

# PlusNews

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GLOBAL HIV/AIDS NEWS AND ANALYSIS

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Office for the Coordination of Humanitarian Affairs  
Integrated Regional Information Networks





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## FROM THE EDITOR'S DESK

The days when children were seen and not heard are long gone, so in this edition of the PlusNews magazine we take a look at their needs and the many ways they are affected by the pandemic. In Southern Africa a generation of children who were born HIV-positive is reaching young adulthood but, with the exception of some projects in Botswana and Zambia, the public sector is not giving these special children adequate support.

To mark the Grandmother Summit held in Swaziland earlier this year, we bring you a personal testimony from the 'dancing grandmother', Anna Matopodza, a Zimbabwean granny living with the virus who spends her time teaching people about HIV/AIDS through song and dance.

Finally, in our news section we sit down with the executive director of the Global Fund to Fight AIDS, Tuberculosis and

Malaria, Michel Kazatchkine, and ask some hard questions about the future of HIV funding and whether national governments are doing enough to fund their own HIV/AIDS programmes.

In coming months we will be doing more 'straight talking' with other key figures in the global AIDS response, so tell us who you would like to see in the hot seat.

Please share your comments and suggestions about the magazine with us by sending me and the rest of the PlusNews team an email at [mail@plusnews.org](mailto:mail@plusnews.org)

Yours Positively,

**Kanya Ndaki**

Deputy Editor IRIN/PlusNews





## CHILDREN'S HEALTHCARE MISSING THE MARK

South Africa has achieved near universal access to health services for pregnant women and their children, but maternal and infant mortality rates have continued to rise making the chances of reaching the Millennium Development Goals (MDGs) on maternal and child health increasingly remote.

A new national study, *Health of our Children in South Africa*, confirms that HIV/AIDS is the biggest cause of maternal deaths, and accounts for 35 percent of deaths in children under five. But the study reveals that poor quality health care, low immunization rates and misguided infant feeding practices also contribute to the poor health of pregnant women and children in South Africa.

The study, released on 13 May, draws on data in a national HIV, behaviour and health survey conducted in 2008 by the Human Sciences Research Council (HSRC) and several partner organizations, including the United Nations Children's Fund (UNICEF) and the Centre for AIDS Development, Research and Evaluation (CADRE).

Similar studies were carried out in 2002 and 2005, but this is the first with data on children younger than two.

Researchers surveyed 8,066 children under the age of

18 to determine their HIV and general health status, what HIV risk factors they had been exposed to, and their access to AIDS information.

Although the overwhelming majority of South African children were HIV negative and in good health, for the nearly 3 percent of children surveyed who were HIV-positive, "mortality during the first five years is high", and those living with HIV were three times more likely to be hospitalized than other children.

Sexual transmission was the main cause of HIV infection in children over the age of 12 - one in seven girls, and one in 10 boys aged between 12 and 14 had already had sex. More than a quarter of girls aged 12 to 18 had had sex with partners at least five years older, putting them at an increased risk of HIV. However, 92 percent of young men and 84 percent of young women reported that they had used condoms the last time they had sex.

Most of the 3.3 percent of children younger than four years who were HIV-positive had been infected by their mothers. A slightly



lower HIV prevalence of 2.1 percent among infants under the age of 2 suggested that South Africa's prevention of mother-to-child HIV transmission (PMTCT) programme was having an impact. Of the 97 percent of pregnant women who accessed antenatal care, 95 percent said they were offered an HIV test.

### POOR QUALITY CARE

Although most mothers reported using the available healthcare services for their children, the study found that the quality of services was often inadequate.

Dr Khangelani Zuma of the HSRC, a study investigator, described the low rates of immunization for preventable childhood illnesses like measles, diphtheria and polio as "missed opportunities", and suggested that the policies and guidelines governing immunization and other maternal and child health efforts were of little use without proper oversight to ensure implementation.

South Africa's new national treatment guidelines include antiretroviral (ARV) treatment for all HIV-positive infants under the age of one year, and for pregnant HIV-positive women with a CD4 count (which measures immune system strength) of 350 or less, which could significantly reduce maternal and infant mortality rates if fully implemented.

"Based on our results, I'm concerned about implementation

unless bigger efforts are put in place to make sure guidelines are followed," Zuma told IRIN/PlusNews. "The new guidelines could see an improvement if more is invested in an accreditation system to monitor the quality of care in our health facilities, and to hold health managers accountable." The study authors include such a system in their recommendations.

### MIXED FEEDING RAISES HIV RISK

Other recommendations address the finding that only a quarter of South African women surveyed exclusively breastfed their babies during their first six months; most relied on mixed feeding (a combination of breast milk and formula), which has been associated with a high risk of mother-to-child transmission of HIV in the first three months of life.

The authors propose revising the current feeding policies to take into account the 2009 World Health Organization guidelines, which recommend that HIV-positive women begin ARV treatment early in pregnancy and continue until they stop breastfeeding.

Zuma said better health outcomes for pregnant women and children would require addressing resource shortfalls, such as the inadequate supply of ARVs at some public health facilities, and staff shortages at others. "What we need to do is invest more in the overhaul of our health system." ♦

## ZIMBABWE



### WORRYING RISE IN STIS AMONG YOUNG PEOPLE

A new report by Zimbabwe's National AIDS Council (NAC), showing a dramatic rise in sexually transmitted infections (STIs) among people aged 15 to 24 in the capital, Harare, has health experts worried that the country's success in reducing HIV could be unravelling.

STI's heightened vulnerability to HIV infection, and this age group is one of the hardest hit. According to the NAC report, more than 24,000 people were treated for STIs in 2009, compared to 8,500 cases recorded in 2008; over 60 percent of the cases were women.

During this time almost 900,000 male condoms and over 155,000 female condoms were distributed in Harare. Itai Rusike, executive director of the Community Working Group on Health (CWGH), a network of civic groups that promote health awareness, blamed the rise in STIs on a too narrow focus on HIV/AIDS treatment.

"In the last two to four years we have concentrated our focus on access to treatment, especially access to ARVs (antiretrovirals), at the expense of preventive services," he told IRIN/PlusNews. *(continued on next page)*

## GRANNIES GATHER FOR AIDS SUMMIT

"Right now the bulk of our AIDS levy money [a 3 percent tax on income] is going towards procurement of ARVs, to the detriment of health education awareness campaigns, especially for the young adults who are supposed to be our hope for the future."

