GLOBAL
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Global Health Council

men&boys
PARTNERS IN PREVENTION

Contents

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

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

Thank you for your interest in *Global AIDSLink*.
Sara Ann Friedman, Managing Editor
sfriedman@globalhealth.org

Cover Photo:
Men as Partners, South Africa EngenderHealth. Photo by Louise Gubb

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Executive Editor
Annmarie Christensen

AIDSLink **Managing Editor**
Sara Ann Friedman

Associate Editors
Tina Flores
Radeyah Hack
Ashley Heaslip

Graphic Designer
Jennifer Shaevel Hopkins

Global Health Council website:
www.globalhealth.org

AIDSLink e-mail:
aidslink@globalhealth.org
To directly contact a Global Health Council staff member, use first initial of the first name and the full surname, followed by @globalhealth.org – for example sfriedman@globalhealth.org

President & CEO
Nils Daulaire

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For information on HIV/AIDS, research & analysis and government relations, contact our Washington office:

1111 19th Street, NW - Suite 1120
Washington, DC 20036
Tel (202) 833-5900
Fax (202) 833-0075

For information on publications, membership, conference activities, the website, finance and administration, contact our Vermont office:

15 Railroad Row
White River Junction,VT 05001
Tel (802) 649-1340
Fax (802) 649-1396

InsideTrack

Ambassador **Mark Dybul** was sworn in as the U.S. Global AIDS Coordinator and will administer the President's Emergency Plan for AIDS Relief (PEPFAR). Dybul, since March, has served as the acting Global AIDS Coordinator and previously as the assistant and deputy coordinator consecutively. Dybul is the "right person to carry on this great program and this great cause," said U.S. Secretary of State Condoleezza Rice, who presided over the swearing-in ceremony. Dybul also served as the chief medical officer for the coordinator's office, and before joining, worked on the planning task force for PEPFAR and served as the Health and Human Services head of President Bush's initiative to prevent mother-to-child HIV transmission in Africa and the Caribbean.

Financier and philanthropist **George Soros** is contributing $50 million to support the Millennium Project, organized and led by economist Jeffrey D. Sachs, which aims to help villages in Africa escape grinding poverty. The Soros donation will pay for fertilizers and improved seeds to raise crop yields, classrooms to improve literacy, and health clinics to reduce deaths in 33 villages in 10 African countries.

Shaun Mellors has been chosen to suceed Phillipa Lawson as the communication focal point (CFP) for the Communities Living with HIV, TB and Affected by Malaria Delegation of the Global Fund Board. Lawson announced her decision to not continue the CFP position last April.

Actors **Angelina Jolie** and **Brad Pitt** each are giving $1 million to Doctors Without Borders and Global Action for Children, an advocacy group based in Washington, D.C. "Angelina Jolie and Brad Pitt not only care, but are taking concrete action to address the fact that there will be 20 million children orphaned by AIDS by 2010, and millions more orphaned by tuberculosis, malaria and conflict or whose parents are sick and dying," said Jennifer Delaney, U.S. director for Global Action for Children.

Lorelai Schoreter was named the new executive director for Business Women's Initiative Against HIV/AIDS. Schroeter came to the BWI from the Planned Parenthood Federation of America, where she served as the organization's director of direct response marketing since 2003.

The Global Network of People Living with HIV/AIDS, (GNP+) has appointed **Deloris Dockrey** as its new chairperson. Dockrey has committed herself to leading GNP+ through the first phase of the renewal process through 2008. Dockrey has been working on HIV issues since 1999. She was the executive director of the New York Ryan White Planning Council from 1999 to 2005. Presently, she is director of community organizing at the Hyacinth AIDS Foundation.

In Memoriam Omololu Falobi 1971-2006

I first met Omololu Falobi in 1998 while working at the Global Health Council. He had just formed a coalition of journalists in Nigeria into an advocacy and communications NGO called "Journalists Against AIDS in Nigeria (JAAIDS)." His enthusiasm for this new NGO was contagious.

Until then, Omololu had been the features editor of Nigeria's largest -selling weekly, the *Sunday Punch*. As JAAIDS grew, Omololu left the newsroom to work full time in HIV/AIDS. Today, JAAIDS' daily Nigeria AIDS e-forum, is a leading communications tool on HIV/AIDS in Nigeria and across Africa. Professionals worldwide use the daily list-serve to share information, news, contacts, debates, etc. on HIV/AIDS in Nigeria.

Through his own focused networking and passion, Omolulu also became a leading global advocate for HIV/AIDS treatment, care and prevention. At HIV/AIDS planning and advocacy meetings on HIV/AIDS, he asked the hard questions and pushed African governments to step up their own leadership.

In 2001, Omolulu was appointed an Ashoka Fellow, joining an elite group of only 2,000 social entrepreneurs worldwide recognized for their outstanding and innovative approaches to 're-engineering society.' In 2004 and 2005, he was selected as the African NGO representative on the board of UNAIDS. In Nigeria, and across Africa where "Journalists Against AIDS" coalitions are starting up, Omololu's vision continues to expand. He felt strongly that everyone, especially African journalists, have a role in advocating for Africa's health and development.

Omololu died Friday, Oct. 6, 2006, from wounds sustained from a gunshot during an armed robbery in Lagos, Nigeria. He was on his way home from addressing young entrepreneurs on the importance of social responsibility. Our fearless colleague in the fight against AIDS was victim to another epidemic in Nigeria – senseless crime. Omololu is survived by his wife, two small children, and many respectful and admiring colleagues around the world. You can learn more about his work at www.nigeria-aids.org.

– Ron MacInnis, Project Director for Health Journalism, Internews

A KEY TO HIV PREVENTION
UNDERSTANDING WHAT DRIVES YOUNG MEN IN AFRICA

By Gary Barker, Executive Director
and Christine Ricardo, Senior Program Officer
Instituto Promundo

In sub-Saharan Africa, nearly 10 million young men and women, aged 15-24, are living with HIV/AIDS. Of this group, more than 75 percent are women, reflecting a worldwide feminization of the epidemic. Increasing research on gender-related risks and vulnerability to HIV has focused almost exclusively on the inequalities and disadvantages faced by young and adult women. At the same time, men and boys are too often ignored or presented in overly simplistic and overtly negative terms with "good girl, bad boy" stereotypes. What does a gender perspective mean when applied to young men and to HIV/AIDS in sub-Saharan Africa? How do rigid notions of manhood and gender hierarchies contribute to the vulnerability to men and women, boys and girls? A better understanding of how constructions of masculinities influence young men's risk behaviors can play a key role in controlling the future of the epidemic.

Gender Norms, Sexuality and HIV Risk

Gender role norms are shown to be among the strongest underlying social factors that influence sexual behaviors and young men, who adhere to traditional views of manhood, are more likely to engage in substance use, gender-based violence and unsafe sexual practices. Ideals of masculinity, such as those espousing male sexual needs as uncontrollable, multiple partners as evidence of sexual prowess, and dominance over women (physical and sexual), can place both young men and young women at high risk of HIV infection. .

Violence and coercion, recognized points of vulnerability to HIV/AIDS, are common features of young people's relationships. Focus group discussions carried out with young men in Nigeria, South Africa and Uganda, revealed varied justifications for committing violence against women: a socially sanctioned extension of male authority in the private realm; a means to impose discipline; a response to proven or suspected infidelity; and refusal to have sex – an expected behavior in a relationship, especially when a bride price has been paid. Indeed, research in Brazil found a strong association between adherence to traditional norms about gender and self-reported use of violence against women.

Cross-Generational Sex of Young Men and Women

On average, young women form partnerships with men five to ten years older whereas young men have relationships with women of similar age or slightly younger – a pattern that leaves women more likely to be infected at younger ages than men. Young men's risk of HIV increases as they get older and have more partners, due in part to the five-year window between sexual debut and marriage. Men over 25 have HIV rates 10 times higher than 15-19-year-old boys. Sometimes, older men may deliberately seek young women and girls as sexual partners believing that they are less likely to be infected.

In many parts of Africa, girls and young women may exchange sex with older men or, "sugar daddies," for money and gifts – in many cases actively or passively encouraged by parents and guardians. Focus group discussions with young men in Nigeria and Uganda suggest that some young men criticize or resent young women for exchanging sex for favors or money, while others seem to understand the conditions that lead them to enter into such relations.

Some young men also report being paid for sex or involved in transactional sex with older and married women, known as "sugar mummies." These relationships are often propelled by economic need and for status among peers. In settings where bride-price is practiced, a young man might become involved with an older woman to help raise the necessary wealth to get married.

Young Men and HIV/AIDS-Related Knowledge and Attitudes

Although awareness about HIV/AIDS, STIs and use of condoms has increased in most parts of Africa, low levels of safer sex, and misconceptions, both about preventive behaviors and the disease itself, still prevail. In Kenya, young men reported conflicting pressures, between what they know they should do and what they actually do. For example, they may associate HIV with high-risk or out-of-the-ordinary sexual encounters, such as rape, sex with commercial sex workers and excessive alcohol, regarding all other sexual encounters as "safe." Throughout the region, an estimated 50-80 percent of young men know that appearance does not necessarily reveal infection status. Yet some still continue to rely on outward appearance as a means of identifying infected individuals.

Young men may also associate HIV with "promiscuous" women, shifting the risk or blame onto them; and some view STIs as a sign of virility. In rural Malawi one study found that some young men boast about the likelihood of being HIV-positive as a badge of manhood before their peers. (These examples suggest the complex ways in which knowledge is filtered through attitudes and social norms, particularly those related to gender.)

Young Men, HIV/AIDS and Use of Condoms

Looking at ABC, in-depth studies have shown that many young men do not view abstinence as a reasonable prevention, although girls might report that they would prefer to delay their first sexual experience. Young men are also less likely than young women to identify monogamy as a way to avoid HIV/AIDS. The prevention method most cited by young men is condom use and sometimes it is the only one mentioned. Furthermore, for some young people, coerced

ALL PHOTOS BY GARY BARKER

Health clinic in Kampala, Uganda. Men and boys often view clinics as "female" spaces.

Boys and young men caught in armed conflict in northern Uganda. Refugee Camp in Lira.

sex and financial necessity, which drives exchanging sex for favors or money, mean that abstinence is unrealistic.

In some settings, masculinity is associated with an ideal of unprotected (flesh to flesh or "live") sex as more pleasurable. As a result, consistent and correct use of condoms is much lower than desired and often varies according to the nature or appearance of the partner or relationship. Condoms are most often used for casual encounters, while a suggestion to use a condom with a steady partner might be viewed as a disclosure or insinuation of a hidden sexual history. Young men may also be belittled by peers for using condoms, and a display of uncertainty about their proper use may be limited by prevailing norms about masculinity and knowledge about sexual matters.

Research also suggests that young women have been socialized to accept the subtle forms of control around sexual activity. A study in South Africa found that young women identified their ideal relationship as one in which the male made the decisions, including the use of condoms and the timing of sex. The same study also found girls reporting it easier to refuse sex than to negotiate condom use. Indeed, many young men believe that a young woman who carries a condom is promiscuous or should be concerned about her reputation. In a focus group discussion, university students in Nigeria, said:
Alfred: I know these two women hookers who carry condoms...
Ali: Sometimes it is hard to know which girl is a hooker; you know you cannot always distinguish.
Andrew: Why would an ordinary woman carry condoms if she was not a hooker?
Halim: I was going out with this one woman and we were not having sex, and she went to pay the bill. Some condoms fell out of her bag. I was shocked and asked her about it. She told me she did not want to have sex until she got married. But she said, we are human, and anything can happen. Morally it was bad, but realistically it was good. That's why it is good to have self-discipline.

Even purchasing condoms, according to young men, requires public disclosure of sexual activity and parental disapproval of adolescent sexual activity. Some may believe they cannot turn down any opportunity for sex when it arises and precious time cannot be wasted on obtaining a condom. Moreover, many young men express concerns about the costs of a condom, especially in refugee camps and in rural areas.

Young Men, Substance Use and HIV/AIDS

Worldwide, men account for approximately four-fifths of injecting drug users and studies have shown that male users are also more likely to share needles and not use condoms. Men and boys also use other substances at higher rates than women and girls, as in Kenya, for example, where boys are more than twice as likely as girls to have tried alcohol and marijuana. For many, using alcohol or another substance may be seen as a means to prove manhood or to fit in with the male peer group.

HIV Testing and Living with HIV/AIDS

In various countries in Africa, only 1-9 percent of young males aged 15-19 have been tested for HIV. Some studies have found that young men are traditionally excluded from information about maternal and child health, a point of entry for VCT testing for young women. Some boys and men view clinics as "female" spaces, and believe that real men do not get sick. A group of HIV-positive fathers in South Africa said that men generally wanted to avoid testing and disclosure, and that women are "braver" when it comes to testing: "Guys are not ready to come out and discuss their HIV status. Women are very brave on that part. Men still do not admit that they have HIV. "

Research also suggests that adult and young men are less likely to care for their health in general and are reluctant to reveal their HIV status. This social isolation leads to stress and can directly impact the health of men. While some may see HIV infection as a sign of virility, others believe that it flies directly in the face of traditional ideals of manhood. As one young HIV-positive father interviewed in South Africa said: "If you are not working and you are HIV positive, like many of us, that is the worst state that a man can be in."

Final Reflections on HIV/AIDS and Young Men

There are anecdotal reports that the dimensions of the AIDS epidemic in Africa and its devastation on families have pushed some men to question their traditional views about manhood. This includes taking on care-giving roles and caring for their own health in new ways. The number of children orphaned by AIDS has also led to changes in family arrangements, with young men taking on roles previously assigned to women. Among the Lango people in northern Uganda, for example, an ancient hunting tradition in which the elders would bless and give counsel to young men has been transformed into a forum for discussing the dangers of AIDS. The elders voiced a fear that AIDS would kill off an entire generation and commented that they used to be happy when young men had a series of girlfriends, but these messages have changed with the AIDS epidemic.

To be sure, these changes are also accompanied by an adherence to many traditional attitudes, taboos and gender norms, but the scale of the epidemic is forcing some men to question gender roles, which in the long run will be positive for men and women. Given the tendency to malign the sexual behavior of African men, it is vital that these voices of change be promoted and that the questioning of gender roles and of men's sexual behavior – in Africa as elsewhere – be taken up as a core cross-cutting issue in the response to the epidemic.

This article is based on a 2005 paper for World Bank. (Barker, G. & C. Ricardo (2005), Young Men and the Construction of Masculinity in sub-Saharan Africa: Implications for HIV/AIDS, Conflict and Violence. World Bank Social Development Papers, Conflict Prevention and Reconstruction. Washington, DC. June 2005.)

For further information contact: barkerpromondo@aol.com; criccardo@promondo.org.br.

