites; women were silent and obedient to men. During the period of heightened political resistance to Apartheid (in the 1970s and 1980s), silence was a defence mechanism that could save one from incarceration at the hands of the security police. But it also became a habit that seeped into many areas of life. The schooling system became a site for the production of silence: corporal punishment was widely used and any signs of curiosity or

***The reluctance to talk about AIDS was my initial experience of silence. I understood that one of the reasons for this silence was the stigma attached to being HIV positive or dying of AIDS***

as a serious problem, not just for the individuals concerned, but as obstacles in the way of gender equality [8].

#### **Silence Widespread**

In South Africa the phenomenon of silence is widespread and its effects deep. Patriarchal power in the household leads to the silencing of women. Women cannot resist gender tyranny unless they are willing to accept violence or contemplate expulsion from the home. Despite the introduction of domestic violence legislation in South Africa, black women seldom press charges. They silently endure abuse. When they do speak out, they are frequently victimised. In the most notorious case of AIDS victimisation, Gugu Dlamini was stoned to death in Durban in 1998 for

independence of thought were taken as impertinence and so punished. However, silence is not universal and neither are schools automatically repressive. There are always places where the unspoken finds expression and there are always people who speak the unspoken.

Silence is not only the effect of repression and of forces external to the individual. As already indicated, boys and men also suffer silence. Alice Miller, the European psychologist, offers some explanation for this destructive condition [9]:

*Experience has taught us that we have only one enduring weapon in our struggle against mental illness: the emotional discovery of the truth about the unique history of our childhood. Is it possible to free ourselves altogether from illusions? History demonstrates that they sneak in everywhere, that every life*



*is full of them – perhaps because the truth often seems unbearable to us. And yet the truth is so essential that its loss exacts a heavy toll, in the form of grave illness.* (Miller 1997, p. 1)

Here Miller commends the acquisition of an emotional vocabulary as a means to confront our ‘illusions’ and avoid ‘mental illness’. In so doing, she argues, people can find their true voices and end the silence that entraps them. In this article, silence refers to the issues, subjects and topics which are not talked about. It also refers to that negotiated, regulated and policed communicative space between people which does not accommodate certain subjects, issues or topics.

**Violence**

South Africa is an extremely violent country. Much of this violence is played out in the interpersonal realm where men use their power over women to affirm their masculinity. It is predicated on the view that, in the words of a young, black informant, ‘Love is worth nothing if [there is] no sex’ [10]. A combination of a belief in male entitlement to women’s bodies and misogyny produced a situation where half the men who participated in a national survey in the year 2000

thought women were to blame for rape. Despite recent legislation making marital rape a criminal offence, 58 per cent of participants believed that a woman could not be raped by her husband [11].

A second explanation for the violence of men towards women intimates is offered by Wood and Jewkes who question whether violence is purely an expression of male power [12]. In the context of South African townships characterised by acute poverty and poor life chances, the emphasis on heterosexual ‘success’ propels boys into sexual competition that makes them vulnerable to their male friends (and rivals) and opens them to ridicule (by boys and girls) if they ‘fail’. Without the words to talk about this state of anxiety, the result of ‘dangerous love’ is normally violence against girlfriends.

A third cause of silence concerns the patriarchal structure of the family and the obedience and submission expected of girl children. This includes the expectation that girls will keep to themselves and not raise difficult issues. The same is not true for boys. There is very little communication between parents and children. Mothers assume that when girls have boyfriends, they will

engage in sex and therefore send them to the clinic for contraception.

**Stigma**

Stigma is a fourth cause of silence. As already mentioned, so great is the stigma that people who publicly declare their HIV status are physically at risk from community members. It is publicly seen as a sign of irresponsibility because it is linked to sex and unregulated sex in particular [13]. The 1998 murder of Gugu Dlamini was justified by her (male) killers who said she had ‘degrad[ed] her neighbourhood by disclosing that she had the disease [thus] bringing shame on her community’ (*The Sunday Times* 27 December 1998).