Zimbabwe's adult HIV prevalence has been on a downward trend, dropping from 14.1 percent in 2008 to 13.7 percent in 2009.

### YOUNG PEOPLE NEGLECTED

In 2009 the CWGH conducted an assessment of young people's needs for sexual reproductive health and HIV/AIDS interventions, which indicated that sex work, intergenerational relationships, early marriage, early sexual debut and unplanned pregnancy were among the challenges they faced.

In its recently published 2009 annual report the CWGH noted that young people had limited access to reproductive health information and services. "If we do not invest in preventive services, all the gains we have scored so far in HIV prevalence rate will be eroded," Rusike warned.

"If we do not invest in preventive services, all the gains we have scored so far in HIV prevalence rate will be eroded"

"Youth-led peer education activities need to be well co-ordinated and supported with financial resources, education materials, mentoring and capacity building, in order for them to be sustainable," he pointed out.

Oirando Manwere, a National AIDS Council (NAC) information officer, agreed that the rise in STI infections was an urgent call to action. "There is a need to carry out a study on why this is the trend, but generally this could be attributed to early sexual debut among the youth, unprotected sex, abuse by older men - particularly among the women and girls."

Manwere said Zimbabwe's current policy on sex education did not allow HIV/AIDS organizations to go into schools and teach young people about issues like condom use, but discussions between non-governmental organisations and government were ongoing. "It is clear that the youth are indeed sexually active and need to be empowered on sexual and reproductive health issues."

### POLITICAL DISRUPTIONS

AIDS activist Martha Tholanah attributed the STI increase to the violence that occurred in the aftermath of the March 2008 election.

"Youths were used to target other youths - we had reported cases of a sexual violence, which I do not think were followed up adequately, as many actors were very fearful of the repercussions if they dealt with these issues."

Many organizations, especially those working with young people, are still struggling to get on their feet after the economic and political disruptions of 2008 and beyond.

"I do not think many organisations working on sexual and reproductive health have regained the impetus they had before political and economic disruptions," Tholanah commented. "I believe we will still see more negative health effects resulting from that era." ♦

"We are the backbone of our communities; with our love and commitment we protect and nurture our orphaned children. Africa cannot survive without us," declared a manifesto released to coincide with the first African Grandmothers' Gathering held in Swaziland from 7 – 9 May 2010.

Eunice Simelane, who has supported and cared for five grandchildren since her son and daughter-in-law succumbed to AIDS-related illnesses, read the manifesto at the meeting attended by 200 grandmothers from Swaziland, 232 from African nations, and 42 Canadian grandmothers representing 7,000 others who have formed groups in Canada to raise funds and awareness to help elderly African women struggling to raise AIDS orphans.

The first Grandmothers' Gathering took place in Toronto, Canada, in 2006, and was the brainchild of former United Nations Special Envoy for AIDS in Africa, Stephen Lewis, whose foundation has been channelling funds to community-led AIDS organizations that support grandmothers in 15 sub-Saharan African countries.

Swaziland's AIDS epidemic is among the worst in the world - around 160,000 children are classified as orphans and vulnerable children (OVC) in a population of less than one million - and was a natural choice to host the first Grandmothers' Gathering held in Africa.

Traditionally the extended family has looked after its own, so there are few orphanages. Grandmothers have become the primary caregivers, but their vital role has been largely overlooked, and their need for help to feed, clothe, house and educate their grandchildren ignored, said Ilana Landsberg-Lewis, Executive Director of the Stephen Lewis Foundation.

"I was reviewing funding proposals, and many of them dealt





with orphan funding, but they seemed written in code. They always referred to 'guardians and caregivers', but didn't say who these persons were. We found the caregivers were the grandmothers of Africa," she said.

People have given generously to support the Foundation's programmes, so Landsberg-Lewis wanted her fellow Canadians to meet African grandmothers personally. "They came to Swaziland, paying their own way ... I knew they would be moved by the heroic grandmothers," she told IRIN/PlusNews.

The three-day conference in Swaziland's central commercial hub, Manzini, was an emotional meeting, often joyous but

*The grannies had hoped to be retired now, and to be taken care of by their children, and to play with their grandchildren, instead of having to raise them*

sometimes harrowing, with many of the grandmothers giving accounts of abuse and poverty.

"A lot of violence is perpetrated against unprotected people like grandmothers - robbery and even rape. In our manifesto we call upon the authorities to recognize this and protect us grannies as we raise the children," said Cynthia Khumalo, a Swazi grandmother.

The delegates compiled a list of demands from their governments, including financial assistance and sustainable projects, created with their involvement. Swaziland's prime minister and several cabinet officials attended the gathering.

"The grannies had hoped to be retired now, and to be taken care of by their children, and to play with their grandchildren, instead of having to raise them. This has to be acknowledged and assisted," said Siphwe Hlope, executive director of Swazis for Positive Living (SWAPOL), a support group for HIV-positive women which organized the event with the Stephen Lewis Foundation. ♦



## Anna Matopodza: "When I tell people I am a grandmother, they do not believe me"

When Anna Matopodza, 55, from a village in the Buhera district of Manicaland Province, Zimbabwe, found out she was HIV-positive, she was anxious about who would look after her five children when she died. The thought of death haunted her for months; then she joined dance group and travelled around the world, teaching people about HIV/AIDS through song and dance.

"I tested HIV positive in 1996, after the death of my husband. My husband had been sick for a very long time; we were always in and out of hospital but I had never got the opportunity to get tested. I got tested after some counselling from an organization called Family Care Trust-Nyanga (Fact-Nyanga).

"Back then, in 1996, we didn't have the New Start Centres that are now offering voluntary counselling and testing around the country, so for someone to get tested it was a very difficult and an expensive thing.

"The result came back positive. I didn't even know what that meant, except that I knew I had a disease that had no cure, no treatment, and that I would soon die in the same painful way my husband had died.

"My concern was for my four girls - I was afraid that after I had died they would be forced to get married early and also expose themselves to the disease. I lost a lot of weight just thinking about all these things.

