AFRICAN WOMEN'S UNIQUE VULNERABILITIES TO HIV/AIDS

Communication Perspectives and Promises

LINDA K. FULLER

African Women's Unique
Vulnerabilities to HIV/AIDS

Previous Publications

Beyond the Stars: Stock Characters in American Popular Film (co-editor), 1990

Communicating Comfortably (co-author) 1990

Beyond the Stars 11: Plot Conventions in American Popular Film (co-editor), 1991

The Cosby Show*: Audiences, Impact, and Implications*, 1992

Beyond the Stars 111: The Material World in American Popular Film (co-editor), 1993

Beyond the Stars lV: Locales in American Popular Film (co-editor), 1993

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Media-mediated Relationships, 1996

Dictionary of Quotations in Communications (co-compiler), 1997

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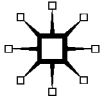

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Amie Joof-Cole, executive director of the Inter-African Network for Women, Media, Gender and Development/Reseau Inter-Africain des Femmes, Medias, Genre et Developpement (FAMEDEV) was my mentor at the African Women's Media Center/Centre Africain des Femmes dans Les Medias (AWMC), and I treasure the fact that our friendship continues, with so many amazing stories.

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PREFACE

> Women are more biologically susceptible to HIV infection and are, especially in Africa, less able to cope with it due to cultural, social and economic factors, experts told the 14th International Conference on HIV/AIDS and Sexually Transmitted Infections in Africa in Abuja, Nigeria.
>
> Helen Vesperini, *The Body*, Agence France-Presse (December 7, 2005).

The germ(s) for this book bored themselves slowly into my system, infecting me at times so deeply that it has taken me more than six years to straighten them out and decide what aspects are most important to stress relative to African women and HIV/AIDS. Because I am an activist at heart, and because I value ethical approaches to so many communications-related topics, you may find the materials here pushing you, also, to new levels of consideration.

Before proceeding, then, a few things must be extremely clear. First and foremost, there is no such thing as a typical African woman. In a continent made up of so many different countries, cultures, languages,[1] religions, and traditions, it would be insane to think that any one woman, even any group of women, would be typical of such richly complex backgrounds.[2] Equally as important is my concern that this book not come off as a propagandistic piece of cultural imperialism. It has been my experience that we have so much to learn from one another, and that those of us who call ourselves feminists and humanists must keep in the foreground a respect for others' places and perspectives.

This is a book about women, rooted in a feminist perspective. As such, it raises questions about those women in an African society surrounded by issues of class, race, religion, age, education, culture and customs, family, and many other implicating circumstances. Whether we are schoolteachers or sex workers, peasants or prime movers, or any number of combinations thereby, we should continue to be sensitive to the stories of others around the world. Mainly, we need to be aware of the feminization of poverty.

It also behooves us to question what we think we know about African women, as well as about AIDS—and from whence we have developed those opinions. Just as Lutz and Collins analyzed cultural constructions in *Reading National Geographic* in 1993, finding photos from the continent were the least liked, we hope world-views do not arbitrarily divide cultures between traditional and modern. This magazine is, after all, many readers' first glance at breasts, and at happy natives who help us think we don't really need to know more about them. Radhika Parameswaran's (2002) analysis of *NG*'s millennium issue offers important post-colonial perspectives that encourage us to go beyond gazing at smiling faces of

African warriors or wasted bodies dying of AIDS. Image-making, we know, is a deliberate, ideological strategy for consumer societies; by way of egregious example, let me highly recommend Rachel Holmes' *African queen: The real life of the Hottentot Venus* (2007, p. 4), putting a name and a background to a woman who became the unfortunate object of colonial curiosity: "Venus was simply a synonym for sex... (while) Hottentot signified all that was strange, disturbing, alien, and possibly sexually deviant." Quentin Gausset (2001) also has concerns about our focus on Africa's exoticism, encouraging us to get beyond them for AIDS prevention programs.

In 1993, I delivered a paper titled "Images of Africa in Popular Film" at a conference sponsored by the Human Sciences Research Council (HSRC) in Pretoria, South Africa, finding that, since Scott Sidney's 1918 version of *Tarzan of the Apes*, stereotyped diametric images of African natives as primitive savages or elite, educated, and English have prevailed.[3] Since then, most of my studies of African film have focused on AIDS (Fuller, 2001a, 2004b, 2006, 2007b, and forthcoming), reported on elsewhere in this book. Most frightening of all are popular cultural images of Africa (and African Americans) that aim to get us off the hook from caring (see Mengara, 2001; Morna and Ndlovu, 2007). In our 1992 analyses of *The Cosby Show*, Jhally and Lewis' *Enlightened Racism* and my book looking at its "Audiences, Impact, and Implications," we both worry about blaming Blacks who don't meet expectations of "making it." One of my South African survey respondents wrote, "I don't see why every question relating to colour should be tied to race and racism. The Cosby Show is a *cultural* and *not* a *colour* thing. Black South Africans, with whom I grew up, do *not* relate with white humour and do *not* relate with American Negroes or 'people of colour.' The Cosby Show portrays life as you would (or *could*) find in a white South African household, *not* in a Black one" (cited in Fuller, 1992c, p. 93). A special case study all its own, my conclusion included the fact that, "Black respondents report that watching *The Cosby Show* encourages them to work hard to attain a higher standard of living. Meanwhile, whites are being educated to another perspective of Blacks than they perhaps would have considered" (p. 111); fifteen years later, though, we educators are still working on the notion of ethnic images.

If this book serves no other purpose than prickling your consciousness about Africa, and about the role that HIV/AIDS is playing out there in terms of the communication of development, my initial goal will have been met. Once we get past Western representations of famine, primitivism, Zulu dancing, and lions in Africa, we need to come to terms with the fact that these are essentially people like us, albeit with different DNAs and stories. Or opportunities. We must learn to be critical consumers of media images in general, but of Africa in particular if we are to advance to my ultimate goal of having each and every one of us get involved in the issue of African women and HIV/AIDS.

Although my research in and travels to Africa first began in the 1980s, in the North, then the South, later to East Africa and again to South Africa, most of the HIV/AIDS reportage here was carried out in West Africa in 2002.[4] The recipient of an "AIDS-related Fulbright to sub-Saharan Africa" (Fuller, 2000), I worked in Dakar, Senegal with the African Women's Media Centre (AWMC), The Baobob Center/ACI Annex on Sexual and Reproductive Health (SRH) and HIV/AIDS, and the Society of Women and AIDS in

Africa (SWAA)—with a portion of the proceeds from this book slated to help their work.

Let me tell you a bit about the amazing city where I lived. Having started as early as 1984 on the pandemic, Senegal has been a pioneer in HIV/AIDS research, which partly explains why it is sometimes cited as a success study. Even prior to the WHO recommendation to do so, the country established a national AIDS committee, composed of a coordination department and subcommittees focused on clinical information, education, epidemiology, and blood bank surveillance. In addition, research and ethical and legal affairs were monitored. Specific target groups have been identified, condoms made available, a program for prostitutes to earn incomes from other sources established, and religious leaders recruited. Most (38%) of Senegal's 7.5 million people live in urban areas, Dakar being the largest city. Although French is the official language, Wolof Serer and other ethnic dialects are also spoken by what is an overwhelmingly Muslim (92%) population. Per capita income is $650, literacy rate 28%, and the infant mortality rate is 82 deaths per 1,000 births. Life expectancy is 48 years.

The Gambia, which is actually enclosed within Senegal, is a small country that has gained fame from Alex Haley's *Roots* search. Even though it is embedded in a French-speaking country, here English is the official language, with Wolof, Mandinka, and Fula also spoken by the population of some 900,000. Islam predominates at 90%, followed by 9% Christianity and other traditional religions. Per capita income is $250, literacy rate 21%, and the infant mortality rate is 143 deaths per 1,000 births. It was quite an eye-opener for me to be able to visit a health clinic in The Gambia, to see firsthand where and how women were having their babies.

Those of us dedicated to educating and enlightening people about HIV/AIDS worry about the sensationalism often surrounding it. Focusing on African women at the center of that stigma makes this study doubly symbolic, in that my approach here, while incredibly moving, has been deliberately aimed at remaining truthful, if touched. Like a process aimed at caring, treatment, and prevention of the disease itself, it is underlined with concern, hopefully treating the topics with sensitivity and providing some suggestions toward not only advocacy needed to erase the epidemic but also steps toward future considerations for our African sisters. To begin that process, we need to apply a cultural logic that considers the situation from an Afro-centric perspective.

Methodologically, a comment about my writing approach here might be necessary. While I am clearly first and foremost a social scientist, accustomed to using strict academic writing styles, this work has something of a modification, as it wants to encourage wide readership. You might note that, in an effort at being researcher-friendly, I am providing a lengthy list of acronyms in one appendix, along with a number of African terms, HIV/AIDS-related organizations, African Web sites, embassies, African media, billboards, African AIDS-related films, and a very detailed index. The references, which contain more than 800 citations, are also here as help for future scholars, and some may not necessarily be included in the text. For example, if you are interested in the role of African children in the pandemic, you will find Derib (2002), Dona (2001), Grainger, Webb, and Elliott (2001), and Mann (2003) listed here—relative to kids in the Sudan, Rwanda, Malawi, and so forth,

even if they might not be cited that way in discussions of street children, refugees, orphans, and other youngsters.

HIV/AIDS as a global injustice is obviously a very personal subject for me. Having examined media images of the disease from both sides of the camera (Fuller, 1998b, 1999, 2001b, 2003b, 2004c), it becomes clear that real-world advocacy by those of us privileged to have expertise in such matters is the key. And the imperative. This book begs your attention, and your feedback. But be warned: It is not easy reading, or responding.

Notes

1. More than 2,000 languages are currently spoken in Africa.
2. See also Chandra T. Mohanty (1997, p. 258), who points out how universalist claims can cause power issues between western feminist scholarship and what she calls third world women.
3. The list of some 300 films representing the continent was during the time of institutional apartheid in South Africa.
4. My trips to Africa have included Egypt, 1985; Morocco, 1988; South Africa, 1993; Kenya, Tanzania, Zanzibar, and South Africa, 2001; Senegal, The Gambia, and the Cape Verde Islands, 2002; Tunisia, 2007; Ghana, Togo, Benin, South Africa and Namibia, 2008.

ACKNOWLEDGMENTS

> A book, like a programme, is an organic thing, growing, sometimes in unexpected ways. It shifts as chapters come in: one never quite knows the shape of it until all the particular pieces are in hand. Even then, new understanding appears as chance brings one article, one point of view, in contrast with another.
>
> Mary Haour-Knipe and Richard Rector, Conclusion, *Crossing Borders: Migration, Ethnicity and AIDS* (1996), p. 239.

This book would not have been possible without my grant from The Fulbright Foundation, allowing me the opportunity to live in Africa and perform HIV/AIDS fieldwork; many thanks go to Debra Egan of the Sub-Saharan Regional Research Program of the Council for International Exchange of Scholars. Although my letter of invitation came from the West African Women's Association (WAWA), I soon learned that they had been in such difficult budgetary problems that they had no electricity, phone, or salaries for staff for the past six months prior to my arrival in Dakar, Senegal in January, 2002. Fortunately, my contact there, Amie Joof-Cole, moved to the African Women's Media Center (AWMC), and I followed her there. She has remained a dear and invaluable friend ever since—even taking me to meet her family in The Gambia. Under the auspices of the International Women's Media Foundation (IWMF), headquartered in Washington, DC, the organization trains women journalists regarding HIV/AIDS reportage, and has produced a helpful manual toward that end. Hitting the tarmac in Senegal, I participated in the first Carole Simpson Leadership Institute (co-supported by Judy Woodruff), a conference for women francophone journalists—me speaking French for the first time in 40 years; later, I worked with Amie on any number of other projects for the Centre Africain des Femmes dans Les Medias. My other work was with Gary S. Engelberg of Africa Consultants International at the ACI Annex, which is dedicated to Sexual and Reproductive Health (SRH) services, particularly the prevention of sexually transmitted diseases (STDs) and HIV/AIDS; there, I helped collate and evaluate films, videos, and print material that might be relevant to the local demographics, and collaborated with sexologist/consultant Valerie Lapine on a Life Skills document called "Window of Hope." And my other main commitment was with Charlotte Faty Ndiaye, President of SWAA, a pan-African organization representing some 40 countries.

Prior to going to Africa, I had an opportunity to meet Ismaila Goudiaby of the Senegal Tourist Office in New York, who alerted me to the many wonders I was about to experience. It was an honor to be invited as a resource person to the NGO forum of the United Nations World Conference against Racism (WCAR)

in Durban, South Africa, 2001—where I befriended South African AIDS activist Zackie Achmat, chair of the Treatment Action Campaign (TAC), who was nominated for the 2004 Nobel Peace Prize for creating awareness of HIV/AIDS and for pressurizing his South African government to provide treatment for those infected with it,[1] as well as other outstanding attendees. John B. Rose of the Information Society Division of UNESCO, in Paris, not only provided invaluable resources and advice, but who also alerted me to the state of telecenters on the continent.

During my stay in Dakar, I met with the following individuals, without whose input this book could never have been written—listed here in chronological order of our exchanges: Gabriel Ayite Baglo, regional coordinator of the Media for Democracy Program of the International Federation of Journalists; Madeleine Valentine, director of International Development, InfoServ; Oumar Diagne, director of CESTI (Centre d'Etudes des Sciences et Techniques de l'Information) at Universite Cheikh Anta Diop; Sonia Marcus, videographer with the Media Center; Seynabou Diop, journalist at Radiodiffusion Television Senegalaise; Agnes John, West African Women's Association; David L. Robbins, academic director, Suffolk University/Dakar; Wilma Jean Emanuel Randle, media consultant; Eleonore Seumo-Fosso of the Academy for Educational Development (AED), attending an AIDS conference in Dakar; Fatou Cisse Niang, president of both Reseau Ouest Africain des Association Pour La Solidarite (ROAPS) and Association Femme, Enfant, Lutte contre la Pauvrete (AFELP); Khalipha Bility, International Partnerships Program, Pennsylvania State University; Adeola Akintoye, Regional Finance and Systems Manager, Oxfam GB; Harriet Elam-Thomas, U.S. ambassador to Senegal; Ramatou Adamou, Communicatrice et Conseilliere en VIH/SIDA for Lutheran World Relief in Niamey, Niger; Amath Diop, Gie-Kabacoto; Steve Most, Program Officer, International Organization for Migrations; Jacqueline Cabral Ndione, Formatrice en Genre et Development; Ellen Wertheimer, reproductive health specialist, Intrah/Prime; Juli L. Majernik, agricultural marketing specialist for West Africa, USDA; Moctar Fall, directeur, Alternative Trading Organisation et Coordinateur Administratif, Forum Civil; Kevin C. Gilligan, Diplomatic Security Service, American Embassy Dakar; Mor Seck, directeur, Centre d'Enseignement a Distance Senegal; Heather Doyle, health program manager, Catholic Relief Services; Yankuba Dibba, executive director, the Gambia Family Planning Association; Marianna Jallow, programme manager, the Gambia Family Planning Association; Peter Gomez, producer/director, the Gambia Multimedia Unit; Louis M. Thomasi, program officer, Environmental Education & Communication, National Environment Agency, The Gambia; Abdoulaye Konate, caseworker, Africa Consultants International; Mouhamadou Tidiane Kasse, Print Media and Publications Department manager, The Panos Institute; and Ibrahima Lamine Diop, executive director, Agence Pour La Promotion Des Activities de Population-Senegal (APAS).

Beyond these professional contacts were more personal ones, people who made my experience in Africa so poignant. Here I must mention Lillian Baer of the Baobab Center, who encouraged me to participate in an intercultural course; Ibrahima Bob, D'Fatim Louise Dia, Alhassane Diahate, and Rudi Gomis (who tried to teach me Wolof) at ACI; Mirko Hempel of the Foundation Friedrich Ebert Stiftung; Cindy Salo, former Peace Corps volunteer who returned as a Fulbright scholar—we sure had lots of laughs; the many Sierra Leone refugees with whom my husband Eric and I worked to help them in various business

ventures; my landlord extraordinaire Doyen Sow of the Baobab Training & Resource Center; many members of the U.S. Embassy of Dakar, especially Steve Taylor, Cultural Affairs officer; neighbor and computer helper Ahmed Ba; friends at Club Atlantique, as well as Lamine, the tennis pro; Lynne and Bill Combs, for their visit; Dimado Ata-Messan and Saida Marone, for their help; and, most of all, Moustapha Diallo, confidant and continuing liaison.

Eric joined me in Dakar at the beginning, middle, and end of my time there, and it was both important and exciting, as ever over our 40+ years of marriage, to share my experiences and new friends with him. It was difficult for me to be away from our sons Will, Keith, and Alex, and daughters-in-law Erin and Dorothee, and especially tough to miss our granddaughter Madison's third birthday, but we celebrated that day by going to a local kindergarten in my neighborhood.

My efforts in Africa are ongoing, as I have been working with a local folklorist (Mame Daour Wade) and a local illustrator (Sidi Lamine Drame) putting together nonverbal "books" about the pandemic. Tentatively called GOATH, for the various characters about whom stories are centered, it is still being field-tested, but at this point includes the following:

- **G**race—the grandmother
- **O**mar—an orphan
- **A**stou—who may be having an abortion, or miscarriage
- **T**apha—a trucker who fooled around with other women, but whose wife has remained supportive
- **H**enriette—a healthcare worker who goes for her own HIV test.

By way of example, let me describe at least the first one in this series: Grace, the grandmother. The script shows her doing everything: greeting friends, going to the marketplace, boarding a bus, carrying water, cooking. And then we realize why all this frantic activity—a daughter lies ill (with AIDS), and Grace is tending her, too: offering a meal, hugging, feeding the children, sitting silently by the bed. At night, we realize she's exhausted, and sad. A friend drops by; they embrace, they share stories. The next day, the friend returns, before Grace is awake, and talks to the children. Next, we see the children helping out: chopping vegetables, cleaning, and setting a special place at the table for their grandmother. When she sees it, Grace beams. The messages this little parable are meant to suggest are the following:

- It's OK to hug a person with HIV/AIDS.
- Caregivers need care too.
- Sometimes outside people can help.

As activism begins with understanding, soon after returning home we threw a party for family and friends at our local science museum's (in Springfield, MA) Africa Hall. We hired a Senegalese music group called Gokh-Bi System, under the auspices of Tony Vacca of World Rhythms, I gave a brief talk, and we served African appetizers. Since then, I have delivered a number of speeches about various aspects of African women and HIV/AIDS and, although this book is at last complete, my interest in and concern for these issues, and these incredible Africans, will always be with me. Not only have we kept in touch since my

experience in Senegal, I have had the good fortune of corresponding with Ed Harris of the Associated Press, and other people who have gone to West Africa.

It has been quite an honor to be named a senior fellow at Northeastern University since 2003, working with the Women's Studies program under the auspices of executive director Lihua Wang and the leadership of Robin M. Chandler, associate professor of the Department of African American Studies. Over the years, we have participated with Brook K. Baker and other colleagues on World AIDS days.

Librarians from several sources have been helpful to this volume, including people from Cheikh Anta Diop in Dakar, the University of Massachusetts, and Northeastern University's Snell Library and Dennis Turner of the law library. My research has also profited from publications provided by the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, Soul City: The Institute for Health & Development—a South African-based project aiming at social change, *Drum Beat*, Integrated Regional Information Networks (IRIN) and, most of all, access to African media by means of Periodic Updates of Sexual and Reproductive Health (The PUSH Journal), providing news e-clips from the Communications Consortium Media Center (CCMC).

In addition, I owe a debt of gratitude to a number of people who have expressed an interest in this book, most of whom have contributed invaluable thoughts and ideas, including the following: Harry Adriance, for insights into Nairobi; Kwasi Ansu-Kyeremeh of the University of Ghana-Legon; Judi Aubel, an independent consultant in participatory approaches who has worked with the Grandmothers to Grandmothers campaign; Dr. Adeyinka O. Banwo, History Department, University of Ilorin, Nigeria; Warren Feek of the *Communication Initiative*; John Lent of Temple University and editor of the *International Journal of Comic Art* (IJOCA); Rico Lie of Wageningen University in The Netherlands; Charles MacCormack, president and CEO of Save the Children; His Excellency Sir Q. Ketumile Masire, former president of Botswana; Joy Morrrison of the Journalism Department at the University of Alaska/Fairbanks; Mohammed Musa of the University of Canterbury in New Zealand; Gladys Simiyu Nangami, doctoral candidate at the University of Massachusetts who shared stories of her Kenyan life with our family at Thanksgiving; Teixeira Nash of Washington, DC; Foluke Ogunleye, Department of African Languages and Literature, University of Swaziland; Ayo Oyeleye of the University of Central England; Scott M. Schonfeldt-Aultman of Saint Mary's College of California; Noel Twagiramungu, formerly a Harvard Scholar at Risk Fellow and now at the Fletcher School, writing his dissertation on Rwandan reconciliation; Ernest Waititu, E. W. Scripps School of Journalism, Ohio University; Tsegay Wolde-Georgis, formerly with the Embassy of Ethiopia and now senior staff associate, Africa Program Coordinator for the International Research Institute for Climate and Society, The Earth Institute at Columbia University; and Metasebia Woldemariam, Plymouth State University. Other people have participated also by answering my various questions and asking permission to quote them, including Kwame Karikari, Executive Director of ECOWAS.

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Information Technologies, Roskilde University, Denmark, for providing me with extra resources and collegiality for this project.

When Palgrave Macmillan first accepted this book, it was under the auspices of Gabriella Georgiades, editor of African Studies; after she left last spring, Luba Ostashevsky became her worthy replacement. Throughout, it has been delightful working with their editorial assistant, Joanne Mericle.

No doubt you have been struck by the cover to *African Women's Unique Vulnerabilities to HIV/AIDS: Communication Perspectives and Promises*. My heartfelt thanks go to Henry Bongyereirwe, a Ugandan photographer who somehow has been able to capture the haunting dignity of African women—always at work.

And of course, as always, the most deserved acknowledgements must go to my family, who put up with all those crates and cartons of material in our living room while I tried to filter through them to do my small part for so many of our African sisters.

Note

1. For more on Zackie Achmat, see Power (2003, pp. 65–67).

C H A P T E R   O N E

Introduction to African Women and HIV/AIDS

> When in high-prevalence African countries each heterosexual act poses a risk to one's health, with women highly susceptible to being infected by the men, what prevents women from effecting a reduction in risk of HIV transmission when they are aware of the threat of AIDS? There is no single answer. However, the major barriers appear to be embedded in a number of African traditions which are reinforced by prevailing economic circumstances. With a low level of education and few marketable skills, and subsequently with no legal rights to inheritance of property and other forms of wealth, the African woman often finds herself married to a much older man, having had relatives receive a bride-price which could bar a return to her own family, having frequently to share a home with other wives who themselves are potentially inherited by brothers or deceased spouses or are shared sexually among kinsmen. Such social vulnerability is most usually manifested as a heavy dependency on men.
>
> E.M. Ankrah, AIDS, Socioeconomic Decline and Health (1996), p. 99.

Originally, this book was going to begin with a statement to the effect that African women do not stand much of a chance. Although there are a few highly notable exceptions to that prediction, many people have told me personally that my first instinct is right on target. The notion of complex vulnerabilities underscores my report. It will not take you long to realize how impassioned it is, and how much it hopes you, the reader, will respond not only emotionally but also actively. There is much that can be done by those of us who have understanding and opportunity. This introductory chapter begins with overviews of HIV/AIDS and Africa, African women and African men, African health care, and then moves into the notion of Africa and HIV/AIDS before making the case for its emphasis on communication for development.

HIV/AIDS

HIV/AIDS is a political issue, and at the same time is a danger to the world. It is a disease that crosses cultural, social, and economic

> boundaries; a disease that ignores political affiliations; and a disease that conquers those who are afflicted. The politics of AIDS are, in a way, simple: HIV/AIDS is a pandemic, one that must be addressed, and one that will not go away by being ignored.
>
> Cameron, Witte, and Nzyuko, Perceptions of Condoms and Barriers to Condom Use along the Trans-Africa Highway in Kenya (1999), p. 162.

Three decades into the worst epidemic known to humankind, the dialogue about HIV/AIDS in North America continues to center on homophobia, sex education, privacy rights, and cocktails of protease inhibitors. "The epidemic inflamed bigotry toward gays and transformed the sexual revolution into a game of Russian roulette," Steve Sternberg (2001) has noted. "It provoked an ongoing debate about morality, abstinence and the way sex is taught in schools. It gave rise to a new branch of law meant to counter AIDS discrimination. It added impetus for the passage of the Americans with Disabilities Act and reform of the USA's drug approval process; it renewed debate over care of the dying and physician-assisted suicide."

In other parts of the world, however, especially in the epicenter of the global HIV/AIDS crisis, in sub-Saharan Africa and increasingly in the developing world, the emphasis is on medical means, orphans, gender discriminations, and declining population and production rates (d'Adesky, 2004). Since being identified by epidemiologists in 1981, AIDS has been culturally influenced; for example, in some places around the world it has been transmitted by sexual contact heterosexually and/or just between men while elsewhere it is passed by tainted blood, dirty needles, mother-to-child, and/or exposure to various bodily fluids ranging from semen to breast milk. In some places around the world, drugs are available and affordable to help extend the lives of HIV-positive people, but that situation joins digital, literacy, and other divides between developed and developing nations. Throughout the world, stigma and discrimination relative to HIV/AIDS still exists.

Monitored biannually and reported on by UNAIDS (Joint United Nations Program on HIV/AIDS), the World Health Organization (WHO), and any number of (NGOs), amongst others, HIV/AIDS is a disease whose experience here will mostly be told in terms of African girls and women whose lives it has changed, or taken. As you will soon see here, African females are the worst hit by HIV/AIDS, vulnerable because of their lack of access to information about health care and treatment, because in general they are less educated, because they are expected to be married and have children and to be caretakers for their families and the aged and the ill, and because they have limited options for employment and so tend to be economically dependent on men—who all too often are unfaithful, migratory, violent, and/or dismissive.

The three worst hit countries numerically of what the United Nations (UN) has determined to be the worst epidemic known to humankind include two African countries—South Africa and Nigeria (India is the third), joining Botswana, Namibia, Lesotho, Swaziland, Zambia, and Zimbabwe in having high HIV prevalence rates. At the other end of the spectrum, Senegal and Somalia have low rates, under 1% of the population, and North Africa's record by comparison is better—Sudan being the glaring exception. The statistics do not stand still,

though; for example, the HIV prevalence rate has recently more than doubled among pregnant women in Cameroon, and some of Uganda's success stories have imploded. "It could be argued that the script for the AIDS story was written centuries ago," Steven Konick (2003, p. 25) has noted; thematically, he argues that these are the major media narratives: AIDS as policy issue, as plague, as scientists' fight, as disease of non-mainstream ("fringe") groups, caring society, times are getting better, uncaring society, and AIDS as business opportunity.

The standard catechism about people infected with HIV globally has been 40 million, 26 million of them residing in sub-Saharan Africa, but just as this book was going to press UNAIDS admitted to overestimating the epidemic by some 6 million people (McNeil, 2007).[1] Whether it was a sampling error, or whether we really believe that infections peaked around 1998, though, tell that to the many Africans infected and/or affected by the disease; after all, the United Nations has predicted that "AIDS may kill 80 million Africans by 2025," and infections could count for more that 10% of the continent, or 90 million people (Mitchell, 2005). Already the epidemic has claimed more than 25 million people globally,[2] causing it to be labeled "the disease of globalization," or "globalization's pandemic" (O'Manique, 2004). Close to 3,000 women are infected daily, and each day in sub-Saharan Africa some 8,500 people become HIV-positive and 6,300 die of AIDS. At the beginning of 2008, some 22.5 million people in sub-Saharan Africa are living with HIV. "In examining the individual histories of communicable diseases, we are inevitably led back onto the broader plane of human history, where we may, like Susan Sontag (1989), find that each era favors a certain disease," I have noted elsewhere (Fuller, 1995, p. viii); what sets HIV/AIDS apart from other communicable diseases is its call to action in the international arena.

Africa

> Ask someone to tell you quickly what they associate with Africa, and the answers you'll get will probably range from "cradle of humankind" and "big animals" to "poverty" and "tribalism." How did one continent come to embody such extremes?
>
> Jared Diamond, *The Shape of Africa* (2005), p. xxvii.

It is difficult to describe the sights, the smells, and/or the sounds of the 54 countries and hundreds of distinct cultures making up Africa, and clearly there is no single pan-African sensory experience, even though one can easily get lulled by the pulse of life.[3] "Roads" team with the traffic of beat-up cars and public transportation with names like "car rapides" or "bache" that permit about 15 to 20 people (plus their packages, livestock, and more than you might ever imagine!) but usually hold about double that amount. They vie with cabs, moped-like scooters, bikes, beasts of burden, and any number of pedestrians. At intersections are collections of beggars, some who approach you, others who patiently hope you will approach them. Women walk along with babies attached to their backs, enormous packages balanced on their heads, and other goods bouncing along in their arms. It may seem discombobulated, but the drama eventually is lulling.

Perhaps it is instructive to put Africa in some kind of geographical perspective. Covering some 11,706,000 square miles, it is large enough to contain China, India, Western Europe, and the United States within its borders, and you could still add Argentina, three Scandinavian countries, and New Zealand and not come close to filling it up.[4] For our purposes, consider the following sections:

- *North Africa*: Algeria, Chad, Egypt, Libya, Morocco, Sudan, Tunisia
- *Southern Africa*: Angola, Botswana, Comoros, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Reunion, Seychelles, South Africa, Swaziland, Zambia, Zimbabwe
- *Central Africa*: Cameroon, Central African Republic, Congo, Equatorial Guinea, Gabon, Sao Tome and Principe, Zaire
- *East Africa*: Burundi, Djibouti, Ethiopia, Kenya, Rwanda, Somalia, Tanzania (and Zanzibar), Uganda
- *West Africa*: Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo.

Of all existing peoples, it has been determined that Africans have the deepest genetic roots, the African woman standing as a model for "Mitochondrial Eve," a biblical reference to the first human mother (Fisher, 1998, p. 14). We know that *Homo sapiens* traces to 100,000 to 150,000 years ago, thanks to the work of Louis Leakey, Jane Goodall, and other anthropologists and Africanists. Excepting Indo-European and Malayo-Polynesian languages imported into Africa through colonization, they include four distinct families: the Afro-asiatic, the Nilo-Saharan, the Niger-Congo, and the Khoisan families (Fisher, 1998). Also due to colonialism, Francophone (French-speaking) and Lusophone[5] (Portuguese-speaking) languages still are heard throughout Africa. Balancing legacies of colonialism (see Allman et al., 2002; Elkins, 2005; James and Etim, 1999; Kapuscinski, 2001; Mikell, 1997; Woodward, 2003), slavery, neoliberalism, "medicine murders" (see Murray and Sanders, 2003), and other historical implications, the continent has been unduly marked by wars, displacements, and recurrent times of promise. Africa has been pinpointed as the place where HIV's ancestry might have begun: "The prevailing theory about the origin of HIV is that somewhere in central Africa, probably between 1910 and 1950, a chimpanzee hunter picked up its virus by cutting himself while butchering a carcass. The simian virus then mutated into HIV and spread among humans, mostly through sex" (McNeil, 2003).

Time, though, is literally temporal, the term "African time" meaning that its residents respect the process of life beyond timepieces that dictate blind respect and responses. Emmanuel Babatune (1998, p. 38) describes the Ketu Yoruba of southwestern Nigeria's idea as being classified as absolute ("the eternal rising and setting of the sun") or contingent (real time, made up of ecological and structural systems). John Mbiti (1990), on the other hand, holds that African time is two-dimensional, encompassing a long past, a present, and hardly any future. Time might be told not by timepieces but by events, such as when a child was breastfeeding, when there was a flood or other climatic occurrence, or when a particular visitor had come. Mbiti distinguishes between potential time and actual time, time reckoning and chronology, life and death in relation to time, space and time, and discovering or extending the future dimension of time.

The smell of sewage permeates around Africa. Katherine A. Dettwyler (1994) describes her experience using a "latrine"; when led to a tiny enclosure and handed a gourd full of water, she was puzzled at not finding any hole. "You just peed on the ground, then use the water in the gourd to wash everything out the hole at the base of the wall." (p. 70) were her instructions. When I hosted two Mauritanian Peace Corps volunteers, they recounted hilarious stories about their "toiletry" facilities. But at the other extreme, it is important to note also that the glorious smell of cooking, the sounds of happy children, and the sights of constant action are everywhere in Africa.

To a one, the women of Africa are intriguing. And hardworking. Dettwyler (1994, pp. 49–50) describes the day of a typical Malian woman that is quite universal:

> Her day usually begins before sunup with at least an hour's worth of millet pounding, followed by lighting the fire and cooking millet porridge for breakfast. The day is filled with heavy manual labor, including hauling water out of the well with a rubber bucket on the end of a rope, chopping firewood, going to the market to buy food for the day, and cooking three meals. At the same time, she is usually either pregnant or lactating (producing milk for breastfeeding), and carrying for one or more small children. Only when her first child is old enough to help does her burden become any lighter; women hope to have a daughter first, as girls help more than boys with domestic chores and child care.

Throughout this book, you will find that there is no such thing as a typical African country, never mind a typical African woman (Ivan-Smith et al., 1988). Because it concerns itself with the HIV/AIDS issue, the bulk of its reportage will be on sub-Saharan Africa, the only place in the world where more women than men are infected with HIV (Onyango, 2007; Barker and Ricardo, 2006), especially young women (Meekers and Calvès, 1997); yet, no doubt you will be amazed to learn about achievements of women from all over the continent that are particularly touching when one considers their many vulnerabilities. "The vulnerability of women and girls to HIV/AIDS is directly related to the relations between women and men and to the attitudes and behaviour of men as boys, as well as to persistent stereotypes about masculinities and about what is appropriate and acceptable behaviour for women, particularly in relation to reproduction and sexuality," Carolyn Hannan (2003, p. 1) has noted at a UN workshop on HIV/AIDS and adult mortality.

Carolyn Baylies (2002, p. 355), a senior lecturer in sociology at the University of Leeds, has outlined some of the vulnerabilities that intersect with age and HIV infection, including (1) marital status—and whether one's sexual relations are confined to or occur outside of the marital union; (2) sexual behaviour of partners; (3) stage of family formation; and (4) economic circumstances. Arguing that vulnerability contexts are relational, Judith V. Jordan (2003, p. 3) points out that, "[i]n a system of radical individualism and cutthroat competition, vulnerability is often a fear-filled experience. In a violating, non-mutual and power-over system, vulnerability is a dangerous experience. And in a stratified and oppressive society, those at the bottom are continually forced into places of vulnerability and then reminded of their vulnerability, partly as a means to

intimidate and control them." It will not take you long to situate where African women belong in her hierarchy when we factor in the triple whammy of AIDS, poverty, and conflict(s).

Beyond the horrific statistics such as how half the population of sub-Saharans lives below the absolute poverty level and how some 90% of the HIV/AIDS pandemic is taking place there, it is time to question the role not only of money but also of information gaps in what has become the most blatant example imaginable of global health injustices. Relative to HIV/AIDS, however, we need to keep reminding ourselves, are *real* people—and this book aims to address the most vulnerable of them all: African women. Still, it must be reiterated right at the start that, although there is no archetypal African—whether man, woman, or child, African women of all ages are central here.

African Women

They do it all: farming, food preparation, childrearing, care-giving, and holding families together. But do not be deluded into thinking any of this is easy. African agriculture is still mainly done with hoes, and rural women spend some four to eight hours a day in their fields, along with five to six hours collecting water and firewood. Bearing and raising children has always brought both delight and difficulty, but especially so in Africa, where food supplies and income might be limited and where extended family members play such a strong role. And, like their counterparts around the world, it is usually women who bear the brunt of care for family members affected by HIV/AIDS—attending to the sick and dying.

African women clearly have a number of vulnerabilities. Physiologically, because they are often married off at young ages, their thin vaginas and wombs are especially susceptible to HIV, and many preteen girls continue to be victims of genital mutilation. In order to attract husbands, some girls might be encouraged to have tattoos embedded in their mouths, an unsanitary and risky process. Educationally, they face a number of access and training issues and deprivations, such as school fees—leading some younger ones to take on transactional, cross-generational sex with "Sugar Daddies" so they can pay for their books and uniforms. Their impoverishment also entails a lack of employment opportunities, so all too often the older girls and women are forced to sell the only thing they have: their bodies. Culturally, due to long-engrained traditions of gender inequities, African women risk being targets against unfounded notions ranging from having sex with a virgin,[6] a disabled girl,[7] or an elder as means of "cleansing oneself" of AIDS. Fortunately, groups such as the Girl Child Network in Zimbabwe, which runs a girls' empowerment village for rape survivors who are given counseling, safe accommodation, and life-skills training, are using theatre to educate traditional healers, along with chiefs, government officials, and religious leaders. Steve Vickers (2006) reports on one such play about an HIV-positive man wanting to be cured, explaining, "The reasoning is that the blood produced by raping a virgin will cleanse the virus from the infected person's blood." Add reportage from some of the girls about their suffering to this performance, and education and sensitivity hopefully begin.

Marriage is expected. As brides, African girls may be as young as 10 years old. As widows, they might have to undergo "cleansing" experiences with male

family members who have intercourse with them under a system known as *levirate*, the stated purpose being to rid them of poisons. Unprotected sex is practically a given, with most sexual practices determined by male partners, along with alarming rates of rape, elder sexual abuse, and out-of-control domestic violence. For a culture overwhelmingly conservative when it comes to discussions about sexuality, there is far too much violence aimed at females. As the Panos Institute (1990) has pointed out, HIV/AIDS places women in "triple jeopardy," impacting them as individuals, as mothers, and as caregivers.

According to its cultural dictates, an African woman's "social security" has been dependent on her ability to have as many children as possible, despite the many difficulties she might encounter with pregnancy, labor, delivery, and recovery—almost exclusively with midwives. The idea has always been that children would, in turn, take care of them in old age. Add to this the draw of urbanization, where wives and mothers are deserted while family members seek work other than in agriculture, and (mostly uneducated) women are left with little attention or support—until, it turns out, they might be needed to care for the sick and their siblings. An infrastructure dependent on a migrant labor system also plays a role, as African men typically have several sexual partners (see Ondimu, 2006).

Throughout Africa, the overwhelming focus is on the family. Patrick Chabal (1999, p. 27) has referred to it as a fundamental "circle of trust," girls being socialized to continue the tradition—their sense of sexual devaluation beginning early on. Life expectancies have dropped as whole countries, such as Central African Republic, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia, and Zimbabwe see HIV/AIDS rates consuming in excess of than one-quarter of their populations, and Sierra Leone having the lowest life expectancy in the world at 34 years. Funerals are so frequent throughout the continent that coffins are mostly made of cardboard. "The grandmothers in Alexandra don't play bowls or bridge. They are members of burial societies," reporter Sally Sara (2004) has written. From a township on the outskirts of Johannesburg, she describes one story:

> There's something painful and wrong about watching a grandparent say goodbye to a grandchild. Even the coffin looks small and out of proportion. Inside it was a little boy. Bongani Mazibuko was ten years old. He was a serious, haunting kid with a skinny neck and big eyes. Bongani died in hospital a week a ago. His grandma clutched his hand and stroked his head as AIDS took him away. His parents weren't there to mourn. AIDS took them too before he could remember them.
>
> For Bongani's grandmother, there's no escape . . . And that's the way AIDS visits families in South Africa. It takes the parents, then the oldest child and keeps going until the youngest eventually falls sick. The funeral tents are put up outside the same house, again and again. Young families just disappear. It's become a routine.

The most productive members of African society, in the 15–49 age group, are also the most heavily hit—forcing the very young and the very old to take

over chores of care-giving and child-rearing. UNAIDS/UNICEF (United Nations International Children's Emergency Fund) inform us that more than 12.3 million, or 12% of African children, are orphans, South Africa and Uganda having statistics of 40% of orphaned children living with grandparents, Zimbabwe 60% (see Jackson, Hall, and Mhambi, 1994)—all part of the breakdown of family, even "extended-extended" family. Although the orphan crisis is clearly not restricted to sub-Saharan Africa, it accounts for 11 of the 14 million AIDS orphans worldwide, and projections are that it will number 20 million by 2010. According to the Food and Agriculture Organization of the United Nations (FAO), some grandparents in Kenya are caring for up to 20, even 30 orphans (World Food Summit, 2002). Stephen Lewis, UN special envoy for HIV/AIDS in Africa and founder of the Grandmothers to Grandmothers Campaign, has discussed the "grandmother phenomenon" as the dominant, best-case orphan program, at the same time worried about what happens when they die and child-headed households come into place (Mutume, 2001). Mark Lynas (2001, p. 1) invites us to visit a massive graveyard in Kitambo, Kinshasa, capital of the Democratic Republic of the Congo, to meet Loba Manima and her grandchildren—a microcosm of the crisis: "Her daughter, mother of the four children she now has to look after, died last year. Her son-in-law, the children's father died two years before."

From the start, I have been made aware of the taboo against many topics mentioned here. We know, for example, that only about one-third of all African women HIV/AIDS patients ever seek treatment. The most horrific part of the pandemic is that it claims women in their prime productive years, of course affecting the economy but just as harrowingly bringing trauma and hardship to children and extended families. AIDS, as we know, is incurable and fatal. It has no single cause or single effect—although some socially marginalized individuals may be more vulnerable to opportunistic infections than others, and physio-socio-economic disparities such as grinding poverty, governmental instability, violence, gender inequities, mobility, cultural traditions such as circumcision, and medical discrepancies also figure as variables. AIDS, as we know, has enormous effects in and on society, health care, education, business, agriculture, transportation, human resources, development gains, and in families. And, to date, there is no magic bullet to prevent or eradicate its myriad effects. We are all, as members of the world community, at risk. This introduction to the topic addresses the health care system in Africa, looking at statistics and sensibilities, and theorizing that its women are so vulnerable because of a deep-seated tradition of male domination. Women are clearly the face of AIDS in Africa (Fleshman, 2004; Mann, 1992).

Think of the numerous African women of Islamic faith who are subjected to the institution of "purdah," whereby married women are placed in seclusion—totally dependent on men, with limited participation in the marketplace other than as consumers. Or, how about the numerous African women who spend their time as unpaid laborers, working on their husband's cash crops? The Swahili word "ujamaa," which roughly translates to "familyhood," helps maintain women and children doing both domestic maintenance activities and communal crop productions under the surveillance of male authority figures. These are just a few examples of women who become virtually hamstrung from regular use of health care facilities. And yet it is women, as Caribbean AIDS researcher Marjan

de Bruyn (1992) has pointed out, who are typically responsible for health care. Small wonder sociology professor Diana E. H. Russell (2001) has labeled AIDS "mass femicide."

African Men

Despite so many strong women (see Alpern, 1998; Edgerton, 2002), you will learn here how tied up is the topic of HIV/AIDS, in Africa, with men; sociologists use the term "hegemonic masculinity." A colonial legacy whereby patriarchal governance and female subordination have been the norm, hegemonic masculinity is a notion drawing largely on the works of the Italian Marxist philosopher Antonio Gramsci in terms of dominating and subversive social structures. Gender relations are lopsided, with men charged with decision making and policymaking to maintain that leadership and power (Makinwa and Jenson, 1995; Mandela, 1993). Perhaps you are beginning to see why the underlying premise here is concern for African women's lack of access—access to good health care, access to education in general and information about reproductive health, safe sex, and HIV/AIDS in particular, and access to change what are so many deep-seated practices. "Because traditional patrilineal communities assign women a subordinate role, women feel unable to oppose community dictates, even when these affect them adversely," writes Olayinka Koso-Thomas (1987, p. 1) regarding the topic of female circumcision but reflecting a universal sentiment. He continues,

> Many women even go to great lengths to support these dictates by organizing groups which mete out punishment to non-conforming, women, and conduct hostile campaigns against passive observers. Women championing many of the cultural practices adopted by their communities do not realize that some of the practices they promote were designed to subjugate them, and more importantly, to control their sexuality and to maintain male chauvinistic attitudes in respect of marital and sexual relations.

What sets apart the HIV/AIDS issue in Africa is the fact that its predominant mode of transmission is sexual—generally, unsafe sex and specifically, heterosexual. Back in 1985, an article appeared in *The New England Journal of Medicine* (Clumeck et al.) suggesting that spread of the infection could be traced to a heterosexually promiscuous sexual lifestyle adopted by a number of African men. Reporting on a study of AIDS-affected African men in Kigali, Rwanda and Brussels, Belgium, Shannon, Pyle, and Bashshur (1991, p. 84) found that, compared with a healthy control population, "The men had a significantly higher median number of different heterosexual partners per year [12 to 60] and more frequent—at least once a month—contact with prostitutes [81%] . . . (and) Sexual partner change among unmarried male warriors in two tribal communities in East Africa over a period of three years ranged from 2 to 38 and averaged 12 per year." To keep this within perspective, they add, the number of sexual partners for these African men occurs at least ten times that of a group of male heterosexuals in the United Kingdom. "Men are a problem," a Zambian informant confided to Mwale and Burnard (1992, p. 56).

"There is a problem . . . because men won't talk and they can't say when they have been unfaithful and it might take up to six months before the disease is seen and even men will refuse and no one accepts the blame."

When Allen et al. (1993, p. 55) studied 3,702 Rwandan women aged 18 to 35, they found two-thirds having no income of their own and a high prevalence of HIV infection among women living with a partner for less than seven years. They also unearthed this pattern: "Men in Kigali become sexually active several years before they take a wife, and their sexual partners during this time are a small group of 'free women' (often single mothers) who have many partners. In this setting, men may acquire the infection before marriage or common-law union and transmit the virus to their partners."

"Sugar Daddies," men who play the power game by providing money and "gifts" in exchange for sex with young women, are unfortunately a fairly common practice throughout Africa. Negotiations for "safe sex" are not even an option. Discussing men's roles in the Rakai District of Uganda, Barnett and Blaikie (1992, p. 44) cite reasons for continued risky sexual behavior: "Male identity is closely connected with sexual conquest and fecundity . . . (and) there appears to be little in the way of male solidarity." Its success in lowering HIV transmission has been credited to word-of-mouth communication, making sure there was a high level of AIDS awareness among Ugandans.

It should also be noted that Africa has some matrilineal societies; in southern Ghana, for example, an Akan girl is highly valued: her children belong to her, she has access to her own farmland, she can keep profits from sale of her produce, and she has considerable independence in terms of not having to move into her husband's household and its extended family.[8] We are encouraged to know that some efforts are being made, both by men themselves and by scholars and organizations dedicated to working with them, toward being open to change (see Morrell, 2001). Predominantly, though, in Africa men rule.

African Health Care

> Discourse is central to the construction of knowledge about misfortune healing. In Central and Southern Africa, discourses of healing take a number of forms: the evocation of distress and hope before others; prayers to God, ancestors, and spirits; songs both out of the cultural stock at hand as well as original compositions from the wellsprings of individual emotion; highly codified dress; instrumental accompaniment and dance; the creation and use of materia medica. All come together in the "doing of ngoma."
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> John M. Janzen, *Ngoma* (1992), p. xi.

No discussion of the HIV/AIDS epidemic in Africa is complete unless it is framed within a broader perspective, particularly as it relates to global medical injustice (Fuller, 2002) and communication for development. Encompassing concerns for behavior change communication (BCC), advocacy, and communication for social change, this perspective is undoubtedly the most humane. "The great majority of Western researchers and reports on Africa present an image of a continent bereft of reasonable medical facilities, competent doctors or governments

capable of dealing with series public health issues. The only hope for the people of Africa is seen to lie in aid from the West," wrote Chirimuuta and Chirimuuta in 1989 (p. 109). Is that true, we must ask ourselves.

In 1976, WHO launched a program of Primary Health Care (PHC) that Williams (1988, p. 195) points out, was meant for, "Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford." Designed to be comprehensive in its emphasis on universal health care, it included nutrition, health education, safe water and sanitation, immunization, prevention and control of locally endemic diseases, maternal and child health, appropriate treatment of common diseases and injuries, and usage of essential drugs. The next logical step was the establishment, in 1982, of a plan of action called Health for All (HFA). The problem in Africa was that all this occurred at the same time as the onset of the HIV/AID pandemic. Another problem is that health care systems in Africa have retained their colonial hold on curative, rather than preventative approaches.

"Although in industrial countries we think of infections as acute and short-lived, in Africa many communicable diseases, such as malaria, tuberculosis, diarrhea, sleeping sickness, and river blindness, are chronic," Meredith Turshen (1995, p. 240) reminds us. AIDS, in other words, is just one of many illnesses. Already there are nearly impossible constraints on medical personnel, hospital beds, medicines and drugs, laboratory services, and other health care demands. Demand for care continually increases, as do costs, but consider the discrepancy of how medical costs in the U.S. average $30 per infected person—not even counting anti-retroviral drugs (ARVs), $10 per person per year in Africa. "Women suffer poor health care and health education, but often, through family planning or pregnancy, have some link into medical networks," according to Virginia van der Vliek (1988, p. 106); yet, "Malnutrition, parasites, infection go untreated. Health education and sex education are often minimal or absent in schools... vulnerability to HIV infection is sharpened by the nature of adolescence itself."

Lack of access to reproductive health care is one of African women's main problems. With statistics of some 250,000 of them dying each year in childbirth—one out of 16, as opposed to one out of 2,800 women in the developed world, we begin to see the depth of the issue. Add malnutrition, anemia, and infections and you begin to appreciate their plight (see Howson et al., 1996); every three seconds, reports Peter Goodspeed (2005), an African child dies of some preventable disease. Gareth Thomas (2006) provides just one example:

> Neema is a 17-year old Tanzanian girl who was raped when she was 15.
>
> Her family arranged for her to marry the rapist—in exchange for six cows. Neema soon became pregnant. After a long, painful labour she had a caesarean section but the baby was stillborn, and she developed a fistula and was leaking urine. Her husband no longer wanted her, but accepted her back after surgery to repair the fistula. He started beating her when he could not immediately resume sexual relations, so Neema ran away. Now she sells vegetables in a market, and sleeps there are night, making her vulnerable to physical and sexual assault.

Although concern about good health is universal, health status around the world is most unbalanced. Guy Carrin (1992, p. 3) compares industrial markets of 1987 that had gross national product (GNP) per capita of $14,670 and life expectancy of 76 years in industrial market economies with that of low-income developing countries (LIDCs) at $278 GNP and estimates of 52 years for living. Think of some of the variables, such as infectious diseases (e.g., cholera, dysentery, typhoid), caused by unsafe drinking water, contaminated food, and unsanitary conditions, never mind all the places that do not even have water or food. Think of discrepancies in housing, in education, in health care such as immunization and sexual and reproductive health. A classic case he cites is Pikine, a "suburb" 15 km from Dakar, Senegal created by the government in the late 1950s to rehouse a slum population. Having no hospital and just a few dispensaries, the people decided to organize and finance their own health services; aided by the Belgian government, a fee-for-service financing process was established that works to this day. The key is community involvement. In terms of equity, Carrin presents data about access to maternal and child health care from a survey of 500 randomly chosen mothers:

> It is important to note that 22% of mothers indicated that they did not receive any care during the last episode of illness and, during the last episode of illness of a newborn child, 23% of infants did not receive any care. With respect to obstetric care, the results are more encouraging: 98% of mothers received prenatal care while 92% have access to a health centre, public or non-public, for delivery. It is interesting to observe that 60% of mothers receive prenatal care and 92% are delivered at one of the Pikine Project's health posts and maternity units. (p. 153)

Recall: when, on June 5, 1981, the first report on AIDS appeared in the Centers for Disease Control (CDC)'s *Morbidity and Mortality Weekly Report*, no one could have predicted the international implications that it would take. It took several years until the viral agent causing the disease was identified, in 1984, as HIV. Notice of the disease first appeared in African medical literature in the September 1984 edition of the *East African Medical Journal*, but it took considerable time for the continent to really address it. In 1985, the face of AIDS for the general population in the United States was made real with the announcement of the death of movie star Rock Hudson, and the next year, the first panel of the AIDS Memorial Quilt was created. In 1987, the FDA (Food and Drug Administration) approved AZT (Azidovudine) as the first drug to treat the disease, ACT UP (AIDS Coalition to Unleash Power) advocacy group was established, and the United States added HIV as a "dangerous contagious disease" to its immigration exclusion list. The National Institutes of Health (NIH) established the Office of AIDS Research in 1988, the same year that the first comprehensive needle-exchange program began. Honoring the brave young hemophiliac Ryan White, the U.S. Congress authorized the Comprehensive AIDS Resources Emergency (CARE) Act to provide federal funds for community-based care in 1990. In 1991, basketball star "Magic" Johnson announced his HIV-positive status (Fuller, 1992b and 1995) and Kimberly Bergalis died after having been infected by her dentist. Tennis champion Arthur Ashe was outed as having

AIDS in 1992 and an HIV-positive Mary Fisher addressed the Republic National Convention.

By 1994, when AIDS had become the leading cause of death of Americans aged 25–44, the U.S. Public Health Service recommended use of AZT by pregnant women. Four years later, the disease had been declared a "state of emergency" in black communities and Congress established the Minority HIV/AIDS initiative, backed by $156 million. Yet, not until June 25–27, 2001 did the UN General Assembly consider ways to "narrow the gap between nations that can afford costly treatment and those that cannot" (Sternberg, 2001, D2.) Hoping for a preventive vaccine for AIDS, the group called on world governments with this appeal: "AIDS is the Great Plague of our modern era... Fully 95% of the new HIV infections are in developing countries, where AIDS is undermining economic stability, reversing decades of progress and devastating families and communities" (http://www.iavi.org/callforaction). Following the Thirteenth International conference on AIDS in Durban, South Africa in 2001, UNAIDS agreed to help poor nations purchase generic AIDS drugs, the U.S. Agency for International Development (USAID) presented Mandela's Children's Fund with $5 million, and both chambers of Congress approved a bill making $1 billion available, over two years, for global prevention, treatment, and research. One of the most important items to emerge from the conference, however, was the clear-cut recognition that *poverty* is a major factor in the breeding of AIDS—in terms of education, desperation, and access to preventative measures, counseling, testing, and/or treatment.

Africa is home, after all, to 34 of the 48 poorest countries in the world, as well as 24 of the 32 least developed countries, and is the largest recipient of donor aid—$18.4 billion from the World Bank alone (Baldauf, 2007a). Although since 1994 wealthy nations have been able to hold down their death rates with expensive drugs, costing about $1,000 a month, they represent only about one-tenth of PWAs (persons with AIDS). And although the myth has floated that Africans would not be good at, or able to follow treatment regimens, in fact that supposition has been seriously debunked, Mills et al. (2006) finding that 77% of patients were taking their drugs properly, as opposed to 55% in North America. Peter Piot, director of UNAIDS, has estimated it would take a minimum of $3 billion a year to stem the tide of the epidemic in sub-Saharan Africa, where more people have contracted the deadly virus than were casualties of both world wars. According to the 2000 UNICEF *Breaking the Silence* study (available at http://www.unicef.org.uk/aboutunicef/campaigns/gau1htm), "HIV/AIDS is not just a health issue":

> It is a developmental issue, with profound social and economic consequences. In many countries, more than one of every four working-age adults is infected. In families where the primary breadwinner is sick and unable to work, household incomes sometimes drop to almost nothing. Many affected families must spend the limited financial resources they have caring for loved ones, leaving them unable to pay for basic necessities or invest in their children's futures. These exact same problems are mirrored at a national level, translating into a major economic and social crisis for the worst hit countries. AIDS is killing off the most skilled and productive members of countries' work forces, crippling economies. Already limited public

> health services are being overwhelmed by the epidemic. In Zimbabwe, between 50 and 70% of hospital beds are occupied by AIDS patients; and it is estimated that by 2005 almost 60% of the health budget will be needed for people suffering from AIDS.

A sideline meeting took place in Spring 2001 when the World Bank and the International Monetary Fund (IMF) met, as top economic and financial leaders of the United States, Canada, Germany, France, Britain, Italy, and Japan convened to consider an international program to fight AIDS and other infectious diseases (Kahn, 2001). There is beginning to be a glimmer of hope that perhaps this pandemic can be stopped, or at least slowed down; the answer, it would appear, is a combination of financial and communicational expertise (Rosenberg, 2001; Stolberg, 2001). At the start of the most recent International AIDS conference, there was both good news and bad news: the good, new (ARV) drugs, the bad being how the epidemic continues to spread around the world; as Sharon LaFraniere (2007) reminds us, "For each sub-Saharan African who was placed on anti-AIDS drugs last year, experts say, five more were newly infected." Remember: there are 14,000 new infections each day—about 10 per minute. Also every minute, six people between the ages of 15–24 become HIV-infected, and as more than 500,000 children under age 15 died from AIDS in 2007 some 13 million children have lost either one or both parents to the pandemic. You should know, too, that AIDS is causing a decline in life expectancy in 51 countries around the world in the next two decades, a demographic effect without precedent in our times (Rwomire, 2001).

From this brief review, it becomes quite clear that we must consider the diverse and complex root causes and effects of the HIV/AIDS epidemic (Baldwin Ragaven et al., 1999). "Remember," Danny Schechter (2000, p. 4), executive editor of MediaChannel reminds us, "Diseases kill people. Pandemics kill families, communities and countries and the hopes for development of whole continents.. AIDS is a global catastrophe, an issue with economic, social and security implications." Only about one-third of all Africans utilize the formal health care services of their clinics and hospitals (Ankrah, 1996). How difficult it must be when there is only one medical doctor for every 40,000 Africans, one healer for every 500, and far too many nurses are dying of AIDS (Sichalwe, 2003). A number depend on traditional medicine, with reports of two-fifths of the total government health budget of Zambia spent on it (Vogel, 1993), even though confirmed data on this subject is difficult to come determine. One of the poorest countries in the world, where some two-thirds of Zambians exist on less than a dollar a day, one out of every six adults is living with HIV, life expectancy is below 40 years, and more than 7000,000 children are AIDS orphans.

At first, AIDS patients were denied admission to various African hospitals, as health care workers worried about its being some kind of contagious disease. Even once they were admitted, a number of wards were given scant treatment, or were ignored. As medical staff have been trained and sensitized to what this illness is really about, many have responded positively; at the same time, a number of Persons Living with AIDS (PLWA) in Africa have opted to spend their final days in their own homes. It is a sight, indeed, to witness whole huge families gathered around day after day, such as I have seen in Nairobi. For Africans, family is

everything, and most accept it as a privilege to share this last stage of life with loved ones. Many people simply quit their jobs and take their place by a deathbed, knowing that others would do the same for them. Ironically, huge numbers of health care professionals in Africa have themselves become affected by HIV/AIDS, with whole sections of the workforce now seeking help for themselves and their families.

Drugs to treat opportunistic infections can be incredibly costly, especially for African health care budgets that are already stretched. They are also tricky, requiring extensive education and ongoing monitoring to make sure they are being taken properly. As they are usually dispensed from health facilities that demand attendance in person, recipients are forced to walk wide distances for help, cutting into their regular workaday worlds. And, when women are put on various drug regimes, many have the further predicament of husbands and other men trying to sell their drugs, or at least diluting them. Oftentimes HIV/AIDS is complicated by other illnesses, as immune systems become weakened, and it can be difficult to know which medicines and treatments might work best for whom. But probably the biggest issue is at what stages drug allotments should be strongest: at the onset and/or early stages of HIV infection, or when full-blown AIDS is determined. To date, no vaccine has yet been developed that can halt the spread of HIV/AIDS, even though scientists, doctors, and pharmaceutical companies have been madly working on this project. Even if and/or when such a vaccine might be available, numerous questions arise as to whether risk status would be a factor and what demographics (i.e., gender, age, socioeconomic status, even religion) might play a role. Regardless, though, the hardest part would be disseminating the information that such a preventative was even available, never mind setting up an action plan for distributing it.

As most health personnel, both in hospital and in clinics, are women, many of them are at risk of infection due to exposure to blood and blood products. Blood, at the same time sacred and taboo, holds great power. The workplace, then, becomes yet another arena of vulnerability for certain African women, as well as caregivers in the home who are ignorant about how one "catches" HIV/AIDS. Andreas Tzortzis (2003) has reported how important it has been to educate traditional African healers, getting them to realize that AIDS is not a punishment from God, not part of a CIA conspiracy, nor spread by a fearsome dog. Still, this all poses a *double crisis*, as Ankrah (1996, p. 99) sees it, presaging a reversal of trends in the improvement of women's health and, by default, Africa's socioeconomic development:

> Challenging AIDS in Africa therefore calls for a broad approach in which the marginalization as well as their lack of provisions for sustaining their health are seen as dual, but interrelated, requirements that must both be addressed for the effective participation of women in the struggle to arrest the spread of the disease. A comprehensive strategy would include, as valid health concerns, the provision of family planning and structures of caring as well as AIDS/health education for prevention.

The crisis of affordability of drugs for AIDS in Africa and other developing countries has been called "the *other* war on drugs," probably the most profound example of all global, and gender, inequalities. Even if you have drugs, you often don't have electricity in Africa, and even places that do have frequent outages.

Africa and AIDS

> To talk of an "African epidemic" is itself problematic. Demographic information and HIV/AIDS statistics are often incomplete, but it seems clear that even if we exclude North Africa, where incidence appears to be low, sub-Saharan Africa shows very variable infection rates.
>
> Virginia van der Vliet, *The Politics of AIDS* (1988), p. 57.

Few would argue that Africa, claiming some three-quarters of the estimated 25 million deaths by the disease so far and nine out of ten new cases of HIV, has been hardest hit by the HIV/AIDS epidemic. Although the continent claims only about 12% of the world's population, it has more than 60% of the AIDS-infected population. Even so, as Shannon, Pyle, and Bashshur (1991, p. 53) remind us, "There is tremendous variation in the international experience with AIDS in Africa, both between and within affected countries." Although some countries there have low reportage of the disease (e.g., Algeria, Eritrea), those numbers can be biased, and good hard scientific research is tough to come by. Much of the research has depended on monitoring and evaluation (M&E)—locally, globally, country-wise, and/or programmatically—but all too often it can be by international funding agencies, looking for results-based rationales (Eaton and Etruel, 2002; Rugg, Peersman, and Carael, 2004).

Throughout Africa, infected women are certainly not limited to those involved as sex workers; rather, most are mothers from every social strata and geographic area, with those living along trade routes being especially at risk. If the truth be known, though, nearly all women are at risk, including—actually, especially—those who have had only their husband as a sexual partner. African family structures are all askew, as elders need to take care of their offspring, instead of the reverse. In Zimbabwe, for example, grandmothers head up nearly half of households with AIDS orphans, Wilson and Adamchak (2001, p. 8) calling it "the grandmothers' disease"—a an emerging phenomenon known as "skip-generation parenting" (Fuller, 2008). Infant mortality rates (IMR), whereby one child in five has a chance to live to age five (or worse in Sierra Leone), continue to climb in Africa due to the disease—whether by mother-to-child transmission or by breastfeeding. We wince at news that one-third of pregnant African women are at risk of transmitting HIV to their fetus or infant during phases of gestation, birthing, and/or breastfeeding—especially when we know that the drug Nevirapine could significantly reduce those rates. "The onset of the HIV/AIDS pandemic and its devastating consequences has left the family crying out very loudly for assistance to help it cope, remain solid, useful and performing its crucial roles and responsibilities to its members," according to Tavengwa M. Nhongo (2004).

From the start, the media has dealt with the topic of AIDS in Africa as part of its "disaster" coverage (Larson, 1990), obsessed with portraying the continent's continual facing up to "insurmountable calamities" rather than dealing with what was happening there as an increasingly complex picture. It also had fun painting the picture of wondering whether AIDS had its genesis from the Central African green monkey (see Crewe, 1991). As is stated in my preface, most of our images of Africa come from exotic media biases, so it behooves us not only to recognize that but also to realize that, no matter where it occurs, HIV/AIDS

does not discriminate. Mainly, I hope too many of you don't listen to travel critic Paul Theroux, whose experience of Africa is so divergent from mine; where he can only see beggars, disease, and squalor, my observations come from actually living there, seeing humankind of a different cut.

Although we know certain areas are more profoundly hit than others, particularly sub-Saharan Africa, women from huge urban areas are as likely to be candidates as those from tiny tribes and villages. What binds them, more than anything else, is community silence and lack of a voice; in this book, you will hear from many of them, speaking of both hardships and strengths, mirroring their unparalleled resilience.[9] We westerners, who have had so many opportunities, can educate others about that venue. That said, it should not be within our purview to be so arrogant as to think we have the answer(s); rather, we need to look and listen, and learn. Taking into account the fact that most African women are the products of colonialism and a history of slavery that actually continues to this day in certain parts of the continent (yes, believe it!), it is easier to understand attitudes conditioned by those years of exploitation (see Berger and White, 1999; Sheldon, 2005; van der Veen, 2004). In terms of HIV/AIDS, notions of victimization abound, and the litany of ills makes for a very bleak perspective.

In the mid-1970s, when an epidemic in Africa was first recognized, it was known as "Slim," as those affected with it simply wasted away, whether or not they were treated. Variously called "the robber," "the one that drains," "the cheater," or "the incurable disease which imprisons us," it was not until 1984 that the disease had a name: AIDS (Acquired Immune Deficiency Syndrome). This is the final, fatal stage of infection from what is known as the etiologic agent of AIDS: HIV (Human Immunodeficiency Virus), when the body's immune system becomes broken down, vulnerable to untreatable, opportunistic infections. Manifesting itself by otherwise unexplainable weight loss, persistent fever, chronic diarrhea, swollen lymph glands, coughs and rashes and, in Africa, pulmonary TB (tuberculosis), it progresses from HIV to what is called "full-blown AIDS" through an incubation period of about a decade and then life continues for another year. For children, however, the process is quicker by less than half even though their clinical signs and symptoms tend to be nonspecific. Pediatric AIDS is also marked by inadequate protein/caloric diets.

Transmission, we know, is by blood: infected blood, blood products like from transfusion, contaminated needles and syringes, or perinatally (infected mother-to-child), or by blood from sexual intercourse, particularly unprotected vaginal and anal intercourse or unprotected oro-genital sex.[10] A global conundrum, Francis and Quinn (1994, p. 237) point this out: "Compared with heterosexual, homosexual, and perinatal routes of HIV spread, bloodborne HIV transmission remains the mode of transmission most amenable to prevention." The concerns are exacerbated, such that, "Indirect contributors to transfusion-related HIV transmission in Africa include poorly functioning health infrastructures, cultural practices, and the clinical conditions of patients needing transfusions" (p. 239). In Africa, from the start to today, while blood recipients remain at risk, spread of the disease still has been overwhelmingly heterosexual (Koch-Weser and Vanderschmidt, 1988; Berkley, 1991), whether vaginal or anal, without condoms. It did not take long to realize that this disease would have far-reaching implications on societies, economies, medical services, policies, and just plain people. Medicine, and history, would never be the same.

Consider the case of Swaziland, which has the world's highest adult HIV prevalence, with 33.4% of the population infected and where two thirds of the country's one million people somehow survive on less than 70 cents a day, where life expectancy has gone from 57 years of age to 31 and where 46% of the population is under age 15, where AIDS kills some 50 people per day and HIV infects 55, where there are 63,000 orphans, where there are only two physicians for every 10,000 people, and where 16,000 Swazis died in 2006 alone from AIDS. Performing a hut-by-hut survey there, Wines and LaFraniere (2004, p. 1) found that, "[AIDS] has spawned street children, prostitutes and drop-outs. It has thrust grandparents and sisters and aunts into the unwanted roles of substitutes for dead fathers and mothers. It has bred destitution, hunger and desperation among the living." A middle-income country, with an established infrastructure and a high level of computer ownership (Kelly and Magongo, 2005), the landlocked kingdom—between Mozambique and South Africa, gained its independence in 1968 and reported its first AIDS case in 1987. Soon, it set up the Swaziland National AIDS Program (SNAP), King Mswati III declared the disease a "national disaster," a controversial condom campaign began (religious and traditional leaders calling them "unSwazi"), and a major thrust included reinstatement of a custom banning all girls under age 18 from sexual activity for five years and payment of a cow to a virgin's[11] family by any man who had sex with her. Yet, hypocrisy reigns in Swaziland, as the King has 13 wives and, despite the poverty in his country, he likes to spend money on himself; for his thirty-seventh birthday, for example, he threw an extravaganza at the palace with "energetic dances by warriors and bare-breasted girls, a 21-gun salute, several hymns and a military band"—for more than a million dollars.[12] Sexual violence is rampant, a 2007 National Survey on Violence Experiences by Female Children and Youth in Swaziland reporting nearly half of Swazi women having experienced gender-based violence (GBV) by age 24, and women's traditionally low status there has been linked to the staggeringly high HIV/AIDS rate. "Swazi tradition teaches submission on the part of both women and young children," Aderanti Adepoju (1994, p. 162) informs us. For a country "where a husband often has many wives, a widow is often obliged to marry her late husband's brother, older men often marry girls in their early teens, and women have so little power that they say they often cannot refuse sex" (Phillips, 2006), it is not surprising that, with only a pittance of the national budget allotted to AIDS, the kingdom could implode.

In the continent's most populous nation, Nigeria—ninth largest in the world, with 131,859,731 people, which has reached a critical threshold whereby rates might soon reach 40% of the population, some citizen—man, woman, or child, is infected with HIV every minute of every day (see Adeyi, 2006; Dhizea and Njoku, 2001). Imagine: nearly 3 million Nigerians are living with HIV/AIDS! A male-dominated society, with women considered inferior and no legal age for marriage, government spending on the disease has had a low priority. Essential obstetric care facilities in Nigeria are known to be hurting, with shortages of staff, drugs, and supplies, long waiting times, outdated equipment, and limited continuing education for health workers. Still, assessing both traditional and modern Nigerian health systems, Falola and Heaton (2006) think the current health outlook is improving.

In 2005, Botswana had some 270,000 HIV-positive people out of a population of 2 million, with a prevalence rate just over 24%, and 120,000 children who had

lost at least one parent to AIDS. Soon after its president, Festus Mogae, realized the country was threatened with extinction, it became the first African country to introduce anti-HIV drugs, and fortunately the tide has turned. Today, the country supports a number of prevention programs, including education and awareness, condom distribution, targeting highly mobile groups, improvement of blood safety, and prevention of mother-to-child transmission of HIV such that HIV-positive mothers choosing to avoid breastfeeding are given a free year of formula. Soon, Botswana was the first country in Africa with a national policy on routine testing, and treatments began to pay off; as such, it has become a model for other countries (see Esilaba et al., 2004). The complexities of gender and HIV/AIDS in Ghana are obvious in Oppong, Oppong, and Odotei's (2006) collection of essays, where we can see how anthropology, health, sociology, and other disciplines interrelate.