Two young men participating in Sibalani life skills program in South Africa.

Male Circumcision

Why is It Now Being Considered Seriously?

By Daniel T. Halperin, Senior Research Scientist
Harvard University School of Public Health

Although male circumcision, which is probably the oldest and certainly the most common surgical procedure, has gone out of favor in some developed countries in recent years, it has now been experiencing a surge of interest, even excitement, as a result of studies about its effectiveness in significantly reducing HIV prevention.

Much of the interest stems from publication this year in the medical journal *PLoS* of the first randomized controlled trial of circumcision among adult men, conducted in Orange Farm, South Africa, which found a 60-75 percent reduced risk of HIV among those who were circumcised. As news of this study, halted prematurely due to the strong findings, began to spread, male circumcision has increasingly caught the attention of HIV and other health professionals, as well as the mass media. A recent modelling study by WHO, UNAIDS and some European and U.S. universities (also in *PLos*) estimates that, based on the Orange Farm findings, circumcision could avert about 2 million new HIV infections and 300,000 million deaths over the next 10 years in sub-Saharan Africa, with a further 3.7 million new HIV infections and 2.7 million deaths averted in the 10 years after that.

It is widely anticipated that if the two remaining randomized trials in Kenya and Uganda (results due as early as December 2006, otherwise mid-2007) confirm the Orange Farm finding, male circumcision will be officially endorsed as a useful adjunctive approach within broader HIV prevention efforts.

The Global Epidemiology of Circumcision

Circumcision is performed in many parts of the world for religious, cultural, social, medical and other reasons. Currently, about 20-25 percent of all males are circumcised, and the majority of African societies continue to practice it. The main parts of the African continent where circumcision is generally no longer practiced are exactly in those countries which make up the "AIDS belt" in much of southern (and parts of east) Africa, where HIV prevalence is vastly higher than anywhere else. Similarly, HIV prevalence in the predominantly non-circumcising countries of south and southeast Asia is much higher than in neighboring, circumcising populations (Indonesia, Philippines, Pakistan and Bangladesh) otherwise having similar sexual and behavioral practices. To date, over 40 epidemiological studies, mostly in Africa, have found a strong relationship between the lack of male circumcision and higher risk of HIV. However, some cross-sectional studies (including some recent demographic and health surveys in Africa) have not found a significant correlation between circumcision and HIV, probably due to issues of demographic/social factors – circumcised men tend to be more urban/educated/wealthier, and thus have riskier sexual behavior – self-report bias, and confounding due to non-heterosexual forms of HIV transmission, etc.

A 2002 meta-analysis of 38 studies by the London School of Hygiene and Tropical Medicine estimated that circumcision reduces HIV risk by approximately 50 percent overall, with about 70 percent reduction among higher risk populations. New data from Uganda suggests that circumcision may also reduce transmission of HIV and some other sexually transmitted infections (such as chlamydia) from infected men to their female partners. This latter finding is currently being tested in another randomized controlled trial, funded by the Gates Foundation, also in Rakai, Uganda.

The Biology of Male Circumcision and HIV Infection

Biological investigators have discovered that the tender mucous membrane surface of the inner foreskin contains a high density of immune system cells such as Langerhans, macrophages and CD4 cells. Ironically, from an evolutionary perspective the foreskin serves a protective function, both physically to guard the sensitive glans (head) of the penis from injury, and because those immune system cells normally protect the body from risk of infection. Yet because HIV enters the body precisely through the immune system, these same cells, which are more vulnerable to HIV infection due to the lack of keratinization (hardening) of the mucous membrane surface in the inner foreskin, now serve as highly efficient portals of entry or "magnets" for HIV. Laboratory investigations have found that absorption of HIV in the inner foreskin is up to nine times more efficient than in other genital mucosa, such as the cervical opening to the uterus.

As with all surgical procedures, circumcision carries some risks, particularly of pain, bleeding and infection. While the rate of complications in most clinical settings is low, and the vast majority are minor, circumcision as practiced in some traditional settings can be quite risky. Each year in South Africa, for example, dozens of boys and young men are seriously injured or die due to infections, exposure and other problems resulting from unsafe practices. The main reason for the decline in popularity of circumcision in Britain in the 1940s was that a number of male infants died each year, nearly all of them from the use of general anaesthesia. Local anaesthesia, which is now the recommendation for infant and teen/adult circumcision, results in no deaths and few serious complications.

Cultural, Ethical and Other Concerns

Some groups have alleged that circumcision is a form of "male genital mutilation," and South Africa recently passed a child protection law that would ban circumcision for those under age 16, in the absence of religious or medical reasons. Certainly, circumcision of neonates and young children probably raises the greatest ethical concerns, with critics asserting that the baby or young child is deprived of his ability to give informed consent for a permanent procedure, yet others argue that, as in the case of childhood vaccinations, parents should be supplied with the most accurate information in order to decide what is in the best interests of the child. In addition to conferring potential future health benefits, there are some more immediate benefits for the neonate, particularly the approximate 12-fold reduced risk of urinary tract infections during the first year of life. In most of Africa currently, the main programmatic issues revolve more around circumcision for men and teens, who would be able to provide informed consent, etc.

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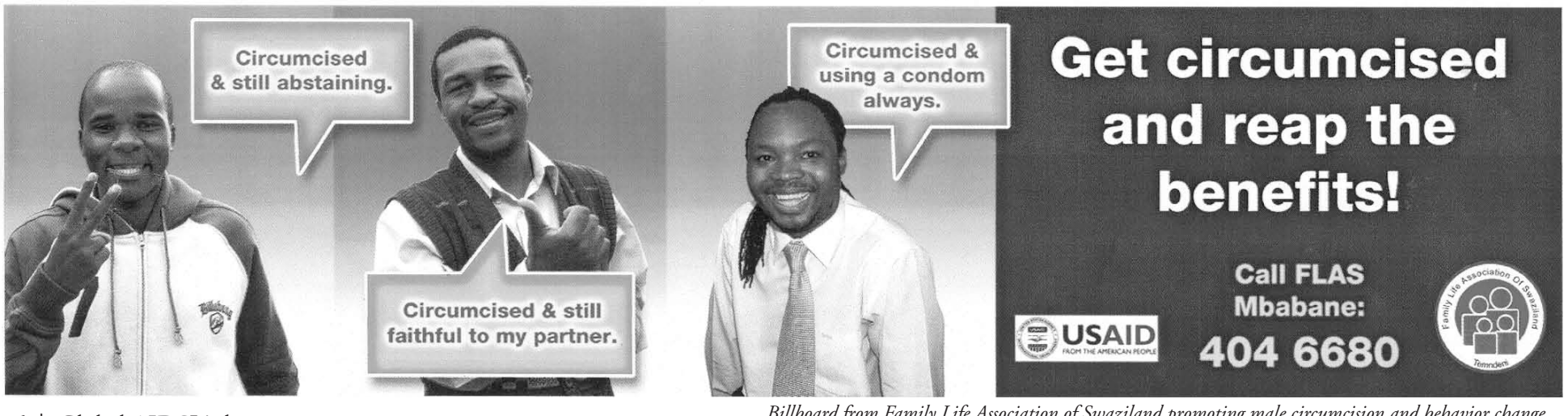


Billboard from Family Life Association of Swaziland promoting male circumcision and behavior change.

Breaking the mold in Brazil and India

Changing Gender Norms for Young Men

By Hena Khan
Communications Specialist
Horizons

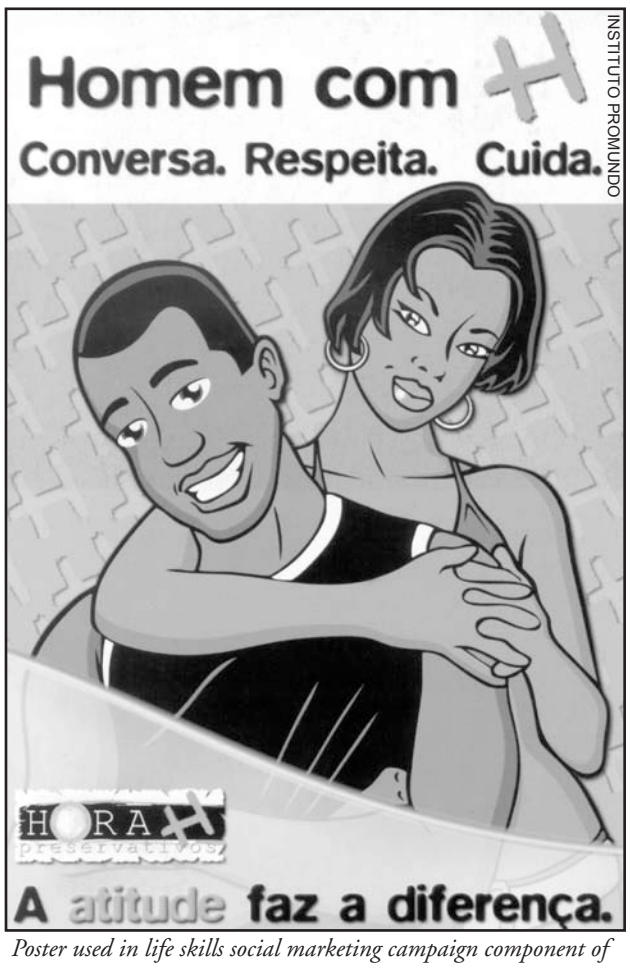
RECOGNIZING THE NEED to address inequitable gender norms in HIV prevention programs, and in order to measure changes in attitudes towards those norms, Horizons conducted research in Brazil from 2002 to 2004 on a gender-based intervention targeting young men.

The in-depth study was longitudinal, following a group of young men over time, and relied on multiple data sources to maximize the validity of the findings. This approach was successfully replicated for a pilot intervention in India where a larger intervention study to measure changes in gender norms is currently ongoing.

Challenging Traditional Gender Norms in Brazil

Teaming with Instituto Promundo, a Brazilian NGO, Horizons conducted a study comparing the impact of different combinations of intervention activities in three low-income communities in Rio de Janeiro: Bangu, Maré and Morro dos Macacos. The study followed a group of 780 young men aged 14 to 25.

The intervention, called Program H (from *homens* "men" in Portuguese), was designed to help young men challenge traditional norms related to manhood. One component consisted of interactive group education led by adult male facilitators, where they discussed sexuality and reproductive health, fatherhood, violence, emotions and preventing and living with HIV and AIDS. The curriculum included a manual and video to promote attitude and behavior change. Eighteen interactive exercises were conducted once a week for about two hours each over approximately six months (see Box at right).



Poster used in life skills social marketing campaign component of Brazil intervention. "Talk. Respect. Care."

The second component was a lifestyle social marketing campaign involving "peer promoters" – young men recruited from the community – to craft messages about how "cool and hip" it was to be a more "gender-equitable" male. The messages were delivered through billboards, postcards and dances. The campaign also stressed the use of condoms as part of this new lifestyle and introduced a new condom brand, Hora H.

In both Maré and Bangu, the young men received group education; in Bangu alone, they were also exposed to the social marketing campaign; Moro dos Macacos served as the control site with no intervention. Young men in each site completed three surveys: before the intervention, after six months, and again after one year. A group of young men in ongoing relationships, along with their female partners, also took part in qualitative interviews. To ensure multiple sources of data, facilitators kept careful records and met regularly with study coordinators to discuss their impressions of the sessions.

Using the Gender-Equitable Men (GEM) Scale, participants were asked whether they agreed, partially agreed, or disagreed with 17 statements focused on inequitable gender norms in five areas: violence; sexuality and sexual relationships; reproductive health and disease prevention; domestic chores and childcare; homophobia and relationships with other men. The young men also answered questions about HIV risk and prevention behaviors and outcomes.

At baseline, more than 70 percent of the young men reported that they were sexually experienced. About 25 percent had experienced STI symptoms during the previous three months, and 10 percent acknowledged physical or sexual violence against their most recent regular partner. Reporting of STI symptoms were substantially greater in those who indicated greater support for inequitable gender norms.

Interventions Change Attitudes and Behaviors

After the intervention, the number of young men supporting inequitable gender norms had decreased significantly, while those from the control site showed little or no change. At six-month follow-up, respondents in Bangu showed improvements in 10 out of the 17 GEM Scale items and 13 out of 17 in Maré. These changes remained or further improved at the one-year follow-up.

In Bangu, for example, 22 percent of respondents at baseline agreed with the statement, "I would be outraged if my wife asked me to use a condom." At six-month follow-up, this number decreased to 15 percent and at one year it declined further to 11 percent.

A program H discussion question

William asks Susana to go out with him one afternoon. They chat a little, have a bite to eat, and William invites her to a motel, saying he has some money to spend a few hours there. Susana agrees. They get to the motel and begin kissing and caressing. William begins to take off his clothes. Susana stops and says she doesn't want to make love. William is furious… He pressures her to change her mind. First he tries to be seductive, then begins yelling … pulling at her forcefully, pushing her down on the bed.

During indepth interviews, young men discussed how the workshops helped them to question their attitudes and behaviors. One young man said:

…I learned to talk more with my girlfriend. Now I worry more about her… it's important to know what the other person wants, listen to them. Before [the workshops], I just worried about myself.

Some female partners of workshop participants attributed positive changes in the partners' attitudes to the workshops. As one young woman said:

…[he] changed a lot [after the workshop]. When we first met each other [and started going out] he was very 'desligado' [focused on himself]…he didn't even want to meet my parents. He always had some excuse…but then he started to value the relationship more…another time he brought some information about STIs for us both to see… now we talk about these things.

Significant improvements were also found in key HIV/STI outcomes. At both intervention sites, participants reported a decrease in STI symptoms and a corresponding increase in condom use at last sex with a primary partner. In Bangu, the combined intervention site, the improvement in both areas was greater. In the control site, no change was found in either area.