"When I joined Tsungai ['be strong' in the Shona language] support group I had no idea what to expect; I just joined because I was probably looking for answers. I found peace at this support group because we were no longer talking in hushed tones about HIV/AIDS.

"While in this support group I heard about the Murambinda Peer Educators Dance Group and I decided to join them. I wanted to let others know about this disease before it was too late.

"The children I was worried about years ago are all grown up now. The four girls are married and have children of their own. They all completed their education and they have good jobs.

"I didn't think I would live to see my children grow up, or to see my 14 grandchildren. My fifth child - my only son - is still at home with me, doing his studies.

"Many people died of stress in the 1990s because there was not much information about HIV/AIDS ... this is why I am part of Murambinda Dance Group, as old as I am.

"When I tell people I am a grandmother, they do not believe me because when I dance I have so much energy - there is no old and young when we are fighting HIV!" ♦

# ORPHANS GROW UP WITHOUT CULTURAL IDENTITY

**A**bigail Mwanashimba has been looking after her five siblings since the age of eight, when her parents died of AIDS-related illnesses. She is now 19 years old, and without relatives to represent her at her lobola (bride price) negotiations, she was forced to hire traditional counsellors to organise the process of marriage according to the tribal customs. They did a bad job.

"I don't know anything about my tribe or its culture because there has never been anyone to teach or show me," she told IRIN/PlusNews. "I got very little lobola, but the last straw was the humiliation I suffered at my in-laws' home, when I embarrassed them by performing the wrong dance."

Losing out on the bride price was one thing, but when she realised that the counsellors she had hired had taught her the wrong traditional dances, she refused to pay them their 500,000 Zambian kwacha (US\$100) fee, and is now facing a lawsuit.

Agnes Ngubeni, from the central town of Kabwe, also knows this kind of humiliation; she has lived with the embarrassment of not having undergone an initiation ceremony when she came of age, and not being able to speak the language of her tribe.

**"We are so engrossed in keeping the children off drugs and alcohol, and the girls from getting pregnant ... that we lose sight of the fact that children need to be socialised in the ways of their tribe"**

"People called us goats ... they said we were 'cultureless' and were not educated in the ways of our tribe. It never occurred to them that there was no-one to teach us - we lived without elders," she said.

Ngubeni and her siblings were orphaned fifteen years ago when her oldest brother was just 10. A Norwegian family living in Zambia committed itself to looking after them, which meant they were clothed and fed, but this presented them with social problems.

Their neighbours ridiculed them for eating pasta, bread and rice, instead of the staple, nshima - thick maize-meal porridge - that neither she nor her three sisters can cook.

"The neighbours laughed at us for eating the white man's food, which they said was not real food, but what are we supposed to do? We eat what we are given. That's just how it is," Ngubeni said.

Ngubeni recommends that people helping child-headed families should consider placing an adult relative or any other person of the same tribe among them to guide and mentor them in the ways of traditional society.

## OUT OF TOUCH WITH CULTURE

In its latest report on Orphans and Vulnerable Children (OVC), the UN Children's Fund (UNICEF) found that about 20,000 households in Zambia were led by children, but the number is increasing.

The report outlines the severe deprivations of food and shelter these children often face, and concludes that with more youngsters having to take on the responsibilities of running a household at an early age, there is every likelihood that more of them will end up on the street.

Joseph Banda heads Tisunge, a local organisation that assists child-headed households to deal with the trauma of loss, and teaches them income-generating and life skills, so that the children are able to fend for themselves and can continue their schooling.

Banda said it had never occurred to him that these children would struggle with cultural issues. "I am ashamed to say that I never saw the children's situation in this way," he admitted.

"We are so engrossed in keeping the children off drugs and alcohol, and the girls from getting pregnant, and making sure that they become good citizens, that we lose sight of the fact that children need to be socialised in the ways of their tribe."

Child psychologist Trina Mayope warned that children growing up without the value of custom and tradition would have problems in future. "It's about growing up with a cultural identity ... The children feel isolation because the communities treat them as aliens, or as something not quite right because of their seeming lack of 'traditional etiquette'."

There is also the stigma attached to being orphaned by HIV/AIDS, as is mostly the case. "If these children don't conform to the cultural norms of the society they live in they will suffer a double discrimination," she noted.

Mayope acknowledged that urbanisation and the passing of time had caused people to discard many traditions, but the basics of culture were still important and largely defined how someone was perceived.

"It's difficult for most people to comprehend how a child can grow up without knowing anything about his or her culture. People think they [children] are trying to act like a muzungu [European], but when you have children whose mentor is a fellow child, how are they supposed to learn traditional norms and customs?" ♦





## WELILE MLILO, "THE SUGAR DADDIES SAY THEY CAN GIVE ME WHAT I WANT"

**W**elile Mlilo, 19, lives with her mother in Manzini, Swaziland's commercial hub, where she does odd jobs to support the two of them. She told IRIN/PlusNews that one of her biggest challenges was avoiding HIV in a country with the world's highest prevalence rate.

"My mother says my beauty is a blessing and a curse - one day, I will find a good man who likes me and wants to marry me. But there are men who come up to me all the time, and that way is trouble.

"The sugar daddies bother me all the time - they say I am pretty. They say they will give me things, things I like. They all have cars. They see me walking, they drive up and say they will give me money, or a meal, or a cell phone. I tell them, 'No'.

"You can't have anything to do with that because you can die - there is HIV all around. I only have one life. If you wreck the one life you have, you are not given another one - my mother says that.

*"I have things I want to do with my life, I have dreams. I am not in school but I want to go back to school, that is why I am working."*

"I have things I want to do with my life, I have dreams. I am not in school but I want to go back to school, that is why I am working.

"I have two older brothers and an older sister. They used to help us with money, but not now. I stopped going to school because there was no money for school fees. I have just found a job as a house cleaner. I want to put half away to save for school, the other money I give to my mother for the house.

"The sugar daddies say they can give me what I want and I don't have to work, but it's not what I want to do with my life. These men are old! Do you know some of them are 40? Some are 38.

"Sometimes they talk to my friends. They tell my friends to ask me to come to them, and they will give me this and that. Do you know that some of these sugar daddies, if you don't give them pleasure like they want they will beat you? It's true.