Or, take South Africa. Claiming some 5 million people infected with HIV, and 250,000 dying each year, South Africa has the dubious distinction of having the highest number of people with HIV/AIDS of any country in the world. With estimates of 1,000 people dying there daily of AIDS, and 1,700 getting HIV-infected, the really rough statistic is that the epidemic affects one in nine South Africans, the number of orphans predicted to be two million by 2010. One in three teenager girl gets pregnant before turning 18, and an equal number is likely to die before or during childbirth (Karim and Karim, 2007). The country's cemeteries are reportedly running out of space, hospitals are overflowing, and schools lack teachers because so many of them are living with HIV/AIDS (see Walker, Reid, and Cornell, 2004; Sekokotla and Mturi, 2004). Although one in five women is HIV-positive, *Pretoria News* (Venter, 2004) has reported, less than 1% has access to ARVs, and IMR are predicted to be almost 100 per 1,000 live births by 2010. When South Africa's minister of health, Dr. Manto Tshabalala-Msimang, began promoting garlic, lemon, and beetroot as protection against AIDS, arguing that the combination help build up the immune system, she alerted the world community to how slowly the country, under the leadership of Thabo Mbeki, was reacting to the pandemic (see also Kelly, 1990). "AIDS denial plays a corrosive role in the health policies of many countries, but nowhere has the damage been as extreme or as enduring as in South Africa," Michael Specter (2007, p. 33) has challenged. The country has since tried a comprehensive response—ranging from prevention to treatment, and of course employing a multitude of media methods to help stem the epidemic. With the motto "Changing the way society treats its children and youth," since 1995 the Nelson Mandela Children's Fund (NMCF) has funded more than 780 projects; in 2002, it partnered with the Nelson Mandela Foundation (NMF) and the Human Sciences Research Council (HSRC) to do a watershed study of HIV/AIDS in South Africa. From a cross-section sample of nearly 1,000 South Africans from all walks of life, it found 11% to be HIV-positive, with women more at risk of infection than men. Although knowledge of HIV/AIDS was generally high, sexual behavior was inconsistent, and it was clear that the disease affects all races.

The Case for Communication

Preeminently, the goal here is to encourage you to consider the role of communication throughout this discussion of African women and AIDS.

Interpersonally and inter-culturally, you should be and/or become sensitive to the deep differences among and between various genders, gender orientations, ages, classes, educational opportunities, religions, and ideas of both individuals and institutions. Language plays a role; for example, we have been working with African journalists and campaign-makers to replace the term "AIDS victim" with something more mollifying such as "person living with HIV" (PLWHIV), "person living with HIV/AIDS" (PLWHA), or PLWA. If this seems nit-picky to you, think of it from the frame of reference of the person involved. Another classic case comes from our interviews with what were very open reports of sexual activity amongst African men: aware of general population statistics, we were surprised to have none admit to being self-described as gay, or homosexual. Yet, when we asked them, "Do you have sex with other men?" we got quite a large number of positive responses, almost a surprised "Of course." In addition to comfortable settings and approaches to data-gathering, we continue to conclude, words are critical.

The role of mass media is highlighted here, ranging from indigenous radio to puppets to film and video. Much of my work in Senegal focused on evaluating various programs and projects in terms of Life Skills, and that critical eye continues to this day (see also Gellar, 1995). Further, the future for Africa looks more promising once we factor in telecenters and ICTs (Information and Communication Technologies), and you may be surprised to learn how the continent has adapted to so many media choices. Communication here is also intricately aligned with development (Ansu-Kyeremeh, 1994; Archer, 2005; Armstrong, 1995; Bakut and Dutt, 2000; BBC World Service Trust, 2006; de Bruyn, M., 1992; de Waal, A., 2003; Fuller, 2002; Gumucio Dagron and Tufte, 2006; Grainger, Webb, and Elliott, 2001; Green, 2003; Hamelink, 2006; Holden, 2004; Hope, 1999; Hornik, 1988; Jacobson, 2004; Japhet, 1999; Jennings, 2005; Kevane, 2004; Mody, 2003; Rasheed and Luke, 1995; Servaes, 2007; Skard, 2003; Wambui, 2005). Although in Africa we mostly see applications for development communication in radio and theatre, in fact you will discover an enormous range of HIV/AIDS' being embedded in its edutainment. No doubt more examples will soon be spotlighted in *Communication for Development and Social Change: A Global Journal*, published by Hampton Press under the editorship of Jan Servaes, that premiered in 2006.

Mass media in the West has recently covered Africa as the new hot spot for celebrities. Think about Bono's *Product Red* campaign or his guest-editorship of a (July 2007) *Vanity Fair* special issue on Africa,[13] Angelina Jolie's having Brad Pitt's baby in Namibia, Madonna's adopting a baby in Malawi, Oprah Winfrey's setting up a girls school in South Africa, Bill Clinton's foundation and efforts against AIDS, Clay Aiken performing in Uganda, Jessica Simpson in Kenya, Don Cheadle's getting involved in Rwanda, Mia Farrow and George Clooney railing against atrocities in Darfur and the Congo. Although some skeptics might question underlying humanitarian agendas, the attention—whether in Live 8 concerts or G-8 conferences, has brought hitherto unknown attention and philanthropy that certainly can't hurt. Frankly, the most impressive of all is that Bill and Melinda Gates have actually made an effort to get to know places where their money will go.

Howard K. French, bureau chief for the *New York Times* in West and Central Africa, captures media's coverage from apartheid to genocide, including good news and bad news, in his aptly titled *Continent for the taking: The tragedy and hope*

of Africa (2004). Just as audiences wanted to replicate Meryl Streep and Robert Redford's experiences in *Out of Africa* from 1985, Alexander McCall Smith has brought attention to Botswana with his private eye Precious Ramotswe, who runs *The No. 1 Ladies' Detective Agency*; the successful series apparently has increased tourism to the continent. My primary purpose throughout, though, is to make what is happening today in Africa *real*, and readable enough here so that legions of us can act to make change(s). It is both my privilege and an indescribable push.

Communication and HIV/AIDS

The mainstay of many HIV/AIDS prevention programs has revolved around the notion of ABC: Abstain, Be faithful, and Use a Condom. Part of faith-based approaches depending on behavioral change that don't take into account the African sociocultural landscape outlined here, you will soon see how critical it is to understand and appreciate gender inequities so that proper action steps can be undertaken. "While the ABC approach has proven to have considerable value, many women are simply not in a position to abstain from sex, rely on fidelity, or negotiate condom use. ABC can only be a viable prevention option for women and girls if implemented as one component of a package of interventions aimed at redressing deep-rooted gender imbalances. These would include, among others, advocacy for the empowerment of women and the promotion of women and girls' rights," (Organizations Working in Kenya, 2006, p. 10).

This response echoes Helen Epstein (2003)'s concern about denial of AIDS reality, and the need for us to assess HIV prevention programs. Communication to and through the many societies on the continent, emphasizing mortality rather than imposing our own morality, calls for comprehensive strategies to overcome numerous vulnerabilities. Recognizing the feminization of poverty is the first step; from there, relative to Africa but undoubtedly also applicable to other areas where HIV/AIDS occurs, we find that advocacy and access—for both women and men, become paramount goals.

Literature Review

Although there have been hundreds of book written about HIV/AIDS,[14] even books detailing bibliographies about the pandemic (e.g., Esilaba, Fidzani, Kebaagetse, and Chipfakacha, 2004; Vinh-Kim, Klot, Phillips, and Pirkle, 2006), there has been surprisingly little written about the connection between AIDS and communication. Scott C. Ratzan (1996) was one of the first, emphasizing health communication and hosting one of the first panels on the subject; in fact, that was the first time my interest in the topic of AIDS was piqued, and I presented a study on reactions to basketball player Magic Johnson's announcement that he was HIV-positive (Fuller, 1992b). My co-edited book *Communicating about Communicable Diseases* (with Lilless McPherson Shilling, in 1995) included chapters on pedagogy, AIDS activism, gays, hemophiliacs, prevention strategies, support groups, caregivers, and coping with AIDS, but there was not much on Africa. Scandinavia, Australia, Thailand, Peru, and Turkey were included in my edited volume *Media-Mediated AIDS* (Fuller, 2003b), but again the continent was noticeably missing.

Corso (2003) has drawn the connection between communication and assistance for FGM-related programs, just as Taverne (1996) did relative for anti-stigma strategy about levirate practices in Burkina Faso. Diop (2000) has emphasized community involvement, Myrick (1996) communication between gay men in the U.S., and Elwood's (1999) edited volume shows a range of approaches about the crisis—if amazingly without mentioning Africa. Ditto for McKee, Bertrand, and Becker-Benton's *Strategic Communication in the HIV/AIDS Epidemic* (2004) and Edgar, Noar, and Freimuth's *Communication Perspectives on HIV/AIDS for the 21st Century* (2007), whose index does not even include any African countries.

Some publications about HIV/AIDS in Africa are country-specific, such as Adeyi, 2006 on Nigeria;[15] African Rights, 2004 on Rwanda; Armstrong, 1995 and Sylvester, 1991 on Uganda; Bate, 2003 and Crewe, 1992 on South Africa; Booth, 2003 on Kenya, Conroy and Blackie, 2006 on Malawi; Esilaba et al., 2004 and Heald, 2002 Botswana, Gausset, 2001 on Zambia; Gronemeyer, 2003 on Namibia; Kimaryo, 2004 on Lesotho; Oppong et al., 2006 on Ghana; UNAIDS, 1999 on Senegal. For more general details about African AIDS, see Barnett and Blaikie, 1992; Chirimuuta and Chirimuuta, 1989; Cohen and Trussel, 1996; Epstein, 2007; Essex et al., 1994; Iliffe, 2006; O'Manique, 2004: Parker et al., 2007; Patterson, 2006; Poku, 2006; Webb, 1997. Gender is also a critical variable (Abraham and McFadden, 1999; Adepoju and Oppong, 1994; Ahikire, 1994; Akukwe, 2005; Allen et al., 2003; Ankrah et al., 1994; Ardayfio Schandorf, 2004; Arnfred et al., 2004; Assie-Lumumba, 1997; Baerends, 1994; Berer, 1993; Bonthuys and Albertyn, 2007; Booth, 2003; Coles et al., 2007; Cooper, 1997; Cornwall, 2005; Egbo, 2000; Fleishman, 2003; Fuller, forthcoming; Greene, 1996; Grosz-Ngate and Hokole, 1997; Hodgson and McCurdy, 2001; Hofnie, Friedman, and Iipinge, 2004; Hoosen and Collins, 2004; Human Rights Watch, 2003a; Imam et al., 1997; Izumi, 2006a; Kafiris et al., 2005; Kalabamu, 2003; Kevane, 2004; Konde, 2005; Larsson et al., 1998; Malherbe et al., 2000; Meena, 1992; Morna and Ndlovu, 2007; Mwale and Burnard, 1992; Nfah-Abbenyi, 1997; Nnaemeka and Ezeilo, 2005; Nwankwo, 1996; Ogbomo, 1997; Omonubi McDonnell, 2004; Oppong et al., 2006: Oyewumi, 2005; Palriwala and Risseeu, 1996; Patton, 1994; Pereira, 2007; Rathgeber and Adera, 2000; Sall, 2000; Schlyter, 1996; Seely et al., 1992; Sherr, Hankins, and Bennett, 1996; Snyder, 1999; Stamp, 1990; Tsanga, 2003; UN Theme Group on Gender and Reproductive Health, 2005; United Nations, 2004; van der Westhuizen, 2005; Van Marle, 2006; Welpe, Thege, and Henderson, 2004; Woodward, 2002; Zeleza, 1997).

Probably the best communication scholarship relative to HIV/AIDS has come from Arvind Singhal (2001, 2003b and c; Singhal and Howard, 2003; Singhal, Rogers, and Sharma, 2003; Singhal et al., 2004), Samuel Shirley and Edna Holt Marston endowed professor and senior research fellow at the Sam Donaldson Center for Communication Studies at the University of Texas at El Palo. "We argue that the world has underestimated the role communication can play in reducing HIV infection in developing countries, which is a social, cultural and gender-related problem—not just a medical one," Singhal has stated.[16]

Most recently, Warren Parker, Asta Rau, and Penny Peppa have put out *HIV/AIDS Communication in Selected African Countries: Interventions, Responses and Possibilities* (2007). Commissioned by The Swedish International Development

Cooperation Agency (Sida), it found wide variations in HIV prevalence between and within their target countries of Botswana, Ethiopia, Kenya, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe. Realizing, then, the importance of different approaches and communication interventions, the authors suggest the following:

- The overall delivery of communication messages pertaining to awareness of AIDS, and knowledge of key aspects of the disease are extensive, and campaigns are impactful;
- A number of communication interventions are well theorized, engage audiences in appropriate languages, and achieve a high-reach through mass media;
- International and non-indigenous organizations provide an important contribution to country-level communication interventions;
- A number of indigenous interventions have been sustained over long periods, and some have expanded to other countries (e.g., *Straight Talk* and *Soul City*);
- Promotion of uptake of resources and services has been extremely successful (e.g., condoms and VCT);
- Considerable expertise for prevention communication exists in the region, via indigenous and nonindigenous organizations. (p. 7).

Conceiving of HIV prevention communication as a broad-based set of communication activities, they consider it to have two dimensions, "one involving the promotion of knowledge about particular modes of transmission and related knowledge of risk reduction or prevention, and the other dimension involving promotion of resources and service that support prevention" (p. 13).

As you will read here, AIDS in Africa goes well beyond being just a medical problem. "The epidemic feeds on the deep divisions within our societies—illiteracy, ignorance, poverty and inequality between the sexes—and deepens those divisions by making our communities poorer," Boafo and Foreman (2000, p. 3) state in their Introduction. Admittedly, once they came on board, the scientific community has made incredible advances in pharmaceutical and clinical care, even if there still is no prevention or no cure. What is needed, quite obviously, is continued cooperation from all professions and publics.

African Gender/Media Organizations

Fortunately, there are a number of communications resources throughout Africa, as well as some elsewhere that have had enormous influence on HIV/AIDS there. What follows here are brief introductions to some that play important roles in disseminating information about HIV/AIDS: the *African Gender and Media Initiative* (GEM), *African Woman and Child Features Service* (AWC), *African Women's Development and Communication Network* (FEMNET), *African Women's Media Center* (AWMC), *AfricaWoman*, the *Association for Progressive Communications* (APC-Africa-Women), the *Association of Media Women in Kenya* (AMWIK), the *Community Health Media Trust* (CHMT), *Eldis*, the *Gender and Media Southern African Network* (GEMSA), *Gender Links* (GL), *The Health Communication Partnership* (HCP), the *Liberia Media Project*, *Media Action Plan* (MAP) on HIV/AIDS and Gender, the *Media Institute of Southern Africa* (MISA), the *Open Society*

Initiative for Southern Africa (OSISA), *Soul City Institute for Health and Development Communication*, *Women'sNet*, and the *World Association for Christian Communication* (WACC).

The ***African Gender and Media Initiative*** (GEM), an alliance between the Harare-based Inter Press Service (IPS) and the Nairobi-based African Woman and Child Feature Service (AWC), brings a gendered perspective to news affecting African women. The Nairobi-based media organization ***African Woman and Child Features Service*** (AWC) trains journalists, media practitioners, and some NGOs on topics of gender, media and development. Established in 1994, it publishes articles in mainstream newspapers throughout Africa and beyond, as well as training manuals, handbooks, news bulletins, magazines, and audio and video productions for radio, television and the Internet. Coming from a progressive gender perspective, according to its Web site (http://www.awcfs.org), "AWC has a vision of Africa as a continent that understands and embraces media and gender as a cornerstone for development. To achieve this vision, AWC seeks to ensure the presence of gender issues in the media and in development. It runs a feature service, which serves as the media arm of the organization."

The ***African Women's Development and Communication Network*** (FEMNET) was established in 1988 "to share experiences, information and strategies among African women's non-governmental organisations (NGOs) through advocacy, training and communications so as to advance African women's development, equality and other human rights" (www.femnet.org.ke).

The ***African Women's Media Center*** (AWMC), a project of the International Women's Media Foundation (IWMF), was headquartered in Dakar, Senegal until 2004 but now operates across the continent. Established in 1997, it has worked with more than 900 African women journalists in various programs and workshops on "leadership development, media management, computer training in new media technologies, journalism ethics, specialized journalism skills, balancing work and family, coalition building and more. In addition to training, the centre is a clearinghouse for information on fellowships, scholarships and exchange opportunities" (http://www.iwmf.org/programs/africa.php). IWMF's main programs in Africa include:

1. The Carole Simpson Leadership Institute (CSLI) is an annual training event offering women journalists the opportunity to build skills as effective media managers. One result has been continued emphasis relative to their reporting on HIV/AIDS.
2. The Maisha Yetu ("Our Lives" in Swahili) project, begun in 2002 with a $1.5 million grant from the Bill and Melinda Gates Foundation, works to improve the quality and consistency of reportage on HIV/AIDS, TB and malaria.[17]

Monthly connecting some 80 women journalists from Ghana, Kenya, Malawi, Nigeria, Tanzania, Uganda, Zambia, and Zimbabwe by means of a virtual newsroom (VNR), *AfricaWoman* (http://www.africawoman.net) was established by Worldwoman in 2001, backed by the British Council, Department for International Development, the Westminster Foundation for Democracy, and the Six Continents Leisure Group.

The ***Association for Progressive Communications*** (APC-Africa-Women) is involved with the Digital Storytelling to End Violence Against Women and

The Harambee ("Let's work together") projects. Working "to empower African women's organisations to access and use Information and Communication Technologies (ICTs) for equality and development" (www.apcafricawomen.org), it aims at social change.

Using media as a tool to help women advance, the ***Association of Media Women in Kenya*** (AMWIK) "recognizes that gender inequality and inequity undermines the effectiveness of development. It also recognizes that media is a powerful tool for social change and agenda setting. AMWIK's challenge however remains to ensure that media outlets positively package and widely disseminate information on issues of concern to enable communities make informed choices" (www.amwik.org).

The ***Community Health Media Trust*** (CHMT), established in 1998 by Jack Lewis of Idol Pictures and Zackie Achmat of the Treatment Action Campaign (TAC), has as its goal giving a voice to people living with HIV/AIDS. Broadcasting *Beat It* and *Siyayinqoba1 Beat It* on SABC television, it has drawn large audiences and been helpful as in training programs.

Aiming "to share the best in development policy, practice and research" online by means of more than 22,000 documents from some 4,500 development organizations, ***Eldis*** (www.eldis.org/gender/index.htm) has produced the *Eldis Gender Resource Guide: Gender and Development* and has performed an *Evaluation of Stepping Stones: A Gender Transformative HIV Prevention Intervention*—showing it to be "effective in reducing sexually transmitted infections and in reducing the sexual risk taking and violence perpetration among young, rural Africa men."

The Inter- African Network for Women, Media, Gender and Development (***FAMEDEV***)/Reseau Inter-Africain des Femmes, Medias, Genre et Developpement focuses on community media and ICTs to accelerate development and participation. Established in Dakar, Senegal in 2000 as an African Regional Media Center, its key objectives are the following:

- To promote the development of the African Continent through information, communication and new technologies.
- To conscientise African people especially women, on main development issues and ways and means of liberating Africa from poverty.
- Create and entertain a network for the production, management and exchange of information on pertinent themes such as poverty, freedom of expression, gender equity, human rights, children's rights, regional integration, civic education, the environment, health and the transfer of technologies.
- To promote information and communication at grassroots level through mass media including community media.
- Involve women and men in the media in conflict prevention, management and resolution through civic journalism.
- To mobilize and encourage men and women of the media to be more interested and sensitive to health issues such as HIV/AIDS, Malaria, and TB which impede Africa's development.
- To promote programmes that are favorable to press freedom, good governance, democracy, regional integration, peace and security in African societies. (www.famedev.org)

Relative to HIV/AIDS, the FAMEDEV staff has long been involved in training Anglophone and Francophone journalists in various sectors of the media and they have developed manuals and resource packs for reporting on HIV/AIDS

in English and French, coordinated research on media coverage of public health issues, produced *HIV/AIDS Research Report and Media Guide* (2006), and presented papers on the African experience at Phnom Penh, Cambodia and Addis Ababa, Ethiopia. Its ongoing work includes publication of *Future Watch*, for young people, and *Alternative Voice* radio program out of The Gambia.

The ***Gender and Media Southern African Network*** (GEMSA) is Johannesburg-based umbrella organization, established in 2004, of individual and institutions working "to promote gender equality in and through the media" (www.gemsa.org.za). With country chapters in Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe, it supports projects such as *Sixteen Days of Activism*, the unpaid care work campaign, and the *Global Media Monitoring Project* (GMMP), an ongoing study sponsored by WACC documenting participation and portrayals of women every five years since 1995. Its network, *South African Gender and Media Network* (SAGEM), links organizations and individuals promoting gender equality in and through the media, its project *Making Every Voice Count* positioned to counter discrimination against women in the press (Morna, 2007).

"Promoting gender equality in and through the media," ***Gender Links*** (GL) has worked since 2001 on "research, training and advocacy for achieving greater gender sensitivity and balance within the media and in its editorial content; as well as strategic communication skills for gender activists and women in decision making to better access and influence media content" (www.genderlinks.org.za). Using strategic communications campaigns, it has been successful in such activities as the *Sixteen Days of Activism on Gender Violence*, the *Gender and Media Baseline Study*, the *Gender and Media Audience Study*, the *Media Action Plan on HIV and AIDS and Gender*, the *Virtual Resource Centre*, *Media Watch*, and more. GL's sponsors include Australian Aid, the Charles Stewart Mott Foundation, the Danish International Development Agency (Danida), Friedrich Ebert Foundation (FES), Hivos, International Institute for Democracy and Electoral Assistance (IDEA), Konrad-Adenauer-Stiftung (KAS), Netherlands Institute for Southern Africa (NiZA), Open Society Initiative of Southern Africa (OSISA), Open Society Foundation of South Africa (OSFSA), Sida, UNDP, UNESCO, and UNIFEM.

"Using strategic communication, engaging communities for change" is the motto for ***The Health Communication Partnership*** (HCP), a partnership between the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, the Academy for Educational Development, Save the Children, The International HIV/AIDS Alliance, and Tulane University's School of Public Health and Tropical Medicine. Its activities include:

- Assessment and program design
- State-of-the-art research and evaluation methods
- Tools and frameworks recognized as best practices
- Evidence-based programming
- Strengthening the capacity of developing country organizations
- Integrated national health communication strategies
- Alliance building and advocacy to build supportive environments
- Community participation and community-driven social change
- Interpersonal communication and counseling/Client-provider interaction
- Gender-based health communication strategies

- Mass media and entertainment-education
- Distance education for service providers
- Working with journalists
- Branding of health services and products

Although all the partners provide invaluable input, special mention should be made about Johns Hopkins' Center for Communication Programs (CCP). "Working for the transformation of conflict through dialogue" is the theme of the ***Liberia Media Project***, a coalition, established in 1998, of International Alert and local Liberian groups (Press Union of Liberia, Center for Justice and Peace Studies, and the Justice and Peace Commission).

Media Action Plan (MAP) on HIV/AIDS and Gender works as a collaborative effort by the Southern African Editors Forum (SAEF) and various NGO partners covering HIV/AIDS and gender. Some of the questions it asks journalists to consider come from *SAEF Guiding Principles for Ethical Reporting of HIV and AIDS and Gender* (2006): (1) Are the facts and statistics being cited in context, verifiable, and current? (2) If the article includes health or medical claims, has the claim been verified by two or more sources? (3) Is the health or medical claim in the public interest or can it cause harm? (4) Is the article sensitive to traditional and cultural practices? (5) Does the language and the image avoid reinforcing stereotypes? (6) Are the headings and captions accurate in their portrayal of the content of the article? (7) Does the article present an independent, analytical perspective that takes into account the views of various stakeholders on the issue? (8) Has the journalist disclosed any conflict of interest if receiving gifts or sponsorship from organizations, institutions and corporations? (9) When appropriate are the perspectives of people living with HIV and AIDS included? (10) Has the individual given expressed or written consent for the use of their name or picture in the article? (11) Does the article take into consideration the interest and safety of children portrayed in stories?[18]

Promoting pluralism, freedom of expression and media diversity, the ***Media Institute of Southern Africa*** (MISA) is a member organization (www.misa.org); headquartered in Namibia, it includes Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Tanzania, Zambia, Zimbabwe, and South Africa.

Publishers of ***Open Space, The Media: Expression and Freedom***, The Open Society Initiative for Southern Africa (OSISA) works in Angola, Botswana, the Democratic Republic of the Congo, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia, and Zimbabwe. Since 1997, the network of autonomous foundations, established by George Soros, focuses on these themes: (1) Education and ICTs; (2) Human Rights and Democracy Building (HRDB) and Media; and (3) Economic Justice and HIV and AIDS. For the last, OSISA's HIV and AIDS workplace policy aims to ensure a respectful and supportive environment:

- To minimize the possibility of HIV infection for OSISA staff, their partners and dependents;
- To ensure a supportive work environment for staff infected and affected by HIV and AIDS;
- To create an environment that respects the rights of employees and the employer, and sets out the relevant conditions of service as they might relate to an employee with HIV and AIDS;
- To manage and mitigate the impact of HIV and AIDS on the work of OSISA;

- To eliminate stigma and discrimination in the workplace on the basis of real or perceived HIV status, or vulnerability to HIV infection; and
- To ensure that employees openly living with HIV and AIDS are treated in a nondiscriminatory manner that avoids moral judgment and instead are supported and given compassion and respect.

Soul City Institute for Health and Development Communication (SC IHDC) uses multimedia approaches for social change through *Soul Buddyz*, which is aimed at 8 to 12 year olds, along with *Soul City*, which is aimed at adults and has a Regional Program partnering Botswana, Lesotho, Malawi, Mozambique, Namibia, Tanzania, Zambia, and Zimbabwe. Its Education, Training and Development unit trains and educates people about HIV/AIDS and other health-related issues by means of various edutainment approaches. Established in 1994 by Garth Japhet (1999) and Shereen Usdin, frustrated medical doctors who turned to media to get across to their constituencies, *Soul City* today has a staff of 50 and more than 100 contract workers, and is the publisher of *HIV/AIDS: A Resource for Journalists* (2003). It has become a model for HIV/AIDS edutainment.

Established in 1998 as a joint initiative of South African Non-Governmental Organisation Network (SANGONeT) and the Commission on Gender Equality (CGE), ***Women'sNet*** "works to advance gender equality and justice in South Africa through the use of Information and Communication Technologies (ICTs) by providing training and facilitating content dissemination and creation that supports women, girls, and women's and gender organisations and networks to take control of their own content and ICT use" (www.womensnet.org.za).

Since the mid-twentieth century, the ***World Association for Christian Communication*** (WACC) has been based on principles declaring that communication creates community, communication is participatory, communication liberates, communication supports and develops cultures, and communication is prophetic. Recently moving headquarters from London to Toronto, it believes that, "Stigmatisation and discrimination towards people living with HIV and AIDS increases the difficulties they experience, fuels the spread of HIV and increases the harm it causes. Many well-meaning efforts to address HIV and AIDS are insensitive to gender issues" (www.wacc.org.uk). WACC Women's Programme advocates for gender equity at national, regional and international levels—all part of the organization's commitment to communication programs and projects to empower people, "especially the dispossessed and marginalised, indigenous peoples, refugees, migrants, women, children and people with disabilities."

Approach of this Book on African Women and HIV/AIDS

> AIDS is not only taking away our children's present, it also has the potential to subtract from their future . . . In the battle against apartheid, the solidarity of people from around the world strengthened us in some of our darkest moments. Now, as we seek to counter the ravages of HIV/AIDS on all continents upon our sons and daughters, we need the same solidarity, the same passion, the same commitment and energy.
>
> Desmond Tutu, Milnerton, Cape Town, South Africa (2005).

What sets this diatribe apart from what has come before is an in-depth, holistic appraisal of biomedical, social, financial, political, and educational vulnerabilities faced by the at-risk population of African girls and women—along with hopeful prospects for development by means of various communication strategies. Painting a portrait of complex interrelationships, at its heart is the profound realization that, regardless of class and cultural heritage, African females are imprisoned by a system dominated by patriarchal practices that are both institutional and insidious (Arnfred et al., 2004; Coles, Manuh, and Miescher, 2007; Cornwall, 2005; Epstein, 2007; Iliffe, 2006; Kolawole, 1997; Malherbe, Kleijwegt, and Koen, 2000; Oyewumi, 2005; Patterson, 2006; Poku, 2006; Regis, 2003; Siplon, 2006; Stichter and Parpart, 1988). Their only hope lies with the next generation, both Africans and the world community, who must be made sensitive to what their future can contain. And so, following Robin Gorna's (1996, p. 294) plea that, "A feminist approach to AIDS is long overdue," this book obviously comes from a womanist point of view.

The crisis includes questioning the role not only of money and/or policy but also of information gaps in what has become the most blatant example imaginable of global health injustices. Transnational in scope, HIV/AIDS nevertheless knows no geo-political boundaries; yet, we increasingly realize it is a disease of *poverty*, something of today's equivalent of nineteenth century tuberculosis as a North-South issue epitomizing divides between developed and developing countries. The culture of African poverty is multidimensional, intergenerational, and gendered. AIDS here goes beyond being a health issue to being a development one, and so it should be also considered from a socio-political-economic perspective.

No doubt it is important to recognize the kinds of biases that are often correctly leveled against researchers such as myself who are westerners (see Fuller, 2003a; Rodlach, 2006). Although my graduate training has been in Human Development in the Carkhuff-Berenson model, emphasizing respect and frame of reference of others, my education in sociocultural sensitivity is constant and continual (see also Herdt, 2004). Disparaging either the continent or its people is my furthest intent here, and hopefully the reader will recognize transparently whatever perspectives may be at play. In analyzing the difficulties inherent in the African health care scene, my approach is meant to be objective and sensitive, not subjective and judgmental. An admonition from more than two decades ago by Edna G. Bay (1982, p. 4) still cautions us: "In a period when little consensus exists either in the West or in Africa on what women's roles *should* be in contemporary society, scholars have been left to evaluate change with little more than their own personal visions of women's proper place." Inserting something very personal into this book, I am all too aware of the multiple roles we women of all configurations must juggle, and yet I can mostly relate to those African women who place family first. We all work, as I've been heard to say frequently to friends, but the pay(offs) certainly come in differing ways.

My initial idea was to use the term "AIDS apartheid" in the title of this book, underscoring the sociocultural gap whereby women in Africa are at particular risk of HIV/AIDS. An Ethiopian friend who saw my early outline told me he thought it critical to incorporate, implying as it does a strong sense of resistance. Consider the cruel irony of postapartheid South Africa, which today has the largest cases of HIV/AIDS in the world (5.3 million). "How will we celebrate our liberation if up to 20 percent of the population may be positive?" inquired Ivan

Toms back in 1990 (p. 13). Even today, the disease is so politicized that it is difficult to develop and diffuse a national AIDS policy. Think of Ethiopia, the second most populous country on the continent, which UNICEF has determined to be "one of the worst places on earth to be born a girl."[19] Girls there, lacking access to education, tend to be highly illiterate, more than 115,000 under the age of 14 are HIV positive, and the country has the dubious distinction of having one of the highest maternal mortality rates in the world.

Emphasis here is on the fact that the many vulnerabilities affecting African women and HIV/AIDS are not mutually exclusive from one another. As Eka Esu-Williams (1994, p. 24), former president of the Society for Women Against AIDS in Africa (SWAA), has pointed out, "AIDS is bringing about personal and collective vulnerability . . . (that) stems from the rapidly progressing force of the pandemic and a receding, weakening global response." Even though the Table of Contents lists a range of concerns—individual/biological, sociocultural, economic, legal/political, educational, and more, it is easy to see how any single topic relates to the others. For example, since they are forced to marry so young and have so many children right away, far too many African girls are forbidden to attend school. Uneducated, far too many African women are unaware of their rights, even if limited. Unapprised of their governmental or medical rights, far too many African girls and women are exploited physically, mentally, and work-wise. Lacking the empowerment that comes with self-awareness and the developments of various areas of expertise, far too few African women participate equitably in the workplace or lead lives of their own choice. Because famine and poverty lie at the heart of too many of their lives, too many African women are forced to work rather than go to school—many on the streets, or trafficked, with no knowledge of or access to criminal justice systems. As most must marry, too many African women become the victims of domestic violence and/or marital rape, with little recourse for redress, rights for inheritance or property, and so they live within proscribed patriarchal customs and traditions.

If those of us with that education, and rights, and money, and expertise do not respond to what is happening to our world's most needy counterparts, we must do more than hang our hands in shame. "The story of the HIV/AIDS crisis in Africa, which has already claimed more than 20 million lives, is one of massive neglect and denial," Human Rights Watch (2003a, p. 4) has correctly claimed. "Millions of Africans had already died before the continent's AIDS epidemic even registered on the global radar screen or was publicly recognized as a problem by decision-makers in affected countries." HRW plays a powerful role in keeping us on our toes about events in Africa (e.g., Schatz, 2007).

But before getting to all that, this book begins, like life itself, in utero. If a fetus lacks proper nutrition, the struggle to exist is all the more challenging. Appropriately, then, chapter 2, on African women's biomedical vulnerabilities, begins with a discussion of physiology. It starts with virginity and contraception, then moves on to female genital mutilation (FGM) and fistula, pregnancy, abortion/miscarriage, childbirth, breastfeeding, gum tattooing, and malnutrition. Sociocultural vulnerabilities, in chapter 3, include a range of rituals and traditions that will have you holding your breath. While you may be familiar with polygamy (also called polygyny), you may not realize its reach in Africa, and the numerous implications it holds for women competing with other wives for their "social security." Under a discussion of the African family, marriage is examined at length, as well as children—including orphans and street children. A number

of practices are outlined when women become widowed, such as levirate and sororate, along with sexual "cleansing" performed by male family members to keep the woman within the tribal network. "Dry sex," made possible by the insertion of certain herbs into the vagina as a means of pleasing one's partner, is another source of infection for compliant, subservient women who live with cultural inhibitions against their discussing, never mind negotiating their sexual lives. The many societal roles African women play are outlined here, ranging from sexuality training to grandmotherhood. And, since it is such an integral part of African women's experience, GBV, including rape, needs to be included in this discussion, along with other male perquisites. Finally, spirituality/religion, witchcraft, and dealing with death round out the many intersecting, fascinating aspects of African culture.

Women's work in Africa, while limited by education and allowances by men, is constant, if hardly compensated. Tainted by persistent poverty, her economic vulnerabilities as outlined in chapter 4 are pitiful. Much of the conversation surrounding HIV/AIDS in Africa concerns money, most of it concentrated on drug costs, or how the disease has affected national budgets. After a general discussion about the African economy, women's work, and the feminization of poverty comes an analysis of transactional sex, including prostitution, cross-generational/intergenerational sex, and Sugar Daddies. Next, because it is at the heart of this book, is a section on gender and development, highlighting AIDS activism and the work of the Panos Institute. Funding and philanthropy for HIV/AIDS rounds out the chapter.

Legally and politically, African laws and regulations also work against women, as witnessed in chapter 5's stories and scenarios. Although it is important to keep African laws and regulations in historical perspective, real life experiences are just as telling. Nationalism and the role of war—however divisive and distracting, play an integral part in explaining how HIV/AIDS has disrupted development. Repeatedly, we realize that educational vulnerabilities inherent in African school systems, the subject of chapter 6, offer few opportunities and far too many obstacles. After introducing the challenges of Africa's schools and schooling, opportunities and obstacles are delineated, including subjects like stigma and African media aimed at children, along with hopeful examples such as the Oprah Winfrey Leadership Academy for Girls and the Bowa Advancement of Girls Education Project. Entertainment-Education (E-E) as a viable approach is defined and described as the perfect prelude to what will follow.

Finally, and fortunately, chapter 7, on Communication Perspectives, begins a positive, important discussion of solutions to the many issues surrounding African women and HIV/AIDS. Beginning with an argument for communication (interpersonal/intercultural, media, and ICTs), it outlines HIV/AIDS-related African media in terms of a number of resources and campaigns before tackling African community media and collaborations, African HIV/AIDS-related print media (including "news," comics and cartoons), African art(s) and the dramatizing of HIV/AIDS in Africa, music, song and dance. Radio in Africa—grassroots, community radio, forms the bulk of this chapter, as it is such a popular form for edutaining citizens about HIV/AIDS. Community television and video are of course also important in Africa, particularly in participatory form. The discussion on African film is supplemented with an appendix with a filmography/videography listing some 135 AIDS-related choices produced by and for Africans in more than two dozen countries. As ICTs also figure in the fight against

HIV/AIDS in Africa, they too are included, with special attention given to libraries, telecenters, multimedia centers, and telephony. The upbeat approach continues in chapter 8, on Communication Promises, concluding with in-depth listings of groups dedicated to the topic of African women and HIV/AIDS (gender/media and health/communication organizations, campaigns, initiatives, and projects), individual contributors, and hopes/plans for Africa's future—pointing out how this topic is more than medicine, what more research is needed, and a perspective for where *you* fit in the picture offering hope for African women and HIV/AIDS.

Back in 2003 (b), Nicholas D. Kristof declared Africa as "broken," needing high-level attention to fix itself; as you read on, and as you see some promise by communication strategies and interventions, you can decide. This is a book, you will find, about real women and their families, touching on health care, human rights, pharmaceutical companies, intellectual property rights, politics, poverty, globalization, trade policies, changing nation-states, tribal practices, outsourcing, technological development, migration, gendered discourses, workplace hazards, sexual violence, exposure to toxic substances, inequalities, access (or lack thereof) to (affordable) drugs and/or legal redresses, burdens of overwhelming foreign debt,[20] the interdependence of treatment for and prevention of HIV/AIDS, corrupt governments, gender inequalities hampering demands for fidelity, the role of war, goal of voluntary counseling and testing without stigma, and so much more. When all is done, it is both maddening in terms of knowing therapies are beyond the reach of too many African women and encouraging in terms of the many actual and potential resources that can help alleviate problems. One thing is clear, though: African women are truly unique in their vulnerability to HIV/AIDS.

Notes

1. Donald G. McNeil, Jr. (2007, p. 4) notes: "AIDS has always been maddening. It moves more slowly than anything that rides sneezes or coughs or rats or mosquitoes. It permits years of symptom-free infectivity and kills, like a torturer, at its leisure."
2. The Black Death of the fourteenth century—bubonic, pneumonic, and septicemic—killed an estimated 75 million people as the plague spread from Asia to Europe from 1347 to 1351, and the 1918 influenza epidemic claimed 25 million lives. See also Hunter, 2004.
3. National Geographic's special issue on Africa (Cobb, 2005) reports that it has 20% of the world's total landmass and 14% of the world's people (900 million)—which includes 15 million refugees. Although there are predictions that the continent's population will double by mid-century, AIDS obviously plays a pivotal role in that progress.
4. See (http://strangemaps.wordpress.com/2006/11/20/35-the-size-of-africa).
5. The Lusophone countries include Angola, Mozambique, Cape Verde, Guinea-Bissau, and São-Tomée Príncipe.
6. The frightening notion of having sex with a virgin reportedly traces to advice from African traditional healers and *marabouts*.
7. Kaori Izumi (2006a, p. 5) points out that this myth from Zimbabwe means that, "Because of their disability, many of these girl victims are not able to testify in court."
8. See Ardayfio Schandorf, 2004, for descriptions on the Ghanaian family.

9. In addition to reportage on everyday conversations and interviews with African women, as well as encouraging their written words, homage also goes to work by Barnett and Stein, 1998; Bond, 2005; Davison, 1989; Hall, 2002; Hoosen and Collins, 2004; Izumi, 2006b; Janzen, 1992; Gronemeyer, 2003; Halperin, 2005; Maathai, 2007; Mabokela, 2004; Mirza and Strobel, 1989; Mohanty, 1997; Parameswaran, 2002; Saur, 2005; Sidikou, 2001; Sutherland-Addy, 2005; White, Miescher, and Cohen, 2001; and Wright, 1993.
10. This refers to sexual activity involving oral contact with the penis and/or the vagina.
11. Virgins are distinguished by wearing woolen tassels on their heads—a Swazi tradition.
12. Swazi king hosts costly birthday bash as subject suffer, *Agence France-Presse*, April 19, 2005.
13. In his editorial introduction to the *Vanity Fair* issue on Africa, with historic shots by famed photographer Annie Leibovitz, Bono declared that, "Africa is the proving ground for whether or not we believe in equality."
14. For starters, see Barnett and Whiteside, 2002; Bond et al., 1997; Farmer et al., 1996; Fuller, 2003b; Haour-Knipe and Rector, 1996; Holden, 2004; Hubley, 2002; Irwin, 2003; Kalipeni et al., 2003; King and King, 2000; Miller and Rockwell, 1988; Poku and Whiteside, 2004; Sabatier, 1988; Vinh-Kim et al., 2006; Whiteside and Barnett, 2006.
15. See also Packer, 2006, on Lagos as "The Megacity," featuring a photo of Nigerian women living in the city dump; the caption reads, "Lagos has become the archetype of the megacity, perhaps because its growth has been so explosive, perhaps because its cityscape has become so apocalyptic."
16. Arvind Singhal's statement is included in Ohio University's *Research News* (December 2, 2002) in a review titled "New book explores how communication can combat HIV/AIDS."
17. Celia W. Dugger (The mystery of malaria: Why is it still killing? *International Herald Tribune*, June 28, 2006, p. 2) has reported that more than 8,000,000 African children die from malaria each year.
18. These questions appear on the back cover of the book; for more information, contact Daniel Molokele, regional coordinator of SAEF (daniel.molokele@yahoo.co.uk)
19. *Ethiopia: UNICEF reports plight of girls* (IRIN, December 11, 2003).
20. Susan S. Hunter (2003, p. 223) has ranted, "More shameful still is the fact that the total amount African nations pay for debt services each year, $14.5 billion, is greater than the total aid they receive, resulting in a net overflow each year from the poorest of the world's poor into the pockets of the rich."

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CHAPTER TWO

Biomedical Vulnerabilities

Although AIDS has a long period of latency—on average, in Africa, about 10 years, women's physiology is partly to account for the fact that they are twice as likely as men to be infected in vaginal intercourse (Koch-Weser and Vanderschmidt, 1988). With African women infected earlier and harsher than men, there are wide concerns about perinatal transmission, maternal and mental health, disabilities,[1]and children's wellbeing. You will be appalled to read here about social injustices relative to these issues: virginity, contraception, female genital mutilation, fistula, pregnancy, abortion and miscarriage, childbirth, breastfeeding, gum tattooing, and malnutrition. It is appropriate to begin this chapter with this quotation from Eka Esu-Williams, a founding member and president of the Society for Women Against AIDS in Africa (SWAA) from 1991 to 2001, an organization that has played a pivotal role in my research.

African Women's Physiology

> We all know that biology alone does not explain why women are being infected at a much younger age than men across Africa, and why, despite being infected, some women choose to have children. It does not explain why women are more likely than men to sell their bodies for money or why many women are unable to leave relationships in which the risk of becoming HIV-infected is a reality. Biology does not explain why men often prefer unprotected intercourse and are more likely to engage in multiple relationships...We also know that, among relatively unaffected nations and communities, the poor and the marginalized are much more likely to face explosive epidemics than the well established and the well-to-do.
>
> Eka Esu-Williams, *AIDS in the 1990s* (1995), pp. 26–27.

A double standard is at play in African society whereby it is understood that young women will enter into marriage as virgins and remain faithful once there, while male infidelity is expected as a form of entitlement. Female sexuality, very much a cultural taboo,[2] lacks both an identity and a recognition of assertiveness.

Physically, it is important to remember that the mucous membranes on the cervix of the uterus of young women are especially vulnerable to sexually

transmitted diseases (STDs), including HIV (McNamara, 1991). Oftentimes, young African girls' first sexual experience, when the hymen is ruptured, creates early infection from what was hardly their own call, and an unlubricated surface itself might be irritated by penile penetration. Douching is certainly no protection against STDs (Gresenguet and Kreiss, 1997). Lars O. Kallings, director of the National Bacteriological Laboratory in Stockholm, Sweden and the WHO Collaborating Centre for AIDS (1988, p. 339) elaborates:

> In young women, the outer part of the cervix, mechanically exposed in the vagina during intercourse, is covered by the same type of delicate epithelium as inside the cervix . . . The vulnerable cells are sensitive to infection by papillomavirus, gonococci and chlamydia and to abrasions causing bleedings. In young women, the hormones used for contraception tend to increase the ectopia.

Horrifyingly, all too often in Africa that young woman's first experience of sexual intercourse comes against her will. Because girls and women have such little value, too many report numerous instances of what might be termed "biological sexism" in terms of sexual assault and rape, their developing mucous membranes particularly susceptible to breakages and bleeding. Further, trauma can cause tears in vaginal skin, encouraging the entrance of HIV, Brooke Grundfest Schoepf (1997, p. 327) reminds us, adding, "Body fluids, particularly semen and blood, are considered powerful substances in African cosmologies. The red/white color symbolism common to many cultures obtains: white semen is believed to join red blood in conception. Their common status as life forces confers a conceptual identity."

Virginity

In some societies, such as the Ketu of Nigeria (Babatunde, 1998, p. 95), where a blood-spattered garment on the wedding day needs to serve as proof, "The preservation of virginity has its individual and collective aspects. The virgin is the epitome of the cultured, the educated. She is a symbol of pure and inaccessible womanhood, the figure of female victory over male machinations." Oftentimes, loss of virginity is associated with fire, as male sexual vigor and virility; Malcolm Ruel (1997, p. 78) points out phrases like "lighting the girl's fire," "coming to beg fire," "sacred fire," or "warming the land." Yet, all too often we find that the culture of virginity comes with its own inherent risks.

Just as a girl's virginity has historically been associated with honor in many cultures, so it is in Africa. The problem is, virginity has had some odd twists there, such as their exploitation under the curative notion that sex with a virgin, or a child, can cure you of AIDS (Meel, 2003). More recent is the "virgin census," facilitating proven purity into bonuses such as cost-free college or sewing machines (Wax, 2005), but the process is not without its detractors—it can be traumatizing, it can stigmatize rape victims, the tests are not always accurate, and, worst of all, they can be criticized as another case of politics interfering into peoples' lives (see Thomas, 2003). With the current Bush administration holding up abstinence as the goal in AIDS prevention, far too many governments have

capitulated to the plan. Gayle Forman (2000, p. 1) provides a first-hand view of the process of virginity testing (VT):

> On a brisk, sunny winter's morning in the South African village of Tshelimnyama, I watch as 17-year old Pumla Majola strips out of her jeans and sweatshirt, and puts on a traditional Zulu outfit of a short purple skirt and beaded necklace. Breasts bared, she marches onto a soccer field and joins hundreds of other girls, some as young as 6. Pumla waits in the U-shaped line, and when her turn comes, she kicks off her panties before lying down on woven mats and opening her legs. An older woman dressed in a bright skirt and turban peers into Pumla's vagina, spreading the lips with her fingers. After about 10 seconds of pawing around, the woman slaps her on the thighs, and Pumla jumps up as the women around her ululate and dance. One of them puts a purple stamp with the examiner's name on it over Pumla's breast and hands her a certificate that says "Pumla has been found to be a virgin."

The Commission on Gender Equality (CGE) held a conference on virginity testing in 2000, questioning renewed interest in the practice under the pretext of returning to African (Zulu) culture and tradition, preventing the spread of HIV/AIDS and teenage pregnancy, promoting morality, and preserving virginity before marriage—when, in fact, only girls were being tested and it did not appear to make any difference in HIV transmission.

Contraception

Although fertility and children are preeminently desirable for African women, who have the lowest levels of contraceptive use and the highest fertility levels in the world, there are certainly times when various forms of contraception are appropriate (see Bledsoe, 1999; Feldman-Savelsberg, 1999; Muller, 1999; Riedmann, 1993; Rosen and Conly, 1998). This is a culture, after all, where continuity of lineage is prized, and where family is at the heart of all interests. Procreation is the main point of existence in Africa; after all, it encourages the continuance of polygyny, and in some areas is even considered a stark necessity. "Marriage and having children is a religious duty has well as a social duty," Robert B. Fisher (1998, p. 82) has declared. Wanting to ensure good labor and happy outcomes, the mother-to-be resorts to several natural and spiritual means beyond collecting and taking various natural medicines:

> To prevent the evil forces that roam the world, witches and sorcerers, from harming her or her child, she enlists the aid of a deity or she wears talismans around her waist. She hangs charms at her door, and at night she mixes herbs with steaming water to purify the air. She is obligated to observe several taboos, such as abstaining from certain foods or drinks, avoiding the sight of blood, and not seeing or hearing about something monstrous or ugly lest her child be ugly...
>
> If the mother's labor is hard, some may consider the possibility of her infidelity toward her husband.

In Uganda during the 1990s, fertility was estimated at 7.3 children per woman, "reflecting high demand for children, low use of contraceptives, and an early marriage pattern" (Armstrong, 1995, p. 17)—Ugandan women having the third highest fertility rate in the world, after Yemen and Niger, and some 43% of girls in the Manafwa District reportedly pregnant before age 16 (Mafabi, 2007[3]). Subfecundity, or a five-year period without a live birth during a woman's reproductive years, is uncommon only in certain areas, even though infant survivorship is common throughout. Reduced fertility was found, though, from a large, controlled three-year study of HIV-positive Zairian women who had just given birth (Ryder et al., 1991). Throughout most of Africa, don't forget, high fertility is a necessary desire, as producing children is seen as the most important—oftentimes the *only* important thing a woman is capable of doing with her life and enhancing the prestige of her man. The problem is, her chances of losing her life at childbirth, including losing the child either then or soon thereafter, are simply too high. A child's welfare takes precedence over a mother's, and there is hardly an issue of whose life will be chosen should a mother-child problem occur.

Infants can become HIV-infected from their mothers before, during, or after birth, with "transplacental" (by means of the placenta) infection having been identified as early as 13 weeks. During labor and delivery there is always the risk of what is called "intrapartum" infection by exposure to maternal blood and genital tract secretions, never mind deliveries by Caesarian section. The breast milk controversy is discussed below.

Although increased condom use as a means of HIV prevention is strongly being pushed through numerous campaigns, at this point most research shows that condoms are mainly used in commercial sexual contacts and not so much at home. Hence, it would appear that fertility rates remain high even as mortality rates are climbing (Howson et al., 1996; Mulama, 2004). Safe motherhood projects, such as Senegal's Maternal Health/Family Planning Project, *Communicating Safe Motherhood in Morocco* (2000), or Khalil and Roudi-Fahimi's 2004 report from Egypt, need to be implemented across the continent. Improving maternal health is goal #5 of the UN Millennium Development Goals (MDGs), but a 2007 update on Africa is most disconcerting: "Maternal health remains a regional and global scandal, with the odds that a sub-Saharan African woman will die from complications of pregnancy and childbirth during her life at 1 in 16, compared to 1 in 3,800 in the developed world."[4]

For the most part, the topic of contraception is not an open one, and much of it is practiced secretly. Victor Agadjanian (2002) found that Mozambican males discussed fertility controls with their friends, but hardly ever talked about it with their wives or girlfriends. Some women prolong breastfeeding, having been told that it works against another quick pregnancy. Mwale and Burnard (1992, p. 54) interviewed 36 women in Zambia, finding frightening comments like this: "There is no way of protecting ourselves since we don't know how it is transmitted and . . . we don't know how to prevent it especially us married elderly people . . . we don't know how to protect ourselves." Vasectomy appears to be roundly rejected.

Although the idea has been around since a prototype was launched in Britain in 1920, only recently has the female condom come back into favor. Today, there is "Femidom" in the United States and Switzerland, "Reality" in the United States, and "Femi" in other countries. A 17-centimeter polyurethene

sheath meant to loosely line the vagina, the female condom has a soft outer rim that remains outside the vagina during intercourse, providing pleasure for both partners. Zambian hairdressers have been trained to tell about them to their clients, Ugandan women have shunned them as not user-friendly, and they are subsidized in Gabon, but still are not widely accepted in Africa. According to James and Weir (1993, p. 167), "If the female condom reaches the market widely, it would become the only available barrier method controlled by women to provide as much protection as male condoms against STDs and HIV. This would be its main advantage." Unfortunately, there are still a number of disadvantages, such as problems with its getting pushed into the woman's vagina, getting bypassed during penetration, or that it slipped out or was drawn out by a penis. Also, its cost is roughly three times that of male condoms, the outer ring can cause soreness, it is only available in one length (17 cm), and it can appear sexually unappealing to see the outer ring loosely hanging at the vulva. But worst of all, some of our clients at SWAA complained about awkward, loud squishy noises that emanated during intercourse. This whole issue is a classic one for us women, one for which we must demand improvements along with relevant tests and trials (see Stadler, Delany, and Mntambo, 2008). And if matters couldn't get worse, the head of the Catholic church in Mozambique has made it clear he thinks European-made condoms are tainted with HIV/AIDS, part of a conspiracy theory to rid the world of Africans.[5] Still, you might get a kick out of knowing that some Zimbabwean entrepreneurs have been transforming female condoms into brightly colored, fashionable bangles.

There are also disadvantages of male condoms, even though we know that, when properly used, they can significantly reduce HIV transmission. Seth F. Berkley (1994, p. 485) of the Rockefeller Foundation paints this frighteningly negative picture:

> Unless the women is empowered to control the sexual relationship, its use depends on her partner; it reduces sensitivity; it may elicit religious disapproval; it cannot be reused, and therefore each couple requires a large number; distribution is problematic in many parts of Africa; it is too expensive for the poorest persons; it is not 100% effective in preventing HIV transmission; it does not have an indefinite shelf life and may degenerate in the heat and sun; and it cannot be used for HIV prevention while a couple is trying to conceive.

Mwale and Burnard (1992)'s interviews found that condoms tended to be a source of problems for Zambian women. One respondent said: "I have heard of the condoms but the men refuse to use them and I don't know why they refuse to use them . . . I wish men would agree to use the condom and even coitus interruptus" (p. 42). Another informant confessed, "I have not heard of the condom since I was born or even seen one" (p. 43).

Attitudes toward condom use in the Kampala section of Uganda by Rwabukwali et al. (1994) found that all of the women in their study, 65 of them HIV-infected and 65 not, had heard of AIDS, knew it was transmitted through sexual activity, but not a single one used condoms. Some of their comments were chilling, such as the 21-year old HIV-positive woman who reported, "I hear that people can use condoms to avoid catching the disease—AIDS—while

having sex, but I have never discussed it with my husband" (p. 81). Or the 18-year old HIV-negative one who declared, "I have never used condoms to prevent catching AIDS. I can't use them even if they are available to me, the implications of men who use condoms is that they are womanizers" (p. 82). A 17-year old HIV-positive girl stated, "I have never used condoms and I don't think I will ever use them because we are told that if you use condoms it sticks to your uterus and you will require an operation to remove it. This operation may result in your death" (Ibid.) Clearly, we are a long way away from a "domestication" of condom usage among married couples, never mind sexual partners in general. Yet, Uganda's Ministry of Health has had success with two innovative strategies to reduce fertility: having nurses live and work in community-constructed health centers, so people have easy access to them, and a process known as *zurugelu* ("togetherness") whereby local volunteers go door-to-door to talk about health and reproductive issues (Low-Beer and Stoneburner, 2004). And so we wait more advancements in vaginal microbicides (Ingham, 2007), gels (Kahn, 2008), and perhaps the female condom as barriers against HIV/AIDS.

Biomedical Issues Relative to HIV/AIDS in Africa

> HIV/AIDS policy fails to address the reasons why sex and birth are more risky in Africa. Malnutrition lowers immunity and increases viral load in HIV-infected persons, making them more contagious. Malaria also increases viral load and thus the risk of sexual and vertical HIV transmission. Schistosomiasis increases risk of sexual transmission of HIV by lowering immune response and by causing genital lesions and inflammation. The weaknesses of developing economies and governance structures also interact with health variables. Often the best investment for improving health and preventing disease is outside the health sector. HIV prevention must go beyond last-minute interventions, such as promoting abstinence or condom use, and address the economic context in which risky behaviors occur.
>
> Eileen Stillwagon, Reducing Environmental Risk to Prevent HIV Transmission in Sub-Saharan Africa (2006b, p. 1). Female genital mutilation (FGM).

Female Genital Mutilation (FGM)

> The practice of female circumcision is therefore not a simple cultural practice but one that is as political as it is economically motivated . . . This ritual has economic implications for the mother for whom it is the culmination of her daughter's commercial servitude and, as she puts it, the old age insurance that she expects and demands of her daughter.
>
> Juliana Makuchi Nfah-Abbenyi, *Gender in African Women's Writing* (1997), p. 87.

Probably no topic better signifies what this book wants to accomplish than this controversial topic.[6] As with all other issues, my goal here is not to sensationalize, nor to judge; rather, it is to delineate the number of vulnerabilities plaguing African

women—hoping to galvanize as many of us as possible to recognize the cultural climate within which our sisters live so that we might help where possible.[7] It is also to point out yet one more overarching example of patriarchal control.

This section is titled Female Genital Mutilation (FGM), but there are many other terms that might be less intimidating. Variously called Female Genital Cutting (FGC), Sunna Circumcision, Clitoridectomy, Female Genital Surgery, Pharaonic Circumcision, Female Excision, or Ablation, it must be kept in mind that, for certain societies, it is known as a traditional, societal initiation rite, for others as a human rights violation (Masterson and Swanson, 2000; Rahman and Toubia, 2000). Circumcision, then, is a euphemism. Throughout most of Africa, female circumcision by any name is a central aspect of gender identification (see Nnaemeka, 2005; Ogbomo, 1997; Swantz, 1995). The term "female genital mutilation" was endorsed in 1989 when it was reported on by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), referring to the severity and irreversible damage inflicted on the body, and it is the chosen one of the UN, the World Conference on Women, WHO, and other organizations. It is often associated with moral outrage.

In the Sudan, Africa's largest country, neither circumcision nor mutilation is the term of choice; rather, the Arabic word is *Tahur*, which translates as "purification." In Nigeria, female genital cutting, valued as an ancient practice mentioned in pharaonic writings, is called "having your bath." And in Tanzania there is a very active organization, established in 1996, called Women Wake Up (WOWAP), a voluntary NGO that fights against FGM.

Cultural, not a religious practice, female circumcision involves the removal of various female genitalia. Although it occurs throughout the world, it is a practice originating from and particularly common today in Africa. What makes it particularly heinous, and unsafe (both physically and psychologically), is when the process occurs under highly unsanitary conditions and without anesthesia. The cutting itself, whether part of an official ceremony and/or performed on just one person or a group of women, can be done with a razor blade, a knife (e.g., a saw-toothed knife in Mali), scissors, a piece of glass, the lid off a tin can, or whatever sharp object may be chosen. In some parts of The Gambia, fingernails pluck out the clitoris from baby girls. Lillian Passmore Sanderson (1981, pp. 19–20) points out that who performs genital excisions varies around Africa: trained midwives in urban areas such as Khartoum and Mogadishu, mothers in Djibouti, old men among the Pokot, the village barber in Egypt. It is often a class or clan thing. Although men are not usually permitted to attend the operations, the fathers are the ones who pay. Sanderson cites one such event, witnessed by L. Bruce-Chwatt among the M'Bwake people of northwest Zaire among a group of girls aged ten to fourteen:

> The ceremony was preceded by singing and dancing. The girls' bodies were painted and adored. On this occasion the operation was performed by an elder of the tribe. In a secluded part of the forest he "grasps the clitoris and labia minora with his fingers and cuts off the parts with one stroke of a sharp knife." Although the girls were given no anaesthetic they did not complain or cry. No attempt was made to arrest hemorrhage, but chicken feathers were sometimes applied to the wound. The girls convalesced in an isolated hut where they were looked after and given some instruction

by elderly women. They returned to their village when their wounds had healed. (p. 21)

Done by an old woman (known as *Gedda* in Somalia), a traditional midwife, a barber, a traditional birth attendant (known as *Daya* in Egypt and the Sudan), a healer,[8] or whomever, the idea is that a woman's desire for sex will be reduced, keeping her faithful and thus maintaining familial *honor* for what is expected of a woman—especially, as the man ages. Sexuality, after all, is more a social gender role than a personal one in Africa. Sexual relationships, oftentimes occurring within a polygamous structure, take place with the explicit notion of increasing a family.

Some African societies consider the clitoris and the labia as male body parts, thinking that their removal will enhance and insure femininity. The clitoris might also be considered impure, so its absence assumes that the female can be trusted to handle food and water, or rub against a man's penis, or have pure breast milk, or generally be clean and become fertile. In some places, it is considered ugly, dirty, disfiguring, unpleasant either to see or to touch; in others, it is feared that an "untrimmed" clitoris might grow until it would hang below the knees. "There is frequent mention (Mali, Kenya, Sudan, Nigeria) of the clitoris being believed to be an aggressive organ," Dorkenoo and Elworthy (1992, p. 13) tell us, "threatening the male organ and even endangering the baby during delivery." Catherine Mwesigwa's recent Op-Ed,[9] citing how more than 6,000 Ugandan women die annually due to pregnancy and childbirth complications due to FGM, points out that, "In many FGM cultures, the first born of a woman often dies because of obstructed labour—the passage is so narrow that the baby has no way through. The babies that make it out alive often have to be resuscitated at delivery because of the long labour. In adverse situations both the mothers and their babies die." In addition, a report in *The Lancet* (Santangelo, 2006) suggests that pregnant women who have undergone FGM face higher obstetric risks during the perinatal period (just before and just after birth); based on a WHO study of births between November, 2001 and March, 2003 in Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and the Sudan, the researchers warned against FGM.

The intact clitoris, the thinking goes, might lead to lesbianism, or encourage masturbation. Hanny Lightfoot-Klein (1989) points out that, "While clitoridectomy appears to have been restricted to those of high social rank, infibulations, on the other hand, seems to have been reserved for slave girls, many of whom were transported from Sudan and Nubia." Consider some of these comments from men about FGM (cited in Dorkenoo, 1994, p. 53):

- "We do not want our women to be prostitutes."
- "We do not want any women's liberation here. This is our culture. The Western culture is degenerate. You have been indoctrinated to feminism which is alien to our culture. The feminists are a group of masturbators obsessed with orgasms."
- "Oh, the African intellectual hysteria! People cannot even get a roof over their heads and they are talking about this. There are more important problems to deal with."
- "My wife, mother and grandmother have had it done, and they are not complaining. When these foreigners talk about female circumcision, I asked them what do they know? I tell them to go and ask my grandmother."
- "You want our women to be lesbians?"

Whether performed at birth (e.g., in Nigeria) or soon thereafter (e.g., certain Arabs), between the ages of four and eight (e.g., Egyptians and the Sudanese), first menstruation, just prior to marriage, as part of an (arranged) marriage ceremony (e.g., the Rendille of Northern Kenya), during pregnancy (in some communities, on a woman when she is six months pregnant), after childbirth (e.g., Kenya or Sierra Leone, where it is performed as part of a "Secret Society"), or even on adult women (e.g., Uganda), female circumcision is a result of local social conditioning, bringing a community together and reinforcing its identity. It behooves us to include details about the aforementioned Rendille excision ceremony during the marriage, arranged by the woman's family without her involvement and negotiated between elders of the two clans, beginning with a ritual procession two days before the wedding:

> A ram is slaughtered and presented to the bride's mother for a feast among married women, and the skin of the ram is prepared for the bride to sit upon while being cut. The procession arrives again on the eve of the wedding, and girls bring red ochre to smear on the bride's beaded necklaces.
>
> On the wedding day, before dawn the circumciser (*kamaratan*), who was selected by the bride's mother, is brought to the hut, and at first light the young bride is circumcised. The groom's family brings animals to pay the *kamaratan* for her service, and one sheep is given as a gift to the bride's mother and tied to the outside of the hut. It is said that the sheep, as it bleats in the midday heat, forewarns the bride of the burden and responsibilities accompanying marriage...
>
> While being cut, the girl is held still by two women, one holding her legs and the other holding her torso. The *kamaratan* kneels between the girl's legs and quickly removes the clitoris and labia minora, and the cut tissue is buried beneath a hearthstone in the center of the hut. The fresh wound is rinsed with milky water steeped with herbs (*ikiroriti*) and examined for mistakes. The bride is then advised to sit quietly with her legs together, and periodically women tending her check to see if her blood has clotted. If the bleeding continues, several remedies may be tried. In some cases, the girl is told to drink plain milk or milk mixed with blood until the bleeding stops. Alternatively, she is given water boiled with small bitter seeds known locally as *khankho*, which are said to make the blood clot. For the next several days the bride will be nursed, resting and rinsing the wound with water boiled with herbs several times a day. Additionally, it is believed that a good diet, one of milk, blood, and meat, will help the bride replace lost blood and regain strength.
>
> Once the operation is complete, the bride's mother and mother-in-law are allowed to enter the hut to see that the bride has fared well. When the news is announced, a collective sense of anxiety vanishes, and a festive celebration begins. (Shell-Duncan, Obiero, and Muruli, 2000, pp. 115–116)

Katherine A. Dettwyler (1994, p. 27) tried to find out why the residents of Magnambougou, Mali performed clitoridectomies on six-month-old infants, only to be told, "It's our tradition. We all do this." For the most part, the subtext of FGM is preventing women from sexual pleasure, making sure they remain either chaste or faithful—for the latter, particularly in Egypt, the Sudan, and Somalia. Sometimes the overt reason appears to be ensuring a young woman's

marriageability, providing evidence of her virginity and loyalty to family and/or tribal value systems. Throughout Africa, whether for sociological, psychological, ceremonial, religious, superstitious, and/or hygienic stated reasons, the main, unquestioned idea appears to be tradition (Harman, 2003). Let me extrapolate some possible explanations from Dorkenoo and Elworthy (1992, pp. 14–15):

- Women have been persuaded, over centuries, to see their sexual impulses in terms of what suits men. This suggestion must be considered in context of the total economic and social structure of the societies concerned, where marriage is the only secure future for a woman.
- It is an irreplaceable source of revenue for operators—mostly older women—who can bring to bear the influence of other older female relatives of the child to have it done.
- Perhaps the reason why it is women themselves who perpetrate the practice with such zeal lies in their own suffering.
- Since mutilations are less visible than, for instance, would be the amputation of children's noses, health education campaigns have not been directed towards them.
- Western efforts to eliminate the practice, on the part of missionaries or colonial administrators, have simply served to confirm in people's minds that colonial destruction of traditional customs weakens their societies and exposes them to the ill-effects of Western influence.
- No forceful replacement, in terms of community identity, has been put forward to convince people to dispense with the custom.

Olayinka Koso-Thomas (1987, p. 5) cites a number of arguments used by proponents of female circumcision: (1) Maintenance of cleanliness; (2) Pursuance of aesthetics; (3) Prevention of still-births (delivery of dead children) in primigravida (first pregnancies); (4) Promotion of social and political cohesion; (5) Prevention of promiscuity; (6) Improvement of male sexual performance and pleasure; (7) Increase of matrimonial opportunities; (8) Maintenance of good health ("It is claimed to have cured women suffering from depression, melancholia, nymphomania, hysteria, insanity and epilepsy, and to have cured and controlled those afflicted by kleptomania or prone to truancy," p. 9); (9) Preservation of virginity; (10) Enhancement of fertility. Yet, he concludes, "None of the reasons put forward in favour of circumcision have any real scientific or logical basis (p. 10) . . . The entire organization of female circumcision is shrouded in secrecy, mystique and tribalism" (p. 13). Koso-Thomas describes the background involved in the Bundo and Sande societies of Sierra Leone: "Training girls to take their place in the community was an important task of initiation societies and a vital element of women's lives. The training periods were usually for one or two years, during which the initiates were taught housewifery, beauty culture, arts and crafts, fishing, mothercraft, child-welfare, hygiene and sanitation, care of the sick, singing, drumming, dancing and drama" (p. 21). Female circumcision has no proven protective value for women's health; instead, it is one of the most hideous decisions made by people other than the subject herself, even to the point of being life-threatening. And that goes for any of its many forms, including the following:

- *Circumcision*: The most basic procedure, this involves circumferential excision of the clitoral prepuce (skin cover). In some Muslim countries, like Egypt and

the Sudan, it is called "Sunna" circumcision, referring to the Arabic term for tradition. Koso-Thomas (1987, p. 1) writes: "In most African countries there are certain traditional practices which affect the health of their population. The greatest scourge, however, seems to have been reserved for African women upon whom it descends with merciless ferocity. Of all the problems traceable to traditional beliefs and which adversely affect the health and lives of girls and women in Africa today, those arising from the practice of circumcision are by far the most serious."

- *Excision*: In addition to removal of the prepuce, excision also entails the glans clitoridis, even the clitoris itself, and may include removal of part or all of the labia minora. It should be noted that some 85% of genital mutilations in Africa consist of clitoridectomy or excision. "The Yoruba practice excision as a form of contraception," Lightfoot-Klein (1989, p. 39) informs us. "They believe that sperm may enter into a nursing mother's milk and cause harm to the child... excision enables the nursing mother to abstain from sex, so that she avoids having her milk contaminated."
- *Infibulations*: The stitching together of both sides of the vulva after varying amounts of tissue have been excised, with a small hole left permitting the flow of urine or menstrual blood, infibulations is sometimes referred to as pharaonic female circumcision. Amongst other problems, the pharaonically circumcised virgin needs at least ten minutes or more to urinate, as it only comes out in drops, and menstrual blood takes well over a week to be emptied. Thorns or stitches can be used to hold the stitches together after the operation, powders or pastes applied to help the healing, and the legs are often bound up for over a month. "In its extreme form, all of the mons veneris, labia majora and minora, and clitoris are removed and the involved areas closed by means of sutures or thorns," as Shannon, Pyle, and Bashshur (1991, pp. 85–86) describe it: "Complete occlusion of the introitus is prevented by the insertion of a match-stick or other wooden object.... In order to have sexual intercourse, it is often necessary for repeated gradual penetration (over a period of 2 to 12 weeks), which is essentially a process of repeated tearing, to stretch the opening and in some instances the vagina must be cut open to facilitate sexual relations and childbirth. After childbirth, the vagina may be resewn, only to repeat the process again." According to Berer and Ray (1993, p. 123), infibulations can result in a number of complications, including the accumulation of menstrual blood for many months, recurrent urinary tract infection, chronic vulval infection, difficulty in penetration during intercourse (If penetration is forced and scar tissue does not yield, tears in tissue and bleeding may occur, and a false vagina may be opened. If penetration is not possible, anal intercourse may be used as a substitute for vaginal intercourse.), and problems during childbirth if labor is obstructed and there are perineal tearing and lacerations. These may have implications when intercourse is resumed.
- *Introcision*: When the vagina is cut or split in the perineum, digitally or perhaps by means of a sharp instrument, it is called introcision—the severest form of female circumcision.
- *Salt Cut*: Called "gishiri" cut or "yankan gishiri" by the Hausa of Nigeria, it involves a surgical cut made by a knife or razor blade on the anterior or posterior vaginal wall. The Kare-kare have a similar practice, called the "zur-zur" cut that is made during obstructed labor on the anterior or posterior lip of the undilated cervix to encourage vaginal delivery.
- *Hymenectomy*: Excision of a hymen that is considered to be too thick, hymenectomy is usually performed by traditional herbalist-barbers on infant girls soon after they are born. The idea, apparently, is that the woman will have an easier time consummating her marriage when the time comes.