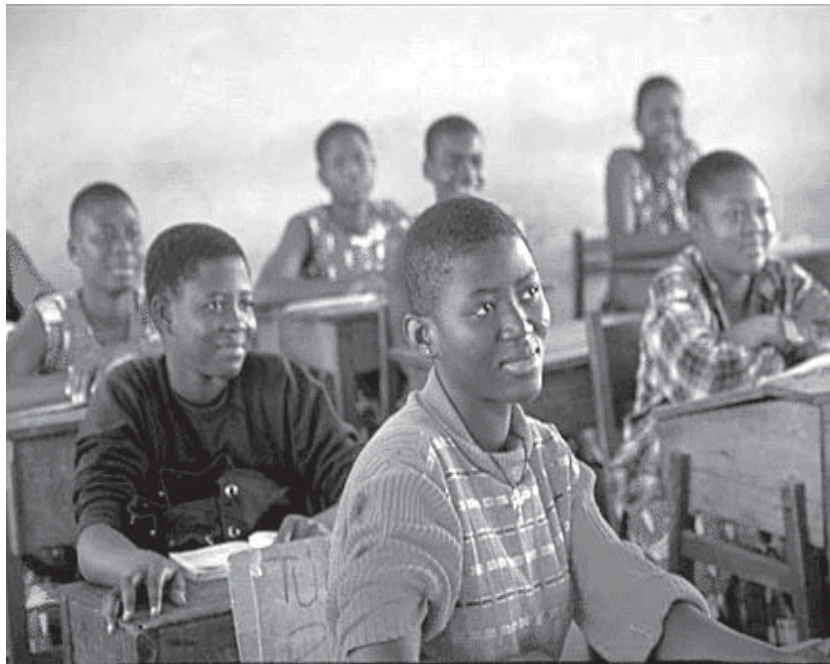
**Gendered Silence**

In this section I draw on interviews and class discussions conducted during a two year British Council-sponsored research project on HIV/AIDS, gender and violence in two Durban secondary schools.<sup>1</sup> The learners interviewed were all African, from working class backgrounds.<sup>2</sup> I was interested to see how the young interviewees (their ages ranged from 15 to 20 years) would talk about AIDS, given the stigma associated with the disease.

Instead of talking about AIDS, learners acknowledge its presence but keep it at a distance. Why bother to find out, they ask, because ‘then you’re going to worry too much’ (Class discussion 10 October 2000). There is a major disincentive to test: ‘To know or believe that one has the HIV/AIDS virus is to feel “spiritually dead” ... You lose hope. You know you’ll be rejected; you know you’re going to die’ [14].

**No Audience**

Many learners have no audience to discuss the problems they encounter. Neither parents nor friends are available. They may not be sympathetic. They might be judgemental. Furthermore, discourses which make available a language of disclosure and which legitimate open discussion on a range of topics are absent in most schools. As has been suggested, part of the explanation lies in South



Credit : UNAIDS/Liba Taylor



Africa's authoritarian past and in oppressive pedagogies. But another part of the explanation is to be found in the gender subject positions of learners. Girls who cannot express or discuss their trauma are left isolated and powerless. Healing is retarded. They are robbed of their agency and avoid developing the relationships that might succour them.

### Challenges

The inability of a person to express emotion can be considered to be that individual's problem. In this article, I have argued that silence should be understood as a social phenomenon. It is of concern to society because in the AIDS pandemic the deadly consequences of people being unable to negotiate safe sex are widespread. To break the silence there are many challenges to be met. These include: promoting gender equity in classrooms and schools; developing a climate of tolerance in order to end the culture of stigma; encouraging discourses of disclosure; and working with young people to reshape gender identities and develop capacity for openness and honesty. These are all challenges not just to individuals locked in cages of silence, but to the gender structures which create and support that silence.

### Breaking the Silence

Two kinds of school-based interventions can break the silence. In the process of conducting research, researchers can provide interviewees with cues and safe space that make it possible for hidden narratives to be accessed [15]. Similarly, certain gender-sensitive, behaviour change interventions which consciously work to access personal history and to explore vulnerability are able to give the young people involved a new language and confidence to speak out.

Hegemonic masculinity and emphasised femininity both depend in large measure on the 'unsaying' of these feelings and emotions. This is why it is so important for the silence to be broken; because in breaking it, the necessary work of reconstructing new gender relations and identities will begin.

AIDS activists working in Uganda and Italy have found that an approach that encourages maximum openness by developing a language to deal with a wide range of sensitive topics is very useful in 'telling children' [16]. This self-revealing approach documents family history and relieves the burden of secrecy. It also facilitates planning (including identifying a future guardian), reduces stigma and increases trust and confidence.

One of the most successful programmes dealing with youth,

that the context of gender relations is vital and that male power must not be ignored when working with men.

It has become quite common in the last few years for researchers to call for the inclusion of men in AIDS work. In fact, it has become the formal position of UNAIDS which argues that 'cultural beliefs and expectations also heighten men's vulnerability ... as politicians, front-line workers, fathers, sons, brothers and as friends they have much to give. The time is ripe to start seeing men not as some kind of problem,

***...gender-sensitive, behaviour change interventions which consciously work to access personal history and to explore vulnerability are able to give the young people involved a new language and confidence to speak out.***

sexuality and AIDS is Gethwana Makhaye's Shosholozza project which works with young African teenagers in KwaZulu-Natal who are united by their passion for soccer. Her work begins with exploring the young men's attitudes towards relationships and sex.

The research findings suggest that masculinities are changing. Young men are finding a language to break the silence. This is very good news and it is fortunately not isolated.

### Conclusion

Silence (particularly in the areas of disease and sex) remains a major challenge for individuals and society. This article has argued for a gendered approach which engages with the construction of gender identities. In the process, silence can be confronted and a contribution made towards breaking down stigma and producing more harmonious and equitable gender relations.

In this article I have drawn on a number of literatures and traditions. From radical feminism there has been the focus on women's sexuality and from education the critical literature on getting boys to talk (rather than fight). From critical men's studies has come the insight

but as part of the solution' (UNAIDS 2000, p. 6).

It will be imperative to tackle silence. Teachers and learners should be encouraged to talk about themselves, to themselves, to reveal their interiors to themselves if not to others. In this way a deadly silence can be broken.

### Acknowledgement

Full article published in *Australian Educational Researcher*, 30, 1, April 2003, 41-62. Reprinted with permission. The author would also like to thank Dr Richmond Tiemoko for his editorial efforts.

### Notes

<sup>1</sup> The two township schools minister entirely to working class African learners. My research collaborators were Debbie Epstein, Lebo Moletsane and Elaine Unterhalter. Informants are identified in the text by pseudonyms which they chose themselves.

