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sexual health

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Botswana stumbles while Uganda checks HIV/AIDS

In chronically poor Uganda, HIV appears to be stable or in decline. Botswana, relatively prosperous by comparison, has failed to control the pandemic. What does this mean for HIV/AIDS policies in Africa?

In the late 1980s, Uganda was widely viewed as the worst HIV/AIDS affected country in the world. It remains a very poor country with extremely limited health and education systems and high levels of illiteracy. However, there has been a decline in both incidence and prevalence at several rural locations and it is now accepted that Uganda has been spared the explosive growth rates of the epidemic experienced in southern Africa.

Botswana has an effective public health service, ethnic cohesion and a highly literate population. It has also enjoyed decades of stable government and economic growth. HIV/AIDS policies, however, have not had the expected results. Life expectancy at birth for 2002 was 38, compared to 43 for Uganda.

A report from the London School of Economics and Brunel University in the UK describes how both Uganda and Botswana were quick to respond when AIDS was discovered in their countries. Botswana launched highly-publicised campaigns but by the mid-1990s these were receiving less attention, including from donors. In Uganda, diverse groups including President Museveni, church groups and local councils were involved in promoting sexually responsible behaviour. Museveni has also ensured that Uganda has never had to fund more than a tenth of its HIV/AIDS awareness and treatment programme.

The authors describe how:

- The Botswana Government acted before the effects of HIV/AIDS were noticed by the public, who were sceptical of its existence; in Uganda, people were aware of AIDS before the government acted.
- In Botswana, many people believe AIDS to be divine punishment for immorality; such ideas were not widely accepted across the ethnic divisions of Uganda.
- Botswana's use of an exclusively western information model led to suggestions that the use of condoms was itself dangerous; Uganda successfully adopted a family values model which avoided promoting condoms.
- Botswana's economic growth – powered by the diamond, cattle and tourism industries, which employ relatively few people – is not seriously threatened by the epidemic; agriculture-based Uganda has strong economic incentives to reduce AIDS mortality.
- Botswana has attempted to lead Africa in the provision of mass access antiretroviral treatment for AIDS, but is facing difficulties due to the reluctance of Botswanans to come forward for testing.
- Botswana's overlapping programmes are poorly coordinated and confusing.

Different results suggest that:

- When treated with respect, groups excluded in one country (such as traditional healers and churches in Botswana) can become active agents against HIV/AIDS elsewhere.
- Linking human rights concerns to HIV/AIDS, as Botswana has done, hinders public health measures.
- Testing should become the norm rather than a choice for the public.

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Trafficking policy harms migrants in Mali and Vietnam

Measures to stop people trafficking can increase the vulnerability of those who migrate voluntarily, by reducing their access to services and social care. Efforts to stop trafficking have made it hard to safely and legally leave their country to work abroad. Many are forced to pay traffickers and leave the country illegally.

Researchers from the London School of Hygiene and Tropical Medicine surveyed 1,000 child migrants from Mali who have returned from the Ivory Coast, and conducted interviews with 100 Vietnamese sex workers in Cambodia. Young people from Mali want to work abroad. However, in Mali, new laws do not distinguish between a trafficker who wants to exploit and an intermediary who is, sometimes for a fee, helping a young person to migrate safely, find housing and employment. Young people who try to leave Mali are arrested and a new 'child's passport', which is difficult to obtain, is now required.

The majority of the 100 female sex workers interviewed in Cambodia knew they were leaving Vietnam to work in the sex trade. Some had clear reasons for travelling to Cambodia. They wanted money and independence.

Many of the sex workers were not happy with their work conditions. Some clients refused to use condoms and there was a constant fear of police violence. Police raids on brothels also scared off customers, reduced earnings and weakened the women's position to negotiate better conditions. Brothel owners limited the women's freedom to prevent them being arrested. However, these problems related to exploitation in Cambodia, not the women's decisions or means of migration for sex work.

The study also found that:

- People described as 'traffickers' are often family members who help deal with corrupt officials at the border, to find accommodation and to find work once they arrive at their destination.
- Of the 100 Vietnamese women interviewed, 6 said they had been 'trafficked'.
- Out of 1,000 Malian children working in cocoa plantations on the Ivory Coast only 4 had been deceived, exploited or not paid.
- Rehabilitation centres for trafficked children in the Malian town of Sikasso are empty. Within days of being returned home against their will the children leave again.
- Vietnamese women forcibly 'rescued' from brothels pay bribes to escape the rehabilitation centres, or summon relatives from Vietnam to collect them so they can return to the brothels.

The report recommends the following:

- Instead of returning migrants home, services should tackle exploitative work conditions in the Ivory Coast and Cambodia.
- Local organisations need to press for better work conditions for migrants.