Historically, the practice of female circumcision was reported by missionaries and explorers in Africa in the late nineteenth century, W. F. Daniell's 1847 "On the Circumcision of Females in West Africa" appearing in the *Medical Gazette of London* (pp. 374–378) describing various types of clitoridectomy and labial excisions. It was considered in the 1948 Universal Declaration of Human Rights, and the 1966 International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights. Following the United Nations Decade for Women (1975–1985), when awareness of FGM became heightened, a UN Working Group on Traditional Practices Affecting the Health of Women and Children was created. In 1997, the WHO made these classifications for Female Genital Cutting: Type 1: removal of the prepuce, with or without removal of all or part of the clitoris; Type 2: removal of the clitoris with partial or total excision of the labia minora; Type 3: the most extreme form—partial or total removal of the external genitalia and infibulations; Type 4: the introduction of corrosive substances into the vagina (see Babalola and Amouzou, 2005).

Fran Hosken began writing a column on female excision in Women's International Network News in 1975, bringing the issue to a wider population; her 1980 publication of *The Hosken Report: Genital and Sexual Mutilation of Females* was nothing less than a bombshell for eradication of the practice. Also in 1980 came Nawal El Saadawi's *The Hidden Face of Eve*, describing the Egyptian doctor/novelist's own circumcision, which carried tremendous weight—especially when parts of it were excerpted in *Ms.* Magazine and Gloria Steinem became involved. Awa Thiam, a young Senegalese woman, wrote *La Parole aux Negresses* (1978, *Black Sisters, Speakout: Feminism and Oppression in Black Africa*, republished in 1986), outing genital mutilations and polygamy; she later become president of the Commission Internationale pour l'Abolition des Mutilations Sexuelles, better known as CAMS.

The year 1982 saw Raquiya Haji Dualeh Abdulla of Somalia's *Sisters in Affliction: Circumcision and Infibulations of Women in Africa* and Asma El Dareer of the Sudan's *Woman, Why Do You Weep? Circumcision and Its Conse*quences, and in 1987 came a third book from Zed: Olayinka Koso-Thomas of Sierra Leone's *The Circumcision of Women: A Strategy for Education*. Soon after appeared Hanny Lightfoot-Klein's *Prisoners of Ritual: An Odyssey into Female Genital Circumcision in Africa* (1989), Alice Walker's novel *Possessing the Secret of Joy* (1992) and then a book and film she did with Pratibha Parmar called *Warrior Marks: Female Genital Mutilation and the Sexual Blinding of Women* (1993). Here is a quotation from Parmar (cited in Robertson, 2002, p. 66) that reflects my own sentiment about this whole topic: "One of the worries I know I have is that it's very easy for Westerners to use genital mutilation as a way of describing Africa as being backward and savage and barbaric and feeding into all those sort of racist perceptions of Africa."

Also in 1993, both the Vienna Declaration and the Programme of Action on the World Conference on Human Rights and the Declaration on Violence Against Women, which both dealt with GBV, included FGM. Next came the 1994 Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children, aimed at eliminating the practice by the year 2007—a time that, in fact, has brought us Fadumo Korn's anti-FGM memoir *Born in the Big Rains*. Consider this 1985 statement by Abdoul Diouf, then president of Senegal (cited in Koso-Thomas, 1987, p. 106):

> Female mutilation is a subject that is taboo…But let us not rush into the error of condemning (it) as uncivilized and sanguinary practices. One

> must beware of describing what is merely an aspect of difference in culture as barbarous. In traditional Africa, sexual mutilations evolved out of a coherent system, with its own values, beliefs, cultural and ritual conduct. They were a necessary ordeal in life because they completed the process of incorporating the child in society.

Estimating that anywhere from 90 to 135+ million African girls and women have been subject to some form of female mutilation, some 6,000 daily, or 2 million annually, you should know that this is a practice deeply entrenched in tradition—dating, it is estimated, more than 2000 years. There are references to female circumcision in the Nile Valley at the times of ancient civilizations in Egypt and the Sudan, and it is easy to see the leap from the term "pharonic circumcision." Sanderson (1981, p. 27) offers this framework: "Herodotus stated that Egyptians, Phoenicians, Hittites and Ethiopians practiced female excision 500 years before the birth of Christ. Aramaics have described excision in Egypt in the second century BC. A Greek papyrus in the British Museum dated 163 BC refers to the circumcision of girls at the age when they received their dowries in Egypt." Now that is tradition! Only recently has the topic been brought to the attention of women worldwide, as international organizations such as the UN, world congresses, NGOs, and many others have worked to educate us toward its eradication. And, to be fair, it must be remembered that oftentimes the female circumcision ritual is presented as celebratory, a coming-of-age, as it were, for a young woman coming in touch with her self and her sexuality. Before, during, and even after the process, she is surrounded by loved ones, sympathetic to her experience. Lightfoot-Klein (1989, p. 73) offers this scenario of the initiate:

> All of her fear tends to be mitigated by the fact that in the period preceding their circumcision, girls are the center of all attention—heady stuff for someone so small! A joyous, festive atmosphere prevails. Loving relatives, some of whom have traveled great distances in her honor, are with the girl constantly, supporting her, encouraging her, focusing her attention away from the anticipated ordeal, and in the direction of the acceptance, love, empathy, and good will that is radiating toward her from all sides. She is given many desirable and valued presents. Her hands and feet are painted with henna, a privilege that only brides and married women are given, and that all girls appear to yearn for. Often she is circumcised along with her sisters. She is never alone during the entire time.

The role of religion also needs to be factored in (Wangila, 2007). Although many Muslims do not follow the practice of FGM, which actually predates Islam and is practiced by some Falasha (Ethiopian Jews), most come from traditional animist religions. Muslims looking for justification cite these words of Mohammed from a discussion recorded between him and Um Habibah on performing infibulations on slaves: "Yes it is allowed. Come closer so I can teach you: if you cut, do not over do it, because it brings more radiance to the face and it is more pleasant for the husband." This is in apparent contradiction

to the Qur'an, the primary source for Islamic law, however, where no mention of FGM appears.

There can be any number of complications from female circumcision, death being not the least, but the difficulty has been lack of research on this topic and continuing concern that the situation will not change. Although the most common consequence is hemorrhage, or severe bleeding either immediately or even in a week or so, the victim might go into shock, retain urine for hours or days, get infection(s) from unsterile instruments, suffer extreme pain during and/or after the operation, or have septicemia (blood poisoning). She can injure other organs, get excessive scar tissue or stones in the bladder and urethra, have kidney damage, keloids (growing, inelastic scars), cysts, and/or, understandably, experience wide-ranging psycho-emotional problems. There are hideous reports of having to redo the procedure, or defibulate a woman to accommodate a penis for penetration. Dorkenoo and Elworthy (1992, p. 8) cite Jacques Lantier's *La Cite Magique* (1972), where he describes a Somalian wedding night where the husband beat his wife with a leather whip and then used a dagger to open her:

> According to tradition, the husband should have prolonged and repeated intercourse with her during eight days. This "work" is in order to "make" an opening by preventing the scar from closing again. During these eight days, the woman remains lying down and moves as little as possible in order to keep the wound open. The morning after the wedding night, the husband puts his bloody dagger on his shoulder and makes the rounds in order to obtain general admiration.

The authors claim that, "The most excruciating result of excision" is the extreme, almost unbearably sensitivity to touch, or "the development of neuroma at the point of section of the dorsal nerve of the clitoris" (Ibid.). Abscesses can develop on the vulva, and various infections can cause sterility. Ditto for problems relative to childbirth, despite risks of too much blood loss, infection, perineal tears, fetal distress, ruptures, bladder problems, and all that pain. Otherwise, the tiny opening left in the vagina (the canal going from the uterus to the vulva) following infibulations has often been known to close completely over time, leaving a woman unable to urinate ("dysuria"), have sexual intercourse, or even menstruate. It can cause a condition called "hematocolpos," or retained menstrual blood in the body. Because the abdomen can increase sizably from this affliction, sometimes families mistakenly think a young woman is pregnant so they kill her to maintain their prestige.

My personal interest in this topic, I might insert, emanates from conversations with Amie Joof-Cole, to whom this book is dedicated, as she was a leader in organizing reform against FGM in The Gambia. It is an advocacy she brought with her to Senegal. Gerry Mackie (2000), comparing the facility for its erasure to the practice of Chinese women's foot binding, discusses a convention shift dating from 1996 when women involved in the Tostan (Wolof for "breakthrough") education program in Senegal's Malicounda Bambara decided to educate their village of about 3,000 to abolish the practice of FGC.[10] It worked, and soon the "Diabougou Declaration" was established, ending the practice of female circumcision in 13 villages representing some 8,000 people. It soon spread elsewhere around the country, supported by the president of Senegal and legislation prohibiting the practice dated January 13, 1999.

Unfortunately, though, numerous sources close to me have refuted the fact of its extinction there, particularly in rural areas and places practicing nomadic traditions.

Connections between female circumcision and HIV/AIDS are easy to envision. Think of all that blood, especially in group operations, and think of all those unsterilized implements risking transmission of blood borne pathogens. Labors, when they involve repeated cutting and stitching, allow yet more vulnerability. Because vaginal intercourse can often be painful (called "dysmenorrhoea"), even impossible, anal intercourse often becomes an alternative—yet another key means of HIV transmission. When all is said and done, however, this is hardly a comprehensive view of female circumcision as practiced in Africa. But for those interested in advocating for women's rights, children's rights, health and educational rights, development and empowerment rights, and more, it is at least an introduction to getting people thinking, maybe even acting. Dorkenoo (1994, p. 91) provides a fascinating graph on "How female genital mutilation is sustained at grassroots level," showing the multicomplexity of the issue. Divided between concepts of women's sexuality and fear on the outside of the circle, inside it includes these aspects: rituals reinforcing womanhood; superstitions based on patriarchal ideology; women's lack of access to resources in the community; economic aspects: income + status for excisor—bride price; sanctions against women; lack of health education; religious propaganda; lack of government policy and action; illiteracy; male fears; and lack of choice. She really has captured it all. Change requires planning and commitment, as well as governmental cooperation and mass education

"The lack of definitive data on the prevalence of FGM is an indication of the neglect of the issue by the scientific community," Nahid Toubia (1995, p. 22) reminds us—an important counterpart to Carol Corso's (2003) recommendation about involving local communities in ending the practice. WHO (1998, p. 38) suggests that epidemiological research should address these questions:

1. Is there sufficient evidence that female genital mutilation is practiced in the particular country or community to justify taking action?
2. What is the scale of the problem: what groups in the country practice female genital mutilation; at what age is it performed; who performs the procedure; and what different methods are used?

In addition, researchers should try to establish prevalence rates, trends, at-risk populations, health effects, mortality and morbidity and effects on education, psychosexual effects, evaluation and monitoring.[11] Only after we begin to understand the issues can we begin to take action on our beliefs about them, educating others and offering counsel to victims. If you are interested in finding out more about female genital circumcision and FGM, please be encouraged to check out the many relevant citations listed both here and in the bibliography. At the very least, you are now more knowledgeable about a topic that has too long been shrouded in silence. But, no matter what our opinion(s), we must all keep in mind the reality of our own cultural perspectives.

Whatever opinion you might have, though, not for one minute should you think that reactions are other than individual-, organizational-, and/ or country-specific. Take the tiny French/Arabic country of Djibouti as an

example. Although it signed the 2003 Maputo Protocol of the African Charter of Rights, stipulating that FGM be forbidden and condemned, and its Article 333 of the Penal Code has also outlawed the practice, until recently some 98% of Djiboutian mothers had been circumcised, most infibulated.[12] Yet, in 2005 its first lady, Kadra Mahmoud Haid, came out publicly against FGM, the same year that a conference called "No Peace without Justice" was held there. Egypt passed laws forbidding FGM in 1997, banning it in public and private hospitals and clinics, but as of 2007 the UNICEF declared it still remains "unacceptably high."[13] Abdoulwahid Halimatou Oueini, Niger's Minister for Social Development and Women's Affairs, has called on a crackdown of FGM, but it remains widespread there.

Yet, advocates against FGM are encouraged that the practice is lessening, if slowly. In Mali, where some 92% of females aged 15 to 49 have undergone the procedure, despite having been banned since 1996, reports are at that, "Since 1991 at least 200 practitioners of the ancient ritual have put down their scalpels and vowed never to cut girls again."[14] Some key Malian artists came together in 2000 to produce a CD called *Stop Excision* that contains eight songs in five languages (Bambara, Senoufo, Pulaar, Dogon, and Sarakole) opposed to FGM. Also encouraging is the news that Dr. Nawal Nour of the Brigham and Women's Hospital in Boston was awarded a MacArthur Foundation "genius grant" in 2004 in honor of the weekly clinic she founded in 1999 to help patients who have had complications from ritual circumcisions and such. The notion of a safe space is at the core of the Listening and Dialogue Approach relative to FGM in Guinea, while an alternative rites approach is being implemented in Kenya (Chege, Askew, and Liku, 2001).

This discussion of FGM would not be complete without my strong urging that you see *Moolaade*, a 2004 from the Senegalese filmmaker Ousmane Sembene, who is often called the father of African cinema. As is part of his signature, here we see a societal act, the film's title meaning "protection," with the ancient act of purification seen in contrast to decisions about continuing under male decisions over women's bodies.

Maddeningly, although it has been recognized recently that male circumcision may reduce their chances of contracting HIV by up to 60%,[15] in fact preliminary data are demonstrating that it actually increases women partners' at-risk probabilities (Cheng, 2007). We await further research, but at this point the irony is writ in bold.

Fistula

> In many African countries it is the custom for women to be married at about 13 years old, but at this age many girls' bodies are not developed enough for healthy childbirth. For example, Fatimata Ataher was married at age 12, and she became pregnant almost immediately. She labored for three days to give birth to her still-born son who was actually killed by her rigorous contractions. Then, because of the position of the fetus and the narrowness of her pelvis, Ataher developed a fistula.
>
> Shelly Cox, Childbirth Dangers Remain High in Developing Countries (2006).

Vescio-vagina-fistula (VVF) occurs when holes are created between a woman's vaginal wall and her bladder, rectum-vagina-fistula (RVF) when the holes are created between her vaginal wall and rectum. If you can believe it, or imagine it, urine and feces then leak uncontrollably through the vagina for the rest of her life. Sharon La Franiere (2005, p. 1) reports from Nigeria on "the obstetric nightmare of fistulas, unknown in the West for nearly a century. Mostly teenagers who tried to deliver their first child at home, the girls failed at labor. Their babies were lodged in their narrow birth canals, and the resulting pressure cut off blood to vital tissues and ripped holes in their bowels or urethras, or both. Now their babies were dead. And the would-be mothers, their insides wrecked, were utterly incontinent. Many had become outcasts in their own communities—rejected by their husbands, shunned by neighbors, too ashamed even to step out of their huts."

According to the UN Population Fund (UNFPA), more than 2 million women worldwide suffer from obstetric fistula—unattended, prolonged labor lasting several days, but it can also occur from a botched abortion or FGM or, more recently, rape and the ravages of wartime atrocities.[16] Worst of all, the fistula victim not only becomes physically debilitated, she all too often becomes a social misfit, ostracized from her family and by her community. And while women in developed countries might have Caesarean delivery rather than go through the agony of a long labor that traps the fetus, they also have easier access to operations to repair fistula—whereas their counterparts elsewhere might never even know about solutions or be able to afford them. In 2003, UNFPA launched a global Campaign to End Fistula,[17] as part of improving maternal health, by means of prevention, treatment, and rehabilitation, and the documentary *Love, Labor Loss* (Governess Films) made its premiere on International Women's Day[18] 2005.

Pregnancy

> Women's reproductive health, as a field, encompasses a set of health problems associated with human reproduction. Reproductive processes are marked by major biologic events, but they involve broader social issues, including human sexuality, health behavior, the health of mothers and children, and the underlying cultural, economic, and political determinants of these processes.
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> Chen, Amor, and Segal, *An Overview of Women's Health* (1991), p. 3.

"In African societies, the birth of a child is a process which begins long before the child's arrival in this world and continues long thereafter," Mbiti (1990, p. 107) informs us about the community role in childbirth and childrearing. Pregnancy becomes "the final seal of marriage, the sign of complete integration of the woman into her husband's family and kinship circle" (Ibid.); if she observes certain taboos and regulations, all should go well. A key concern is abstinence from sexual intercourse that, varying across cultures, may work to prevent transmission of HIV/AIDS to mother and child (see Macgoye, 2000; Moore, 2003).

Whether because it is so socially valued or because a woman is competing with co-wives, pregnancy is a frequent goal in African kinship networks. A child is the supreme legacy. Nevertheless, it has its obstacles. For one thing, pregnancy leaves a woman more susceptible to malaria; in addition, raised nutritional demands can lead to a depletion of iron and a deficiency of folic acid. My cook in Senegal had just this happen in her first trimester, and she was very sick besides being very tired and frightened until she acquired some pills for anemia. Maternal malaria and anemia account for about one third of perinatal deaths in Africa, with surviving infants having low birth weights and lowered immune status that can be compromised by infection, malnutrition, and other possible problems. Still, we cringe knowing that the infant mortality rates in sub-Saharan Africa are 102 of 1,000, to 33 per 1,000 in North Africa (Cobb, 2005). Sudan, which has the fifth-highest maternal mortality in the world (1,700 women out of 100,000 dying while giving birth), has had some relief from its efforts to train midwives (Baldauf, 2007c); a win-win, situation, he shares Aziza Jiddu Suleiman's story: "Married at age 10, she became pregnant almost immediately. The birth was complicated; Ms. Suleiman, still a child, lost her baby and suffered an injury that left her unable to control her urine. Her husband divorced her soon afterward, citing unpleasant side effects of her injury, and her inability to bear further children. She was just 11 years old." Today, she has been trained to help other mothers and their babies.

For these and other cultural reasons, pregnancy in Africa is a taboo topic, the thinking maybe being that to talk about it brings bad luck. Among the Igbo, a woman's mother is usually the first to hear the news, and then begin a series of prohibitions ranging from eating certain meats to not looking at ugly objects (Agbasiere, 2000). Clemmons and Coulibaly (2004) have groundbreaking research in Mali to increase communication between wives and husbands about it relative to health-seeking behavior by means of song, story (and griot, or storyteller), and traditional clothing, moving from what was an embarrassment to a classic Knowledge-Practice-Coverage adaptability. They also make some good points about how print materials can be unsuitable, due to illiteracy and difficulty decoding drawings—especially on flip-charts, posters, and brochures. Another wonderful resource about Mali is Kris Holloway's *Monique and the Mango Rains: Two Years with a Midwife in Mali* (2006), about her experiences as a Peace Corps volunteer in one of the world's poorest countries at what was known as the Woman's Birthing House; she writes of her friend, "Monique, with a sixth-grade education and nine months of medical training, was birthing babies. Lots of babies. She was responsible for the future of this village. No electricity, no running water, no safety net or ambulances and emergency rooms. I knew that Mali had one of the highest rates of maternal death in the world. I'd read a sobering statistic that placed a Malian woman's lifetime risk of dying in pregnancy and childbirth at one in twelve, compared to a U.S. woman's risk of one in over three thousand" (p. 8). In an article titled "Pregnancy a Dangerous Pursuit in Zambia," Isabel Chimangeni (2007) elaborates, especially for women in rural areas:

> Poor women are virtually voiceless and by custom put their families' needs ahead of their own. Some seek medical help when it is too late. It is estimated that 70 percent of deaths during childbirth in Zambia occur in rural areas where women have to walk long distances to reach a clinic,

> where the staff and the facilities may be ill-equipped and ill-prepared to handle the delivery. There are no ambulances...It is therefore not uncommon for mothers to die while trying to find health care.

We know that an infected pregnant woman has about a one in three chance of passing on the HIV/AIDS virus to her child, although the jury is still out as to whether that transmission comes mainly from her uterus and/or from breastfeeding (Fuller, 1999). Her reproductive role becomes severely jeopardized, but at least there is hope when we have learned that ARV drugs administered to HIV-positive mothers shortly after giving birth can block transmission of the disease to their babies. The key to Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT), researchers agree, are communication strategies including increased access to condoms and voluntary counseling and testing (VCT), dealing with stigma, and including traditional healers in the process (see Chipfakacha, 1997; Cohen, 2003; Green, 1992; Heald, 2002; Hodes, 1997). Botswana has been able to reduce this rate of HIV transmission by giving infected mothers dual drug treatments of AZT and Nevirapine—quite a feat when some 34% of its pregnant women, 14,000 in all, are HIV-positive (Donnelly, 2007). Femmes Actives de Cote d'Ivoire, a support network for pregnant women infected with HIV/AIDS, offers psychological outlets that might be a model elsewhere.

Still, we worry that not enough pregnant women are accessing available medical services. In Angola, for example, where maternal mortality rates are 1,000 deaths per 100,000 births and mortality for infants is 250 per 1,000 births, few pre-natal consultations—such as about nutrition, hygiene, AIDS and malaria prevention, are made due to workloads, financial concerns, and/or general ignorance.[19] One shining hope may be needed at this point, so take heart at the fact that the Central African Republic (CAR) has launched an Operational Plan to reduce maternal and infant morality by 2015. Levine et al. (1994, p. 131) provide a general description of a typical birthing:

> When labor begins, a woman paces about the room fully clothed, periodically crouching or reclining in response to her pains. As the contractions accelerate in frequency, she undresses and, wrapped in a blanket, sits on a low stool. Grasping its rim on either side, she braces herself, her legs stretched out in front of her. When the baby enters the birth canal, she is held from behind by her mother-in-law or an older woman and exhorted to push the baby out. Around her the other women sing and dance, shouting at her to make haste.

Abortion/Miscarriage

Globally, according to the Academy for Educational Development's SARA Project (www.sara.aed.org), some 120,000 girls and women die each year from pregnancy-related causes, 4.2 million unsafe abortions in Africa being part of that picture (see McKee et al., 2003). Kenya reportedly has 300,000 abortions annually, Nigeria 610,000, some 15% of women in Gabon have had an abortion, and in Uganda, more than 1,000 women die annually from unsafe

abortions and 68,000 others suffer serious health complications (Temmerman and Nabusoba, 2007). Although laws relative to abortion vary among the countries—ranging from prohibition to provision to save a woman's life, the practice quite obviously still occurs. Togo is one of few countries legalizing abortion if a pregnancy results from rape or incest, and Mozambique is said to be so concerned about back-street abortions that it is liberalizing its abortion laws, but most African countries prohibit the procedure. Disclosing "What really causes high maternal deaths," Mildred Ngesa (2004) describes a situation in East Africa:

> By the time the young woman was wheeled into ward 1B of Kenyatta National Hospital, it was immediately clear that she would not make it. It was too late. She had haemorrhaged into unconsciousness and the whole of her lower body was covered in blood. Even as the nurses and doctors set to work to save her, they knew it was a long shot. By the time she was breathing her last, her uterus had been evacuated, her fallopian tubes badly damaged. There were also the remnants of a foetus. The doctors gave up, and she became yet another statistic.

This apparently is such a frequent event, with some 10 to 15 women admitted each day with post-abortion complications, that Dr. Katini Nzau-Ombaka of the African Alliance for Women's Reproductive Health and Rights compares the urgency to a jumbo jet with 300 women crashing each month. Although eight women die each day in Madagascar during pregnancy or at childbirth, some 6,000 Ugandan women die each year from pregnancy- and childbirth-related complications—far too many instances that could have been prevented if they had access to trained, skilled midwifery care. Boyfriends and husbands can benefit from education about the dangers of pregnancy; Will Ross (2003) reports how some won't take their women to a hospital, the "I was born in a banana plantation" theory prevailing in their minds, along with customs of depending on herbs. A recently installed program called Rural Extended Services and Care for Ultimate Emergency Relief (RESCUER), which works as a solar-powered radio communication system, is situated to address the country's high maternal mortality rate.

While not many studies about maternal complications for HIV-positive pregnant African women have been performed, we do know that risk of miscarriage was found to be double for some such women from Malawi, stillbirth for some women in Kenya (Berer, 1993, p. 19). It is obvious, though, that comprehensive, controlled research on interactions between pregnancy and HIV/AIDS need to be performed that look at long-term effects and outcomes, both for mothers and children. My friend Ellen Wertheimer has done what is called "post-abortion care" in Francophone Africa, working with women suffering from miscarriages or incomplete abortions, where she could introduce the notion of family planning—a euphemism for contraception. "A comprehensive global study of abortion has concluded that abortion rates are similar in countries where it is legal and those where it is not, suggesting that outlawing the procedure does little to deter women seeking it," Elisabeth Rosenthal (2007) reported from a study performed by WHO and the Guttmacher Institute, and yet it remains illegal throughout most of Africa.

Childbirth

> Anaemia, and blood loss during childbirth, which require transfusions in situations where HIV sero-prevalence is high and blood safety uncertain, pose immediate threats, but the medical procedures preceding, during and after childbirth, and throughout women's whole reproductive careers, especially where unsterile instruments or syringes are used, put them at far greater risk of medical transmission than most men experience.
>
> Virginia van der Vliet, *The Politics of AIDS* (1988), p. 92.

"Childbirth often serves as a *rite de passage* into adulthood," as in Africa a woman who doesn't have offspring is considered something of an oddity, a social outcast, Virginia van der Vliet (1988, p. 92) reminds us. "She risks being supplanted by a more fertile rival, particularly where polygyny is permitted. She will have no children to look after her in old age." And it goes without saying that, not unlike elsewhere in the world, boys are the baby of choice, girls having value only as future mothers. We hear horror stories of pregnant women walking miles—some as far as 45 miles, to reach healthcare facilities where they might deliver their babies.

Estimates are that some 60% to 80% of African deliveries are performed by what are called Traditional Birth Attendants (TBAs), most of whom have low levels of training except by personal practice. While they clearly mean well, not all TBAs may be aware of the potential hazards of using unsterilized instruments. Midwives, who have been at the heart of the system, are increasingly worried about infections that can occur during childbirth, and so their numbers have been dwindling. A traditional healer is cited thus: "They do not believe we have a role to play. We want to help. We could counsel. We are being isolated through newspaper reports, our initiatives are being discouraged. We are being isolated without consultation from an important medical event which affect us all" (in Laver, 1988, pp. 283–284). Babatunde (1998, p. 131) describes delivery among the Ketu of Nigeria, which "takes place in the ancestral shrine of a compound. This assures the protection of the ancestors and their help . . . (It) also sets the seal of ownership on the *pater* who cements his claim by being the one to dispose of the placenta." That claim continues, by the way, as men in many African societies have privilege over all children that his women have, including those conceived after his death (Levine et al., 1994).

Among African women, according to Barnett and Blaikie (1992, p. 44), "One of the most distressing experiences, and a threat with which they have to live, is the birth of an infected child. Its suffering is a continual reminder of the consequences of past actions and an indication of what will certainly be in store for them, too." Although pre-eclampsia, whose symptoms include elevated blood pressure of the mother and protein in the urine, is one of the leading causes of maternal mortality in Africa, what we also worry about is what is termed "peri-natal," or mother-to-child transmission of HIV, whether *in utero* or during breastfeeding. From the age of two on, risks continue, especially from blood transfusions due to malaria-induced or sickle cell anemia. Contaminated needles and syringes, as part of various immunizations, are also worthy of attention. The

statistic is easy to remember, if difficult to swallow: a child born in Africa stands a one in five chance of living to age five.

Save the Children's annual *State of the World's Mothers* report (MacCormack and Tinker, 2006) reminds us that two million newborns die within their first 24 hours of life, another 2 million before they turn a month old. The organization is working to change an age-old tradition of scrubbing newborns with cold water and soap, then putting them on the floor to dry; instead, they encourage a "skin-to-skin" method where the baby is gently wiped and then left to be cuddled next to the mother for a few days, breastfed according to need and desire. They remind us that, "One in five mothers has lost at least one baby in childbirth—a terrible rate of grief. So many newborns die in sub-Saharan Africa babies are often not named until a week to 40 days old" (p. 2). This notion of "kangaroo care" has been recently introduced to Malawi, which has the worst maternal mortality of any non-conflict country in the world—a pregnant mother dying during childbirth every hour there; Louise Gray (2007) reports from what she calls Bottom Hospital: "Women deliver their babies on beds covered in a plastic sheet and there are no towels or sanitary products. There are few cots so most babies lay beside their mothers." With just one doctor to 50,000 people, and most nurses working 24-hour shifts, the needs are glaringly obvious.

While lactation time may vary, toilet training begins as early as possible. Amongst the Akan people of Ghana and the Ivory Coast, Anthony Donkor (1997, p. 87) reports the following: "Cloth diapers are used by handing them around the waist beads from behind the infant and passing them through its legs. These cloth diapers are very porous. Thus it is not uncommon to notice mothers wet at the waist level." Just think of all these African women have to juggle, literally.

Horrifyingly, death rates for HIV-infected infants is higher in Africa than elsewhere in the world, with various studies reporting percentages as high as 21% or even 37% of babies born to seropositive mothers. ("Seroprevalence" is defined as the frequency of cases where blood shows evidence of antibodies to infectious agents at a designated point in time). In Zambia, many babies are at least a week old before being named—it's psychologically easier to lose them, so the conventional wisdom goes, if you are not too attached. How bizarre it is, realizing that pregnancy and poverty are among the key reasons why African women are imperiled.

Breastfeeding

> The lives of a million babies could be saved every year by the simplest and most natural remedy of them all—breastfeeding. Field workers running a research project in remote Ghanaian villages have discovered that the surest way to keep a baby alive is for the mother to start breastfeeding within an hour of the baby being born. If the first feed from the mother's breast is delayed for even one day, they found the risk of the child dying within a month more than doubles.
>
> Andy McSmith, Breast Milk Is Key Weapon (2007).

Although much research has been done on the issue of HIV transmission from breast milk (Mabilia, 2006), questions remain. Soon into the epidemic in Africa,

however, it was decided that milk collected from other mothers for those unable to nurse their own babies would be stopped. Even as early as 1983 hospital personnel realized what risks there were that milk from other mothers could be contaminated, so the various milk banks were terminated. The feeling seems to be that mother's milk, even if tainted, might still be better for infants with so much against them anyway. Globally, the WHO has recommended the continuance of breastfeeding, especially in developing countries, and the World Alliance for Breastfeeding Action (WABA) continues its outstanding advocacy.

Formula feeding, by contrast, is often imperiled due to unclean water and sanitary conditions or, worse, husbands or other men who try to make money by diluting formula and selling it to other customers. Another sentiment seems to be that the HIV infection can be passed from cracked nipples, a theory that supports the notion of blood borne transmission.

Gum Tattooing

"Facial tribal scarring is practiced on both men and women in all of Sudan and usually takes the characteristic form of three vertical strips of flesh gouged deeply from the cheeks, beginning just below the lower eyelid and running the length of the cheek to the jaw line," Lightfoot-Klein (1989, p. 49) informs us. The difference between that and FGM, she points out, is that it is both highly visible and optional. Rawal et al. (2007) report on a study of West Africans with gingival pigmentation due to traditional methods of tattooing, wondering what effects it might have on a number of diseases, including HIV infection. "People of all ages and ethnic groups tattooed the area above and below their teeth with powder from roasted peanuts to enhance the whiteness of their teeth and prevent gum disease," reports Renaud (1997). The painful procedure is yet another rite women endure with courage, showing how they can take pain (Falade, 1963; Renaud, 1997).

The film *Mon Beau Sourire* (2005), directed by Angèle Diabang Brener, aims to answer the question "Where do Senegalese women get their beautiful smiles?" As such, it exposes the ritual of gum tattooing, an ancient West African custom still performed today to accentuate white teeth. We see here how the painful ritual is performed, accompanied here by the beat of djembes. SWAA and UNIFEM supported research to study gender dimensions of HIV/AIDS (Ward and Samuels, 1999), finding from focus groups in Senegal that tattooing, along with other traditional practices like infibulations, female circumcision, polygamy, levirate/sororate, and early marriage continued to be supported. In the case of tattooing, 99.3% of respondents said it was a good, safe practice as it "cleared the sight" and let out bad blood that led to headaches. Tattooing of lips and gums, as my Senegalese dentist friend Charlotte Faty Ndiaye alerted me, is yet another biomedical vulnerability African women face.

Malnutrition

Malnutrition is, unfortunately, much a part of an African way of life. Eritrea has been cited as having the highest rate of undernourishment, at 73%, as compared to neighboring Ethiopia, at 46%,[20] but of course we can only imagine conditions in areas of civil war. When one combines malnutrition and early motherhood, the results can be hazardous in terms of competition for nutrients (Allen, 2004),

as it takes a while for the pelvic cavity to become fully developed—setting up pregnant young girls to particularly precarious situations. Sylvester (1991) reports on the linkage of malnutrition with AIDS and food security:

> The extent to which malnutrition rates will rise when households are affected by AIDS will depend on: coping mechanisms due to the loss of an adult, particularly the mother who is the principal food preparer and caretaker of the young; vulnerability of the household to changes in economic status; and the ability of survivors to withstand the associated social and emotional stress of AIDS deaths.

"Hunger, undernourishment, and poorly balanced diets are the lot of millions in Africa," Michael J. Kelly (2003, p. 71) alerts us about yet another vulnerability, explaining, "As the media pictures of children with scabrous skin and inflamed eyes shows, malnutrition weakens the skin and membranes. Instead of being the first line of defense against infection during a sexual encounter, the thin, torn, ulcerated skin and mucous membranes in a malnourished child's genital areas provide ready entry for viral infections of all kinds, including HIV."

HIV/AIDS comes at a time of African women's peak childbearing and most sexually active years, which traditionally is determined to be between the ages of 15–49. Key to the concerns of this book, HIV prevalence levels are higher among African women than men—referring to an epidemiological term having to do with the number of persons with a given condition at the given point of time. In this instance, women are 1.3 times as likely to be infected. Taken further, predictions are that nearly a quarter of African women will be carrying the virus in 2010, while a decade later that number will be reduced to a fifth. Why? Infection rates will go down because so many women will have already succumbed to the disease.

Life expectancies overall, which in the early 1990s were about 49 years for both men and women, had of course been predicted to increase until the onset of the HIV/AIDS pandemic. Instead, those numbers have decreased. "Many sociocultural variables, alone or in combination, can undermine a woman's potential to negotiate," van de Vliet (1988, p. 101) has declared:

> Patriarchal relationships, machismo, pro-natalism, the availability of alternative women, the acceptance of multipartner relations and encouragement by peers, male control of critical resources like housing and land, the extreme youth of the woman, an anti-condom attitude among men, men's fear of loss of control over women, nonchalant attitudes to sexual abuse, even rape—each reflects the interrelationship of gender and power, and influences women's ability to control sex and reproduction.

Too seldom do we also factor in the psychological and emotional effects of the HIV/AIDS epidemic on African women's mental health. To date, there is hardly any research in this area, and we can only hope reports of various counseling efforts by various individuals and organizations might be helpful. For our part, let us at least be sensitized to all those African women who might be feeling guilt, bewilderment, mixed loyalties, shame, sadness, depression, loss, isolation, fear, and general hopelessness and helplessness. At the next level, let us enable their much-needed biomedical support, both physical and mental. As Arvind

Singhal (2003c, p. 40) has noted, "AIDS is a disease of ignorance and intolerance, as well as a biological illness."

"Possible factors contributing to the HIV epidemic in Africa include sexual behavior as influenced by pre-existing cultural attitudes and practices, ineffective disease control measures, or co-infection with other sexually transmitted diseases (STDs)," Zewdie and Tafari (1991, p. 85) have written. What follows in the next chapter are descriptions of some of those cultural traditions.

Notes

1. The African Union set the African Decade of Persons with Disabilities, 1999–2009 to raise awareness about disability issues.
2. See, e.g., Mauritania: Taboos, denial and shortage of data hinder fight against AIDS. *Irin* (February 14, 2005).
3. David Mafabi cites a report by the African Rural Development Initiatives (ARDI) showing that, "The majority of the girls have unprotected sex, exposing them to the risk of contracting HIV/AIDS...After getting pregnant, many of the girls are banished by their parents, rejected by the fathers of their children and end up living with their helpless grandparents."
4. Africa and the MDGs 2007 update (http://www.un.org/millenniumgoals). The goals, with a target date of 2015, are (1) Eradicate extreme poverty and hunger; (2) Achieve universal primary education; (3) Promote gender equality and empower women; (4) Reduce child mortality; (5) Improve maternal health; (6) Combat HIV/AIDS, malaria, and other diseases; (7) Ensure environmental sustainability; and (8) Develop a global partnership for development.
5. Charles Mangwiro (2007), European condoms AIDS-tainted: Mozambique bishop, (Reuters, September 26).
6. The literature is wide ranging; see Abdulla, 1982; Babatunde, 1998; Boddy, 1982; Caplan, 1987; Corso, 2003; Daly, 1978; Dettwyler, 1994; Dorkenoo, 1994; Dorkenoo and Elworthy, 1992; Dualeh, 1982; El Dareer, 1982; El Saadawi, 1980; Gruenbaum, 2001; Hicks, 1996; Hosken, 1980, 1993; James and Robertson, 2002; Janzen, 1992; Kassindja, 1998; Koso-Thomas, 1987; La Fontaine, 1985; Lantire, 1972; Lightfoot-Klein, 1989; Mackie, 2000; Morgan and Steinem, 1983; Nelson, 1987; Nnaemeka, 2005; Rahman and Toubia, 2000; Robertson, 2002; Sanderson, 1981, 1986; Shell-Duncan and Hernlund, 2000; Shell-Duncan, Obiero, and Muruli, 2000; Singateh, 1985; Thiam, 1978, 1986; Toubia, 1995; Walker, 1992; Walker and Parmar, 1993; Wangila, 2007; World Health Organization, 1998; Zabus, 2007.
7. See Nahla Abdel-Tawab, 2005, on the ethics of interventions research.
8. See Renaat Devisch, 1993, on healing practices of the Yaka.
9. Catherine Mwesigwa (2007), Op-Ed: Female genital mutilation puts women's lives at risk. *New Vision* (Uganda), March 22.
10. See also Mike Crawley (2005), Africa spurns female circumcision (*Christian Science Monitor* [April 5]: 6–7) and Yvette Collymore (2004), *Activists seek to replicate small successes in bid to end FGC*. Washington, DC: Population Reference Bureau.
11. For more on this topic, see Afrol News (http://www.afrol.com/Categories/Women/index_fgm.htm), Female Genital Mutilation: An Islamic Perspective (http://www.minaret.org/fgm-pamphlet.htm), General Discussion of Female Genital Mutilation in Africa and the Middle East (http://www.religioustolerance.org/fem_cirm.htm), Tostan (http://www.tostan.org), and the World Health Organization (http://www.who.int/inf-fs/en/fact241.html).
12. Female genital mutilation lives on in Djibouti (Reuters, November 7, 2004).

13. UNICEF urges end to female genital mutilation in Egypt (Voice of America, September 18, 2007.
14. Communication key to stopping genital excision (2007). *Irin* (February 13, 2007).
15. Alexander G. Higgins (2007), Circumcision recommended to fight HIV (Associated Press, March 29).
16. Emily Wax's (2003) A brutal legacy of Congo war (*Washington Post*, October 25) describes how soldiers stuck branches and guns up women's vaginas, their targets being girls as young as 8, women as old as 73. See also Shapiro and Tambashe, 2003.
17. For more information contact fistulacampaign@unfpa.org.
18. International Women's Day (IWD)—March 8, is a global celebration for the economic, political, and social achievements of women.
19. Angola: Few pregnant women access medical services, *Irin* (April 21, 2004).
20. Abraham McLaughlin (2005), UN and firms team up to tackle hunger. *Christian Science Monitor* (June 3), p. 7.

CHAPTER THREE

Sociocultural Vulnerabilities

> What determinants aggravate the problems that AIDS poses for African women? A critical factor is the definition of the African woman's place in society, which has perpetuated her subordination to men. Most sub-Saharan African cultures are patriarchal. In these cultures marriage can loosely be defined as a more or less enduring, legally and socially sanctioned relationship between a man and woman within which procreation—a young man's familial obligation to extend the lineage—takes place. Procreation, or childbearing, occupies a central role in the security and prosperity of the lineage, and thus is highly valued in the African family system. Whereas female fidelity is usually viewed an essential for the lineage, male infidelity is consistent with the extension of the familial line.
>
> Ankrah et al., *Women and children and AIDS* (1994), p. 534.

Few would argue that Africa has been hardest hit by the HIV/AIDS epidemic. If we wonder why, it behooves us to examine its social structure, looking at issues such as family, marriage, and children, rituals and traditions, African women's societal roles, and how various cultures continue (Levine et al., 1994; Suggs, 2002). When we consider issues such as polygamy, GBV and sexual coercions, economic and educational inequities, and customs that keep African women powerless, we begin to realize why they represent well more than half of all cases of HIV/AIDS, and why factoring culture into the equation is so vital (Gould, 2007; Kethusegile et al., 2000; Sichona, 1992; Singhal, 2003b). Ranging from wife seclusion (Mack, 1992) to wife inheritance, we need to know why and how it figures so deeply in African life.

Predominantly rural and agrarian (about 80%), Africa has as its mainstay an agricultural economy for most of its gross domestic product (GDP), much of which is exported (Piot, 1999). For example, food and foodstuff products account for more than 90% of exports from Burundi, Malawi, Rwanda, and Uganda, and nearly the same from Cote d'Ivoire and Tanzania. Most Africans live in rural areas (estimated at anywhere from 60 to 90%), so that is where most production and activities take place. Rarely do women leave the places where they are born, and extended families usually live contiguously. In West Africa, where religion mainly operates to counteract evil, spirit worship has the following characteristics: (1) The deities all have shrines and priesthoods; (2) Spirit possession of both priests and patients; the deity inhabits the body of human beings usually by riding

the head; (3) The use of animal sacrifice; (4) Peculiar patterns of drumming, dancing, and singing, even special types of drums for each deity and festival; and (5) The use of talismans and charms as representations of the spiritual powers of each deity (Fisher, 1998, pp. 122–123).

Named the "dark continent" at the Berlin Conference of 1884/1885 as a means of justifying its colonial occupation, we have a long way to go to break negative stereotypes of Africa. "The stereotypical images of African women oscillate between strong independent women," writes Efua Dorkenoo (1994, pp. 43–44), "for example, the market women in West Africa, to very oppressed women, for example, mixed Arab/African women from the north-east and the Horn of Africa. It is not uncommon for people to support these images by citing historical black warrior queens, female chiefs and 'queen mothers,' women holding key positions in governmental services and in religion." Racist stereotypes abound, particularly in Western cultures, "best encapsulated in Tarzan movies," according to Claire C. Robertson (2002, p. 59):

> Africa is presented as one place, usually a jungle inhabited by wild animals and primitive people belonging to an unchanging time warp worthy of Gene Roddenberry. These peoples are organized into "tribes" who lead isolated lives in rural settings and have implacable enmities toward each other. They exist on the remote periphery of the world. Africans' characteristics are presented as ranging from maliciousness to ignorance and naiveté. Even when they have some Western education they are not able to cope on their own (the infantilized stereotype). Women, in particular, are seen as victims.[1]

Within Africa, as elsewhere around the world, migrants are at particular personal risk. Renee Sabatier (1996), director of the Harare-based Southern African AIDS training Programme, had some heart-stopping interviews, including these comments:

1. Viviane, a Rwandan commercial sex worker now back in Mombassa after six years in Marseilles compared how she was treated: "Here, they don't call me 'black pig' and 'dirty monkey' and treat me like I have a disease. We are in Africa now" (p. 90).
2. Vesta is a 26-year old newspaper vendor by day, a "bar girl" at night who wants to make this clear: "I am not a prostitute. I do not live for men's pleasure... If I wasn't working in the bars I would surely be giving carpet interviews [a form of sexual harassment by prospective employers, the Zimbabwean equivalent of the 'casting couch'] so what is the difference? At home I might have to brew beer, and that is not much better. Why are we women called 'prostitutes' when we come to town looking for work? They say we are responsible for the spread of AIDS, but what about these men? How else am I going to feed my children, which the father fails to support?" (p. 92)
3. When her husband left her, Joyous started selling vegetables, then took maize to town, and now she supports her four children, her sister's family of five, and other relatives by being a *mudhira*, or "dealer" of kitchen goods that she gets quarterly from Johannesburg. Yet, Sabatier points out, she

encounters occupational hazards, involving "Various sexual pay-offs ('lobbying' is the term often used in Zimbabwe to denote this type of sexual networking) to market officials, immigration police, bus and lorry drivers, merchants, flop-house landlords, and other men encountered along her route" (Ibid.)

4. Imelda, a 33-year-old Zambian mother of five, trades in used clothing, or *saluala*, and although she "lobbies" less often with truckers because she makes more money these days, transportation issues are always there.
5. "Selling sardines is a good job" for 20-year-old Martha in her Tanzanian town. When she was harassed by the market inspector who said she could sleep with him to get approval, she got the services of a local AIDS organization who took a video of him with her and other market women. Confronted with the threat that they would show it in the community, he held off and she reported, "They tried to educate him about AIDS. Condoms aren't the only way to fight AIDS!" (p. 93)
6. Chipo, a 39-year-old Zimbabwean says it all: "AIDS is no one thing. AIDS is there when your husband drinks and comes home late at night and beats you . . . (or) when he loses his job and turns to other women . . . (or) when the rains don't come and the borehole dries up . . . (or) when you are working very hard selling vegetables until the police come and push you out and take away your vegetables and you have no money to buy more. AIDS is when your children are hungry and there is no food . . . (or) when your baby is sick and the clinic says nothing can be done. Your husband pushes you out of the house and you have not even clothes enough to cover you, so what can you do? He doesn't want to talk about AIDS. Now he is dead. His family comes to take away all the things in the house, so you have nothing. No one is there to help you. It is a long story. That is the story of AIDS" (p. 98).

Just as migrants are often cited as a country's problem for the spread of HIV/AIDS, so too are refugees. In 2005, UNHCR estimated some 2.3 million Africans living outside their homelands, millions more internally displaced persons (IDPs).[2] Amongst their many problems and despite advocacy on the part of groups like the International Rescue Committee, International Refugee Rights Initiative (IRRI), or the Women's Commission for Refugee Women and Children, we realize that rape—whether intentionally, or not, to infect someone with HIV, is endemic. Besides the shame and the stigma, the trauma, and the desperation of such situations, probably the worst outcome is becoming pregnant from these atrocities and not knowing if the child could also be HIV-positive. Jean-Marie Vianney Kavumbagu (2003) has written about *Communication as a Tool for Advocating the Rights of Refugees*, taking particular note of the role of media and the Internet. It is exciting to know of *Radio Kwizera* (RK) in Tanzania, a project of the Jesuit Refugee Service (JRS) broadcasting to some 5000,000 refugees not only about peace and conflict resolution but also about HIV/AIDS awareness; the *Reach Out Speak Out* comic book published in 2006 by UNHCR and the Roll Back Xenophobia Campaign of the South Africa Human Rights Commission; *Battery Operated Systems* for Community Outreach (BOSCO) social enterprise that provides computers, Internet, and WiFi to refugee camps in Uganda; and *Elles Parlent, Elles Ecoutent* (She Speaks, She Listens) radio show for women refugees in Chad and Sudan.

Although we know that the major reason for such high prevalence of HIV/AIDS is through heterosexual intercourse, what has happened in Africa is what we call a social construction of the epidemic. Lesley Doyal (1994, p. 14) phrases it thus: "For many women, their economic security—sometimes their very survival—is dependent on the support of their male partner. Sexual intercourse done in the way he desires may be the price they pay for that support." Although we realize that HIV/AIDS is widely viewed as a disease of women, that early perception focused strictly on female prostitutes, since they were the first ones to contract the disease. And so the stigma remains, blaming the victim as it were. Some of the blame, too, is reportedly based on racism (see Chirimuuta and Chirimuuta, 1989), the origins of AIDS claimed to be a green monkey from Africa. Even though that seems ridiculous, Shannon, Pyle, and Bashshur (1991, p. 53) cite a sexual custom of the Idjwi, residents of an island between Rwanda and Zaire that could, in fact, constitute a risky transmission practice:

> Pour stimuler un homme ou une femme et provoquer chez eux une activité sexuelle intense, on leur inocule dans les cuisses, la région du pubis et le dos du sang prélevé sur un singe, pour un homme, sur une guenon, pour une femme. (To stimulate a man or a woman and induce in them intense sexual activity, monkey blood [for a man] or female-monkey blood [for a woman] was directly inoculated in the pubic area and also in the thighs and back.)

Most behavior change communication interventions relative to HIV prevention, treatment, and support have tended to focus on individual change; for that reason, the continuing lessons we are learning from one person, and/or one group or culture, are all too often not true of other individuals or other cultural groups. Just as some individuals tend to be more self-disciplined than others, though, Sarna and Weiss (2007) want efforts made to teach treatment literacy. Relative to looking at the wider market, Singhal (2003c, p. 22) recommends these strategies: viewing culture as an ally; reconstructing cultural rites; employing culturally resonant narratives; and creating a culturally based pedagogy of HIV preventions. He offers as an example attributes of the Nhuni people in southern Africa, for whom extended family play a pivotal role. Sexuality education for their young people is usually delegated to an aunt or uncle, and the emphasis is on abstinence—such as the *Aunties Project* of Cameroon, which trains young adolescent mothers to become "aunties" offering support and advice to other teenage mothers (Arnfred et al., 2004). Both to preserve virginity and to prevent pregnancy, the Nguni, like some Ethiopians and the Kikuyu of Kenya, practice non-penetrative sex, known as "ukusoma" in Zulu: either "The woman keeps her thighs closely together, while the man finds sexual release" (p. 25), or a bent elbow might be used in a similar manner. For some Africans, though, the language of chance is at play, perhaps influenced by witchcraft. Some variants on this thinking is the idea that if men pay certain women for sex that they propitiate one of the lesser gods who might activate the infection.

The African Family

In Africa, the family is the key unit. While individuals are important, and one might worry about orphans, or about grandmothers, or any number of people

within the clan—even nomads (see Dirie, 2007), it is the family itself that is at the center of contemporary life on the continent. Respect for the elderly predominates, and kinship networks are central (Baerends, 1994; Palriwala and Risseeuw, 1996). Strong women predominate, but they are hardly given credit (see Kaberry, 2004; Kyomuhendo and McIntosh, 2006). Koso-Thomas (1989, pp. 13–14) paints this negative picture:

> In many African communities the female is delegated a derogatory role from the day she is born, and she stays without redemption until her death. The disquieting feature of this is her acceptance of this inferior role which is enforced by tradition and maintained by superstition. It seems that the only place where the female is allowed to assert her own authority is in the home, where she is completely in charge of the family's welfare. She is the first to wake up and the last to go to bed. She works constantly and ever harder than her husband. She works in the home, in the fields, market places, shops, offices, etc. In most cases she is neither appreciated nor thanked.

What worries us is that HIV/AIDS is a disease that potentially can work to disintegrate the family unit. Philista Onyango and Pervin Walji (1988, p. 302), both with the Department of Sociology at the University of Nairobi, have made these observations about the role of the African family as contributors in the care of AIDS patients:

1. The family is the basic institution where members learn socially approved as well as disapproved behaviors.
2. The role behaviour learned in the family becomes the mode and prototype for the role behaviour required in other situations.
3. The individual's behaviour is easily visible to the family, the family can evaluate with accuracy that behaviour and act as a source of pressure on the individual either to adjust or change.
4. It is through the family that society is able to elicit from the individual his necessary contribution to the society.
5. One of the tasks the family still proudly performs for its members is the maintenance of the health of the members through the provision of food, shelter and clothing, and the family is a primary source of care for ailing persons.

As elsewhere, the stigma surrounding AIDS in the African family can lead to feelings of guilt and shame and an opting for isolation. Concealing a loved one's condition can be difficult at best, and can lead to resentments, deep-seated rage, even nasty little reprisals. "The family has always taken care of its sick ones in Africa," Onyango and Walji (p. 305) remind us, "using other alternative sources whenever the recognized sources become ineffective or not accessible." Then, too, as van der Vliet (1988, p. 105) sees it, "The factors that so affect women—poverty, illiteracy, social upheavals, family breakdowns, urbanization, mobility, changing social and sexual values—put the youth at even greater risk, particularly where the vulnerability of youth is accompanied by the vulnerability of having a single mother." And, depending on how you define "youth," recall that more than half

of Africa is under age 19—making them, according to Edwinah Orowe (2006, p. 1), "the most infected and affected group of people on Earth." The really hideous thing is that nearly 10 million of those African young people are living with HIV/AIDS—nearly three-quarters of them being females.

Marriage

> The social group at highest risk is married women, as most HIV infection occurs through external marital relationships conducted by men. In most of the countries in the region, women's access rights to land and property depend on their relation to their male family members as a wife, daughter, sister or mother.
>
> Kaori Izumi, *Reclaiming Our Lives* (2006b), p. 1.

Emphasis in Africa is on marriage, especially early marriage that is usually (pre) arranged such that older men (sometimes as old as 70 years older!) add a new young wife to what are often several others. The African girl goes from her father to a husband, "given away" and kept dependent on men—usually for a pre-arranged "bride-price" (Amadiume, 2000; Besha, 1994; Cooper, 1997; Kuper, 1982; Miescher, 2005). She becomes a community wife, except in the conjugal bed, and her progeny are community children. Carin Vijfhuizen (2000, p. 11) breaks down living arrangement in a homestead of 386 Ndua in Manesa village, Zimbabwe:

WWH (women without husbands): 26 percent
WAH (women with absent husbands): 13 percent
PS (polygynous separate—wives in different homesteads): 8 percent
POL (polgynous at present and wives in one homestead): 13 percent
PP (polygynous in the past, but monogamous at present): 14 percent
M (monogamous): 18 percent
E (extended): 7 percent

Maasai wives are communal; although associated with one member of the tribe, they perform all wifely duties to other men in her age group—a practice that is spreading HIV like wildfire (Braverman, 2003). How well I recall visiting such a group of Maasai in 2001, outside of Kenya and, when asked to do so, talking through a local translator to a group of women about AIDS. Trying to emphasize fidelity, not fright, it went well—they asked many questions, and together we laughed and learned.

It was only in 2001 that the UN denounced child marriage, so that entrenched practice is still the norm in many African countries. What an equal exchange it is, though: families might get some money from an older man, while their daughter loses opportunities for an education and independence. According to the International Center for Research on Women, some 100 million girls worldwide will be married before age 18 in the next decade, including 50% of Ugandan girls, 82% in Niger.

Submissive and subordinate, the African wife is an easy target of discrimination, such as being included in AIDS vaccine trials.[3] Wife-beating

evolves as a regular practice, with both physical and verbal abuse an almost expected part of the partnership. Reporting on the Shona, Michel Gelfand (1973, p. 34) describes it this way: "The wife is part of the family, a co-partner in a unit. She dare not lay a finger on her husband although he may beat her. She cannot take him to the local court unless there is unfair, excessive and repeated punishment . . . A woman is completely dependent on him." For a number of reasons, Nicholas Kristof (2005) has noted, "The stark reality here is that what kills young women is not promiscuity, but marriage. Indeed, just about the deadliest thing a woman in southern African can do is get married." Monogamy and fidelity on the wife's part can still leave her vulnerable (Sinding, 2005), but it is hardly a two-way street (Epstein, 2004). In fact, Clark (2004) has come up with the grizzly, counterintuitive finding that early marriage actually increases your African girls' HIV risks, as they are subjected to more frequent coitus, less condom use, and no excuses for abstinence—while the husband is three times more likely to be infected than a boyfriend.

Marriage is often the core of African social structure (Agbasiere, 2000). It establishes adult status for both women and for men, non-marrieds carrying with them a particular social stigma. It is assumed, and unavoidable, necessary for psychological/societal approval. For most African girls, marriage determines an economic survival strategy; as Hanny Lightfoot-Klein (1989, p. 67) points out, "It has often been noted that in African Muslim societies a woman who fails to marry virtually does not exist." But mostly, marriage represents "alliance that provide social and economic advantages for the families. The more land and cows a family has, the higher its standing in the community," Brenda Wilson (2007) reminds us.

Once involved in a marriage, especially a traditional one, it is rare that the woman would exhibit risky sexual behaviors. She stands, near paralyzed, between being seemingly revered as wife/mother and realistically resented because husbands are expected to remain in performance mode; as Obioma Nnaemeka (1997, p. 1) has phrased it, the African woman is set up as "victim and goddess simultaneously." "A woman's life is defined as male-centered and community-oriented; she achieves nothing if she fails in this respect," Mercy Amba Oduyoke (1995, p. 53) reports of her native Ghana. She continues:

> Custom demands that a girl never question a male, however unreasonable he appears to be. Of course, this means that a girl finds herself in a double bind: as a young person, she must not question adult authority and, since she is usually married to an older man, her subordinate position is doubly established. She makes no choices, except as pertain to her sphere of operation as housekeeper or homemaker. What she thinks and how she sees life are almost never ascertained in the conjugal home, usually not until she reaches the position of the oldest member of the family.
>
> Survival in such a situation depends on how skillfully a woman can manipulate circumstances to her advantage. Her status of non-being is turned into authentic being, as helplessness and powerlessness are construed as virtues (pp. 53–54).

In terms of African women's vulnerability to HIV/AIDS, it is clearly only the men who can makes changes—a point that needs to be underscored. Further, according

to Ankrah et al. (1994, p. 537), "Where polygyny is still culturally valued, the virus may be spread from an infected husband to all his wives." The competition between them doesn't help. With maybe the exception of homosexual relationships among migrant miners confined to compounds in southern Africa who practiced "metsha" (a Xhosa term for rubbing the penis between the thighs), the pattern is predominantly heterosexual. Two-third of 3,702 Rwandan women, 86% of them married, reported having a single lifetime sexual partner (Allen et al. (1993), a faithful, monogamous relationship that repeats itself across the continent.

When that marriage has ended in widowhood, African women typically find themselves particularly vulnerable physically, psychologically, economically, and sexually. It brings on a whole new identity. When she became a widow after 28 years of marriage, Marvis Hadziucheri of Zimbabwe reports how her in-laws came several weeks later to dig up their son's body, leave it in her house to decompose, and took all her household goods and harvest: "My home has been completely destroyed. There is nothing left: no cows, dishes, plates, not even my clothes. Nothing." (cited in Izumi, 2006b, p. 100). Oftentimes, widowhood also can bring on a whole new slew of responsibilities as they become heads of households at the same time that they might be facing bereavement, unfocused futures, and added workloads. Scariest of all, many widows increasingly realize that they may be next succumbing to that horrifying disease that is such a part of the African landscape. E.A. Ajisafe Moore (n.d., p. 75) outlines requirements of Yoruban widows:

> When a man dies his wife mourns him for three months. She must not plait her hair and if already plaited she must loose it. She must not take a bath for three months. She must not change the clothes which she was wearing at the time of her husband's death. She must sleep on rag mats. She must keep indoors for the three months, and if she cannot help going out, it must be in the evening.

One of the most touching aspects that visitors to the continent experience is clumps of women and children sitting at urban intersections, patiently and pitifully waiting and hoping for help. Most of them are widows, either banished from their townships or wanting new horizons in their widowhood.

African Children

The statistics associated with child welfare in Africa are stunning.

- In the Democratic Republic of Congo, 3.8 million people have died as a result of war... Nearly half of them were children under 5, most of whom fell victim to malnutrition and other preventable diseases.
- In Sierra Leone, where a decade-long war ended in 2002, 3 of 10 children will die before their fifth birthday... and many onetime child soldiers in the war now dig for diamonds in exchange for a bowl of rice.
- In Nigeria, the world's sixth largest oil exporter, fewer children—just 13 percent in 2003—were immunized against chronic childhood diseases than

in 1990. Nigeria also famously put polio back on the map, when Islamist politicians in the north, egged on by their clerical allies, accused the West of plotting to sterilize their children with polio vaccinations.

Somini Sengupta, Farewell, Africa:
Beggar, Serf, Soldier, Child (2004), p. WK 5.

Pediatric AIDS, which can occur as a result of perinatal HIV transmission from infected mothers during pregnancy or at the time of birth, is difficult to pin down. To date, it has been found that some fetuses aborted in the first or second trimesters of pregnancy were infected. Otherwise, maternal secretions and blood that are part of delivery can also be sources of infection. "The skin-piercing procedures of traditional scarification, cosmetics, and circumcision of children also hold a potential danger that would require public health campaigns to avert," Ankrah et al. remind us (1994, p. 534).

Recalling that a baby born in Africa stands a one in five chance of living to age five, realize that even if s/he makes it past the problems of vertical transmission (mother-to-child) of HIV/AIDS, there are still fears of horizontal transmission, such as from breastfeeding, blood transfusions, contaminated needles used in immunizations, and other potentially infected items. Because of the high instances of malaria, malnutrition, anemia, and obstetric hemorrhages in Africa, pediatric blood transfusions are fairly prevalent. These are children, remember. We worry about child labor practices,[4] high rates of illiteracy, gender discrepancies,[5] coping and survival skills,[6] child slavery and trafficking practices,[7] and, most of all, about how many are deprived of childhood. And yet, we stand in awe at their resilience (see Dlamini, 2005; Evans, 2005; Green, 2006; Mallmann, 2003; Ngcobo, 1999).

Currently, the technology is lacking that might help in the diagnosis and treatment of perinatal HIV transmission, but it may be encouraging to know that both the WHO and the CDC have proposed clinical criteria toward such care. For many futurists, this issue commands prime importance: Healthcare costs, production loss, and the human impact of losing whole generations are sometimes beyond our imaginations. Yet, too few African children are beating the odds. "A child born to infected parents at worst will die in the first few months or years of life, at best will probably have to face life as an orphan," Van der Vliet (1988, pp. 96–97) has stated. "As in so many other areas, these hard facts are forcing even liberal thinkers to evaluate very carefully what constitutes appropriate HIV/AIDS counselling. AIDS has the unhappy knack of pitting 'individual rights' against 'public good.' In spotlighting the paediatric epidemic, policy guidelines carry a whiff of eugenics disquieting to those who are concerned with issues of individual reproductive choice."

Orphans are becoming too frequent a phenomenon in Africa as HIV/AIDS continues to decimate whole societies there; in fact, they represent more than 90% of all AIDS orphans worldwide (Ansell and Young, 2004; Anyadike, 2007; Guest, 2001; Foster, Levine, and Williamson, 2005; Kartell and Chabilall, 2005; Subbarao and Coury, 2004; Williamson, 2003; Williamson, Foster, and Levine, 2006). When one or another or even both parents die, their surviving children might be adopted by relatives (especially grandparents), or by friends, or even by organizations. Or, they might be simply abandoned. A dozen years ago, UNICEF anticipated what it called an "impending calamity" in terms of HIV/

AIDS for African children, estimating some 10% under the age of 15 in East and Central Africa would become orphaned by the epidemic. In fact, today that number is some 12 million orphans in sub-Saharan Africa alone, with estimates that their number will be 15.7 million by 2010. According to Avert (http://www.avert.org/aidsorphans.htm), in 2005 the highest number of orphans due to AIDS were in South Africa (1,200,000), closely followed by 1,100,000 in Tanzania, Zimbabwe, and Kenya, one million in Uganda and nearly that in Nigeria, with 710,000 in Zambia, 680,000 in the Democratic Republic of the Congo, and 500,000 in Malawi.[8] Stephanie Hanes (2007) informs us that there is a movement afloat to move children from orphanages into a system of "community-based care."

Burkina Faso's orphans and abandoned children account for nearly 18% of the country's population; some 7,000 babies are born HIV-positive each year in Lesotho; maternal orphans in Mozambique are 120% more likely to be severely malnourished than the general child population; Rwanda has some 260,000 AIDS orphans, Zambia nearly triple that number; Friends of Orphans in Uganda provides financial support for education and advocates for children's rights relative to abduction, murder, rape, war, and HIV/AIDS; and *Orphan CyberGateway* aids Zimbabwe's 1.4 million children orphaned by HIV/AIDS by teaching them about technology. Generally, Africans do not like the idea of institutionalization of orphans, as family kinship networks, seen as maintenance of the clan, are always preferable. Yet, more and more orphanages keep appearing, and in all fairness the children there often receive better nutrition and education, along with psychosocial support, than they might otherwise. Although those in Western society might associate orphanages from Charles Dickens' sad and scary descriptions, my own experience in Africa found them to be nurturing, responsive. Besides, they are often the only option. *Children on the Brink* (2002), includes a fascinating framework for improving the lives of orphans and other children affected by AIDS: (1) Strengthen and support the capacity of families to protect and care for their children; (2) Mobilize and strengthen community-based responses; (3) Strengthen the capacity of children and young people to meet their own needs; (4) Ensure that governments develop appropriate policies, including legal and programmatic frameworks, as well as essential services for the most vulnerable children; and (5) Raise awareness within societies to create an environment that enables support for children affected by HIV/AIDS.

Orphan households, lacking extended family support, might become self-sufficient if there are enough people to hold the unit together and if there are enough resources for their survival. All too often, however, they end up as street children (Baldauf, 2006; Bourdillon and Rurevo, 2003). Working the streets to simply survive, "(they) are in no position to turn down clients, who almost always refuse to use a condom. Most of the girls know that what the men do to them will eventually make them sick, but their immediate other option is even less appealing—starvation. Selling sex is a survival strategy for many women and girls," Mark Lynas (2001, p. 2) reminds us. As we walk around large urban spots like Nairobi (estimated to have around 50,000 street kids), or Harare, Dar es Salaam, Johannesburg, or other major cities, it sickens us to see so many young boys and girls hawking goods by day, as we know that their bodies will be sold after hours in exchange for food and shelter. Those few who make it to adulthood are forever scarred, as well as being scared of HIV/AIDS transmission.

Calling street children the "most powerless and vulnerable of all," van der Vliet (1988, p. 110) has declared: "Their numbers are destined to grow by leaps and bounds as societies can no longer absorb their AIDS orphans, and the young take to the streets where they live by their wits. Petty crime, prostitution and drug use create children inured to risk, and resistant to the 'safer sex' message. For street kids, sex has many meanings—money, comfort, status—and even where they know about AIDS they commonly disregard its message."

Small wonder that African children are known as "a generation at risk" (Pharoah, 2004). Ethiopia's *Children at Risk from HIV/AIDS* project is aimed at the 5,000 street children of Addis Ababa; using peer educators, it is a model for life skills. There are a number of programs dedicated to helping African street children. *Shangilia Mtoto wa Afrike* ("Rejoice Child of Africa") and *Mapenzi Tamu* ("Sweet Love") focus on Kenyan kids through theatre, raising money for a street children's home; Community Media for Development and GOAL Mozambique have radio programs addressing children's rights and HIV/AIDS; *Beautiful Gate* in Cape Town has outreach programs for them; Doors of Hope in South Africa deals with the 40 to 50 babies abandoned each month in Johannesburg; *Humuliza* ("consolation" in Kihaya) works to meet the psychological needs of orphaned Tanzanian children; and *140 Baabas* in Uganda uses role-plays. Resourceful and real, they are poignantly portrayed in Kilbride, Suda, and Njeru's *Street Children in Kenya: Voices of Children in Search of a Childhood* (2000).

Some 10 million young people in sub-Saharan Africa, defined as between ages 15 to 24, are currently living with HIV/AIDS; of that number, more than 75% are women—yet more evidence of the global feminization of the pandemic. A great deal of effort has gone into educating them about prevention, and we hope that those messages, based on advocacy (Shannon, 1998), behavior change (Erulkar et al., 2004), media (Mpambara, 2004), stakeholder concerns (Action Health, 1998), social marketing (Hisel, 2000), and/or integrated communications (Cohen, 2003) make their mark. There is continuing media interest in the topic of Africa's children,[9] which we hope will continue. In South Africa, the television shows *Beat It* and *Positive* have targeted young adults relative to HIV/AIDS, along with the talk show *Take 5,* and some, such as the soap opera *Isidingo*, have incorporated it into their plots (Fox et al., 2002).

Wanting to take some action steps to help empower African children as they confront HIV/AIDS, Singhal (2003a) offers some lessons, or communication strategies: (1) Break the silence—and shout about it; (2) Frame that shout by setting media, public, and policy agendas; (3) Get beyond ignorance and intolerance by creating safe, non-stigmatized communicative spaces; (4) Refine the problem by harnessing cultural undercurrents; (5) Use culture as an ally. By considering and coming from the frame of reference of the people we want to teach and/or train, we find, helps the whole process of self-realization (Fuller and Schilling, 1990).

African Rituals and Traditions

> Ritual is social action; its performance requires the organised cooperation of individuals, directed by a leader or leaders. There are rules indicating what persons should participate and on what occasions; often the rules excluding certain categories of people are of as much significance as those

> which permit or require others to take part. Ritual is also social in that there is a general recognition of a correct, morally right pattern that should be followed in any particular performance. While changes in ritual procedure do occur, whether to accommodate particular contingencies or, on a more long-term basis, to adapt to changes in the organization of society, there is generally a sense that ritual has a fixed structure.
>
> Jean La Fontaine, *Initiation* (1985), p. 11.

Africa is renowned for rituals, but we have hardly been privy to knowing much about the details. There was a Ghanaian initiation rite for girls aged 14–20 called "dipo," banned by the British in 1892, whereby they were trained in housework, cooking, and parenting for a year to ready themselves for courtship. When the practice went underground, girls as young as eight could be considered qualified, and now early sexual activity, even pregnancy, are not frowned upon in that culture. Quite the opposite is true of the Ndebele, who treat premarital intercourse with scorn, but who may include as part of a girl's initiation an attack with switches upon her naked body; according to Bozongwana (1983, p. 21), "This is said to harden her so that when her husband beats her, she won't feel much pain." Chikovore et al. (2003) confirm this about Zimbabwean men, who tend to react violently when their girlfriends become pregnant—even when they were the obvious partners.

Throughout the continent, oral traditions help maintain the status quo. Oduyoke (1995) has made the argument that myths, proverbs, and folk tales ("folktalk") socialize young girls, keeping them oppressed by means of an implicit patriarchy. All of Africa has been subject to an infrastructure of dominance—religious, colonial, military, masculine. What follows next are descriptions of some of those rituals, including polygamy, levirate and sororate, sexual "cleansing," "dry sex," and other practices.

Polygamy

> There is agreement by all Kikuyu men and women that the male sex drive is strong. Men need a lot of sex and a variety of sexual partners. Faithfulness is not a real issue for men, as it is for women. There is a sense, conveyed more by men than women, that regular sex with a variety of partners is a man's right—a logical extension of a commonly held view that men are naturally polygynous (though women should be monogamous by nature).
>
> Nici Nelson, "Selling Her Kiosk" (1987), p. 219.

A fairly common and culturally valued practice, polygamy (also spelled polygyny)—the custom of a man's having many wives—is pervasive in Africa (Coles and Mack, 1991). Even though Christian missionaries have tried assiduously to preach against this pattern predating the arrival of Islam in northeast Africa, and even though today indigenous Christian sects have called for the practice to be abandoned, multiple wives continue as a practice endorsed by many societies even though the need for many children has been reduced as urbanization grows (Hodgson, 2005). If the truth is told, polygamy clearly continues because men, particularly elders, want it to. It is systemic to African ancestral cults. "The existence of the institution of polygyny," Ellen Gruenbaum (2001, p. 160) reminds

us, "its popularity among men, and women's concern that it might become a reality in their own family can all be significant factors in women's decisions about their own and their daughters' lives."