Building on and Replicating Success in India

In 2005, Horizons and CORO, an Indian NGO, with input from Instituto Promundo, adapted the Brazilian

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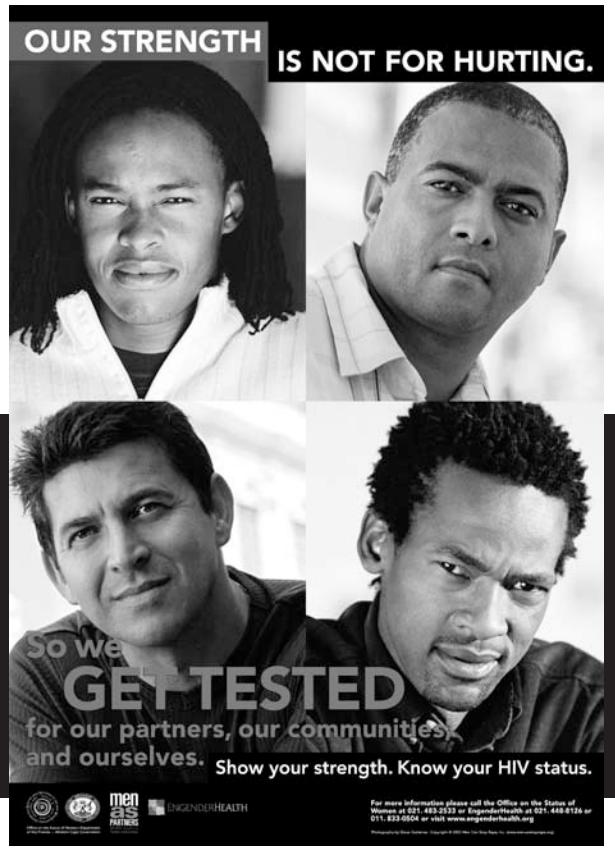
Transforming Male Gender Norms to Address the Roots of HIV/AIDS



By Andrew Levack
Director, Men as Partners Program
EngenderHealth

It is widely recognized that gender norms – societal expectations of men's and women's roles and behaviors – fuel the global HIV epidemic. Women's low status in many societies contributes to limiting the social, educational and economic opportunities that would help protect them from infection. At the same time, traditional male gender norms encourage men to equate a range of risky behaviors – the use of violence, substance abuse, the pursuit of multiple sexual partners, the domination of women – with being manly. Rigid constructs of masculinity also lead men to view health-seeking behaviors as a sign of weakness. These gender dynamics all play a critical role in increasing both men and women's vulnerability to HIV.

A Model for Working with Men

Over the past decade, a growing number of innovative HIV-prevention programs around the world have worked with men to challenge traditional gender norms. They are unique in allowing men to participate in a reflective process that explores how gender inequities and rigid messages about masculinity contribute to HIV, STIs, gender-based violence and other health-related problems. These programs also share a "transformative approach" that encourages men to challenge harmful gender norms and embrace alternative models of masculinity that support their own health. This can lead to improved communication with partners, increased condom use, reduction of sexual partners, delayed initiation of sex, increased utilization of HIV services, and an increased role in the care and support of people living with HIV/AIDS.

Transformative approaches share a set of operating principles. First, they view men in a positive light. Rather than portraying men as vectors of disease, these programs recognize that many are already playing a constructive role in the lives of their families and supporting the rights of women. They also recognize that masculinity can be defined and expressed in a variety of ways. Using the term "masculinities," suggests that gender norms are diverse, complex and dynamic. Transformative programs explore how masculinities are deeply intertwined with culture, race, class, age, socioeconomic status and sexuality.

Finally, all transformative programs recognize the need to work with women's groups to ensure partnership with and accountability to women. In the end, the goal of this work is to develop respectful, trusting and egalitarian relations between men and women that will attack the deep roots of HIV infection and enhance the lives of both sexes.

Implementing Transformative Approaches

Transformative programs for men exist in many countries, with most initiated by local and international NGOs. However, as this work expands, local and national governments are joining the process in settings such as schools, prisons, police wards and military bases.

Most transformative programs offer some type of intensive group process that encourages a very personal reflection on gender values, examining the costs to both sexes of negative gender dynamics. The workshops also provide an opportunity to explore progressive views of gender relations in a safe and supportive environment. Following the initial activities, participants are given information on a range of health issues, including HIV, and engage in exercises that constantly refer back to the issue of gender. For example, an activity about HIV transmission would explore what societal messages men receive that put them at higher risk for HIV.

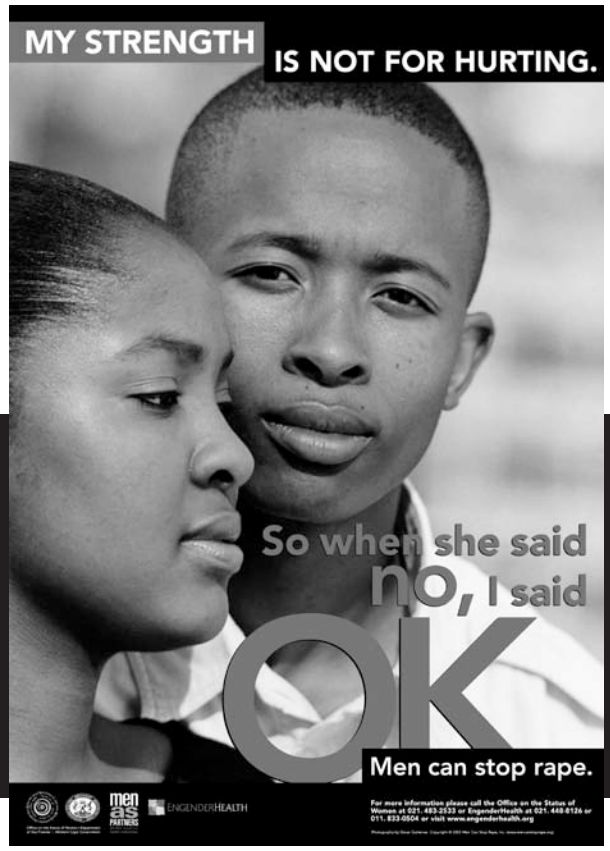
Transformational educational processes can work with men alone or bring men and women together. One of the best examples of the latter is Stepping Stones, a participatory gender-focused process that brings together men and women from a community to engage in a discussion and analysis of factors in their environment that make them vulnerable to HIV. This training methodology was designed in 1995 in Uganda and has since been adapted and modified to suit the needs of populations in varied settings throughout the world. Stepping Stones uses a series of 18 workshops with four groups of older men, older women, younger men, and younger women. At the end, the groups come together and the entire community entertains "requests for change" as the groups perform dramas reflecting the lessons learned. A great strength of the Stepping Stones approach is that it is works directly with a diverse group of community members to challenge harmful social norms within that environment.

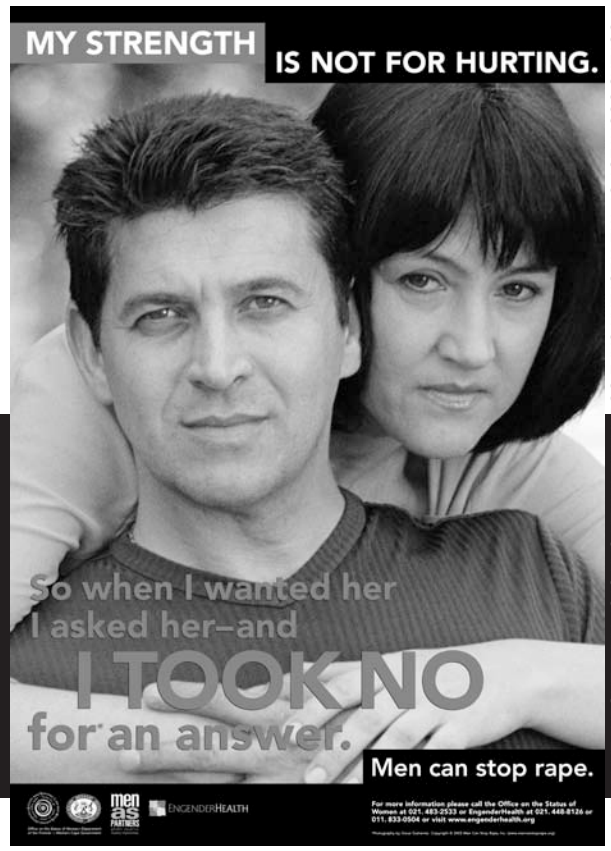

PHOTO BY OSCAR GUTIERREZ

PHOTO BY LOUISE GUBB

PHOTO BY OSCAR GUTIERREZ

From left, South African men taking an active stand for gender equality at community mobilization events.; far right, Mural reinforcing the Men as Partners message.





POSTERS COURTESY OF THE WESTERN CAPE GOVERNMENT/MEN CAN STOP RAPE/ENGENDERHEALTH

L-R: South African posters promoting positive male gender norms addressing HIV and gender-based violence.

An Ecological Model

Workshops with small groups of individuals in a community can be very powerful, but can also be limited in creating large scale social change. Once a workshop ends, participants return to a patriarchal society where change is not supported. To address this, many transformative programs with men have adopted an ecological model that addresses multi-faceted aspects of an environment to effect personal and social change. This includes implementing small workshops, mobilizing communities, supporting local institutions such as schools, NGOs and religious bodies to implement this work, working with media partners to conduct large scale campaigns, and supporting government structures to develop supportive policies and legislation.

There are many excellent examples of this holistic ecological model. In South Africa, for example, EngenderHealth's Men as Partners Program establishes community action teams made up of workshop participants to promote and sustain change in their personal lives and in their communities. The teams work closely with trained staff from NGOs to support events such as health fairs, community theatre and mural paintings with gender-related themes. Working together, team members reinforce a new social norm in which men take an active stand for HIV/AIDS prevention and the elimination of gender based violence, also introducing this norm in the environments where they live.

Other NGOs have adopted a variety of creative ecological efforts. In Brazil, Instituto Promundo's Project H implemented a lifestyle social marketing campaign that disseminated messages about gender equality through advertisements, peer promoters, and magazine articles. The campaign also associated gender equality with a specifically-designed brand of condom.

Another example comes from India, where a coalition of local NGOs and gender activists established a statewide campaign called Men's Action for Stopping Violence against Women, creating a social movement of men taking an active stand against gender-based violence. The campaign involves marches, rallies and large community events that reach thousands of men.

Larger media efforts are also starting to take hold. In South Africa, a consortium of NGOs working on men's issues has convinced the South African Broadcasting Corporation to devote news coverage and public service announcements to gender issues. Meanwhile, MenEngage – an international alliance of organizations working on gender issues – is recruiting national and international male celebrities to serve as gender equality ambassadors who will be mobilized to reinforce progressive gender social norms.

The Evidence Base of Transformative Work

There is an emerging base of evidence for the effectiveness of transformative approaches with boys and men such as the study from the Horizons Program and Instituto Promundo covered on p. xx in this issue. The World Health Organization recently commissioned a systematic review of the evidence base for health interventions that target men and boys. The review analyzed the findings from evaluations of 57 interventions. The majority confirmed attitude or behavior changes with men. In addition, the 27 interventions within the study identified as gender transformative were found to be more effective in achieving attitude or behavior changes than the other interventions in the sample.

Challenges for the Future

The emerging movement of work with men and boys brings optimism and also challenges. As the field grows, programs are being challenged to scale-up their interventions to reach larger numbers of men while also accounting for the complex nuances involved in adapting to different regions, countries and communities. Programs cannot be generically replicated in new settings, and communities are initially likely to resist the idea of challenging existing gender norms. To address this, programs must identify gender activists and professionals from within communities to champion this work and navigate it in an appropriate manner. As these leaders initiate new male programming, they should always retain the shared operating principles of this important work: to always serve the shared interests of women and men, and to view men as positive resource in creating a healthier more gender-equitable world.

For further information contact: alevack@engenderhealth.org.

PHOTO BY OSCAR GUTIERREZ

PHOTO BY OSCAR GUTIERREZ

Educational workshop from EngenderHealth's Men As Partners Program in South Africa. Participants work as teams to reinforce new social norms.

a letter from the president

Nils Daulaire
Global Health Council

Over the past quarter century, HIV/AIDS has shown its cruel propensity for flowing down through societies to selectively burden those with least power. In recent years, the global community has highlighted the "feminization" of the pandemic, recognizing the particular vulnerability of girls and women and the significant limits on their power to control their own sexual risks in social contexts where men control decision-making. Those who are most vulnerable and least able to protect themselves are appropriately the focus of global efforts to fight HIV/AIDS.

However, in highlighting those at greatest risk, there is a danger that we might neglect those who are both the vehicles for women's disempowerment and the source of their infections. To protect women and girls, we must better understand, and be better able to act on, the perceptions and behaviors of men and boys that heighten their risk of infection to themselves and to their partners.

Who are the high-risk transmitters of HIV? They are men in the armed forces, truck and bus drivers, men separated from their families because of labor conditions such as mining and migrant labor. They are injecting drug users, men who visit sex workers on a regular basis, men who have sex with men. They are older men who routinely victimize adolescent girls, and younger men who maintain a sexual scorecard. And they are husbands who have multiple partners and refuse to use condoms.

These are not easy behaviors to change, and our knowledge and tools to effect change are woefully inadequate. Condom distribution is a far cry from regular and appropriate condom use. Information dissemination on changing risky behavior generally falls on deaf ears among those who most need to be reached. Laws regarding gender violence are often ignored, both in the household and among local authorities.

This is not to say that changing male behavior is a hopeless task. But it is critical to recognize that the forces behind such behaviors are driven by deeply entrenched cultural norms that are manifest from earliest childhood as family, peer, social and even media pressures combine to buttress deeply unequal and harmful gender roles.

In the best circumstances, sex is about love, caring and nurture. But all too often it is about the exercise of power over another human being. Power drives violence against women, substance abuse, the pursuit of multiple partners. It inhibits care seeking, and even the willingness to listen to alternatives among those whose self-image and status are tied to appearing strong and certain. Sadly, the social consequences among peers of stepping out of these roles can be harsh for young men, so the cycle is deeply resistant to change.

The rigidity of the social definition of gender roles is particularly destructive when it comes to issues relating to men who have sex with men. Widespread homophobia drives clandestine and risky behavior that greatly increases the threat of infection and its spread. In fact, mass media campaigns in five Latin American countries have identified homophobia, not homosexuality, as a major driver of the pandemic.

But as our study and understanding of gender issues expands, made necessary by their central role in the spread of HIV, both new knowledge and new tools are emerging. This issue of *Global AIDSLink* is devoted to illuminating these questions and providing care providers with ways to better address these issues in their own communities. Changing social norms is always a slow process, and particularly with issues as deeply embedded as gender roles, but the stark reality is that cultures do change and evolve. Given that the survival of a large segment of humankind depends on it, a thoughtful and intelligent approach to modifying men's and boys' perceptions and behaviors is essential to accelerating and guiding those changes.

Perhaps a legacy of AIDS will be a world in which those gender norms that have been so deeply harmful to both men and women over the ages will finally be pushed aside for our common good.

MSM IN ASIA

DIVERSE, COMPLEX, EXCLUDED AND HIGH RISK

By Kevin Robert Frost
Vice President, amfAR
Director, TREAT Asia

Until the late 1980s, no Asian country had experienced a major AIDS epidemic, but by the late 1990s, the disease was well established across the entire region. UNAIDS reports some 8.3 million people living with HIV in Asia at the end of 2005, with more than two-thirds of them in one country – India. In the region, roughly one in six people, or 16 percent, who need antiretroviral treatment are now receiving it. And while significant progress has been made in Thailand, India still lags far behind providing antiretrovirals to less than 10 percent of people in need. Although the true size of China's epidemic has been difficult to estimate, the reported 650,000 people in China living with HIV is considered by most experts to be a significant underestimate. Injecting drug users (IDUs), of whom there are at least 1 million registered in China, account for nearly half the people living with HIV.