"I don't like going hungry and I am sad because it's hard getting an education, and that is holding me back. But I have my family and lots of friends." ♦

## POSITIVE TEENS FIND REFUGE AT THEIR OWN CLUB

Raging hormones, peer pressure and coming to terms with a changing body image – growing up is difficult enough without the added burden of living with HIV, and keeping it hidden from friends and classmates.

"Being a teenager is very hard; you have to keep up with the changing life, do what the others do," agreed Katlego Lally\*, 17, in Botswana's capital, Gaborone, who was born with HIV but only learned of her status six years ago. "My school friends don't know; if you bring up HIV they're quite ignorant."

As one of the first countries in southern Africa to start rolling out a national antiretroviral (ARV) treatment programme that now reaches nearly 100 percent of those who need the medication, Botswana has a rapidly growing population of children infected at birth who are surviving into adolescence.

Simply referring these teenagers to adult clinics and ignoring their special needs could lead to a reversal in the gains Botswana has made in combating HIV, argues Ed Pettitt, coordinator of the Teen Club programme at the Botswana-Baylor Children's Clinic Centre of Excellence in Gaborone.

"Adolescence, as a period of development, has the highest risk for therapeutic failure - not just for ARVs, but any medication for a chronic illness," he told IRIN/PlusNews.

"I call it the 'inconvenient truth' of paediatric HIV - it's great that you can put children on ARVs, but you have to realize that one day they're going to grow up and become teenagers, and all the challenges and headaches that come with adolescence are going to impact on their behaviours."

Julia Rosebush, a doctor at the Children's Clinic, which provides care and treatment to HIV-infected infants and children through a partnership between the Baylor International Pediatric AIDS Initiative and the Botswana government, has already seen how teenage rebellion can translate into treatment failure. "A lot of kids throw away their pills - we're finding a lot who are failing first-line treatment already."

Pettitt said only three lines of drugs for treating HIV were available in Botswana, and if interrupted treatment caused resistance to these to develop during adolescence, "your long-term prognosis doesn't look good".

### A WHOLE NEW WORLD

The first Teen Club started in Gaborone in 2005 with just 23 teenagers, but now has over 400; that number is expected to reach over 1,000 by 2012, and five satellite clubs have launched in other parts of the country.

Clinic staff and some of the older teenagers who serve as "teen leaders" run monthly events at the clubs, providing support and sanctuary to the vast majority of members who

have never disclosed their status to anyone besides their caregivers.

"When there's only one other person that knows their status, they're leading kind of double lives," said Pettitt. "They can't even tell their best friend because they fear that friend will tell others, and they'll never be able to go back to school."

**"A lot of kids throw away their pills - we're finding a lot who are failing first-line treatment already"**

For Lally, who started coming to Teen Club last year, realizing that there were other teenagers like her was life changing. "I was just living in a dark tunnel, waiting for the day I would die," she said. "The doctor I was seeing told me about Teen Club and I saw a whole new world ... I thought it was just me, but I saw a whole lot of excited and happy teenagers."

She is now a teen leader and thinks of her friends at the club as "like my family". "Everyone is open with each other, because when you're in the same situation you understand each other," she said. Mostly they talk about "normal teen stuff" rather than their HIV status.

The monthly events are usually focused on fun and general life skills rather than HIV-related issues. Past activities have included pool parties, salsa classes and movie nights, although the most recent event focused on how to disclose one's status to friends and family.

After a panel discussion in which several adults and one teen leader shared their experiences of disclosure, the teenagers broke into small groups to act out skits where they practised disclosing to best friends, girlfriends, teachers and cousins.

Sexuality and relationships are particularly fraught for HIV-positive teenagers, but giving them tools for disclosing to romantic partners is vital if they are to use prevention methods, said Pettitt.

Mpho Mosala\*, 17, another teen leader at the Gaborone Teen Club, has been dating the same girl at his school for the past two years but he has yet to tell her of his status. "Right now, I don't think it's so important because we're not doing anything that would expose her," he said. Lally has decided to stay "out of the dating mode", at least until she finishes school.

While younger club members attended the session on disclosure, older teenagers were busy clearing undergrowth from a plot across the street where a drop-in centre for HIV-



positive adolescents is to be built. They were joined by volunteers from Barclays Bank, which contributes part of the funding for the programme as well as financial literacy training to the teenagers.

The centre will provide a much needed place where teenagers and their caregivers can come between clinic appointments and monthly events for counselling, training and sports, or just to hang out.

## MODEL PROGRAMME

The success of Botswana's ARV programme and its prevention of mother-to-child transmission (PMTCT) programme means that while the number of infants born with HIV is dwindling, the number of HIV-positive adolescents is growing every year. "In three or four years we'll pretty much be an adolescent clinic," said Pettitt.

Recognizing the growing need, Botswana's Ministry of Health is partnering with Baylor to develop an adolescent care package to train health care workers at government ARV clinics in how to cater for teenage patients.

While Botswana is slightly ahead of the curve, other countries in the region are also dealing with growing numbers of HIV-positive adolescents and looking for models they can adapt.

Baylor has launched similar clubs attached to its Children's Clinics in Swaziland, Lesotho, Malawi and Uganda, and a number of other countries and organizations have requested materials on adolescent care and support.

Pettitt welcomes the interest, saying: "A lot more attention and resources needs to be put towards finding ways to keep adolescents adherent and prevent them from infecting others." ♦



## Katlego Lally: "Being a teenager is very hard"

**A** Katlego Lally\*, 17, belongs to a club for HIV-positive teenagers run by the Baylor Children's Clinic Centre of Excellence in Gaborone, Botswana's capital. She talked to IRIN/PlusNews about how the club has helped her overcome feelings of isolation and depression.

"I was born in 1992. Back then, there was no PMTCT [prevention of mother-to-child transmission] so I got the [HI-]virus from my mother, but I wasn't diagnosed then. I just grew up falling sick every time, and we didn't know why.

"In 2003 we did some tests and then they found out that I had the virus, and my mother also. I don't think I understood at that time ... But as time went by I came to understand the disease, and that's when I told my brain: 'Okay, this is a death sentence', and that's when I became depressed.

"I remember in 2007, I was falling sick often and my exams were about to come, so I was a bit down, always just kicking myself – 'Why? Why me? What have I done?' - I was just living in a dark tunnel, waiting for the day I would die.