Nigeria, the most highly populated country in Africa (100+ million people), is a classic example of a polygamous, patriarchal society. Polygyny there, endorsed by Islam and the Nigerian Native Laws and Customs, denies women little access to decision making or resources, offers unequal health services, and forbids land ownership or inheritance upon widowhood. In addition, men having extramarital affairs and keeping mistresses besides their wives make for common practices, along with marrying very young, certainly "circumcised" women—by arrangement, and impregnating them while they are still adolescents. All this adds up to increased concern for the passing along of HIV/AIDS.

Sekai Nzenza-Shand (2005, p. 75) reports returning to her native Zimbabwe for the funeral of an aunt who had died of AIDS, finding the second wife especially upset—losing a friend, lacking access to condoms, and, "If she is to become sick, she lacks basic medical treatment that is essential to empowerment." She is a classic example of how difficult it is to hope for behavior change: "This man looks forward to having sex with his wife. In his eyes she symbolizes purity and tradition away from the corrupt city and commercial sex temptresses. Village women who try to initiate change in behavior are vulnerable to domestic violence." In terms of the high transmission of HIV/AIDS from men to women, the virus can pass from an infected man to all his wives. Meanwhile, competition between co-wives can be fierce: not only are they constantly vying for the attention and affection of the husband, they are desperately trying to get pregnant so they can have more children than his other partners. Such submissive behavior often defers concern for condoms, and so one more vulnerability is unveiled.

Levirate and Sororate

In some African cultures widows are inherited by one of her husband's brothers, an arrangement with the understanding that she will be sexually available to him from then on (Dow and Kidd, 1994; Malungo, 2001; Sow and Gueye, 1998; Taverne, 1996). Gruenbaum (2001, p. 162) describes what happened according to Nuer lineage from her ethnographic research in the Sudan:

> The widow can object to a particular kinsman, but particularly if she is a young woman still able to bear children, the bridewealth cattle transaction that contracted her marriage is still considered to be in effect and the family of the deceased man has the right to continue to father children in his name unless the bridewealth cattle are returned. For older women, though, who have already borne several children or are past menopause and generally grow their own food and can affiliate with another kinsman's household if they wish, their lives are in practice fairly independent if they want them to be.

Everything is shared within the household: food supplies, work, shelter, children, sex, and, by default, sexually transmitted diseases. A common feature of the Tonga region of Zambia, Mwale and Burnard (1992, pp. 54–55) point out,

inherent problems with the practice: "Inheritance of wives raises many issues, such as the potential transmission mode for the virus, even though they may have stopped the old method of ritual cleansing. If the partner dies of HIV/AIDS, his wives carry the potential risk of infecting their new husband and family." Called *kungena* in Swaziland, where the custom continues, only now are locals realizing the link between it and HIV/AIDS.

Sexual "Cleansing"

> In the hours after James Mbewe was laid to rest three years ago, in an unmarked grave not far from here [Mchinji, Malawi], his 23-year-old wife, Fanny, neither mourned him nor accepted visits from sympathizers. Instead, she hid in his sister's hut, hoping that the rest of her in-laws would not find her. But they hunted her down, she said, and insisted that if she refused to exorcise her dead husband's spirit, she would be blamed every time a villager died. So she put her two small children to bed and then forced herself to have sex with James' cousin.
>
> Sharon La Franiere, AIDS Now Compels Africa to Challenge Widows' "cleansing" (2005a)

Some African countries encourage a ritual cleansing of widows following a spouse's death, where a designated member of his family is chosen to purge the ghost of the deceased. Although a number of local chiefs, organizations, and even governments have discouraged the practice, many senior women insist on keeping the practice, and it still persists in certain areas. One of Mwale and Burnard's (1992, p. 51) 36 Zambian interviewees reported, "Problems like the ritual cleansing, especially widows of HIV/AIDS patients." There is controversy as to whether it has actually stopped, another informant stating, "People are still using the ritual cleansing, especially if the relatives insist... I doubt if the people have stopped... I really doubt... you think the people can stop, I doubt that they have stopped, some are still doing it" (p. 52). Fortunately, as Webb (1997, p. 30) has noted, alternative practices such as jumping over brooms or cows or non-penetrative but close body contact have been adopted in some African areas.

"Dry Sex" and Other Practices

Another cultural norm from Africa comes from preferences, particularly from some men in central African societies, for women to have a dry vagina during intercourse (Brown and Ayowa, 1993; Civic and Wilson, 1996; Hardy, 1988; Myer and Kuhn, 2005; Sandala et al., 1995). Human Rights Watch (2003a) reports from Zambia, for example, about women using various herbs and plant extracts, cotton, detergent, salt, even shredded newspaper to reduce vaginal fluids so friction during intercourse will be increased. The problem, of course, is that this makes the female vulnerable to tears and lacerations in the vaginal wall and, as such, a natural place for blood and semen to seep (see also Kangende, 2004). Recent studies by researchers at the University of Zambia, blaming "entrenched traditions and

gender inequality which places women in a subservient position,"[10] pointed out how dry sex often causes genital ulcerations that facilitate a means for the HIV virus to easily enter a woman's body.

"Women use a variety of agents which are designed to tighten the vagina and dry up its natural secretions," Virginia van der Vliet (1988, pp. 90–91) explains, "everything from herbs to aluminum hydroxide to rock salt, stones or cloth . . . Both mechanical and chemical methods could cause inflammation, lesions and the danger of haemorrhages, with consequent susceptibility to HIV and other infections. If dry sex is the cultural preference, the use of condoms which require lubrication would also be unpopular." Within Africa, she cites a number of places where the practice is thought to continue, including Malawi, Cameroon, Ghana, Kenya, Zaire, Zambia, and Zimbabwe.

Part of Mark Schoofs' 1999 Pulitzer Prize-winning series "Death and the Second Sex" refers to how, "African women subordinate their sexual safety to men's pleasure," citing how one woman prepared for dry sex: "Mhakeni used herbs from the Mugugudhu tree. After grinding the stem and leaf, she would mix just a pinch of the sand- colored powder with water, wrap it in a bit of nylon stocking, and insert it into her vagina for 10 to 15 minutes. The herbs swell the soft tissues of the vagina, make it hot, and dry it out. That made sex 'very painful,' says Mhakeni. But, she adds, 'Our African husbands enjoy sex with a dry vagina' " (p. 67).

African Women's Societal Role(s)

> African women are the matrix of their societies. The pillar of strength in many homes, financial wizards in businesses, architects of the family destiny, and the great defenders of traditional practices, some of which are detrimental to their own health and that of their children.
>
> Olayinka Koso-Thomas, *The circumcision of women* (1998), p. 93.

From childhood on, African girls and women have been considered second-class citizens (Ankrah, 1996). All sorts of machinations are performed so that boy children will be born, as little girls are mostly valued for their help around the family. "The discrimination against women in society starts in childhood," Efu Dorkenoo (1994, p. 54) reminds us. "In patrilineal societies, male preference is very strong and at birth girls will not be as welcomed to the family as boys. . . . Girls are socialized to be self-effacing, obedient, humble, respectful and hard working." In what might seem an odd twist to westerners, Mauritanian women have been force-feeding themselves as an antidote to their culture's view of thinness as being associated with being poor (Soares, 2006).

Relative to the differential power between African men and women, Howson et al. (1996, p. 40) point out how gender inequality is impacted by STDs: "First, because women are constrained from either asking about or controlling their husband's sexual activities; second, because women are inequitably served by appropriate health facilities, or constrained by fear or stigma or inability to pay for services; third, because they may view reproductive

ill-health fatalistically, as part of their natural female lot; and fourth, women's limited economic opportunities may have made some sort of exchange for money a necessary option."[11]

As has been noted throughout this diatribe, African women are expected to (re)produce by extending families, despite a number of vulnerabilities for personal risk of becoming HIV/AIDS infected. "The consequence of failure in these roles," Ankrah et al. (1994, p. 537) say, "could be abandonment or divorce by her husband, blame from relatives for the husband's illness if he falls sick, and a deep sense of shame, anxiety, guilt, and depression if she produces a child who fails to thrive or who dies. Because many African wives and mothers lack formal education and independent means to free themselves from the quagmire of problems that AIDS creates, they are often trapped in a hopeless situation."

Grandmothers

Grandmothers play a pivotal role in Africa (Altman, 2006; Aubel, 2006; Aubel et al., 2001; Baylies, 2002; Ferreria, Keikelame, and Mosaval, 2002; Fuller, 2008; Ingstad, 1994; Schatz and Ogunmefun, 2007; Wilson and Adamchak, 2001). Far too many have lost their adult children to HIV/AIDS, as well as their husbands, and are conscripted into rearing their grandchildren. Lacking any form of welfare or social security, inevitably they are left with little financial or material support in this process, and end up depending upon their own resources, physically and philosophically. Even though they may not be up to it, grandmothers nevertheless end up, by default, as the most competent, sometimes the only competent ones around. Beer et al. (1988, p. 172) paint this grim scenario about what has come to be known as "skip-generation parenting":

> Where both parents and some infants are terminally ill in a society where there are no adequate medical, hospice or counselling facilities, the grandmother will be required over a long terminal period to nurse patients suffering from a disease which is unfamiliar, and whose symptomatology is still unaccounted for, and for which local traditional remedies have no application and no effect. It is a disease for which the grandmother may have no access to advice on treatment or prognosis. She will herself be at risk and perhaps afraid. She will have little or no knowledge of prophylaxis, either for herself or the surviving infants.
>
> It is likely that the family resources of income and the family's ability to produce or procure food supplies will have been cut off. The grandmother will have to become the wage earner or food producer.

Although the role of grandmothers is usually that of caretaker, HelpAge International has pointed out that they, too, need care; according to the IEC (Information, Education, and Communication) model, older people should be considered as an anti-risk group, as educators, and as carers for the sick and orphaned. Recognizing that many older people are sexually active, and can therefore both become infected by HIV and infect others, they propose a partnership: (1) Promote the maintenance of older people's physical, psychological, social and financial wellbeing through the formation of cooperatives and

community support groups; (2) Support this population as assets in the care and support of HIV/AIDS patients and their orphans; through small scale income generation activities, and most importantly; and (3) Increase their capabilities through the above, to ensure that orphans are not further deprived of access to resources and services in these economically deprived environments (Agyarko, Kalache, and Kowal, 2000, p. 4).

In 2006, CNN chief international correspondent Christiane Amanpour presided over a special, situated in Kenya asking *Where have all the parents gone?* Sensitizing viewers to the plight of orphans, the focus is on "the amazing phenomenon of African grandmothers—a whole generation of elderly women now looking after their grandchildren, after the mothers and fathers died of AIDS. Without them, these vulnerable children would be dead, or turn to a young life of crime and prostitution."

Sexuality Training

> As reproduction is not only a socio-cultural but also a religious duty in Africa, women's bodily discipline takes on a theological dimension. Beauty becomes a key factor in women's lives as a prerequisite for "catching and holding a man." Ornaments in nostrils, in the earlobes, elongated necks, anklets that can only be called manacles and are fitted by metalsmiths show to what extent women will go to please men.
>
> Mercy Amba Oduyoye, *Daughters of Anowa* (1995), pp. 165–166.

Given that it is economically imperative for African women to have a man and children, it should not come as an enormous surprise that premarital sex is tolerated, even encouraged in many areas (see UN Theme Group, 2005; Van Marle, 2006). A social sanction of the Lese of Zaire, for example, encourages the custom of sexual relations between young men and women during the period following puberty and before marriage. "In the so-called matrilineal belt centered in south central Africa," Shannon, Pyle, and Bashshur (1991, p. 61) report, "there is an especially high degree of adolescent promiscuity and uncertainty about paternity." Sexual activity in Africa is thought to begin early, usually in one's preteen years, with first marriage taking place between 15 and 22 years of age. Girls anxious to simulate virginity have been known to insert pre-soaked pellets in their vaginas that dry up the lining and tighten muscles, but medical people have warned against the practice as leading to complications such as cancer, HIV infection, or even cancer.[12]

In Zambia, an annual traditional initiation ceremony that takes place in August or September called *Nkolola*, for children who have matured during the year, is said to be a source of promiscuous activities that can lead to AIDS. Although in the past girls were secluded for up to three months preparing for womanhood, now the girl is taken to the bush on the back of an elderly woman, who is responsible for teaching her; upon return, there are lots of songs and dances, as well as the slaughter of goats and pigs and the brewing of beer. "Money is donated to the new initiate and also there is beating of drums and singing and dancing. People are invited from the neighbouring villages and they have all come to take part in the feast," write Mwale and Burnard (1992, p. 46). Like *Makogo*, a beer

ceremony that takes place anywhere from a month to a year after a person's death as a means of releasing the deceased's spirit, these rituals can lead to unsafe sexual practices.[13] Although we giggled about the beaded belts my African female friends wore as seductive symbols for their boyfriends and husbands,[14] it was fun to also have them confide in me about how they were instructed as to what soft cloths worked best for bathing their lovers, and what kinds of erotic words they were told to whisper in their ears.

We are appalled to learn that sexuality training for young men might involve a presumption of power over women. Kenyan guys, for example, are said to associate STIs with virility, just as men from Malawi boast of being HIV-positive as a "badge of manhood" (Barker and Ricardo, 2006, p. 2; see also Booth, 2003). PSI's 2003 study of young Zambian males found them miserably ignorant about risk perception of STDs and HIV/AIDS—a combination of misconceptions, folk beliefs, and denial.[15]

Although recently some African gays and lesbians have come out of the closet (Bloch, 2005), for the most part homophobia prevails (see Epprecht, 2004). Sexual politics in Africa still tend to be such that the culture keeps queer talk quiet (Constantine-Simms, 2000; Grosz-Ngate and Kokole, 1997; Spurlin, 2007; Niang et al., 2002, 2003; Wood, 1999). Nigerian society, averse to notions of men having sex with men (MSM), nevertheless admits that at 10,000 such persons living there are fueling the spread of HIV.

Gender-Based Violence (GBV)

> Prevention of GBV begins with a broader analysis of power imbalance in intimate relationships and the social norms that relegate women's status as lower than that of men. In this broad conceptualization, a whole range of issues become linked to GBV prevention, particularly HIV/AIDS. Women's vulnerability to HIV infection is closely related to their autonomy and status in their intimate relationships, their ability to negotiate safer sex with their partners, and the level of communication, respect and mutuality in their partnership. Women's vulnerability to both GBV and HIV is a result of a core set of issues including gender inequity, imbalance of power in their personal relationships and their low status in their community.
>
> GBV Prevention Network home page (available: http://www.preventgbvafrica.org/program_approaches/hiv.html)

Rooted in patriarchal structures that have long defined cultures around the world, GBV unfortunately remains an insidious part of societies around the world. For our purposes, we worry—correctly, about its role relative to HIV/AIDS; in Namibia, for example, cultural practices exacerbate its spread (Hofnie, Friedman, and Iipinge, 2004; Talavera, 2002). Throughout Africa, sexual violence has become institutionalized. Whether domestic violence, rape, rough sex, intimate femicide, sexual slavery (*trokosi*),[16] murder, and/or a weapon of war,[17] GBV in Africa is a subject out of control. Most gruesome of all, violence against African girls continues to grow, Mugawe and Powell (2006) reporting how annually some 40 million children under age 15 endure some form of violence, and we hear how deliberate rape to infect whole communities has become endemic in

some war zones. Remembering/knowing that this has to do with power, with taking away dignity, we are appropriately outraged.

Violence can, of course, be physical, verbal, psychological, sexual, even financial. In Africa, it may not discriminate over age or gender, but it might be ethnic, religious, nationalistic, economic, or philosophically based, even if its scars are not always apparent. Domestic violence, according to El Rafei and Mekheimar (2004, p. 1), "represents a hidden obstacle to economic and social development. It saps women's energy, undermines their self-confidence and compromises their health, thus depriving society of their full participation." Mozambique records more than 10,000 cases of domestic violence each year, which makes us wonder not only about the unreported ones there but also what else happens across the continent.

The UN' Declaration on the Elimination of Violence Against Women (General Assembly resolution 48/104 of December 20, 1993) deals specifically with gender-based violence, defining and describing it and suggesting it can occur within the family, the community, and the state. Its literature relative to Africa is extensive (Bakyawa, 2004; Burton, 2005; Couldrey and Morris, 2007; El Rafei and Mekheimar, 2004; Ferme, 2001; Green, 1999; Heninger and McKenna, 2005; Human Rights Watch, 1995, 1996, 2001, 2002, 2003a and b; Human Rights Watch/Africa 2004; Hund, 2003; Jacobs, 2003; Karanja, 2003; Malaquias, 2007; McCloskey, Williams, and Larsen, 2005; Muthien and Combrinck, 2004; Nowrojee, 1995, 1996; Outwater and Abrahams, 2005; Pelser, 2005; Pronyk et al., 2006; Schuler, 1992; Smith, 2002; Taylor and Stewart, 1991; Vetten, 2005; Webster, 2005; White et al., 2003).

Violence associated with HIV/AIDS manifests itself in terms of sexual coercion, rape, lack of negotiation—especially relative to condom usage, disclosure about HIV status, susceptibility to infectivity, and attitudes about general gender inequality. "Denial, blame and silence are often part of the experience of women who live with abuse and/or HIV/AIDS," Tanya Jacobs (2003, p. 3) reminds us. In Africa, we realize, gender inequality denies too many women the luxury of demanding fidelity from partners, insistence on contraception, and/or even participation in sex acts—no matter what the male's infection state may be.

Somewhere, somehow, a ridiculous rumor began being spread around Africa that having sex with a virgin would cleanse one of HIV/AIDS. Or, how about the one claiming that anal intercourse is a safe way of preventing AIDS? We hear horrendous stories about really young women being forced into sexual situations—the most hideous being the media outing of South African babies being raped. All too often, young girls are put at risk by rape and then become double victimized by the humiliation, never mind the loss of innocence along with the loss of virginity. Sexual assaults of girls as a means of sexual abuse all too often brings with them dangers of HIV infection, regardless of age. Very few of these assaults are reported to the authorities, then, so although statistics are unavailable, word of mouth prevails. An extreme example comes from Cameroon, Sylvestre Tetchiada (2006) reporting on a procedure called "breast ironing" by mothers not wanting their teenage daughters' becoming the object of male attention.

Based on interviews with more than 200 women (and several men) raped during the Rwandan genocide of 1994, came concerns about HIV/AIDS and other sexually transmitted infections (STIs); in fact, 83 of them became HIV-positive. Here is a reaction to that event by African Rights (2004, p. 6): "For some victims, there is no life after rape; they lose their health and happiness. Women raped during

the 1994 genocide in Rwanda lead a uniquely troubled existence and many feel their survival is its own form of torture. They are desperately impoverished, commonly infected with HIV/AIDS and are responsible for several children. They see their lives as 'finished' or 'another form of martyrdom'; one woman described herself as 'a living dead person.'" Recognizing rape as a standard weapon of war, this description underscores the depth of the suffering, trauma, and hopelessness, it can cause. Age was hardly a variable for vulnerability, as the youngest victim was six, the oldest 71. Nor was pregnancy, as 28 of the women were pregnant at the time of their attack(s), and 31 became pregnant as a result of their rape(s). Of the many reports they cite, one that really struck me had to do with Josette, who returned to her native home after her husband was assassinated, but nevertheless she, as well as her sisters, was raped. It became a pattern of attacks, so frequent she could barely recall the details, or recognize the perpetrators. "They transformed their act of violence," she declared, "into a habit, like drinking water." Although finding it an ordeal to recount her experiences, she reported:

> I was raped by a lot of people and at different times. I can't think how many times. Each time that the killers found me in the sorghum field or in the house, they did nothing but rape me. Once they tried to throw me in the toilet at the home of my older brother. As we were in a crowd, I slipped between them and escaped. On the way back, when they had just killed all the people who were with me, they found me in the field again. They gave me the big blood-stained stick that they had just used in massacring my people, a short distance away, and they began to rape me in the same field. They were many of them. I didn't even dare look at them and so I didn't recognize them. The génocidaires raped me whenever we met, until they felt satisfied.
>
> Sometimes, you would meet a very nasty man who would beat you before or after his vile deed. Some women or girls were also tortured in their private parts, but that didn't happen to me. Another act of savagery, which happened often, is that you were tortured by seven génocidaires, or even more, at the same time. (p. 12)

There was a single bright, light, however: the creation of community by a number of women's organizations (see also Ogundipe, 1994). Mostly those founded by survivors, these support groups have played a special supporting victims. Recall: it was at the 2004 International Day for Elimination of Violence Against Women that Kofi Annan called for "a bold transformation in men's attitudes and behavior." Gender inequity is found to fuel HIV infection—a finding underscored by The United Nations Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa (Baylies and Bujra, 2000; Baylies, 2001; United Nations, 2004). In addition to women's lack of negotiation power in terms of safer and/or unwanted sex, gender inequity also affects their socio-economic status such that they are nearly the only ones who labor for the sick, the orphaned, and the dying. Recognizing complexities in these issues, the Task Force established these action steps:

1. Prevention of HIV/AIDS among young women and girls
2. Girls' education

3. Violence against women and girls
4. Property & inheritance rights of women and girls
5. The role of women and girls in caring for those infected and affected by HIV/AIDS
6. Access to HIV/AIDS care and treatment for women and girls.

You need not have much further proof than the sham evidenced ruling the recent trial on charges of rape of Jacob Zuma, former deputy president of South Africa, and now deputy president of the African National Congress (ANC). He not only knew his accuser, who was a friend of his daughter, he also knew she was HIV-positive; so, after what he claimed was consensual, unprotected sex, he took a shower.[18] The young woman, who reportedly had considered Zuma to be something of a father figure, found herself in the middle of many conflicting emotions and mechanisms, the prosecution dragging up her sexual past but anti-rape and AIDS activist groups rallying around her (see Makinana, 2007; Motsei, 2007). As to who won in the long run, since the court dismissed the charges, remains to be seen, but the *One in Nine* campaign (www.oneinnine.org.za), referring to the number of South African women who have reported rape, has been one good outcome.

South Africa has one of the highest rape rates globally (see Kistner, 2003), with some 125 girls and women raped each day—one every 26 seconds, closely followed by Kenya's statistic of every 30 minutes. Part of the violence the nation has endured since holding its first democratic elections, in 1994, the rapes include everyone from baby girls to grandmothers. Recovery can be draining, both physically and emotionally, and may, in fact, never be resolved. To guard against HIV/AIDS, a 28-day course of two ARVs—zidovudine and lamivudine, might be administered. But really, we wonder, can anything counter spoils of war that spoil lives? And what will happen relative to rural and tribal traditions that support male domination and emerging legal standards supporting women's rights? Think about how *Afrol News* (December 3, 2007) has expressed it: "Violations of women's rights escalates the rate of HIV infections throughout the continent. Sexual oppression combined with a high biological receptiveness of viral transmission, put women as risk. As a consequence, the violence against women threatens to destroy whole communities."

"Entrenched machismo is one of the biggest challenges in the war on AIDS," it has been pronounced.[19] More than one man who has read this manuscript, or heard about my research, has commented on how African men have it "made," have it figured out how to keep a system that revolves around and works for them; they are, as such, in the driver's seat.

The Role of Religion

> On the threshold of the third Christian millennium, religion in Africa astonishes and intrigues the world with its vitality, diversity, and complexity. Three interrelated dimensions of religious development in Africa particularly fascinate both general observers and scholars in the wider world.

> One is the exponential growth of Christianity and Islam in Africa during the 20th century, so that the entire continent is now a major sphere for two of the great world religions. Second, alongside this growth of world religions is the survival and, indeed, revival of African religions that pre-date world religions' entry upon the scene and which exist in dynamic relationship with Christianity and Islam. Third, is it clear to even the casual traveller that people in Africa have developed forms of religious thought and practice that incorporate both indigenous traditions and distinctive features of the immigrant world religions.
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> Titus Leonard Presler, *Transfigured Night* (1999), p. 10.

Coming from a perspective of the theological motif *imago dei*, Elias K. Bomgmba (2007) has pointed out how far HIV/AIDS has come from early responses by some people, such as Christian conservatives, as a divine judgment, or by anti-condom groups as against God's will. Now that it has been recognized as a virus, and not a sin, he calls on the Christian community to have compassion and to take responsibility: "HIV/AIDS has created new opportunities for the church in Africa. It has opened up a space for caring, compassion, creative thinking, collaboration, and combat. To think creatively, the church must employ new tools to inquire about what it means to be human in the context of an illness that has no cure and resists treatment even where it is available" (p. 5).

For centuries, both Islam and Christianity have had a presence in Africa, with about half the population currently identifying itself as Muslim. Still, hundreds of separate, indigenous African Traditional Religions predominate, along with smaller groups of Christians, Jews, Hindi, and others. We must be cautious about not making broad statements here, though, as Africa boasts some 3,000 tribes, each one with its own religious system. It is also difficult to distinguish between the sacred and the secular. Further, it is staggering to consider the role of religion in Africa in terms of missionaries' trying to convert and enslave people as early as the sixteenth century, or colonization attempts to subvert local religious traditions. Yet, despite labels calling some of those practices primitive, or fetishist, or animist, or any number of other negative terms, many different religious and spiritual forms remain to this day both in Africa and in the African Diaspora. Many different traditions, both oral and living, abound, handed down from one generation to the next. Robert B. Fisher (1998, p. 7), focusing on the Akan of Ghana, supplies details: "The griots, the elders, the storytellers, and the drummers keep alive the corpus of material that serves as a moral guide and as a foundation to the thought and behavior of a given people within its cultural environment."

John Mbiti's *African Religions & Philosophy* (1990), first published in 1969 and widely recognized as the standard work, claims that, for Africans, religion is "an ontological phenomenon; it pertains to the question of existence or being" (p. 15). He divides it into five categories:

1. *God* as the ultimate explanation of the genesis and sustenance of both man and all things.
2. *Spirits* consist of extra-human beings and the spirits of men who died a long time ago.
3. *Man* including human beings who are alive and those about to be born.
4. *Animals and plants*, or the remainder of biological life.

5. Phenomena and objects without biological life. (pp. 15–16)

Writing about Niger, Adeline Masquelier (2001, p. 237) points out how, "Popular perceptions of women as the embodiment of purity, modesty, and productivity seem to increasingly give way to disturbing images of female identities profoundly at odds with indigenous and Islamic notions of femininity and fertility." Religion, it has been noted, is central to Africans. For women, that means devotions to divinities as yet another form of subordination. "The African church is a human community in which women are commanded to be stationary," Oduyoye (1995, p. 189) complains, encouraging her sisters to participate according to their own God-given talents rather than the dictates of men. In essence, she encourages women to support one another: "With our collective strength."

The Reverend W. Bozongwana (1983, Foreword) describes the Ndebele of Zimbabwe, where religion predominates in the community: "For example, if you go to the field, you find religion there; if you have a wedding, cattle, a new baby, illness, happiness, death or drought, religion is there." Looking at dreams, omens, witchcraft, and ancestral spirits, he traces various taboos and customs that are maintained to protect believers. And men. "While it is the man's obligation to feed, clothe and comfort his spouse," he writes, "the woman is expected to cook and bear children for the man. She must prepare bedding, please the husband, remain faithful and bring up children strictly according to custom" (p. 8). Presler (1999, p. 138) cites a sermon from Shona Spirit Religion by Anglican priest Reverend David Manyau challenging men's oppression of women:

> Biblical and theological themes that Manyau emphasised were the creation of woman as well as man in God's image, the time Jesus spent in the homes of people and the resurrection appearances to women. On these bases he discussed a broad range of issues in women's oppression: men's treatment of women as property rather than as persons in the negotiation of bride-price; their tendency to commend women verbally but behave unjustly toward them; the socialisation of men to be violent toward women; the ease with which some men divorce their wives; the injustice of polygyny; and the imperious behaviour of mothers-in-law toward their daughters-in-law. Other speakers, both male and female, denounced the role of men in infecting their wives with AIDS through frequenting prostitutes at Zindi's Pungwe Hotel, often called *Rambanai*, which means "divorce."

A powerful predictor of intergenerational transmissions of knowledge, beliefs, and values, religion in Africa plays an important role in terms of how individuals and societies alike respond and/or react to the HIV/AIDS epidemic (Ackermann, 1991; Ahanotu, 1992; Amadiume, 1997; Assimeng, 1989; Blakely, van Beek, and Thomson, 1994; Bozongwana, 1983; Brenner, 1993; Byamugisha, Steinitz, Williams, and Zondi, 2002; Callaway and Creevey, 1994; Dubbey, 2006; Donkor, 1997; Fisher, 1998; Gekawaku, 2003; Kagimu, 2004; Masquelier, 2001; Mbiti, 1990; McDermott, 2007; Musopole, 2007; Olupona, 1991; Onwubiko, 1991; Phiri, Haddad, and Masenya, 2003; Ruel, 1997; Soothill, 2007; van Dyk, 2001; Wangila, 2007). In more than 2 million mosques, churches, and traditional gathering places, the Quran, the Bible, Hindu texts, and other inspirational and instructional works are read, songs are sung, and prayers offered up by the faithful.

Consider: according to *WorldAIDS* (March, 1992), at a 1991 landmark conference in Cairo on "The Role of Religion and Moral Behavior in the Prevention and Control of AIDS and STDs," leading Muslin and Coptic Christian theologians decided to reject safer sex education and condom usage in favor of early marriage and marital faithfulness as appropriate weapons against HIV infection. What is wrong with this picture? Whether belonging to churches that rule against condom use or churches that deem their body, as God's temple, belongs to their husband, African women's religion can be yet one more factor putting them at risk for AIDS.

While nearly half the 750 million people on the continent claim Christianity, and some one-third adhere to Islam, traditional religions still abound. Just slightly more Christian (410 million) than Muslim (358 million), African religion takes many forms, and traditional folk religion or syncretism is practiced alongside more mainstream approaches (see Soothill, 2007). Missionaries have long been present on the continent, and recently their role(s) relative to HIV/AIDS have been helpful in behavior change. *Circles of Hope*, which was established by the umbrella church organization Council of Churches in Zambia (CCZ), supported by DanChurchAid, uses Joy Lubinga as a PLWHA spokesperson within the church community; she has testified: "This project is vital to me. In order to uplift the living conditions of HIV positive people and their relatives, spaces must be created within the church communities of Zambia for us to be open about our status and support each other in self-help groups" (cited in Dylande, Klinte, and Africa, 2006, p. 27).

As ridiculous as it may seem, religion is cited as one of the reasons why many Africans forego educational, experiential and medical knowledge about HIV/AIDS, believing the idea that the act of marriage makes people immune from infection (see Dubbey, 2006). While Muslim,[20] Anglican, Catholic, and other religious and societal leaders push the idea of marriage and "zero grazing" (marital fidelity), it does not insure freedom from the disease. Even though religion in some social networks leads to the prohibition of contraceptives, Cohen and Hubert (1997, p. 198) point out that in Tanzania, "The understanding of this cultural constraint led to a redefinition of condom use. Muslim clergy redefined it from contraception to a method of disease prevention," so context religion leaders could encourage their followers to use them. Conditions there are particularly grim anyway, with both morbidity and mortality levels unacceptably high, one out of every ten children not surviving to a first birthday, and more than three of every 1000 mothers-to-be dying as a result of pregnancy (*Tanzania*, 1992).[21]

Regardless of religion, traditional African funeral practices have had to change with the times (Berkeley, 2001). Whereas mourning periods used to last a week or more, the sheer numbers of deaths due to AIDS has reduced that bereavement time to something more like a day and a half. Still, religious leaders and practitioners can and do play a vital role relative to HIV/AIDS (Bate, 2003). In an interview with Michael Czerny, director of the African Jesuit AIDS Network (AJAN), Jim McDermott (2007, p. 1) got this response to his question about the role of medicine: "We learn as we go along that AIDS is very complex. HIV is a virus that reduces and destroys the immune system. But it's also a cultural, familial, communal and spiritual reality. The fight against AIDS has to be carried forward on all those fronts. The people who specialize in medicine, especially the pharmaceutical companies and the big funders, don't see this breadth. They see

the pills; they want to see them distributed, taken and effective." Czerny sees it all as a time for healing—at many levels.

In 2001, The Balm in Gilead launched the *Africa HIV/AIDS Faith Initiative* in Cote d'Ivoire, Kenya, Nigeria, Tanzania, and Zimbabwe by means of raising awareness and using advocacy communication strategies to do the following: speak out against stigma; educate people, especially adolescents and youth, about AIDS; support VCT; prevent MTCT of AIDS; promote low-risk behaviors and seronegative status; and provide long-term care and advocate for the rights of PLWA, as well as orphans, widows, and women. *Positive Voices* (2005), edited by Gideon Byamugisha and Glen Williams, contains person stories of 12 Christian and 2 Muslin religious leaders either living with or personally affected by HIV/ AIDS; part of a "Called to Care" toolkit developed by the Strategies for Hope Trust, it is a promising beginning for getting beyond stigma. Another helpful publication is Mark G. Winiarski's *Community-based counseling for people affected by HIV and AIDS* (2005), published by Catholic AIDS Action—valuable interpersonal strategies surround a range of difficult issues. Whether for encouraging voluntary testing and counseling, preaching monogamy and fidelity, denouncing discriminations against PLWHA, discussing family planning, and/or providing ways of dealing with disease in general, religious institutions in Africa have an awesome responsibility.

Special envoy of the UN Secretary-General, Stephen Lewis, gave an address in 2002 to the African Religious Leaders Assembly on Children and HIV/AIDS that puts all this into perspective, complaining that, "The voice of religion has been curiously muted." He goes further: "Religious leaders must do something about the mothers who are infected and are dying prematurely, leaving behind those orphans who wander the landscape of Africa, soon to be an entire generation seething with resentment and fear... When the history of the AIDS pandemic is written, you want it said that every religious leader stood up to be counted."[22]

Witchcraft

> South Africa's medical system boasts modern hospitals and pharmacies, but it coexists with bone-throwing healers whose prescriptions sometimes include the most grisly of curatives. Faith in them is more widespread than this nation's modern veneer suggests, some say.
>
> Sharon LaFraniere, Toddler's Killing Exposes Ghoulish South Africa Practice (2003).

"AIDS has proved a fertile field for both prejudice and politics," van der Vliet (1988, p. 55) has written, "dangerously politicizing AIDS in a revival of racism and homophobia. The fact that the first victims were from stigmatized groups unleashed a wave of victim blaming." Many stories perpetuate images of women as demons, involved in witchcraft; Mercy Amba Oduyoye (1995, p. 122) outlines the following:

> If a woman has many children when those around her—especially sisters or sisters-in-law—have none, she is a witch, calling attention to herself alone. If a woman is childless, she is a witch or a victim of witchcraft; others close

> to her may have sold her ovaries for money or tied up her womb out of vindictiveness. Unmarried women who are independent of male support are also likely to be accused of witchcraft. Widows, especially multiple widows, are often accused of causing the death of their husbands through witchcraft. Even a woman who is considered quarrelsome or who may have been plagued with constant ill-luck is considered a possible witch. If a woman cannot succeed in any economic enterprise, she may be a witch; if she prospers too obviously in it, she may also be a witch. If a successful woman has been cleared of witchcraft, she is often suspected of being prodigious with sexual favors.

Because witchcraft is still considered so integral even in postcolonial African society, there is quite an extensive literature relative to it (Ashforth, 2002; Geschiere, 1997; Green, 2003; Hund, 2003; Ogembo, 2006), most drawing on the seminal piece by Evans-Pritchard's study of the Zande in 1937. Like so many other subjects in this book that could be its entire subject, suffice it to say that most witches are thought to be hosts of evil or healing ancestral spirits, although there are of course many variations. "Traditional medicine in Africa attributes illness to contamination, witchcraft, natural causes or vengeful spirits," Mercedes Sayagues (2003) has noted. "Blood, especially menstrual blood, is a contaminant. It this view, sex with a menstruating woman brings disease—including AIDS. It follows that post-menopausal and very young women are safe—a factor in the alarming incidence of child and 'granny' rape." As some people wonder if this is not just one more attempt to keep women down, and discriminated (Amatenstein, 2006), we do have to wonder about the motive(s).

Since what concerns us is witchcraft's association with HIV/AIDS, we mostly worry about Africans who live in fear of sorcery. John Vidal (2005) reports on a Zambian who fell ill and visited 15 witchdoctors, "who all told him he had been possessed. One said he had a snake in his body drinking his blood, another inhabited by a ghost, a third bewitched by jealous neighbours. They took his money, washed his evil spirits away, exorcised him and gave him roots and powders." Fortunately, this story has a happy ending for now, though, as Medecins sans Frontieres intervened and put him on ARV drugs.

Dealing with Death

> Nairobi, a city of raucous African vitality, has little sense of crisis. Honking buses careen along bumpy streets crowded with shoe-shiners, paper vendors and born-again preachers. By night, prostitutes line the pavements, shivering in the cool air and casting sly glances at passing cars...On average, one in 10 people in the daytime throng has HIV, the virus that causes AIDS. Among the prostitutes, it is probably four in five. The dead stuff the shelves at the stinking city mortuary. Many cannot afford to be buried; those who can silently fill the graveyards.
>
> Declan Walsh, *Death in the Heart of Darkness* (2004).

Sometimes referred to as "crossing the river," death in Africa often means going from this life to that of an ancestor. Involving a process from burial rites to funerals and ongoing worship, it can include a wide range of procedures

and philosophies for the departed. All too often associated with magic, or sorcery, or witchcraft, many societies believe in reincarnation, or being reborn (Nzioka, 2000).

Reporting on funerals in the Republic of Zaire, which can involve whole communities from a week for a small child to several months or longer for an elder, Blakely and Blakely (1994, p. 424) found few people believing in "natural causes": "Yes, Bahemba agree, the lion may have eaten the man, or the woman may have died of cholera or in an auto crash. But, Bahemba will ask, why did it happen to that person on that day and not to someone else?" Funerals, which give license to singing and dancing, wailing and commenting about the human condition, are different for men and women; they report on the latter:

> Since a married women usually lives with her husband in his patrilineage segment's village, when she dies, an emotionally charged *musuusa* performance is often done in this village where the majority of prime suspects live. Female relatives from the deceased's patrilineage, her matrilineage, her mother's patrilineage, and her father's patrilineage, as well as various affinal relatives, are prominent (p. 425).

Regardless of religion, traditional African funeral practices have had to change with the times. Whereas mourning periods used to last a week or more, the sheer numbers of deaths due to AIDS has reduced that bereavement time to something more like a day and a half. Today, there are far too many funerals around Africa. Mortuary space in some countries is at a premium, and going to funerals has become a more frequent pastime for some Africans than church-going. Akan women (of Ghana) are central in mourning rituals ranging from care and disposal of the dead to helping members of its society adapt to bereavement.[23]

"To understand AIDS as a possible stimulus for change," conclude Ankrah et al. (1994, p. 535), "we must examine how African women experience AIDS. Intervention measures targeted toward women must consider that their vulnerability may be due less to the risks they take in their individual sexual behavior than to the prevailing sociocultural context in which they live." That context, which Kristof (2003a) has called "a self-replicating cycle of AIDS, poverty and hopelessness," is one perspective. As you review this book, you begin to realize, though, that there is no prototypical African woman. For our purposes, she might be a fetus, a newborn, a daughter, a cousin, a sister, a young girl, an orphan, a street kid, a woman, an aunt, a wife or a co-wife, a mother, even a grandmother and/or any combination of these designations. Whatever her identity or status, she is currently prized for her productive and reproductive roles within a complex clan society. We need to realize that she is unique: She is our counterpart, in Africa. She could be us, we could be her, and we need to know about her and to know her as a real person. Forget the "them/us" paradigm; we are all sisters, sisters who need to understand and help one another.[24]

Notes

1. Let me go on record as supporting December Green's (1999) notion of not looking at African women as victims, but rather as resilient, as resistors.
2. Refugees around Africa (*Christian Science Monitor*, February 8, 2005, p. 5).

3. Esther Nakkazi, Cultural barriers keeping Kenyan and Ugandan women out of AIDS vaccine trials, *The East African* (Nairobi), August 4, 2003.
4. See Michael Bourdillon (Ed.), *Earning a life: Working Children in Zimbabwe* (Harare, Zimbabwe: Weaver Press, 2001); Malawi's women gang up against child labour (*SAPA*, September 15, 2003); *HIV/AIDS and child labour in Zambia: A rapid assessment on the case of Lusaka, Copperbelt and Eastern Provinces* (London: International Labour Office, 2003).
5. See *Guinean youth drive HIV/AIDS and pregnancy prevention program* (2003), available: (http://www.jhuccp.org/pubs/ci/16/16.pdf).
6. See *Child-centered approaches to HIV/AIDS—Kenya and Uganda* (London: Healthlink Worldwide, 2004).
7. See: Jonathan Clayton (2004), *The lost children of Nigeria's sex trade* (*The Times* [London], April 5).
8. For a promising story on orphans in Malawi, check out the Jacaranda Foundation (www.jacarandafoundation.org).
9. See: V. Woog, *Annotated bibliography on HIV/AIDS and youth in sub-Saharan Africa* (New York: Guttmacher Institute, 2003); W. Bird, R. Bray, G. Harries, M. Meintjes, J. Monson, and N. Ridgard, *Reporting on children in the context of HIV/AIDS: A journalist's resource* (Minneapolis, MN:Children's Institute, 2005); M. H. Stigler, K. C. Kugler, K. A. Komro, M. T. Leshabari, and K. I. Klepp, *AIDS education for Tanzanian youth: A mediation analysis* (Minneapolis, MN: School of Public Health, University of Minnesota, 2005).
10. Risky practices in Zambia weakening fight against HIV/AIDS (Xinhua General News Service November 27, 2007).
11. For other data on African women's vulnerabilities to STDs, see Ibekwe, 2002.
12. Kenya: instant "virginity" trade blossoms (*African Woman and Child Feature Service*, July 7, 2005).
13. The *Ethiopian Herald* (August 31, 2005) identifies 162 "Harmful traditional practices on women."
14. "In Africa, beads are associated with a number of social and cultural perceptions," Kondwani Magombo has written from Malawi (Planning your family—the beads way, *The Chronicle*, September 5, 2006). "Among other things, beads worn around women's waists are believed to serve as a sexual catalyst while those worn around the neck improve the looks of the women."
15. Misconceptions, folk beliefs, denial hinder risk perception among young Zambian men (*PSI*, September, 2003).
16. See Abayie B. Boaten's The trokosi system in Ghana: Discrimination against women and children (in Rwomire, 2001, pp. 91–103).
17. For a sampling of war-related GBV, see Owen Bowcott (2005), Tens of thousands raped by militias in Congo: Children and elderly not spared (*The Guardian*, March 8); [Lesotho] Govt intensifies efforts to help rape survivors (*Irin*, June 7, 2006); Epidemic of brutal rape traumatizes women in eastern DR Congo (*Agence France-Presse*, June 12, 2006); Craig Timberg (2006), Gender-based violence galvanized warlords' foes (*Washington Post*, June 17); Thalif Deen (2007), Rape, gender violence the norm in post-war Liberia (*Inter Press Service*, March 7); Nora Boustany (2007), Janjaweed using rape as "integral" weapon in Darfur (*Washington Post*, July 3, 2007); Jeffrey Gettleman (2007), Rape epidemic raises trauma of Congo war (*New York Times*, October 7).
18. In fact, it has been found that uncircumcised men who wash their penis after sex increase their risk of acquiring HIV (see Altman, 2007).
19. Lillian Omariba (2003), Entrenched machismo is one of the biggest challenges in the war on AIDS (*Agence France-Presse*, September 25).
20. Be sure to check out Women's Learning Partnership (WLP)'s *Guide to equality in the family in the Maghreb* (Bethesda, MD, 2005), developed by a coalition of women's organizations from Algeria, Morocco, and Tunisia.

21. See Ayaan Hirsi Ali's *The caged virgin: A Muslim woman's cry for reason* (2007) and David Robinson's *Muslim societies in African history* (London: Cambridge University Press, 2004).
22. Special thanks to Edward Harris of Associated Press for sending me a copy of Stephen Lewis' speech from the African Religious Leaders Assembly.
23. See Osei-Mensah Aborampah, 1999, for details on the music and dance associated with Akan mourning rituals.
24. For more on African feminism, see Oyewumi, 2003.

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CHAPTER FOUR

Economic Vulnerabilities

The African Economy

> Rapidly increasing rates of HIV and AIDS in women should be viewed within the context of a steady socioeconomic decline of a region highly dependent upon primary modes of production in which they play key roles. The needed transition to the industrialization of Africa is threatened by unanticipated geopolitical upheavals which are ushering in changes in economic alliances. These portend a shift of assistance away from Africa to other Third World countries. The ability of women in the face of AIDS to sustain productive outputs may be critical to the success of strategies to avert further regional socioeconomic deterioration. The roles of women in reproduction and family care giving are equally crucial to the maintenance of the quality of life of the population.
>
> Ankrah, AIDS, Socioeconomic Decline and Health (1996), p. 99.

It has been said that the African economy is dysfunctional, with its drastic poverty, staggering debts, low ranking in terms of development and per capita income, corrupt, dictatorial governments (think Robert Mugabe of Zimbabwe, Charles Taylor of Liberia, Omar Al-Bashire of Sudan, Isayas Afewerki of Eritra, Teodoro Obiang Nguema of Equatorial Guinea, along with the former Idi Amin of Uganda or Mobutu Sese Seko in the Congo), and high unemployment rates. According to UNDP, more than a third of the population lives on less than a dollar per day. Famine and malnutrition are rampant (see Fair, 1996), and African women are the worst hit. The prevailing wisdom, we hear, is something like, "AIDS may kill me next month or next year, but hunger will kill me and my kids tomorrow."

Yet, the continent continues to have investments and active foreign trading, and rich resources continue to be exploited for the few. According to Elie B. Smith's *2007 Africa economic report*, "Sadly, while African economies are growing, the growth rates are not strong enough to reduce poverty and also attain the UN's Millennium Development Goals... Nevertheless, with an average growth hovering between 5% and 6%, the continent's economic growth rate is twice faster than her population growth" (p. 1). The largest African economies pretty

much stay the same, the Republic of South Africa being the biggest, with a GDP $272.2 billion, followed by Nigeria ($141.3 billion), Algeria ($137.2 billion), Egypt ($111.8 billion), Angola ($66.1 billion), Morocco ($61.1 billion), Libya ($56 billion), Sudan ($45.7 billion), Tunisia ($33.1 billion), and Zimbabwe tenth with $26.4 billion. For more, check out the Economic Commission for Africa website (www.uneca.org).

Economics has been the subject of a number of relevant books here (Amadiume, 1997; Bakut and Dutt, 2000; Bentley, 2004; Chabal and Daloz, 1999; Cobb, 2005; Davachi et al., 1988; de Waal, 2003; Gordon, 1996; Guest, 2004; House-Midamba and Ekechi, 1995; Kaberry, 2004; Meer, 1997; Nnaemeka and Ezeilo, 2005; Oboler, 1985; Robertson, 1984; Snyder, 2000; Tripp, 1997; Welpe, Thege, and Henderson, 2004; The World Bank, 1994; YWCA of Uganda, 1997); continually, we realize its role in nearly every aspect of society. Charlayne Hunter-Gault (2006) points out how African women, who produce three-quarters of the continent's food and yet still remain the poorest of the poor, are, "the backbone of the rural African economy. They farm small plots, sell fruits and vegetables and other items in the villages, and provide basic necessities such as food, medicine and clothing for their families. They toil often the in absence of men, many of whom work in the mines or other migrant labor far from home. Often the men take second wives and create other families. Some never return, or they return infected with HIV." She then informs us of the transformation in their lives by a simple savings-and-loan program started by CARE is making in Tanzania, with profits shared by members who have pooled their resources. Resources like the African Women's Development Fund (AWDF), the African Federation of Women Entrepreneurs (AFWE), the Global Fund for Women (GFW), Cameroon's Association for Support to Women Entrepreneurs (ASAFE), Southern Africa Institute for Media Entrepreneurship Development (SAIMED), and UNIFEM all play invaluable roles. Peggy Ntseane (2004) has studied entrepreneurial women in Botswana in a moving demonstration of empowerment in the formal economy, coming a far distance from unemployment.

Much of the conversation surrounding HIV/AIDS in Africa concerns money, most of it concentrated on drug costs, or medical manpower costs, or how the disease has affected national budgets. The alarming budget estimate comes from UNAIDS, who has declared that more than $22 billion will be needed by the time this book comes out for low- and middle-income countries to be able to deal with prevention, treatment, and care of HIV/AIDS. The world community needs to be on alert. As countries funnel much-needed labor and capital into the epidemic, financial implications abound, not the least being dwindling work-forces. Yet, nursing care costs and direct costs such as overhead for hospitals and clinics are given far more attention, it would seem, than human costs. All levels of society are affected. Because his comments come from my beloved Senegal, and because this was such an issue for me, let me share Somini Sengupta's (2004, p. WK1) observation:

> They stand at my taxi window, scrawny and unwashed, holding up empty tomato tins. They scratch their scabby arms. They wipe their running noses. Listlessly, they chant verses from the Koran. More often, they dispense with the formalities and beg: "Cent francs, ma tante, cent francs, cent francs."[1]
>
> These are the talibes, or beggar boys, of Senegal, dispatched onto the streets by religious leaders, called marabouts, and ordered to collect a daily

quota ranging from 250 francs to 650 francs (50 cents to $1.30), along with whatever else is dropped in their tin cans: sugar cubes, biscuits, milk powder, kola nuts.

If they fail, they face a beating.

At its base, African society in neocolonial, capitalistic essence sees land, or property, as one of its most important economic variables (see Dingake, Aphane, and Gwaunza, 2001; Goheen, 1996; Izumi, 2006a and b; Kalabamu 2006; LeBeau, Conteh, and Iipinge, 2004; Meer, 1997). Since under patriarchy that value is typically owned solely by the man, woman's role is limited to reproduction. Her labors, both in childbirth and in the field, define her role within the kinship group. More than likely, she is the key breadwinner, the principal economic support for the family. Her social approval comes from being marriageable and producing children so the notion of family can continue.

Although she is married, the African woman is at the service of each and any member of the family, but at any time when she becomes husband-less, his property and her rights can be taken away. Whether divorced (which is rare) or widowed, she may also lose custody of her children along with everything else, and may even be forced to start a new life for herself despite a specified lack of skills. All this helps explain why the status of African women in terms of education and employment, which are the crux of any economy, is ranked so low. Jeffrey D. Sachs (2003), who headed WHO's Commission on Macroeconomics and Health, reminds us of an incredible statistic: "If rich countries contributed a total of around $25 billion per year, the increased investments in disease prevention and treatment could prevent around eight million deaths each year in poor countries throughout the world. The U.S. share would be around $8 billion, given the size of its economy in relation to other donors. Most of this money is needed in Africa, where the countries are among the poorest and the disease burden is the highest."

Women's Work

> Traditionally, African women have farmed, traded, processed, prepared and sold food, made pottery, woven and dyed cloth, and made it into wearing apparel. To do this, we required no male direction or education. We learned through an apprenticeship with our own mother or another skilled woman.
>
> Mercy Amba Oduyoye, *Daughters of Anowa* (1995), p. 100.

In fields, in the home, and in marketplaces throughout Africa, women workers reign (Adepoju and Oppong, 1994; Alexander, 1995; Bay, 1982; Bryceson, 1995; Cinar, 2001; Clark, 1994; Cock, 1980; Coquery-Vidrovitch, 1997; De Villiers, 1989; Hansen, 1992; Hay and Stichter, 1995; Ivan-Smith, Tandan, and Connors, 1988; Kempadoo and Doezema, 1998; McCormick and Pedersen, 1996; Ondimu, 2006; Pittin, 2002; Sheldon, 1996; Skard, 2003; Stichter and Parpart, 1988; Wright, 1993). Although "household activities" are not calculated into the national income, we all know how invaluable their work, while sometimes invisible and nearly always uncompensated, can be (Schlyter, 1996). Consider some of these chores listed by Jarawan (1991): growing, storing, grinding and

processing food; caring for animals; selling, exchanging produce; fetching water and firewood; childcare; cooking; cleaning, house building and house repair; and community projects. For most women, chores are secondary to "real" jobs they may have outside the home. Predominantly, though, African women's work involves social labor along with agricultural production, and women make up only 4% of formal sector workers (see Pittin, 2002). Another major source of income, especially for older women, is the performance of female circumcisions; no matter what your opinion about the practice, women excisors have tremendous power. This story about a woman from Tillabery, Niger, makes these details come alive:

> Every day, Minta, a 40 year-old mother of six, fetches water for the household, does the laundry in the river, labours on her millet farm and, if there is food, prepares the family meals before collapsing into bed, exhausted. But during this particularly difficult lean season, there is no food, and the daily grind has become even more unbearable. With her youngest child wasting away from hunger, Minta has had to walk three hours in the scorching sun on an empty stomach in the hope of getting some food aid. "My husband has a donkey, but I don't know how to ride it," she said apologetically. She sits under the trees, sharing the shade with hundreds of other women hoping to receive food and medical aid at the main hospital in Tillabery, some 100 km northwest of the capital Niamey in one of the areas worst affected by Niger's ongoing food crisis. Minta has never been to school. She can't read or write. She has never even used a telephone. Once—and only once—she travelled in a car. For Minta, and the other women at the hospital, the hunger that has reduced her children to skin and bone is just another hard fact of life.[2]

African women's livelihoods, it has been argued (e.g., Bay, 1982), has been continuously threatened since colonial systems began to disrupt traditional means of productivity. "In fact, in the roughly 40 years since these countries have freed themselves from Europe's colonial rule, the plight of children in Africa has only grown worse," Sengupta (2004, p. WK 1) has declared. "In the 20 countries of sub-Saharan Africa, the average citizen is poorer than she was a decade ago." Although they work ever harder, in other words, their efforts are handicapped by numerous sociopolitical and economic means of institutionalized oppression. Whether as farmers (Gladwin, 1991), marketplace salespersons (see Clark, 1994; Small, 1995), entrepreneurs (see McCormick and Pedersen, 1996; Rasheed and Luke, 1995; Spring and McDade, 1998), cross-border traders (see Burnett and Manji, 2007; Muzvidziwa, 2005), or even employees outside of the home, African women's contributions to their families and their nations are incalculable.

Because women's work has traditionally centered around the home, it is quite natural that some African women have been employed as domestic servants in households that could afford it. Although we may not want to face it, slavery in many brutal faces has clearly been an indigenous system. In a classic study about such arrangements under racial apartheid in South Africa, Jacklyn Cock (1989, p. 149) describes various vulnerabilities and oppressions:

> Their exploitation is evidenced by deprivation of their family life, of reasonable working hours, of time to pursue social and leisure interests of their

own choosing, of a negotiated wage, of favourable working conditions, of the ability to rent or purchase accommodation in a chosen place, to sell their labour in the place of their choice, of respectful treatment, or the acknowledgement of the dignity and importance of their labour, of legal protection, or membership in an effective worker organization, of effective bargaining power, of regular paid leave—all of which show a great deal of variability between different areas and employers.

The Feminization of Poverty

> Throughout the continent, poor women and children have experienced most severely the effects of structural adjustment policies; the deepening crisis contributes to the feminization of poverty and consequently to the spread of AIDS.
>
> Brooke Grundfest Schoepf, The Social Epidemiology of Women and AIDS in Africa (1993), p. 51.

Reporting on a compendium of UN documents and other materials, Ankrah (1996, p. 103) paints a picture whereby some 400 million African women's socioeconomic crisis keeps getting bleaker. More than half are trapped in poverty (see Bentley, 2004; Cohen, ND; Conroy and Blackie, 2006; Einarsdottir, 2004; Farmer, Connors, and Simmons, 1996; Poku and Whiteside, 2004b; Poku and Schott, 2006; Stillwagon, 2006a and b; Wax, 2005; Whiteside, 2004; The World Bank, 1999), despite working at least 65 hours per week—from 12 to 13 more hours than do men. Although about 80% are engaged in agriculture, she writes, "They are largely ignored by credit schemes, extension services and other measures to increase farm production...Collectively, less than 10 per cent of the economically active women are earning wages in the formal economy. But there, as in the informal economic sector, they earn the least." Recognizing that HIV/AIDS "is the major threat to development, economic growth and poverty alleviation in much of Africa," Alan Whiteside (2004, p. 123) suggests that we need to look beyond financial and income impoverishment to household- and community-level impacts; seen as a development crisis, we begin to see how complex a topic it is.

Chinua Akukwe (2005), a member of the Board of Directors of the Constituency for Africa, writing about what he terms "the so called feminization of AIDS," challenges African leaders on practical solutions that have as their base a number of pressing socio-economic concerns:

- First, are African leaders and governments ready to mount a comprehensive and sustained information, education and communication campaign against risk-behaving practices of men that put women at risk of HIV infection? I am not aware of any African country that is currently implementing a sustained, nationwide campaign against sugar daddies, the use of large sums of money by male clients to encourage sex workers to engage in unprotected sex, the rape of young girls by school teachers, the molestation of young girls by family members and the molestation of street children. African men who have disposable income are at the root of sexual networking in various communities that spread HIV, according to the UNAIDS.

- Second, are African leaders and governments ready to address cultural practices that may put women at disadvantage in the fight against HIV/AIDS?
- Third, are African leaders and governments ready to invest for the long term on female education?
- Fourth, are African leaders and governments ready to create enabling environments for empowering African women?
- Fifth, can African leaders and governments create political space for women?
- Sixth, are African leaders and governments ready to create necessary legal climate and framework that protects women from discrimination and lack of due process?
- Seventh, are African leaders and governments ready to invest in public health services that are friendly and accessible to women? National spending on public health services is low in Africa, about US$30 per capita.
- Eighth, are African leaders ready to position gender issues as a major priority of international development assistance?
- Ninth, can African leaders lead the fight against sexual violence against women?
- Tenth, African leaders and governments must win the battle against widespread poverty in the continent. Poverty is a major reason why individuals, including women, knowingly engage in high risk behaviors that facilitate the spread of HIV. Feminization of HIV/AIDS is closely intertwined with poverty and harsh living conditions. African leaders and governments should create opportunities for poor women to escape poverty through sustainable macroeconomic policies that improve their vocational skills, provide access to literacy programs, provide incentives for self-employment and allow them to accumulate capital and properties. Rich nations, including the United States should work closely with Africa leaders in this regard. Comprehensive debt relief, increased access to trade for African farmers and businesses, and comprehensive microcredit programs are also critical policy issues that rich nations can assist African nations as part of a comprehensive fight against poverty.[3]

Kidan Felomon, a widow with nine children at age 47 in Eritrea, Africa's newest country,[4] had to adjust when her well-to-do merchant husband died of AIDS in 1999 and she found out that she, too, was infected. "I felt like killing my children and myself, but the nurse helped me to accepted the problem," she confessed (in Izumi, 2006b, p. 14). Finding herself impoverished, she sold all their furniture and belongings, and eventually worked with her children to begin a new life.

Children are affected on many levels by the HIV/AIDs pandemic, but when they themselves need medical care, the financial burden on the African household can be devastating. Davachi et al. (1988, p. 169) collected data on 33 families with infected, hospitalized children in Kinshasa, Zaire, finding that the cost for an average of 25 days, when nearly a quarter of them died anyway during their healthcare treatments. They concluded: "A single hospitalization of a child with AIDS equals three months of a father's salary and the child's demise equals eleven month. Therefore, a minimum of 14 months of salary must be paid by the family, the employer, or the State for each child with AIDS." All too often, we learn about children being trafficked and/or being used as domestic workers,[5] especially knowing that more than half contract HIV. With UNICEF estimated some 200,000 children being smuggled annually across the borders of West and Central Africa alone, mostly by parents or distant relatives being convinced they would get a chance at a better life, it has been appropriate for the Population Media Center (PMC) to air *Cesiri Tono* (All the Rewards of Courage and Hard Work) radio soap around Burkina Faso, Cote d'Ivoire, and Mali about their plight.

Early on, it was recognized that HIV/AIDS would have a wide-reaching impact on developmental agendas (Jill Armstrong, 1995). As the basis of the African economy is agrarian and labor-intensive, whole populations feed and tend themselves from their own farms and cooperatives. "A combination of famine and AIDS is threatening the backbone of Africa—the women who keep African societies going and whose work makes up the economic foundation of rural communities," then UN secretary-general Kofi A. Annan (2003, p. 36) has declared. "At the United Nations, we have always understood that our work for development depends on building a successful partnership with the African farmer and her husband." According to Michael Czerny, director of the African Jesuit AIDS Network (AJAN), AIDS is, "A disease of poverty and of hopelessness, of conflict, of suffering, of all the things that happen because we are countries that cannot produce, cannot export, cannot run ourselves well, are often at war and full of refugees, full of corruption" (cited in McDermott, 2007, p. 2).

Microeconomically the impact of HIV/AIDS falls on households and companies in terms of resources, production, expenses, and various outcomes such as nutrition/health (Hutchings and Buijs, 2004) and educational status, per capita consumption (see Burke, 1996), and assets. Yet, the wider macroeconomic implication is that the disease selectively affects women in what are coincidentally their prime productive years, both in terms of childbearing and the work force. With fewer people performing labor, there are fewer products and services, and hence, less money in the economy (see Guyer, 1994; Meekers and Calvès, 1997; Wojcicki, 2002). Even those African women who might find employment are often found to have unstable work records. Consider: they may have to help other members of the family who are infected with the disease, they may have to assume responsibilities of co-workers who are infected with the disease, or, they may have to get check-ups or medical treatment to ensure that they are not infected with the disease. We learn about young people in Gabon more afraid of unemployment than of catching AIDS, rural women in Angola who face transportation troubles getting their goods to market, untitled gravestones in Ethiopia because people are too poor to list the names of their lost loved ones, beggars in unbearable heat in Niger, how the 91% of economically active women in Mozambique are peasant farmers who nevertheless lack household power, how kids as young as six years old labor in cocoa fields of Cote d'Ivoire, how Ghanaian women lose all property rights when they become widowed, how poverty is preventing Ugandan mothers from using drugs to prevent mother-to-child transmission of HIV, how Nairobi slum dwellers lust to learn about ICTs,[6] how Malawian women have had such a food crisis they are forced to do what they can just to survive—just as Maasai girls get traded for cows during times of drought.

As nearly every African family is affected by HIV/AIDS, limited household labor means limited disposable income. It becomes a vicious cycle, where agricultural or industrial supplies cannot be supplemented or replaced, so assets for both families and whole communities become fast depleted. And that does not even include burial costs. Sometimes, the sadness is too much to bear (see Einarsdottir, 2004). Funeral expenses, following traditional African beliefs demanding a great show of respect for the deceased, can last anywhere from two days to a week or more. During the mourning period, the bereaved family not only pays for a casket and a clean sheet to cover it, it also is responsible for feeding family and friends who come to grieve and give moral support.

Add transportation for the casket and the guests to a final ceremony and the total can be the equivalent of nearly a year's salary. Orphaned households are another case in point. Without family support, they are often reduced to dire poverty, if not there already.

Because African households have been traditionally male-dominated, few women have thought to, or been encouraged to, establish any kind of credit. This not only negates the possibility of planning for rough times, which are often dictated by weather and seasonal changes, it also disallows any control of funds to be divided. Securities of cash and nutrition become subsistence at best.

In 1990, it was estimated that approximately $3 per capita was the annual amount spent for all healthcare, including drugs, for Africans. A lifetime of required AIDS drugs was set at about $13.80. Compare that figure to other medical costs, such as about $2 for vaccine immunizations for children or just under 20 cents on a treatment course for malaria, using chloroquine. We must also factor in the role of major corporations in the HIV/AIDS discussion. "A humble microbicide used intra-vaginally in a gel, tablet or pessary form is not Nobel prize territory," Virginia van der Vliet (1988, p. 104) posits. "Pharmaceutical companies, who are happy to create products, with often far-reaching effects, which 'help' a patient, perhaps curing 40% or 80% or 100% of those who use it, may be wary of marketing a product that promises to prevent a condition as severe as AIDS."

Although AIDS does not discriminate in whom it afflicts, at first African statistics identified the urban elite as being disproportionately affected. Then, as that group tends to be more educated, more receptive to informational campaigns, it has taken to behavioral changes such that its numbers have been somewhat reduced. On the other side of the spectrum, Seely et al.'s 1992 study of 15 villages in Masaka, Uganda found that "An individual's lack of access to resources leads to risk-prone, income-generating activities, especially for poor women." Oftentimes that extra income is from the brewing and selling of alcohol and often that transaction comes with sexual services.

Transactional Sex

> An alarming trend is helping to fuel the HIV/AIDS pandemic in sub-Saharan Africa, where nearly 30 million Africans are living with the infection, and in some countries nearly 40 percent of the population is HIV-positive. While extreme poverty, polygamy, and female genital mutilation all contribute the spread of HIV/AIDS, one of the most tragic factors is known academically as transactional sex—essentially, informal sex work.
>
> Betsy Illingworth, *Sugar Daddies in Africa* (2004), p. 1.

With economic asymmetry at play, there are several ways that women and girls are made to feel inferior so that they will participate in sexual transactions; what worries us most, of course, are the associations that transactional sex has with gender-based violence (Dunkle et al., 2004, 2007; Swidler and Watkins, 2007). Some of those exchanges include prostitution, Intergenerational/cross-generational sex, and Sugar Daddies.

Prostitution

Just as in societies around the world, prostitution takes place in Africa, particularly around rapidly urbanizing areas where it serves as an economic necessity. Too many women are dependent on contributions from family and steady sexual partners, as well as extras known as "pneus de rechange," French for "spare tires." Sex workers take many different forms, including the following:

- Barmaids (see Chernoff, 2003)
- Courtesans (high-class workers)
- "Femmes libres" (loose women)
- Ghanian "karuas," who provide food and lodging for migrants
- "Good-time girls"
- "Outside wives"
- "Tou tou prostitutes"
- "Walk-about women"

Societal reactions to sex workers also differ, depending on geographies (urban areas being a bit more tolerant), religion, attitudes toward virginity before marriage and marital fidelity, and, most of all, male-specific decision-making. Don't miss the irony, though: the same men who loudly decry economically dependent sex are all too often the very ones who support systems allowing and/or encouraging polygamy, mistresses, and prostitutes. Young girls might sell their bodies so they can have enough money to pay for schooling. Young mothers might do the same to feed their families. And far too many African women, without opportunities for other kinds of employment, are driven to exchange sexual services as a survival strategy' dehumanized and desperate, they see no other options. It becomes harder and harder to draw the line between prostitution and girls/women who exchange their bodies for goods and services. "Sexual politics leaves women who want to avoid infection three options," according to van der Vliet (1988, p. 101): "stay out of the game, negotiate with men, or find a clandestine method of protection." Commercial sex workers constitute 42% of Guinea's infected population, along with bus and truck drivers and miners at 7% each, and soldiers at 6%; according to a 2003 report by STAT-VIEW, HIV was spreading due to unprotected sex, promiscuity, migrations, poverty, and the remarriage of widows whose husbands had died of AIDS.

There also is a double standard regarding prostitution. African women can represent sexual and moral threats. Even before the threat of HIV/AIDS was an underlying fear in some communities regarding prostitution, seen as "unregulated female sexuality, threatens to drain essential fluids from men's bodies and leave them as empty shells" (Masquelier, 2001, p. 252). Realizing that this is a "culturally and morally sensitive framework" for its advocacy and provision of HIV/AIDS prevention and care for women and children, the Society for Women and AIDS in Africa (SWAA) set its objectives relative to commercial sex work:

1. To steer clear of any efforts or campaigns to legalise commercial sex work anywhere in sub-Saharan Africa;
2. To reinforce SWAA's commitment to non-discriminatory practices in the provision of HIV prevention and care services;

3. To reinforce SWAA's commitment to working with young people (15–24 years) as most infections occur during or soon after adolescence; and
4. To reinforce SWAA's commitment to provision of alternate skill development and economic empowerment projects for the benefit of all women, including commercial sex workers and their families (Musisi, 2005, p. 10).

In an effort to teach community-risk reduction, workshops on empowerment were provided by an organization in Africa called CONNAISSIDA. Brooke Grundgest Schoepf (1995, p. 252) describes sessions for 15 sex workers in Kinshasa, most of whom could not read, involving role playing, posters, small group discussions, and structure group "processing" aimed at eliciting reflection on means of reducing their risk of AIDS:

> Locally they are called *mingando*, a disparaging term that refers to their ethnic origin, their poverty, and their virtually exclusive reliance on sex with multiple partners for a livelihood. The women reported receiving payments equivalent to 50 to 60 U.S. cents per encounter. Low fees and family responsibilities meant that they needed numerous partners: between 5 and 40 clients per working week. None used condoms; most reported recurrent bouts of sexually transmitted diseases.

Despite knowing this lifestyle could lead to AIDS, "With no other way to support themselves and dependents, however, their attitudes included apathy, fatalism, and denial" (Ibid.) Happily, after a number of effective training sessions, "The workshops provided a forum in which to practice communication skills and to develop confidence in parrying male resistance, denial, and deception" (p. 253). Making a strong argument for action-research, based on projective techniques, participatory learning, and empowerment exercises, Schoepf points out that informants acting as reflexive performers of their culture can help bring about change: "The devastating pandemic raises fundamental questions about the development and health strategies of many African governments and international donors. It is unrealistic to expect African governments to sustain AIDS prevention programs given the prolonged economic crisis. Health 'on the cheap' will not stop AIDS" (p. 263). That cheapness might be the cost of a soft drink, or a cab ride, with no negotiation power over condom use. Truckers are particularly prone to barter, but then they expect to be able to call the shots (see Basil et al., 2002).

Prostitutes face a number of stigmatizations and discriminations, oftentimes bearing the blame for spread of HIV/AIDS in Africa (see Gysels and Pool, 2002; Sabatier, 1988; Lindsay, 2003). Although too few decision-makers have tried to understand its root causes as economic imperatives, women's advocacy groups have begun to put a face on prostitution. Geography plays a part, too: just as South Africa is set up to have settlements for migrant laborers, which encourages sex workers, eastern Africa is host to people traveling along the Addis-Djibouti and the Great Northern corridors, and we know how truckers are natural spreaders of disease. We learn about Ugandan girls supporting their younger siblings forced to have unprotected sex to make more money, about Zambian prostitutes who sideline in human organ trafficking, about prostitutes in Nigerian brothels willing to be guinea pigs for pills said to prevent HIV infection, "highway girls"

along Zimbabwe's major roadways undergoing rape and sexual abuse, about Mozambican girls being trafficked into domestic servitude and sexual exploitation, and about how Nigerian sex slaves are threatened by voodoo rites to keep them in line.