It is important to understand that Asia is dealing with multiple, overlapping and interconnected epidemics that have largely targeted marginalized, hard to reach populations, including IDUs, sex workers and men who have sex with men (MSM). And contrary to what many believe, these epidemics do not move in a single direction – from commercial sex workers (CSWs) to the general population for example – but in bi-directional or often multiple directions at the same time.

Male and female commercial sex workers and IDUs were the first communities seriously affected by HIV/AIDS in most of Asia and the Pacific with the epidemic spreading rapidly to sex industry clients and sexual partners of both populations. Today, sexual transmission is the driving force behind the burgeoning AIDS epidemic, with injection drug use playing a key role in several regions.

More recently, rapidly emerging epidemics among MSM have begun to raise concern. Male-to-male sexual activity is common but clandestine in Asia. A socio-cultural emphasis on having children compels many MSM to marry, and consequently have multiple partners, including women. MSM are often hard to reach with prevention messages, and condom use remains low, putting them at particularly high risk.

All successful HIV prevention work, from epidemiology and behavioral surveillance to planning, outreach and prevention programming, relies on understanding the target population. Gender roles and sexual behaviors among Asian MSM (as in many parts of the world) have been poorly understood, making it difficult to design effective interventions. Even MSM itself is an oversimplified term, within which lies a wealth of geographic, social, sexual, and gender diversity.

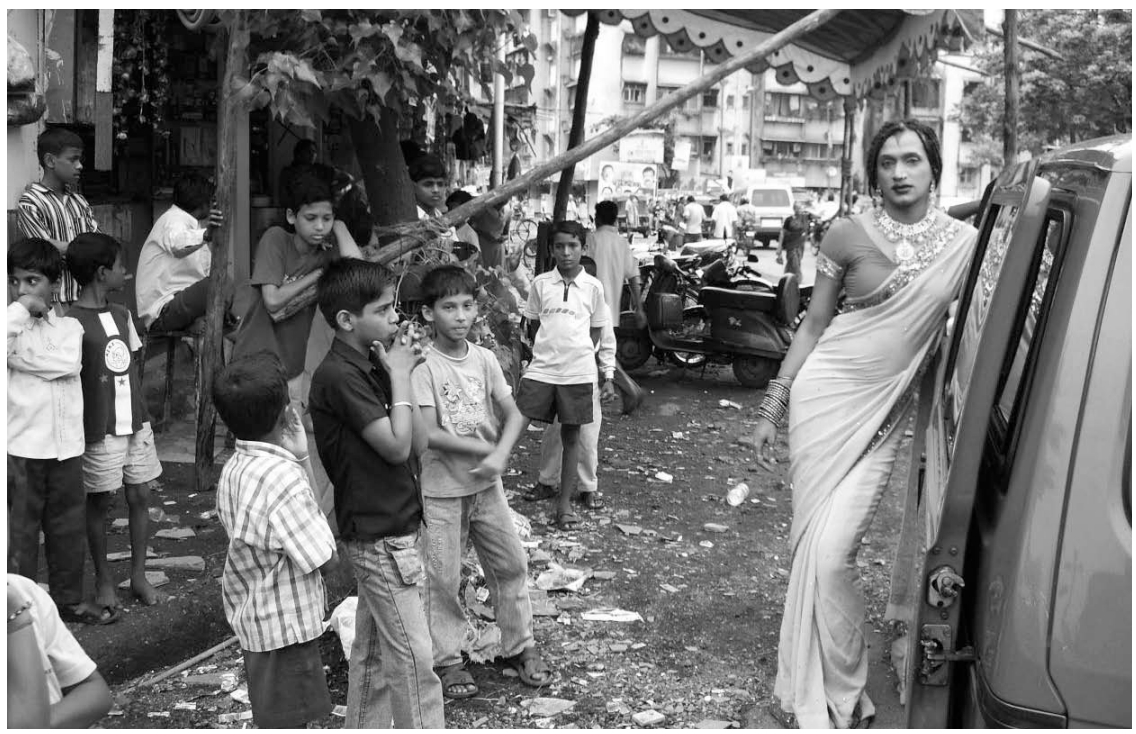
No Typical MSM

A "gay" or "homosexual" identity rarely applies in Asia. Instead, many Asian MSM define themselves by their adopted gender roles, as feminine and masculine, shaping both sexual behavior and personal relationships. The term "MSM" has been adopted in an attempt to focus on behavior rather than identity, and to include all men who have sex with men, regardless of how they see themselves. The term encompasses males who define themselves either by their sexual behaviors (e.g., gay men) or by their feminine gender identities (kothis, waria, katoey), in addition to their masculine identified sexual partners.

Importantly, external appearance and behavior (more feminine or masculine) often do not map neatly or predictably onto sexual behaviors such as insertive versus receptive roles for anal sex. And behavioral heterogeneity is also common to transgender communities, which have a significant history in Asia. These groups adopt identities ranging from a "third gender" distinct from male or female (the hijras in India) to that of a heterosexual female or even an effeminate male.

But even when several categories of MSM are detailed, this is not an adequate basis for understanding behaviors that can transmit HIV. Although it is imperative to understand the language and classifications of local sexual cultures, this research can easily reinforce cultural stereotypes rather than explaining why the stereotypes exist. MSM behaviors are often personally more fluid and variable than popular stereotypes convey.

Asia is a vast region of both industrialized and developing countries where traditional and more modernized conceptions of MSM identity exist, often side by side. The balance may shift as countries develop, but local variation is a persistent theme. Detailed studies are needed to determine the nature of different sub-groups of MSM and their distinct beliefs and behaviors.



Transgender communities in Asia adopt different identities ranging from a "third gender," such as the hijrus in India to heterosexual female or even effeminate male.

The evolving mix of identities within MSM populations in Asia creates additional threats for the spread of HIV/AIDS. MSM in the West are particularly vulnerable to infection because their social networks are dense. If sexual contacts within a network are frequent, HIV can spread rapidly – a more recent infection is up to 1,000 times more likely to be transmitted than an earlier one. But even without frequent sexual contact, dense networks present a significant risk of a concentrated epidemic and create conditions for a rapid rise in prevalence rates. Once a few individuals are infected, there are many pathways through which the contagion can be spread.

The complexity of MSM populations in Asia means that there are both dense and overlapping looser networks of more widely dispersed individuals who have male-male sex more sporadically and opportunistically. The first group provides the substrate for initial rapid rises in prevalence rates, while the second group provides the conduit for spread to wider populations.

Many countries with low overall HIV prevalence will have HIV rates among MSM that are far higher. This is reflected in the disproportionately high MSM caseloads. For example, of reported HIV cases in the Philippines and Hong Kong, 23 percent and 24 percent respectively are attributed to MSM compared to overall prevalence of less than 1 percent in each country.

MSM in Asia show multiple risk factors that include: misconceptions about risk factors; high levels of unprotected anal intercourse; high levels of transactional sex; high numbers of sex partners; and low perception of self-risk. Stigma contributes to these behaviors by reducing self-esteem, creating an antagonistic policy environment (blocking condom access; marginalizing MSM relationships and venues), and causing neglect by those who should be providing appropriate health messages. With male-male sex often illegal or unacknowledged, most MSM cannot gather in socially sanctioned venues. Instead, they congregate where sex is solicited or sold. This greatly

Continued on page 19

MUYENDE BWINO TRAVEL WELL

PHOTO BY ELDSON CHAGARA/WFP

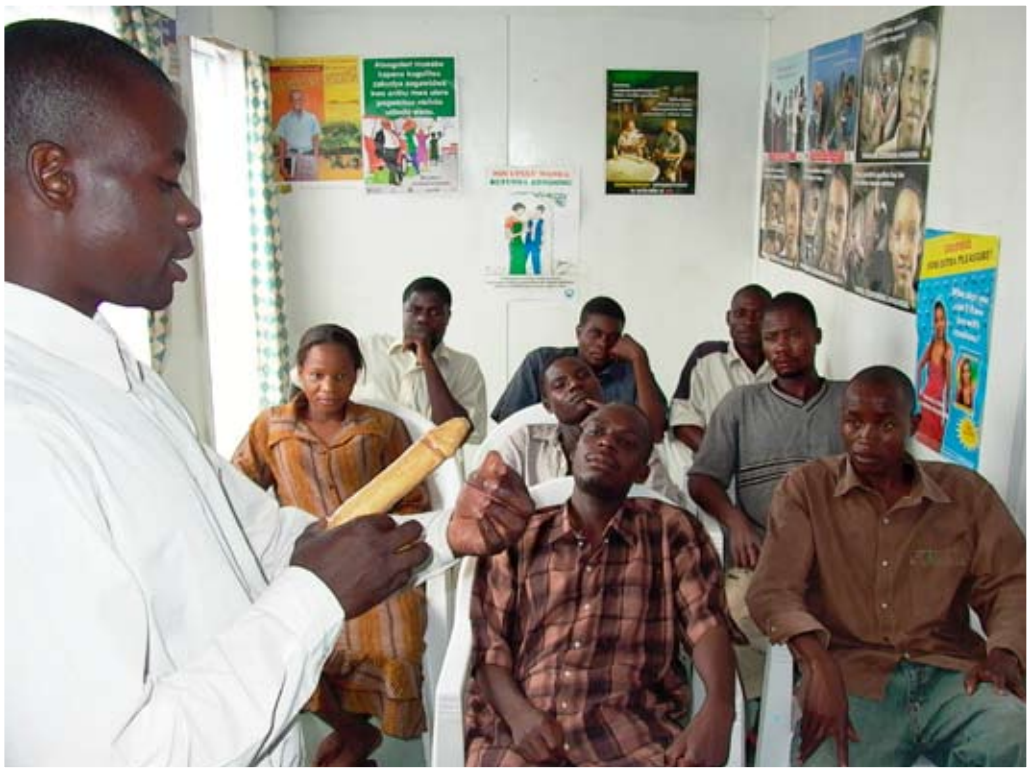


PHOTO BY ELDSON CHAGARA/WFP

PHOTO BY LAURA MELO/WFP

A multi-partner HIV prevention program for long distance drivers in Malawi

By Robin Landis
HIV/AIDS Program Adviser
World Food Program

"Most of the truck drivers, they do sleep around … from one place to another they change women just like that… We are seeing people suffering and dying of all these diseases which are not being treated."

– A truck driver in Malawi

IN SOUTHERN AFRICA, humanitarian crises result in huge quantities of food being transported by road. Sexual networks flourish along transport routes, placing long-distance truck drivers, including those who move food aid for the World Food Program (WFP) at the intersection between saving the lives of others and risking their own.

As the world's largest humanitarian agency and a major transport contractor, WFP depends on long distance truck drivers to haul food aid to areas in critical need. Ironically, the truckers who enable WFP to fulfil its mission may also be endangering their own lives as they unknowingly expose themselves to HIV while on the road. WFP's core business depends heavily on the health of truck drivers as well as on the business health of the companies they work for.

No Free Ride for Truckers or their Partners

It is nearly impossible to fully measure the economic impact of HIV/AIDS on the transport sector. Recent evidence from southern Africa found that 46 percent of transport companies were suffering as a result of AIDS-related deaths and absenteeism. One transport company in Zimbabwe calculated AIDS-related costs add up to 20 percent of its operating budget; and a transport owner in Malawi considered closing down because it was so difficult to find enough qualified drivers. Long distance truck drivers work long hours, go without sleep, and stay in inhospitable places while away from their wives and families. When they stop, many find companionship with sex workers or strangers. Young women are attracted by the economic opportunities in stopover towns and often willing to trade sex for cash, goods or a free ride. But the ride is not free either for the driver or his partner, as these junctions become "hotspots" for HIV transmission.

Pictures depict the Muyende Bwino Pit Stop in Mwanza, Malawi, at the border point with Mozambique, which offers HIV and STI prevention information, condoms, treatment of STIs and minor ailments, and referrals to HIV testing and treatment programmes free of charge. Man-to-man education sessions are held regularly with drivers and group sessions are open to women at risk and other community members. In its first year of operations, over 1,200 STIs were treated and 110,000 male and female condoms were distributed.

Truckers have received much attention around HIV prevention. But evidence continues to show that few know enough to protect themselves and others. With an estimated 5 million long-distance drivers in India alone, truckers everywhere are at a critical crossroads between preventing and spreading the virus. Programs designed specifically with truckers needs in mind are limited in scope.

Under immense pressure to deliver their cargo regardless of road conditions, weather, or even their own health, truckers are moving targets – impossible to reach through standard health-delivery systems. Many never get treatment for even the most common ailments because clinic hours don't match their schedules, there is insufficient parking for heavy vehicles, or their cargo might be stolen while they are inside a facility.

Along for the Ride

Based in Amsterdam, TNT is a global mail and express delivery company that operates in 200 countries. The attacks of Sept. 11, 2001, became a decisive moment for the company's focus on global social responsibility. TNT CEO, Peter Bakker, looked for ways to use the same core competencies that make TNT a worldwide corporate success. He was also seeking a respected, global partner that could benefit from the company's expertise as well as one that shared TNT's hands-on, no-nonsense culture. This led him to WFP, with whom, in 2002, TNT established a multi-million dollar partnership to tackle the greatest logistics challenge of all: fighting world hunger.

Businesses, such as TNT, which rely heavily on road transport, are in a unique position to help put the brakes on the HIV epidemic. Although the Global Business Coalition Against AIDS stated recently that the transport industry lags behind other sectors in its response, TNT is working to change that. When management realized that industry practices can endanger its drivers and fuel the epidemic, they switched into high gear. Along with WFP, which fields up to 5,000 trucks in 83 countries on any given day, the two joined forces to quickly become part of the solution rather than part of the problem.

Hitting the Road

After several years of fruitful partnership, WFP and TNT executives looked for other ways to address the burgeoning epidemic in southern Africa. Landlocked Malawi presented a unique opportunity to work in a place that was experiencing both high HIV prevalence and increased road traffic due to a food crisis.

The WFP/TNT team consulted numerous stakeholders, and from all corners of Malawi – government, business, NGO and UN – repeatedly heard the same reprise: "We are tired of studies. You need to do something." So WFP, TNT and a few other key partners turned what started out to be a three-month feasibility study into a full-blown pilot project.