"Then last year I was referred to Baylor [Children's Clinic] and that's when I think my life changed. The doctor told me about Teen Club; then I came and I saw a whole new world that I never knew.

"This year I was elected to be a [Teen Club] leader. I have to be a role model to the younger teen members, I help with serving lunch, lead ice-breakers and train other teen leaders from satellite clubs.

"I've made a lot of friends - they're like my family. Everyone is open with each other, because when you're in the same situation you understand each other.

"Being a teenager is very hard - you have to keep up with the changing life, do what the others do. My school friends don't know [about being HIV-positive], but just like most people here generally in Botswana, especially teachers when they talk about HIV, they bring it up in a whole negative way.

"I have friends who drink, who have sex, and sometimes you try to tell them: 'this is not good'. But how are you going to make them understand? You'd maybe have to start by saying, 'I'm HIV positive and you don't want to be HIV-positive', and that would be like, ugh, so I just leave it.

"I want to be a lawyer, but if not law, then radio journalism, and if not, then accounting ... or I want to be a movie star.

"I go on dates, but sometimes I can just be out of the dating mode. I want a person I can spend the rest of my life with, but when the time comes for us to maybe have sex, how am I going to disclose my status?

"You never know what they'll think. What if that person is not that trustworthy? Once you tell him he'll get really angry and start to spread rumours about you, so I just have to leave it." ♦

## LOW HIV PREVALENCE RATES ON CAMPUS

HIV prevalence rates among South Africa's university students remain low, but risk is never far off according to one of the largest surveys ever conducted in the country.

The study of almost 24,000 students and staff found a national HIV prevalence rate among college students of about 3 percent – a sharp contrast to the national prevalence rate of around 18 percent estimated by UNAIDS. A combination of individual questionnaires, interviews, and dried blood spot HIV testing was used.

The research was conducted by the Higher Education HIV/AIDS Programme (HEAIDS) a government initiative to strengthen the AIDS response in the higher education sector.

The study also found that prevalence rates were about three times higher in students more than 25 years in age and that female students were hardest hit, exhibiting a prevalence rate of 4.7 percent - more than double the 2 percent rate found among their male peers .

"We can provide as much skills and training as we want, but if we do not include HIV education [in our higher education institutions] we will simply be training young people for the grave."

"The study is really the first comprehensive attempt to define the impact of HIV in the higher education sector," said Gail Andrews, HEAIDS programme director.

"To some extent, it is reassuring that HIV among students and staff at higher education institutions is less common than in the general population, but ... it does not mean that any institution can afford to be complacent. Both the survey and the qualitative research ... indicate that the sexual and social behaviour of sections of university communities puts them at risk."

A similarly low prevalence rate of about 1.5 percent was detected among academic staff, but a much higher rate was found in university service staff, who were also least likely to have health insurance.

### RISK, WRITING AND ARITHMETIC

The research revealed that about 60 percent of sexually active students had been tested for HIV before, and a similar percentage reported using a condom the last time they had sex.

Still, campus life is risky. Study researcher Dr Warren Parker said the self-administered questionnaires allowed under-researched topics to be explored, such as risky sex, and same-sex relationships, reported by 6 percent of male students.





## THE SLANG OF SEXUAL NETWORKS

Risky sexual behaviour has a language of its own on the University of Zimbabwe's (UZ) campus in the capital, Harare.

When female students arrive, they join an informal sorority known as the "university spinster association", or USA, while their male counterparts are inducted into the "university bachelor association", or UBA.

Their sexual networks are coded in a slew of slang that, according to University of Pretoria researcher Tsitsi Masvawure, masks high-risk behaviours, including multiple concurrent partnerships and cross-generational sex, which facilitate the spread of sexually transmitted infections and HIV.

Induction into these risk behaviours comes soon after orientation week, when the "gold rush" begins and first-year female students, perceived to be "sexually pure", are targeted by older male students for a one-night stand, or "one-day international".

These young women are categorized as "gold", those in their second year as "silver", and third-year female students are labelled "bronze" members of the USA.

I don't want you to rush ... [in making] me yours; don't rush, this is not a land reform programme

Older female students often engage in multiple concurrent relationships, not to survive in cash-strapped Zimbabwe, but to secure access to luxury goods like expensive hair extensions or high-priced foodstuffs, or because they perceive older men to be better boyfriends, Masvawure told IRIN/PlusNews.

"UBAs are not romantic," one young woman told Masvawure in an interview. "I don't want you to rush ... [in making] me yours; don't rush, this is not a land reform programme."

Younger male students also helped connect female friends with wealthier, older men, often finding potential sugar daddies at transport hubs en route to the university in Harare's city centre – an exercise known as "pimping".

"This disputes the traditional analysis that transactional sex is about money and sex, with boys giving money and girls giving sex. These girls were not from the poorest households, they were from families that, in some cases, were politically connected," Masvawure noted.

She said her study revealed problems in HIV prevention programmes on campuses, and hoped it would lead to more targeted HIV interventions for students.

The government is looking to strengthen sex education to better equip young people before they reach tertiary level; and develop a policy on adolescent sexual and reproductive health. ♦

About 8 percent of all students reported engaging in anal sex; Parker told IRIN/PlusNews that some participants mistakenly perceived anal sex as less risky than vaginal intercourse.

Other high-risk student behaviours that failed to raise red flags included multiple concurrent partnerships and inter-generational sex, where male and female students took partners at least ten years their senior, often for material gain.

"Some new students, especially those from poor backgrounds, may show up to campus with no accommodation. They may have their school fees paid, but no money for food," said Dr Kevin Kelly, director of the Centre for AIDS Development, Research and Evaluation (CADRE), and part of the research team. "This question of students' basic needs cannot be separated from the HIV question."

### KNOW YOUR EPIDEMIC

Andrews, of HEAIDS, stressed that many institutions – even those engaged in HIV research – might not "know their epidemic" as well as they should because campus HIV responses usually did not include men who have sex with men, anal sex, or male students with older partners.

Many students and staff felt that on-campus HIV-related health services were lacking or inadequate, which hindered voluntary counselling and testing (VCT) for HIV.

The report's recommendations included mandatory HIV and AIDS awareness as part of university staff induction, improved links between VCT and psycho-social support on campus, and expanded bridging programmes during orientation week for vulnerable first-year students. Researchers found that first-year female students were often targeted by older male students and campus visitors.