<sup>2</sup> I conducted a survey in September and October 2000 among 450 African learners at the schools aged 13-20. The sample was 44 per cent male and 56 per cent female.



# 2

# Issue in Focus

## HIV/AIDS and Sexuality in Africa

### Background

The overwhelming majority of people with HIV, some 95% of the global total, live in the developing world. The proportion is set to grow even further as infection rates continue to rise in countries where poverty, poor health care systems and limited resources for prevention and care fuel the spread of the virus.

After enduring hundreds of years of oppression, conflict and crisis, Africans now face the most challenging threat to their survival - the HIV/AIDS pandemic. In Africa, 25.3 million people are currently infected with HIV. Specific cultural ideals, identities, and gender roles are crucial factors in the development of particular behaviours that support the

perpetuation of HIV. Furthermore, the lasting effects of European colonialism have significantly influenced individual and socio-cultural identity.

### Wrong Notion

The notion that the North Africa region has sidestepped the global epidemic - perhaps due to strict rules governing sexual behaviour - is not supported by the latest estimates, which indicate that 75,000 people became infected with HIV in the past year. This brings the total number of people living with HIV/AIDS in the Middle East and North Africa to an estimated 600, 000. AIDS killed a further 24,000 people in 2003. [1]

Hard statistics are difficult to come by in this area of the world. A Ugandan UNAIDS official says, "Most people with HIV do not know they are infected because testing for HIV is not widely available in Africa" [2a, 2b]. There is a deep shame associated

with AIDS and most people in this region who die of AIDS do so in silence. Men in particular are rarely tested or know their HIV

status. Those women who bravely tell of their sickness are often shunned, ridiculed, and beaten. Because of this stigma, many do not admit that they are dying of AIDS, others do not want to know - and so the cycle continues.

### Cultural Implications

Although genetic, biological, political and economic factors influence the susceptibility, continuation, and spread of HIV infection in Africa to some extent, it is maintained that cultural behaviours and beliefs have provided ideal conditions for the deadly HIV virus to flourish in this region. Cultural issues of gender identities, roles, and expectations, marriage and family, sexual practices, and the ways in which males and females identify and relate to one another within their cultural and social constructs play a broad and significant role in the spread of HIV infection.

### Policies

Usually HIV/AIDS policies are developed along two axes: moralism/pragmatism and coercion/compassion. These reflect the different interests and positions to be found within society. The coercion/compassion axis opposes a behavioural disposition emphasizing compulsion or force to one which puts the emphasis on understanding the social needs and plight of people living with HIV/AIDS or those at risk while acknowledging that every human being is a potential victim of

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**Access to antiretroviral (ARV) treatment in Botswana:** Governments should promote much greater community participation in the provision of HIV/AIDS services.  
*Credit: WHO/Eric Miller*



HIV/AIDS. The moralism/pragmatism axis opposes a disposition to judge certain types of sexual conduct as morally wrong to one that emphasizes what is practicable rather than what is ideal. Thus four general policy approaches emanate from these two axes:

*The approach that lies between coercion and pragmatism.* Here policy advocates external but not necessarily punitive, actions targeting those living with HIV and those defined as belonging to high-risk groups seen as dangerous to society. Policies emanating from this approach emphasize containment combined with pragmatic education and prevention.

*The approach that lies between coercion and moralism.* Here policy is punitive against those living with HIV and those seen as belonging to high-risk groups. There is a bias towards institutional controls, with the infected and members of high-risk groups seen as "them" out there who typify what is wrong with society. Therefore, quarantines are advocated, and the distribution of condoms is opposed as unethical. Policy emphasizes punishment as an example to others. Born-again groups of persuasion have been a vocal minority promoting this policy approach. Some groups even think that discussing risk factors is premature and that preventative measures are unacceptable [3].

*The approach that lies between moralism and compassion.* Here policy rejects as inhumane mechanisms such as quarantine but also rejects practical interventions such as provision of condoms, sterile needles and sex education on the grounds that they encourage immorality. Policy therefore emphasizes the need for awareness-raising through preaching what is right and wrong. Mainstream churches and traditionalist circles have argued for this policy alternative.

*The approach that lies between compassion and pragmatism.* Here HIV is recognized as a danger to society, but the rationality of external controls is questioned. Society is seen as having a responsibility to fight the spread of HIV/AIDS in the most humane way. What is envisioned is a positive interaction

between society on the one hand and people living with HIV/AIDS and those at high risk on the other [5]. Here policy endorses the provision of condoms, sterile needles and sex education and resolutely opposes quarantines and compulsory testing of individuals. Policy recognizes that people are not going to stop having sex and emphasizes measures which are humane and practical. The idea is that HIV is a problem that subjectively and hypothetically exists in everyone.

Most AIDS policies in Africa have shunned moralism on pragmatic grounds. Even if it were true that HIV/AIDS is a result of "immoral" sexual activities, policy makers generally realise that widespread behavioural change will never be brought about by preaching morality or by threats of punishment. There have been important advocates both of HIV disease containment combined with prevention through education on one hand and of doing whatever works without infringing people's rights on the other hand [4].