Getting a load of partners on board, (the Malawi ministries of health, transport and labor, the Malawi Revenue Authority, the Road Transport Operators Association, the Transport Workers Union, the Malawi Business Coalition against AIDS, GDC Whelsons Transport, Banja La Mtsogolo, Project Hope, Ikaheng HR Services) and with support from the Swedish Trust Fund, TNT and WFP all bought into the plan. Just eight months after the first exploratory visit to Malawi, the Muyende Bwino Pit Stop opened its doors to the public.

Muyende Bwino – Travel Well

Realizing early on that other groups had already figured out what works and what doesn't, TNT and WFP partnered with them to avoid wasting time, talent, money and maybe most importantly, professional credibility on any more studies. The South African network of roadside clinics, part of the Trucking against AIDS project, served as a model pilot project in Malawi. The Malawi government, private sector, UN, NGOs and donors stepped up to contribute money, drugs, condoms, the site for the center and the portable containers that house the education materials and the clinic.

Only a year old, the Wellness Center has already covered some ground. Strategically placed at the Mwanza border crossing between Malawi and Mozambique, it is open at convenient hours for the truckers required to stop at the border post for clearance in and out of Malawi.

The center has a private examination and treatment room as well as an assortment of multimedia education materials on preventing HIV and sexually transmitted infections (STIs). It is staffed with a clinician who treats STIs and other ailments, provides individual counselling, condoms and referrals to voluntary counselling and testing (VCT) and follow-up services. The outreach worker is trained in health promotion and regularly holds man-to-man education sessions or group sessions on demand. In its first year, more than 1,200 STIs were treated; more than 10,600 people received prevention information; almost 110,000 male and female condoms were distributed, and 1,600 people were referred for HIV testing. Although specifically targeted to male drivers and their assistants, women at risk in the area as well as the wider community are welcome to, and do use, the services.

PHOTO BY ELDSON CHAGARA/WFP

According to Dr. W. Tamaona, district health officer in Mwanza, "The establishment of Wellness Centres in Malawi is a milestone in the delivery of health services." The Wellness Centre in Mwanza has generated essential lessons and illuminated several issues for the future. Below are some of the most important points:

- Transport owners are reluctant to lead but will follow. Although it was unanimous that something needed to be done, no transport owner felt it was his place to take the lead. Yet, all said that if someone else started they would follow.

- Location, location, location. Sites need to be selected where drivers already congregate. After waiting at the border for many hours, often overnight, the last thing they want to do is to stop again.

- Broaden focus beyond HIV and STIs. Providing treatment for common ailments, like headaches and backaches and flu symptoms as well as STIs helps minimize the stigma around HIV-related services.

- Emphasize responsibility. Counselling and education sessions should include information and discussion about taking personal responsibility for one's own health and the health of partners and families.

- Sustainability rests with the transport industry. Ensuring sustainability will require buy-in by a range of stakeholders and ultimate ownership by the road freight industry itself.

The Road Ahead

Borders are irrelevant for both truckers and HIV. Transport workers need access to quality primary health services while on the job. A regional network of wellness centers could include a "smart card system" that would keep track of diagnosis and treatment details, allowing any driver to report to any center in the network to get personalized care.

The ultimate goal is to keep truckers healthy, productive and on the job in order to protect their partners, their families and their livelihoods. That means keeping businesses running smoothly and the paychecks coming in.

WFP cannot save lives unless it invests in the good health of its transport workers. Humanitarian agencies partnering with the transport industry can reduce the risk to both the industry and those who depend on it.

All Aboard

Both TNT and WFP recognize that the rolling out of wellness centers on a grand scale will depend on creative, multi-sectoral partnerships, led by the transport sector. So both partners are continuing and expanding their catalytic role to promote a new foundation that will bring together transport-related businesses and other socially responsible corporations to finance and sustain the replication and scale-up of these services.

The North Star Foundation will take a leading role in involving the industry in reducing the growth of HIV/AIDS in the transport sector and supporting the creation and growth in the network of wellness centers for transporters in sub-Sahara Africa, Asia and Latin America. The foundation is working with local partners and international donors to address the transport sector's role in spreading HIV and other illnesses in poor countries. It is seeking support from businesses, especially those related to the transport sector.

For more information on the WFP/TNT partnership or Wellness Centres in Malawi contact robin.landis@wfp.org. For information on the North Star Foundation write to info@north-star-foundation.org.

Realities of HIV/AIDS in Russia's Armed Forces

ALL PHOTOS BY YULIA ZUBKOVA

Russian military medical workers and soldiers receiving HIV prevention training in Pskov, Mizhnu Novgorod and Orenburg.

A beginning response

By Ari Davidov
Program Officer
Population Services International CPSD/Russia

Over the past decade, Russia's million-man-plus armed forces have had to adapt to a host of new realities. No longer part of the former Soviet Union, the Russian military has had to modernize many aspects of its inner workings, while remaining the guarantor of security and stability in a region spanning 11 time zones from Europe to the Far East.

In the background of well-publicized geopolitical and economic dynamics, a new kind of threat has gathered: the increasing spread of HIV and other STIs in Russia and the wider region of Eastern Europe and Central Asia. The need to upgrade the Russian military's response to HIV is now being recognized as urgent.

Russia, HIV and the Military

Russia is now experiencing one of the fastest growing HIV epidemics in the world. Although the overall prevalence rate is less than 1 percent, the incidence has increased dramatically in recent years – more than 90 percent of the roughly 350,000 officially registered cases of HIV infection in Russia occurred since the year 2000, according to the Federal AIDS Center, 2006. UNAIDS (2005) puts the actual number of infections in Russia at more than 1 million.

Data presented in September 2006 at the Russian-American Conference on HIV/AIDS Prevention shows a total of 2,275 HIV cases diagnosed in the Russian military since 1988, the year monitoring began. The number of diagnosed cases peaked at 664 in 2001, and by comparison, 2005 saw only 100 new cases. The actual extent of HIV infection among members of the Russian armed forces is difficult to ascertain because testing for HIV while in the service is not common. Clearly, if HIV testing were to become more readily available, or even routine, to the troops, this data would become more representative.

Empirical evidence from armies around the world shows that HIV prevalence in the armed forces is often in line with (if not worse than) that of the general population. Recruits are primarily young, sexually-active men stationed far from their homes who become prone to practice risky behaviors. Indeed, anecdotal evidence from a variety of sources in the Russian military suggests high incidence of drug use, unprotected commercial sex taking place in proximity to military bases, and a highly stressful environment, including sexual violence among recruits. Credible research in this area, if conducted, has not been released.

The majority of recruits come into the Russian military from remote rural areas where exposure to HIV prevention messages is sparse. This is a key reason why their general knowledge associated with HIV transmission is woefully inadequate. First-ever research conducted by PSI/Russia (2006) at the Pskov military division demonstrated considerable deficiencies in knowledge, attitudes and perceptions relating to HIV. Responses of 344 soldiers to surveys showed that only one-third knew that HIV cannot be transmitted through dirty dishes. A low 59.2 percent reported condom use, and overall, a bare 25 percent demonstrated adequate risk perception of STIs and HIV.

Several factors paint a worrying picture of the potential danger HIV presents to the Russian armed forces. The small number of officially registered HIV cases combined with a low level of basic

knowledge on HIV transmission, and high-risk behaviors among personnel may result in the unfolding of an underreported HIV pandemic in the armed forces at any time. A robust prevention program is needed to counteract this danger.

Building Awareness

Although acceptance of the real threat to Russia of HIV has been slow in coming, growing recognition that the stability of the military and the security of the country is at stake has driven renewed attention to HIV and STIs.

This recognition has also been stimulated from the outside, in large part by the U.S. Department of Defense and USAID, which initiated a joint program with the Russian Ministry of Defense aimed at opening up channels of communication on HIV though roundtable discussions and exchanging experts and observers. While this joint work has achieved tangible results at the higher levels of military command, implementation has not yet filtered down to the troop level where it is most needed and where currently most resistance is occurring. Field commanders most often expect the education system to teach young people the particulars of safe behavior, believing the military's own education system is in no position to do so.

Existing HIV programs for personnel were instituted in the early 1990s (prior to the sharp increases and awareness of HIV infection rates in Russia) and modified only slightly since. Prevention programs have been, and largely remain, a small part of a single module on healthy lifestyle incorporated in the standard soldier training curriculum, among general topics on hygiene and STIs. It is supplemented by scattered behavior change communication materials on sanitary practices such as rudimentary "refresher" booklets and standard posters.

Creating a Collaborative Climate

A more intensive HIV epidemic, such as the one now observed in Russia requires a much greater level of prevention knowledge, skills and engagement by the military's medical staff and service members alike. Working with NGOs such as PSI's Russia mission is proving beneficial in moving toward this goal.

A series of preparatory steps initiated by PSI/Russia laid the ground work for what has become a vanguard HIV prevention pilot program, a model to be replicated and scaled up. These steps began with a necessary policy dialogue with senior military leadership – stakeholders who are in a position to make or break any effort that is undertaken. Their willingness to work with an NGO was not immediate. But initial resistance gradually diminished in the course of ongoing meetings, which went a long way in building a fund of trust necessary for collaborative headway.

Given the dearth of information about the HIV/AIDS situation in the Russian military, PSI/Russia began to identify specific risk factors, discuss possible prevention strategies and learn the mechanics and protocols of conducting HIV-related activities in the armed forces. Engaging military doctors, sanitary specialists, commanders and advisers in constructive dialogue proved effective, leading to the endorsement of the project, which took the form of an official letter of approval from the highest level of the ministry of defense.

The Strategy Takes Hold

Once agreement was reached in April 2006, intense work to develop, pre-test and revise the details and materials of PSI/Russia's education program began. An important lesson learned at this stage was that chief medical officers' buy-in at the target military bases is equally as essential as the special orders from the higher-ups. This phase culminated during the summer months, when final approval was secured from the Russian Ministry of Defense.

What became known as PSI/Russia's VOIN project (an acronym translated as "military initiative") is the most comprehensive HIV and substance abuse prevention program in the Russian military to date. It comes under the umbrella of GLOBUS, a broad HIV prevention and treatment strategy implemented by a consortium of Russian NGOs and supported by the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis.

The VOIN project is currently being implemented in Pskov oblast, one of the western-most regions of Russia. This pilot program consists of in-depth training of military medical personnel and unit elders, who in turn provide training for the soldiers according to a set curriculum. This is supplemented by wide-scale distribution of materials. Barely out of the gate, this new program has already had successes – 120 military medical professionals have received training, they have already trained close to 1,000 soldiers, and roughly 2,000 pieces of material have been distributed at this division alone.

New Chances for New Beginnings: Scaling up

The VOIN project is central to the future of HIV prevention in the Russian military. First of its kind, the model designed to create a model of military HIV prevention to be replicated at military installations and medical schools in other parts of the country. The program is already being reproduced in Orenburg, Tver, Nizhniy Novgorod and other regions. In 2007, it hopes to reach more than 500 military medical workers and, by way of training them to become HIV prevention trainers, it is projected to reach roughly 10,000 soldiers.

Comprehensive HIV prevention programs need to be activated force-wide across the country, and the VOIN project can serve as a benchmark for their implementation. Initial steps are being taken to encourage the scale up of the VOIN project to the national level, thus encompassing the full gamut of the military services.

On the policy level, the effort would benefit greatly if centralized directives were issued, emphasizing HIV prevention programs to the troop level commanders, making them higher priority, and institutionalizing them into the inner workings of the military medical establishment. Of course, more needs to be known about the real presence of HIV in the military. For that to happen, consistency is needed in the federal statutes concerning HIV testing of recruits, as currently only a handful of municipalities perform it on their own at drafting stations.

At the troop level, improving the generally low levels of HIV prevention knowledge and skills of the medical staff and soldiers must be addressed with greater intensity. Increasing the capacity of individual divisions' HIV and substance abuse prevention programs is imperative. All this takes vigorous advocacy on an individual basis, from one division to the next across the country.

Work in these areas is in various stages, but one thing is hitting home – a far more adequate response is needed to the threat that HIV nowadays poses to Russia and its armed forces.

For more information contact: ari@psirussia.ru.

Youth in India Explore Gender Norms and Risky Behavior

Young girls in slum community in Chennai where they engage in full participation to decide on focus and content of the interviews.

By Aprajita Mukherjee, Program Associate,
HIV/AIDS and Development, India
Praneeta Varma, Program Manager, Research and Mis, APAC, India
and Sarah Degnan Kambou, Director HIV/AIDS and Development
International Center for Research on Women (ICRW)

"When you establish sexual relationship with a girl in love, it is a way of making the relationship complete and keeping the girl."

– Adolescent boy in slum community of Chennai, Tamil Nadu, India

As the trajectory of the HIV epidemic in India becomes more clearly identified, national prevention strategies are placing greater emphasis on youth as a key high-risk group. Young people between the ages of 15 and 24 are both the most threatened – globally accounting for more than half of all new infections – and the greatest hope for turning the tide against AIDS. The few countries that have successfully decreased national HIV prevalence have achieved these gains mostly by encouraging safer behavior choices among young people.

Socio-cultural norms act alternately as sanctioning and disciplining forces, yet when it comes to gender and sexuality they are difficult to untangle and often remain unexplored by program designers. Engaging youth, particularly young men, in redefining their norms of masculinity and femininity is an emerging area of prevention programming in India where a key factor contributing to new HIV cases is the pressure of societal norms that maintain women's low status and encourage men's control over decisions and resources. This also includes decisions that affect sexual behavior and HIV risk, such as use of condoms or engaging in multi-partner relationships.

Testing a New Strategy

Gender Mainstreaming in HIV/AIDS was a two-year USAID-funded community-based intervention project from 2004 to 2006 that explored gendered vulnerabilities to HIV in select key populations in the states of Tamil Nadu and Maharashtra. The International Center for Research on Women (ICRW) collaborated with two partners in Tamil Nadu: the AIDS Prevention and Control (APAC) Project, a USAID partner; and the Brother Siga Social Service Guild, a local NGO that implements an AIDS slum intervention project under APAC's supervision and technical guidance.

Aiming to develop more gender-responsive interventions, the project piloted a participatory approach to increase staff knowledge, awareness and capacity to deal with gender, sexuality and HIV-related stigma. Central to its strategy was the expanded involvement of targeted populations in determining the focus and content of interventions. In Chennai, Tamil Nadu, the project broadened the scope of its slum interventions to look at the gender-differentiated risks and vulnerabilities of unmarried youth between 17 and 24 years. In Sangli, Maharashtra, the project addressed systemic HIV-related stigma, experienced by widows living with HIV and AIDS who are often denied their rights to property and inheritance and subjected to discriminatory practices in the household, community and judiciary spheres.

With an eye to social change, the project adopted a participatory strategy of interactive methodologies that empower individuals and communities to undertake analysis and action-planning and address community-defined challenges – in this case the risks and vulnerabilities of unmarried adolescents.