South Africa's Minister of Higher Education and Training, Dr Blade Nzimande, told IRIN/PlusNews: "We can provide as much skills and training as we want, but if we do not include HIV education [in our higher education institutions] we will simply be training young people for the grave." ♦

## POSITIVE TEENS START TALKING ABOUT SEX

How do you tell your boyfriend that you're a 20-year-old virgin living with HIV? *Zambian Chanda Nsofwa* was born infected and is now at an age where she has to deal with this and other ticklish questions about sex and HIV.

"We know that some of these children are already having sex or simply want to have it. They hear about sex from their friends and think its time they had it as well," said Dr Chipepo Kankasa, Head of Paediatrics at the University Teaching Hospital (UTH), one of the largest medical facilities in the capital, Lusaka.

The answers are available. The hospital has started a programme to help a generation of children born HIV-positive and reaching young adulthood find their way through the thickets of sex and sexuality among teenagers living with the virus.

"The hospital decided to start sessions where teenagers come together with their counsellors and share the concerns they have. The findings have been shocking - the children have a lot of things they want to know, and being given a platform here at the hospital has really helped them," Kankasa said.

She admitted that teenagers were not receiving adequate support at the adult clinic where they got their antiretroviral (ARV) drugs and had to return to the paediatric hospital for group counselling sessions. "So we have reorganized ourselves and opened up sessions for these children to speak about sex and sexuality among them."

The paediatric hospital decided to adopt the World Health Organization (WHO) definition of adolescents - people between the ages of 10 and 20 - and divided them into two groups: those aged 10 to 14, and those who were older.

"This helps us give the right kind of key messages around issues of sex and sexuality appropriate to each group ... We teach ... [the older ones] about unwanted pregnancies, opportunistic infections and sexually transmitted infections [STIs]," Kankasa said.

### COMING TO TERMS WITH HIV

Nsofwa knows the difficulties of living with HIV and dealing with it in relationships. "Every time I have met a guy I really like, I feel I have to tell him about my HIV status. It was difficult at first, but after sessions with my doctor I knew that was the right thing to do," she said.

"Many have pulled out of the relationships while others opt to just remain friends with me. I know there is Mr Right for me somewhere. When I find him, we shall have two beautiful children together."

Dr Manasseh Phiri, an HIV activist who has also treated children born with the virus, noted that HIV-positive teenagers could have a hard time coming to terms with their status, and sometimes even stopped taking their medication.

"The knowledge levels of HIV and AIDS are very high among these children. Unfortunately, they also know that one [mostly] gets HIV from sleeping around or, simply put, from illicit sex. They are also aware that they have not had sex;

*"Why should I be condemned to taking drugs for the rest of my life? I did not infect myself. I simply got the virus through mother to child transmission"*

so, when they find out they have HIV, they go into a crisis ... They get angry with their mothers for infecting them."

Grace Tembo, 21, still finds it difficult to accept her status. "You know, I have been through a lot of things in my life and sometimes I felt like hitting back. Why should I be condemned to taking drugs for the rest of my life? I started ARVs when I was 9 years old," she said during a group session.

"I did not infect myself. I simply got the virus through mother-to-child transmission. I was sick most of my young life and ended up missing classes. I began to ask myself why my mother infected me with HIV and messed up my life."

Kankasa said the group sessions have begun to yield positive results. "We have had children who are very withdrawn, and we have seen them open up in these sessions and share their deepest fears and concerns. For most, hearing other peers' experience provided healing."

However, Phiri expressed concern about having the counselling sessions at the hospital, and urged health officials to introduce similar initiatives in the community.

"Hospitals are about ailments; HIV is multifaceted. We have, for instance, primary caregivers of these children, such as parents; we can trust them with the programme - they also are faced with tremendous challenges, and they also need to hear from these children, and each other." ♦



## LESS SEX, MORE VIOLENCE FOR TEENS

Schoolchildren in South Africa are having less sex, and those that are, are doing it more safely, the second National Youth Risk Behaviour Survey by the Medical Research Council (MRC) has found.

Over 10,000 students in their last three years of high school participated in the survey, which showed "significant reductions" in risky sexual behaviour.

The first survey, in 2002, found that 41 percent had "ever had sex", but this dropped from to 38 percent in the current survey; the number with two or more sexual partners in their lifetime showed a significant decrease from 45 to 41 percent.

Fewer pupils - 52 percent compared to 70 percent - had had one or more sexual partners in the past three months; the rate of new sexually transmitted infections went down from seven to four percent, and condom use increased slightly.

However, at least two-thirds of sexually active students did not use condoms consistently, and one-fifth reported being pregnant or making someone pregnant.

MRC researcher Dr Sheg's James attributed the move towards safer sex to the "huge emphasis" on this in South Africa's HIV/AIDS awareness campaigns, but warned against complacency. "The numbers are still quite high - a lot more effort is needed to bring down these figures," she told IRIN/PlusNews.

The Youth Risk Behaviour Survey called for sexual education programmes to be tailored to individual group needs, and said a "concerted effort needs to be made to increase correct and consistent condom use, as well as contraception use".

Substance abuse was another major concern: one-third of students reported having used alcohol in the 30 days before the survey, and most of the young people who used alcohol also engaged in risky behaviours, like binge drinking and driving while under the influence of a mind-altering substance.

Before having sex, 16.2 percent used alcohol and 14 percent used drugs. "Using alcohol or drugs reduces your inhibitions and it becomes much easier for learners to engage in unsafe sexual activity," James noted.

The survey also found "an unacceptable prevalence of violence" in schools - over 15 percent of pupils had carried weapons and 19 percent belonged to gangs, while 1 in 4 had considered or tried to commit suicide. "This is alarming and disappointing, and it's [the survey] has alerted us to these problems. It's time for action," James commented.

The government should help schools "re-orientate themselves as places of safety for learners who may be adversely challenged outside the system," the survey recommended. "Learners, in their increased affiliation to gang membership, are demonstrating a need to feel aligned to a system that they perceive as protective." ♦





## STRAIGHT TALK WITH GLOBAL FUND DIRECTOR MICHEL KAZATCHKINE

The executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Michel Kazatchkine, sat down with IRIN/PlusNews at the launch of the organisation's 2010 report, where he answered some hard questions on what may be a turning point in HIV/AIDS funding.