#### **Women and HIV/AIDS**

The prevalence of HIV among women in Africa is of particular concern in the bid to improve the living conditions and health of women because of their connection to pregnancy, childbirth, nursing, and childcare. Consequently, the degeneration of this connection directly impacts the primary family unit and thereby the social structure of the community. According to the Centres for Disease Control and Prevention, "In June 2000, UNAIDS reported more than one in five women under the age of 25 are infected with HIV in Africa" [5].

#### **Child Marriage**

The traditional practice of child marriage is another factor that contributes to the spread of HIV among young girls in Africa. North Africa is one of the regions where they are least common [6]. Facing economic hardship, some parents marry off young daughters in order to ease themselves of what they consider an economic liability and to receive a bride price. UNICEF reports that, "For both boys and girls, early marriage has profound physical, intellectual, psychological and emotional consequences, cutting

off educational opportunities and chances for personal growth" [7].

Moreover, young girls are also more susceptible to sexually transmitted diseases, including HIV, because their bodies are not fully developed [7], because there exists a general ignorance about reproductive health due to illiteracy and lack of education, and because they may be married off to older and more sexually active men.

#### **Religion**

Comparatively, North Africa maintains one of the lowest HIV rates worldwide. It appears, at least statistically, that in countries where there exists a dominant and central religious influence, the HIV rates remain comparatively lower than in countries exhibiting various and sometimes conflicting religious ideals. The African countries most highly infected with HIV - Namibia, Zambia, Botswana, Zimbabwe and South Africa - all indicate a combined presence of indigenous religions and/or a form of Christianity. In North Africa, correlation between cultural-religious ideals and the rate of HIV infection, suggests that the religious unity and prevalence of Islamic religious law provides a social structure that deters the spread of HIV.

Religion should be an important and continued consideration when evaluating the HIV epidemic in Africa. Religious beliefs provide insight as to how a culture perceives itself, how its people approach conflict and relate to crisis.

#### **Conclusion**

AIDS policies in Africa have seasawed between containment of victims and potential victims and their sympathetic treatment. Obviously policies, which do not emphasize containment, are preferable. However for these to work, the conditions that make Africa the most AIDS-affected region in the world, must be addressed. Poverty, inequality and underdevelopment must be seriously tackled if real progress is to be made in the fight against HIV/AIDS. [2,8].

#### **The Way Forward**

Firstly: the scale of the epidemic requires organized responses that promote effective ways to combat

Continued on P.12





## 3

Region  
Watch**Focus on  
Botswana National  
Youth Council (BNYC)****Background**

Botswana has one of the worst HIV/AIDS epidemics in the world. There are many reasons for this, but men's attitudes and behaviours are among the most significant. Men are brought up to believe that they are superior to women. Having sex with many women is often seen as a way to be a 'real man'. Men believe that they are entitled to sex with women but that family planning is the woman's responsibility. Men are hardly ever seen at the clinics with their children, wives or families, and do not usually belong to any club or

society that addresses social issues related to health.

**"Feeling Left Out"**

But some men also report feeling 'left out' of sexual health matters and want to be more involved. Men get few opportunities to talk about their questions and concerns about sex. Yet when asked, men have many anxieties, often relating to sexual performance (for example, penis size, erectile dysfunction, premature ejaculation). The pressure on men to prove themselves through sex is rarely discussed. Sex between men is a taboo subject.

*From "Supporting  
Community Action on  
AIDS in Developing  
Countries"; an  
e-publication of Interna-  
tional HIV/AIDS Alliance*

**Men, Sex and AIDS**

The Botswana National Youth Council (BNYC) began its Men, Sex and AIDS Project in 1997 to respond to this situation. Since the BNYC opened in 1996, it has concentrated its efforts on youth empowerment. Its mission is 'to empower young people through a coordinated range of programmes, in pursuit of the stated goals and objectives of the National Youth Policy'. HIV/AIDS poses perhaps the most serious threat to the development and empowerment of young people in Botswana, and thus has become an important focus of BNYC's work.

**Programme Objectives**

BNYC decided to target this work at men because of the central role they play in the HIV/AIDS epidemic in Botswana. The objectives are to:

- Educate men about HIV/AIDS and safer sex
- Talk with men about their sexual behaviour and sexuality more broadly
- Assess the needs of young men in relation to decreasing the rate of HIV/AIDS infections
- Develop strategies, networks and methods of fieldwork to reach more men with a more comprehensive programme addressing their needs.

**Target Group**

BNYC works with men between the ages of 14 and 49 years. The



*Men receiving condoms. Credit: L. Lartigue / USAID in Africa Photo Gallery*



project targets men from different economic backgrounds, in both urban and rural areas. A lot of attention has been given to school youth. The project states clearly that it works with men of all sexual orientations. The project seeks to work with men in social settings, such as bars, nightclubs, sports fields and so on. It also targets men in a range of institutions, such as prisons, the armed forces, private companies and schools. The project works both with men at the grassroots level and with men in leadership. Below are some observations made by men>

'I do not expect for my wife to be my equal. Men and women are simply not equal; the man is the head of the house and he has the final say when it comes to issues of the house, including family planning.' - 50-year-old married man

'I have had more than one sexual partner. Women love me and love that I have money. But I think that as of this day on, you need to help me to stay focused because I really want to break up with all these girls and have one steady partner.'" - 30-year-old workshop participant - now an active member of 'Men, Sex and AIDS'

#### **Strategies**

The approach of the project is to focus on male sexuality rather than just HIV/AIDS education, emphasising the importance of dialogue between friends and partners. Strategies include:

**Outreach work:** Skilled fieldworkers make contact with men within their social networks. They provide men with information on sexual health and HIV/AIDS, and distribute condoms. They also open up discussions with men about sex and sexuality.