Although commercial sex work is illegal throughout sub-Saharan countries, in Uganda it falls under legal concerns for morality, and the Human Trafficking Project has been discussing the implications of legalizing prostitution in time for FIFA 2010 World Cup in South Africa. Meanwhile, it is encouraging that the first international conference on human trafficking, a billion-dollar industry and one of the fastest growing crimes, was scheduled in 2008. Also, to its credit, the Open Society Institute (OSI), a Soros Foundation Network (2006), has produced a synthesis of legal/regulatory environments relative to sex workers' health and human rights, focusing on the concept of Golden Rules. Senegal decided to decriminalize, or actually to semi-legalize prostitution in 1969, tolerating prostitution among women over 21 years who are willing to be tested for HIV and other STDs, but lately it has been reconsidering this stance. Michelle Lewis Renaud (1997, p. 3) gives voice to some of those prostitutes from Kaolack, Senegal's third largest town, blaming men: "Fathers did not allow them to go to school. Fathers forced them to marry against their wishes. Husbands beat them. Husbands took other wives with whom they did not get along. Husbands died. Ex-husbands did not pay mandatory child support. Grown sons did not assume financial support of their widowed or divorced mothers, as tradition dictates."

Sex workers in Africa have had some of their own ideas about how to ameliorate the AIDS pandemic. As reported by Priscilla Alexander (1995, pp. 109–111), physicians identified leaders in Cameroon who came to establish peer educators. In Nigeria, women who worked in hotels were organized to work with police, rather than being harassed by them, toward improving conditions by enforcing condom usage. The focus was on clients in Zimbabwe, where entertainment was combined with education and skills became strengthened all around. There have been efforts to raise awareness about female sex workers (FSWs) in Nigeria, with the AIDS Prevention Initiative in Nigeria (APIN) and Women Health, Education and Development (WHED) joining to alert the public to injustices inflected on them. Community-organizing interventions were used in Ethiopia. And then there is hardly discussed subject of men pimping for their wives—encouraging them to bring extra income into the family, even organizing enough to send them abroad and arrange for them to transfer money home.

Cross-Generational/Intergenerational Sex

> Cross-generational sex leaves young women vulnerable to HIV infection for a number of reasons. First, older men are more likely to have or have had other partners, including spouses, and therefore are more likely to have been exposed to HIV. In fact, many of the men who engage in cross-generational sex do so because they perceive younger girls to be "HIV-free." In addition, the power imbalance in these sexual relationships leaves young women unable to negotiate condom use.
>
> Montgomery and Brocato, Younger Women, Older Men, and the Spread of HIV in Africa (2004), pp. 4–5.

A sexual relationship between a young girl and a man at least ten years older can be called "cross-generational"; in Africa, it is the result of yet one more vulnerability—in this case, economic disempowerment. It is a huge problem in Uganda, especially because many infected children engage in such behavior. "In the past, children born with HIV used to die before one or two years," explains James Kinobe, the youth and children affairs minister, explaining that, as they live longer, they reach dating age (cited in Natukunda, 2007). It is easy to draw the conclusion, then, that this is an economic issue, underscored with power. "Cross-generational and transactional sexual relations in sub-Saharan Africa goes along with adolescence and young adulthood," Luke and Kurz (2002, p. 8) have stated. "Gifts such as soap, perfume, dresses, meals out, and jewelry have become symbolic of a girl's worth and a man's interest, and girls who do not receive gifts in exchange for sexual relations are humiliated. Because of the limited negotiating power of adolescent girls with respect to sexuality and reproduction, sexual partnerships between adolescent girls and older men are fundamentally imbalanced, with men having more power."

Intergenerational relationships are relatively common in southern Africa, Leclerc-Madlala (2007) has asserted—albeit mostly covert, quasi-condoned, sometimes encouraged and sometimes forced. He offers the following assertions that help us understand yet again the vulnerabilities of young African women:

1. Multiple concurrent partnerships (MCP) are a normative pattern of sexual behaviour in the region; intergenerational liaisons are one form of MCP.
2. MCP is legitimated through socialization & enculturation of both men & women with pervasive notions that men are incapable of sexual restraint,and women should tolerate unfaithfulness.
3. Men & women seek age-disparate partners for a variety of reasons.
4. Economic transfers of money or gifts (transactional sex) are a common feature of most all sexual relationships; they are a dominant feature in intergenerational relationships.
5. Transactional sex is about much more than "survival sex," consumerist aspects come to the fore with expansion of economies, growing aspirations and widening wealth gaps.
6. Many young women are active agents in seeking/exploiting partners for gain. For some it's a way to assert themselves & demonstrate "control."
7. There is a significant & negative association between the value of the transfer and likelihood of safe sex.
8. There is a significant & negative association between the age disparity & likelihood of safe sex.
9. While there is a significant & negative association between the economic disparity & likelihood of safe sex, wealthier men are more likely to use condoms (but also likely to have more partners).
10. Our understanding of 'sugar daddies' is far too limited & stereotypical.

Sugar Daddies

A great deal of anecdotal evidence suggests that "sugar daddies" are common in Sub-Saharan Africa and are helping to fuel the spread of HIV. The

> stereotypical sugar daddy is an adult male who exchanges large amounts of money or gifts for sexual favors from a much younger woman. Sugar daddy relationships are associated with both age and economic asymmetries, which are believed to limit young women's power to negotiate safer sexual behavior.
>
> Nancy Luke, Confronting the "Sugar Daddy" Stereotype (2005), p. 6.

Recognizing the impotence young African girls feel when it comes go negotiating sex—never mind safe sex, researchers have come to particularly point the finger at Sugar Daddies, wealthy older men who encourage the exchange of gifts—luxuries such as perfume, food, jewelry, but more likely money for school uniforms, textbooks, or healthcare, for sexual favors. To exacerbate the problem, teachers have been known to proposition students, and peer pressure almost encourages this kind of institutionalized abuse (Leach and Machakanja, 2001). Sex in Africa, it is said, can be a poor person's food.

Some young African men, whose risk of HIV increases as age and they have more partners, are lured by affluent, married women, known as "Sugar Mummies" (Kuate-Defo, 2004; Meekers and Calves, 1997), but this is usually more from peer pressure than financial necessity—the same mentality reported in Barker and Ricardo (2006) about young men in Malawi boasting about HIV-positive status as a badge of manhood.

Based on grants from the National Institutes of Health, a team from the University of California/San Francisco interviewed eight focus groups of 71 16- to 19-year-old coeds in Zimbabwe, two-thirds of the girls reporting a norm of boyfriends at least five years older and boys reporting at least one sexual experience with a girls at least 10 years older than them (van der Straten et al., 2002). "It is girls with no money like me," one reported. "Big Dharas (Sugar Daddies) buy you clothes, send you to high school. If you refuse, you stay poor. If you take his money and refuse sex, he will rape you. He will say you ate my money for nothing" (p. 1). Most appallingly, Ian Mader (2004) has cited how "Girls as young as 10 are getting infected." Too often actively or passively encouraged by adults in their lives, whether parents or guardians, the cycle of transactional sex here is a major means of HIV infection (Luke and Kurz, 2002). All too often, Sugar Daddies refuse to use condoms—one teen reporting that, "Big dharas don't like their sweets wrapped" (cited in Chase, 2004). They also like lots of girls, saying they can't always eat chicken, but want to try all kinds of meat.

Sometimes a Sugar Daddy is referred to as a *Big Dhara* (Mozambique), "Big Bellied" (rural Uganda), "folded neck" (Cameroon), or "duzi" (Tanzania, meaning "a goat to milk")—all indications of wealth. And/or power. "There are also more-subtle reasons young women accept sugar daddies," notes McLaughlin (2005a, p. 10). "Due to a traditional African deference-to-elders wisdom, many young women believe an older man is wiser in the ways of sex. Also, the respect children here must show elders makes it harder for young women to reject an older man's advances." He reports on some measures Uganda is taking: billboards, "chastity scholarships" as an economic counterweight, a radio soap character who realizes the downside of Sugar Daddy relationships, the "Go Getters" program persuading women to rebuff their advances—all intriguing efforts.

In Swaziland, where some two-thirds of the population lives below the poverty line of $1 a day, the Swaziland Action Group Against Abuse reports

that the Sugar Daddy syndrome, a fixture of life there, has actually gotten worse (cited in Hall, 2005). There, they are called "sponsors." In a perverse way, it sometimes is argued that a girl's prospects for marriage might improve if she looks good, and has been given goods from older men. Melanie Peters (2007) refers to the phenomenon of "sugar parents" as the "third wave" of AIDS victims, following homosexual men in South Africa and low-income heterosexuals, while Silberschmidt and Rasch (2001) declare their prey as vulnerable victims.

At some point, we must ask ourselves how this grim perversion of materialism has been able to occur in Africa, and elsewhere around the world. Is it a question of (family) values, lack of (religious) principles, or role models, and/or maybe is it the fault of advertising and the media? Some researchers have pointed out the status "3 Cs"—*c*ash, *c*ars, and *c*ell phones, as being the problem, but others of us suspect it is much more complicated than that. Whatever one's stance, the scary part is that cross-generational relationships are driving the AIDS epidemic, and yet, as social and moral factors, they are hardly being addressed enough. Encouragingly, the Cameroon Association for Social Marketing (ACMS) has organized a peaceful protest march and "No to Sugar Daddies, No to AIDS" campaign against the practice, and a former ethics minister in Uganda decreed that, "The root cause of this is our traditional and cultural practices which undermine girls as sex objects" (cited in Natukunda, 20007).

Gender and Development

> The cause of AIDS is underdevelopment. The best prevention is development. My argument is that the causes of AIDS risk behaviours are structural, social, economic and political in addition to individual, familial and cultural in origin. The communication component of a solution needs to address these complex root causes that are invariably relational and therefore involve relational situational analyses.
>
> Bella Mody, AIDS Versus Development: Victim-blame Continues (2006), p. 30.

A merging area of scholarship, the notion of gender in terms of development is drawing the attention of many different disciplines (Ardayfio Schandorf, 2004; Bryceson, 1995; Creevey, 1986; Gebremedhin, 2002; Gordon, 1996; House-Midamba and Ekechi, 1995; Jarawan, 1991; Larsson et al., 1998; Parpart, 1989; Samba, 2005; Snyder and Tadesse, 1995; World Bank, 1994). The John Templeton Foundation has recently been sponsoring a two-page spread asking experts to answer the question "Will Money Solve Africa's Development Problems?"[7] Some of the "No" replies concerned taking responsibility for aid follow-through, systematic dependency and corruption in post-colonial Africa, "violent conflict, bad governance, excessive external interference, and lack of an autonomous policy space," getting away from Checkbook Development, putting the focus on the African mind, and how the western biomedical model for AIDS, emphasizing prevention, has been ineffective. If "Yes," suggestions are made to invest in African capabilities, empowering citizens, and to improve literacy and education.

Pronyk et al. (2006) have demonstrated that Microfinance for AIDS and Gender Equity (IMAGE), combined with proper training intervention, can help reduce HIV infection from intimate-partner violence. Economic empowerment can lift women from what Hallie Ludsin (2005) has termed a "spiral of entrapment," and it is obvious that drastic measures need to be taken to deal with Africa's alarmingly high HIV rates for girls and women.

AIDS Activism

> A feminist approach to AIDS is long overdue. AIDS activists and feminists need to join together to articulate an agenda which places women and our diverse needs at the centre of the way this crisis is imagined and fought. This should be articulated for women who are living with HIV, for women profoundly affected by AIDS and for all the women who are vulnerable to infection, and whose (sex) lives are affected by the epidemic. The existing generic research can be used to extract what is useful for women, and it is essential that women identify the areas where research has not been developed, or where protocols and analyses should be adjusted to answer women's questions. Awareness must be intensified into the ways in which women are misused in policies which purport to be in our name—how can we shift the emphasis to bring these back into line with women's real needs? An effective feminist agenda will forge alliances and stand in solidarity with other communities who are affected and devastated by AIDS, discovering the common ground and the battles which can be waged together. As feminist thinking about AIDS depends, and as the impact of the AIDS crisis on women achieves greater visibility, so too should the feminist agenda mature and develop.
>
> Robin Gorna, *Vamps, Virgins and Victims* (1996), p. 382.

Amazing, is it not, that the above was written more than a decade ago? Gorna's call for feminist action aims to take on misrepresentations, to question statistics and treatment, to replace stigmatization and discrimination with empowerment, to factor in risk, maternity, sexuality and sexual orientation, and to urgently take steps toward prevention (see Nattrass, 2004). HIV/AIDS in Africa, we are learning, does not simply involve health; rather, it deals with gendered development and gendered inequities (Barnett and Whiteside, 2002; Baylies, 2002; Bryceson, 1995; Dos Santos, 2002; Farmer, Connors, and Simmons, 1996; Fleishman, 2003; Wojcicki, 2002). It also deals with disabilities and the disabled, who oftentimes need special forms of advocacy (see Livingston, 2005).

Although a number of international agencies and donor countries contribute funding for HIV/AIDS prevention and treatments, clearly we need to reprioritize how and where money is used. Far too often it comes with strings and/or blind requests for its utilization, and far too often contributions become contradictory to one another. How frustrating it is, for example, when agencies specify that monies should go just to tuberculosis, or malaria, or malnutrition, when we realize that AIDS is endemic in all these issues; what is needed, we must know, is an holistic approach that begins with the individual. This is what we activists must monitor.

The Panos Institute

With communication at its base, since 1986 Panos has believed in "putting people at the heart of development," explaining thus:

- The capacity to receive information, to debate, and to express one's own ideas and needs is a right in itself and an essential part of people's ability to lift themselves out of poverty and participate in the life of their society.
- Communication is part of the fabric of societies. By receiving, giving and discussing information and ideas we are able to make decisions and form opinions—parents decide if their child will go to school, an HIV positive person decides whether to declare his or her status, and individuals decide how to vote in an election.
- Communication enables health services to ensure the supply of medicines in their clinics, farmers to find out the price of their crops, and diaspora communities to send remittances back home. Communication underpins development.
- The opportunities for communicating have increased enormously, especially over the past two decades. A technological revolution has brought us digital communication, satellites, the Internet, and mobile phones.
- And many countries have become more democratic, allowing greater freedom of speech and a more varied and independent media.

So why should development agencies, donor organizations and civil society groups focus on communication? Because there are still many gaps: (1) Mass media (newspapers, radio and TV stations, and online news services) may have increased in number, but this is not always matched by the quality, variety, or relevance of their content; (2) Poor people in rural areas of many developing countries still lack access to telephones, the internet and other forms of media, even if they could afford them; (3) The English language continues to dominate the internet, which is primarily geared toward people in rich countries—little content is produced by and for people in developing countries; (4) The potential of communication to be "bottom-up"—empowering poor people to speak for themselves and participate in democratic processes, not just to receive information—has not been fully exploited; (5) Development planners often neglect communication, failing to appreciate how essential it is for sustainable development strategies; fragmented approaches to communication for development have led to confusion, poor decision-making and missed opportunities (www.panos.org).

Funding and Philanthropy for HIV/AIDS in Africa

Although there are hundreds of supportive groups, agencies, religious affiliations, non-profit organizations, and NGOs (see Shivji, 2006) that appear throughout this book, and are listed in appendix II: African HIV/AIDS-related organizations,

the following deserve special note for the amounts of money they dedicate to the cause of preventing and treating HIV/AIDS: ActionAid International, Africa Action, Africa Files, Africa Renewal, African Resource Centre, Association for Women's AIDS Research & Education (Project AWARE), Howard G. Buffett Foundation, Canadian International Development Agency (CIDA), Department for International Development (DFID), the Elton John AIDS Foundation, Ford Foundation, The Bill and Melinda Gates Foundation, Hunt Alternatives Fund, the Henry J. Kaiser Family Foundation (KFF), the W. K. Kellogg Foundation, the Stephen Lewis Foundation, Oxfam, the Panos Institute, the Rockefeller Foundation, Royal Tropical Institute, the Soros Foundation, Treatment Action Campaign (TAC), UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, USAID, the World Association for Christian Communication, World Vision, WHO, and the World Bank.[8]

Some of my personal favorites include Doctors Without Borders (Medecins Sans Frontieres), Save the Children, and the Society for Women and AIDS in Africa (SWAA)—all of which will receive a portion of the profits from this book. Although all of these funding agencies care about medicine, and Africa—and though they all have a vested interest in the best means of communication to reach their goals, their wider concerns are much more humane.

And then, too, there are those who make money from the pandemic. By way of example, billing itself as "a Social Enterprise Company that strives to make an impact on HIV AIDS," *CompuTainer* of South Africa (www.computainer.com) provides mass awareness, education, prevention, rapid test kits, and nutritional care programs in the form of HIV/AIDS awareness games, bracelets and beadwork, education and training materials, branded and sponsored condoms, educational playing cards, and the like. As we are all too aware, someone or some company is always around to capture a capitalistic opportunity. This is all part of our continuing interest in the economy of Africa, and why it is important to monitor its partners, competitors, and individual business(es).[9]

Notes

1. Loosely translated, they are asking for pittance, and the term "tante," for auntie, is standard. I was given the advice to choose my beggar, and it soon became obvious that this ritual was not only expected, it made sense—whomever was my chosen person at a particular place, whether a regular or newcomer, shared it with others. What made me more comfortable was stopping with groceries by a group of women, explaining that I had too much for my household; we all knew what was going on, but the semi-ruse seemed to work well, and on occasions that I just dropped by for conversation was easily accepted.
2. Niger: Women bear the brunt of hardships and food shortages (*Irin*, August 23, 2005).
3. De Waal (2003) would add his concern about how HIV/AIDS is a structural threat to governments and economies of Africa.
4. Eritrea seceded from Ethiopia in 1993.
5. See Mike Dottridge, Trafficking in children in West and Central Africa (*Gender and Development*, Vol. 10, No. 1, March 1, 2002: 38–42); Kathryn Farr, *Sex trafficking: The global market in women and children* (London: Worth Publishers, 2004); Gilbert King, *Woman, child for sale: The new slave trade in the 21st century* (New York: Chamberlain Bros., 2004); Craig McGill, *Human traffic: Sex, slaves and immigration* (London: Vision,

2003); Selloane Mokuku, *Hear us! Shedding light on the plight of child domestic workers in Lesotho* (Lesotho: United Nations System in Lesotho, 2005).

6. Rasna Warah, *Divided city: Information poverty in Nairobi's slums* (Malmo, Sweden: School of Arts and Communication, University of Malmo, 2004). Some 85% of Nairobi's sex workers are said to be HIV positive.
7. To see the essays, go to www.templeton.org/africa.
8. Lamboray and Ehmendorf, 1992.
9. The *Christian Science Monitor* series Is China good for Africa? Lessons from Sudan (June 25, 26, and 27, 2007) is particularly telling.

CHAPTER FIVE

Legal and Political Vulnerabilities

> Gender-based discrimination constitutes one of the greatest threats to women's health and lives worldwide. Equality along with reproductive and sexual rights are guaranteed in international and regional human rights treaties, as well as in many domestic laws. However, such guarantees are empty promises if not recognized and enforced by national-level courts, which are important venues through which women's rights are affirmed or denied. Unfortunately, existing human rights resources focus primarily on international norms and their national codification; very few examine the interpretation and application of such norms by national courts. Even fewer resources consider whether and how national jurisprudence addresses women's human rights.
>
> The sub-Saharan Africa region suffers from even greater scarcity of accessible information regarding the jurisprudence of African national courts, particularly on how the courts deal with women's human rights. This compilation is a preliminary step toward enhancing access to and knowledge about some of the gender-relevant jurisprudence of African Commonwealth countries, with particular emphasis on reproductive and sexual rights.
>
> Kibrom Isaac, Introduction, *Legal Grounds* (2005), p. 14.

Historically, it is thought that the first African woman to die from HIV/AIDS was a "freewoman" (meaning a woman who was not living under the control of a father, brother, or husband) from Zaire's Equateur Region and a surgeon from Denmark who had worked there in the 1970s.[1] Their situations were quite different, the first victim having supported herself by selling sex to multiple partners, the second operating without surgical gloves, which were in short supply. "The resulting dichotomies are Cartesian in their simplicity," Brooke Grundfest Schoepf (1993, p. 53) has posited: "white woman/black woman; missionary/sinner; heroic work/dirty work; innocent victim/perpetrator; valued and named/unvalued and unnamed; good woman/bad woman." These labels are just a hint of the many legal and political issues surrounding African women's contractual vulnerabilities.

For our purposes, one of the biggest legal concern deals with African implications from faith-based policies emanating from the Global AIDS Initiative, parts of which include an abortion gag rule that reduces funding to

family planning centers, abstinence-only restrictions, anti-prostitution pledge rules, lack of financial support for microbicides, and allowances for both male and female condoms. Although some of us think of this as backwards thinking, it has nevertheless been at the heart of plans such as the President's Emergency Plan for AIDS Relief (PEPFAR). For those monitoring development in Africa,[2] legal and political issues become the backbone. A. Waafas Ofosu-Amaah's *Unprotected women: Gender and the legal dimensions of HIV/AIDS* (2004) points out how legal and regulatory systems such as property rights, employment laws, reproductive rights, rape, sexual harassment and coerced sex, and marriage affect women; as a consequence, she suggests a multi-sectoral response with these entry points for solutions: safe and secure environments for young girls; privacy and confidentiality in voluntary counseling and testing (VCT) services, legal literacy and legal aid services; sensitization of law enforcement officials, police, legal profession and judiciary about the gender and legal dimensions of HIV/AIDS; strategic litigation; anti-stigma and anti-discrimination laws, criminalization of willful transmission; and reproductive law and policies.

Laws and Regulations

Begin with the fact that, "The passage of bridewealth from husband's to wife's family often entails a contractual obligation for the woman—or a substitute provided by her family if she fails to fall pregnant—to produce a child," as van der Vliet (1988, p. 94) reminds us. Although civil law came along as a part of colonialism, customary rules and regulations still take precedence in Africa. Much of what goes in Africa is determined by Islamic law, which includes these rights and obligations (Lightfoot-Klein (1989, p. 68):

1. Girls are in the custody of their fathers until they marry, at which time their husbands take over their responsibility and the women are placed under their tutelage.[3]
2. Polygamy is allowed for men and they are permitted to have four wives at the same time, so long as they are able to pay the bride-price for each wife and treat all of them equally.
3. Divorce is the privilege of men alone. The wife has the right to divorce only in exceptional cases, such as maltreatment by the husband or if he cannot fulfill his responsibility for her physical well-being, etc. Even for these cases women rarely go to courts to reinforce their limited rights.
4. A wife's rights to the family property are unequal to her husband's and she must have his consent to dispose of it.
5. The wife's share in inheritance varies from one-eighth to one-sixteenth of the property left by the husband (depending on whether or not she has children).
6. The shares of the men's inheritance are twice as large as a woman's.
7. The testimony of two women witnesses equals that of one man and the penalty for killing a woman is only half that for killing a man.
8. Muslim men can marry not only Muslim women, but also women of the "Book" (Jews and Christians). But Muslim women are allowed to marry only Muslim men.

9. Obedience of women to men and to the canons of proper dress and modesty in their behavior are also enshrined in the law (*Sharia*).

Islamic religious law, *Sharia* means "the way"—the legal framework for both private and public spheres of Muslim life, based on a united consensus of spirit. Qur'an-based on the actions and words of Muhammad and his early followers, it is a jurisprudence dealing with daily life issues such as economics, politics, family, and society. While it works well for its practitioners, *Sharia* nevertheless makes headlines when it manifests itself in topics such as honor killings, stoning a woman accused of adultery (maybe you remember the Amina Lawal case?) or a man for forcing himself on a step-daughter, cutting off a thief's hands, teenage Sudanese refugee girls impregnated and forced to keep their offspring, or ordering the death of a non-Muslim critic of Muhammad or the Qur'an. As Charles Adams Cogan (2002) reminds us, *Sharia* has value as thought that has "developed over the past 1,400 years. These different strains of legal tradition reflect the differing needs of local circumstances as the religion spread through the world."[4]

Although it is beyond the scope of this book to give a detailed chronology of legal decisions relative to African women and HIV/AIDS,[5] it is at least instructive to consider some key documents:

1948: Article 14 of the Universal Declaration of Human Rights

UDHR's Article 14 includes these stipulations: 1) Everyone has the right to seek, and to enjoy in other countries, asylum from persecution, and 2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations. African feminists have interpreted this law to deal with women's rights to make decisions about their sexuality in terms of decisions relative to contraception, fertility, reproductive rights, whether or not to have children and, if so, how many and when, as well as protections against sexually transmissible infections (including HIV/AIDS), and rights to be informed about their health status, their partners' health status, and rights relating to family planning education. They, and feminist lawyers, cite it as yet another example of the gendered nature of African law. (see Bonthuys and Albertyn, 2007; Burnett, Karmali, and Manji, 2007; Wanyeki, 2003)

1998: *International Guidelines on HIV/AIDS and Human Rights*

Produced by UNAIDS and the office of the UN High Commissioner for Human Rights, it clarified guidelines in the United Nations Charter, Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights, Convention on the Elimination of All Forms of Racial Discrimination, Convention on the Elimination of All Forms of Discrimination Against Women, Convention on the Rights of the Child, Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment, and various International Labor Organization conventions and recommendations.

1999: *Handbook for Legislators on HIV/AIDS, Law and Human Rights*

Prepared by UNAIDS and the Inter-Parliamentary Union, this stands out for its inclusions on women, children and other vulnerable groups, changing discriminatory attitudes, development of public and private sector standards and mechanisms, and state monitoring and enforcement of human rights.

2000: *Organization of African Unity (OAU) Summit on HIV/AIDS*

Although this conference also included TB and other related infectious diseases, it was important because of the "Declaration of Commitment on HIV/AIDS" that the delegates adopted; in addition; in addition, heads of state agreed to devoting at least 15 percent of their annual budgets to health.

2000: *UN Millennium Declaration*

This drew on policy and strategy frameworks from Millennium Development Goals (MDGs) for developing countries by 2015, including eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability, and developing a global partnership for development.

2001: *The Justice for Widows and Orphans Project* (JWOP)

Under a commission of the Embassy of Finland, the Justice for Widows and Orphans Project (JWOP) came about as a response to needs of Zambians. Formerly known as Northern Rhodesia, Zambia has the dubious distinction of having the highest proportion of orphaned children in the world, with 67% of its children until 18 fitting into that category. The non-profit NGO, made up of Women and Law in Southern Africa Education Trust (WLSA), National Legal Aid Clinic for Women (NLACW), Zambia Civic Education Association (ZCEA), Young Women's Christian Association (YWCA), Forum for Democratic Process (FODEP), and Social Welfare and Police Victim Support Unit (VSU), pursues these activities:

- Advocating for laws and policies that promote Justice for Widows and Orphans;
- Formation of Widows and Orphans' support groups;
- Training of the target groups in the Laws of Succession; General sensitisation programmes on television and radio;
- Workshops at community and national levels;
- Documenting of case studies and establishing a Resource Base;
- Addressing the consequences of HIV/AIDS through counseling, survival skills training and treatment.

Guided by the U. N. Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), part of JWOP's aim, according to its website (www.jwop.org.zm), is advocacy for constitutional and legal reform—ensuring that its government be held up to its responsibly for "promoting, protecting and safeguarding the rights of all citizens, especially Widows and Orphans in Zambia, in order to enhance justice and sustainable development" (see also Liebenberg, 1995; Oloka-Onyango, 2001).

2003: *The Eighth Summit of the Heads of State and Government Implementation Committee (HSGIC) of the New Partnership for Africa's Development (NEPAD), Maputo, Mozambique*

Delegates decided to continue with established Clusters, which included Human Resource Development, Employment and HIV/AIDS.

2003: *Resolutions of the 59th Session of the UN Commission on Human Rights*

Addressing issues of discriminations and human rights violations of people infected, affected and vulnerable to HIVAIDS, several resolutions were adopted,

including one "on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and another on the elimination of violence against women.

2006: The first *African Feminist Forum*, Accra, Ghana

More than 100 women's rights activists from 22 African countries came together to address these key concerns:

1. Building knowledge of African feminism and developing strategies to strengthen positive aspects of African cultures that dignify and empower women.
2. Assessing women's rights organizing in Africa and prioritizing the documentation of the lessons of African feminist history.
3. Politicizing women's organizing, in contrast to generic gender mainstreaming.
4. Challenging and negotiating state and multi-lateral institutions whose policies reverse women's rights and African sovereignty.
5. Developing strategies to challenge fundamentalisms and subordination of women's sexual rights, the lack of response to women's vulnerability to AIDS.
6. Determining available resources to advance African feminist organizing and institutional capacity.
7. Rejuvenating the African feminist movement with effective leadership and mentoring of young feminists. (www.globalfundforwomen.org)

The secondary, subordinate cultural place of women in African society is also evident in its legal/regulatory system. A. Waafas Ofosu-Amaah (2004, p. 1), senior gender specialist for Gender and Development, Poverty Reduction and Economic Management at World Bank, has outlined how this puts them at disadvantage in property rights (they generally deny women the right of inheritance or succession), employment (laws seldom provide benefits for HIV/AIDS victims and their families), reproductive rights (some laws don't not grant rights to control fertility), rape, sexual harassment and coerced sex ("narrow definitions for these offenses in some legal systems, coupled with the associated stigma, transform a rape victim into a suspect, deny rights if the victim is married to the offender, or decriminalizes many kinds of unwanted sexual advances"), and marriage (relative to co-ownership of family property or equal division of it upon termination of marriage, or relative to the topic of marital rape). Kenya passed a landmark sentence of life in 2003 for the rapist of a four-year-old year, and recently South Africa recognized forced anal sex as rape (le Roux, 2007).

We worry about the lack of political salience that AIDS continues to have in so many African countries (see de Waal, 2003; Patterson, 2006). Yet, Namibia has an AIDS Law Unit (ALU) that, as part of its Namibian Legal Assistance Centre promoting a human rights-based response to HIV/AIDS, focuses on civil and political rights, deals with violations of those rights on the basis of HIV status, and provides legal advice and assistance for PLWHA. The AIDS Law Project (ALP) and the AIDS Legal Network published *HIV/AIDS and the Law: A Resource Manual* in 1997, the second edition released in 2001.

Of course different countries and different societies within Africa have different governing rules; still, it is encouraging to know that women are making inroads into that governance (Geisler, 2004; Konde, 2005; Kuenyehia, 2004). In the West, according to Ankrah and Gostin (1994, pp. 547–548), health laws and ethics are founded on these core concepts:

a. The right to personal autonomy and determination, as reflected in the doctrine of informed consent;
b. The right to personal privacy, as reflected in the doctrine of confidentiality;
c. The right to know information that is necessary to protect the health of individuals and communities to protect against neglect or corrupt government as reflected in the doctrine of freedom of information; and
d. The right to be treated with dignity and respect, as reflected in the doctrine of anti-discrimination.

Applied to African society, we quickly see that informed consent might be viewed in an entirely different way, where patient consent is not so much individual as the result of decisions from the family or kinship group or, perhaps, a community or clan leader (Oheneba-Sakyi, 1999; Poku and Whiteside, 2004). A person with HIV/AIDS might be encouraged, for example, to ritualistically slaughter an animal rather than to take certain drugs. Confidentiality and privacy go beyond being medical issues to moral ones, where again in Africa what might be considered individual rights become societal instead. That also holds for the withholding of information, such as Mbeki has done in South Africa, whether in denial or for public relations purposes (Iliffe, 2006). Lastly, in terms of basic rights, HIV/AIDS is prejudicially laden with stigma and discrimination, associated as it is with promiscuous, risky sexual behavior. This is particularly difficult for young women, at risk of HIV infection because of their developing biological systems, their precarious position relative to date and means of initial sexual involvement, lack of negotiation skills, lack of education about sex, lack of access to condoms, and lack of access to reasonable healthcare services.

The sacking of South Africa's deputy health minister, Nozizwe Madlala-Routledge, "a longtime member of the ruling African National Congress credited with hammering out the country's first strategic plan for the AIDS crisis" (Baldauf, 2007a) bespeaks, in microcosm, how political the topic is; despite having the most number of AIDS patients in the world, South Africans have hardly any access to anti-retroviral treatments. Scott Baldauf discusses the roots of defensiveness: "It's a crisis that took root during the apartheid era, when black men had to leave their families behind in townships to find work in the cities, a setup that weakened black families. But it's the black-majority government that has been left to deal with the consequences, and the presidency of Thabo Mbeki in particular has dealt with criticism over its handling of AIDS almost as a racial slur" (Ibid.) Hitting headlines globally, the incident's most frightening by-product has been a distraction from the real work at hand.

These gender inequities continue in terms of access to education, to employment, and to the political system (see Goetz and Hasim, 2003; Lwanda, 2005; Omonubi, 2004). If they are employed, there is often a requirement for HIV/AIDS testing, and for women those results, if made public, can lead to

horrendous discriminations such as abuse, abandonment, even complete ostracism by their families and their communities. Yet, we celebrate the number of women who have successfully entered into the world of African politics, encouraged by the 2005 election of Ellen Johnson-Sirleaf of Liberia as modern Africa's first woman president; called "Mother of a nation," we get a glimpse of her from this description of her efforts at reconciliation for her nation: "At the First United Methodist Church in downtown Monrovia, President Ellen Johnson-Sirleaf sits in the front row for the Sunday morning service, wearing a golden robe and headdress befitting a queen. Hours later, she wears white sneakers and a baseball cap as she dribbles a soccer ball across a soccer stadium, showing off some of the moves she learned as an 8-year-old girl on an all-boy soccer team" (Ackerman, 2007, p. 13). "Nobody doubts her sincerity. But look at what she's up against," Joshua Hammer (2006, p. 32) reminds us. "For decades, men driven by a lust for power and self-enrichment have ruled the country and stripped it bare. Between 1990 and 2003, ragtag militiamen murdered, raped and plundered with abandon, leaving 150,000 dead and displacing half of the country's 3 million people. Monrovia hasn't had electricity since 1991. Unemployment stands at 80%, most schools have been shut down and the infant-mortality rate, at 129 per 1,000 births, is among the worst in the world. Annual per capita income, about $100, is the lowest anywhere." If prayers help, most of the world's women are wishing Johnson-Sirleaf all the best.

While Charity Ngilu and Nobel Prize winner Wangair Maathi of Kenya headed political parties in the 1990s, Joyce Mujuru is vice president of Zimbabwe, Ngozi Okonjo-Iweala is Nigeria's first finance minister, Luísa Dias Diogo is Mozambique's first female prime minister, as is Maria Silveira for Sao Tome, and in 2007 Asha-Rose Mtengeti-Migiro of Tanzania became the first African woman to be named UN deputy secretary-general. In Rwanda, women make up 48.8% of seats in the lower house of parliament—the greatest number of any such body in the world, and more the half the country's judges are female. Both Burundi and Tanzania have a third of their parliament seats occupied by females, "There is already evidence of progress," Jocelyn Zuckerman (2006, p. 21) gloats:

> In November, the women of Kenya played an instrumental role in voting down a draft constitution they deemed too vague in its time frame and specifics for reform; far more significantly, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa went into effect that same month, after ratification by 15 countries. Beyond providing a comprehensive legal framework for women's human rights, the protocol guarantees a wide range of gender-specific civil, political, economic, social, and cultural freedoms.

Not surprisingly, there has been a wide literature relative to reproductive autonomy[6] and human rights for African women.[7] And, "Abortion laws and policies in the Africa region are among the most restrictive in the world," Kibrom Isaac (2005, p. 14) reminds us. "Correspondingly, Africa has the highest mortality due to abortion in the world—an estimated 680 deaths per 100,000 procedures. In addition, Africa accounts for 25% of the 20 million abortions performed annually in illegal, often unsafe, conditions." In 1994,

at the International Conference on Population and Development in Cairo, governments agreed that reproductive rights were inalienably linked to established international human rights, but it took until 2003 for the Protocol on the Rights of Women in Africa, offering women protection for reproductive and sexual rights, to be adopted. By 2005, when the African Union officially recognized the Africa Protocol on Women, it also noted the importance of African diaspora (Gouws, 2005; Musa, Mohammed, and Manji, 2006). Yet, the Women's Rights Protocol has thus far been ratified by only five African states: Comoros, Libya, Lesotho, Namibia, and Rwanda, so not much action toward their reinforcement has taken place. To this day, the Society of Septists and Gynaechologists of Nigeria (SSGON) worries about passage of the National Institute for Reproductive Health (NIRH) and Convention on the Elimination and Discrimination Against Women (CEDAW) bills pending at Nigeria's legislative houses. Legal reforms in Africa, as Amanda Gouws (2005) and Amy Shupikai Tsanga (2003) have noted, certainly have their challenges.

"South Africa is not a tolerant or accepting society," Mary Crewe (1992, p. 15) has remarked. "In order for the white minority to engineer the social control of the vast majority of South Africans, apartheid has trained us—indeed required us by law—to see people in terms of the groups or races they belong to rather than as individuals with rights. So too with AIDS."[8] As throughout Africa, women realize that while their husband may grant her land on which to farm, he has permanent rights to the property, their children, and to all her years of free labor. Estimates of women as heads-of-households range from one out of two to one out of five, but African male relatives still rule in legal matters.

Stories and Scenarios

> The impact of AIDS is distinct for each broad category of people affected by the disease. Where African women and children are concerned, this is so because their roles, functions, and rights in society differ from those of men. African women, through reproduction and production, are inextricably linked to the survival and development of Africa. The health, development, and number of African children influence the present and future quality of life of African communities.
>
> Ankrah, Mhloyi, Manguyu, and Nduati,
> *Women and Children and AIDS*(1994), p. 533.

Fortunately, we are seeing some African women—both urban and rural, become involved in the process of protest, fighting for access to their rights for social action (see Hartwig, 2005; Hassim, 2006; Hoad, Martin, and Reid, 2005; Leslie, 2006). Depending on different legal schools of thought, we read about child custody willy-nilly going to fathers, about Algeria's not meeting human rights standards in terms of "protecting" its female population, about Angolan officials not addressing maternal-infant death rates, about unmarried pregnant Zanzibari women being sentenced to two years imprisonment, about Zimbabwean women learning about their country's Wills and Inheritance Laws, about Ugandan women having to prove multiple grounds for divorce (e.g., incestuous and/or bigamy with adultery, rape, sodomy, bestiality)—by the way, adultery in Uganda

is only criminal for women, but not for men (!) We read about South African women whose doctors did not tell them their HIV status, about Malawians unaware of the impact of family law there, about condoms being outlawed in Somalia, about Morocco's lifting its reservations on the *Elimination of All Forms of Discrimination against Women*, and about encouragement from UNICEF for Cape Verdian cooperation.

Marriage is mostly beyond the African woman's choice, as too many are denied decisions as to whom they might marry, when and where, and if they want to continue with the covenant. Associated with this dilemma, of course, comes concerns about reproductive choices and child custody, about property rights, about sexual abuse, abandonment or widowhood, and about concomitant "inheritance" issues relative to customary and/or religious laws (see Kalabamu, 2006; LeBeau, Conteh, and Iipinge, 2004; Lesetedi, 2005; Munalula and Mwenda, 1995; White et al., 2003). A 2004 editorial in the *New York Times* (Africa's Homeless Widows, June 16) makes a compelling case:

> Women feed Africa. They grow 80 percent of the continent's food, yet the land they cultivate is not theirs. Women own only 1 percent of the land in sub-Saharan Africa. Tradition says that when a man dies, his property passes to his adult sons or brothers. The widow and her children are often evicted and left destitute. These inheritance customs have long taken land away from those who cultivated it and helped to impoverish the most vulnerable women and children.
>
> But AIDS now magnifies the harm. Since men are dying young, they often leave no sons old enough to inherit their property and thus save the family from homelessness—so more widows are evicted.

Because gender-based violence has been so prevalent in South Africa—with a woman being killed every six hours there by her intimate partner (Human Rights Watch/Africa, 2004; Mathews et al., 2004), its legal responses have implications both in terms of state interventions and women's rights around the continent. In 1996, the National Crime Prevention Strategy (NCPS) declared that crimes of violence against women and children would be a national priority; in 1997, the Criminal Law Amendment Act tightened bail conditions for people charged with rape; in 1998, the Domestic Violence Act (DVA) was passed; in 1982, *National Policy Guidelines for the Handling of Victims of Sexual Offences* was finalized; and in 2003, the *Policy Framework and Strategy for Shelters for Victims of Domestic Violence in South Africa* was passed. Still, as Lisa Vetten (2005, p. 7) has pointed out in terms of the DVA, "While South Africa has eleven official languages, the application forms for the protection order are available in only two of these languages. Over and above language, the written completion and reading of the application forms challenge women with varying degrees of literacy." The 'rape capital' of the world, South Africa has established courts dedicated just to this problem. Nicole Itano, author of the recently-released *No place left to bury the dead: Denial, despair and hope in the African AIDS pandemic*, reports here on a lanky little 11-year-old at the Teddy Bear Clinic in one such spot:

> "Hello," says the doll on the hand of Ntombi Mkwanyana, a matronly volunteer counselor who sits beside the girl, "I am the magistrate." "Hello,"

> responds the girl quietly to the gray-haired, black-robed puppet. The doll and the girl chat back and forth in Zula, a widely spoken South African language. The puppet explains the job of a judge; the girl asks questions or simply indicates that she understands. She is timid at first, but then begins to enjoy the play. Eventually she picks up another puppet. This one is a pig-tailed girl. It represents her, the child rape victim who is learning to testify in court. (2003, p. 9)

Sierra Leonean women have joined with a number of groups to form an initiative called *The Voice of Women* aimed at ending violence against girls; in April, 2007, thousands marched in the main streets of Freetown, seeing their advocacy also as a platform against stigmatization against HIV/AIDS. Ghanaian women also recently organized a *March to Raise Awareness of Women's Health and Reproductive Rights in Africa*, and Cameroonian women have formed a network with traditional rulers with the theme of *Human Rights Based Approach to Combating Violence Against Women*.

Nationalism and the Role of War

> Some girls have been recruited into the war machine. They have been sent to battle or used as spies. Most often they have served as 'wartime women.' The girls are nearly always taken forcibly and raped. In addition to sexual services, they are forced to cook, wash clothes, get water and keep house in general. If they don't get pregnant themselves, they take care of the children of others, but many babies die under the harsh conditions.
>
> Torild Skard, Continent of Mothers, Continent of Hope (2003), p. 26.

Many African countries have undergone and/or are undergoing unrelenting civil warfare (e.g., Cote d'Ivoire, Liberia, Sudan, Sierra Leone, Somalia,[9] Zimbabwe) or threats from other countries (e.g., the Congo, Ethiopia, Zimbabwe, Rwanda, Malawi), refugee crises (e.g., Angola, the Congo, Rwanda, Burundi), ecological changes (e.g., Kenya, Tanzania), financial upheavals (e.g., South Africa), famines (e.g., Biafra, Somalia), and other forms of flux. We cannot escape the strong role that nationalism continues to play out around the world (Fuller, 2004a).

Although this book mostly focuses on African women's basic insecurities, from the wider view of national and/or international security these have been precarious times. From the top down, government to the people—such as South Africa's president Thabo Mbeki's denial of the disease, or even from the bottom up, AIDS has been used as both a social and political weapon (see Pharoah, 2005). Think of how Malawians have struggled this last quarter-century under Banda's dictatorship, and how it has hampered efforts there to fight the country's ever-rising AIDS rates (King and King, 2000); already, AIDS has claimed some 650,000 people in Malawi, and ten die every hour—mostly women, mostly young people, and mostly sex workers, truck drivers, and other mobile groups. Nationalism can work well for mobilizing people, too—such as how Eritrean women have struggled for their country's independence (Muller, 2005), or

how Lesothoans have responded to the HIV/AIDS pandemic in their country (Kimaryo, 2004)—where 23,000 people died of AIDS in 2006 and where 23% of adults remain HIV-positive.

Much media has focused on wartime ramifications for HIV/AIDS (African Women and Peace Support Group, 2004; Malaquias, 2007; Soyibo, 2005), but unfortunately to date little action has been taken to combat it—and so, governments and military continue to oppress Africa's powerless. For more than a quarter-century, southern Sudan's continuous civil war, where more than 220,000 have been forced to cross the border into Chad, has helped it rank as "worst in the world for women and children."[10] "Pregnancy due to rape is an extremely complicated issue," Heninger and McKenna (2005, p. ii) have explained. "It is culturally unacceptable to be pregnant outside of marriage, and to be carrying a child fathered by the 'enemy' compounds the problem dramatically. Health staff reported that women pregnant as a result of rape did not report the rape due to the social stigma attached. There were some reports of women abandoning babies of the janjaweed; however, in other camps programs were being developed with refugee communities to integrate and support mothers and their children born as a result of rape."

War-related violence, including systematic sexual violence, has unfortunately also been playing itself out in Darfur—undoubtedly the world's worst humanitarian crisis, where 400,000 innocent people have died and 2.5 million more displaced from their homes,[11] as well as in the Democratic Republic of the Congo,[12] Sierra Leone,[13] Burundi, Uganda, Rwanda,[14] Nigeria, and far too many other African countries; at some point, we need to face ourselves and ask what we have done about these holocausts. UN secretary-general Ban Ki-moon has declared that this violence has reached such "hideous and pandemic proportions" that measures must be taken to end them (Lederer, 2007). Rape has been rampant in refugee camps, in military scenarios, even in training groups. With all else, we worry about girls and women trying to cope, maybe at some point trying to (re)integrate into society (McKay, 2004). On International Women's Day 2007 (March 8), IRIN introduced *The Shame of War: Sexual ViolenceAagainst Women and Girls in Conflict*, an important follow-up to its invaluable *Broken Bodies, Broken Dreams: Violence Against Women Exposed* (2005).

In terms of the military, think how many soldiers are HIV-infected[15]—limiting their abilities, affecting their physical and psychological prowess, and nevertheless having them pass on the disease to other Africans (see Rupiya, 2006). And how about the fact that we are also learning about military personnel supposedly on peacekeeping missions who take advantage of the very people they should be helping, passing on HIV/AIDS infection to constituencies. The first film to provide an African perspective on this topic, *Ezra* (2007), directed by Newtown Aduaka, was awarded Grand Prize at FESPACO and was selected for International Critics Week at the 2007 Cannes Film Festival.

We shudder, too, at thoughts of all those child soldiers who have been inducted into wars throughout Africa (Beah, 2007; Bul Dau, 2007; Nolen, 2007; Singer, 2005; Voeten, 2002). According to the Coalition to Stop the Use of Child Soldiers (www.child-soldiers.org), Africa has some 100,000 kids, some as young as nine years old, involved with armed political groups. Mostly boys, their numbers also include girls in roles as sexual slaves. "Of the 27 countries

with the worst child mortality rates, 26 are in Africa," writes Somini Sengupta (2004, p. WK 1) from West Africa. "Children here not only reflect all that ails their countries, but they also pay the dearest price. AIDS has orphaned them, poverty has driven parents to sell them as cheap labor. And everywhere, warlords turn them into soldiers." Electric Pictures' documentary *Child Soldiers* (2002) is wrenching in its depictions of children recruited to fight in civil wars and armed conflicts; in Uganda, Sudan, and Sierra Leone we sense the cycle of (re) connections they are brainwashed to endure, awed at their very sense of survival. *Duty to Protect* (2006) documents girl recruits in the Democratic Republic of the Congo, and the weekly radio program *Sisi Watoto* ("We, the Children") there is geared toward war-affected youth and child soldiers ages 15–17. Beatrice Lamwaka (2004) reports on the role of storytelling for former child soldiers conscripted into the Lord Resistance Army, finding it an ideal healing tool, while Sierra Leone's *iEARN's Child Soldier Project* educates them about ICTs. *Communicating Justice*, a joint initiative of the BBC Trust and the International Center for Transitional Justice (ICTJ), was launched in 2007 to address human rights issues in the post-conflict countries of Burundi, Democratic Republic of Congo, Liberia, Sierra Leone, and Uganda.

Although it may not have been something they set out to do, women have played powerful roles bearing witness to Truth and Reconciliation commissions in South Africa, Rwanda, Sierra Leone, the Central African Republic, Ghana, Morocco, Nigeria, Kenya, Liberia, the Democratic Republic of the Congo, and other countries; while it is beyond the scope of this book to discuss them in depth, we realize these experiences as one more trauma African women have had to endure. Some of the best sources for exploring effects of "truth telling" include Boraine, 2000; Des Forges, 1999; Gibson, 2004; Graybill, 2002; Graybill and Lanegran, 2004; Ross, 2003; Steidle and Steidle, 2007; Temple-Raston, 2005; Tutu, 1999; Uchendu, 2007; Villa-Vicencio and Verwoerd, 2000. And let me recommend the *Christian Science Monitor*'s series "Paths to forgiveness: Africa after war" (October 23–26, 2006).

In the end, "The AIDS epidemic raises the ethical issue of distributive justice, which goes beyond mere sociocultural or medical concerns," according to Ankrah and Gostin (1994, p. 554). "The huge disparity in resources, health, and standard of living between developed and developing countries has long been the subject of debate, that has never come close to resolution. What can and must be resolved is the need to ensure that safe and effective drugs and vaccines for AIDS at other endemic diseases in Africa are accessible to populations at greatest risk." When women are so systematically marginalized from political power, as they are in Africa (see Mama, 2001 on gender politics), it is small wonder that so little is done on their behalf.

Of the many factors converging to isolate women from power, Oduyoye (1995, pp. 169–170) cites inequality of access to modern sectors of the economy, persistence of the male dominance ideology, costs of domestic labor, inability to pay labor or get modern technology, progressive breakdowns of cooperation in the traditional sector, and conflicts between being both wife and employee—issues all occurring throughout Africa. She encourages women to support one another: "With our collective strength—numerical, financial and cerebral—we can draw on this bifocal system to gain entry into political structures to help formulate laws under which we all can live as free and responsible human beings" (p. 198).

Notes

1. See Setel, Lewis, and Lyons, 1999.
2. For more on African development, see James S. Etim and Valentine Udoh James, *The feminization of development processes in Africa: Current and future perspectives* (Westport, CT: Praeger, 1999); Ulf Himmelstrand, Kabiru Kinyanjui, and Edward Mburugu (Eds.), *African perspectives on development: Controversies, dilemmas and openings* (New York: Martin's Press, 1994); Giles Mohan and Tunde Zack-Williams, *The politics of transition in Africa: State, democracy and economic development* (Oxford: James Currey, 2004); William Tordoff, *Government and politics in Africa*, 4th edition (Bloomington: Indiana University Press, 2002).
3. Advocating constitutional, legislative, judicial, educational, and budgetary reforms, Uche U. Ewelukwa (2005, p. 133) has noted that "The position of female children in societies in Africa raises serious questions of inequality, indifference, and exclusion."
4. For more information about *Sharia*, see (www.shariah.net).
5. For more information on African law, here are some helpful resources:
   African Journal of Criminology and Justice Studies (http://www.umes.edu/AJCJS)
   African Journal of Legal Studies (http://www.africalawinstitute.org)
   Afrilex (http://www.afrilex.u-bordeaux4.fr/menu.htm)
   AIDS Law Project (South Africa) (http://www.alp.org.za)
   Association des Cours Constitutionnelles ayant en Partage l'Usage du Français (ACCPUF)—French (http://www.accpuf.org)
   Banque de Donnees Juridiques du Burkina Faso—French (http://www.legiburkina.bf)
   Coalition for an Effective African Court on Human and Peoples Rights (http://www.africancourtcoalition.org)
   Coalition for the International Criminal Court (http://www.iccnow.org)
   Coopération Internationale pour le Développement et la Solidarité (http://www.cidse.org)
   Diario da Republica—Portuguese (http://dre.pt/stp/index.html)
   Djibouti. *Journal Officiel de la République de Djibouti*—French. (http://www.presidence.dj/page5.htm)
   Ethiopian Bar Association (http://www.ethiopian-bar.org)
   Gesellschaft für afrikanisches Recht—German (http://www.rechtinafrika.de)
   Ghana Land Law (http://www.ghanalandlaw.com)
   Global Rights (http://www.globalrights.org)
   High Court of Namibia (http://www.superiorcourts.org.na/high court)
   Human Rights First (http://www.humanrightsfirst.org)
   IDEE (Informatique Documentaire Edition Electronique) (http://www.idee.sn)
   Ifejika Okonkwo & Associates—Nigeria (http://www.iuo.gq.nu)
   International Commission of Jurists—Kenyan (http://www.icj-kenya.org)
   International Constitutional Law (http://www.oefre.unibe.ch/law/icl)
   International Criminal Court (http://www.icc-cpi.int)
   International Criminal Tribunal for Rwanda (http://www.ictr.org)
   International Labour Organization. (http://www.ilo.org/public/english/employment/gems/eeo)
   Institutional Reform and the Informal Sector (IRIS) (http://www.iris.umd.edu)
   Islamic Family Law (http://www.law.emory.edu/IFL)
   Journal of African Law (http://uk.cambridge.org/journals/jal)
   Judicial Services of Ghana (http://www.ghanacourts.com)
   JuriBurkina—French (http://www.juriburkina.org)
   Jurid'ika—French (http://www.juridika.com)
   JuriSTEP—Portuguese and English (http://www.juristep.com)
   KwaZulu - Natal Law Society Library (http://www.lawlibrary.co.za)
   LawAfrica.com (http://www.lawafrica.com)

The Law Publisher (http://www.lawpublisher.co.za)
Law Society of Kenya (http://www.lsk.or.ke)
Laws of Kenya (http://www.lawsofkenya.com)
Lawyers' Environmental Action Team (LEAT) (http://www.leat.or.tz)
Legal Assistance Centre, Namibia (http://www.lac.org.na)
Legal Brief Today (http://www.legalbrief.co.za)
Legal Resources Foundation of Zambia (http://www.lrf.org.zm)
Library of Congress—Ancient Manuscripts from the Desert Libraries of Timbuktu (http://www.loc.gov/exhibits/mali)
Mali—Journal Officiel—French. (http://www.sgg.gov.ml)
Nigeria Law (http://www.nigeria-law.org)
Nigerian Law Registry (http://www.nigerianlawregistry.com/home.html)
Réseau sénégalais—French (http://www.refer.sn/rds)
Senlex—French (http://www.senlex.com)
Sierra Leone Web–Laws (http://www.sierra-leone.org/laws.html)
Southern African Society of Legal Historians (http://www.legalhistory.org.za)
Special Court (http://www.specialcourt.org)
Uganda. Justice Law and Order Sector (http://www.jlos.go.ug)
Uganda Law Society (http://uls.or.ug)
United Nations High Commission for Refugees (http://www.unhcr.ch)
University of Pretoria. Faculty of Law (http://www.chr.up.ac.za)
Women and Law in Southern Africa (http://www.wlsa.org.mz/index.php)
Women in Law & Development in Africa (http://www.wildafghana.org)

6. See Loretta Ferris, 2005, for a discussion on reproductive health rights in South Africa.
7. Banda, 2005; Benedek, Kisaakey, and Oberleitner, 2002; Bentley, 2004; Bond, 2005; Butegwa, 1993; Fox and Hasci, 1999; Human Rights Watch, 2003b; Human Rights Watch/Africa, 1995, 1996, 2001, 2002, 2004; Leslie, 2006; Nnaemeka and Ezeilo, 2005.
8. Let me recommend Lauretta Ngcobo's political novel *And they didn't die* (New York: The Feminist Press, 1999) for an eye-opening view of the brave women who opposed apartheid in South Africa.
9. See: Judith Gardner and Judy El Bushra (Eds.) (2004). *Somalia: The untold story—the war from the eyes of Somali women* (London: Pluto Press, 2004).
10. Sudan: Study ranks south worst in the world for women and children (*Irin*, June 17, 2004).
11. *Darfur diaries: Stories of survival*, by Jen Marlowe with Aisha Bain and Adam Shapiro (New York: Nation Books, 2006) follows three independent filmmakers into the heart of the conflict; both the book and the film offer numbingly perceptive views of how it all has affected peoples' lives. The Save Darfur Web site, part of the campaign calling "When rape is the weapon, the wounds never heal," is www.SaveDarfur.org.
12. Michael Kleinman has reported in an op-ed (Confronting epidemic of rape in an African conflict zone) to *The Baltimore Sun* (November 19, 2007) how UN officials recently reported 27,000 cases of sexual violence in a single province of the Congo. See also Gerson, 2007; Jacobson, 2007. Although some 4 million people have died in this past decade in the Democratic Republic of the Congo as a result of war, the public and media outrage has hardly matched how horrified we should be.
13. George Packer's The children of Freetown (*The New Yorker*, January 13, 2003, pp. 50–61) is spell-binding, telling about how resilient so many amputees there have become.
14. Paul Rusesabagina, the real hotelier played by Don Cheadle in the 2004 film *Hotel Rwanda*, tells his story in *An ordinary man* (New York: Penguin, 2006) about how 800,000 of his fellow citizens were killed in the 1994 genocide; in 2005, he established the Hotel Rwanda Rusesabagina Foundation for financial assistance to

children and women affected by the genocides in Rwanda and other African nations. See also Allan Thompson's *The media and the Rwanda genocide* (London: Pluto, 2007).

15. Estimates of HIV-positive military personnel range, according to Robert L. Ostergard (2002, p. 344) include incredible infection rates of 40% for South Africa, 50% for Angola and the Democratic Republic of the Congo, 66% for Uganda, 75% for Malawi, and 80% for Zimbabwe.

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CHAPTER SIX

Educational Vulnerabilities

> The problem of AIDS in Africa lies not only in the dimensions of its transmission. It is fraught with political and cultural sensitivity, and compounded further by economic and social problems which already impede progress in many spheres of development. Misconceptions about the transmission of the disease are common and diverse, ranging from exogenous and endogenous theories to the retributionist theories alluded to by many workers elsewhere . . . So while it is important to note that education has been wisely accepted as an appropriate weapon in the AIDS drama, health professions should not discard historical evidence of the successes achieved in health care programmes, where participation by communities in the information sharing process, has been accorded equal weighting as a tool in the struggle against ignorance and misunderstanding.
>
> Laver, African Communities in the Struggle Against AIDS (1988), p. 281.

Educational challenges in Africa are compounded by a number of deep-rooted sociocultural sources at whose root is the notion of girls' secondary status. They begin in primary grades and are evident, Mabokela (2004) and Pereira (2007) argue, even at the university level. Add AIDS and the scene becomes circular: when students are directly affected by the disease, they may be forced to quit school—either because they themselves are ill, or to take care of other family members who are, and their stunted educational opportunities manifest themselves throughout the economy and the social infrastructure of their countries. In Africa, this is all part of steps backward from human development that need to be addressed. As reported in *The Post of Zambia*, on the eve of the December, 2004 Global Summit on Orphans and Vulnerable Children, James D. Wolfensohn, president of the World Bank from 1995 to 2005, pointed out that one of the worst effects of vulnerability was that its prevention of children from access to education; pointing out how, as AIDS ravaged African countries, more children were dropping out of school. Two years later came a startling statistic: "Nearly half of young women in Zambia and Ghana cannot read a simple sentence even after six years of schooling" (Kaunda, 2006).

With ignorance come additional problems. Health-wise in Africa, systems are set up so that healthcare workers only report cases to the Ministry of Health

that they directly observe, so pregnant and/or infected women who do not, or cannot make it to formal facilities simply are not counted. Or counseled. Worse, far too many African school situations include gender-based violence, discouraging many young girls from going to school in the first place (see Burton, 2005). Sometimes it is tough to connect all the jeopardizes that African girls and women have intersecting in their lives: as daughters, as family and maybe tribe members, as mothers, as sexual partners, as members of religious affiliations, and as members of wider societal groups. Think of it this way: if most Africans find it difficult to talk about sex—with friends, with family, with educators, with healthcare workers, we have our work cut out for us.

It is obvious that we need much more education about HIV/AIDS. Too many Africans report thinking mosquitoes can transit HIV, or that it is associated with witchcraft, or that sharing a meal or touching an infected person puts you at risk. Just as we need to teach families in Lesotho about the link between using the same knife for ritual circumcision and cutting the hair of family members in mourning so too do we need to support groups such as YouthNet and Counselling (YONECO) in Malawi, promoting the notion of civil education on HIV/AIDS, human rights, gender, democracy, and good economic development. Sample some of these statements by 36 female informants interviewed in Zambia by Mwale and Burnard (1992):

- "I hear that AIDS kills and that it's contagious. It is contagious because it comes about through meeting men and working with blades which have been used on other people." (p. 27)
- "I have heard about the disease although I have never seen anyone with AIDS... I have only heard... I hear that it enters you by not respecting yourself, being promiscuous." (Ibid.)
- "We only hear that AIDS has finished people and that AIDS kills and that people become thin and then they become very sick with diarrhoea, then they finally die... that is all I have heard about AIDS." (Ibid.)
- "I hear about AIDS, people are talking about it... we hear that the water which we drink that it has germs and is unclean, then you will contract AIDS." (p. 28)
- "It comes about from tattoo and from using razors." (p. 29)
- "Anyone is at risk of AIDS even in town or in the rural areas because people are mobile. When a person from the village goes to town and finds a woman they can get AIDS and vice versa, people from town." (p. 34)
- "The problem is that most women are usually at home but it's the husbands who move about who are bringing the disease." (p. 37)

For the disabled, there are all new rules for teaching about HIV/AIDS. "To say AIDS in Kenyan Sign Language requires placing the index finger and thumb of both hands close to the face, which is supposed to a re-creation of the skeletal appearance of a victim on the verge of death," explains Marc Lacey (2004). "In other parts of Africa, other signs are used for the disease. AIDS can be conveyed by pretending to pluck clumps of hair out of one's head. Or by forming the letter A with both hands. Or by running one's fingers down the center of one's torso to indicate extreme slenderness." Although in a way it may help to not watch loved ones slipping away, or to hear their despair, we need to be especially sensitive to Africa's blind and deaf citizens, the most marginalized of all. Just as we need to be aware of holding educational seminars in wheelchair-accessible arenas, to

have materials in appropriate languages, including Braille, and to discover which media is best suited to a particular message, for the best HIV/AIDS education we need to consider students' abilities and interests (Kolawole, 1997). Jugbaran Nazliand and Eliza Melissa Moodley[1] (2003)'s testing the efficacy of HIV/AIDS interventions with autistic children found many of them were sexually active without having any idea about consequences.

Take the case of Angola, which traces its ancestry through the maternal line, and where fertility is quite high—the average woman having seven children. With only 40% of the population over age 18, we realize that Angolan adolescents shoulder the burden of dealing with health issues such as HIV/AIDS; yet, studies show there is an extremely low level of knowledge about the disease, as demonstrated in findings that more than 10% of those tested are HIV-positive. When a Princeton team, hosted by UNICEF/Guinea, performed an assessment of girls' education there (Addy et al., 2005), the French translation of their title, meaning "We love to study," says it all. Pre-conceiving of the topic as a problem, and announcing themselves as "coming from the perspective of the primary stakeholders who are at the receiving end of these initiatives: parents, teachers, administrators, and students," we can easily see why Africans resent Western approaches to analyses of their situations. It cannot surprise you to learn that their biggest concerns were on infrastructure and funding. They asked questions, but we have to wonder whether they listened. One of my favorite responses was from female students at what was categorized as a nonformal school who, when asked what they liked about it, first mentioned lunch being served. "A husband may desert you but a career never will," one reported, but all the girls agreed that, although they had high aspirations, see themselves as having families. Most girls get married at 16 or 17. For now, this is a typical day for them:

- *Wake up*
- *Help mother with cooking and cleaning*
- *Clean up and get dressed*
- *Walk to school-school starts at 8.*
- *Break from school at noon—go home or play.*
- *Back to school at 3.*
- *Walk home at 5:30*
- *Help with chores*
- *Study under candlelight*
- *Go to sleep* (p. 63)

Or, look at Ethiopia. World Learning's *Odyssey* newsletter of Winter 2004 supplies this scenario: "Obtaining a basic education is difficult and sometimes hazardous for children in rural Ethiopia. The school day beings and ends with a long walk—often several kilometers. The school buildings are often mere huts of sticks and mud, with sheet metal roofs that turn them into ovens in the sunshine and create a deafening din the rain. They often lack latrines or potable water, not to mention basic furnishings like desks and chairs, books and other learning materials" (p. 1). The encouraging thing is that they, with USAID, are working to overhaul the system—adding teachers so the ratio will no longer be 100 to 1, repairing roofs, buying books, and providing gender equity.[2]

For more about World Learning for International Development (WLID), see (www.worldlearning.org/ethiopia).

Luckily, some success stories can encourage us. In Rwanda, where 60% of the population is literate, a campaign to educate citizens about HIV/AIDS has proven highly effective (Panos, 1989). When, in 1985, the small East African state was listed as having the twelfth highest number of AIDS cases per capita, it embarked on a well-coordinated educational plan. Using both radio and informational booklets under the auspices of a communicative infrastructure based on units ranging from districts and sub-districts to local family groups, the local Red Cross was available to answer questions and offer counseling. Radio campaigns have been waged in Benin, Burkina Faso, Guinea, Guinea Bissau, Mali, Senegal, and Togo for the 2003 *I Am a Child but I Have My Rights Too!* program, each country adopting stories to its own culture. Interactive Radio Instruction (IRI) has been helpful in reaching remote children in eastern Ethiopia, and the SIRIP project (Somali Interactive Radio Instruction Program), scheduled to last until September of 2008, is especially aimed at reaching girls.

Family Health International (FHI)'s *Teacher Training* (2004) focuses on Africa, providing challenges and projects in Ghana, Kenya, Uganda, and Zimbabwe, and since 2005, Formation des Enseignants par la Radio/Teacher Training via Radio (FIER) has used radio and digital technologies to provide support for both in-service and pre-service teacher training in Mali. Stephen E. Anderson's *Improving Schools through Teacher Development* (2002) offers examples from Kenya, Tanzania, and Uganda. "READ Educational Trust is a South African-based NGO that operates in the education and literacy sectors broadly, and in educator training and school resource provision specifically; established in 1979 and funded by foreign donors and the private sector, READ works alongside the Department of Education to implement teacher training and literacy projects in schools" (www.read.co.za). Djibouti has trained female peer-educators on the dangers of HIV/AIDS, a group of Christian missionaries has formed a school to save Maasai girls from early marriage, Angolan teens meet at a center sponsored by Population Services International, and Nairobi's *Binti Pamoja* ("girls together," in Kiswahili) reproductive health education program has young women explore a number of complex issues. Still, Phillipe Talavera, author of *Challenging the Namibian Perception of sexuality* (2003)[3] has talked about how important it is to get teachers involved in sexual health education, despite so many efforts.

According to Kelly (2005, p. 67), there are four imperatives for existing educational structures:

- Eliminating all primary school cash costs.
- Easing the cash and labor losses sustained by poor families when children attend school.
- Establishing school conditions and an environment in which every child can experience real and relevant learning.
- Involving a wide variety of partners in a collaborative education process.

More radically, he adds, "we need an expanded vision that seems the answer to the needs of all children, including those affected by HIV/ADS, as lying within communities. This expanded vision would place the school at the heart of the community and the community at the heart of the school."

This notion of relevance, a basic sociocultural concept, is particularly important in educational resources. Examining 112 educational software products, Roberts and Butcher (2003) learned that teachers found images and animations needed to be relevant to the African context. And a number of researchers want to emphasize gender (Bloch, Beoku-Betts, and Tabachnick, 1998; Egbo, 2000; McFadden, 1999; Meena, 1992) in educational settings.

Fortunately, a number of refugee camps have some form of preschool programs—some Koranic, some including health education, some whose teachers have had psychosocial training. Knowing that in rural areas only 8.7% of children within public schools at Primary Six level can read and write, Ibis decided to use *Education for Empowerment* (EfE); targeting children, especially girls aged 6 to 15 living in refugee camps and rural communities in certain areas of Ghana, it uses these communication strategies: (1) Strengthening literacy and numeracy programmes; (2) Empowering teachers; (3) Improving educational opportunities for girls and young women; and (4) Applying the Teaching in Emergency model to the refugee situation in Ghana. Here are some other stories, from Chad and Sudan.

1. Chad: One of the world's poorest countries, with some 80% of its 9 million people living below the poverty line, life expectancy only 44.7 years, Chad's educational system includes a primary 6-year program for ages 6 to 12 based on a curriculum called "école elémentaire," followed by "college d'enseignement genéral" for ages 12 to 16 or "Collège technique," and in some instances "Lycée" for ages 16 to 19. Its only university is the Université de N'Djamena, divided into these four faculties, taught in French and Arabic: Law, Economics and Business Administration; Modern Languages and Human Sciences; Exact and Applied Science; and Medicine. With nearly half of the population of Chad being under age 15, women having a 39.3% literacy rate, the picture is grim.
2. Sudan: The largest country in Africa, about one-third the size of all North America, Sudan supports compulsory education for ages 6–14, general secondary school for ages 14–17, as well as technical/vocational choices. Instruction is in Arabic and English, and nomadic enrollment accounts for 24% in schools. Like Chad, less than half the population is under age 15, but female literacy is 50%. But the conflict in Darfur—recognized as one of the world's worst humanitarian crises, has had a particularly tough toll on girls and women's educations and lifestyles. (Heninger and McKenna, 2005)

Amounts of materials are not enough, we realize. Different individuals have different needs, needing different messages and different follow-through(s). Mjomba Leonard (2006), who has both taught and done administrative work in Kenyan schools, worried about the lack of HIV/AIDS prevention education there, especially the fact that communication for behavior change there "valorizes literacy-based, Eurocentric approaches such as lectures, brochures, posters and ignores oral African traditional forms of communication which are a powerful transforming agent." His preference to Western scientific method is for what he calls the five Ps of contagiousness: pervasiveness, popularity, persistence, persuasiveness, and passion, in keeping with grassroots approaches where people have long expressed themselves through drumming, singing,

talk-singing, poetry, drama, dancing, storytelling, feasting, and other cultural rituals. In particular, he chooses *Ngoma*, which vaguely translates to mean dancing, drumming, and singing for healing and transformation (see Janzen, 1992). For illiterate Africans, whose numbers are as high as 94% in rural areas (Ankrah, 1996), word of mouth—from family and friends, educational or religious institutions or even acquaintances, may be the answer. Illiteracy, after all, compounds not only lack of knowledge but also it breeds a sense of powerlessness; moreover, as Michael J. Kelly (2005, p. 66), a Jesuit priest and former professor of education at the University of Zambia, has pointed out, "In a disastrous feminization of illiteracy, two-thirds of those not attending school or dropping out early are girls."[4]

For those without electricity and hence no radio or television, public meetings or political rallies might serve. Sometimes videos can do the trick, and comic books should never be discounted. Access to education in Africa, or lack thereof, is particularly important in terms of health education (Bennell, Hyde, and Swainson, 2002; Umeh, 1997; UN Theme Group, 2005; Webster, 2005; World Bank, 2000). "The world's attention is increasingly focused on the devastating effects of HIV/AIDS, particularly in Africa. However, the discussion has rarely featured an assessment of the effects of HIV/AIDS on girls and girls' education, nor the potential of girls' education to mitigate HIV/AIDS" declared the 2000 Colloquium on Girls' Education, recognizing its effects of families, communities, and educational arenas.[5] It focused on these issues:

- HIV/AIDS threatens to undermine the substantial progress made in increasing girls' access to and completion of basic education;
- In addition to its many other benefits, girls' education is a critical mitigating force, because through education girls gain strong identities, develop knowledge and life skills, acquire the means to support themselves, and as women take better care of their own families;
- By helping girls overcome the effects of HIV/AIDS and supporting them to gain access to and achieve higher levels of education, families and communities support their own well-being as well as national development.