### **Is AIDS still exceptional? Is it still the threat we once thought it was?**

It's a huge threat; it's the largest epidemic the world has witnessed in history. It's about 34 million people living with HIV worldwide, and there are about 2 million deaths every year [from it] – deaths that should be preventable.

Why has the world focused so much on AIDS? It's about the dimension of the epidemic and the number of deaths - but because of the strong evidence that this epidemic was hitting people in the most productive age of life it was having huge societal, micro-economic and macro-economic [effect] ... So that has led to this concept of 'AIDS exceptionalism'.

### **What would you say to arguments that we've invested too much in HIV and AIDS, to the detriment of other illnesses?**

You may think [this has been] unfair to the other diseases but ... [the concept of AIDS as exceptional] has helped mobilize - as we've never seen before - resources that go to AIDS.

I want everyone to understand they're not just buying condoms or antiretroviral [ARV] drugs; these resources, in Africa, have allowed us to make progress when it comes to infrastructure, health worker training, to drug procurement ... Over a third of the overall funding of the Global Fund is actually going to strengthening health systems."

### **How has the global recession affected HIV programmes?**

None of our donors have not honoured their pledges to the Fund, despite the hard times. Where the impact may be the strongest is often in the [poor] countries. People may not realize that poor countries have suffered disproportionately more from the crisis than rich countries, because their exports have been going down and the price of imported goods has not decreased.

Poor countries, in times of crisis, have been struggling with keeping up their social investments ... their priorities are in the social sector. We've achieved significant progress that is very fragile. We know what we could achieve if we were to sustain or expand the funding ... now the challenge is our 2010 replenishment, and what will happen for the next three years.

### **What is the future of HIV funding?**

I mean, basically, the Global Fund and PEPFAR [the US President's Emergency Plan for AIDS Relief] together are providing 100 percent of the funding for ARV treatment in the developing world. The United States is the highest contributor to the Global Fund, contributing about 29 percent of Global Fund income. To me all news about flat-lining support is worrying. Flat-lining will not take us far enough in treatment or prevention – we need to expand.

### **Are countries overly reliant on the Global Fund? Does that put national programmes at risk of funding delays?**

I would argue that countries ... cannot deal with 24 donors. If you have to report to 24 people separately, countries ... [would be] drowning [in reporting commitments]. By having a Global Fund, we have a global political commitment ... and we significantly decrease transaction costs.

I am aware of a number of programmes where the money ... [has been delayed] ... Most often it's because we do not receive the request on time. There are bureaucratic reasons ... this is why we have a large amount of money channelled through civil society.

### **Is there anything countries should be doing now in order to prepare themselves for a worst-case funding scenario?**

No - countries have to build their ... plans to scale up prevention and treatment, and demonstrate what the macro- and micro-economic and societal impacts will be, to build a case for the donors. Never give up.



## MORTALITY DATA REVEALS HIV TREATMENT PROGRESS

A new study of adult mortality tells the tale of HIV over decades and across borders and how treatment may have helped to rewrite the ending.

Published in The Lancet's 30 April early online edition, the study compares adult mortality between 1970 and 2010 in 187 countries.

Using data from various sources, including censuses and household surveys, researchers found that HIV was key to reversing the worldwide decline in mortality from 1970 to 1990.

Even though worldwide mortality is still about 26 percent lower than it was 40 years ago, there are regional imbalances. In sub-Saharan Africa, hard hit by HIV, mortality is at levels not seen in developed countries such as Sweden since the 1700s.

But study co-author Christopher Murray of the Institute for Health Metrics and Evaluation at the University of Washington said that while the data bore testament to HIV's devastating impact, it also revealed a story of hope that was only just beginning to emerge.

"To give you a sense of the impact of HIV, we analysed maternal mortality numbers for all countries in the world and were able to show that 20 percent of all maternal deaths could have been avoided if HIV had not been a factor," he told IRIN/PlusNews. "An emerging public health success story is the scale-up of antiretroviral [ARV] therapies in Africa, [which]

seems to be one of the drivers in the declines in mortality that we have seen in many countries there since 2005."

According to Murray, the data reinforces arguments for mainstreaming ARV treatment and services aimed at preventing mother-to-child transmission of HIV within maternal health programmes.

However, the study also found that gaps between countries with high mortality rates, such as Zambia and Swaziland, and those with low rates, such as Iceland, continue to widen.

According to UNAIDS, Zambia has an HIV prevalence of about 15 percent while Swaziland has the world's highest HIV prevalence at 26 percent.

"AIDS continues to be a big problem, despite the improvements there. This is why it is so important for countries to monitor where they are making progress and see what they can do to improve on that progress," Murray added.

There was a need to improve adult mortality monitoring with better data collection to track not only the impact of HIV but also chronic diseases such as diabetes, alcoholism and heart disease that are emerging as income rises in more countries, he said. ♦



# FUND GETS RESULTS, BUT WILL IT GET FUNDING?

Achieving targets to eliminate mother-to-child transmission of HIV and halve tuberculosis rates hang in the balance as donor commitments to the Global Fund to Fight AIDS, Tuberculosis and Malaria come up for review.

For the past seven years, the Geneva-based Global Fund has made some of the largest contributions to health aid in history, said the Fund's executive director, Michel Kazatchkine.

International donors will meet in October 2010 to decide whether, and how much money, they will give the international financing organization. Kazatchkine said progress so far had put the world on track to reaching important health milestones by 2015, but reaching these goals would depend on renewed funding.

"The next replenishment will be absolutely key to where the world will be in 2015. If we continue to scale up we should be able to reach or surpass some of the health-related Millennium Development Goals (MDGs), such as containing the spread of multidrug-resistant TB (MDR-TB), and virtually eliminating mother-to-child transmission by 2015," Kazatchkine told IRIN/PlusNews.

In Africa, 94 percent of ARV patients access treatment due to outside sources, Sidibe said.

UNAIDS executive director Michel Sidibe agreed. "Without a fully-funded Global Fund, our shared dreams of universal access to HIV prevention, treatment, care and support could become

our worst nightmare, putting the lives of millions currently on treatment in jeopardy."