Using Participatory Tools to Determine Attitudes

The project used a host of participatory tools with outreach workers and youth facilitators to elicit gendered attitudes and behaviors that influenced the HIV risk among youth living in the Chennai slum. Some 10 boys and 10 girls in separate groups over a period of four days explored their attitudes and beliefs around gender and sexuality and how these beliefs increased their risk to HIV.

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The results revealed a range of gendered vulnerabilities readily identified and cataloged by the youths themselves. Peer pressure, entrenched notions of femininity and masculinity which encourage risk-taking behavior such as multiple partners, sexual coercion, and lack of access to information on transmission and prevention put both young men and women at high risk.

Not surprisingly, prevailing norms of masculinity exert a huge influence on how young men behave and interact with the opposite sex. Sexual experience is an important component of their self-definition, as is the ability to hold onto sexual partners. 'A man should be like a man' – was a phrase they often used to express ideal masculine behavior. This usually included virility, physical strength, and the ability to earn money.

'Aunty Sex'

Male youth were found to be particularly vulnerable in relationships euphemized as 'Aunty Sex' which refers to sex between young men or boys and married women for money or sexual experience. Young men discussed how they saw these relationships as mutually beneficial. Married women were able to derive sexual pleasure from a physical relationship where they could 'ask for' and 'receive' pleasure lacking in their marital relationship, especially where the husband invariably played a dominant

sexual role. For young men, sex with a married woman was viewed as a 'perfect learning ground' since she was not perceived as 'risky' for HIV infection as a sex worker. They also mentioned how young boys yearning to gain sexual experience established relations with eunuchs; but when they wanted to end this relationship, the eunuchs paid them money to continue it. In all such sexual encounters, condoms were rarely used.

Where Young Men Get Their Information about Sex

The exercises also highlighted the sources of information about sex accessed by young men. Prime among these are 'blue films,' or soft-core pornographic videos and they cited a widespread lack of information on sexual health and hygiene.

Given the strong patriarchal nature of Indian society, where gender norms are strongly etched and upheld, male youth clung to well-defined views on the characteristics of an ideal woman. Drawing cartoons, male and female youth described the qualities of an ideal man and woman. They associated femininity with personal qualities such as tolerance, patience and gender roles such as 'good mother' or 'good daughter.' They also identified fidelity as an important characteristic. It is interesting to note that while most of the boys preferred an educated wife, their expectations were deeply traditional and included the importance of her cooking well, keeping the family together, and nurturing and caring for family members.

Building a Core of Activities

Based on these findings, the Chennai project initiated a process to determine specific activities in the slum with the youth and outreach workers that would meet the following objectives:

- Address gendered norms that increase vulnerability of young boys and girls;
- Create an enabling environment for young boys and girls to discuss issues of sex, sexuality and sexual and reproductive health;
- Address stigma and discrimination directed at people living with HIV/AIDS.

Building on a pre-existing slum intervention model, the project identified a core group of male and female peer educators as well as core groups of 'significant others,' such as parents, as separate sex-identified groups of mothers and fathers. In addition, three separate modules that addressed gender norms, sexual health and stigma related to HIV/AIDS were developed.

Through systematic training and capacity building, Bro Siga Social Service Guild staff learned how to apply these tools, and once trained, the outreach workers and peer educators animated a series of trainings and discussions after which the group spread the message through formal and informal means to others in the community – youths to their peers, and mothers and fathers to their own social networks.

In the intervention sites, a focused and intensive implementation phase, which lasted only six months, showed significant movement in young people's perspectives on gender and sexuality, while the control site showed little if any change. Data described graphically in Table 1 demonstrate clearly the shift in how young people value women's role in the family. In responding to the statement "A woman's most important role is to cook and take care of her family," an increasing number of youths, including boys and girls, disagree with the statement denoting a shift in attitudinal thinking about gender roles. This change is significant for both male and female youth although the change is slightly greater for young women.

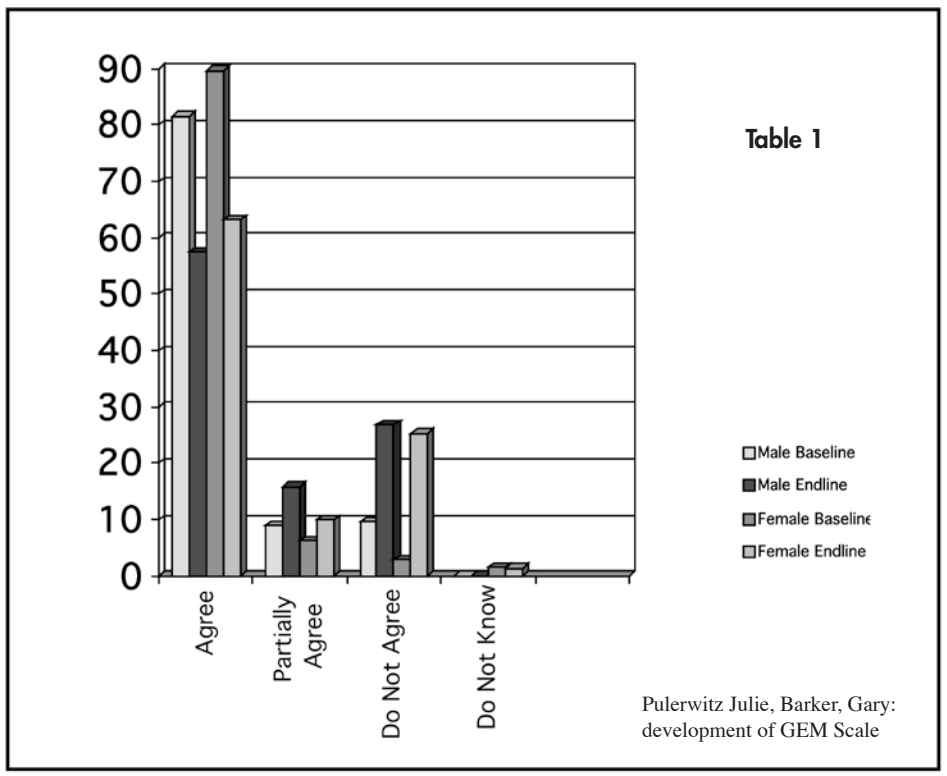

Table 1

Pulerwitz Julie, Barker, Gary: development of GEM Scale

Similar changes were also recorded in knowledge related to sex and sexuality as well as on the desired nature of sexual interactions. In responding to the statement: "You don't talk about sex, you just do it," and as illustrated by Table 2, the endline results showed an increase in youths who disagreed with the statement as compared to the baseline data. It is significant to note here that such changes in perception were recorded in both boys and girls. The endline results thus highlighted more open communication about engaging in sex and the importance of partner communication – especially by young women. There was a parallel increase in knowledge regarding HIV prevention, particularly in correcting information on modes of transmission and in expanding knowledge of local condom sources – where significant increases were recorded, particularly among young girls. New sources were identified and greater percentage of girls now knew where they were available.

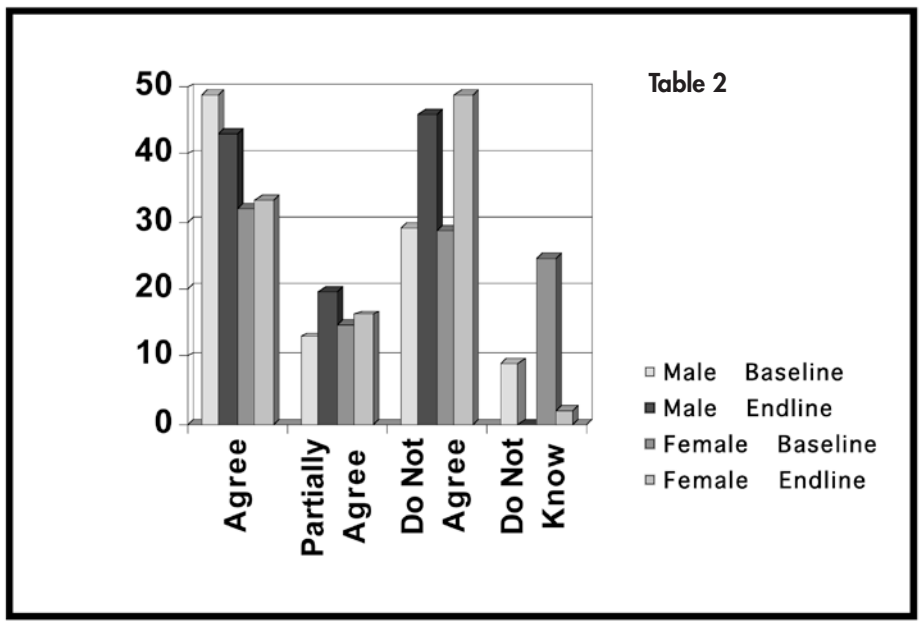

Table 2

A similar trend also emerged on how 'women' who carry condoms with them were perceived by both male and female youth. The endline compared to the baseline showed a reduction in condemnation of girls who carry condoms. As in the other cases, the larger change in attitude was registered among female respondents. This change in perception has significant implications for HIV prevention. To be able to create an enabling and non-judgmental environment where youth, particularly young girls, are able to access services without feeling discriminated against and stigmatized is critical to successful strategies. Community norms and peer influence and perception often act as impediments restricting access, so influencing such perception is critical.

Lessons Learned

The planning, implementation and results of the pilot project indicate lessons and pathways to mainstream gender into HIV/AIDS programming and address the underlying factors that create and exacerbate risk for youth as an essential program component.

The Chennai experience demonstrates clearly that an experiential approach to project planning and implementation enhances staff confidence around sensitive issues such as gender and sexuality and increases their effectiveness. It also clearly establishes that addressing gender norms strengthens the design and implementation of technical intervention programs like HIV prevention. What is of great importance here is the complete involvement of the target group in defining the focus of the exploration and intervention. "Ownership" of the project by the target group, who then lead the implementation, is the key to successful project management and to achieving significant impact

Mainstreaming and Integrating Gender – the Only Way to Go

The underlying and entrenched social norms around gender and sexuality need to be explored and addressed through community-driven and community-led interventions. Participatory processes work, best when anchored in iterative cycles of reflection, experimentation and application of learning. In addition, gender should be reflected systemically across all program sectors within an organization and not be limited to specific projects. There is no doubt that gender mainstreaming as a process begins as an added responsibility for the implementing project staff, but with the creation of skills, space and scope and the gradual demonstration of the model's effectiveness, gender mainstreaming activities can become integrated into everyday activity. Gender mainstreaming thus becomes an essential part of organizational development and evolvement rather than a separate project activity.

For further information contact: a.mukherjee@icrwindia.org.

Circumcision – Continued from page 6

Are African Men (and Women) Interested in Male Circumcision?

Ascertaining the acceptability of adult male circumcision, especially in the high HIV prevalence regions of Africa is essential. In more than a dozen studies from nine African countries so far, the median proportion of uncircumcised men wanting to become circumcised, if the procedure were offered safely and affordably, was 65 percent (range 29-87 percent). In the studies, which surveyed women (also in areas where circumcision is not traditionally practiced), a majority similarly reported preferring a circumcised male partner. The most common reason given by both men and women is the belief that it results in improved penile hygiene, which is reported nearly universally across all the studies.

Another very common reason reported is perceived protection against other sexually transmitted infections. For example, in an unpublished study of 400 Swazi men in January of this year, 81 percent believed that circumcision reduces the risk of sexually transmitted infections, while only 18 percent said that it reduces the risk of HIV infection. Furthermore, 54 percent of the non-circumcised men said they would want to be circumcised, and when asked, "if circumcision reduces the spread of HIV, would you like to do it?" 87 percent said yes, suggesting, as in other studies, that if information that circumcision definitely reduces HIV risk is circulated, an even greater increase in demand for services is likely to occur.

In fact, men in some parts of Africa have recently been "voting with their feet," with some public and private facilities in southern Africa reporting being inundated with men seeking out clinical circumcision services. Wait lists for elective circumcision at public hospitals in several countries, including Lesotho, Swaziland and Zambia, are now six months or longer.

One important concern, similar to the introduction of a future HIV vaccine, microbicide, etc., is that people who opt for circumcision may engage in "risk compensation" i.e. may increase their level of risk-taking behavior (have more partners, use condoms less, etc.) resulting from a false sense of security. Clearly it will be very important to ensure that scale-up of circumcision services is carried out within the overall rubric of comprehensive HIV prevention and male reproductive health efforts, and the message must be disseminated widely and continually that it certainly does not offer 100 percent protection.

What about Sexual Pleasure?

Another question often raised is whether male circumcision reduces sexual pleasure. Most of the evidence to date seems to suggest otherwise. Although some believe that circumcised men experience less "sensation," they appear to have fewer sexual problems overall, including less premature ejaculation and erectile dysfunction. Only a few methodologically sound studies of female preferences have been conducted. In all of them, including studies conducted in Botswana, Kenya and United States, most women, including those who had an uncircumcised partner and were familiar with both types, reported preferring the circumcised penis, mainly for reasons related to hygiene, as well as the belief that, for example, circumcised men "last longer" during intercourse.

As previously mentioned, some critics of male circumcision argue that it represents a form of "mutilation" that causes hidden trauma, which may in turn lead to a higher risk of post-traumatic stress disorder, rape, suicide, and even warfare, among other consequences. There are, however, no scientific studies to support such views. Also, some people oppose circumcision on a more philosophical basis – "nature makes no mistakes" – whereas others disagree, arguing that the natural form is imperfect and that, as with other cultural or medical practices such as piercing or vaccinations, circumcision "improves" on nature.

Conclusion

In several regions of Africa, such as Botswana and parts of South Africa and Malawi, a principal reason for the disappearance in the 19th and early 20th centuries of traditional initiation rites of passage, which included male circumcision, was the influence of Christian missionaries, who deemed such practices as pagan. More recently some faith-based institutions, such as Chogoria Hospital in Kenya, have established programs which combine traditional African coming-of-age practices with a safe clinical circumcision procedure and counseling around HIV prevention, reproductive health and gender issues. Certainly many health facilities in Africa and some other developing regions, whether public, private or faith-based in nature, could potentially help to meet the expected surge in the – already substantial – demand for safe, affordable, voluntary male circumcision and reproductive health/prevention services, especially in those areas beset by very high rates of HIV infection.

For further information contact dhaperi@camail.harvard.edu;dhalp@worldwidedial-up.net. Websites for further information: www.circinfo.net; www.circinfo.net/htmlnew/circumcision_sources.htm; www.medicirc.org; www.circumcisioninfo.com/halperin_bailey.html; http://circum.cjb.net; www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=40384

Horizons – Continued from page 7

model to Mumbai, India, developing a pilot program of activities called *Yari-dosti*, Hindi for friendship or bonding among men. Preliminary research highlighted concepts of masculinity in the Indian context, such as the physical and social attributes of a "real man" or *asli mard* in Hindi. These traits included being dominant and aggressive, and demonstrating sexual power over women. Condom use did not figure prominently into the lifestyles of the young men, except with sex workers whom they associated with AIDS.