Action can be simple, such as setting aside a day to "Take Our Daughters to Work," which in fact is already celebrated in Benin, Bulgaria, Burkina Faso, Cameroon, Côte D'Ivoire, Kenya, Mali, Mauritania, Morocco, Romania, Senegal, Togo, Zambia, and Zimbabwe.

African School Systems

> Gender-based disparities in education are among the most troubling issues affecting women's lives in African countries today. Women's education is inextricably linked to economic development, national unity, and social progress and it considered a basic human right, yet the educational attainment of women continues to lag behind that of men throughout most African countries.
>
> Kate L. Webster, Sociocultural barriers to the Education of Kenyan Girls (2005), p. 179.

The literacy gap between African men and women, the highest in the world, continues to grow at the same time that enrollments for young girls continues to drop in all levels of education (Fredo, 1995; Odaga and Heneveld, 1995). Fatima Agnaou[6] (2004) has documented how it has empowered women in Morocco, and many agencies continue to work toward that end, as Africa has a proud tradition of literature (James, 1990; Hudson-Weems, 2004; Newell, 1997; Nfah-Abbenyi, 1997; Stringer, 1996; Tsabedze, 1994) and writing. Knowing that some 30 million school-age girls in sub-Saharan Africa do not attend any educational institution,[7] we bemoan the fact that enrollment of girls in Botswana has dropped to below 50%, knowing that one-fifth of all girls there aged 15 to 19 are HIV-positive, but we applaud efforts in Tunisia, where illiteracy has gone from 25% in 1984 to 6% in 2004 (www.albawaba.com).

"Educate a woman, you educate a nation," said Deputy President, Phumzile Mlambo-Ngcuka at the 4th annual Women's Parliament Conference in Cape Town, Africa on Tuesday, 28 Aug. 2007, as she spoke out on the importance for girls education.[8] Gender parity has been a problem throughout Africa, especially in Benin, Burkina Faso, Chad, Guinea-Bissau, Mali, and Niger, so the *Education For All* campaign aimed to change statistics where some 57% of children—in some places as high as 63% not in school, were female. You can get a sense of how important this is in Benin by reading this by Somini Sengupta (2003),[9] dateline Koutagba:

> For as long as anyone could remember, the girls of this village had been forbidden to go to school. They were to be educated instead by the local voodoo priest, in a secret rite of passage not to be spoken about to anyone. When they finished, they were to be married. They and their children were to forever enjoy the protection of the voodoo priest. That was until six years ago, when, with prodding from local government and United Nations officials, an extraordinary deal was struck. Every family in Koutagba could send one girl to school, the priest agreed, so long as it also sent another to him. The mothers of the village fell on their knees, laid bottles of home-brew at his feet and prayed. Two years ago, two Koutagba girls finished primary school. Today 8 of the 27 pupils in fifth grade are girls. So is nearly half of the first grade. The story of this tiny, remote hamlet in the heart of West Africa offers a metaphor for the challenges facing girls' education on the continent.

Uganda's Universal Primary Education program, promoting girl child education, has seen direct results in terms of lessening poverty and helping the country's development, and Nigeria has made efforts to change its boy-child enrollment dominance.[10] Whether for reasons of living too far from where education was taking place, not being able to afford books or uniforms, or being made to work, getting an education should be a human right.

Conditions for that schooling are critical, too. When then UNICEF executive director Carol Bellamy visited Nigeria in 2003, she called for flexibility in the school system to accommodate girls, addressing issues such as not enough teachers,[11] not enough schools, not enough learning materials like textbooks; her suggestions: sensitivity to seasonal calendars and nomadic lifestyles, formal and non-formal education, and the enlargement of Koranic school curricula that would include "innumeracy, literacy and life skills."[12] The idea would be

child-friendly schools, "where children are free from risk, where they have access to clean water, where girls and boys have separate toilet facilities and where both teachers and pupils are motivated to ensure that effective learning takes place." UNICEF published an evaluation of the African Girls' Education Initiative (Chapman, 2004) by studying six of the countries where it operates (Botswana, Burkina Faso, Eritrea, Ghana, Guinea, and Uganda), finding "The changes that have occurred in girls' participation, retention, and achievement over the course of the AGEI programme are the result of many factors... [It] was a significant force in making a widespread and meaningful contribution to improving girls' education across sub-Saharan Africa." And in 2005–2006, UNICEF collaborated with the Network of Ethiopian Women Association (NEWA) to establish the *Girls Forum*, facilitating discussions on what makes girls vulnerable to HIV/AIDS.

The flip side, of course, is that uneducated girls impact on an entire family's health, increasing risk of disease(s) and decreasing economic and social development. Around the time of Bellamy's visit to Nigeria, a National Sexuality Education Curriculum was being introduced, divided into these themes: (1) Human development, (2) Personal skills, (3) Sexual health, (4) Relationships, (5) Sexual behavior, and (6) Society and culture. In essence, students were being asked to abstain from sex and to be "ambassadors against AIDS," and the idea was to learn about Biological Sex Education ("organ recital,"), Comprehensive Sex Education ("value-free" facts about human reproduction, sexual development, preventing sexual abuse, birth control information, abortion, and contraception), and Chastity Education ("Education in Love" on how to resist pressures and temptations). Oh, that it should be that easy.

Teaching conditions can be tough. Adam Cohen (2003) describes an experience he had in Ghana with Global Volunteers in a grim classroom lacking windows and electricity but with frequent goat visitors, 10 old books for triple that number of readers, and unfailingly polite students. Learning conditions can also be trying for female students, too, as all too often we learn of abusive male teachers who harass girls or even demand sex from them for passing grades.[13]

The ideal situation is where school systems include HIV/AIDS education in the health syllabus; see UNESCO's *HIV/AIDS at school: Living and learning in a world with HIV/AIDS* (2004). The Ghana Education Service's Girls Education Unit's *Stop AIDS Love Life* national HIV/AIDS program, geared to 11- to 15-year old girls, aims at their self-esteem, self-efficacy, decision-making skills, and personal risk perceptions. Where students are involved it works best. Burundi schedules annual AIDS conferences in all the schools; Guinea-Bissau sponsored an AIDS song contest; students in Sierra Leone have written a play about AIDS that travels the country; Uganda uses a UNICEF plan in its primary schools; Zambia has a health club; and Zimbabwe, where life expectancy for women is the lowest in the world, at 34, and where half of the population is infected, depends on locals for its educational campaigns.

Opportunities and Obstacles

Denial has in nearly every country been followed by a tendency to blame others for introducing and for spreading HIV. The United States

> has blamed homosexual men and Haitians; Europeans and Indians have blamed Africans; Africans have blamed Europeans; Asians have blamed American seamen; others have blamed students, or foreigners, or prostitutes, or ethnic minorities, or capitalists, or unbelievers.
>
> Jim Tinker, Introduction to *AIDS and the Third World* (1989), p. iv.

The vicious cycle of blame and denial has stood in the way of encouraging education to African girls and women (Sabatier, 1988; Sall, 2000). In terms of education there, we must realize that gendered socialization begins at birth and follows the young girl/woman throughout any formal schooling that may be available. Dependent on men for decision-making along the way, it should come as no surprise that illiteracy rates are so high for women when their educational levels are so low. That is just the way it is, too many Africans conclude. "I have met girls who will never go to school because their mothers rely on them to fetch water and firewood, one reason girls' education rates in sub-Saharan Africa remain the lowest in the world," Somini Sengupta (2004, p. WK 1) has shared. Something that might seem so simple to us as water can, in fact, hamper a whole attitude toward education, as described by Pilirani Semu–Banda (2007):

> Rita Kalikokha of Dowa, a rural district in central Malawi, thinks about abandoning school every time she menstruates. The hard-working, resolute 13-year-old attends a primary school that has no running water. All 350 pupils at Rita's school have only two pit-latrines to share, and there is no tap where they can wash their hands after using the toilet. Rita says she and other adolescent girls find these sanitation conditions even more awkward when it is time for their monthly periods...Many girls in her school drop out as soon as they reach adolescence as they cannot bear the inconvenience and embarrassment of having to do without water.

Barnett and Blaikie (1992, p. 12) describe the rural infrastructure of a school system in Uganda, where, "Children can be seen being taught under the trees...However, there is no money for maintenance, the teachers themselves often go without pay, which is meager when they receive it. Responsibility for resourcing this rural school has increasingly moved away from government and has fallen on the shoulders of the parents and the local community." Part of that responsibility means paying for school uniforms, books, pencils, rulers, and other items needed for primary and secondary education. When the authors interviewed 55 schoolchildren aged 14–17 (39 boys and 19 girls) for their concerns about HIV/AIDS, they found the following major categories:

1. AIDS deaths are a loss of resources to the country and to the district. This includes the idea of waste of economic investment.
2. Disapproval of behaviour of the elite who are seen as acting irresponsibly.
3. The evil intent that some men have in seeking out young girls or raping women.
4. Identification of women as the main culprits for the spread of the disease.
5. A person who gets infected is acting immorally and is dishonouring their parents (p. 47).

Another added difficulty is the shortage of teachers in Africa—many of whom themselves have been infected and/or affected by HIV/AIDS. Zambia loses some five teachers each day to the disease (Lynas, 2001, p. 3). And, for students and teachers alike, there is the problem of sexual abuse in schools (see Leach et al., 2003)—the act(s), the reportage(s), the lack of reprisal(s).

Participatory peer education as an HIV/AIDS prevention strategy has been found to be quite popular in Africa (see Deutsch and Swartz, 2004; Speizer et al., 2001). "There is little doubt that peers have easier access to each other, that peer influence shapes young people's minds and behaviour," report Goergen and Ndonko (2006, p. 11) relative to the "Aunties Project" in Cameroon. "The teenage mothers who grouped themselves together developed as a peer group. Listening to testimonies of other teenage mothers and speaking out with her own story helps a young mother to better understand the context which made her fail. Retrospectively, she can analyse what happened, draw conclusions and set new objectives for her future. A trained teenage mother can better handle her sexual life and make sure that she protects herself from unwanted outcomes." Further, they concluded, there was empowerment and capacity building in terms of communication roles, intervention in schools, sensitization of headmasters and teachers on the prevention of early pregnancies, HIV/AIDS, and STIs (p. 20; see also Ainsworth et al., 1997; Assie-Lumumba, 1997). Pregnancy was recently allowed for high schoolers in Swaziland, who previously were expelled; still, since women's primary role there is considered to be raising children, education is thought of as a luxury and some men are actually known to resent educated wives. As some one-third of Swazis in secondary school reported having had sex by age 16, and traditionalists consider condom usage "unSwazi," the consequences are worrisome.

Campbell and MacPhail (2002) bemoan how little communication about sexuality is available for young girls except for peer education, and place their hopes on social and community development initiatives. A study performed in Kenya of 70,000 students in grades 6 to 8 by the Partnership for Child Development (Dugger, 2006) found that it helped to have school uniforms provided to girls, so they would be able to afford attending school; in addition, "Researchers also found that classroom debates and essay-writing contests on whether students should be taught about condoms to prevent the spread of HIV increased the use of condoms without increasing sexual activity."

Dylande, Klinte, and Africa (2006, p. 8) make the case for including People Living With HIV/AIDS in training efforts: "PLWHA are able to qualify HIV/AIDS interventions as they have internalised the disease and know the social, physical and emotional consequences of being HIV positive. PLWHA often have specific knowledge of the AIDS related stigma in the local community." One such successful educational situation is Mozambique's *Kindlimuka* ("Wake up," in Ronga), a non-profit educational association supporting PLWHA, which uses HIV-positive role models as advisors.

In terms of higher education in Africa, inroads are being made thanks to advances in national information technology policies, Internet access, and e-learning (Beebe et al., 2003). New Partnership for Africa's Development (NEPAD)'s e-School Program aims to provide computers and Internet access to all African schools by 2013—a total of some 600,000 schools. Internet and computer skills can be taught to Uganda young people who use a Web-based CD-ROM called *World States with Me* (WSWM), a sexuality education and

HIV/AIDS prevention tool. Still, we are told, Africa's best universities are collapsing: "It is partly a self-inflicted crisis of management and neglect, but it is also a result of international development policies that for decades have favored basic education over high learning even as a population explosion propels more young people than ever toward the already strained institutions" (Polgreen, 2007).

Libraries in Africa are important repositories for information about HIV/AIDS. Nigeria's *HIV/AIDS Library Through Online Volunteering* is located at a health center; Zambia's *Lubuto* project is for orphans and vulnerable children; the Zimbabwe Women Resource Centre and Network (ZWRCN) features a documentation center and sponsors lectures on gender and development

Stigma

I am HIV positive
And I am so ashamed
Of our world
That has been so slow
To respond
To HIV/AIDS
I am so ashamed
Of a world
That sits back
While millions die
Of a disease
That is preventable
And treatable
I am so ashamed.

Mwaganu wa Kaggia, submitted to the
STIGMA-AIDS forum (2003)[14]

In 2001, the Stigma-AIDS eForum was first established, co-sponsored by Health and Development Networks and the AIDS-Care-Watch Campaign, and I immediately began monitoring the material. Discussions revolved around definitions of stigma; stigma and health care providers; stigma and the religious sector; stigma and media; stigma and politicians; stigma and people living with HIV/AIDS (PWHA); stigma and discrimination; stigma and injection drug users; stigma in the workplace; self-stigma; and stigma and disclosure. This book is all the better for it, as seen in the poem cited above.

"Stigma," Arvind Singhal (2003c, p. 34) reminds us, dates to the days of Greek civilization, referring to a tattoo branded for wrongdoing: "The physical mark publicly identified the blemished individual as one to be avoided. So *stigma* is prejudice and discrimination against a set of people who are regarded by others as being 'flawed, incapable, morally degenerate, or undesirable,' and who are treated in a negative way. Prejudice is an attitude, while discrimination is overt behavior. The two usually go together." Singhal, Rogers, and Sharma (2003, p. 83) point how, as HIV-related stigma is closely related with taboo topics of sex and death, they quite naturally are associated with metaphors such as "AIDS

as death," "AIDS as punishment," "AIDS as crime," "AIDS as war," "AIDS as otherness," "AIDS as shame."

Because, from the top down, community, religious, and governmental leaders, even husbands and wives, are reluctant to talk frankly and sex, one of the consequences has been endemic ignorance about and stigma relative to HIV/AIDS in Africa. We celebrate volunteers in the fight against discrimination, with organizations such as Groupe Chretien Contre le SIDA au Togo (GCCST) working within medical, psychological/spiritual, and nutritional venues in care-taking for adults as well as AIDS orphans. As a way of dealing with its 500,000 AIDS orphans, the Malawian government established the 'Free Primary Education Program' in 1994; here is a poem on the website of the Jacaranda Foundation (www.jacarandafoundation.org), which works with some of those orphans:

To children around the world, education means freedom.
Freedom to learn and grow.
Freedom to study, embrace a career and raise a family.
Freedom to choose a path in life, explore one's passions and make a difference in the world.
To an AIDS orphan in Africa, education also means:
Freedom to escape extreme poverty.
Freedom to fight AIDS.
Freedom to become a leader and develop his or her home country.

Although homosexuality remains a strong taboo across Africa (Niang et al., 2003), the LGBTI community of South Africa has been active in awareness raising campaigns and media. Real-life stories, we keep finding, mean the most. Citing a Zambian man—"It is not sometimes the disease that kills . . . it is the bad words and remarks from people," Nyblade et al. (2003, p. 21) go on to declare that, "In each country, specific derogatory words and phrases have emerged to describe people living with HIV or AIDS or the syndrome itself. The use of these words is a powerful means to stigmatize.

Terms with negative connotations are part of daily conversation and are used in rumors, gossip, and even the media. Often, however, speakers are not aware that they are stigmatizing with their words or of the damaging impact of what they are saying. Nonetheless, the phrases that highlight deviant behavior in connection to HIV or euphemisms for death and physical appearance only reinforce perceptions that people with HIV are unproductive, useless, responsible for their infection and a burden to those around them. Common terms to describe PLHA or the syndrome include the following:

In Ethiopia:
"yeminkesakes atent"—moving skeleton
"mote bekeda"—almost dead although still living
"menfese mute"—ghost

In Tanzania:
"maiti inayotembea"—walking corpse
"marehemu mtarajiwa"—a dead person to be
"utakufa kilo 2"—you will die weighing 2 kilos

In Zambia:
"makizi yaku mochari"—keys to the mortuary

"kaliyondeyonde"—skeleton
"kalaye noko"—say goodbye to your mother (p. 38).

One of the most disturbing aspects of young women's discrimination in the educational environment is the fact that some girl students seek paid sex as a means of supporting their educational expenses ("Selling Sex for School Fees," 1990). There have been, fortunately, some solutions. The *Jali Watoto* ("Care for Children") Anti-Stigma and Discrimination campaign trains and educates young Tanzanians about tolerance; Botswana has held a Miss Stigma Free beauty pageant for HIV-positive women; Imams (religious leaders) in Mauritania have helped sensitize local populations about HIV/AIDS. Nyblade (2002, p. 1) identifies six key themes relative to stigma: (1) People are largely unaware that their attitudes and actions are stigmatizing; (2) Language is central to how stigma is expressed; (3) Knowledge and fear interact in unexpected ways that allow stigma and discrimination to persist; (4) Sex, morality, shame, and blame are closely related to HIV-related stigma; (5) Disclosure of positive HIV status is advocated, but acknowledged as difficult and unusual; and (6) Widespread care and support for people living with HIV/AIDS (PLHA) coexists with stigma and discrimination.

Sharing his fieldwork experiences in Grahamstown, South Africa, Thomas Tufte (2006a) found community challenges in terms of stigma, fear, lack of social support systems, superficial use of communication initiatives, and lack of joint community efforts. He provides some telling testimonials on the first point, saying of stigma, "It cuts across most of the other challenges—the fact of massive social condemnation and marginalization making disclosure of your status, or simply revealing your uncertainly about having the virus, one of the most difficult decisions in life" (pp. 26–27). One boy reported, "They always think if they tell a friend, family member or girl/boyfriends, that they will get into an argument and get dumped. They think that their families will start to dislike them. Every thing their families are doing, they won't include them." And a local girl said, "People with this disease are always ill-treated and it undermines their ability to live."

The literature on HIV/AIDS and stigma is quite significant (Boesten, 2007). Ross Kidd and Sue Clay constructed a toolkit called *Understanding and Challenging HIV Stigma* in 2003 for AED that included modules moving from naming the problem through understanding, caring, coping, and moving to action. Based on their research with AIDS activists from 50 NGOs in Ethiopia, Tanzania, and Zambia, they determined root causes of stigma and then developed strategies—many involving feelings, to challenge it. In 2007, they added Chipo Chiiya as co-author to revise and make the toolkit into a picture book. EngenderHealth produced *Reducing Stigma and Discrimination to HIV and AIDS: Training for Health Care Workers, Trainer's Manual and Participant's Handbook* in 2004, available free for users in developing countries.

Determining that fear, HIV/AIDS information, the fact that HIV/AIDS is linked to sex, poverty, not enough open discussion, and lack of HIV/AIDS services are the root causes of stigma, Campbell et al. (2005, p. 51) see hope in support groups, with these goals:

- To create "communities" of people with AIDS who can discuss ways in which they can help each other.

- For people to assist one another in making well-informed decisions whether or not to disclose, and who to disclose to.
- For people with HIV/AIDS to share skills and assist one another in accessing welfare grants or medical support most effectively.
- To begin to identify and challenge those who hold on to stigmas and who discriminate against people who have HIV/AIDS.
- To encourage people with HIV/AIDS to play as active a role as possible in challenging these stigmas and in improving the discriminatory social environment that they face.

When the *Compassion, Tolerance and Sensitivity* (CATS) campaign was launched World AIDS Day 2003 in Ethiopia, it included input for a song from well-known musicians, a poet, and videographers. Clearly, inroads are being made.

African Media Aimed at Children

Like their older counterparts, African children love radio, and fortunately, there are a number of programs geared just to them. *Mundo Sem Segredos* "World Without Secrets" airs in Mozambique, telling kids there about HIV/AIDS in terms of understanding it and respecting those who are infected, and in South Africa *Beyond the Classroom* focuses on how teachers can use media in the classroom. Starting in 2002, teens were encouraged to participate in a South African conference on the Africa Charter on Children's Broadcasting under what was called Radio Kidocracy, and the process continued to respond to their interests. Representatives from community radio stations and local youth groups worked with Bush Radio Children's and Youth Radio Workshop (CREW) members to produce a manifesto for what they want from the media.

Girl Child Art Foundation (GCAF) "promotes girl child education, rights of the girl child, health and hygiene of the girl child, HIV/AIDS awareness programs, capacity building for Nigerian youths, and peer education among youths through all forms of arts especially through the media" (www.gcafy.org). "Nigerian youth are fighting AIDS by tackling a new national curriculum and teaching each other," Elizabeth Bryant (2004) writes, highlighting the value of *Girls' Power Initiative* as hope for the young women to break "the cycle of cultural denial about sexual matters and its grim fallout" (p. 11).

The *Tuseme Project* ("Let's speak out") in Tanzania, part of Education for Democracy, considers HIV/AIDS as an international development crisis, the greatest drama of our time. Performance- or workshop-based, some good examples of Theatre for Development (TFD) might be Ethiopia's Gemini Trust Adugna dance theatre, which gives contemporary dance performances with added messages on sex education and discrimination; puppetry for social education in South Africa (African Repertory and Educational Performance Programme), Botswana's Phuthulogo theatre company, which has created a drama on mother-to-child transmission; and Circus in Ethiopia (CiE), which conveys messages on health matters, including HIV/AIDS and social issues. In conjunction with *See the Tree in the Seed*, visual artist Ntare Guma Mbaho Mwine developed an HIV/AIDS advocacy program, launched in Uganda in 2003 that developed audience interactive performance pieces for HIV/AIDS prevention and care, wanted to restore hope to individuals infected or affected by HIV/AIDS, and act as a core base of trainers to ensure continuity of theater-based HIV/AIDS advocacy.

Media professionals have produced some noteworthy resources relative to African children and HIV/AIDS:

- *Child Participation in Education Initiatives: How-to Guide*, by Carolyn W. Fanelli and Mildred Mushunje (Baltimore, MD: Catholic Relief Services, 2007).
- Peter McIntyre's *Child Rights and the Media: Putting Children in the Right: Guidelines for Journalists and Media Professionals* (International Federation of Journalists, 2002).
- Ruth Nduati and Wambui Kiai's *Communicating with Adolescents About AIDS: Experience from Eastern and Southern Africa* (IRDC, 2003).
- *Educate Girls, Fight AIDS* (2006), by the Global Coalition on Women and AIDS (http://womenandaids.unaids.org).
- Fatima Agnaou, *Gender, Literacy, and Empowerment in Morocco* (Routledge, 2004).
- *A Handbook for Advocacy in the African Human Rights System: Advancing Reproductive and Sexual Health* (Ipas, 2003).
- *The HIV and AIDS Question and Answer Handbook: Nigeria* (Johns Hopkins, 2004).
- *Review of the Evidence: Girls' Education and HIV Prevention* (UNAIDS, 2006).
- James Rosen, Nancy Murray, and Scott Moreland, *Sexuality Education in Schools: The International Experience and Implications for Nigeria* (Policy Project, 2004).
- *Social Marketing for Adolescent Sexual Health: Results of Operations Research Projects in Botswana, Cameroon, Guinea, and South Africa* (2000), edited by Lisa M. Hisel, was published by Population Services International.
- *Teachers' Exercise Book for HIV Prevention* (2004), published by Educational International, WHO, and Education Development Center.
- Tijuana A. James-Traore, William Finger, Claudia Daileader Ruland, and Stephanie Savariaud, *Teacher Training: Essential for School-Based Reproductive Health and HIV/AIDS Education* (Family Health International, 2004).
- Pat Made, Liesl Gerntholtz, and Colleen Lowe Morna, *Gender and HIV: A training manual for southern African media and communicators* (Gender Links, 2002).

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The Oprah Winfrey Leadership Academy for Girls

> The Oprah Winfrey Leadership Academy for Girls—located near Johannesburg and educating girls in Grades 7 through 12—is therefore a wonderfully appropriate gift to the people of South Africa, one that will endure over many lifetimes. When I went to the opening of her school, I looked at the shining faces of these young women and thought every one of them has the potential to be an Oprah Winfrey. The school is important because it will change the trajectory of these girls' lives and it will brighten the future of all women in South Africa. Oprah understands that in Africa, women and girls have often been doubly disadvantaged. They have had the curse of low expectations and unequal opportunities[26]
>
> Nelson Mandela, Time's 100 Most Influential People (May 7, 2007).

"Building a Dream" is how the Oprah Winfrey Leadership Academy for Girls has been framed since its opening in South Africa on January 2, 2007. Making good on a pledge she had made to Nelson Mandela, and fulfilling a goal of her own to further a safe environment for African girls to get educated, Oprah's ultimate mission is to develop "a new generation of women leaders who, by virtue of their education and leadership, will lead the charge to positively transform themselves, their communities, and the larger world around them" (http://oprahwinfreyleadershipacademy.o-philanthropy.org). Beginning with just 7th and 8th grader, the free, residential Academy aims to grow by one grade each year until it reaches full capacity in 2011, with approximately 450 academically talented students from disadvantaged families or communities in grades 7 through 12. Starting off from $40 million, the non-profit encourages continuing contributions—$1,250 to support a student for an entire year to $10 for school supplies, with would-be "O Philanthropists" encouraged to make donations online.

Ever the role model, Oprah had an HIV test soon after the school opened, encouraging everyone else to follow.[15] One of the key underlying issues is making sure the girls stay in school, which is a continuing problem in Africa:

> The reasons are myriad. In urban areas, pregnancy and poverty limit educational access. In rural regions, poor families need girls to help in the fields. When a financially strapped family must chose between sending a son or daughter to school, cultural norms favor the boy. And across southern Africa, when relatives fall ill from AIDS, girls are the ones who stay home to give care.[16]

Despite some criticism that the award-winning talk show host/actress/philanthropist billed as "the most influential woman in the world" should have kept her money in the country, along with allegations of abuse at the school that she quickly dealt with personally, Oprah's dream soon expanded to a second school in South Africa. Seven Fountains Primary School, funded by Oprah's Angel Network, is an environmentally friendly institution positioned to be yet another model for public education.

Bowa Advancement of Girls Education Project

When the *Christian Science Monitor* ran an article in July, 2006 profiling a Malawian woman who could not afford to send her daughter to school—trying as she was to survive on a dollar a day, weekly spending 8 cents on tomatoes and saving $1.25. Readers responded (McLaughlin, 2006), sending in some $6,000, which was enough to sponsor six African girls to attend high school. Living together in a one-room, concrete-floored house that they rented for $20 a month, and spending about $7.50 per girl each week for food, "By Western standards their school is rudimentary. Only teachers have textbooks. And roughly 30 teens crowd into each of the small brick classrooms" (p. 12). Still, these scholarship recipients smile.[17] In an update a year later (Harman, 2007), the newspaper featured a front page beaming photo of Matilda Chakaka, the first girl from her village to complete high school.

Entertainment-Education (E-E)

> Advances have been achieved in planning, implementing, and evaluating E-E. Many of the advances sought and found have taken place in the context of the HIV/AIDS communication challenge...Both South Africa's *Soul City* as well as Nicaragua's *Puntos de Encuentro* were highlighted as best practices. Key achievements: (1) successfully broadening awareness of HIV/AIDS, (2) increasing knowledge of how HIV/AIDS is contracted, (3) placing HIV/AIDS in the context of human rights, (4) increasing knowledge and demand for effective services, and (5) mobilizing political support for national HIV/AIDS plans.
>
> Thomas Tufte, *Soap Operas and Sense-Making* (2004), p. 404.

Variously called edutainment (education and entertainment), infotainment (information and entertainment), and/or enter-education, Entertainment-Education (E-E) basically aims to teach in a pleasing manner. Whether by radio or television, movies or music, computer games or comics, newspapers or handouts, the main point is that it is compelling, it emanates from the grassroots level, it draws and keeps audiences and, in a word, it works. Under "Lessons Learned," David O. Poindexter (2004, pp. 35–36) lists the following:

1. If properly designed and implemented, the mass media can convey the essential information messages to help carry out a national development policy in population, HIV/AIDS control, female equality, and protection of the environment.
2. The goal of such a mass media E-E effort is to achieve widespread change in behaviors that lead to development in a nation.
3. To achieve such massive behavior change, a methodology that informs and motivates mainly by stimulating interpersonal communication among peers is needed.
4. The E-E methodology has been demonstrated to be effective.
5. Extensive research on the effects of dozens of E-E projects over the past 25 years established that this methodology is transferable and effective in achieving behavioral change.
6. An E-E project requires a basis in cultural values and must have a moral foundation in national and international documents.

Miguel Sabido has been called the "father of entertainment education," based on his work in 1970s Mexico on telenovelas (serial dramas)'s embedding pro-health messages for consumers. A self-described "hands-on communication theoretician" (Sabido, 2004, p. 61), he drew on the work of psychologist Albert Bandura's social behavior theories, Eric Bentley's dramatic theory, and Carl Jung's theory of archetypes. Social learning theory was also part of communication practitioners David Poindexter's work with Population Communications International and Everett M. Rogers' applications of his diffusion theory (1995). Soon, E-E's basic tenets were expanded also by persuasion theory and the theory of reasoned action; today, it thrives around the world (see Nariman, 1993; Singhal and Rogers, 1999; Singhal, Cody, Rogers, and Sabido, 2004; Vaughan et al., 2000; Widmark, 2002). Key characters in various episodes act as vicarious role models, demonstrating and talking about desirable behavior. Based on a tremendous

amount of formative research, many final products are disarming in that they seem so facile, but policy frameworks, value systems, and audience feedback are all part of the process.

Stories and storytelling are at the heart of entertainment-education, a classic element for both literate and illiterate populations (Fuller, 1998a; Slater, 2003; Tufte, 2006c). As people lean toward different role models, they begin to relate and critique various elements. Africans who know HIV/AIDS close-up can certainly relate to portrayals of people likewise affected. *Kids and Teens Concerns* (K&TC), a Nigerian NGO, has an adolescent program on behavior change, reproductive health, values, and HIV/AIDS called *Omo se suuru* (Be Patient, my friend), and *UgaBYTES*, an East African non-profit, encourages kids to tell their stories at telecentres.

In Africa, the model for entertainment education has been *Soul City*, the South African radio show that features messages and parables about AIDS prevention. Other examples can be found throughout this book, including *Takalani Sesame* and dozens of radio programs promoting family planning, voluntary testing and counseling, dealing with discrimination, abortion, AIDS. Clacherty and Kushlick (2004) found the formative and content research right on track relative to E-E in their analysis of *Takalani Sesame*; by constructing a comfortable participatory setting with culturally relevant edutainment, then observing the children's behavior, they saw individual growth in terms of social development. Also by way of example, *Yeken Kignit* (Looking over One's Daily Life) in Ethiopia dealt with environmental awareness, gender equity, and other HIV/AIDS-related issues; Voice of Kenya's televised *Tushauriane* (Let's Talk About It) and *Ushikwapo Shikamana* (If Assisted, Assist Yourself) on radio encouraged men to think about family size, land inheritance, and elder support—leading to a notable increase in contraceptive usage in the country. Radio Tanzania, with support from the United Nations Population Fund, had positive responses relative to family planning from *Twende na Wakati* ("Let's Go with the Times"), a four-year soap opera that played there in the mid-1990s, and Madagascar had similar results from its popular radio show.

In terms of edutainment for social change, the following are classic cases used in Africa: *Cinema Numerique Ambulant* (CAN) uses mobile cinema project vans traveling across Niger to talk about child brides, HIV/AIDS and malaria prevention, water and sanitation; *Dance4Life* is a South African non-profit providing a platform for young people to get involved in HIV/AIDS issues; *Eating Out Safely* is a radio show based in Zambia that discusses safe practices in food preparation, serving, and sales; *Forum Theatre in HIV/Education* is an interactive DVD developed by the Mozambican group Hopangalantana that deals with domestic violence, stigma, HIV testing, and sexual abuse; *How Long*, written and directed by Zimbabwean playwright Raisedon Bayathe, aims at discussions of homosexuality; *Just About Education* (JAE)[18] draws on the notion of celebrity, "Jae" being a pop star/role model AIDS activist; *Moving Walls*, an online photographic exhibition presented by the Open Society Institute, includes both Africa and AIDS; USAID-funded *Project Cinemobile* brings health education to rural Madagascar by means of mobile video; *Safe Journey*, featuring the musician Bhudaza, is a road show aimed at raising HIV/AIDS awareness among SeSotho-speaking migrants in Lesotho and South Africa, with songs expressing their experiences and touching upon their concerns.[19]

For our purposes, the key to entertainment education is that it is integral to communication for development; nonthreatening and nonbiased in approach, it

encourages viewers/listeners to distinguish between the good guys and the bad guys—and then to decide with whom they most relate.

Our own education about HIV/AIDS continues to twist and grow, as does our sense of what we can do about that knowledge. Barbara Browning (1998, p. 137) phrases it well: "If the AIDS pandemic might teach us anything, it is that xenophobia, racism, sexism, and homophobia all rest on a false assumption of the hermeticism of identity."

Notes

1. Nazliand, J. and Moodley, E. M. (2003). *Testing action media and Entertainment Education with autistic children*. Available: (http://www.comminit.com/en/node/57644).
2. For more about World Learning for International Development (WLID), see their Web site (www.worldlearning.org/ethiopia).
3. Talavera's book *Challenging the Namibian perception of sexuality* (2003) is subtitled *A case study of the Ovahimba and Ovaherero culturo-sexual models in Kunene North in an HIV/AIDS context*. This data comes from Namibia: Children seen as window of hope for HIV prevention (Inter Press Service, April 4, 2005).
4. For more on female dropout rates, see *Promoting girls' education through community participation: A case study in Kenya* (FAWE Best Practices Paper No. 1, 2001).
5. The Office of Women in Development, USAID, "Colloquium on Girls' Education: A Key Intervention Against HIV/AIDS and Its Effects?" was held in Washington, DC in October 2000.
6. Fatima Agnaou, *Gender, literacy, and empowerment in Morocco* (London: Routledge, 2004).
7. Pan Africa: 30 million girls out of school (*The Monitor* [Uganda], April 26, 2004).
8. For research on education for African girls, see: M. Adeyemi and A. Adeyinka, The principles and content of African traditional education. *Educational Philosophy and Theory*, Vol. 35, No. 4 (2003); E. Kane, *Girls' education in Africa: What do we know about strategies that work?* Africa Region Human Development Working Paper Series (Washington, DC: World Bank, 2004).
9. Somini Sengupta, African girls' route to school is still littered with obstacles (*New York Times*, December 14, 2003: YT 1, 18).
10. Chuka Odittach, For the girl child, too many hurdles (*This Day* [Nigeria], March 23, 2005). Some of the hurdles it cited included "poverty, lack of child friendly environments in schools, distance to schools, safe toilets, and clean water."
11. After examining teachers' roles in Botswana, Mozambique, Uganda, Tanzania, Zambia, and Zimbabwe, Nilsson (2003) determined that, according to the Education for All (EFA) process, teacher attrition is fast outstripping supply. HIV/AIDS of course is part of that problem.
12. UNICEF tasks northern governors on girl education, *Daily Trust* (July 31, 2003).
13. For example, see Ofeibea Quist-Arcton, Fighting prejudice and sexual harassment of girls in school (*News* [Uganda], June 12, 2003).
14. This is the last stanza of a poem titled "Not Ashamed, But So Ashamed."
15. Clare Nullis (2007), Oprah gets HIV test, hopes students will (*Associated Press*, January 7).
16. Stephanie Hanes, Oprah's academy: Why educating girls pays off more (*Christian Science Monitor*, January 5, 2007: pp. 1, 7).
17. If you would like to contribute to this endeavor, contact The Monitor Readers' Bowa Fund, Treasurer's Department, A10–01, The First Church of Christ, Scientist, 175 Huntington Avenue, Boston, MA 02115, USA. The update was by Danna Harman (2007), For Malawi girls, high school is only the first hurdle, (August 15, pp. 1, 4).

18. See Alan Finlay, *Employment of live mass information/entertainment in terms of broad principles of Entertainment Education* (Zimbabwe: Open Research, 2004).
19. For more on migrants' education, see: Brian Ramadiro and Salim Vally, *The education of rights refugees, asylum seekers and migrants in South Africa* (London: Witswatersrand University Press, 2005).

CHAPTER SEVEN

Communication Perspectives

> Communication has been neglected for too long in development projects, and still is. Even when development citizens and staff realize today that beneficiaries have to be involved, they fail to understand that without communication there can be no long-term dialogue with communities. The fact the development projects are mostly in the hands of economists and technicians impedes the understanding of social and cultural issues that are key to a communication strategy.
>
> Alfonso Gumucio Dagron,
> *Making Waves* (2001), p. 9.

You should be pleased to know that, after slogging through the depressing chapters on African women's vulnerabilities to HIV/AIDS in terms of bio-medical, socio-cultural, economic, legal/political, and educational vulnerabilities, it is time to learn about exciting prospects for dealing with these issues. In a word, that answer is communication—communication for development. I'm in good company in my optimism. For starters, it is encouraging to know of the work and words of Stephen Lewis, former UN special envoy for HIV/AIDS in Africa and now a scholar-in-residence at McMaster University, whose *Race against time: Searching for hope in AIDS-ravaged Africa* (2006) is now in its 2nd edition. In a March 28, 2006 talk before the Carnegie Council,[1] Lewis emphasized both the ethical underlining and human concerns that need addressing. His foundation (SLF) "helps to ease the pain of HIV/AIDS in Africa at the grassroots level. It provides care to women who are ill and struggling to survive; assists orphans and other AIDS affected children; supports heroic grandmothers who almost single-handedly care for their orphan grandchildren; and supports associations of people living with HIV/AIDS."

We who teach communications often find ourselves needing to explain what it means. My own definition includes interpersonal/intercultural communication, mass media (print, electronic, visual), and ICTs. As you have read to this point, the role of communication in our exploration of and understanding about African women and HIV/AIDS clearly encompasses this broad definition. Under the category of interpersonal communication comes the language (see Some, 1998; Foertsch, 2001; Pietila, 2006), or learning the importance of using terms such as substituting the notion of an AIDS sufferer or victim as

a "person living with HIV/AIDS" (PLWA). Barbara O. de Zaluondo (2001), director of the USAID-financed Synergy Project, has identified what she calls a "second generation of HIV/AIDS communication"—a growing paradigm whose sensitivity encourages moving from prevention and care concerns to changing attitudes along with behaviors. Media might be books, advertising, radio, television, movies, news reports, newspapers, magazines, newsletters, journals, art(s), Web pages, photographs, billboards, and any number of combinations herein. It can be private or public, governmental, organizational, or commercially owned and/or controlled, and media legislation and financing are particularly important in terms of gender and HIV/AIDS reporting (see Tapfumaneyi and Banda, 2004).

"The media in Black Africa are unique," Louise M. Bourgault (1995, p. 2) has noted. "In no other region of the world have the media been forced to endure change so rapidly. No other peoples have so quickly shifted from face-to-face communication to electronic communication without first passing through a stage of writing and literacy." What follows here are discussions of print media and "news," community radio, television and video, ICTs, gender/media organizations, campaigns, initiatives, and projects. Beginning with a general approach to media, you will read about African media organizations and efforts and then how HIV/AIDS is communicated—with some outstanding examples of development communication strategies already in place and hopes for action strategies in the future.

HIV/AIDS-Related African Media

African media, much of which had inherited infrastructures from colonial systems, has come a long way from a town crier, the village "gongman," even palace messengers to today's methods of informing and entertaining. To cite just a few for our purposes of dealing with HIV/AIDS, Zambia alone has had the popular *Z-Magazine* since 1962 as well as *Trendsetters*, a youth-run newspaper established in 1997 that provides sexual and reproductive health information, available through the Internet since 2000, the Swahili magazine *Si Mchezo !* ("No Joke") targets rural, out-of-school Tanzanians; and *Kwacha Kum'mawa*, a newspaper that has been written by teenage girls since 2002. *Thembi's AIDS Diary*, an audio documentary, follows a teenager for a year into her odyssey as a PLWA; broadcast on South African radio stations in 2007, it offers an insight into her innermost thoughts. *Positive Nation Nigeria* (www.nigeria-aids.org/eforum.cfm) is a monthly health magazine with research updates, community activities, articles, and encouragement for advocacy. Nigerian teens are both the team and the target of the newspaper *Straight Talk*, focusing on sexuality and reproductive health. *New African*, established in 1966, has a monthly circulation of about 28,000, and there are a number of medical journals such as *East African Medical Journal* (EAMJ)—dating to 1923, and the *Central Africa Journal of Medicine* (CAJM), since 1955. In 2004, at a meeting in Mangonchi, Malawi, the Southern African Editors Forum determined that, as it needed to play more of a role in the HIV/AIDS pandemic, it would promote an environment for that reportage and that it would look to its own media institutions.

African Media Resources on HIV/AIDS

We already know there are a number of noteworthy African gender/media organizations that deal with HIV/AIDS, as introduced here in Chapter 1. Some noteworthy African general media include the following:

- ***Africa Media Review***/Revue Africaine de Media is a collaboration between CODESRIA (Senegal) and the African Council for Communication Education (ACCE) in Nairobi.
- The African Community Radio Manager's Handbook (2005). AMARC.
- ***African Woman and Child Feature Service*** out of Nairobi has this vision of Africa: "A continent that understands and embraces media and gender as the cornerstone for development" (www.awcfs.org).
- ***African Women's Media Center Reporting on HIV/AIDS in Africa: A Manual***. (2002). Dakar, Senegal: AWMC—a result of their training 270 African women journalists.
- ***African Women's Media Center Reporting on HIV: A Resource Guide***. (2004). Dakar: AWMC—compiled by project manager Gifti Nadi of IWMF, this came out of AWMC's online training for female journalists.
- ***The African Media Development Initiative*** (AMDI), launched by the BBC World Service Trust in 2006, this project brings together African media practitioners and organizations. Its earliest Research Reports, based on findings from Angola, Botswana, Cameroon, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Mozambique, Nigeria, Senegal, Somalia, South Africa, Sierra Leone, Tanzania, Uganda, Zambia, and Zimbabwe, point to increasing diversity and challenges.
- ***The African Studies Companion: A Guide to Information Sources***. (2006), by Hans Zell Publishing, has a wide range of resources.
- ***Agenda*** journal is a South African feminist media project giving women a forum and a voice about gender relations.
- ***Association of Journalists Against AIDS in Tanzania*** (AJAAT) participates in training, has a website and newsletter, and works with Hope Productions.
- Helen Meintjes and Rachel Bray's "*But Where Are Our Moral Heroes*?" An Analysis of South African Press Reporting on Children Affected by HIV/AIDS (2006)—discourse analysis revealed "layer upon layer of moral messaging."
- ***Communicating Beyond AIDS Awareness*** (2006), by Warren Parker, Lynn Dalrymple, and Emma Durden, commissioned by the HIV/AIDS and STD Directorate of the Department of Health of South Africa.
- ***Confronting Corruption Source Book***, available in Albanian, English, French, and Spanish; to order: (http://www.transparency.org/sourcebook/index/html).
- Nguyen Vinh-Kim, Jennifer Klot, Alton Phillips, and Catherine Pirkle (2006). ***Culture, HIV and AIDS***. Paris: UNESCO.
- The ***Eastern Africa Media Institute*** started on January 27, 1997 in Mauritius, bringing together 14 countries.
- ***Fem'Mediafrique***, partnering with PRB, Panos West Africa, and ACI, works with print and broadcast journalists and policymakers from Burkina Faso, Cote d'Ivoire, Mali, Mauritania, and Senegal relative to women's health and political-economic issues.
- ***Gender and HIV***: *A Training Manual for Southern African Media and Communicators* (Made, Gerntholtz, and Morna, 2002), produced by Gender Links—useful for intensive training or self-study.

- Carolyn Green, Mandeep Dhaliwal, Sarah Lee, Vinh Kim Nguyen, Hillary Curtis, and Georgina Stock (2003). ***Handbook on Access to HIV/ADS-related Treatment***. UNAIDS, WHO, and the International HIV/AIDS Alliance.
- ***HIV/AIDS: A Resource for Journalists***. (2002), by Soul City, SANEF, Health-e, and the South African Department of Health.
- University of Witwatersrand's HIV/AIDS and the Media Project produces ***Journ-AIDS*,** a website for journalists reporting on health issues.
- Based in Dakar, Senegal, the 30-member organizations of the African region of the ***International Federation of Journalists*** (IFJ) focuses on "the development of independent and quality journalism in support of democratic, social and economic development" (www.ifj.org).
- ***Journalists for Human Rights*** (JHR), a Canadian NGO, has offered training and online information since 2002.
- ***Live From Africa: A Handbook for African Radio Journalists*** (2007), by Ivor Gaber, Brian Barber and Fiona Ledger, has hands-on standards.
- MEASURE Communications has produced ***Media Coverage of Women and HIV/AIDS*** (2001), available at (http://www.prb.org/pdf/CC_AIDS_BW.pdf). Global in scope, including Ghana and Kenya for Africa, it has helpful sections on women's vulnerability to HIV/AIDS, mother-to-child transmission of HIV, girls and female migrants, and also reportage from Costa Rica, India, Nepal, the Philippines, and Romania.
- The ***Media Foundation for West Africa*** (MFWA), an Accra-based NGO, has focused, since 1997, on media rights and freedom of expression.
- ***Media Handbook on HIV/AIDS*** (2003), published by Journalists Against AIDS Nigeria (JAAIDS), contains facts, myths, ethical issues, a practical guide to reporting HIV/AIDS, and a good glossary.
- The Panos Institute's ***Reporting AIDS****: An Analysis of Media Environments in Southern Africa* (2005)—based on research in Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, this report points out how the media environment in Africa is experiencing change due to these trends: (1) Major liberalization and opening up of the media sector, (2) The emergence of a wider variety of print and broadcast media houses, and (3) New technologies, like the Internet and mobile telecommunications.
- William Bird, Rachel Bray, Gemma Harries, Helen Meintjes, Jo Monson, and Natalie Ridgard (2006)'s ***Reporting on Children in the Context of HIV/AIDS****: A Journalist's Resource*, produced by the Children's Institute, the Centre for Social Science Research, the Media Monitoring Project, and the HIV/AIDS and the Media Project.
- The ***Southern African Media and Gender Institute*** (SAMGI), formerly the Women's Media Watch, was established in 2003 with the purpose of creating a bias- and discrimination-free media system.
- ***Uganda Media Women's Association*** (UMWA) has aimed at capacity building, sharing and disseminating information for development since 1983.
- ***Watchdog's Guide to Investigative Reporting*** (2005), published by Konrad-Adenauer-Stiftung (KAS), offers advice on legal and media resources, much like how the Friedrich-Ebert Stifting Media Project Southern Africa has *Tool Boxes* on media law, broadcasting regulation, public broadcasting, and access to information and the Fraunhofer Institute for Media Communication has developed the *Kim Possible* interactive children's television show.
- ***What's News****: Perspectives on HIV/AIDS in the South African Media* (2002), by Joanne Stein, includes the advocacy of the media vis-à-vis HIV/AIDS reportage, perceptions of its coverage, representations of PLWHA, constraints to improved coverage, and potential interventions for improving HIV/AIDS coverage.

African HIV/AIDS Campaigns

Beyond scientific/medical efforts, Africa's approach to HIV/AIDS has typically depended on word of mouth and available media. For example, check out the clever billboard statements on appendix VII. Joy Kitsnasamy and Jan Jordaan's (2004) evaluation of the *Break the Silence* billboard campaign, carried out by Art for Humanity (AfH), found a nearly 76% positive response. Based on an All Media Products Survey (AMPS), Parker et al. (2002)'s *Commuter AIDS Information Project* left leaflets, referral information, and condoms at convenient kiosks in South Africa. PSI developed a mass media campaign called *Delayed Debut* in Zimbabwe to encourage postponing sexual activity, and HSRC's *Fatherhood Project* in Durban, South Africa was also targeted toward getting men involved in decision-making the repercussions of sexual activity. The *Love Life Caravan*, part of the HIV/AIDS Abidjan-Lagos Corridor Project aimed at transporters, travelers, commercial sex workers and such, combined live pop concerts with theatre and dance extravaganzas to draw attention; coordinated with World AIDS Day 2006, it was expected to reach some 100 million Africans. It is not to be confused with the *LoveLife* campaign initiated in 1999 in South Africa that aimed to halve HIV in 15 to 20 year olds by promoting condoms; amongst other methods, it incorporated telephone help lines.

In her analysis of HIV/AIDS media campaigns in the U.S., Julia Davis (2006) found five distinct periods: (1) 1981–1985: a new treat and activist response; (2) 1986–1989: the HIVB/AIDS PSA is born; (3) 1990–1995: reaching communities at risk; (4) 1996–2000: HAART (highly active anti-retroviral therapy) brings hope, but is AIDS over?; and (5) 2001–2006: global AIDS. While the continent has hardly had the luxury of extravagant campaigns, by now you no doubt are familiar with some from Soul City, Sesame Workshop, and the Center for Communication Programs, Bloomberg School of Public Health at Johns Hopkins University. Some especially successful HIV/AIDS campaigns in Africa have included *To Give Life and Live*, a reproductive health campaign held in Cote d'Ivoire aimed at HIV/AIDS among women, maternal mortality rates, early and unwanted pregnancies, prevention of mother-to-child HIV transmission, and the value of networking. *Take Control*, part of Namibia's National Strategic Plan on HIV/AIDS, used print and broadcast media—along with posters, coasters, red ribbons, T-shirts, and such, to demonstrate role-model specific HIV prevention behaviors and other strategies aimed at young people; with wide partnerships, the program premiered with a recognition of generating interpersonal communication for risk-reduction practices. Zambia's *Helping Each Other Act Responsibly Together* (HEART) used television spots, posters, messages on busses, music videos and more in its promotion of condom efficacy, and Chipawo, a Zimbabwean organization using arts education for development, works with children from the age of four in song, dance, music, theatre, video and television.

African Community Media and Collaborations

Community media has served as an alternative voice in numerous ways (see Aldridge, 2003; Ansu-Kwereh, 2006). Kenya Community Media Network (KCOMNET), a national network of individuals, media organizations and professionals, and NGOs, communicates through radio listening groups and shows,

street theatre, community newspapers and newsletters, songs and poetry, live musical bands, telecentres, and community video, and the Mathere Youth Sports Association (MYSA) is organized through art groups known as *vikundi*. The BBC World Service Trust has helped sponsor public service announcements (PSAs) combating the spread of HIV/AIDS in Africa, using English, French, Portuguese, Hausa, Swahili, Somali, Kinyarwanda/Kirundi, and whatever other languages target populations use. Its 2006 study *African media development initiative* recognized that, "The picture is of a sector undergoing significant growth and transformation due to democratic reform and globalization," (p. 13). PSAs have also been effective as mini-dramas on the dangers of HIV/AIDS and its transmission, such as those produced by the Football Association of Zambia (FAZ) and the Zambia Family Planning Services Project (ZFPSP), performed during intermission of league matches. Folk media—storytelling, puppetry, proverbs, visual art, drama, role-play, concerts, gong beating, dirges, songs, drumming, dancing, and such are also used for African behavior change communication (see Panford et al., 2001; Theuri, 2004).

"Four decades of independence in Africa have certainly changed life across the continent but many things remain the same and the situation in some countries even seems to have deteriorated—rural mud huts and urban slums, fatalistic resignation, widespread famines, helplessness before curable and easily preventable diseases, endemic poverty," Nguri and Kimani (2005, p. 2) have noted. Yet, they see hope in the participatory process,[2] citing the example of Radio Mangelete in Kenya, a women's community project focusing on nutrition and HIV/AIDS, we see how broadcasting can work against many kinds of "interference." Kingo Mchombu (2002) of the Department of Information and Communication Studies at the University of Namibia sees the solution to the AIDS pandemic within the social sciences, urging usage of Africa's library and information centers.

Along with the mix of choices, agencies, and individuals using media in HIV/AIDS campaigns and programs, some depend on multimedia—and, as Bertrand and Anhang (2006) have found, the most comprehensive programs are most valuable for influencing HIV-related outcomes among youth. *Alertos Da Vida*, a Portuguese-language participatory media mix of young people of Mozambican heritage living in South Africa, for example, combine live theatre with radio and music; some of their projects have included *Tenho dos Factos Antes de Ir* ("Get the facts before you go"), on human trafficking awareness, and *45 Minutos Para Alertar* ("45 minutes to alert"), on safe sex and condom use. USAID's *Vision* project for family planning and reproductive health (FP/RH), HIV/AIDS, and child survival services in Nigeria included radio dramas and discussion clubs, print material, and sports outreach, results showing people with high program exposure being one and one-half times more likely to have discussed HIV/AIDS with a partner (Keating, Meekers, and Adewuyi, 2006). The *Trusted Partner Campaign* for safe sex by PSI in East and southern Africa complements radio and television with posters, billboards, flyers, and discussion guides, although its project for behavior change in Malawi, *Pakachere*, depended on print and broadcast media. Egypt's *Communication for Healthy Living* (CHL) combines radio and television spots with edutainment show formats, press inserts, media contests, and media coverage of special events. *Heartlines Media Project* in South Africa, which addresses HIV/AIDS but also prejudice, parenting, poverty, forgiveness and reconciliation, depends on multimedia of radio, television, storybooks, and print media, while Newkom and Asford (2003) report how social marketing

was helpful toward changing youth behavior in Cameroon, Madagascar, and Rwanda. As I have argued elsewhere (Fuller, 2007a, p. 7), "At the heart of interest in community media are lessons learned and models for success that might help us progress from theoretical to practical applications."

African HIV/AIDS-Related Print Media

There have also been some outstanding media-related African publications dealing with HIV/AIDS. One of the earliest was by veteran reporter Ed Hooper (1990), who got to know AIDS first hand in East Africa. Going to Uganda in 1981, he soon heard about a mysterious epidemic, known locally as "Slim" because that is how its victims grew to look. Although at first the government was interested in his evidence, when he wrote of their inefficiencies they expelled him—but by then his own promiscuous affairs had caught up with him. In the ultimate irony, there are hundreds of book about Africa and HIV/AIDS, but the population is predominantly illiterate. Still, Strategies For Hope (SFH) has produced a number of books about HIV, including *A Common Cause* (1997—about young people, sexuality and HIV/AIDS in Nigeria, Botswana, and Tanzania); *Under the Mupundu Tree* (1999)—volunteers in home care for people with HIV/AIDS and TB in Zambia's Copperbelt; *Open Secret* (2000)—how people in Uganda have faced up to HIV/AIDS; *Journeys of Faith* (2002)—church-based responses to HIV/AIDS in Mozambique, Namibia, and South Africa; and *United Against* (2007)—the Story of TASO, the AIDS Support Organization in Uganda. SHF's (www.stratshope.org) series, the *Called to Care* toolkit for church leaders, has included *Positive Voices* (2005)—religious leaders (12 Christians and 2 Muslims living with, or affected by, HIV/AIDS), *Making it Happen* (2005), a guide for congregations to do HIV/AIDS work, and *Time to Talk* (2007)—family life in the age of AIDS.

Other books of interest include Tapfumaneyi and Banda's *Lessons for today and tomorrow: An analysis of HIV/AIDS reporting in Southern Africa* (2004). Soul City Institute for Health and Development Communication includes a print component to compliment its outstanding television series, booklets such as *Living Positively* and *Disability Rights are Human Rights* being available through national newspapers or another half a million available on request to schools, clinics, and organizations. The *Ten Million Hero Book Project* (10MhbP), which encourages the child-owner to be author, editor, illustrator, and main character in his/her book; it aims to reach ten million South African kids by 2010. Sales from Lutanga Shaba's novel *Secrets of a Woman's Soul* (2004), about a Zimbabwean woman forced to have sex to earn money for her daughter's education and soon finding out she has contracted HIV, are part of a scholarship fund for young female orphans, just as Kwele Books' *Nobody Ever Said AIDS: Poems and Stories from Southern Africa*, a 2004 anthology with writers from Botswana, Lesotho, Malawi, South Africa, Zambia, and Zimbabwe, allows real voices to be aired. ABC Ulwazi and the Foundation for Human Rights have established *Women's Rights Programmes* in South Africa to address issues of abuse and domestic violence, taking English programs like *Fight Against the Fist* and *Talking Man, Talking Woman* and translated them into Afrikaans, Sotho, Tswana, Xhosa, and Zulu—reminding us how important it is to consider the many languages that need to be factored in for HIV/AIDS messages in Africa.

Print Media and "News"

> The media provide spaces in which social, political and cultural issues are presented, debated and discussed. They play a significant role in determining which issues will be considered important and legitimate in a society and how they will be defined and discussed. The media do not simply disseminate particular messages to passive audiences. Instead, both through news and entertainment, they produce and disseminate many of the resources—information, ideas, ways of thinking, assumptions, frameworks, beliefs, values, narratives—which we actively and continuously use to understand and think about the world, others, our relationships and ourselves.
>
> Media resources shape our understandings, which guide our individual actions and activities, and also influence collective decision-making processes and policy formation in the public and political spheres. Thus, the media can play a role in bringing about social changes.
>
> Kafiris et al., *Gender and Media Handbook* (2005), p. 8.

Reviewing news highlights from Zimbabwe this last year in "The good, the bad and the ugly in 2007," Wongai Zhangazha (2007) wrote in the Harare-based *The Herald* about controversy dominating celebrity circles. Although the players may not be familiar to us, it is almost amusing to consider how the newspaper titillated readers with "publicized issues ranging from suspected under-age pregnancies, attempted suicides, brawls, divorces to ugly spates" (p. 1). For example, one of their Star Kids (Makanaka Wakatama), who had supposedly gone to the United States to study and work at CBS, instead is now a teenage parent—and a second wife of a businessman; a pastor (Admire Kasingakori) and a gospel musician (Ivy Kombo) publicly confirmed their relationship; another pastor/gospel musician (Lawrence Mujeye Haisa) defied both custom and traditional law by marrying his sister's daughter; the former Miss Zimbabwe had a child out of wedlock and several Miss Rural Zimbabwe contestants claimed abused by men in several shows; musician/faith healer Pharaoh Mujengwa's eighth wife accused him of abuse; actor/Rhythm Unlimited presenter Jerome Gailao was at the center of a quadrangle relationship with his live-in and two married women; and an unnamed "respectable member of a certain church"—a Sugar Daddy had a spat with a student at the University of Zimbabwe and soon found his car burnt. With tidbits like this, who needs the soaps?

Comics and Cartoons

> African comic art comes in a variety of styles, languages, and formats, with the usual (and an occasional unusual) objectives and uses. There are the Arabic-language, Islamic-oriented comic books of North Africa, United States-influenced, superhero comics such as *Powerman* in Nigeria, the Afrikaans-language, underground style comic book *Bitterkomix* in South Africa, and developmental comics in many countries. Strips in daily newspapers and magazines range widely, from the moralistic, with ideological and developmental concerns; to social commentary, with satiric and parodic elements; to humor for humor's sake, often with dregs-of-society type characters.
>
> John A. Lent, The Richness of African Cartooning (2006b), p. 71.

Mostly based on the Behavior Change Communication (BCC) model, researchers have found that animation, cartoons, comics, graphic novels, and the like are invaluable teaching tools for HIV/AIDS information, prevention, and care. UNESCO'S *Africa Animated!* Draws on the oral tradition of storytelling in training Kenyan, Tanzanian, and Ugandan youth to produce their own cartoons, just as *Badilika Uishi* , sponsored by the Global Fund for AIDS, Malaria and TB, dwells on four Kenyan teens who discuss life decisions under what is known as the Participatory Interactive Media Model (PIMM) and Kenya's *Nuru Comic Project* targets school kids with cliff-hangers about how the daughter of a trucker deals with delaying sex, HIV counseling and testing, economic hardships, and much more. Ethiopian armed forces are the topic and target of the *Black Tigers* 26-issue series, in Amharic, aimed at preventing HIV transmission. *Hai Ti!* (Listen Up! in Oshiwambo) is a Namibian comic intended to encourage students and teachers alike to understand and enjoy the computer age; *The Journey*, featuring Mozambican migrant workers, aims to dispel discrimination against them; *eKasi* comics in South Africa deal with a range of topics, but of the 24 in the series about heroine Thandi the one with her confession about being raped by an uncle who infected her with HIV was riveting.

The deaf community is asked *Are Your Rights Respected?* in deaf artist Tommy Motswasi's comic book that takes place at a school for the hearing-impaired in South Africa as part of outreach education; using images more than words to spell out the storylines, it addresses a community of some half-a-million people. For those of us dedicated to helping the disabled, it is also encouraging to know that Sesame Workshop has recently produced a DVD for military personnel and their families about dealing with injuries from war. And although they are clearly not disabled, it is also uplifting to know about a comic called *Eyes Wide Open*, dealing with real-life experiences of lesbian, gay, bisexual, transgender, and intersex (LGBTI) youngsters in South Africa.

One of my favorite comic books is one published in 2006 by UNHCR called *HIV and AIDS: Human Rights for Everyone*, subtitled "A welcoming and discrimination-free environment for refugees and returnees," which not only has authentically appealing characters but also a poignant story about a boy named Fatou whose father seems to be infected so the other kids don't want to play with him; it's an ideal scenario for teaching about stigma when an elder intercedes, saying "All people deserve respect and love regardless if they are sick or not. You cannot get HIV or AIDS simply by playing together." Another one of their comics, produced in conjunction with Role Back Xenophobia, is *Reach Out Speak Out!* which has high-schooler Aphonse of Angola combating stereotyping when he first comes to South Africa, then everyone learning tolerance.

When, in 2007, the first-ever exhibit of African comic art was displayed at the Studio Museum in Harlem (New York), showcasing artists from Angola, Benin, Central African Republic, Cameroon, Democratic Republic of Congo, Cote d'Ivoire, Equatorial Guinea, Eritrea, Gabon, Kenya, Madagascar, Mali, Mozambique, Nigeria, Republic of Congo, Rwanda, Senegal, South Africa, Tanzania, and Toga, it soon became clear that, "Far more often than not, humor is a sugar-coating for disquiet" (Cotter, 2006, p. B40). Nowhere is that more obvious, of course, than when they deal with HIV/AIDS (see Obonyo, 2004). Jigal Beez (2006) has pointed out how the Tanzanian cartoon *Kingo* included an ad for a condom with a "bulky soccer player with a smile, while he is being attacked by players of three other teams and still retains ball possession" (p. 121),

the accompanying metaphorical comment being *Hakuna ya kunipenya* ("There is no way getting past me"). Condoms and safe sex are also at the heart of the cartoon Three Amigos—they are funny, and are our friends.

African Art(s)

Art(s)-wise, we might date our realization about the potency of symbols in this HIV/AIDS era to the 1987 poster with a pink triangle above SILENCE=DEATH, followed soon thereafter by red ribbons, the AIDS quilt, Keith Haring's safe-sex doodles, *Amazwi Abesifazane* ("Voices of Women," the South African memory cloths), movies like Larry Kramer's *The Normal Heart* (1985) or Tom Hanks's winning an Academy Award for *Philadelphia* (1993), Broadway bringing us the still-running *Rent*, plus Tony Kushner's *Angels in America* (1993), television opening new worlds with *An Early Frost* (1985), and any number of other media activities that encouraged advocacy (see Fuller, 1995). In Africa, as elsewhere, artists can be authors, painters, singers, dancers, musicians, actors, filmmakers, fashion designers, poets, writers, playwrights, and/or multimedia artists.[3]

For starters, do not dismiss the communication that can come through murals, such as are documented in CADRE's *Beyond Awareness* Campaign that tells of AIDS murals in South Africa, or the *Book Café Academy of Performing Artists* (BOCAPA) in Zimbabwe that, since 1997, has had Open Mic night, roundtable discussions, "Be True" edutainment materials, and more. Agenda for Community Development (AFCODE) has sponsored *Painting for Development in Nigeria*, involving teens and adolescents in addressing drug abuse, HIV/AIDS awareness, and prevention of nonviolence. *Positive Women*'s Access to Care and Treatment Theatre Campaign there has raised awareness about gender discrimination. *Chipawo* is a Zimbabwean organization using arts education for development and employment, much like the *Art and Media Access Centre* (AMAC) in Cape Town, *Ikhwezi Youth Theatre* in the Western Cape, and *Talented Youth Theatre* (TYT) in Ghana. The *Girl Child Art Foundation* (GCAF) in Nigeria promotes health by encouraging participation in activities and using creative abilities, just as Arts for Global Development, Inc.'s *TreasurePostcards Project* has contests highlighting art as a communication approach for raising HIV/AIDS awareness. The *Hope Ambassador Doll Art Project*, dealing with Botswanians infected/affected with HIV/AIDS and facing obstacles such as isolation, stigmatization and discrimination, thinks of art therapy to educe anxiety and stress.

Dramatizing HIV/AIDS in Africa[4]

Joy Morrison (2003), a South Africa native now teaching journalism in Alaska, worries about western "experts" who construct top-down social development projects when, she argues, they are mostly intended for urban Africans; if rural residents are to be reached, and if we don't want an urban-rural divide, she argues, theatre offers an ideal medium. Theatre and drama of course play significant roles in terms of expressing religious, ritualistic, and social practices. For example, *Swaziland Theatre for Children and Young People* (SWATCYP)'s "Be Seen, Be Heard, Be HIV-free" project has been a powerful educational tool (Matsebula, 2007); *Atelier-Theatre Burkinabe* (ATB) in Burkina Faso uses theatre

to educate, entertain, and sensitize; the National Union of Eritrean Youth and Students have performed publicly to promote debate about FGM (Musa, 2005); and Kenya's *Amani Peoples Theatre* (APT) is interactive, participatory. So too is the women artists collective Mothertongue's *Laphum'Ilanga Theatre Project* in South Africa, on violence like rape relative to HIV, as well as Shoestring Theatre's *DramaBea*t and the *Interactive Themba Theatre HIV/AIDS Project* there, incorporating interactive drumming to bond the audience. *Hecate*, an industrial theatre company based in Johannesburg, specializes in producing and performing message-based interactive corporate theatre or infotainment. These productions are mainly related to HIV/AIDS education and human resource issues and can be generic productions or productions specifically tailored to a specific company. Barbaig groups in northern Tanzania also aim for two-way communication (Hatar, 2004). African performance, Bourgault (2003) is convinced, has a great deal to tell us about social indicators ranging from economy to AIDS to geography and climate.

Tanzania's *Tuseme Project* is school-based, Lesotho's *Winter/Summer Institute in Theatre for Development* (WSI) a university collaboration addressing gossip and silence in the country's staggering spread of HIV/AIDS, and since 1987 South Africa's *arepp: Theatre for Life* has been traveling to schools to dramatize sexuality, self-concept, self-image, and self-esteem. Students in Rwanda have organized human rights competitions on GBV, girl-child education, torture, and trauma in secondary schools across the country (Majyambere, 2006).

Zimbabwe's *Amakhosi Theatre for Social Change* involves rural community members in the HIV/AIDS fight, taking the message to some 80,000 people. Committed to accessible, relevant methods, *One Love HIV/AIDS Awareness Theatre* of Ethiopia uses circus performances that have been appreciated by thousands of audience members. *MADaboutART* emphasizes skills and knowledge about HIV/AIDS for young South Africans, just as the Forgotten Angle Theatre Collaborative (FATC)'s *Anti-Retroviral Theatre* (ART) probes social issues surrounding HIV/AIDS; Senegal's *Kaani-Gui* troupe does dance and theatre so well for AIDS awareness that a documentary (*Funu-Jem*, which means "Where do we go from here?") has been made about them; and Ghana's *Sankofa Center for African Dance and Culture* (SCADC) aims to foster health education among young people. Mohammed K. Yahaya has written a play about polygamy (*Ignorance Is a Disease*, 2004b) that addresses development issues of public health.

In 2006, the Southern African Development Community (SADC)[5] was formed to build capacity for HIV/AIDS education, and *Drama for Life* was one of its earliest projects; to date, outputs have included training, productions, and manuals. PATH's *Magnet Theatre* troupe involves East African audiences into considering consequences from risky behavior and early marriage; *Reseau Arts Vivants* (RAV) of Niger promotes performing arts in communication for development; *ActALIVE* is an arts coalition with members in Burundi, Cameroon, the Democratic Republic of Congo, Ghana, Kenya, Malawi, Mozambique, Nigeria, Republic of Congo, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. *Khuluma Afrika* ("Speak Africa") is a community theatre project to raise awareness about human trafficking and migration for Mozambicans—so the stories are told in Portuguese, Shangaan, English, and isiZulu. The Southern African Counter-Trafficking Assistance Programme (SACTAP) uses radio PSAs to spread awareness about human trafficking. Established in 2005 as part of the

South African *16 Days of Activism on Violence Against Women and Children* campaign, it has been highly successful in Mozambique.

Many of these theatre project use Entertainment-Education (E-E), discussed in chapter 6, on education, at their base. Drawing on theories of participatory communication theory, Paulo Freire, and Augusto Boal's forum theatre methodology, Durden and Nduhura (2003) show how E-E is used in development communication; and Gerritt Maritz (2004) shows its applicability for the South African mining sector. Encouraging peoples' participation in decision-making, with a verbal, horizontal communication flow, ideas are shared (Mefalopulos, 2003).

Puppetry, one of the oldest and most popular of the performing arts, is often presented as a classic case for how health and development messages can be combined—yet another important application of E-E.[6] Especially effective for embarrassing, sensitive, and/or taboo topics, puppetry as visual representation can appeal to a wide range of ages, persuasions, and (il)literacy levels and can serve symbolically as symbols of deceptively basic messages. The only problem, researchers realize, is that sometimes their easy entertainment style might turn off critics trying to find more to the metaphor. *The Puppet Has a Cough*, part of Ethiopia's Medical Missionaries of Mary (MMM), aimed to educate about counseling and services for HIV/AIDS, the idea being that a someone needs to help the coughing puppet while the inter-active audience wonders who and how. *Talking Hands* in South Africa uses puppet theatre for awareness issues; *Community Health and Awareness Puppeteers* (CHAPS) in Kenya has a network of more than 350 puppeteers; Namibia's Puppet Power Team works with the Red Cross in spreading HIV/AIDS awareness.