The October replenishment meeting comes at a time when donors like the United States and the UK Department for International Development (DFID) have backed away from increasing their HIV funding commitments. The US President's Emergency Plan for AIDS Relief (PEPFAR) contributes one-third of all Global Fund monies.

A new 126-page report, "The Global Fund 2010: Innovation and Impact", released this week, details progress made by Fund-supported programmes, including increased access to antiretrovirals (ARVs), improved TB cure rates, and reduced levels of AIDS-related mortality and new HIV infections.

According to the report, 2.5 million people have received ARV treatment since 2002 through the Fund, which provides half of all ARVs dispensed in developing countries; the Fund also accounts for two-thirds of TB funding worldwide.

In sub-Saharan Africa, the organization is the single largest multilateral funding mechanism in the health sector, and its support has meant that countries like Namibia, Rwanda and Zambia are likely to reach their MDG targets for universal ARV access.



The Fund recently awarded South Africa about US\$43 million as part of its Round 9 of grants. South African Health Minister Dr Aaron Motsoaledi said the country relied heavily on partners like the Global Fund to provide treatment to the 920,000 people enrolled in the country's public-sector ARV programme.

## FUNDING THE FUND

Within eight months of ARV introduction, adult mortality had decreased by 10 percent in Malawi

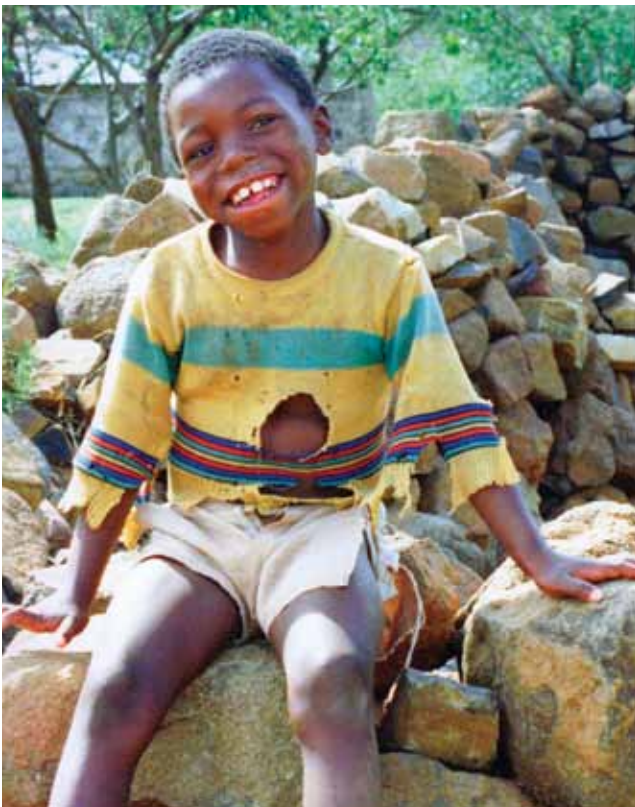
Kazatchkine said he hoped donors would renew or increase their commitments, come October, and that developed nations would realize that the economic downturn plaguing their domestic constituencies had often been felt much harder in countries with a high disease burden and export-driven economies.

Sisonke Msimang, executive director of the Open Society Initiative for Southern Africa, told guests at the report launch that international donors needed to bear in mind that funding HIV also meant funding broader goals, such as strong civil societies, improved health systems, and better health outcomes.

The report noted that the introduction of HIV services in Rwanda was followed by an increase in the uptake of primary health care services.

Sidibe said highlighting the wider benefits of funding could be the way to secure donor money for HIV in future. "The Global Fund has helped us to change completely the architecture of aid - it has changed completely the governance system of aid; it has created an alternative service delivery approach that has expanded government's capacity to deliver."

"We need to leverage resources to push broad health objectives, and this means integrating, bringing in the links between reproductive health, maternal and child health," he told IRIN/PlusNews. "We need to take HIV/AIDS out of isolation." ♦



## NEWS

# AMBITIOUS PLANS TO PROLONG LIVES

Malawi's government has set itself a major challenge this year, announcing plans to more than double the number of people receiving antiretroviral (ARV) drugs to half a million by the end of 2010.

The country recently adopted new World Health Organization (WHO) guidelines that raise the threshold for starting antiretroviral (ARV) therapy from a CD4 count (a measure of immune system strength) of less than 200, to a CD4 count of 350, regardless of whether the patient is displaying symptoms.

Although implementing the changes will be expensive, some experts argue that starting patients on ARVs earlier could actually save the government money in the long term by reducing the need to treat them for opportunistic infections such as tuberculosis.

UNAIDS Country Coordinator Patrick Brenny said the targets were reachable, provided the country could mobilise the resources, including money, drugs and manpower. An estimated 200,000 HIV-positive people are on treatment in Malawi, where HIV prevalence is at 12 percent.

"Malawi is an extremely resource-constrained country ... more than 90 percent of Malawi's HIV response is externally funded," Brenny told IRIN/PlusNews.

He noted that the Global Fund to Fight AIDS, Tuberculosis and Malaria - which is visiting Malawi - had expressed willingness to fund implementation of new WHO treatment guidelines.

Malawi successfully utilized its Round 1 Global Fund grant and was awarded a rolling continuation channel grant, which extends the Round 1 funding for six years. The country and the Fund are now looking at how to make best use of the money in relation to the new guidelines.

Brenny said Malawi was very aware of the risk that accompanied its high dependence on foreign aid and was looking at ways to reduce this, including the possibility of building a local ARV manufacturing plant in partnership with Indian drug companies.

"We are making progress ... We do not have local production of ARVs at the moment. There are a number of challenges we will face - like financing of the project - hence the need for partners," said Mary Shawa, principal secretary for HIV and Nutrition in the Office of the President and Cabinet.

The National Association of People Living with HIV and AIDS (NAPHAM) has commended government for adopting the new guidelines, saying the move would help people access life-prolonging ARV medication.

"The new WHO guidelines will save lives ... in the past NAPHAM members were dying because they were not put on ART [antiretroviral therapy] on time," said Amanda Manjolo, executive director of NAPHAM. "People were just clinically observed, without using a machine to determine their CD4 count." ♦

# PlusNews

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