**Group work:** The project runs about one workshop a month. The aim is to train men to take on active roles in the fight against HIV; this includes running workshops on gender, sexuality and HIV/AIDS for other men in their social networks. Workshops have been targeted at different kinds of men (such as the unemployed, men in the workplace, men in the armed or police forces) and are held in venues close to these men. They usually last three to three-and-a-half days and

include a range of interactive methods.

**Community mobilisation:** The project supports local groups of men to organise themselves. They are responsible for mobilising men in their area, sharing information, distributing condoms and participating in HIV/AIDS-awareness activities. These groups draw men from workplaces, the armed or police forces, the unemployed, schools and so on.

**Recreational activities:** The project runs a variety of recreational activities, especially with young people. These include sponsored walks, fêtes and indoor soccer. When necessary, the project brings in outside experts to help with these activities. Radio and local newspapers, as well as pamphlets and letters, are used to attract men to such events.

**Promotional events:** Project staff participate actively in HIV/AIDS-related events; for example, World AIDS Day, Month of Youth against AIDS and Condom Week.

**Service referrals:** The project gets a number of requests for legal assistance from the men with whom it works. Rather than provide legal services directly, the project works in partnership with a local human rights organisation (Ditshwanelo) to provide any legal or human rights services that are required. The project also partners with the local HIV testing centre, PSI (a condom social marketing organisation), Botswana Family Welfare Association (BOFWA) and the Coping Centre for People Living With AIDS (COCEPWA).

#### **Positive Response**

The response from individuals and institutions has been very positive. The project gets an overwhelming number of invitations to address people at various places of work, schools, the University of Botswana, the armed forces and so on. The number of men's groups has grown around the country in the past five years. There are about 10 groups around the country. A lot of men approach the office to volunteer their services.

Men report a number of changes in sexual attitudes and behaviour. These include: men who claim to have reduced the number of their sexual partners; men who say they

appreciate the condom more; and men who say they have changed their sexual 'ways' since they have understood sexuality better, and now appreciate themselves and their partners more

#### **Lessons Learned**

Men are willing to learn more about themselves as men, their sexuality and how it can influence their lives and relationships. Given the opportunity, men are willing to learn from each other's experiences.

Men need accurate information on all aspects of sexuality and a chance to ask questions and discuss concerns.

In order to encourage men to talk about issues of sexuality and gender, it is important to be open, talk about your own experiences and how you feel about discussing these issues.

Helping men to feel comfortable is essential. It helps to get men to appreciate that sex is natural. Working with many older men or men with strong religious beliefs is a challenge because of their preconceived ideas. The best way is to listen and learn from them, and adapt your information and message based on what they have to say. This is better than trying to change their beliefs, because this will meet with resistance. Workshops are not a platform for challenging beliefs but for imparting knowledge and, where appropriate, sharing experiences.

Funding proved to be the biggest problem for many of the recreational activities that the project wanted to carry out. In raising money for recreational activities, it is essential to make clear how these activities contribute to the goals and objectives of the project.

#### **Botswana National Youth Council**

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# 4

# Research Notes

## Calculating HIV/AIDS Estimates

*One question that is raised often all around the continent of Africa is: How do the international agencies like The Joint United Nations Programme on HIV and AIDS (UNAIDS) and the World Health Organization (WHO) arrive at their estimates for epidemics such as HIV/AIDS? This is an important question because estimates are used not only to determine how international resources to fight HIV/AIDS will be allocated to countries but also remain the primary source of information about the extent of the epidemic and its impact for both researchers and lay people*

### Introduction

This paper describes the procedures and process used to make the 2001 round of UNAIDS/

WHO estimates of HIV/AIDS. The paper focuses on the different approaches used to make estimates of prevalence in countries with generalized and low-level and concentrated epidemics as well as on new curve-fitting software that was developed to produce epidemic curves for each country. In addition, it presents the assumptions used (e.g. survival from infection to death, the rate of mother-to-child transmission) that are required to derive estimates of incidence and mortality in adults, as well as prevalence, incidence and mortality in children. The paper describes the general process by which the estimation and modelling procedures have been refined and