Music, Song, and Dance

My initial introduction to real African music came from my Wolof teacher, Rudy Gomis, who was one of the original members of Orchestra Baobab, a group dating to 1970 Dakar that has had an influence on other musicians such as Youssou N'Dour, now a UNICEF goodwill ambassador. Although African music is worthy of a book all its own, it is nevertheless important to note that most artists have, such as Corneille of Rwanda, Salif Keta of Mali, Cheb Mami of Algeria, Koffi Olomide of the Democratic Republic of Congo, Mahmoud Ahmed of Ethiopia, Baaba Maal of Senegal, Angelique Kidjo of Benin, Chiwoniso of Zimbabwe, Joaojoby Eusebe of Madagascar, and many others, joined in events such as *Africa Live* to raise money for various health benefits. John Lwanda (2003), who did his doctoral dissertation on popular discourse in Malawi, argues against Western, colonial and postcolonial models that fail to examine musical and oral public spheres in the fight against HIV/AIDS. In a response to a Pulse Poll from *Drum Beat* on whether or not popular music helps to stigmatize people living with HIV and AIDS, Tawanda Chisango (2004) responded that exactly because music is so universal, songs "should deliver quality information that is not only correct but is sensitive to people living with HIV and AIDS and respects and recognizes the inalienable human rights that they are entitled"; in Zimbabwe, for example, most of the music has dwelt on fatalism and fear appeals—getting the scourge from promiscuous behavior, how painful it is to know you are infected, how a baby in an infected mother's womb won't survive, about people on their deathbeds, AIDS as divine punishment from God.

By the same token, just as ethnomusicologist Gregory F. Barz has worked with women's groups in Uganda to educate about HIV/AIDS,[7] Mohammed K. Yahaya (2004a) has combined drama with folk music as outreach in Niger State of Nigeria, and a number of collaborations for songs and CDs by African artists have been released, such as *Leve-toi, Afrique!* ("Wake Up, Africa") by Artistes Contre Le Sida (ACS) for youth in Burkina Faso, Cameroon, Cote d'Ivoire, and Togo (2005), the Ethiopian *We Shall Survive: A Music for Life Project* (2006), Nigerian Afro-rock star Femi Kuti and his *Positive Force Band*, and *Rage for the Revolution*, part of the *Red for Life* music-based AIDS awareness/advocacy campaign in South Africa. The *Safe Journey* campaign was a 2005 musical road show to raise awareness about HIV/AIDS in migrant communities in Lesotho and the Free State province of South Africa, just as *Caravan of Hope* (2004) moved through Mauritania raising AIDS awareness; speaking from life experiences rather than lecturing, *Qoleng Ea Kobo* deals with prevention and awareness, *Tlala Ea Bosiu* is about loneliness, and *Koatsi* about family responsibility. Meulenberg and Gesthuizen (2004) have documented how rap is a viable alternative for youth in Tanzania and Zanzibar in *Hali Halisi*, Swahili for "the real situation."

"Dance in Africa is not a separate art but a part of the whole complex of living," Leonard Mamalia Mjomba (2003, p. 3) has written. "Unlike many dances of the west, African dance is not detached from the lives of the people but is a spontaneous emanation from the people. It translates everyday life experiences into movement. Based upon the spoken language, African dance is a source of communication through which it is possible to demonstrate emotions, beliefs, everyday life activities and other reactions through movement." Stating that non-Africans often associate it with juju, voodoo, and ritualism (so, by association, savage, licentious, heathenistic), Mjomba instead encourages its study and use as a means of communication for social change, much as Malian *griots* have been used as significant storytellers to embed educational messages. UNICEF Mozambique has had transformative success choreographing kids from a local orphanage, Alexia Lewnes (2006) reporting one barrier broken when a young boy dancer declared, "You don't get AIDS when you hug, dance, play sports, or shake hands."

Radio in Africa—Grassroots, Community

> Their transmitters may reach only a few miles, but community radio stations are enabling isolated communities across Africa to voice their own concerns. On air, ordinary citizens discuss issues that are central to them, such as gender relations and combating HIV/IADS. They share farming tips and income generation ideas and explore ways to improve education.
>
> Itai Madamombe, Community Radio: A Voice for the Poor (2005).

State broadcasting ruled most of Africa until around 1985, when social, economic, and political change was such that a number of community radio stations opened up around the continent and, while locally oriented, have since acted as yet one more implication of globalization (Ansu-Kyeremeh, 2007). Encouraging access to media (Fuller, 2007[8]), allowing citizens voice in their homelands,

the phenomenon of citizen journalism has been helpful in areas ranging from offering agricultural information to development to empowering women. In terms of the opening quotation about radio, think of the African Farm Radio Research Initiative (AFRRI), a collaboration between Developing Countries Farm Radio Network (DCFRN) and World University Service of Canada (WUSC), funded by Bill Gates, for Ghana, Mali, Malawi, Uganda, and Tanzania to share ideas interactively. The Health and Agriculture Community Radio Network uses cassettes exchanged between HIV/AIDS-affected households.

Variously called "Africa's Internet," or a linkage between producers and the public, radio's role in democratization and its concomitant place as an educator about HIV/AIDS cannot be underestimated. Further, it has been found to have financial sustainability, as determined by The Southern African Institute for Media Entrepreneurship Development (SAIMED). There are a number of print publications relative to radio in Africa, a goodly amount dealing with HIV/AIDS (Adam and Harford, 2003; Bathily, 2004; *Brief report*, 2003; Buckley, 2005; Fairburn, 1999; Gaber, Barber, and Ledger, 2006; Ishmael-Perkins and Cassidy, 2002; Jennings, 2005; Kessler and Faye, 2006; Kruger, 2006; Manyozo, 2005; Metcalf, Harford, and Myers, 2007; Mtimde, Bonin, Maphiri, and Nyamaku, 2005; Nguri and Kimani, 2005; van Zyl, 2005).

In terms of what is called Development Through Radio (DTR), we know that community media is critical—solving issues of isolation, lack of access to technology, illiteracy, and opportunities for training, learning, and self-expression. Mercy Wambui (2005) has reported on such a case study from Sierra Leone, where women got a chance to voice opinions on the country's Truth and Reconciliation Commission process.

Just as Alan O'Connor (2006) has made a case for considering the role of anthropology in radio studies, Mike Hickcox (2006, p. 1) recognizes the role of communication as a powerful tool, a "precious resource in a land where phone lines don't exist and no one delivers letters." As director of audio and radio ministries at United Methodist Communications, concerned about so many African deaths due to HIV/AIDS, he visited radio stations in South Africa, Uganda, and Kenya and concluded the following:

- Radio reaches people wherever they live, in both urban shantytowns and in rural villages.
- Radio communicates with everyone, even those who cannot read.
- Radio needs to communicate in many languages, including the local colonial language (English, French, and Portuguese), Kiswahili and local languages.
- Community radio needs to empower and use the collective power of women's groups in the region.
- Radio is an excellent way to deliver accurate information on health care, and it helps to counter much of the misinformation commonly distributed in conversation.
- Community radio in Africa needs money to maintain equipment and facilities, pay a few staff members, and purchase fuel to operate studios and transmitters when the power system fails (p. 2).

Soul Beat (soulbeat@comminit.com) supplies regular supplements relative to communication radio in Africa: programs, publications, awards, training opportunities, evaluation and research results, and more. Whether offering guidance on media initiatives, ways for fighting poverty from the bottom up, journalistic

practices, promoting free expression and media freedom, and, what concerns me most—encouraging access to and reportage of accurate HIV/AIDS information. Over the years, *Soul Beat* has reported on such promising events as an investigative training session for journalists by Transparency International (TI) Uganda or how Radio Apac in northern Uganda helps educate and sensitize listeners about HIV/AIDS; how Radio Maendeleo (RM) and *Radio Ndeke Luka*, both of the Democratic Republic of the Congo, have been integral in pushing a regional peace process; South Africa's 24-hour community-owned Qwa-Qwa Radio whose slogan *Lestswe la Hao* stands for "Your Voice"; or Bright Phiri's study of Catholic-run Radio Icengelo in Zambia for social marketing. Soul City Institute for Health and Development Communication (www.soulcity.org.za), headquartered in South Africa, aims at multi-media health promotion and social change. Since its inception in 1992, its entertainment schemes reportedly reach more than 16 million citizens by means of Soul City, which targets adults and, since 2000, Soul Buddyz, targeting 8 to 12 year olds and adults. In addition, the institute's Regional Program, a partnership with local organizations, broadcasts in much of Africa, Latin America, the Caribbean, and Southeast Asia. "Healing Hearts," a 13-series television drama and 60-part radio drama, was its foray into the area of health behavior change; available in Zulu, Sotho, and Xhosa, it included medical issues such as tuberculosis, tobacco, HIV/AIDS, and hypertension along with violence against women, land distribution, and personal finance. That success was such that it has since been expanded into many more languages and now comes with backup educational and advocacy materials.

In South Africa, the National Community Radio Forum (NCRF) serves as an umbrella organization for more than 100 community radio stations; its history dates to the 2000 establishment of SA Community Radio AIDS Network from a workshop in Durban. Bearing the motto "Try it!", the goal encourages behavioral change—whether avoidance, abstinence, compassion for and not discriminating against people living with the disease, using condoms, respecting one's partner, and/or living a full life if you are infected. The South African Broadcasting Corporation (SABC), which has a network of 19 radio stations and a collective listenership of 20,834 million, includes Ukhozi FM; based on social responsibility, it is only appropriate that this largest radio station in the southern hemisphere includes programming about HIV/AIDS in weekday broadcasts.[9] *Nimechill* (I Have Chilled or I Am Abstaining), a Kenyan youth abstinence campaign, was designed to be empowering and future-oriented. Women'sNet (www.womensnet.org.za) of South Africa has launched several multimedia projects concerning women, Internet and media: In 2003, in partnership with the National Community Radio Forum (NCRF) and Agenda, it began the Open Society Foundation-sponsored "Recording Women & Gender Issues" to encourage gender programming on community radio, *She-Bytes* is an audio website for dramas and PSAs, and GirlsNet offers training camps. Alexander McLaughlin (2005b) has reported from Soweto about a popular program called *Cheaters* on Jozi FM, a community radio station: "One of the first public forums addressing a common behavior that's spreading AIDS fast: infidelity" (p. 1); womanizers and man-eaters take note.

Taxi Tunes in Zimbabwe, produced and distributed by Radio Dialogue, use cassettes to reach a wide population on a range of social, sexual, political, and environmental topics. Botswana's *Programme Towards Improved Productive Health and the Promotion of Safer Sex Among Young People in Urban Areas* is part of the Southern

African Youth (SAY) initiative, while *Choose Life* uses radio along with print and television to bring health communication to Lesotho, Malawi, Mozambique, Namibia, Swaziland, and Zimbabwe. The 26-episode Zimbabwean radio serial *Zvingangokuwanawo* (Even You Can Catch It) provides a particularly helpful example:

> In the drama, a young married man is using his financial status to woo young girls in his community into love affairs. He is also going out with commercial sex workers at the same time. In most cases he does not use condoms. Despite warnings and advice from his friends and workmates, he continues this behaviour, saying HIV/AIDS is imaginary.
>
> He believes that what people call HIV/AIDS is actually "runyoka," which is a constructed disease. (According to Zimbabwean culture, runyoka is actually some herbs, which a man puts on his wife if he suspects that she is cheating on him. So when another man has sex with her, that man ostensibly suffers a variety of illnesses, including weight loss and a protruding stomach.)
>
> In the end, this young man gets HIV/AIDS and infects many girls in the vicinity as well as his wife. Even some other young guys still at school (who were having some affairs with their counterparts at school) got infected. In fact it becomes a triangle of HIV infection. When this young man starts getting ill, he thought it was this runyoka as he was losing a lot of weight, along with other symptoms. But when he finally got tested for HIV/AIDS, he was found to be HIV-positive.
>
> He decided to go public and this news spread around the community, making those people he had had affairs with afraid. In his addresses to the public, he advises people to avoid promiscuity, lest they catch HIV/AIDS like he had. He emphasizes the value of faithfulness and advises school-going youth to delay sexual activity until they have completed their careers.[10]

The radio drama *Makgabaneng* aims at safe sex for Botswanians, while *Hannu Daya* (Hausa for One Hand Cannot Mount a Thatched Roof) acts as a forum for exchanging Nigerian ideas, and *Gugar Goge* (Tell Me Straight) was produced in northern Nigeria to prevent obstetric fistula and encourage delaying marriage and childbirth until adulthood. *Future Dreams*, a radio program in Nigeria, focused on these themes: (1) "future fertility," (2) "sexual past," (3) "we can negotiate," and (4) "I'm not embarrassed."

In terms of community change initiatives, consider the Zambian community radio show *Ku Mudzi Wangu* ("In My Village") that looked at agriculture/forestry, education, food security, health and HIV/AIDS, income generation and civil society; radio is so important in Zambia that Listening Clubs have been established there. Burundi's *Umbanyi Niwe Murango* ("Our Neighbors, Ourselves") has brought together Hutu and Tutsi families in humorous episodes focusing on refugee issues, police harassment, HIV/AIDS, alcohol abuse, teen pregnancy, mistreatment of women, and more—with imbedded ideas of the effects of ethnic hatreds. The Great Lakes Reconciliation Project combined radio dramas with grassroots activities for people living in Burundi, Rwanda, and the Democratic Republic of the Congo—much as *Camatonda*'s informative stories about healthy living worked in postwar Angola. *Peace Talks* in Nigeria, which began in 2001,

also helped raise public awareness about wider issues. *Radio for Peacebuilding*, a project of Search for Common Ground (SFCG), surveyed 423 radio professionals from Burundi, Cameroon, the Central African Republic, Chad, the Republic of the Congo, the Democratic Republic of the Congo, Guinea, Cote d'Ivoire, Kenya, Liberia, Nigeria, Niger, Rwanda, Sierra Leone, Somalia, Sudan, Tanzania, Uganda, and Zimbabwe in 2004, finding some 89% of them used techniques relative to peace-building in their programs.[11] "There seems to be a great need to escape the reality of everyday life in war-torn Angola," Inge Ruigrok (2005) has noted about the Portuguese program *Camatondo*. "Development organisations have also noticed this. [B]ut the soaps have proven to be a perfect instrument for spreading complicated messages—like reconciliation and preventing AIDS—to an audience that is difficult to reach." *Mo Kamba* (My Mate) is aimed at sexually active Angolan young people.

Speaking Up on Disability is a classic case of how radio can work as a change agent. A collaboration between the National Union of Disabled Persons of Uganda (NUDIPU), Leonard Cheshire International (LCI), Radio for Development (RfD), and Action on Disability and Development (ADD), it served as a public education campaign both for people with disabilities (PWDs) and for others to become aware of their needs.

Children and youth form a critical target for radio (Bosch, 2003). UNICEF's Somalia Radio Project, partnering with the country's Ministry of Information and youth groups in a country where radio remains the major media source, broadcasts information on hygiene, HIV/AIDS, female genital mutilation, immunization, and children's rights, *Bua Fela* ("Just Talk") allows kids to talk to one another, and *Macallinka Raddiyaha* ("The Radio Teacher") helps rural Somalis learn to read and write. Radio Infantil/Mozambique encourages children to participate in topics such as health, education, HIV/AIDS, and children's rights. The *Suzie and Shafa Show* in Namibia addresses issues confronting kids relative to perceptions of risk toward HIV testing and infection. The Okhayeni Strong Records of Kwazula-Natal deals with the development of public awareness of HIV/AIDS in terms of how it affects children, with these positive outcomes:

- The improvement in the confidence of some of the most troubled children involved in the project, and much enthusiasm and pride on the part of all the children who participated;
- The children developing skills in story-telling and interviewing techniques, a range of art techniques, and in the production of radio recordings;
- The demonstration of how critical it is that children's perspectives be made accessible to adults. At the end of hearing the programmes for the first time, the children's parents and caregivers reiterated one after the other the crucial lessons they had learnt from their children through the programmes (and in particular, how they had never realised how important it is to talk to their children about the illness and death they are experiencing around them);
- Initiatives on the part of the school to introduce more participatory methods in the classroom and into after-school club activities;
- The school encouraging parents and caregivers to come forward with information about children who are sick, or who are experiencing other difficult circumstances at home, so that the school can better support them; and
- The development of a relationship between children and their school, and children and support organisation Zisize, that did not previously exist with such depth or trust on the part of the children.[12]

In 2005, Formation des Enseignants par la Radio (FIER) combined radio and digital technology for in-service teacher training in Mali, and UNESCO has established "Suitcase Radio" in Timbuktu to encourage Internet usage. Moyamba District Children's Awareness Radio (MODCAR) in post-civil war Sierra Leone, child-led, focuses on peace and reconciliation. And, "Rural children behind the microphone. Children talking to children on the radio. Children making information available to their parents. Children earning the confidence and respect of their community," is how Alfonso Gumucio Dagron (2001, p. 229) describes the workings of Radio Gune Yi in Dakar, Senegal.[13] Further from the capital, Mbissao Community Radio works as a link between village children's Senegalese school and their parents—by means of 40 oil lamps linked to an FM receiver that gets powered by their flames.

Just outside of Dakar, Radio Oxyjeune, named as a conjunction of the French terms for *oxygen* and *youth*, holds a special place in my heart—my friend Sonya Marcus became a regular there after our visit. The popular community radio station has phone-in shows that "regularly tackle subjects many consider taboo such as HIV/AIDS and women's rights" (http://www.comminit.com/en/node/1419). "Anonymous interviews with HIV positive individuals have helped to drive home their message in an environment that still attempts to hide from the epidemic. Organizers believe that the use of personal stories is one of the most effective ways to get the message about AIDS across to the community." Broadcasting in both local and national languages, Radio Oxyjeune literally reaches out to the community—with trainers "to go out to beaches, football stadiums, nightclubs and other places people gather to spread the word about safe sex. Despite some threats, during recent elections, the station also held meetings to help locals put questions to politicians standing for office."

Radio Kidocracy on Bush Radio (www.bushradio.co.za) encourages this notion of granting participatory social equality by making sure youngsters are represented in programming—much as ABC Ulwazi has had success with it *Hey Mum, that's Me on the Radio!* and *A Friend for Life*. *Soul Buddyz* radio and television programs reportedly reach nearly 75% of South African children aged 8 to 12 (see Goldstein et al., 2003). Young women in Ghana from the Osu Young Women's Radio Group have developed a series of HIV/AIDS messages on a radio series with accompanying activity books, looking at issues like buying condoms, HIV/AIDS prevention, getting tested, negotiation skills, and unfaithful boyfriends. The Ghanian show *He Ha Ho*, (for HEalthy HAppier HOmes), focused on childhood illnesses. And African lesbian, gay, bisexual, transgender, and intersex (LGBTI) youth should be encouraged to know that they, too, have been considered in radio projects.[14]

Health-related radio, which might cover a range of topics, includes cases such as *Ashreat Al Amal* ("Sails of Hope") in the Sudan, a 150-episodic serial drama dealing with pre-natal care, female circumcision, HIV/AIDS education, and negative consequences of too much drinking or gambling. The Story Workshop Trust (SWET) has produced *Zimachitika* ("Such is Life") in Malawi, which deals with "barriers to maternal-child health," and *Kamanga Zulu* ("Prevention is better than cure"), which addresses root causes of GBV. *Kimasomaso* (Kiswahili for "To speak out boldly") is a radio series launched by the BBC World Service Trust in East Africa exploring sexual and reproductive health issues. The Institute for Democracy in South Africa's (www.idasa.org.za) *Making a Difference: We are All Affected*, available in Afrikaans, SeSotho,

isiXhosa, and isiZulu, aims to improve HIV/AIDS-related programming by means of a dozen themes:

1. Positive living—know your status
2. Family ties—a truck driver comes home
3. Fighting fit—you are what you eat
4. Back to school—teach your children well
5. Staying alive—know your medicines
6. Gender bender—bringing equality home
7. Work for all—at home and away
8. Growing together—what does it cost to be healthy?
9. People first—democracy, delivery and the spirit of Ubuntu
10. Living together—safe, sexy and supportive
11. Healing memories—dealing with death
12. Embrace life—life, love and the future

Family planning is at the heart of *Zinduka!* ("Wake Up!"), a 52-episode radio drama in Tanzania, a theme supplemented with notions of HIV/AIDS prevention, domestic violence, teen sexuality, and notions of behavioral consequences also in *Yamba-Songo: Les Cles de la Vie* ("Keys to Life") and in the highly received *Twende Na Wakati* ("Lets Go with the Times").[15] The country's Mambo Elimu project was established for children not in school—kids at risk of being exploited as child laborers and, by default, in need of education, health advocacy, and HIV/AIDS prevention, and the *RISE* (Radio Instruction to Strengthen Education) there has aimed at literary for children.

Of particular note too is *Urunana* ("Hand in Hand"), a radio soap sponsored since 1997 by Health Unlimited as the Well Women Media Project in post-genocide Rwanda for a largely illiterate female population—encouraging them to discuss sensitive subjects.[16] "You see small battery-powered radios everywhere in our country," Paul Rusesabagina (2006, p. 51), famous from the film *Hotel Rwanda*, has written. "They are playing on the edges of cornfields, inside taxicabs, in restaurants and Internet cafes, balanced on the shoulders of young men and old women and on the kitchen tables inside mud-and-pole houses on distant hills."

One of the best media means for social change, researchers have found, can be from soap operas. *Better Tomorrow*, a 40-episode radio drama aimed at out-of-school East African youth, outlined outcomes of risky behavior. Population Media Center (PMC) Ethiopia's radio soap, broadcast in 2002 in the country's two languages to what have been high-risk groups, "addressed issues of reproductive health and women's status, including HIV/AIDS, family planning, marriage by abduction, education of daughters, spousal communication and related issues"[17] Diaries of everyday Ethiopians—living with HIV/AIDS, form the basis of the radio series *Betengna*, "problems and pleasures" of living in rural Ethiopia is the theme on *Filega*—the first radio drama recorded on location, and one in five urban youth report awareness of *Journey of Life*. PMC has also sponsored evaluations of the country's soaps, finding some 45% of women and 47% of men self-reporting as regular listeners.[18]

Let's Talk, a soap aiming to reconcile Burundian refugees living in camps in western Tanzania, has helped in encouragement and reconciliation efforts—part of the country's storytelling tradition, according to Herbert F. Makoye of the

University of Dar es Salaam.[19] "After years of civil conflict, thousands of people in the Horn of Africa are unable to gain access to education, health or information," Isobel Booth[20] has written relative to Somali radio and the need to educate people about female circumcision and sexual relationships. "Levels of HIV/AIDS are also on the rise in the region and the infection needs to be fought before it reaches the epidemic levels found in other parts of Africa." *Elles Parlent, Elles Ecoutent* ("She Speaks, She Listens") was aimed at Sudanese survivors of Darfur in Chad, while *Cesiri Tono* ("All the Rewards of Courage and Hard Work") targets child trafficking for audiences in Burkina Faso, Cote d'Ivoire, and Mali—UNICEF projecting that, annually, some 2000,000 children in Central and West Africa are smuggled across national borders for forced labor or sexual slavery. And it chills us to learn about Rwanda's Freeplay Lifeline project, targeted at some 65,000 orphaned child heads of households unable to attend school; technically, the self-powered radio was able to provide distance education via wind-up energy or solar power.

Gender Links (www.genderlinks.org) and partner Gender and Media Southern Africa (GEMSA) have determined that women's voices are missing in radio talk shows, whether as callers, hosts, and/or guests.[21] In 1998, UNESCO helped a Malawi media women's group be granted a radio license, and the Story Workshop Education Trust's *Kamanga Zulu* ("Prevention is better than cure") has a powerful program dealing with gender-based violence in the country. Population Media Center partnered with Sudan's National AIDS Control Programme (SNAP) in 2002 on a radio project tackling HIV/AIDS, reproductive health, and the status of girls and women. The Miss Koch Initiative, owned and operated by young women in the Kenyan slum of Korogocho, have as their mission a response to sexual abuse there, Radio Mangelete outside of Nairobi is operated by and for women, and the Health and Agriculture Community Radio Network, an HIV/AIDS prevention program, uses radio cassette players for information exchange for Kenyan women. Elizabeth Gold and Mia Malan (2006), Internews' Senior Advisors for *Health Journalism*, have reported how radio has impacted HIV in Kenya from its project Local Voices. Still, just as DevTech (2005) has studied difficulties reaching women in Mali, where some 72% aged 15–49 are not educated, so too has Jennifer Sibanda (2006) worked to improve their access to radio.

Community Television and Video

"Global collaborations among government, public health organizations and media companies have turned the entertainment industries on several continents into one of the most powerful public health communications tools of the 21st century," Steve Sternberg (2006, p. 1) has noted. *Africa' Fight Against HIV-AIDS*, a Johannesburg-based television project of Young Africa Television (YATV), is a classic example, as it imbeds themes of defining and describing the disease, addressing macho teens, myths, traditional African sex ed, children and orphans, spirituality, testing, therapy, and bereavement in the 13-part series. *Sida dans la Cite* ("AIDS in the City"), a 16-episode series in West Africa used these communication strategies:

- *The Story of Fiancés* dealt with pre-nuptial testing and accepting HIV status;
- *Adams, the Truck Driver* showed what can happened from risky behavior;
- *Amoin Sery* introduced the issue of polygamy; and
- *Fatoumata, the HIV-positive Mother* dealt with mother-to-child transmission.

Centre 4, a 13-episode televised medical drama from Uganda, had its characters show how to lead a healthier life, while *Makutano Junction*'s 13-part drama dealt with sustainability for rural audiences in Kenya, Tanzania, and Uganda. Some 700,000 viewers in Zimbabwe catch the award-winning *Who's Next?* television talk show. Ghanaian young people watch *Things We Do For Love*, which has won many awards. Like *Alam Simsim*, the Egyptian *Sesame Street* (see Cowley, 2003; Parsons, 2007), the Ethiopian educational television show *Tsehai Loves Learning* features giraffe puppets who speak in Amharic—a first for that language. It targets pre-schoolers and kindergarteners as part of a plan to teach social issues like the environment, HIV, and gender along with academic, socio-emotional, and physical development, and personal values; still, with some 80% of the country's 77 million residents living in rural areas, though, we worry about how few of them have television, never mind reliable electricity.[22]

We realize how important government support is in HIV/AIDS campaigns and programming.[23] Hadland, Aldridge, and Ogada (2006) reveal the role of policy in South Africa, while at the governmental and NGO level *Ukimwi Ni Huu* (This Is AIDS) aims to address issues in Tanzania on poor housing, sanitation, and nutrition along with the scarcity of health services. The peer-led *Digital Interactive Video Online* (DIVO) project between young Muslim females from Accra, Ghana and students in London uses participatory storytelling techniques in their sharing of experiences with gender and sexual health. Steps for the Future (2002), a video collection from Lesotho, Mozambique, Namibia, South Africa, Zambia, and Zimbabwe, centers around HIV/AIDS-related topics such as discrimination, disclosure, treatment, and living positively. *Attendre Demain* ("Awaiting Tomorrow: HIV/AIDS in the Democratic Republic of the Congo) uses video as a call for governmental action, including free HIV/AIDS testing and medical care, and *Against the Tide of History* called on the Senegalese government to provide assistance to landmine survivors.

Participatory video, which Johansson, Knippel, de Waal, and Nyamachumbe (1999/2000, p. 35) define as "A scriptless video production process, directed by a group of grassroots people, moving forward in iterative cycles of shooting-reviewing," is helpful for engaging groups in interactive, face-to-face communication.[24] The *Tichezerane* AIDS support group in Malawi used examples of visiting a sick neighbor who opts for a witchdoctor rather than the hospital, filming members going about their daily lives, and using group therapy. Dedicated to giving Nigerian young people access to reproductive health information and life planning skills, the *Action Health Participatory Video Project* uses dramas and mini-documentaries to harness the creative forces of their subjects, and in Guinea, Communication for Change (C4C) and La Cellule de Coordination Sur Les Practiques Traditionelles Affectant La Sante des Femmes et des Enfants (CPTAFE) produced a participatory video aimed at stopping FGM. *Tikambe* "Let's Talk About It"), a Zambian documentary video following two families' struggle living with HIV/AIDS, opens our eyes to notions of discrimination that can take place even in households.

African Film[25]

Having analyzed media representations of HIV/AIDS, particularly of women, from both sides of the camera, my argument throughout my

> recent writings has been that not until we realize how representations are constructed, examined, received and, most critically, interpreted can we begin to understand and then act upon ideologies. An examination of AIDS-related African films provides such an opportunity. What they say and, just as importantly, what they leave out can bespeak volumes.
>
> Linda K. Fuller, The Politics and Process of Critiquing African AIDS Films (2007b), pp. 129–130.

This small section could easily be a book in itself. As gleaned from the above quotation, much of my work has focused on filmic representations of HIV/AIDS in and about Africa (Fuller, 1993, 1998b, 2001a and b, 2003b, 2004b and c, 2006, 2007b, and forthcoming). As a member of the Francophone Film Society, I am well aware of the continually growing interest in African film,[26] yet, to date, no one else has drawn the connection between visual representations and their effect on the continent. Toward that end, let me draw your attention to Appendix V111: African AIDS-related films, a list-in-progress of some 135 AIDS-related films and video produced by and for Africans in more than two dozen African countries.

We have clearly moved well beyond the *Tarzan* image of Africa, with box office hits like the socially conscious *Constant Gardener* (2005), *In My Country* (2005), with Samuel L. Jackson as a reporter covering the South African Truth and Reconciliation Commission, *The Interpreter* (2005)—Nicole Kidman as a UN interpreter with South African ties, the message film *Blood Diamond* (2006), and the award-winning *Last King of Scotland* (2006). The Rwandan genocide was well represented in *Hotel Rwanda* (2004), *God Sleeps in Rwanda* (2005), *Sometimes in April* (2005), and *Beyond the Gates* (2007). Too bad these outstanding cinematic examples have as a counterpart the stupid *Sahara* (2005), with Matt McConaughey. And, from Disney's success of *The Lion King* (1994), filmmakers have taken note by introducing two movies for kids in 2005: *Duma*, about a pet cheetah, and *Madagascar*, about animals escaping from a New York zoo to find their roots. Far too few African artists are acknowledged by the global community, but the Senegalese film director Ousmane Sembène (1923–2007) has been called "the Father of African film" (see Murphy, 2001), and there are many outstanding African filmmakers who I encourage you to consider.

From the continent itself, FESPACO, the Panafrican Film and Television Festival of that takes place in Ouagadougou, Burkina Faso, continues as the largest African film festival—the next one scheduled for February 28 to March 7, 2009. But the biggest news is the continuing growth of what is known as Nollywood (Barrot, 2008). Like Hollywood in Los Angeles or Bollywood in Bombay, the center of African film is in Nigeria. As is shown in Franco Sacchi's *This is Nollywood* (2007), the booming film industry there released 2,000 features in 2006 alone, including some collaborations on issues such as reproductive health (Auta, 2007).

Lucinda Engelhart (2005) has determined that where people watch AIDS films makes a difference in how they are interpreted. Ombetja Yehinga Organisation (OYO) of Namibia, wanting to reduce the spread of HIV/AIDS, relies on promoting discussion and understanding of sexual and reproductive health and other social issues. Meaning "Red Ribbon," it has had some successful short

films, including: *Amanda*, *Can Love Cry?*, *I Can't Imagine*, *It Is Me and You*, and *The Days are So Long*; see (http://ombetja.org). Part of my work in Senegal was with sexologist Valerie Lepine, on a Life Skills program called "Window of Hope." Concerned about high HIV/AIDS prevalence among young people, due to their ignorance, their early sexual activity, and various vulnerabilities, the idea was to analyze available materials under the Information, Education, and Communication (IEC) model. My role, analyzing and evaluating a series of films, found that of all the AIDS films and videos we reviewed (Lepine et al., 2002), these were the most promising:

- *Consequences* (1988, Zimbabwe): We hold our collective breaths, watching the good girl/good student be seduced by her boyfriend, then watch as she struggles with the consequences of pregnancy, rejection, and need for compassion.
- *More Time* (1993): a Zimbabwean teenager learns the hard way about how AIDS is transmitted.
- *Fakhastalu* (1995, Senegal): The translation is "Youth Error," describing a young pregnant girl who wants an abortion.
- *Everyone's Child* (1996, Zimbabwe): Designed to help people find ways to care for orphans, this film comes with a support manual.
- *The Silent Epidemic* (1996, Kenya): Graphic images of the relationship between STIs and HIV/AIDS, aimed at young adults.
- *About you . . . A toi qui changes:* a 1998 ten-minute French video aimed at young people (13 to 18), about physical and psychosocial changes occurring in puberty.
- *Grand Frere de Gono* (1998, Cote d'Ivoire): When two sexually active young men go to the hospital for treatment of an STD, they inadvertently learn they have had the same conquests.
- *Regarder, ecouter, decider ou* (1998, Senegal): This documentary follows young people from Senegal, Cape Verde, the Gambia, and Guinea Bissau as they talk about sexuality and the problems they encounter looking for user-friendly healthcare services.
- *Feeling Yes, Feeling No* (2000, Namibia): Probably my favorite, this video tries to encourage pre-adolescents about situations that might lead to sexual abuse and/or molestation. Primary school children are encouraged to be in touch with their emotions, to learn the self-efficacy of articulating their senses, and being aware of who might help them in that process. They role-play comfort levels, and we feel more comfortable knowing they know.
- *Scenarios from the Sahel* (2001)—available in French, English, Dioula, Pulaar, and Wolof, they come from Global Dialogues Trust (GDT), which organized an AIDS film scenario contest for young people in Senegal, Burkina Faso, and Mali; then, from some 22,000 submissions, they selected enough for hour-long videos including titles like *Advice from an Aunt* (elder knowledge), *Iron Will* (a man covers himself up with a metal chain over his penis, thinking that's what an "iron will" meant), *To the Rescue* (of condoms dropped in an elevator), *Just Once* (his wife is HIV positive), and many more creative cases.
- *Yellow Card* (2000, Zimbabwe): We follow Tiyane, who loves football and loves Juliet, but he is hardly ready to become a father. It is an ignominious and fast fall from being the school hero; now, he must play the game of life.[27]

As you peruse the filmography/videography, you can see there are many more helpful films that can be used both in educational settings and in our own advocacy efforts. Our big job is getting word out about them. *Cinéma Numérique*

Ambulant (CNA) brings mobile entertainment and education to rural villagers in Benin, Niger, and Mali, its open-air viewings containing health messages about malaria prevention, child brides, HIV/AIDS prevention, and water and sanitation. By whatever means, film offers an ideal venue for edutainment about HIV/AIDS.

ICTs in the African HIV/AIDS Fight

> At the Technology, Education and Design (TED) Global 2007, I witnessed one small skirmish in a larger ideological conflict between those who believe that Africa needs more and better international aid, and those who think entrepreneurialism and technology will lift the continent out of poverty and thus reduce its miseries.
>
> Jason Pontin, What Does Africa Need Most: Technology or Aid? (2007).

ICTs are revolutionizing our world, and Africa is no exception—where a number of the best innovations deal with sexual and reproductive health. Perhaps the best place to begin is with the *AIDS Clock*, an online global count of people living with HIV, ticking away to remind us that every seven seconds someone contracts HIV and every eleven seconds someone dies of AIDS; in other words, time is running out in too many lives. "Technologies have proliferated with revolutionary speed, leaving even their greatest enthusiasts—the young and youthful—panting to keep pace with daily innovations," Francis Nyamnjoh (2005, p. 32) has written about the *Changing communication dynamics in Africa*. "The advent of the Internet and cell phone have transformed communication remarkably. The bulk of ordinary Africans, who would otherwise stand little chance of ever making or receiving a phone call, are today served . . . in fascinating ways."

Online and/or print shared community news/information, Citizen Journalism is community media coming from participants, whether text/blog(s), digital storytelling, images, audio file, pod-casting or video; see (www.citizenjournalismafrica.org). An example of online gaming might be *Ungefanyaje* ("What would you do?" in Swahili), which takes the players through some scenarios dealing with relationships concerning HIV prevention and testing.

Although by some standards African countries lag behind some other places around the world and are judged by pessimistic standards (see Stanbridge and Ljunggren, 2004), in 2001 Eskom (www.eskom.co.za) found these figures for the 816 million Africans:

- One in 4 had a radio (205 million)
- One in 13 had a TV (62 million)
- One in 35 had a mobile phone (24 million)
- One in 40 had a fixed line (20 million)
- One in 130 had a PC (5,9 million)
- One in 160 used the Internet (5 million)
- One in 400 had pay TV (2 million)

Still, "The power and potential of traditional and new communication technologies for development in Africa is not to be doubted," Myers, Jensen, and

Southwood (2004, p. 2) have determined. "They are already invaluable tools in all sectors, from business generation, culture expression and health awareness, to fostering respect for human rights, good governance, and pace." Some countries have a number of success stories, if only a few are highlighted here. For example, ***Abantu for Development*** (www.abantu.org) in Kenya has strengthened African women's cyberspace presence working on issues such as poverty, governance, and conflict. ***APC-Africa-Women*** (Association for Progressive Communications), headquartered in Johannesburg, is formed from a network of individuals and organizations using ICTs for equality and development. ***BellaNet*** follows donor funding for ICT programs in Africa. The ***Community Centre for Enhanced Health Technologies*** (CCTAS) in Senegal has one database of traditional healers and another one of their medicinal plants and how they are used. ***C-MET***, Sierra Leone's Center for Media Education and Technology, is a nonprofit NGO promoting media development, human rights awareness, and use of ICTs. ***Girls'Net*** (GN), part of Women'sNet (www.womensnet.org.za), is a South African NGO using ICTs to help women and girls in self-development by means of a multimedia program whose goal is to get girls actively involved with technology. In addition to their website, since 2004 it has had training camps, provincial clubs, a newsletter, a workshop on 'Girls against Violence,' and Girls'Net radio productions. ***Enhancing Reproductive Health Through Mass Media*** uses satellite radio to reach refugee populations in Kenya and Uganda and the *TeleInViVo* project allows for transportable telemedicine workstations at hospitals. The ***Fantsuam Foundation*** in Nigeria has blended traditional healthcare with ICTs to encourage best practices and safer sex. ***iConnect-Africa***, a quarterly Web, paper, and e-mail service, was established by the Economic Commission for Africa as a development tool. ***Journalists Against AIDS*** in Nigeria set up an e-mail network to keep information about HIV/AIDS timely and accurate (see Falobi, 2003). Zambia's ***Kalomo Bwacha Women ICT Club*** helps members market their produce and manage their money via the Internet and its ***QUESTT*** (Quality Education Services Through Technology) project aims to mitigate the impact of HIV/AIDS for children. The ***Kubatana Trust of Zimbabwe*** (www.kubatana.net), which incorporates the Network Alliance Project (NNAP), is working to strengthen the use of email and Internet strategies by its website archives. ***Macallinka Raddiyaha*** (The Radio Teacher) offers literacy training all over Somalia and in parts of Djibouti, Ethiopia, and Kenya. ***Naledi3d Factory*** in South Africa focuses on virtual reality, visual training such as interactive simulations for education, edutainment, e-commerce, and modeling. ***Nata Village Blog*** in Botswana focuses on controlling HIV/AIDS, and the website documents its spread with stories. UNESCO's ***Regional Information Society Network for Africa*** (RINAF) trains people in rural, isolated, and disadvantaged African communities by means of projects like Virtual Multimedia Academy, website design competition, distance education, and the Cheap Hardware and Open Software project. *Women'sNet* (www.womensnet.org.za) has launched lots of innovative projects, such as "Recording Women & Gender Issues" on community radio, and *(S)he-bytes*, a web-based audio archive in South Africa. ***Women of Uganda Network*** (WOUGNET) is an NGO that was established in 2000 and ***World Starts With Me*** (WSWM) is a web-based Ugandan project started in 2003 by the World Population Foundation (WPF), offering IT information on sexual and reproductive health (see also Gitta and Ikoja-Odongo, 2003 on cyber cafés in Uganda).

In terms of gender and ICTs in Africa, Patricia Stamp (1990, p. iii) argues that, "The power of women is central to an evaluation of development efforts in Africa." Eva M. Rathgeber and Edith Ofwona Adera (2000) say they depend on women realizing their information needs and then getting participation from other sectors. Radloff, Primo, and Munyua's *The role of information and communication technologies in the development of African women* (2004) is encouraging not only about women being trained in ICTs but also how creative they can be in applications. "Information and communication technologies could give a major boost to the economic, political and social empowerment of women, and the promotion of gender equality," they write (p. 8), amending with, "But that potential will only be realized if the gender dimensions of the Information Society—in terms of users' needs, conditions of access, policies, applications and regulatory frameworks—are properly understood and adequately addressed by all stakeholders." Some of the promising examples they cite of African processes include UNIFEM's Digital Diaspora Initiative, New Partnerships for Africa's Development (NEPAD), the UN Economic Commission for Africa (UN-ECA) and Africa Information Society Initiative (AISI), and Gender Research in Africa into ICTs for Empowerment (GRACE). Women'sNet's *Advancing rural women's empowerment* (2004) sees ICTs as tools for development; declaring, "You can't eat democracy" and citing how half of sub-Saharan Africans subsist on less than $1 per day, they particularly worry about the impact of HIV/AIDS on food insecurity (p. 18). Cummings, van Dam, and Volk's *Gender and ICTs for development: A global sourcebook.* (2005) includes radio communication and ICTs in Sierra Leone along with sustainable fisheries production in Ghana, both areas concerned about applications for HIV/AIDS.

Africa has a number of electronic journals and newspapers; for such a listing, see (http://www.columbia.edu/cu/lweb/indiv/africa/ejournals.html), put out by the Columbia University Libraries. For example, it includes data about *AIDS Analysis Africa*, an online publication from the Health Economics and HIV/AIDS Research Division at the University of KwaZulu-Natal. But beware: as Fursich and Robins (2002, p. 190) have found, oftentimes national websites from sub-Saharan countries reflect "identity mirroring Western interests." Amnesty International has recently set up a web-based project called *Eyes on Darfur*, to monitor by satellite some of the unfolding events there, much like the Open Society Institute has begun *Eyes on Zimbabwe* to check on human rights issues. As you begin to see, we have multimedia in terms of bringing various media together, such as videos on ICTs, or Balufu Bakupa-Kanyinda's *Afro@ Digital*, a documentary on the digital revolution in Africa. Communication is everywhere.

Libraries, Telecentres, and Multimedia Centers

Telecentre.org's definition of a "telecentre" is: "A public place where people can access computers, the Internet, and other technologies that help them gather information and communicate with others at the same time as they develop digital skills." Best of all, they have allowed access to citizens throughout Africa (see Parkinson, 2005). Ghana's solar-powered *Asante Akim Multipurpose Community Telecentre* (AAMCT) offers health-related services and training, just as *Time to Get*

Online encourages training in the Internet, and Nigeria's *Owerri Digital Village* trains young people for employment and communities for self-sustainability (see also Ogbu and Mihyo, 2003).

There are also a number of Community Multimedia Centers (CMCs) throughout Africa. While the ones I am most familiar with are in West Africa, their main general purpose is to promote community empowerment technologically by means of educating citizens to telephone, community media, and Internet usage. The idea is that, once people have access enough to cross the digital divide and become acquainted with information resources, they can educate themselves and their families about agriculture, business, health, HIV/AIDS, the environment, culture, governance, the arts, and more.

Telephony in Africa—Moving toward Mobile

> Cellphones are already used for music downloads, text messaging, and video games. But here in South Africa, they are beginning to perform another function: personal piggy bank. With the new technology, a grandmother in rural areas can receive one from her son, working hundreds of miles away, with the beep of her cellphone. A teenager can buy groceries with a few punches of keys. Not a coin need change hands. It's a high-tech solution designed to help poor people here who never have had access to banks, cash machines, or credit cards. And it's another example of using digital technology to fast forward development in rural areas.
>
> Nicole Itano, Africa's Cellphone Boom Creates
> a Base for Low-Cost Banking (2005).

No one is more amazed than Africa herself at her success in going mobile, with some 75% of telephone subscribers using mobile telephony by 2004 (Gray, 2006). Although this is good news in terms of access, it is especially exciting for tracking epidemics such as HIV/AIDS (see Wagh, 2007 on Rwanda). Since 1995, *INFO SIDA* has been a hotline run by the Association des Femmes Africaines Face au Sida (AFAFSI) in Ouagadougou, Burkina Faso, encouraging users to talk to one another and keep informed about AIDS. *Freedom HIV/AIDS*, a gaming initiative using mobile telephones to engage people in awareness, was launched on World AIDS Day 2005, and in 2007 it received a TERI (The Energy and Resources Institute) award.

HIV/AIDS hotlines and talklines evolved early on in the pandemic, offering anonymity and sensitive ears for calls worried about basic issues and/or needed advice in nonbiased feedback. While they might deal with drugs, depression, violence, treatment topics, or much more, they have provided a haven for people needing to communicate. Introduced early on in Ghana, Uganda, South Africa, Nigeria, Mozambique, Kenya, and Zambia, more recently they have emerged in Ethiopia.

Wegen AIDS Talkline, established in Ethiopia—one of the hardest hit sub-Saharan countries, where secrecy and stigma about the disease reigns supreme, offers free information, free counseling, and free referrals. Widely diverse, and the only country in Africa that never has been colonized, Ethiopia consists of

many different people speaking many different languages; for the talkline, it provides services in the country's three major languages: Amharic, Oromifa, and Tigrigna. Established in 2004, some of the HIV/AIDS topics it takes range from testing to prevention of mother-to-child transmission to therapies. And although it depends mostly on peer education, *Youth-to-Youth* in Ethiopia, Kenya, Uganda, and Tanzania also uses a youth hotline.

Although this chapter has offered a wide range of African media and communication potential for HIV/AIDS awareness, nevertheless we realize that particularly rural women throughout Africa, the poorest of the world's poor, lack access to media. One of the earliest organization to work with them has been the Food and Agriculture Organization (FAO), has actively engaged in rural radio since 1966. Burkina Faso, which ranks fourth last on the UNDP Human Development Index, has had luck with the Viim Kuunga Radio Project, which tells of two families making personal decisions relative to behavior change in the midst of much poverty. We can only advocate for more.

Notes

1. A transcript of Stephen Lewis' interview at the Carnegie Council is available at (http://www.cceia.org/resources/transcripts/5338.html).
2. See also Anthony A. Olorunnisola, Community radio as participatory communication in post-apartheid South Africa, available: (http://www.personal.psu.edu/faculty/a/x/axo8/Joburg/manuscript.htm).
3. See The Top 50 African Artists, *Utne* (September–October, 2007): pp. 42–49.
4. A literature review on Theatre for Development relative to Africa might include Martin Banham, James Gibbs, James and Femi Osofisan (Eds.) *African theatre in development* (Oxford: James Currey, 1999); Lee Dale Byam, *Community in motion; Theatre for Development in Africa* (London: Bergin and Garvey, 1999); Ross Kidd, *Strategy and workplan for designing trainer's guide on HIV/AIDS stigma* (Washington, DC: Academy for Educational Development and International Centre for Research on Women, 2002); Zakes Mda, *When people play people: Development communication through theatre* (London: Zed Books, 1993); Penina Mlama, *Culture and development: The popular theatre approach in Africa* (Uppsala, Sweden: Scandinavian Institute of African Studies, 1991); Dixon M. Mwansa and Pia Bergman, *Drama in HIV/AIDS prevention: Some strengths and weaknesses: A study in Botswana, Tanzania, South Africa, Kenya, Ethiopia and Uganda* (2003), available: (http://www.sida.se/shared/jsp/download.jsp?f=DRAMA_+IN_+HIVAIDS_+prevention.doc&a=19561); Kamel Salhi (Ed.), *African Theatre for Development: Art for self-determination* (Exeter, UK: Intellect Books, 1998).
5. SADC member countries include Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe.
6. For more on puppetry, see George Omondi Ayoma, *Puppetry as a tool in HIV/AIDS awareness and behaviour change motivation* (Cape Town, South Africa: EE4, 2004); Timon Choro, *Role of puppetry in the dissemination of culturally sensitive messages in HIV/AIDS associated behavior change* (Cape Town, South Africa: EE4, 2004); Marie S. Kruger, *Puppets in Entertainment-Education: Universal principles and African performance traditions as a model for interaction* (Cape Town, South Africa: EE4, 2004); Ogova Ondego, Establishing puppetry as an artistic and cultural medium in Eastern Africa, *Art Matters* (2004).
7. See *Singing for Life*, available: (http://www.vanderbilt.edu/exploration/exploration.html).

8. See also: Robert C. Moore, *Transforming communities in Africa: Community journalism can transform African communities* (Elizabethtown, PA: Elizabethtown College, 2005); World Association for Christian Communication, What is the special significance of community media to civil society? *Media Development*, Vol. 4 (2002).
9. Musi Khumalo, *Talking about HIV/AIDS in the weekday entertainment-education radio drama series* (South Africa: University of Natal, 2003).
10. Zvingangokuwanawo-Zimbabwe; available: (http://www.comminit.com/en/node/124685).
11. *Attitudinal Baseline Survey of Radio Professionals in Sub-Saharan Africa*; see www.radiopeaceafrica.org.
12. Helen Meintjes, Growing up in a time of AIDS: The Okhayeni Strong Recorders (*In Focus*, No. 5, [June 2006]).
13. See also Savina Ammassari and Jean Frederic Bernard's 1999 report *Radio Gune Yi: Evaluation Report* for the Centre for Development Communication and Rosita Ericson's *I am a child but I have my rights too!* (Dakar, Senegal: Plan, 2005).
14. Tonya Graham with Sarah Kiguwa, *Experiences of black LGBTI youth in peri-urban communities in South Africa: Formative research for an LGBTI radio drama* (Johannesburg, South Africa: CMFD and Cape Town, South Africa: IDASA, 2005). The radio drama *Outside the Lines* has targeted LGBTI life in terms of dealing with discrimination.
15. See also Peer J. Svenkerud, Nagesh Rao, and Everett M. Rogers, Mass media effects through interpersonal communication: The role of "Twende na Wakati" on the adoption of HIV/AIDS prevention in Tanzania, in William N. Elwood (Ed.) *Power in the blood: A handbook on AIDS, politics, and communication,* pp. 243–253 (Mahwah, NJ: Lawrence Erlbaum, 1999).
16. See also Elizabeth Furness, A nation tuned in: The explosion of local private radio in Senegal, (*Yegoo*, No. 7 [December, 2003]: 11, 22).
17. *Using soap operas for social change: Ethiopia*, available: (http://www.comminit.com/africa/evaluations/evaluations2006/evaluations-238.html).
18. Ibid.
19. Herbert F. Makoye (2003), *Tale-telling tradition techniques in Africa and soap opera* (hmakoye@yahoo.com).
20. Isobel Booth (2003). *Somali radio soap for health education*, available: (http://www.eldis.org/fulltext/soap.pdf).
21. *Mirror on the media: Who talks on talk shows?* (2005), Open Society Initiative for Southern Africa, available: (http://www.genderlinks.org.za/page.php?p_id=301).
22. Lea-Lisa Westerhoff, Tsehai loves learning (October 2, 2006), available: (http://www.ethiomedia.com/addfile/tsehai_loves_learning.html).
23. For training purposes, see *Video for change: A practical guide for activists*, produced in 2000 by WITNESS.
24. For more on participatory video, see Su Braden, *Whose media? Action research for participatory representation* (South Africa: ActionAid, 2003); Tegan Molony, Zeze Konie, and Lauren Goodsmith, Through our eyes: Participatory video in West Africa, *Forced Migration Review* 27 (January, 2007); Torja Ngenge, *Sex, AIDS and videotape: Video as a tool in informing about HIV/AIDS among young people in rural Mozambique* (Malmo University: Communication for Change, 2003); Kole Ade Odutola, *Participatory use of video: A case study of community involvement in story construction* (Rutgers University, 2004).
25. Some of the key producers of film and video relative to Africa and HIV/AIDS include California Newsreel, P. O. Box 2284, South Burlington, Vermont 05407 (www.newsreel.org); Media for Development International (MFDI), 184 Crescent Lane, Glenwood Springs, CO 81601 (www.mfdi.org); WITNESS, 353 Broadway, New York, NY 10013 (www.witness.org).
26. A literature review of African film might include Roy Armes, *Postcolonial images: Studies in North African film* (Bloomington: Indiana University Press, 2005); Imruh

Bakari and Mbye Cham, *African experiences of cinema* (London: BFI, 1996); Isabel Balseiro and Ntongela Masilela (Eds.), *To change reels: Film and culture in South Africa* (Detroit, MI: Wayne State University Press, 2003) ; Olivier Barlet, *African cinemas: Decolonizing the gaze* (London: Zed, 2001); Vivian Bickford-Smith and Richard Mendelsohn (Eds.), *Black and white in Colour: African history on screen* (Oxford: James Currey, 2007); Kenneth Cameron, *Africa on film: Beyond Black and White* (New York: Continuum, 1994); Manthia Daiwara, *African cinema: Politics and culture* (Bloomington: Indiana University Press, 1992); Beti Ellerson, *Sisters of the screen: Women of Africa on film, video and television* (Trenton, NJ: Africa World Press, 2000); June Givanni (Ed.), *Symbolic Narratives/African Cinema: Audiences, Theory and the Moving Image* (London: BFI, 2001); Josef Gugler, *African film: Re-imagining a continent* (Bloomington: Indiana University Press, 2004); Kenneth W. Harrow (Ed.), *African cinema: Postcolonial and feminist readings* (Trenton, NJ: Africa World Press, 1999); Lahoucine Ouzgone and Onookome Okome (Eds.), *Men and masculinities in African film and fiction* (Oxford: James Currey, 2008); Francoise Pfaff (Ed.), *Focus on African films* (Bloomington: Indiana University Press, 2004); Sharon A. Russell, *A guide to African cinema* (Westport, CT: Greenwood, 1998); Melissa Thackway, *Africa shoots back: Alternative perspectives in sub-Saharan francophone African film* (Bloomington: Indiana University Press, 2003); Nwachukwu Frank Ukadike, *Black African cinema* (Berkeley, CA: University of California Press, 1994) and *Questioning African cinema: Conversations with filmmakers* (Minneapolis: University of Minnesota Press, 2002).

27. See Debra Buenting, *Audience involvement with* Yellow Card, *an Entertainment-Education initiative promoting safe-sex behaviour among African youth*. (Unpublished dissertation, Regent University, Virginia Beach, VA, 2003).

CHAPTER EIGHT

Communications Promises

> We recognize the grave implications of the HIV epidemic in Africa. The current rate of infection and spread can predict only tragic consequences for millions of Africans. The modes of transmission of HIV are well recognized and methods for their prevention are known. It is critical that available methods and resources be employed as rapidly as possible to limit the further spread of HIV in Africa.
>
> Piot, Goeman, and Laga, The epidemiology of HIV and AIDS in Africa (1994), p. 167.

Considering the urgency of this message, above, it is difficult to imagine that it was written more than two decades ago and hardly anything has changed. Many of us wonder where we are nearly *a quarter century* into this HIV/AIDS pandemic (Scalway, 2003).

Concluding Thoughts on African Women and HIV/AIDS

As African women are at the heart of the HIV/AIDS crisis, increasingly and disproportionately transmitting the virus to their children, the continent is losing not only invaluable individuals, it is ruining any hopes for future growth. In a 1994 preface to the second printing of their book *AIDS in Africa*, Tony Barnett and Piers Blaikie (1992, p. ix) commented on how, "The long term impact of HIV/AIDS is very considerable. It removes the productive members of a nation—farmers, doctors, truckers, mothers, medical auxiliaries, lawyers, politicians—and burdens the economic and social fabric of already poor countries."

Needless to say, there have been a number of theories as to how to "solve" the HIV/AIDS pandemic in Africa and other hotspots around the world. Behavioral change, particularly as to encouraging fidelity, or at least having fewer sexual partners, or maybe incorporating condom usage with all those partners, has been at the heart of a number of campaigns. Much emphasis has been placed on programs offering education—including sexual health education, or treatment, or perhaps a mixture of the two. Maybe it's microbicides. Or condoms. At heart, of course, is the basic issue of empowerment—encouraging African girls and women to learn life skills, ranging from learning about socio-political-economic

realities to actually negotiating and putting into place their own ideas. And, while medical science has hardly accomplished so much so fast to prevent a fatal disease, nevertheless it is obvious that communication here is key.

Clearly, a number of questions remain. For starters, how do we respond to some of these comments from Zambian women interviewed by Mwale and Burnard (1992):

- As we are saying, AIDS is transmitted via sexual intercourse by men and women sleeping with other partners . . . what if your husband refuses to stop sleeping with other people and says 'I will move as I please' and he refuses to wear the condom, what can I do? (p. 66)
- If we are married, how can we protect ourselves from the disease . . . if we are faithful and our husbands are not faithful? (Ibid.)
- What can I do if my husband doesn't want to wear the condoms? (p. 67)
- If one of us wives gets tempted (two wives) and has an adulterous affair . . . and the man she goes with is infected . . . how do I, as the other wife, protect myself? (Ibid.)
- What about knowledge? I want you to explain to me how it really comes about . . . doesn't it mean that there is no medicine and prevention is the only cure? (Ibid.)

There have been some bright spots. Uganda is often cited as something of a success story, as it acted early on in confronting HIV/AIDS. Establishing an AIDS Control Program (ACP) in the Ministry of Health, it later worked with the WHO to develop and adopt plans for spreading public health messages, screening supplies of blood, and tracking the disease in various sectors. In 1991, Uganda began its own National AIDS Commission, followed by a National Multisectoral Strategy that included these goals:

1. Prevent HIV transmission attributable to sexual behavior and blood transfusion and passed from mother to child;
2. Mitigate the adverse health and socioeconomic impact;
3. Strengthen the national capacity to respond to the epidemic;
4. Establish a national information base on HIV/AIDS; and
5. Strengthen national capacity to undertake research relevant to HIV/AIDS.

Healthcare workers are key. Gaining the trust of patients and families and understanding local customs and traditions, they can provide both education and encouragement. "It should be remembered, however," Mwale and Burnard (1992, p. 72) caution us, "that we, as health workers, should work with the women as we go through the process of changing cultural practices and not for them, as this would help us identify obstacles to the programme we aim to institute."

At this point in the HIV/AIDS pandemic, since neither a cure nor a vaccine is yet on the horizon, it becomes clear that the role of communication is key as we try to talk to individuals and whole populations about prevention strategies. While we push monogamy and faithfulness, we know that all too often in Africa that is a one-way street. Preserving one's virginity until marriage is rarely a young girl's choice there, just as sexual abstinence or non-penetrative forms of sex hardly seem feasible. We can encourage reductions in the number of sexual

partners, but again that tends to be more of a masculine than feminine decision. And so we push for the use of barrier methods in general, condoms in particular during intercourse, waiting and hoping for improvements in technology and changes in societal thinking.

Organizations

As can be seen in Appendix III: African HIV/AIDS-related organizations, there are hundreds of organizations already mobilized and working in this field (see Hassim, 2006). Whether nonprofits, NGOs, private or public, their commitments offer enormous hope. It is heartening to know, too, that the international community is invested in the issue of HIV/AIDS in Africa, even if sometimes that cooperation may be the result of guilt and self-image and even if sometimes donations are too niche-oriented or based on underlying biases.

You are undoubtedly already familiar with the work of the Canadian International Development Agency (CIDA), the Global Coalition on Women and AIDS (GCWA) initiative, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the President's Emergency Plan for AIDS Relief (PEPFAR), the Joint United Nations Program on HIV and AIDS (UNAIDS), the United Nations Development Program (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Office on Drugs and Crime (UNODC), the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), the World Bank, and/or the World Health Organization (WHO), but you will find many more mentioned here. What follows are some brief profiles of key gender/media, health/communication, and campaigns, initiatives and projects from organizations highly relevant to the topic of African women and HIV/AIDS.

Gender/Media Organizations

For starters, be bowled over with the 2006 online document *Organisations Working in Kenya to Address HIV and AIDS in Women* (http://data.unaids.org/pub/Report/2006/20060630_GCWA_RE_Directory_Women_AIDS_Kenya_en.pdf), organized by these themes: preventing HIV infection, protecting ownership and inheritance rights of women and children, ensuring access by women and girls to care and treatment, supporting ongoing efforts toward universal education for girls, promoting new prevention options for women—including female condoms and microbicides, enacting social protection measures to support women in their domestic and caring responsibilities, and ending violence against women. Although each one there is worth wider illumination, a selected general few relative to gender and media will be highlighted here: *The Communication Initiative* (The CI), the *Communication for Social Change* (CFSC) Consortium, *FAMEDEV, It begins with you*, *Local Voices, Memory Book Project*, *Society for Women and AIDS in Africa* (SWAA), *Soul Beat Africa*, *Stepping Stones*, *Swazis Positive Living* (SWAPOL), *TASO*, and Rwanda's *Village of Hope*.

An online network "for sharing the experiences of, and building bridges between, the people and organisations engaged in or supporting communication as a fundamental strategy for economic and social development and

change" (www.comminit.com), The CI summarizes information for groups and individuals interested in development. Its data about HIV/AIDS and media and edutainment in Africa are especially helpful. CI partners with a number of agencies whose names appear throughout this book: Agencia de Noticias dos Direitos da Infancia (ANDI), BBC World Service Trust. Bernard van Leer Foundation, Calandria (Asociación de Comunicadores Sociales, Communication for Social Change (CFSC) Consortium, Canadian International Development Agency, The Department for International Development (DFID), Food and Agriculture Organisation of The United Nations (FAO), Ford Foundation, Fundación Nuevo Periodismo Iberoamericano (FNPI), Healthlink Worldwide, Healthlink Worldwide, Inter-American Development Bank (IDB), International Institute for Communication and Development (IICD), Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP), Media Institute for Southern Africa (MISA), Pan American Health Organization (PAHO), The Panos Institute, The Rockefeller Foundation, SAfAIDS, Sesame Workshop, Soul City Institute, Swiss Agency for Development and Cooperation (SDC), UNAIDS, UNDP, UNICEF, USAID, World Health Organization (WHO), and W.K. Kellogg Foundation.

The Inter- African Network for Women, Media, Gender and Development (***FAMEDEV***) focuses on community media and ICTs to accelerate development and participation. Established in Dakar, Senegal in 2000, its key programs are Child Abuse: Victims of Circumstance and Cyber Love. Its objectives include:

- To promote the development of the African Continent through information, communication and new technologies
- To conscientise African people especially women, on main development issues and ways and means of liberating Africa from poverty
- Create and entertain a network for the production, management and exchange of information on pertinent themes such as poverty, freedom of expression, gender equity, human rights, children's rights, regional integration, civic education, the environment, health and the transfer of technologies.
- To promote information and communication at grassroots level through mass media including community media
- Involve women and men in the media in conflict prevention, management and resolution through civic journalism
- To mobilise and encourage men and women of the media to be more interested and sensitive to health issues such as HIV/AIDS, Malaria and TB which impede Africa's development
- To promote programmes that are favourable to press freedom, good governance, democracy, regional integration, peace and security in African societies (www.famedev.org).

The ***Communication for Social Change*** (CFSC) Consortium is an international non-profit whose stated goal is "to build local capacity of people living in poor and marginalized communities to use communication in order to improve their own lives" (www.communicationforsocialchange.org). Established in 2003 from work within the Rockefeller Foundation, it now networks to encourage bottom-up communication. Amongst its many projects is *aids2031*, which brings together multidisciplinary teams to pool thoughts beyond short-term, crisis management approaches to considering sustainable options.

It begins with you (www.itbeginswithyou.org), also known as the YOU campaign, is an initiative of the African Broadcast Media Partnership Against HIV/AIDS (ABMP) focusing on gender inequity, peer pressure, sexual coercion, stigma, and concerns for an HIV-free future. It was developed and is now supported by the Coca Cola Africa Foundation, the Henry J. Kaiser Family Foundation, the Bill and Melinda Gates Foundation,[1] the Nelson Mandela Foundation, and Merck & Company—a result of the 2004 Global Media AIDS Initiative (GMAI).

"***Local Voices***," a USAID-funded program in Chad, Côte d'Ivoire, Ethiopia, Kenya, Rwanda, and Nigeria engaging media professionals in public health issues, is managed by Internews (www.internews.org). By means of interviews, HIV/AIDS reporting has significantly improved thanks to training of radio journalists, disc jockeys and talk show hosts.

Kaori Izumi (2006b, p. 7) emphasizes ***The Memory Book Project*** that began in Uganda, encouraging keeping track of assets and activities: "This project teaches the basics of parenting and communication skills to both parents and children, and guardians and foster children. It promotes the disclosure of HIV status and parents to children, and vice versa, and prepares for eventual separation of families in the event of death. It also trains families and children how to handle death when it arrives."

The ***Society for Women and AIDS in Africa*** (SWAA) is a pan-African organization that, since 1988, has been dedicated to women and their families in the fight against HIV/AIDS "by strengthening capacity to prevent, control, and mitigate the impact of the epidemic" (www.swaainternational.org). It has country offices in 39 countries: Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Republic of Congo, Democratic Republic of Congo, Cote d'Ivoire, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Sudan, Swaziland, Tanzania, Togo, Uganda, Zambia, and Zimbabwe. SWAA's key areas of intervention include the following: prevention of HIV transmission with currently available technologies (male and female condoms, clean syringes) and promotion of future technologies in addition to behavior change communication, advocacy for orphans and vulnerable children, human rights promotion, protection of mother and child (PMTCT services), microbicides, access to treatment and anti-retro viral drugs (ARVs),[2] having a policy on sex workers, integration of HIV/AIDS into grassroots programs, psycho-social support, and voluntary counseling and testing.

Soul Beat Africa (http://www.comminit.com/en/africa/about-soul-beat.html), a collaboration between Soul City and The Communication Initiative, aims to be—according to its Web site, "a space for communicators across Africa to share communication for development knowledge, experiences, materials, strategic thinking and events, and to engage in discussion and debate." Using varied communication approaches, ranging from advocacy, entertainment, social marketing, and media to development issues, it provides invaluable summaries of programs, evaluations, strategic thinking, materials, awards and funding opportunities, events and training, universities, links, discussion forums and polls through theme Web sites of community radio and edutainment.

Based on a training package developed by Alice Welbourn (1995), part of the Strategies for Hope (SFH) series, ***Stepping Stones*** is a life-skills series about

HIV/AIDS, communication, and relationships. Its workshop process, for which the trainers have a 240-page manual and videos, centers on gender inequalities and gender violence; it is divided into these themes:

- *Introductions and group cooperation development*: It asks, "What is love?", and then discusses stigma, promoting respect, support for and solidarity with HIV-positive people.
- *HIV and safer sex*: STI and HIV reduction, VCT and access to treatment update, care and support for people with HIV and their carers, unwanted pregnancy, challenging homophobia and embracing diversity, fertility protection, and condom use.
- *Why we behave in the ways we do*: hopes and fears for the future, self-esteem and self-efficacy, substance use, traditions, and sharing household expenditure and tasks.
- *Ways in which we can change*: acting assertively, trust and honesty, preparing for death, coping with grief, and looking to the future.

With emphasis on local and personal issues and traditions, Stepping Stones (www.steppingstonesfeedback.org) has been used by more than 1,500 organizations in 100+ countries and is listed in the UNAIDS best resources for community mobilization. In their evaluation of the program, Jewkes et al. (2007, p. 4) concluded that, "Stepping Stones is the first HIV prevention behavioural intervention to have been subject to the most rigorous level of evaluation in Africa and to have provided some evidence of success in reducing sexually transmitted infections in women and in changing men's sexual risk taking behaviour and reduced their use of violence."

Swazis Positive Living (SWAPOL), launched as a support group for HIV-positive women by five women who had experienced stigma and discrimination from their families and communities, relies upon a self-sustaining agricultural cooperative for its funds. Its work, home-based, includes child protection, training community counselors, and helping AIDS orphans, widows, and PLWHA. With approval from the 55 chiefs of Swaziland's 55 districts, the women adopted an empty field that they soon cultivated, using sales from their crops to maintain the program; although no one gets a salary, half the profits go to fertilizer and tools, and the other half is divided among members and their constituencies. "Most of our members are without jobs, either retrenched or lying at home," reports SWAPOL director Siphiwe Hlophe (in Izumi, 2006a, p. 60). But the organization's broad-based activities continue, and many of the members report being positive at least about their involvement.

Cindy Patton (1994, p. 130) cites an exciting example called ***TASO*** (The AIDS Support Organization):

> Although focused on the individual person with AIDS, TASO approaches women's HIV-related needs through their families. Because identified AIDS cases in urban Uganda typically include a man and one or more female partners and their children, TASO is able to effectively address many of the women's needs for HIV-related counseling through supporting the women's families. TASO peer counselors, who are usually themselves persons with HIV/AIDS, replace or augment the roles in the family that have been disrupted by AIDS. Thus, TASO brings together a community of formerly unrelated family units for mutual support.

Rwandan Women's Community Development Network (RWCDN) established the ***Village of Hope*** following the country's genocide in 1994, when so many women were targeted victims of sexual and gender-based violence. With emphasis on healing from trauma and trying reconciliation schemes, programs in two places in the country work with PLWHA for communication and behavior change—facilitated by low-cost housing as shelter. Part of the Stephen Lewis Foundation, its objectives include training of trainers (TOT) for home care, health, and psychosocial support, sensitization to and education about HIV/AIDS relative to awareness and prevention, and building capacity for those in need.

In addition, check out these gender/media organizations: *AfricaWoman* (a women-led news/broadcasting service in Ghana, Kenya, Uganda, and Zimbabwe), *Feminia* (Cameroon), *Journ-AIDS* (HIV/AIDS and the Media Project, Journalism Programme, University of the Witwatersrand, South Africa), *Journalists for Human Rights* (JHR)—Ghana and Sierra Leone, *Media Foundation for West Africa* (MFWA), *Media Resource and Advocacy Centre* (Nigeria), *African Rural Press in Action* (ARUPA), the *South African Media and Gender Institute*, *Women, Media, and Change* (WOMEC) in Ghana.

Health/Communication Organizations

Because health—especially sexual and reproductive health, is so central to the discussion of African women and HIV/AIDS, it seems appropriate to elaborate a bit on these key organizations: *Africa Consultants International* (ACI), *African Women's Development Fund* (AWDF), *Aids & Africa*, Ethiopia's *AIDS Resource Center* (ARC), Amanitare, The *Center for Communication Programs* (CCP), *Fantsuam Foundation*, *Ikhaya Lobomi Organisation*, *The Stephen Lewis Foundation* (SLF), *Stepping* Stones, Tostan, *Well Women Media Project* (WWMP), and *Wola Nani*.

Africa Consultants International (ACI), an American non-profit headquartered in Dakar, Senegal, is involved in these activities:

- Strengthening the capacity and skills of national and community-based organizations.
- Supporting advocacy and policy dialogue initiatives.
- Developing systemic responses to HIV/AIDS in the Education Sector.
- Disseminating health-related information and technology.
- Designing and implementing research and studies.
- Developing IEC documents and learning tools.
- Transforming the results of scientific research into user-friendly, advocacy and policy dialogue documents.
- Designing and facilitating responsive, participatory training.
- Building communication networks.

Established in 1984 by Lillian Baer and Gary Engelberg, its Health Department aims to foster "appropriate, effective responses to the HIV/AIDS epidemic and its consequences, and to related problems of reproductive health and sexually transmitted infections" (www.acibaobab.org). Both at its offices and through its journal, *Yegoo*, ACI's Areas of Concentration include Poles of Excellence, advocacy and policy dialogue, promoting better media coverage of health issues in Africa, and HIV/AIDS education in West Africa—mainly the Gambia, Ghana, Guinea, Mali, and Senegal.