Working with the Program H curriculum, the team conducted workshops and community consultations and pre-tested 20 group exercises. Adaptations for India included changing characters, story lines and examples, and, in a few cases, the format and content of the exercises.

The pilot intervention involved 126 young men, aged 18-29, over a six-month period. Participants were divided into four groups and enrolled in an intensive week of group educational activities, facilitated by both peer leaders and adult gender "specialists." This was followed by two- to three-hour sessions led by peer leaders every week for six months. Changes in attitudes toward gender norms were measured using a 24-item GEM Scale that was pre-tested in Mumbai.

Shifting Gender Norms for Improved Health

At baseline, as in Brazil, the young men in India largely supported inequitable gender norms. For example, almost half agreed with the statement: "It is the man who decides what type of sex to have;" and over a third agreed with the statement: "A woman should tolerate violence in order to keep her family together." Those who reported physical violence against a female partner over the last three months and those who consumed alcohol regularly were more supportive of inequitable gender norms.

Substantial positive attitude changes were reflected after the intervention. For example, the proportion of young men who agreed that, "There are times when a woman deserves to be beaten" decreased from 31 percent to 14 percent. Respondents who agreed that, "Women who carry condoms on them are easy" decreased from 55 percent to 19 percent.

In addition, there were some post-intervention indications of reduced violence and other risk behaviors. Self-reported harassment of girls over the past three months (referred to as "eve teasing" in India) significantly declined. There was also a small reduction in reported violence against sexual partners, and a trend toward increasing condom use at last sex with any sexual partner.

Real Men Have the Right Attitude

Based on the results of the pilot intervention, a larger evaluation of the intervention is currently in progress in India with more than 1,000 young men in urban Mumbai and rural settings in the state of Uttar Pradesh. In some sites group education activities are combined with a community-based lifestyle social marketing campaign, similar to that used by Program H in Brazil. The campaign in India promotes a gender sensitive and violence-free lifestyle for young men in the community. With a tag line of "*soch sahi mard vahi*" ("real men have the right attitude"), the campaign consists of street plays, posters, pamphlets, banners and a service and information booth. Intervention results, forthcoming in 2007, will provide additional data about the impact of a gender-focused intervention.

The results from Brazil and India have been taken up and utilized in a number of contexts, including sites in Africa, where gender-based intervention activities are being implemented and the GEM Scale is being used to evaluate them.

For more information about these studies, visit www.popcouncil.org/horizons.

Resources

The Global Fund, with its partners **Friends of the Global Fight** and the **United Nations Foundation**, has launched a new interactive mapping project to support the *"Hope Spreads Faster than AIDS" campaign*. The campaign allows people to support the Global Fund and its life-saving work by signing a Declaration of Hope and adding themselves to an interactive map. Once registered on the map, individuals can build a network of supporters for the Global Fund and the fight against AIDS by inviting friends and family to join and literally watch hope spread across the globe. Visit www.jointheglobalfund.org today and help show the world that *"Hope Spreads Faster than AIDS."*

The HIV/AIDS Alliance and its partners have produced a CD-ROM containing more than 200 publications and resources. Available in multiple languages, it includes lessons learned, reports and studies, technical support publications, policy reports and briefings on a variety of HIV/AIDS issues ranging from prevention, civil society development, care, support and treatment, as well as orphans and other vulnerable children. A free copy can be ordered at www.aidsalliance.org/sw10249.asp.

Focusing on antenatal care (ANC), **Frontiers in Reproductive Health (FRONTIERS)** released two publications analyzing the implementation of WHO's new ANC package in Kenya and Ghana. In Ghana, the study compared the performance of clinics implementing the new policy with those using the standard ANC approach and found unevenness in the implementation and the impact of the policy. The Kenyan adaptation also includes measures to detect, treat and prevent the transmission of HIV and malaria. To view the full reports, e-mail frontiers@pcdc.org.

The **International HIV/AIDS Alliance** and **Family Health International** have published an updated version of the CD-Rom on supporting orphans and other vulnerable children with more than 650 documents. Topics included community-based support to orphans and vulnerable children. Each section and sub-section has explanatory notes as well as the accompanying resources. This toolkit is for people and organizations that support NGOs and CBOs in developing countries that work with children. For a free copy of this CD-ROM go to: www.aidsalliance.org/sw31913.asp.

Measure DHS released four new publications focusing on 2004 assessment surveys in Guyana, Egypt and Guinea. The report for Guyana found that advanced services, including antiretroviral therapy and PMTCT are available in less than 10 percent of health-care facilities. In Egypt, the survey found that 95 percent of facilities assessed offer family planning services and have supplies of modern, temporary contraceptive methods. In Guinea, the DHS found that infant mortality rates remain very high at 91 deaths of babies under age one out of 1,000 live births. Overall, about one child out of six died before reaching their fifth birthday. Malnutrition rates among children are also high; one out of every three children suffers from chronic malnutrition. To view the full report on Guyana, visit www.measuredhs.com/pubs/pub_details.cfm?ID=591&srchTp=advanced, Egypt, www.measuredhs.com/pubs/pdf/SPA7/SPA7.pdf and Guinea, www.measuredhs.com/pubs/pub_details.cfm?ID=582&PgName=country&ctry_id=67.

Assembled by the **Bridge Project**, the *Hope Kit* is a package of resources designed to facilitate discussion about HIV prevention among community groups in Malawi. The Hope Kit is a collaborative effort that consists of locally developed posters, information cards, booklets and sample materials to support community facilitators. To see materials, go to www.m-mc.org/spotlight/malawi_hopekit/index.php.

The latest in its biennial series of AIDS vaccine blueprints, **International AIDS Vaccine Initiative (IAVI)** has released a new publication of the *AIDS Vaccine Blueprint 2006: Actions to Strengthen Global Research and Development*. This year's Blueprint takes a comprehensive look at the achievements and challenges facing AIDS vaccine science and policy, and provides a series of recommendations and related goals to move the field closer to developing a vaccine. It includes an assessment of vaccine candidates in the pipeline, a discussion of key scientific obstacles challenging the discovery and development of a vaccine, an analysis of critical financial, policy and developing country capacity building issues that need to be addressed and recommendations to speed progress on a vaccine. For copies, go to www.iavi.org/blueprint or email pubs@iavi.org to obtain a hard copy by mail.

MSM – Continued from page 11

increases the chances of greater promiscuity. In Bangladesh, for example, 26 percent of MSM respondents to a recent survey averaged over 10 different sexual partners a month. In Cambodia, MSM participating in focus groups stated that the more hidden MSM tended to have a greater number of partners, and fewer long-term relationships. And in India, the stigmatized and disempowered kothi (feminine men who are nonetheless often married) are more fatalistic about HIV risk.

This has led to rapidly rising rates of HIV infection among MSM in Asia, led by an exploding epidemic in Thailand. Research conducted by the Thai Ministry of Public Health and the U.S. Centers for Disease Control and Prevention Collaboration (TUC) showed HIV prevalence of 17.3 percent among MSM in Bangkok in 2003. The picture has continued to become more dismal. When the study was expanded to three cities in 2005, prevalence had risen to 28.3 percent among MSM in Bangkok. This figure was actually higher than the corresponding figure for Bangkok male sex workers, which was 15.4 percent for venue-based and 22.6 percent for street-based male sex workers. Infection of Bangkok MSM was happening early too: more than 20 percent were HIV-positive by age 22. Remarkably, not one of the 491 men who tested positive in the 2003 study had reported that they were positive in an earlier questionnaire, probably because few had been tested and others were unwilling to disclose their status.

Swift and Specific Action Needed

The complexity of Asia's HIV epidemics in MSM is so daunting as to have left many governments without the knowledge or technical expertise to deal with such diverse and often loosely defined populations. Further, the societal taboos which prevent the frank and open discussion of such sensitive topics has meant that political leaders are unwilling or unable to support the kinds of programs that will be necessary to address these rapidly expanding epidemics. Thus, if Asia is to avoid the wide spread devastation of rapidly increasing epidemics in its MSM populations, swift and specific action will be necessary, including more vigorous political leadership that recognizes the problem, encourages groups to provide services for MSM, and adequately supports these services. The programs will require the inclusion of MSM in all efforts to address the epidemic, including all partnerships between government and civil society. The inclusion of MSM in routine HIV/AIDS surveillance so that all parties can assess needs, plan a response, and evaluate outcomes is essential to the acceptability and appropriateness of these programs to MSM. The unique nature of MSM communities and the social rules by which they live must be investigated so that appropriate interventions can be designed. And finally, recognition of male-male sex in all education, prevention, and clinical efforts to stem the epidemic, i.e., accurate education about the risk factors associated with anal sex; prevention messages that address male-male sex without supporting stigma; condoms and lubricant made more readily available at sites where MSM have sex; clinics for HIV testing and STI and HIV/AIDS treatment must be made easily accessible to all MSM.

The best programs are built around a participatory approach in which peers help each other overcome barriers to adopting safe behaviors. Early successes are emerging that incorporate many of these recommendations: one program in Indonesia has reported a threefold rise in consistent condom use among MSM and a fourfold rise in lubricant use. Such peer-led programs are often run by nongovernmental organizations. But the need remains to bring government into the equation so that those in power realize the extent of the MSM epidemic and contribute to the response. Real partnerships between government and civil society are the only way that both large-scale and community-based responses can be effectively marshaled. The time has come to educate, deploy political capital, and deliver the financial resources needed so the continent can minimize the rapidly emerging and devastating epidemics in its MSM populations.

For further information contact: kevin.frost@amfar.org

GlobalUpdates

AFRICA

Zimbabwe ARV Prices Increase Monthly

The price of antiretroviral drugs in Zimbabwe has increased by 50 percent to 65 percent over the last three months. A month's supply of imported ARVs sold at pharmacies increased from about $40 to $66 in August. The cost of locally manufactured drugs rose from $40 in July to $62 in August and again in September from $83 to $103. Locally manufactured drugs can cost more than imported ones because of the high cost of raw materials. About 600,000 HIV-positive people in Zimbabwe need antiretroviral treatment, and the government's treatment program covers only about 42,000 people.

– *Xinhua News Agency*, Sept. 26

Uganda Seeks Death for HIV-Positive People who Have Sex with Minors

Ugandan law-makers are drafting a bill that seeks the death penalty for HIV-positive people who perform sexual acts with minors with or without consent. Some human rights groups in the country say the bill is "off target," adding that instead of emphasizing capital punishment, more effort should go toward increasing HIV/AIDS awareness campaigns. Other groups opposed to the bill worry that if capital punishment becomes mandatory, the problem will be driven underground.

– *Mail and Guardian*, Sept. 14

African Broadcast Media Campaign to Fight HIV/AIDS

The African Broadcast Media Partnership against HIV/AIDS, which includes 37 major public and private broadcast companies, is launching the first multi-year, pan-African campaign across 24 countries to raise public awareness about HIV/AIDS. The campaign is part of a five-year effort to significantly increase the amount of HIV/AIDS-related programming by African broadcasters. African television and radio stations will devote at least 5 percent of airtime – about one hour per day – to HIV/AIDS programming. The partnership aims to halt the spread of HIV, inform HIV-positive people that they can live normal lives and urge young people to practice safer sexual habits that reduce their risk of contracting HIV.

– *Reuters*, Sept. 22

ASIA

Filipino Government Urged to Increase Condom Promotion

The Filipino government was urged to increase promotion of the country's "100 percent condom use" program in a joint statement issued by the World Health Organization and the U.N. Population Fund. The Roman Catholic Church, which has a strong influence over government policy in the Philippines, has refused to condone condom use to prevent disease transmission and instead encourages people to use natural birth control methods or to abstain from sex. According to officials, the country needs to increase HIV prevention efforts targeted at groups that engage in high-risk behaviors to prevent the spread of the virus to the general population. The government since 1984 has recorded 2,566 HIV cases and 287 AIDS-related deaths. Some experts estimate the number at 10,000 to 15,000 HIV-positive people.

– *South African Press Association*, Oct. 6

Chinese Government to Boost Cooperation with NGOs

The Chinese government plans to increase its support for NGOs working on HIV/AIDS. Since 2002, the government has appropriated about $2.5 million for 231 NGO projects to fight the epidemic in 30 provinces, municipalities and autonomous regions. In addition, 72 NGOs in China have received $450,000 from the Global Fund. About 43 percent of the $29 million Global Fund pledge to China in the latest funding round will be used to support NGO programs. The Chinese government estimates there to be 650,000 HIV-positive people in the country, 75,000 of whom have developed AIDS. According to the government, in 2005 there were 70,000 new HIV cases and 25,000 AIDS-related deaths. The country's current HIV/AIDS prevalence is approximately 0.05 percent, according to government statistics.

– *China Daily*, Oct. 4

Ho Chi Minh City expands HIV Treatment to Pregnant Women

Ho Chi Minh City is expanding access to no-cost HIV/AIDS treatment for pregnant women to prevent mother-to-child transmission. In July 2005 the city's health department launched an HIV prevention program in two main obstetric hospitals and in 24 health clinics. The program provides pre- and post-natal care, HIV follow-up tests and free antiretroviral drugs for HIV-positive pregnant women and their infants. In 2005, 684 of the 133,622 pregnant women who received an HIV test were found to be HIV-positive, and, of those women, 90 percent received no-cost ARVs, and their infants received formula for six weeks at no cost. The ministry of health is reviewing the program's efficacy to determine whether it should be applied to other provinces.

– *Vietnam News Service*, Oct. 3

HIV-Positive Matchmaking in India

The Network of Surat People Living with HIV aims to help as many HIV-positive people as possible find compatible partners by hosting sessions called "HIV+ Find a Life Partner," where HIV-positive men and women, often shunned by their families and communities, meet and talk about marriage. "Let them find, choose and decide on a partner. It will add a new spark to the lonely lives and give them a new zest to start all over again," said Daksha Patel, an event organizer. Many HIV-positive people "face acute stigma" because of misconceptions and lack of education. HIV-positive people and advocates have been pushing for a law to prevent discrimination against people living with the virus but have said the Indian government is intentionally delaying action on the legislation.

– *Reuters UK*, Oct. 2

HIV Discrimination High in South Korea

Despite high levels of knowledge about HIV/AIDS, discrimination against HIV-positive people is widespread in South Korea, a recent survey conducted by the Korea Federation for AIDS Prevention reports. According to officials, more than half the respondents said HIV-positive people "should be subject to complete isolation." In addition, foreign workers in the country who test positive for the virus could be deported. In 2005, there were 3,829 reported new HIV cases among South Korean residents and 512 reported new cases among foreigners, but many were likely not reported out of fear of discrimination.