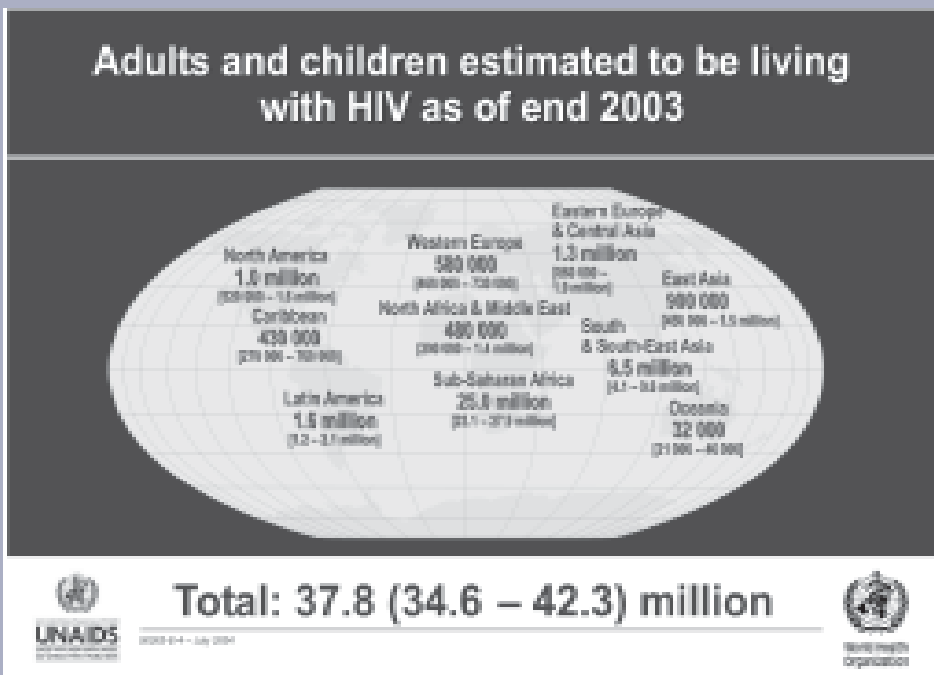
improved over time. The paper also discusses the limitations and weaknesses of the procedures and the data used to make the estimates, and suggests areas where further improvements need to be made.

### Calculation of Estimates

UNAIDS/WHO estimates are based on all available data, including surveys of pregnant women, population-based surveys such as household surveys conducted by individual countries such as Kenya, Mali, Zambia and Zimbabwe, as well as other surveillance information. UNAIDS views such information as complementary and useful in helping to estimate the number of people living with HIV in a country.

There have been steady improvements in the modelling methodology used by UNAIDS/WHO and partners, along with better data from country surveillance. These have led to lower global HIV/AIDS estimates, not just for the current year but also for past years, despite the continued expansion of the global epidemic. Current estimates therefore cannot be compared directly with estimates from previous years, nor with those that may be published subsequently.

UNAIDS and WHO continue to work with





countries, partner organizations and experts to improve data collection.

UNAIDS/WHO publish updated country estimates biannually. The most recent estimates for end 2003 are contained in the 2004 Report on the global AIDS epidemic, released at the International AIDS Conference in Bangkok (11-16 July 2004).

For more information, see the Questions & Answers sections on UNAIDS methodology and epidemic in Africa:

*Q&A II: Basic facts about the HIV/AIDS epidemic and its impact*

*Section II: The status of the global epidemic and modes of transmission in different regions*

*Section III: Other epidemiological and related issues*

### Methodology

UNAIDS/WHO, in close consultation with countries, employs a six-step method to obtain national estimates of HIV prevalence. The following is a brief description of the methodology, software and assumptions produced by the UNAIDS reference group on estimates, modelling and projections to provide the relevant technical basis for the UNAIDS/WHO global estimates and projections of HIV

prevalence. The software packages and their manuals may be downloaded from Epidemiological software and tools.

In countries with a *generalized* epidemic, national estimates of HIV prevalence are based on data generated by surveillance systems that focus on pregnant women who attend a selected number of sentinel antenatal clinics. This data is entered into the Estimation and Projection Package (EPP) software which fits a simple epidemiological model to find the best fitting curve that describes the evolution of adult HIV prevalence over time. This adult prevalence curve along with national population estimates and epidemiological assumptions are then entered into the Spectrum software program to calculate the number of people infected, new infections and deaths.

### Assumptions

This method assumes that in countries with a *generalized* epidemic HIV prevalence among pregnant women is a good approximation of prevalence among the adult population (aged 15-49). Studies conducted at subnational level in a number of African countries have provided the

evidence for this assumption (by directly comparing HIV prevalence among pregnant women at antenatal clinics to that detected among the adult population in the same community).

In countries with a *low level or concentrated epidemic*, national estimates of HIV prevalence are primarily based on surveillance data collected from populations at high risk (commercial sex workers, men who have sex with men, injecting drug users) and estimates of the size of populations at high and low risk. This information is entered into point prevalence and projection spreadsheet models, the Workbook Method, to find the best fitting curve that describes the evolution of adult HIV prevalence over time. This adult prevalence curve along with the national population estimates and epidemiological assumptions are then entered into the Spectrum software program to calculate the number of people infected, new infections and deaths.

More detailed explanation of methods and assumptions may be found on the UNAIDS reference group on estimates, modelling and projections website <http://www.epidem.org/Default.htm>.

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it. Clear-cut policy is necessary to assist behavioural change.

Secondly: HIV/AIDS is accompanied by stigma. The infected and those perceived to be at high risk are widely discriminated against. Such discrimination violates or undermines the basic human rights of certain groups of people in society. Policy is necessary to safeguard these rights both as a matter of ethics and as part of the strategy to combat HIV.

Thirdly: policy is also necessary to deal with the escalating costs of the disease, especially with regard to education and employment.

Governments should promote much greater community participation in the provision of HIV/AIDS services by decentralizing the management of programmes and by forming partnerships in cooperation with local non-governmental organizations and private health-care

providers. All types of non-governmental organisations, including local women's groups, youth and religious groups, should be encouraged to become involved in HIV/AIDS programmes.