Criminalising migrants and sex workers forces them underground, making them more difficult to reach with the services they need and increases the risk of exploitation.

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Learning about sex Problems for young people in Pakistan

There are approximately 25 million young people aged 15 to 24 in Pakistan. Little research has been done on their sexual and reproductive health needs. Experience between genders differ, and adults' reluctance to discuss puberty and sexual development means that young people rely on their peers and the media for information.

Researchers from the UK's University of Southampton and the Pakistani non-governmental organisation, 'Helping Hands for Community Development', examined young peoples' experience of learning about sexual development in Pakistan where discussion of such issues is often suppressed. They looked at the process and context in which knowledge is gained; young people's views on the adequacy of information received; and key differences in how young men and women access it.

The researchers conducted 24 focus group discussions with young men and women aged between 18 and 24 in Lahore and Faisalabad. Discussions were conducted in the local language and led by trained bilingual researchers who were a similar age to the participants.

The following key findings emerged:

- While young women mostly gain information from their mothers, fathers are unlikely to discuss sexual development with their sons. Fathers expect their sons to obtain such knowledge outside the home, or from another relative.
- Information is often given in response to an event, such as the onset of menstruation.
- Information obtained by young people is superficial and focuses on personal hygiene or expected behaviour rather than the biological and emotional changes of puberty.
- Young men felt their sources of information were unreliable and believed that young women gained information from more reliable sources such as their mothers.
- A female relative may give a young woman information about marital relations immediately before marriage. Young men are more likely to have access to sexually explicit pornography and may seek information on sexual relations and techniques before their wedding.

The participants wanted more information to be given at an earlier age through the school curriculum. Community-based information provision was seen as appropriate for young men, but problematic for young women.

The findings reveal significant differences between young men and women in the way they gain knowledge of sexual health and development. Information can be inadequate and from unreliable sources, and the study highlights a lack of formal, neutral and private sources of information.

Policy implications include:

- Any programme to provide information will need to be gender specific. Young women must be targeted in the home or family, whereas young men can be reached through social and community networks.
- Any sex education programme must balance social and cultural information with reproductive biology, and give prominence to the latter. The timing of such information is also important.
- Sex education curriculum in schools should be designed so that they reach all pupils, not just those who chose science subjects. Single sex classes are essential.
- Young women who drop out of school are often supervised by their parents and community leaders: including these 'gatekeepers' in community-based initiatives may be an effective way of ensuring they receive the information they need.

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Refugee women and HIV/AIDS What role for relief organisations?

Refugee women are particularly at risk from HIV/AIDS, but relief organisations often see gender and HIV/AIDS as development issues that are not their responsibility. If they do run HIV/AIDS prevention programmes, they may be secondary to shelter and feeding programmes.

A paper from the University of Oxford's Refugee Studies Centre (UK) reviews studies of refugees in sub-Saharan Africa to urge relief organisations to view the HIV/AIDS pandemic as a socio-economic as well as a medical issue. The humanitarian community should understand how society perceives HIV/AIDS, including the way in which women with the virus are stigmatised.

Refugees are exposed to the increased danger of HIV infection at all stages of their experience: starting with the conflict in their country of origin, forced movement from their homes, settlement elsewhere and during repatriation or resettlement. The risk of HIV infection is intensified for women as social structures break down and threats to their safety increase. Prostitution thrives in and around refugee camps as sex becomes the means by which women pay for their survival. In West Africa young women have been forced to exchange sex for relief supplies and security by local aid workers, peacekeeping soldiers and refugee leaders.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has developed an essential minimum package for the prevention of HIV/AIDS in emergencies. This package includes preventing infection through blood transfusions, provision of condoms, information campaigns and the treatment of sexually transmitted diseases.

Despite these measures:

- Information campaigns may be so removed from the reality of a refugee camp that it is unrealistic to expect that the information provided will help.
- Distribution of condoms and information alone cannot enable refugee women to protect themselves from HIV infection.
- Women's needs are neglected because organisations tend to work through male-dominated camp structures.
- Little is being done to challenge ideas that focus on women as the transmitters of HIV.

Relief organisations must tackle HIV/AIDS with a human rights approach, focusing on the participation of women. The author calls for:

- recognition of the importance of long-term development aims during the initial stages of an emergency response
- HIV/AIDS prevention programmes to take account of gender-related violence and women's lack of power within relationships
- measures to prevent infection: ensuring adequate food supply reduces the need for women and girls to use sex to survive; accessible water and firewood supply can reduce women's exposure to sexual violence; employment schemes for men in camps can reduce tension and abuse
- an end to discrimination against refugees found to be HIV positive.

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