– *Korean Times*, Sept. 29

India Doubles Access to No-cost HIV/AIDS Treatment

India's National AIDS Control Organization (NACO) has increased the number of health centers that provide no-cost ARVs from 54 to 100. All centers have physicians, laboratory technicians and counselors on staff, and are located in states with high HIV incidence. NACO officials are also planning a massive publicity campaign that will include newspaper, radio and television advertisements, and posters detailing treatment centers to be placed in health centers across the country. According to a NACO statement, 85,000 HIV-positive people are expected to use the centers over the next six months.

– *Reuters India*, Sept. 28

CENTRAL AND EASTERN EUROPE

Conference Calls for Increased Regional Support

An international parliamentary conference on HIV prevention in Eastern Europe and Central Asia in Kyrgyzstan, called for more commitment and leadership to reduce the spread of HIV in the region. There are an estimated 90,000 HIV-positive people in the region concentrated among young people and fueled primarily by injection drug use. Erkinbek Alymbekov, deputy speaker of the Kyrgyz parliament said, "Law-makers in the region have the most important role in the adoption and implementation of effective measures to fight the HIV and AIDS epidemic." Conference organizers said that the spread of HIV over the next 10 years would stall economic growth by about 20 percent in Uzbekistan and 10 percent in Kyrgyzstan and Kazakhstan.

– *IRIN News*, Sept. 26

Kazakhstan to Launch $53M Program to Fight HIV

Kazakhstan is planning to roll out a $53 million program through 2010 to fight the spread of HIV in the country. The program from 2006 through 2010 will target people ages 15 to 49 and will address five key issues: HIV/AIDS policy, HIV prevention, HIV/AIDS treatment, care and support programs for HIV-positive people and social programs for those affected by the disease. Kazakhstan has recorded more than 5,000 HIV cases.

– *Kaiser Daily HIV/AIDS Report*, Sept. 24

Homophobia Hinders HIV/AIDS Efforts in Jamaica

Negative attitudes toward homosexuality is one of the biggest challenges to addressing HIV/AIDS in Jamaica, where sexual relations between men carry a penalty of up to 10 years in prison. Although "great strides" have been made toward the acceptance of gays and lesbians in Jamaica, a "kernel of violent bigotry remains," making the work of HIV/AIDS advocates more difficult, according to HIV/AIDS advocates. The common perception that HIV affects largely the gay population, has not been totally wiped out," said Daniel Townsend, Jamaica AIDS Support. "We now need to focus our energies on women, who are one of the most vulnerable groups in our population."

– *Inter Press Service*, Sept. 26

LATIN AMERICA

HIV/AIDS in Caribbean Greatest Threat to Region's Security

HIV/AIDS in the Caribbean poses the single greatest threat to the region's security, delegates at the Fifth Caribbean Chiefs of Mission Conference on HIV/AIDS in Barbados declared. AIDS-related illnesses are the leading cause of death for people ages 15 to 44 in the region, accounting for 27,000 deaths in 2005. The Caribbean remains the region most affected by HIV/AIDS after Africa, with 330,000 infected with HIV/AIDS.

– *Caribbean Media Corporation*, Sept. 26

UNESCO Continues Jamaica HIV/AIDS Initiative

UNESCO's Caribbean Office recently said the agency will continue funding "EDUCAIDS" to fight HIV/AIDS in Jamaica. The initiative is funded primarily by the Japanese government, the Global Fund, UNICEF and the World Bank. Several countries are involved in EDUCAIDS, but Jamaica is the only Caribbean island participating. EDUCAIDS in Jamaica will focus primarily on improving professional development and strategic planning to fight the spread of HIV and will help produce HIV/AIDS educational materials to support the ministry of education and youth.

– *Caribbean Media Corporation*, Sept. 25

NORTH AMERICA

NYC increases HIV Tests in Prisons

As part of its mayor's campaign launched in 2004, HIV tests administered in health clinics, jails and prisons have increased by 50 percent in New York City. The city's Health and Hospitals Corporation (HHC) tested 92,000 people for HIV through June 30, an increase from 58,000 people the previous year, as well as identified 1,514 patients in 2006 as HIV-positive, compared with 720 in 2005. The increase in HIV testing was aided by the use of rapid HIV tests producing results in minutes and by the adoption of a state rule that eliminates some pretest counseling requirements. HHC over the next year plans to test 150,000 people.

– *The New York Times*, Oct. 13

New Jersey to Establish Needle Exchange

A controversial New Jersey bill aims to establish needle exchange programs in six cities and provide $10 million to drug treatment programs. According to the New Jersey Department of Health and Senior Services, 14 percent of new HIV/AIDS cases in the state in 2005 were attributed to injection drug use. The state budget and appropriations committee must approve the bill for it to go to the state Senate and Assembly for consideration. But the committee has not yet taken action on legislation that would have allowed the nonprescription sale of up to 10 syringes. The bill still faces opposition. Needle-exchange programs in the U.S. are not federally-funded and are opposed by the White House.

– *USA Today*, Oct. 3

California Governor Vetoes Prison Condom Distribution

Governor Arnold Schwarzenegger of California recently vetoed a bill that would have allowed not-for-profit organizations and public health organizations to distribute condoms, dental dams or "other sex-related protective devices" to California's 162,000 prison inmates. The bill was sponsored by the AIDS Healthcare Foundation, AIDS Project Los Angeles and the Southern California HIV/AIDS Coalition. "We are disappointed that the governor missed an important opportunity to interrupt one of the major paths of transmission of HIV, from paroled prison inmates who unknowingly expose their spouses or significant others to HIV," said Michael Weinstein, president of AHF.

– *Los Angeles Times*, Oct. 2

WESTERN EUROPE

EU Residents' Misconceptions about HIV Transmission

Nearly 50 percent of EU residents ages 15 years and older continue to have misconceptions about how HIV is transmitted, according to a survey released by the European Commission. According to the survey, 54 percent of respondents said that HIV can be transmitted through kissing, and 45 percent said that sharing drinking glasses or toilet seats with or donating blood to HIV-positive people can result in transmission. Most of the respondents said they know that eating meals prepared by, shaking hands with or holding objects touched by HIV-positive people cannot result in HIV transmission.

– *AP/San Francisco Chronicle*, Oct. 2

Timeline

January 2007

Jan. 22-25
HIV/AIDS and the Impact on Business in Africa
Location: Sandton Convention Centre, Sandton, South Africa
Organized by: IQPC SA
Join distinguished speakers in finding solutions to minimize the effect HIV/AIDS is having on business. There is an increase in loss of skills, and absenteeism is on the rise. Join the First Open space Technology conference. For more information contact Cheryl Smith or visit www.aidsafricaconference.com.

May 2007

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

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

May 29 – June 1
34th International Conference on Global Health: Partnerships Working Together
Location: Washington, D.C.
Organized by: The Global Health Council
The conference is dedicated to exploring global health relationships: how they are built, what they have and can deliver, and how those living in poverty and disease can best benefit. For more information, visit www.globalhealth.org/conference/.

May 31 – June 3
ACTHIV
Location: Dallas, TX
Designed for all front-line clinicians who provide HIV care for adults, adolescents, children and pregnant women. For more details, visit http://acthiv.org; and contact: Molly Bartkowski.

June 2007

June 25-28
International Union against TB and Lung Disease – Eastern Region
Organized by: Ministry of Health Malaysia, Malaysian Association for the Prevention of Tuberculosis, International Union against Tuberculosis & Lung Disease
Location: Kuala Lampur, Malaysia
The conference will address the growing trend of HIV/TB co-infections in Asian countries. Emphasis will also be placed on the other core challenges of the TB control programs, such as early diagnosis, effective treatment access and equity, and treatment compliance with Directly Observed Treatment- Short Course (DOTS). For more information, visit www.tibi2007.com; contact: Grace Chong.

July 2007

July 4-7
International Women's Summit – Changing Lives, Changing Communities (Women's Leadership on HIV/AIDS)
Organized by: World YWCA, International Women's Summit and International Community of Women Living with HIV/AIDS
Location: Nairobi, Kenya
The conference will bring together 1,500 women leaders of all ages and HIV status. Diverse workshops will celebrate and expand the power of women's leadership. This summit will build skills, help strengthen existing networks, and create new partnerships in order to mobilize needed change and address the global HIV and AIDS pandemic and its impact on women and girls at all levels. For more information, contact Clarissa Balan at clarissa.balan@worldywca.org.

July 22-25
4th IAS Conference on HIV Pathogenesis, Treatment and Prevention
Organized by: International AIDS Society
Location: Sydney, Australia
For more details visit www.ias2007.org; contact: Karen Bennett.

August 2008

Aug. 3-8
XVII International AIDS Conference
Location: Mexico City, Mexico
Organized by: International AIDS Society
Visit website at www.aids2008.org, contact: Karen Bennet for more details.

Waking Up in Prison

PositiveVoice

By Dmytro Sherembey,
Co-founder of Chernihiv branch of All-Ukrainian Network of PLWH and
Regional Development Specialist of All-Ukrainian Network of PLWH.
Translated by Alexander Kulchenko

WHEN I WAS DOING DRUGS and my life lost all sense I said – "If there is any higher power that created this Universe then answer me – " 'Why do we live at all?' "

I was heard – in exactly 12 hours I was put in jail. My "happy" life was over and I had time to think about my past life and find sense and strength for new. I understood there may be no other chance to do so.

My teenage years were turbulent. I wanted to try everything and believed that was exactly what life was all about. But I didn't understand what it was leading me to. I started doing drugs when I was 13, but even before that I had started smoking and drinking. I loved to travel, but ironically and thankfully, at the age of 14, prison became my final destination, where I spent nine and a half years. Why do I say thankfully?

In prison, I realized that I cannot continue to lead the same lifestyle. Living for drugs and other "pleasures" doesn't differ from an animal life, in which there is no choice. I came to understand that my life is limited by the times I do drugs and takes me to nowhere. I didn't want to see my family, didn't want them to see me in that condition. I was avoiding everyone and understanding that I hurt them made me think. That's why I told myself – there should be some sense in my life.

I found out that I was HIV positive in 2002 when I was 25 and out of prison for two years. My years of doing drugs caught up with me. I had taken one of my friends to a rehab center and decided to get tested, too. It wasn't much of a surprise when the doctor asked a nurse to leave the room before telling me the results of the test. I wasn't afraid; I was more concerned about the effect that the positive result of the test would have on my family. I was thinking about the sorrow that I brought on my parents and siblings. I never told them myself, but they learned about it from my friends a year later.

I guess it was reading all kinds of religious literature in prison, but more than anything else, it was Leo Tolstoy's C*onfession* that brought me to the decision that I could do something good about my life. In 2003, I met people from the All-Ukrainian Network of People Living with HIV/AIDS and started working with them, helping other people like me to come to terms with the disease, first on local level and after a couple of years in other regions of the Ukraine.

I have lived with HIV for six years now and my job is about helping people like myself – those who live with this virus. I try to help them believe that life goes on even if one is HIV positive and that society still needs us. Maybe I help because it's difficult for me to see other people suffering and remain indifferent. People react differently when they find out about my positive status; some positively, some negatively, but what matters the most is that I have come to perceive myself in a positive light and believe that nothing good will come out of negative thinking. These days any HIV positive person has a chance to live a normal life in the Ukraine. It is not a death sentence or the end of life anymore. There are diagnostics, there is treatment, and they are free. Those who need treatment can get it. This is very important. I personally started taking antiretroviral therapy almost two years ago. It greatly improved my health. I gained weight and don't feel as tired as I did.

I have a job, a home and lots of other pleasant duties that need my participation. I can say with absolute certainty that I'm happy. I take strength from my family to live. My mother, my sister, give me a lot of support. And, my child. I'm a single father and have a four-year-old daughter to raise. Her name is Albina. I love her unconditionally and thank God she is negative. Some people may say it's difficult but it's easy to be with someone you love. It's pure pleasure for me to raise the kid. Besides, many of my good friends help me. I don't have enough experience but I read books, take advice from my friends, and believe that a child shouldn't be forced into things but rather be shown a decent way of life. I don't know if it works with Albina, and don't think I'm an ideal father, but I try to raise her the best, in my opinion, way. I haven't given a serious thought to my private live but I hope that I will meet that one person with whom I'll be ready to live for the rest of my life.

Unfortunately, there is still the problem of discrimination against HIV positive people. Not so much by the general population even, but by those who are responsible for helping, such as health-care workers. Several days ago, I had to talk about stigma and discrimination of positive people in front of journalists at a conference. After the session one of the reporters came to me and said with a knowing smile on her face – "I guess they pay you well to tell people that you're an HIV positive drug addict but I think it's not true…" I didn't even try to persuade her otherwise. It was useless. Some still think that you can tell by appearance and behavior if a person is HIV positive. People have their perceptions and love to put labels both good and bad on everything and everyone. We try to fight it.

I like to travel. I mostly travel in my country and at the moment, I've been to most of the major cities since I help develop organizations similar to mine in other regions. I also traveled abroad to see the work of social programs in the HIV/AIDS field. I understand that not everything is perfect in the West but I hope that someday the scope of services and attitudes will be at least close to what I saw there in the Ukraine.

Recently, I went on a trip to the Crimea. We were supposed to fly Boeing on the way back but instead took an old soviet plane. It was raining and it took our plane three attempts to take off. When it was finally up and we were all alive, I tried to make the passengers laugh and get rid of their fears. We were all in the air together and there was no sense in thinking why didn't I fly by Boeing. One should live in the present moment, be happy with the situation one is in, and try to share that happiness with others.

A human's fate is in his/her own hands, not in the hands of governments or other people. One should be happy with life and not turn it into a graveyard.

For more information contact: lgvs@yandex.ru.

DEAR FRIENDS AND COLLEAGUES.
On the night of Nov. 19, 2005, the office and Community Center of the Chernihiv regional Branch of All-Ukrainian Network of People Living with HIV/AIDS was set on fire by unknown arsonists. This was the only place in the city were HIV positive people could get help, support and understanding. Only in the last year of our work, we helped more than 500 adults and children living with HIV/AIDS. Forty one of HIV positive children were using our services. Fifty clients in terminal stage were receiving non-medical care and support. We were also working on HIV/AIDS prevention among youth and mother-to-child transmission.We lost not only our office but also all the documents, literature, furniture and computer hardware.

We are not giving up though. We still have people to work for, we still have our staff. We would appreciate any help. C*ontact lgvs@yandex.ru.*

Global Health Council

15 Railroad Row
White River Junction, VT 05001
e-mail: aidslink@globalhealth.org
www.globalhealth.org