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## 5

## Viewpoint

# Women, Sexuality and HIV/AIDS

*Cesnabmihilo Dorothy Aken'Ova, Executive Director International Centre For Reproductive Health And Sexual Rights (Increase), Niger State, Nigeria*

## A Woman: Who Defines Me?

Over the years, our communities have put customs in place, which have been the source of the prescriptions handed down to us. These prescriptions determine how women and men interact with one another. In Africa, these prescriptions favour one group at the detriment of the other: Boys are socialised to be aggressive, macho, dominant and in control. They have been socialised to always be ready for sex, and given the impression that their sexual urge is uncontrollable. On the other hand, the girl has been socialised to be passive and submissive, to desire a man to always be in control of her life. She has been socialised to give in to a man's sexual power and desire and, yet, not to have sexual desires of her own.

## How the System Works

Culture plays an important role in the way we think and behave. We are made to believe the standards that have been set and we fashion our lives after them. We even begin to feel these prescriptions are natural and resist change when it comes.

## The Need To Conform

Persons are expected, generally, to conform to the same sex model. This is why women behave like women and are seen as feminine while on the other hand, men

behave in a so-called 'man-like' manner and are said to be masculine by so doing.

Deviation(s) from the models set by our cultures always give(s) rise to social concern and disapproval. Women are, therefore, compelled to conform and cannot afford to be disapproved of because this will lead to alienation and withdrawal of benefits and support. They will attract stigma.

## Sexuality: At What Price?

*A Case Study:* Mr. Ndagi was diagnosed HIV positive along with his ailing wife who died a few months after the diagnosis. Everyone knew that Ndagi was the source of the infection. Good looks, wealth and a good position in government, gave him the power to conquer women. He kept late nights. He often disappeared for days. But his good wife dared not report, and dared not suggest the use of condoms to him. The woman died. The community sang her

everyone referring to her as an ideal wife.

Since the man is brought up in our setting not to be without a woman, Ndagi married a 25-year-old girl. She dared not investigate the sickness that took the first wife's life. She did not use any condoms; in fact, she



*Credit: Board of Regents of the University of Wisconsin System*

praise -



desired to have children with him. The regulation on ethics and a defective national policy on HIV did not let anyone breathe a word of it to her. The new wife got divorced after their second year of marriage. She would not tolerate the man's long absences from home. She did not receive sympathy from anyone, not even her family members. She was accused of trying to "spoil" her husband's name by reporting him around. She died of AIDS a little after two years. She lived to see her ex-husband marry one of the girls he had been spending time with while she was still married to him.

The third wife was also divorced Ndagi after two years. At this time, Ndagi's condition was deteriorating. His wife was accused of being a witch and scheming to do away with him to inherit his wealth. He offered her all she requested to get the divorce. She is in the final stage of the infection. Her pain is that they did not live together till death do them part!

Ndagi died two years after this divorce without admitting that he had AIDS; and so have numerous of his known girlfriends! In this case, manipulation of women's sexuality cost the women their lives.

#### Long Debates

Our sexuality has often been used against us. Imagine the tension and sleepless nights that accompany the debates on women's sexual rights at the UN! Who is in a better position to tell us what is good for us, than ourselves? Who is in the best position to negotiate for the goodies for us but ourselves?

#### The Splint In Your Eye

A man once argued that women need to be mutilated because the sight of the vulva of an uncircumcised woman is ugly. Who is man to decide for a woman whether her vulva is ugly or not? Who is a man to decide what parts of the vulva are to be excised to make it good looking? Good looking for whom? How good looking is the man who is giving the prescription?

#### Conclusion – The Way Out

We have seen, read or heard about those cultures where the relationship between men and women is worked at openly and purposefully towards

equity. The relationship between men and women is more egalitarian than what obtains in our setting. In those cultures, parents are happy to give birth to girls, they are given equal opportunity, protection and quality of life as their male counterparts. In those cultures, girls and women are recognised as human beings, they enjoy their human and women's rights by far more than us, and have control over their bodies, and what is done to their bodies. They feel just as important as their male counterparts.

In those societies, women negotiate relationships, limits and protection in a manner that their needs, interests and desires are recognised in reaching a consensus. In those settings, they have not witnessed the exponential rise in HIV/AIDS transmission like we are currently experiencing in Africa. Yet, women make immense contributions to their families and communities. Until we realize the power vested in our contributions, and use these as

tools for a re-negotiation of our sex and gender roles, the staggering figures of people infected with HIV will continue to soar.

#### Acknowledgement

Full article published in <http://www.dawn.org.fj/publications/docs/wcardot.doc> and presented at DAWN Panel at the World Conference on Racism NGO Forum - Unmarking Bodies in Durban, South Africa, 2001. Reprinted with the kind permission of the author.

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# Notes to Contributors

The editors welcome submissions on the thematic focus of future issues of the Magazine, as well as other areas of sexuality, sexual health and rights. Themes for upcoming 2004 issues include:

2005 issues will cover the following subject areas:

- Rethinking Masculinities
- Sexuality and Religion
- Sexuality and the Media, and
- Sexual Violence and HIV/AIDS

ARSRC seeks articles for submission which are objective, analytical and mirror current /contemporary issues and debates in the areas of Sexuality, Sexual Health and Rights in Africa. Articles should reflect a holistic / comprehensive approach to sexuality; taking sexuality discourse beyond health to incorporate broader issues of the expression of sexuality without

guilt, fear or ill-health. While priority would be given articles that have not been previously published, already published material may be considered depending on how relevant the subject area and focus is to ARSRC's work. However, for already published articles, full details of previous publication and where to seek permission for reprint must accompany the article.

We particularly welcome articles related to our thematic focus for the following sections :

**Region Watch:** Topical issues with a country or sub regional focus  
**Programme Feature:** best practices from programme implementers

**Research Notes:** Focus on relevant research and methodologies

**Viewpoint:** Reactions to previous magazine issues or on a subject area that a reader wishes to express very

strong views or opinion.

## **Length**

Feature articles : 1,000 -1,500 words

Research issues : 800-1,000 words

Opinion articles : 400-500 words

## **Photos**

We welcome photos with or without articles and will give appropriate credit when photo is used.

## **Presentation**

Please submit initially, an abstract with your name, contact address, phone number, email address and details about yourself as you would wish it to appear on the list of contributors

\*\*\*\*\*All contributors will receive a copy of the issue in which their contribution has been published.

## About Contributors to this Edition

**Cesnabmihilo Dorothy Aken'Ova**, a linguist by profession, is a feminist and a sexual rights activist. She founded and heads the International Centre for Reproductive Health and Sexual rights (INCREASE) - an NGO which works for a favourable environment, and expands access to sexual and reproductive rights and health information and services. Dorothy has conducted research on homosexuality in Nigeria, and on transvetitism. She has also done some research work in the area of sexual pleasure in women. She has also been involved in international-level advocacy and lobbying.

**Mervat M. Mohamed** is professor of biomedical research in the Human Reproductive Research Unit, and director of the research and training units, International Islamic Centre for Population Studies and Research (IICPSR), Al-Azhar University, Cairo, Egypt. She coordinated the United Nations Population Fund (UNFPA) Project - "Population in the Context of Islam" from 1999 - 2003.

**Robert Morrell** is a professor in the Faculty of Education at the University of KwaZulu-Natal in Durban, South Africa. He trained as a historian at the Universities of Rhodes, Witwatersrand and Natal. He has taught at the Universities of Transkei, Durban-Westville and Natal. His current areas of research interest are: the history and sociology of masculinity in Africa, gender and education, youth, sexuality and masculinity. He is the author of *From Boys to Gentlemen: Settler Masculinity in Colonial Natal, 1880-1920* (2001); editor of *Changing Men in Southern Africa* (2001) and co-editor (with Lahoucine Ouzgane) of *African Masculinities* (2004).



## Sexuality Resources

### ***AIDS AFRICA : Continent in Crisis***

*Author : Helen Jackson*

*Publisher : SAfAIDS, Harare, Zimbabwe, 2002*

*ISBN: 0-7974-2428-8*

Southern Africa countries currently bear the heaviest burden of the AIDS epidemic – its effects permeate societies, affecting children, women, men, rich and poor. HIV/AIDS threatens short and long-term development across all sectors and requires policies, resources and action commensurate with the enormity of the crisis.

This book concentrates on the hardest-hit countries. It explores the driving forces behind the epidemic, the impact of HIV/AIDS at different levels, and policies and programmes to make a difference. The author provides a comprehensive overview of prevention, care and impact mitigation, providing up-dated information and raising challenging issues for policy makers, planners, programme managers and professionals in health and human development.



### ***The Moral Economy of AIDS in South Africa***

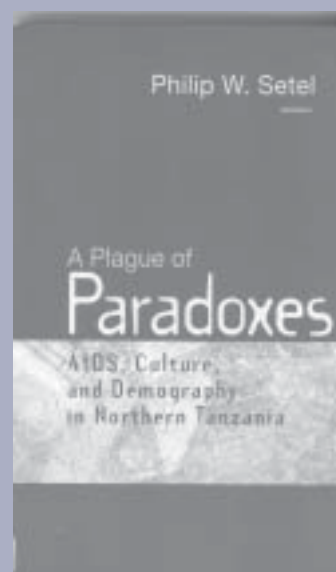
*Author: Nicoli Natrass*

*Publisher: Cambridge University Press, UK, 2004*

*ISBN 0-521-54864-0*

Relatively few people have access to antiretroviral treatment in South Africa. The government justifies this on the grounds of affordability. Nicoli Natrass argues that the government's view insulates AIDS policy from social discussion and efforts to fund large-scale intervention.

Natrass addresses South Africa's AIDS policy from both an economic and ethical perspective, presenting: a history of AIDS policy in south Africa; an expert analysis of the macroeconomic impact of AIDS; a delineation of the relationship between AIDS and poverty and the challenges this poses for development, inequality and social solidarity; amongst other critical areas.



### ***A Plague of Paradoxes: AIDS, Culture and Demography in Northern Tanzania***

*Author: Philip W. Setel*

*Publisher: The University of Chicago Press, Chicago and London, 1999*

*ISBN (Paper) 0-226-74886-3*

*“This is a book about an epidemic and the cultural and demographic circumstances out of which it emerged”*

The author attempts to show that AIDS in Kilimanjaro has been an outgrowth of culture, history, demography and political economy. He argues that it has been a disorder of social reproduction that emerged through the intersection of HIV with people engaged in a conscious struggle with forces both impinging upon and internal to their cultural worlds. Sexuality, of such proximate importance to the study of AIDS, has itself been framed as an outcome of sociocultural change in productive and reproductive regimes.