A fundraising and grant-making initiative, the ***African Women's Development Fund's*** (AWDF) vision is "for African women to live in a changed world in which transformed women can live with integrity and in peace" (www.awdf.org). Established in 2000, it has already awarded grants worth nearly $5,000,000 to 386 women's organizations in 40 African countries. Its HIV/AIDS Fund, targeting African women's needs and circumstances in prevention, treatment, support and community care, includes the following: "Support for groups of women living with HIV/AIDS, advocacy and campaigning for gender sensitive treatment access and health care delivery systems, home-based care and all forms of support necessary to ensure women's dignity and well-being, treatment literacy programs for HIV infected women, support for orphans, particularly young children heads of households, support for voluntary testing and counseling, anti-stigma campaigns, young women and young men in tertiary institutions, and adoption counseling."

"Action, not silence" is the motto of ***Aids & Africa*** (www.aidsandafrica.com), an NGO using the Internet to encourage people to help fight AIDS in Africa. Established in 2000, it provides current data, stating, "No one needs to become a full-time AIDS activist to get involved in the fight against HIV/AIDS in Africa."

Ethiopia's premier source of HIV/AIDS information comes from ***The AIDS Resource Center*** (ARC)—a library and clearinghouse providing health information. Established in 2002, these are ARC's goals:

1. Provide Ethiopians with up-to-date and accurate HIV and AIDS and related information by developing and maintaining a clearinghouse on all HIV and AIDS, voluntary counseling and testing (VCT), sexually transmitted diseases (STDs) and Tuberculosis (TB) materials (print, electronic and audiovisual).
2. Develop a materials and networking database (www.etharc.org/aidsineth) and a Web site (www.etharc.org) with international links and email list-servers.
3. Oversee the development of high-quality Ethiopian print and audio-visual HIV and AIDS BCC materials.
4. Develop a strong relationship with the Ethiopian media by training print, radio, and television journalists and editors in HIV and AIDS reporting and serving as an ongoing source of information for these journalists.
5. Establish and maintain an AIDS Hotline to ensure that Ethiopians have an additional resource to access free and anonymous HIV and AIDS information, counseling and referrals.
6. Establish 11 regional AIDS Resource Center sites at regional HAPCO offices that will serve as information centers and be linked electronically to the main ARC in Addis Ababa.
7. Encourage networking and coordination of HIV and AIDS players.

A Rainbo (Research, Action and Information Network for Bodily Integrity of Women) initiative, ***Amanitare***: The African Partnership for the Sexual & Reproductive Health & Rights of Women & Girls is involved in these efforts:

- Curtail the spread of HIV/AIDS,
- Reduce maternal mortality and
- Promote family planning (www.rainbo.org/amanitare.html)

Established in 2000 with a name honoring an ancient Nubian queen, it is made up of 50 members from 21 African countries.

Johns Hopkins Bloomberg School of Public Health Center, in Baltimore, Maryland, has been sponsoring ***The Center for Communication Programs*** (CCP) since 1988—focusing on communication in health behavior change. Producer of an award-winning documentary about HIV/AIDS stigma in Zambia, a television program on family health in Egypt, a comic book on health-seeking behavior among students at Addis Ababa University, and much more, its reach has been evident across the continent.

"Pioneering gender- and youth-focused microfinance and ICT services in rural communities in Nigeria," the ***Fantsuam Foundation*** (www.fantsuam.org) works on healthcare needs of local women by introducing them to safer techniques and cataloguing their traditional medical wisdom. In particular, it has dealt with non-sexual transmission of HIV/AIDS such as through using unsterilized razors for circumcision and facial tribal marks.

The ***Ikhaya Lobomi Organisation*** is a community-based hospice offering "respite and terminal care to AIDS sufferers from the KwaNyuswa area, South Africa" (www.homeoflife.org.za). Accommodation and medication are free, and the staff are all volunteers, many of whom themselves are HIV-positive.

"Easing the pain of HIV/AIDS in Africa" is the overarching motto of ***The Stephen Lewis Foundation*** (SLF). Working at the grassroots level, it "provides care to women who are ill and struggling to survive; assists orphans and other AIDS affected children; supports heroic grandmothers who almost single-handedly care for their orphan grandchildren; and supports associations of people living with HIV/AIDS" (www.stephenlewisfoundation.org).

Stepping Stones, a South African program for HIV prevention aiming to improve sexual health through communication between partners, uses participatory approaches (Jewkes et al., 2007).

"To empower African communities to bring about sustainable development and positive social transformation based on respect for human rights" is the stated mission of ***Tostan*** (www.tostan.org), an education program that means "breakthrough" in Wolof—the language of Senegal. Established in 1991, thanks to the work of Molly Melching, today Tostan operates in Senegal, Guinea, The Gambia, Mauritania, Somalia, and Djibouti, and parts of its program have also been implemented in Burkina Faso, Mali, and Sudan. Focusing on modules of hygiene, problem-solving, women's health, and human rights, the NGO won the 2007 Conrad N. Hilton Humanitarian Prize.

Health Unlimited, a UK based NGO supporting communities affected by war or conflict, launched the ***Well Women Media Project*** (WWMP)—interactive radio and television shows centering women's reproductive and sexual health in Somalia and Rwanda. Whether call-ins, soap operas, the audience-participation shows deal with issues such as domestic violence, HIV/AIDS, FGM, birth spacing, girls' rights to education, sexuality, and income generation for women.

Wola Nani ("We embrace and develop one another" in Xhosa) is a South African NGO focusing on HIV-positive women and their children. Established in 1994, it has participatory programs for coping strategies, safer sex drives ("Condom Bashes"), dispelling myths, training and income-generation programs (such as AIDS ribbons), lay counseling, and encouragement of HIV/AIDS de-stigmatization; in addition, Wola Nani published *Antiretroviral Treatment Literacy for Caregivers of Children on Treatment* (2006).[3] Combining interpersonal,

entrepreneurial, mental health, and outreach/educational initiatives, it is a classic example of economic development.

Campaigns, Initiatives, and Projects

Even though some organizations cross many lines in terms of gender, health, and/or communication, it is worth noting a number whose contributions to the topic of African women and HIV/AIDS is invaluable: *Clowns Without Borders, Development Through Media* (DTM), *DramAidE, Femmes Actives de Cote d'Ivoire*, *GOLD Peer Education Development, Green Belt Movement* (GBM), *GROOTS Kenya*, IRIN, *Jali Watoto*, the *Mutapola* Campaign, Positive *Muslims*, *Right To Play* (RTP), the *Sara Communication Initiative*, *Save the Children*, *Scenarios from Africa*, *Story Workshop*, *TackleAfrica, Takalani Sesame*, the *Teenage Life Programme* (TELIP), and *Watu Wa Watu*.

Bringing laughter to children in crisis areas—including refugee camps, conflict zones, and emergency situations, ***Clowns Without Borders*** is an international humanitarian organization that, since 1993, has had hundreds of expeditions. Its Project Njabulo focuses on providing "psycho-social support to children orphaned and affected by HIV/AIDS in Southern Africa" (www.clownswithoutborders.org). So far, it has visited Kwazulu/Natal, South Africa, Swaziland, and Lesotho.

Development Through Media (DTM), a non-profit organization headquartered in Nairobi that concerns itself with social development throughout East Africa as it might impact global communities, uses broadcast monitoring, talk shows, documentaries, PSAs, drama feature films, and special A/V media activities.

Using drama to critically encourage young people to communicate about sex, sexuality and HIV/AIDS, ***DramAidE*** (Drama in AIDS Education) works with a network of peer educators out of the Centre for Communication, Cultural and Media Studies at the University of KwaZulu-Natal (UKZN), the province with the highest HIV prevalence rate in South Africa. Its goal of helping young people manage the epidemic include these aims:

- Reducing stigma and discrimination about HIV/AIDS.
- Addressing gender issues and how they relate to HIV/AIDS.
- Initiating and establishing clubs and support groups.
- Promoting healthy behaviours such as VCT.

Established in 1992 at the University of Zululand (UZ), today it collaborates with primary, secondary and tertiary educational institutions, as well as in surrounding communities. In keeping with South Africa's proud oral tradition, story-telling and theatre for encouraging behavioral change are ideal.

The ***Femmes Actives de Cote d'Ivoire*** network works as a support group for HIV/AIDS- infected pregnant women, encouraging them to dialogue and to listen to one another.

"Generation Of Leaders Discovered" is for the ***GOLD Peer Education Development Agency***, a non-profit in Botswana and South Africa that works through peer education to direct youth leadership in HIV/AIDS prevention.

The Kenyan-based ***Green Belt Movement*** (GBM) advocates for women's human rights, good governance, and "peaceful democratic change through the

protection of the environment" (www.greenbeltmovement.org). Established in 1977 by Dr. Wangari Maathai, the first African woman and the first environmentalist to be awarded the Nobel Peace Prize (in 2004), its capacity-building program includes assisting young girls and women in educational decisions about sexual and reproductive health relative to protecting themselves against HIV/AIDS.

GROOTS Kenya (Grassroots Organisations Together in Sisterhood), a grassroots NGO network situated in the slums of Nairobi, reports this from its homepage (www.groots.org): "The most effective response to HIV/AIDS among poor communities has been the strengthening of Home-Based Care. Communities have been able to recreate social networks to support care for the sick and the growing number of children orphaned by AIDS. These women volunteer their valuable time to care and train their communities on HIV/AIDS." Visiting their neighbors, carrying for them and cleaning their shelters, these women all too often then have to return to their own families who are in similar situations; whether they realize it or not, this is African culture at its finest in terms of sharing.

Integrated Regional Information Networks (***IRIN***), part of the UN Office for the Coordination of Humanitarian Affairs, provides news and analysis about sub-Saharan Africa, the Middle East, and parts of Asia for the humanitarian community.

Jali Watoto ("Care for Children"), a community-based Tanzanian HIV/AIDS anti-stigma and discrimination campaign, was established in 2006 as a means of supporting prevention, care, education, and support activities.

The ***Mutapola Campaign***, a collaboration of the Southern Africa Partnerships Programme (SAPP), Action Aid International, and Open Society Initiatives for Southern Africa (OSISA), advocates and defends the rights of, and gives voice to, South African girls and women living with HIV/AIDS.

Positive Muslims, an NGO established in 2000, offers education, counseling, and support services to PLWHAs among South Africa's Muslim population. The awareness-raising support group follows a 'theology of compassion' that uses the Qur'an to help see Allah (God) as a compassionate being. Based on a buddy system, it has shifted to "a new vision, which requires accepting the importance of one's self, together with an appreciation of the greater importance of others over oneself" (Ahmed and Noordien, 2001). Needing to get beyond notions that AIDS is a curse from Allah, or that it is a gay disease, or that it only affects black people, its biggest challenge is convincing fellow Muslim how much the disease can and does affect them.

Right To Play (RTP) "uses specially-designed sport and play programmes to improve health, build life skills, and foster peace for children and communities affected by war, poverty, disease" (www.righttoplay.com). Implementing Sport for Development and Peace programs, the humanitarian organization is especially helpful for youth at risk for, and/or orphaned by HIV/AIDS. In Africa, it is working in Angola, Benin, Ethiopia, Ghana, Guinea, Kenya, Mozambique, Rwanda, Sierra Leone, Tanzania, Uganda, and Zambia.

Based on a teenager character in peri-urban Africa, the ***Sara Communication Initiative*** (SCI) was established in 1996 by UNICEF-ESARO (East and Southern Africa Regional Office) as a regional communication package dealing with the rights of the child. Designed as an empowering role model for girls in Ethiopia, Malawi, Mozambique, Rwanda, Tanzania, and Uganda facing HIV/AIDS.

Stories about safe school environments, role models, dealing with boys, and courage, presented in comic books and animated movies, are meant to highlight the heroine's determination to improve herself and her community. The episodes come with a guidebook, and Sara clubs, songs, and dramas were part of the process.

Billing itself as "the world's largest independent organization for children, making a difference to children's lives in over 120 countries," ***Save the Children*** (www.savethechildren.org) is dedicated to securing and protecting children's basic rights.

With headquarters in the U. S., the International Save the Children Alliance is in London.

"A community mobilisation, education and media project about HIV/AIDS carried out with and for young people," ***Scenarios from Africa*** is a project of Global Dialogues (www.globaldialogues.org). Inviting contestants to produce and participate in competitions educating themselves and others about HIV/AIDS, to date it has involved more than 105,000 young people from 37 African countries. The films are broadcast on local television stations throughout sub-Saharan Africa and are available on DVDs and VHS cassettes in a wide range of languages.

Since 1996, ***Story Workshop*** has operated out of Malawi. Its first project was *Zimachitika*, a radio soap about family health, and since then it has used creative entertainment to deal with issues on food security, health and HIV/AIDS, environmental protection, human rights and democracy, and gender.

"Helping to kick AIDS out of Africa" is the motto for ***TackleAfrica***, an organization "Using football to reach young people in Africa to increase their understanding of HIV/AIDS and enabling them to live safe and healthy lives" (www.tackleafrica.org).

In an effort to educate South African children ages 3–7, as well as their caregivers, about the HIV/AIDS pandemic and how to cope with its impact, ***Takalani Sesame*** ("Be happy Sesame," in Venda) began broadcasting in 2000. One of the main characters is Kami, a 5-year-old HIV-positive Muppet. As part of its AIDS awareness curriculum, emphasizing tolerance, literacy, and life skills, Kami ("Acceptance," in Tswana) is cuddly, smart, and fun—the ideal role model of an asymptomatic infected person. Looking like a regular kid, not skinny and sickly, we learn than her mother died of the disease and now a loving family has adopted her. A partnership of the South African Broadcasting Corporation (SABC), the South African Department of Education (DoE), and Sesame Workshop, supported by USAID and the financial services group Sanlam, *Takalani Sesame* (www.schooltv.co.za/TakHome.htm) uses all of South Africa's languages, including Afrikaans, English, Ndebele, Sesotho, Northern Sotho, Swazi, Tsonga, Tswana, Venda, Xhosa, and Zulu. Archbishop Desmond Tutu, Kofi Annan, and other notable South Africans have made guest appearances on the show.[4]

Established in Dar es Salaam, Tanzania in 2002, ***Teenage Life Programme*** (TELIP) "warns youth about prostitution, rape, drug abuse, drunkenness, and robbery—all of which are believed to play a significant role in the spread of HIV/AIDS" (www.teenagelife.4t.com). Like Sisi Kwa Sisi, a grassroots community organization that works with young Tanzanians, it is a consultative member of the International Humanist and Ethical Youth Organisation (IHEYO).

Watu Wa Watu ("People Serve People") is a Tanzanian NGO working at the grassroots level to fight the spread of HIV/AIDS by raising awareness about it. Its communication strategies revolve around these principles: unity, commitment, participation, non-corruption, relationship and mutual respect, human rights, protection of the environment, spiritual freedom, development of the human creative potential, universal and adult education, and poverty eradication.

Individual Contributors to HIV/AIDS

> HIV/AIDS communicators have been successful in broadening awareness of HIV/AIDS; increasing knowledge of how HIV/AIDS is contracted; placing HIV/AIDS in the context of human rights; increasing knowledge and demands for effective services, and mobilizing political support for national HIV/AIDS plans. Local, national and international communities, however, have struggled to make an impact on overall HIV/AIDS rates.
>
> Fox and de Bruin, HIV/AIDS and Communication Strategies (2002).

Although it is tricky to single out certain individuals, and most of them would humbly credit teams of others in their efforts, there are some people who have stood out for their heroic efforts in and about Africa. For example, just think about the pan-African impact that Wangari Maathai of Kenya has made, establishing the Green Belt Movement and winning the 2004 Nobel Peace Prize; you might want to read her autobiography, *Unbowed: One Woman's Story* (2007). And of course there is Oprah Winfrey, whose efforts at educational reform are cited here in Chapter 6; echoing (U2 singer) Bono, she has labeled AIDS, "The greatest moral issue of our time. It is necessary to every human being who has had an understanding of the issue to do something to fight it. We need change politically, medically, socially, emotionally and spiritually because we are all affected and infected in one way or the other."[5] You have undoubtedly also read about Bill Gates' and George Soros' philanthropy, Bono's breakthrough work with *Project Red*, Bob Geldorf's involvement with Band Aid.

You may know about Dr. Peter Piot, UNAIDS Executive Director and Under Secretary-General of the United Nations; Jeffrey Sachs, director of the Center for International Development at Harvard University, who has advocated that more money be donated to fight AIDS in Africa; Stephen Lewis, United Nations Secretary General's (UNSG) Special Envoy on HIV/AIDS in Africa; Carol Bellamy, former executive director of UNICEF and now president of World Learning; Sudanese businessman Mo Ibrahim, founder of the Achievement in African Leadership Prize ($5 million); the former president Bill Clinton for his Clinton Foundation HIV/AIDS Initiative (CHAI); physician Paul Farmer of Partners In Health (PIH), who also oversees AIDS projects in Malawi, Lesotho, and Rwanda, and no doubt you can name and nominate others.

In the journalistic arena, the impeccable reportage of Sharon La Franiere and Nicholas Kristof for the *New York Times*, Michael Specter for the *New Yorker*, Paul Salopek for the *Chicago Tribune*, Charlayne Hunter-Gault for PBS, Christiane Amanpour for CNN, Danna Harman for the *Christian Science Monitor*, Ken Silverstein for the *Los Angeles Times* (now with *Harper's*), Mark Schoofs for the *Village Voice*, John Donnelly for the *Boston Globe*, Emily Wax for the *Washington*

Post to name a few. MediaChannel's "Media Challenges in Africa" (www.medichannel.org/atissue/africanmedia) also are admirable—describing challenges of African journalists, drawing the link between communication technologies and community media, analyzing AIDS in the media, and spotlighting affiliates from Botswana, Kenya, southern and South Africa.

From Africa itself, notice should be taken of Ernest Darkoh, who is heading Botswana's free AIDS-drug program; Ayisi Makatiani of Kenya, who started Africa Online and Gallium Capital; Chris Kayomba, who started Rwanda's first daily opposition newspaper; Bruktawait Dawit Abdi, married at age 16 and the mother of three children, who created one of Ethiopia's first private banks; Uhuru Kenyatta, much in the news relative to Kenya's civil unrest; the Reverend Molefe Tsele, general secretary of the South African Council of Churches. No doubt you can add many more names.

This book has obviously benefited greatly from their commitment and courage in keeping up with the extremes of Africa. Then again, think of all those individual, if nameless, African women who manage to make it through each day. Many are inspired by mentors, by religion, by media examples, even by dint of their own experience (see Kalabamu, 2003).

Hopes/Plans for Africa's Future

> What is needed is real, positive change that will give more power and confidence to women and girls... change that will allow women to play to the full their role in the fight against HIV and AIDS. Empowering women in this struggle must be our strategy for the future.
>
> Kofi A. Annan, address to the UN (December 1, 2004).

It is quite clear to me as to why it took me so long to tackle this book. At first, I became too emotionally involved in the stories about and situations of African women; then, as my research accumulated, I became overwhelmed by the many intersecting issues involved in their vulnerabilities to HIV/AIDS. It was only when I began to realize that the very work that has consumed my practical professional life—access, community media, ICTs, and the value of teamwork, did it all come together as a solution: how communication is critical to development. Maybe because I'm optimistic by nature, it helped to glom onto articles such as that advanced by John Williamson, Senior Technical Advisor of USAID's Displaced Children and Orphans Fund (2003), where he insists our media factor in the following:

> ...the heroic efforts I've been privileged to see, where people (most of them poor) come together in villages and urban communities to do what they can to help children and adults worse off than themselves. Such people and extended families are the first line of response to HIV/AIDS, and what is done by governments, NGOs, religious groups, international organizations, donor agencies, and others will only make significant impact in the long term only if
>
> it supports and strengthens the ongoing, daily efforts at family and community level. The truth is that there is great capacity in Africa and the situation is not hopeless.

Clearly, the issue of HIV/AIDS goes far beyond one of health. In terms of mental health, we find that women's groups working together can be extremely powerful. It is all part of empowerment.

There is actually a resource known as the *Hope Kit*—available through the Media/Materials Clearinghouse (www.m-mc.org/spotlight/malawi_hopekit)—for facilitating discussion about HIV prevention issues in Malawi. It includes such materials as the *Journey of Hope Activity Book*, *The Message Guide*, *Nditha! Campaign Materials*, *National AIDS Commission Info Voluntary Counseling and Testing of HIV Information*, and *Living Positively with HIV and AIDS*. And we can't help but get excited at the recent announcement by Namibia's Ministry of Health and Social Services that is has started a program called Communication for Behavioural Impact (COMBI), which aims to address prevention by people knowledgeable about HIV/AIDS who engage in high-risk behaviors (Schier, 2007). South Africa and Zimbabwe have organized the *Hoops 4 Hope* project, inviting kids to participate in both basketball and life-skills development through the notion of teamwork. And *Africa Mercy*, the world's largest charity hospital ship, has provided free healthcare to people in Liberia and Sierra Leone, with plans to go around the continent; with 80 beds, 400 multinational volunteers, and 6 operating theatres, it can perform 7,000 operations annually (Toweh, 2007).

More than Medicine

> Last month, scientists invented the AIDS vaccine. Missed it? Perhaps that's because you were still seeking the vaccine fantasy: the magic bullet, the impenetrable shield that finally pitches this disease into the trash bin, the shot that will end not only the AIDS epidemic but our anxiety about the AIDS epidemic as well. The vaccine thunderbolt didn't strike—and might never. Drearily, the real AIDS vaccine is likely to be imperfect: one more tool in our arsenal, to be used along with condoms and all our other tools. It will most likely avert millions of infections and save millions of lives. But it will not end the Age of AIDS.
>
> Tina Rosenberg, A Real-World AIDS Vaccine? (2007).

From what you have read here, you can see that the topic of African women relative to HIV/AIDS is an extremely complex, regionally-specific issue (Campbell, 2003; Craddock et al., 2003; Easterly, 2006). It becomes ever clearer that HIV/AIDS is really a human rights issue, a development issue, a social inequality issue, an educational issue, a legal/political issue, an economic issue and, most of all, a moral/ethical issue.

We have long looked to medicine for the answer. We know that pharmaceuticals can slow the disease, but we also know that they come at a high cost. For most Africans, the prices are astronomical, the treatments seem insane (how can a person be programmed to take certain pills at certain times when s/he doesn't know how to read or tell time?), and their dissemination can be close to impossible. We see studies confirming that circumcision helps protect men from HIV infection, but are nearly helpless in convincing a bulk of them about these findings. We remain stagnated on issues like breastfeeding when mothers are HIV-positive, we wonder when microbicides and the female condom will be available at a reasonable rates, and despite many efforts ARVs are unavailable

for most Africans. Until we realize the tie between African women's biomedical health status and the continent's socioeconomic future, development both for individuals and for whole cultures is on hold.

We grasp at the least glimmer of hope for Africa. Whether it is the recent enlightenment of fertilizer to help Malawian farmers, the invention of a female anti-rape condom[6] in South Africa, improvements in microbicides, the discovery of a group of prostitutes in Nairobi who appear to have natural immunity against HIV,[7] or efforts to develop an AIDS vaccine, we keep the faith.

Although some African countries have bleaker prospects than others, it becomes clear that their futures, in terms of HIV/AIDS, are multisectoral. There is no single answer for the many people and places in Africa (see McDermott, 2007). Until there is the realization that a number of interrelated issues are at play, governments, agencies and organizations, bilateral donors and individuals will get nowhere fighting its many battles. We need to talk to one another in a common language: the language of human decency. We need to communicate our feelings and our ideas.

Further Research

In 1990, Catania, Kegeles, and Coates constructed a three-stage model for AIDS Risk Reduction: recognition and labeling of one's behavior as high risk; making a commitment to reduce high-risk sexual contacts and to increase low-risk activities; and taking action. Not much later, Clayton, Williams, and Bridbord (1994, p. 599) suggested these categories of research topics worthy of consideration:

- Maternal and child health with an emphasis on perinatal transmission in Africa;
- Detection of other retroviruses with an emphasis on other strains of HIV in Africa;
- Sociocultural behavioral patterns that predispose to heterosexual transmission;
- Development of low-cost antiretroviral agents that interfere with viral replication;
- The possible relationship of HIV to malignant neoplasia;
- Development of drugs effective against AIDS-associated opportunistic infections, especially those more common in Africa;
- Development of HIV vaccines;
- Development of new technologies for the rural areas to facilitate rapid diagnosis and screening for blood transfusions and other purposes; and
- Research on surveillance to monitor impacts of intervention programs.

In contrast, Fox, Oyosi, and Parker (2002, p. 28) suggest these implications for communication programming: addressing issues of children affected directly or indirectly by HIV/AIDS; issues of stigma and discrimination; socioeconomic issues such as poverty, street children and children in rural contexts; children's older siblings, caregivers, families and communities; dying and bereavement; family/household issues after the death of a parent; orphan hood; disclosure of HIV status; understanding emotional responses to HIV/AIDS impacts; child participation in program development and understanding research relative to HIV/AIDS knowledge, attitudes, beliefs and practice. So, where are we today? It is quite obvious that HIV/AIDS has become an epidemic of globalization,

its trajectory linked to gender inequities. Once we realize the power in and of information, the notion of communication strategies follows easily.

Keeping Perspective

For all the curse brought on us by the HIV/AIDS epidemic, at least it has made us examine ourselves and our priorities and values. Throughout the world, it has opened the discussion on attitudes toward homosexuality, needle exchange, prostitution, blood donations and transfusions, drug testing, euthanasia, the role of media, "outings" and other privacy rights, prisoners' rights, patients' rights, and reproductive rights, breastfeeding, sex education, medical/dental safety, hospice, biomedical research, and much more. It has demonstrated the power of advocacy groups, such as ACT-UP, Treatment Action Group, and many others, and their role in the public eye. Similarly, it has made a role model of the "buddy" program of caregivers that evolved almost simultaneously.

"The silence and anonymity of the African woman are her greatest handicaps," Mercy Amba Oduyoye (1995, p. 82) has written. "Burdened with so many restrictions, she has not found it productive or of enough consequence to educate her Western sisters about herself. Indeed, the oppressed rarely have time for such luxuries." Recognizing that, indeed, we are all sisters, and need to consider ourselves as such regardless of age, race, religion, education, and/or socioeconomic status, at the least this book encourages us to share sensitivities and solidarities. We need to begin to understand the frames of reference that mark African women, especially appreciating their dignities amidst difficult survival strategies under oppressive patriarchal systems. We also need to encourage our sisters around the world to use their own voices; as Oduyoye (p. 170) points out, "For if we ourselves do not deliberately attempt to break the silence about our situation as African women, others will continue to maintain it." Together, we can build empowering networks that can work to combat not just medical, but also moral issues (see Nattrass, 2004; Van Niekerk and Kopelman, 2006).

From the many vulnerabilities outlined here, it becomes clear that those of us with opportunity and expertise need to nurture those under less fortunate circumstances than we find ourselves. Just as Africans envision themselves as being part of wide kinship groups, we all—men and women alike—need to join the village that shares, and cares. Listen to this from a Downtown Social Lady in Harare, Zimbabwe, cited in Laver (1988, p. 283): "How can I fight this problem alone? Others won't believe me, change will be difficult unless it is accepted by my group. I'll be isolated, lose money. I have no insurance, it's hopeless talking about AIDS in these circumstances. We need to be heard as a group, not isolated."

Clearly, while we continue to advocate for an AIDS vaccine, microbicides, and any number of treatment strategies in Africa, we need to move beyond just ideas of HIV/AIDS prevention to ideas of protection from its many adverse effects. What we also need to do is realize that such reciprocal arrangements are the only way we can live with ourselves in the world community (see Campbell, 2003). As feminists and human rights activists, we realize the first step is recognizing gender inequities, and the African face of women when we talk about poverty, before we can even begin to address issues like health and welfare. Chinua Akukwe 2005, p. 5) has declared that, "Efforts to end the feminization

of AIDS in Africa must be African-based and African-implemented"; still, I would argue that we all, as members of the world community, are encouraged to play whatever part we can in the process.

In 2001, the UN General Assembly Special Session on HIV/AIDS produced a Declaration of Commitment, which states: "Empowering women is essential for reducing vulnerability." So, when all is said and done about African women's unique vulnerabilities, we still need to factor in their invincibilities at the same time that we work on promises and programs to help improve their lot.

What happens next for African women, vulnerable to HIV/AIDS, depends on local communities, global communities, governments, civil society, human rights organizations, and you.

What can you do? Let me offer some suggestions:

- Join an organization to help African women with fistula
- Give money to an organization to help African women with literacy
- Write a poem about African women and HIV/AIDS
- Sing a song about African women and HIV/AIDS
- Talk to a friend about African women and HIV/AIDS
- Find out more about needle exchange
- Find out more about safe blood transfusions
- Save some African babies
- Adopt some African babies—actually, or through some organization
- Advocate for inexpensive drugs in Africa
- Advocate for counseling and testing in Africa
- Advocate for an AIDS Peace Corps
- Deal with our local AIDS czar, then discuss having an African AIDS czar
- Go to Africa and meet the (incredibly friendly) people
- Welcome Africans who come to your country
- At the international level, get politically involved in civil society issues
- At the national level, get actively involved in advocacy efforts
- At the local level, work with media to talk about our African sisters
- At work, coordinate donations for critical causes
- At home, get your family involved in global perspectives

In your heart, know that you have taken the first step by reading these stories.

Notes

1. In 2003, the Bill & Melinda Gates Foundation announced the $450 million *Grand Challenges in Global Health* initiative, which included the following:
   Goal 1. Improve Childhood Vaccines
   Grand Challenge #1: Create Effective Single-Dose Vaccines
   Grand Challenge #2: Prepare Vaccines that Do Not Require Refrigeration
   Grand Challenge #3: Develop Needle-Free Vaccine Delivery Systems

   Goal 2. Create New Vaccines
   Grand Challenge #4: Devise Testing Systems for New Vaccines
   Grand Challenge #5: Design Antigens for Protective Immunity
   Grand Challenge #6: Learn about Immunological Responses

   Goal 3. Control Insects that Transmit Agents of Disease
   Grand Challenge #7: Develop a Genetic Strategy to Control Insects
   Grand Challenge #8: Develop a Chemical Strategy to Control Insects

Goal 4. Improve Nutrition to Promote Health
Grand Challenge #9: Create a Nutrient-Rich Staple Plant Species

Goal 5. Improve Drug Treatment of Infectious Diseases
Grand Challenge #10: Find Drugs and Delivery Systems that Limit Drug Resistance

Goal 6. Cure Latent and Chronic Infection
Grand Challenge #11: Create Therapies that Can Cure Latent Infection
Grand Challenge #12: Create Immunological Methods to Cure Latent Infection

Goal 7. Measure Health Status Accurately and Economically in Developing Countries
Grand Challenge #13: Develop Technologies to Assess Population Health
Grand Challenge #14: Develop Versatile Diagnostic Tools

2. Guinea-Bissau bemoans having no anti-retroviral (ARV) treatments available. See also Sarna and Weiss, 2007.
3. With a push toward anti-retroviral therapies (ARTs), and as access to them improves, information and communication about their role in treatment become ever more important (see Dunn, 2007).
4. For more on *Takalani Sesame*, see Peter Hawthorne, Positively Sesame Street (*Time*, September 22, 2002) and Danna Harman, A Muppet tackles AIDS attitudes in South Africa (*Christian Science Monitor*, January 14, 2003).
5. Cited in Ngwenya, 2003.
6. The anti-rape condom, called “rapex,” works by hooking on to the attacker’s penis.
7. Anita Gates, Diseases now in the past, and new ones up ahead (*New York Times*, November 1, 2005).

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APPENDIX I: ACRONYMS

AAAA/HEART	Artists Action Around AIDS/Highly Effective Art—South Africa
AAAO	AIDS Analysis Africa Online
AACP	Association of African Communication Professionals
AAU	Association of African Universities
AAMCT	Asante Akim Multipurpose Community Telecentre—Ghana
AAVP	African AIDS Vaccine Programme
AAWORD	Association of African Women for Research and Development
AAWS	Association of African Women Scholars
ABC	Abstain, Be faithful, Use a Condom
ABMP	African Broadcast Media Partnership Against HIV/AIDS
ABUBEF	Burundian Association for Family Well-Being
ACA	Advertising and Commercial Association
ACAPES	L'association culturelle d'aide à la promotion éducative et sociale
ACAS	Association of Concerned Africa Scholars
ACCE	African Council for Communication Education
ACCORD	African Centre for the Constructive Resolution of Disputes
ACFODE	Action for Development
ACHAP	African Comprehensive HIV/AIDS Partnerships
ACHPR	African Commission on Human and Peoples' Rights
ACI	Africa Consultants International
ACP	AIDS Control Program
ACS	Artistes Contre Le Sida
ACT-UP	AIDS Coalition to Unleash Power
ACW	African Centre for Women
ADB	African Development Bank
ADD	Action on Disability and Development
ADMA	Advertising Media Association
ADMC	Association pour le Développement des Médias Communautaires
AED	Academy for Educational Development
AEGIS	AIDS Education Global Information System
AFA	Ark Foundation of Africa
AFAFSI	Association des Femmes Africaines Face au Sida—Burkina Faso
AFCODE	Agenda for Community Development—Nigeria
AFELP	Association Femme, Enfant, Lutte contre la Pauvrete
AfH	Art for Humanity
AfriMAP	Africa Governance, Monitoring and Advocacy Project
AFRRI	African Farm Radio Research Initiative
AFWE	African Federation of Women Entrepreneurs
AFWOSCHO	Association of African Women Scholars
AGECO	Agence de Communication, Madagascar
AGEI	African Girls' Education Initiative
AGI	African Gender Institute

AHI	Action Health Incorporated, Nigeria
AHRLA	The Association of Human Rights and Legal Aid
AHRTAG	Appropriate Health Resources and Technologies Action Group
AI	Amnesty International
AIC	African Initiated Church
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
AIDSNET	The Danish NGO-Network on AIDS and Development
AIDSTECH	Technical Intervention for the Containment of AIDS
AIF	African Internet Forum
AIM	Agencia de Informacao de Mocambique
AIP	Association of Independent Publishers
AIPPA	Access to Information and Protection of Privacy Act
AIR	American Institutes for Research
AISI	African Information Society Initiative
AITEC	African Information Technology and Exhibition Conference
AJAAT	Association of Journalists Against AIDS in Tanzania
AJPH	American Journal of Public Health
ALC	Africa Learning Channel
AIPPA	Access to Information and Protection of Privacy Act
AITEC	African Information Technology and Exhibition Conference
ALF	Africa Leadership Forum
ALTERCOM	Association des Femmes pour la Communication Alternative
AMAC	Art and Media Access Centre—Cape Town
AMARC	Association mondiale des radio diffuseurs communautaires (World Association of Community Radio Broadcasters)
AMCS	Mozambican Media Women's Association
AMDI	African Media Development Initiative
AmFAR	American Foundation for AIDS Research
AMPS	All Media Products Survey
AMR	Adult Mortality Rate
AMREF	African Medical and Research Foundation
AMSOPT	Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles
AMUJA	Angola Media Women's Association
AMWIK	Association of Media Women in Kenya
ANAIS	Advisory Network for the African Information Society
ANC	African National Congress, South Africa
ANCEFA	Africa Networks Campaign on Education for All
ANDI	Agência de Notícias dos Direitos da Infância (Brazil)
ANOCA	Association of National Olympic Committees of Africa
ANPPCAN	African Network for the Prevention and Protection against Child Abuse and Neglect
ANSFE	African Network for Support to Feminine Entrepreneurship
APAC	African Population Advisory Council
APAS	Agence pour la Promotion des Activities de Population
APC	Association for Progressive Communications
APDF	Association pour le Progres et la Defense des Droits des Femmes Maliennes
APIN	AIDS Prevention Initiative in Nigeria
APT	Amani Peoples Theatre
ARBEF	Rwandese Association for Family Well-Being
ARC	AIDS Related Complex
ARC	AIDS Resource Center (Ethiopia)
ARDA	African Radio Drama Association

ARDI	African Rural Development Initiatives—Uganda
ARI	Acute Respiratory Infection
ARSRC	Africa Regional Sexuality Resource Centre
ART	Antiretroviral therapy
ART	Agence de Régulation des Télécommunications
ART	Anti-Retroviral Theatre—South Africa
ARUPA	African Rural Press in Action
ARVs	Anti-retroviral drugs
ASAFE	Association for Support to Women Entrepreneurs—Cameroon
ASASA	Advertising Standards Authority of South Africa
ASC	Association Sportive et Culturelle
ASCAC	Association for the Study of Classical African Civilizations
ASFV	African swine fever virus
ASO	AIDS service organization
ATAC	African Technical Advisory Committee
ATB	Atelier-Theatre Burkinabe—Burkina Faso
ATR	African Traditional Religion
ATRCW	African Training and Research Centre for Women
ATV	African Together Vision
AU	African Union
AVEGA	Association of the Widows of the Genocide of April (Rwanda)
AVU	African Virtual University
AWARE	Association for Women's AIDS Research & Education
AWC	African Woman and Child Features Service
AWCY	Association of Working Children and Youth
AWDF	African Women's Development Fund
AWOGNet	African Women Global Network
AWSA	Arab Women Solidarity Association
AWMC	African Women's Media Centre
AYA	African Youth Alliance
AZT	Azidovudine (anti-retroviral drug)
BaHiCo	Basics for HIV/AIDS Control Project
BBC	British Broadcasting Corporation
BBSAWS	Babiker Bedri Association Scientific Association for Women's Studies
BCC	Behavior change communication
BCG	Vaccine to protect against TB
BHP	Biomedical health practitioners
BMJ	British Medical Journal
BOCAPA	Book Café Academy of Performing Artists
BOSCO	Battery Operated Systems for Community Outreach—Uganda
BP	British Petroleum
BRTI	Bio-medical Research and Training Institute
C4C	Communication for Change (USA)
CABA	Children Affected by AIDS
CADRE	Centre for AIDS Development, Research and Evaluation
CAFEC	Exchange Centre for Congolese Law
CAFM	Centre Africain des Femmes dans les Medias
CAFS	Centre for African Family Studies
CAJM	The Central Africa Journal of Medicine
CAMS	Commission pour l'abolition des mutilations sexuelles
CAPF	Coalition for Accountable Political Financing—Kenya
CARE	Cooperative for American Relief Everywhere
CASET	Cassette Education Trust, South Africa
CATIA	Catalysing Access to ICT in Africa

CATS	Compassion, Tolerance and Sensitivity campaign—Ethiopia
CATV	The Coalition Against Trafficking in Women
CAUP	Campaign Against Unwanted Pregnancy
CBC	Community Based Communication
CBH	Communications for Better Health
CBO	Community-based organization
CBR	Crude Birth Rate (annual births/1,000 population)
CCAD	Centre Culturel Americain de Dakar
CCATH	Child-centered approaches to HIV/AIDS
CCK	Communication Commission of Kenya
CCMC	Communications Consortium Media Center
CCP	Center for Communications Programs (Johns Hopkins University)
CCTAS	Community Centre for Enhanced Health Technologies—Senegal
CD	Country director
CDA	Community development agent
CDC	Centers for Disease Control
CDD	Control of Diarrheal Diseases program
CDR	Crude death rate (annual deaths/1,000 population)
CDSC	Communicable Disease Surveillance Centre
CE	Code of Ethics
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEDDERT	Centre for Democratic Development, Research and Training
CEDOVIP	Center for Domestic Violence Prevention
CEDPA	Centre for Development and Population Activities
CEEWA	Council for the Economic Empowerment of Women in Africa
CEMAC	Central African Monetary and Economic Community
CERPOD	Centre de Recherche en Population et Developpement
CESCR	Covenant on Economic, Social and Cultural Rights
CESPA	Centre de services de production audiovisuelle, Mali
CESTI	Centre d´etudes des sciences et techniques de l´information
CEWLA	Center for Egyptian Women's Legal Assistance
CfDSC	Communication for Development and Social Change
CFMS-CI	La Cellule des Femmes de Média engagées dans la Lutte contre le Sida
CGE	Commission on Gender Equality
CGI	Clinton Global Initiative
CHAI	Clinton Foundation HIV/AIDS Initiative
CHAPS	Community Health and Awareness Puppeteers—Kenya
CHDC	Child Health and Development Centre
CHIPS	Community Health Intervention Project against STDs
CHL	Communication for Healthy Living—Egypt
CHMT	Community Health Media Trust
CHOGM	Commonwealth Heads of Government Meeting
CIDA	Canadian International Development Agency
CiE	Circus in Ethiopia
CIERRO	Centre regional de formation a la radio en Afrique de l'Ouest
CLAN	Children's Legal Action Network
CLARION	Centre for Law and Research International
CLC	Community Law Center (South Africa)
CMC	Community Multimedia Center
CMR	Child mortality rate (probability of dying between 1–5 years under age 15)
CMV	Cytomegalovirus

CAN	Cinéma Numérique Ambulant/Mobile Digital Cinema—Benin, Niger, Mali
CNRA	Conseil National de Régulation de l'Audiovisuel (National Council for the Regulation of Broadcasting)
CODE	Communication pour de Development, Madagascar
CODESRIA	Council for the Development of Social Science Research in Africa
COHRE	Centre for Housing Rights and Evictions
COMBI	Communication for Behavioural Impact—Namibia
COMNESA	Community Media Network of East and Southern Africa
COPE	Client-oriented, Provider-efficient
COSEPRAT	Comite National Senegalais contre les Pratiques Traditionnelles Nefastes
COVAW (K)	The Coalition on Violence Against Women - Kenya
CORNET	Community Radio Network
CP	Central pharmacy
CPBD	Community Peace Building and Development
CPDA	Christian Partners Development Agency
CPM	Crisis Pregnancy Ministries
CPS	Center for Partnership Studies (CPS)
CPTAFE	La Cellule de Coordination Sur Les Practiques Traditionelles Affectant La Sante des Femmes et des Enfants
CR	Community Radio
CRADLE	The Child Rights Advisory Documentation and Legal Centre
CRC	Convention on the Rights of Children
CREAW	Centre for Rights, Education and Awareness
CREDO	The Centre for Research Education and Development of Rights in Africa
CREW	Children's and Youth Radio Workshop
CRLP	Center for Reproductive Law and Policy
CRTV	Cameroon Radio and Television
CSAE	Child Sexual Abuse and Exploitation
CSD	Civil Society Development
CSEC	Commercial Sexual Exploitation of Children
CSLI	Carole Simpson Leadership Institute
CSO	Civil Society Organization
CSW	Commercial sex work(er)
CSW	Commission on the Status of Women
CTBI	Centre for Technology and Business Incubation
DAC	District AIDS Coordinator
DART	Development Anti-retroviral Therapy
DASA	Democracy in South Africa
DCFRN	Developing Countries Farm Radio Network
DDRRR	Disarmament, Demilitarisation, Repatriation, Resettlement and Reintegration
DFI	Digital Freedom Initiative of America
DFID	Department for International Development
DHE	District Health Educator
DHS	Demographic and Health Survey
DIESA	United Nations Department of International Economic and Social Affairs
DISD	Development Information Services Division
DIVO	Digital Interactive Video Online
DMO	District Medical Officer
DMS	Director of Medical Services

DoE	Department of Education (South Africa)
DoH	Department of Health (South Africa)
DramAidE	Drama in AIDS Education
DTM	Development Through Media—Kenya
DTR	Development through radio
DV	Domestic Violence
DVA	Domestic Violence Act
EADCF	East African Development Communication Foundation
EAMI	Eastern Africa Media Institute
EAMJ	East African Medical Journal
ECA	Economic Commission for Africa (UN)
ECD	Early Childhood Development
ECE	Early Childhood Education
ECOMOG	Economic Community Monitoring Group
ECOSOC	United Nations Economic and Social Council
ECOWAS	The Economic Community of West African States
ECPAT	End Child Prostitution, Child pornography and Trafficking of Children for Sexual Purposes
ECWD	Education Centre for Women in Democracy
EDC	Education Development Center
EDP	Essential Drug Program
EE	Entertainment Education
EEA	Ethiopian Economic Association
EFA	Education for All
EfE	Education for Empowerment
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EKOWISA	E-Knowledge for Women in Southern Africa
ELISA	Enzyme-linked Immunosorbent Assay
ENA	EcoNews Africa
ENAWA	European and North American Women Action
ENC	Egyptian Society for the Care of Children
ENDA	Environmental Development
EOC	Emergency obstetric care
EPI	Expanded Program for Immunization
ERTU	Egyptian Radio and Television Union
ESG	European Study Group on Heterosexual Transmission of HIV
ESSA	The Economic Society of South Africa
ETU	Ethiopian Telecommunications Corporation
ETV	Ethiopian Television
EU	European Union
EWET	The Education With Enterprise Trust
EWL	Econet Wireless
FAMEDEV	Inter-African Network for Women, Media, Gender and Development
FAMW	Federation of African Media Women
FAN	Forest Action Network
FAO	Food and Agriculture Organization (UN)
FARG	Fund to Assist Survivors of the Genocide (Rwanda)
FAS	Femmes Africa Solidarite
FASIC	Faculty Institute for Information and Communication Sciences
FATC	Forgotten Angle Theatre Collaborative—South Africa
FAWE	Forum for African Women Educationalists
FAZ	Football Association of Zambia
FBO	Faith-based organization
FC	Female circumcision

FDA	Food and Drug Administration
FEMNET	The African Women's Development and Communication Network
FES	Friedrich Ebert Stiftung organization
FESPACO	Festival Panafricain du Cinema a Ouagadougou
FFP	Foundation for Female Photojournalists—Ghana
FFP	Fondation Femme Plus
FGC	Female genital cutting
FGD	Focus group discussions
FGM	Female genital mutilation
FHI	Family Health International
FIDA	International Federation of Women Lawyers
FIER	Formation des Enseignants par la Radio/Teacher Training via Radio
FINCA	Foundation for International Community Assistance
FLAK	Family Planning Association of Kenya
FLAS	Family Life Association of Swaziland
FLE	Family Life Education
FNPI	Fundacion Nuevo Periodismo Iberoamericano
FNUAP	Fonds des Nations Unis
FOC	Forum of Conscience
FOCA	Friend of Children Organization
FODEP	Forum for Democratic Process
FOMWAN	Federation of Muslim Women Association of Nigeria
FONEYO	Fountain Neighborhood Youths (Nigeria)
FORWARD	Foundation for Women's Health, Research and Development
FPAK	Family Planning Association of Kenya
FP/RH	Family Planning and Reproductive Health
FSC	Future Search Conference
FSCE	Forum for Street Children-Ethiopia
FSW	Female sex workers
FVI	First Voice International
FX	Sound effects
FXI	Freedom of Expression Institute
GAA	Global AIDS Alliance
GAI	Global AIDS Initiative
GAMS	Group Femmes pour l'Abolition des Mutilations Sexuelles
GAP	Global AIDS Programme—Panos Southern Africa
GAPC	Global AIDS Policy Coalition
GAVI	Global Alliance for Vaccines and Immunization
GAWW	Ghanian Association for Women's Welfare
GBC	Ghana Broadcasting Corporation
GBM	Green Belt Movement
GBV	Gender-based violence
GCA	Global Commission on AIDS
GCAF	Girl Child Art Foundation—Nigeria
GCCST	Groupe Chretien Contre le SIDA au Togo
GCIS	Government Communication and Information System
GCN	Girl Child Network—Zimbabwe
GCWA	Global Coalition on Women and AIDS
GDP	Gross Domestic product
GDT	Global Dialogues Trust
GEAR	Growth, Employment and Redistribution, a Macroeconomic Strategy
GEEP	Groupe pour l'etude et l'enseignement de la population

GEM	Africa Gender and Media Initiative
GEMSA	Gender and Media South Africa
GFW	Global Fund for Women
GIPA	The Greater Involvement of People Living with or Affected by HIV/AIDS
GIS	Geographic Information System
GJA	Ghana Journalists Association
GKP	Global Knowledge Partnership
GL	Gender Links
GMAI	Global Media AIDS Initiative
GMBS	Gender and Media Baseline Study
GMHC	Gay Men's Health Crisis
GMMP	Global Media Monitoring Project
GN	Girls'Net
GNP	Gross National product
GP	General Practitioner
GPA	Global Programme on AIDS (under WHO)
GPI	Girls Power Initiative—Nigeria
GRACE	Gender Research in Africa into ICTs for Empowerment
GRAF	Groupe de Recherches sur l'Afrique Francophone
GRET	Groupe de recherché et d'échanges technologiques (Research and Technology Exchange Group)
GROOTS	Grassroots Organizations Operating Together in Sisterhood
GSMF	Ghana Social Marketing Foundation
GTZ	Gesellschaft ue fuer Technische Zusammenarbeit
GUD	Genital ulcer disease
GUM	Genito-urinary medicine
GWS	Gender and Women's Studies
HAART	Highly Active Antiretroviral Therapy
HACI	Hope for African Children Initiative
HAM	High Authority for Media
HAR	Hope After Rape
HBE	Home-based enterprise
HBM	"Health beliefs" model
HDI	Human Development Index
HE	Health education
HEA	Health Education Authority
HEAP	HIV/AIDS Emergency Action Plan
HEART	Helping Each Other Act Responsibility Together (Zambian youth group)
HEP	Health Education Project
HEU	Health Education Unit
HIP	Health Information Project—Tanzania
HIPC	Highly Indebted Poor Country Initiative
HITD	Harnessing Information Technology for Development
HHRAA	Health and Human Resources Analysis for Africa
HHS	U.S. Department of Health and Human Services
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HIVAN	HIV and AIDS Networking
HIVOS	Humanist Institute for Cooperation with Developing Countries (Humanistisch Instituut voor Ontwikkelingssamenwerking—Dutch)
HLY	Healthy life years
HPV	Human Papilloma Virus
HRW	Human Rights Watch

HSGIC	Heads of State and Government Implementation Committee
HSRC	Human Sciences Research Council
HTA	Human Development Area
HuNo	Humanite Nouvelle
IAC	Inter-African Committee (on Traditional Practices Affecting the Health of Women and Children)
IAEN	International AIDS Economic Network
IAJ	Institute for the Advancement of Journalism
IAMCR	International Association for Media and Communication Research
IAS	International AIDS Society
IBA	Independent Broadcasting Authority, South Africa
ICA	International Communication Association
ICANN	Internet Corporation for Assignment of Names and Numbers
ICASA	Independent Communications Authority of South Africa
ICASO	International Council of AIDS Service Organizations
ICD	Information and Communication for Development
ICJ	International Commission of Jurists
ICPD	International Conference on Population and Development
ICRC	International Committee of the Red Cross
ICRW	International Center for Research on Women
ICS	Social Communication Institute
ICTJ	International Center for Transitional Justice
ICTR	International Criminal Tribunal for Rwanda
ICTs	Information and Communication Technologies
ICT4D	Information and communication technology for development
ICW	The International Community of Women Living with HIV/AIDS
id21	Institute of Development Studies
IDASA	Institute for Democracy in South Africa
IDB	Inter-American Development Bank
IDRC	International Development Research Centre (Canadian)
IDS	Institute for Development Studies
IDU	Injecting drug user
IEC	Information, Education, and Communication
IED	Institute for Education in Democracy
IFAA	Institute for African Alternatives
IFC	International Finance Corporation
IFEX	International Freedom of Expression Exchange
IFJ	International Federation of Journalists
IFRP	The Infant Feeding Research Project
IFWE	International Federation of Women Entrepreneurs
IGO	Intergovernmental organization
IGWG	Interagency Gender Working Group
IHEYO	International Humanist and Ethical Youth Organisation
IIA	Internet Initiative for Africa
IIAV	International Information Centre and Archives for the Women's Movement
IICD	International Institute of Communication and Development
IJC	Independent Journalism Centre—Nigeria
ILO	International Labor Organization
IMAGE	Microfinance for AIDS and Gender Equity
IMAU	Islamic Medical Association of Uganda
IMF	International Monetary Fund

IMR	Infant Mortality Rate (deaths of children under age one/1,000 live births)
INFODEV	World Bank Program for Information and Development
INFORMORAC	INitiative pour la FORmation MObile de RAdio Comunitaire
INFORMOTRAC	INitiative FOR MObile TRAining of Community Radio
INGOs	International NGOs
INS	U.S. Immigration and Naturalization Service
IMS	International Media Support
INGO	International Non Governmental Organization
INIIT	The International Institute for Information Technology
INRA	French National Institute of Computer Science Research
(I)INTACT	International Action against Female Genital Mutilation
IOM	International Organization for Migration
IOWD	International Organization for Women and Development
IPAA	International Partnership against AIDS in Africa
IPDC	International Programme for the Development of Communication
IPEC	International Program for the Elimination of Child Labor
IPPF	International Planned Parenthood Federation
IPV	Intimate Partner Violence
IRIN	The United Nations Integrated Regional Information Networks
IRRI	International Refugee Rights Initiative
ISAI	Institute of Studies for the Free Flow of Information
IREX	International Research and Exchanges Board
IRI	Interactive Radio Instruction
IRIN	Integrated Regional Information Networks
ISDA	Informal Sector Development in Africa
ISOC	Internet Society of Senegal
IST	Infection Sexuellement Transmissible
IST	Information Society Technologies
IT	Information technology
IUD	Intra-uterine device
IWD	International Women's Day (March 8th)
IWMF	International Women's Media Foundation
IWPR	Institute for War & Peace Reporting
IWTC	International Women's Tribune Centre
JAAIDS	Journalists Against AIDS Nigeria
JWOP	Justice for Widows and Orphans Project
J.AIDS	Journal of Acquired Immune Deficiency Syndromes
JADE	African Journalists for Development Network
JAMA	Journal of the American Medical Association
JASPA	Jobs and Skills Program for Africa
JED	Journaliste en Danger (Journalist in Danger)
JHR	Journalists for Human Rights
JHU/CCP	Johns Hopkins University Center for Communication Programs
JWOP	Justice for Widows and Orphans Project (Zambia)
KAACR	Kenya Alliance for the Advancement of Children
KABP	Knowledge, attitudes, beliefs and practice
KAIPPG	Kenya AIDS Intervention Project Group
KANCO	Kenya AIDS NGOs Consortium
KAP	Knowledge, Attitude, Practices
KAS	Konrad-Adenauer-Stiftung
KAWI	Kenya AIDS Watch Institute
KCOMNET	Kenya Community Media Network
KEFEADO	Kenya Female Advisory Organization

KENWA	Kenya Network of Women With AIDS
KFF	The Henry J. Kaiser Family Foundation
KHRC	Kenya Human Rights Commission
KIST	Kigali Institute for Science Technology and Management
KNCHR	Kenya National Commission on Human Rights
KS	Kaposi's Sarcoma
K&TC	Kids and Teens Concerns—Nigeria
KZN	KwaZulu Natal (South Africa)
LACA	Local action committee on AIDS
LAHI	Law and Health Initiative
LAMA	Legal Age of Majority Act
LASO	Lusophone African Studies Organization
LAWA	Leadership and Advocacy for Women in Africa
LBWHAP	London Black Women's Health Action Project
LCI	Leonard Cheshire International
LGA	Local Government Administration, Nigeria
LGBTI	Lesbian, gay, bisexual, transgender, and intersex
LHRC	Legal and Human Rights Centre
LIASSO	Language Intervention Associates
LIDC	Low-income developing countries
LIJ	Liberia Institute of Journalism
LIVA	Life Vanguards
MACs	Multicenter AIDS Cohort Study
MACRA	Malawi Communication Regulatory Authority
MAIPPG	Muslim AIDS Intervention Prevention Project Group
MAMWA	Malawi Media Women Association
MARP	Most-at-risk person
MCH/FP	Maternal Child Health/Family Planning
MCIT	Ministry of Communications and Information Technology
MCP	Multiple concurrent partnerships
MCT	Multipurpose telecentres
MDDA	Media Development and Diversity Agency
MDGs	Millennium Development Goals
M&E	Monitoring and evaluation
MESMAC	Men who have Sex with Men—Action in the Community
MFC	Men for Change
MFDI	Media for Development International
MFWA	Media Foundation for West Africa
MH	Maternal health
MHRRC	Malawi Human Rights Resource Centre
MISA	Media Institute of Southern Africa
MISOC	Morocco Internet Society
MFI	Micro-finance institution
MFWA	Media Foundation for West Africa
MIC	Media and Information Commission
MIGS	Mediterranean Institute of Gender Studies
MMM	Medical Missionaries of Mary—Ethiopia
MMP	Media Monitoring Project
MMS	Media Marketing Services
MMWR	Morbidity and Mortality Weekly Report
MODCAR	Moyamba District Children's Awareness Radio
MOH	Ministry of Health
MRAC	Media Resource and Advocacy Centre (Nigeria)
MSF	Medecins Sans Frontieres
MSM	Men having sex with men

MTC	Media and training center
MTCT	Mother-to-child transmission (of HIV)
MTN	Mobile Telephone Network
MTP	Medium Term Plan
MUKA	Most United Knowledgeable Artists project—South Africa
MVA	Manual vacuum aspiration
MWASA	Media Workers' Association of South Africa
MYSA	Mathere Youth Sports Association—Kenya
MYWO	Maendeleo Ya Wanawake
N9	Nonoxynol 9
NACA	National Action Committee on AIDS
NACC	National AIDS Control Council
NACP	National AIDS Control Program
NAFEO	Network of African Freedom of Expression Organisations
NALEDI	National Labour and Economic Development Institute—South Africa
NAMEC	Namibian Men for Change
NAPWA	National Association of People with AIDS
NASCOP	National AIDS and STI Control Programme
NATSSAL	National Survey of Sexual Attitudes and Lifestyles
NBC	Namibian Broadcasting Corporation
NCA	National Communications Authority
NCC	Nigerian Communication Commission
NCIH	National Council on International Health
NCPA	National Committee for the Prevention of AIDS
NCPS	National Crime Prevention Strategy
NCRF	National Community Radio Forum
NDC	National Democratic Congress
NDHS	National Demographic and Health Survey
NEJM	New England Journal of Medicine
NEMISA	National Electronic Media Institute of South Africa
NEPAD	New Partnership for Africa's Development
NEWA	Network of Ethiopian Women Association
NGEN+	National Guidance and Empowerment Network of People Living with HIV/AIDS
NGO	Nongovernmental organization
NICIs	National Information and Communication Infrastructure plans
NIH	National Institutes of Health
NIPILAR	National Institute for Public Interest Law Research
NiVWA	Nigeria Vulnerable Women Association
NiZA	Netherlands Institute for Southern Africa
NLACW	National Legal Aid Clinic for Women
NMAC	National Minority AIDS Council
NMF	The Nelson Mandela Foundation
NMC	National Media Commission
NMCF	Nelson Mandela Children's Fund
NNAP	NGO Network Alliance Project (NNAP)
NNVAW	National Network on Violence Against Women
NOAH	Nurturing Orphans of AIDS for Humanity
NOCIRC	National Organization of Circumcision Information Resource Centers
NOPE	National Organisation for Peer Educators
NPPHCN	National Progressive Primary Health Care Networks, South Africa
NRA	National Resistance Army

NSJ	Southern African Media Training Trust
NTIC	Nouvelles Technologies de l'Information
NTIF	Nouvelles Technologies de la Formation
NUDIPU	National Union of Disabled Persons of Uganda
NUJ	Nigerian Union of Journalists
NUSOJ	National Union of Somali Journalists
NZP+	Network of Zambian People living with HIV/AIDS
OAU	Organization of African Unity
OB/GYN	Obstetrics and gynecology
OCBO	Orphans Community Based Organization
OCCGE	Organization to Combat the Great Endemic Diseases
ODA	Overseas Development Administration
OECD	Organization for Economic Cooperation and Development
OIT	Organisation Internationale du Travail
OJT	On-the-job training
OMS	Organisation Mondiale de la Sante
ONG	Organisation non governementale
OPC	Overall Programme Coordinator
ORT	Oral rehydration therapy
OSAGI	Office of the Special Adviser on Gender Issues
OSF-SA	Open Society-South Africa
OSI	Open Society Institute
OSISA	Open Society Initiative for Southern Africa
OSIWA	Open Society Initiative for West Africa
OSSREA	Organization for Social Science Research in Eastern and Southern Africa
OVC	Orphans and vulnerable children
OWA	One World Africa
OWWA	Organization of Women Writers of Africa, Inc
OYO	Ombetja Yehinga Organisation—Namibia
PAAN	Puppeteers Against AIDS, Nigeria
PAC	Post-abortion care
PACOM	Programme d'Appui a la Communication au Madagascar
PADIS	Pan African Development Information System
PAHO	Pan American Health Organization
PAI	Population Action International
PAMRO	Pan African Media Research
PANA	Pan African News Agency
PAP	Poverty Alleviation Programme
PATH	Program for Appropriate Technology in Health
PAZA	Press Association of Zambia
PCP	Pneuemocystis carinii pneumonia
RDP	Reconstruction and Development Program
PEPFAR	President's Emergency Plan for AIDS Relief
PHAMSA	Partnership on HIV/AIDS and Mobile Populations in Southern Africa
PHC	Primary health care
PHLS	Public Health Laboratory Service
PIAC	Project for Information Access and Connectivity
PICTA	Partnership for Information and Communication Technologies in Africa
PID	Pelvic inflammatory disease
PIH	Partners In Health
PISA	Panos Institute Southern Africa
PLWA	People living with AIDS

PLWHA	Person living with HIV/AIDS
PLWHIV	People living with HIV
PMC	Population Media Center
PMSA	Print Media South African
PMTCT	Prevention of mother-to-child transmission of HIV
PNLS	Programme National de Lutte contre le SIDA
PNP	Policies, norms, and protocols
PPASA	Planned Parenthood Association of South Africa
PRB	Population Reference Bureau
PRSP	Poverty Reduction Strategy Plan
PS	Program support
PSA	Public Service Announcement
PSAMAO	Prevention du SIDA sur les Axes Migratoires de l'Afrique de L'Ouest
PSF	Private Sector Foundation
PSI	Population Services International
PSTN	Public Switched Telephone Network
PUSH	Periodic Ppdates of Sexual and Reproductive Health
PVVIH	Personne Vivant avec le VIH
PWA	Person with AIDS
PWDs	People with disabilities
QUESTT	Quality Education Services Through Technology—Zambia
R2EP	Rights to End Poverty
RAINBO	Research, Action and Information Network for the Bodily Integrity of Women
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
RAV	Reseau Arts Vivants—Niger
RDG	Rwanda Development Gateway
RECIF	Reseau de communication et d'information des femmes
RECONCILE	Resource Conflict Institute
REDESO	Reseau pour le developpement soutenible—Tanzania
RESCUER	Rural Extended Services and Care for Ultimate Emergency Relief
RfD	Radio for Development
RH	Reproductive health
RINAF	Regional Information Society Network for Africa—UNESCO
RIPS	Rurual Integrated Project Support, Tanzania
RISE	Radio Instruction to Strengthen Education
ROC	Rights of the child
RTP	Right To Play
RTS	Radio Television de Senegal
RVF	Rectum-vagina-fistula
RWCDN	Rwandan Women's Community Development Network
RWM	Rural Women's Movement, South Africa
RWN	Rwanda Women's Network
RWS	Race Welfare Society
SAARF	South African Advertising Research Foundation
SABA	Southern African Broadcasting Association
SABC	South Africa Broadcast Corporation
SACA	State Action Committee on AIDS
SACOD	Southern Africa Communications for Development
SACRIN	South African Community Radio Information Network
SACTAP	Southern African Counter-Trafficking Assistance Programme
SADC	Southern African Development Community
SAEF	South African Editors' Forum

SAfAIDS	Southern Africa AIDS Information Dissemination Service
SAGCA	South African Girl-Child Alliance
SAGEM	South African Gender and Media Network
SAGO	Society of African Gynecologists and Obstetricians
SAHARA	Social Aspects of HIV/AIDS Research Alliance
SAHRIT	The Human Rights Trust of Southern Africa
SAIMED	Southern Africa Institute for Media Entrepreneurship Development
SAMDEF	Southern African Media Development Fund
SAMGI	Southern African Media and Gender Institute
SAMTRAN	Southern African Media Trainers Network
SANASO	Southern African Network of AIDS Service Organizations
SANCO	South African National Civic Organization
SANEF	South African National Editors' Forum
SANGONeT	South African NGO Network
SAP	Slum Aid Project
SAPA	South African Press Association
SAPP	Southern Africa Partnerships Programme
SARPN	South African Regional Poverty Network
SAY	Southern African Youth
SARA	Support for Analysis and Research in Africa
SCADC	Sankofa Center for African Dance and Culture—Ghana
SCF	Save the Children Fund
SCI	Sara Communication Initiative
SC IHDC	Soul City Institute for Health and Development Communication
SDC	Swiss Agency for Development and Cooperation
SFCG	Search for Common Ground
SFH	Society for Family Health
SFH	Strategies for Hope
SHARP	Sexual Health and Rights Project
SHAZ	Shaping the Health of Adolescents in Zimbabwe
SHD	Sustainable human development
SIDA	Syndrome d'Immuno Deficience Acquise
SIRIP	Somali Interactive Radio Instruction
SIV	Simian immunodeficiency virus
SLAWW	Sierra Leone Association on Women's Welfare
SNA	SchoolNet Africa
SNAP	Sudan's National AIDS Control Programme
SNJ	Mozambican Journalists' Union
SOCDA	Somali Organisation for Community Development Activities
SOMARC	Condom Social Marketing Programme
SORAC	Society of Research on African Cultures
SPF	Secours populaire français
SSA	Sub-Saharan Africa
SSGON	Society of Septists and Gynaechologists of Nigeria
STD	Sexually transmitted disease
STI	Sexually transmitted infection
STREAM	Strengthening African Media
SVRI	Sexual Violence Research Initiative
SWAA	Society for Women and AIDS in Africa
SWAGAA	Swaziland Action Group Against Abuse
SWAK	Society for Women and AIDS in Kenya
SWAPOL	Swazis Positive Living
SWAT CYP	Swaziland Theatre for Children and Young People
SWET	The Story Workshop Trust

SYFA	Safeguarding Youth from AIDS
SYNFEV	Synergie, Genre et Developpement
SYNPICS	Syndicat des professionnels de l'Information et de la Communication du Sénegal (Senegal Union of Information and Communication Professionals)
TAC	Technical Advisory Committee of the National AIDS Task Force
TAC	Treatment Action Campaign
TACC	Technology Access Community Centres
TALC	Teaching aids at low cost
TAMWA	Tanzania Media Women's Association
TAP	Township AIDS Project
TASO	The AIDS Support Organization
TB	Tuberculosis
TBA	Traditional Birth Attendant
TCM	Traditional Communication Media
TE	Treatment Episode
TELI	Technology Enhanced Learning Initiative
TELIP	Teenage Life Program
10MhbP	Ten Million Hero Book Project
10MMP	10 Million Memory Project
TFD	Theatre for Development
TFR	Total fertility rate (children born alive to a woman during her lifetime)
TH	Traditional healers
TI	Transparency International
TIWA	Technology Initiatives of West Africa
TM	Traditional medicine
TNCs	Transactional corporations
TOR	Terms of reference
TOT	Training of trainers
TRASA	Telecommunications Regulators Association for Southern Africa
TRC	Truth and Reconciliation Commission, South Africa
TRCS	Tracing and Family Reunification, Tanzania
TWLA	Tanzania Women Lawyers Association
TWN	Third World Network
TYT	Talented Youth Theatre—Ghana
UAC	Ugandan AIDS Commission
UCCRNN	Uganda Child Rights NGO Network
UJA	Uganda Journalists Association
UMWA	Uganda Media Women's Association
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNCRC	United Nations Commission on the Rights of the Child
UNDP	United Nations Development Program
UNECA	United National Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNF	United Nations Foundation
UNFIP	United Nations Fund for International Partnership
UNFPA	United Nations Population Fund
UNGEI	United Nations Girls' Education Initiative
UNHCR	United Nations High Commission on Refugees
UNIC	United Nations Information Centre
UNICEF	United Nations International Children's Emergency Fund
UNIDO	United Nations Industrial Development Organization

UNIFEM	United Nations Development Fund for Women
UNILAG	University of Lagos
UNINSTRAW	United Nations International Research and Training Institute for the Advancement of Women
UNPC	Union Nationale de la Presse du Congo (National Union of the Congolese Press)
UNRISD	United Nations Research Institute for Social Development
UNSO	United nations Statistical Office
UPHOLD	Uganda Programme for Human and Holistic Development
URTNA	Union of National Radio and Television Organisations of Africa
USAID	United States Agency for International Development
UWESO	Uganda Women's Efforts to Save Orphans
VCT	Voluntary counseling and testing
VIH	Virus de l'Immuno deficience humaine
VNR	Virtual newsroom
VOA	Voice of America
VOP	Voice of the People
VRI	Virus Research Institute (Entebbe, Uganda)
VSU	Victim Support Unit
VT	Virginity Testing
VVF	Vescio-vagina-fistula
WAAD	Women in Africa and the African Diaspora
WABA	World Alliance for Breastfeeding Action
WACC	World Association of Christian Communication
WACOL	Women's Aid Collective
WAJA	West African Journalists' Association
WAMATA	Waliokatika Mapambano Na AIDS Tanzania
WANAD	West African Newsmedia and Development Centre
WARA	West African Research Association
WARO	West Africa Regional Office
WB	World Bank
WER	Weekly Epidemiological Record (of WHO)
WFP	World Food Programme
WHA	World Health Assembly
WHED	Women's Health, Education and Development
WHO	World Health Organization
WICSA	Women's Information Communication Services Agency
WID	Women in Development
WIEGO	Women in Informal Employment: Globalising and Organising
WIF	Worldview International Foundation
WILL	Wireless Local Loop
WINN	Women's International News Network
WIRES	Women's Information Resource and Electronic Services
WLC	Women's Legal Centre (South Africa)
WLID	World Learning for International Development
WLP	Women's Learning Partnership
WLSA	Women's Law Southern Africa and Education Trust
WMW	Women's Media Watch
WOFAK	Women Fighting AIDS in Kenya
WOMEC	Women, Media and Change
WOUGNET	Women of Uganda Network
WOWAP	Women Wake Up
WOWESOK	Widows and Orphans Welfare Society of Kenya
WPF	World Population Foundation
WRAP	Women, Risk and AIDS Project

WRAP	Women's Rights Awareness Programme
WSF	WorldSpace Foundation
WSI	Winter/Summer Institute in Theatre for Development—Lesotho
WSIS	World Summit on Information Society
WSWM	World Starts With Me
WTO	World Trade Organization
WUSC	World University Service of Canada
WWB	Women's World Banking
Y2Y	Youth to Youth
YADDI	Youth Association for Dissemination of Development Information
YATV	Young Africa Television
YONECO	YouthNet and Counselling—Malawi
YWAP	Young Widows Advancement Program (Kenya)
YWCA	Young Women's Christian Association
ZaCoMeF	Zambia Community Media Forum
ZAMCOM	Zambia Institute of Mass Communications
ZAMPS	Zimbabwe All Media and Products Survey
ZAMSIF	Zambia Social Investment Fund
ZAMWA	Zambia Media Women's Association
ZAMWATCH	Zambia Media Watch
ZANU-PF	Zimbabwe African National Union-Patriotic Front
ZFPSP	Zambia Family Planning Services Project
ZLDC	Zambian Law Development Commission
ZWOT	Zimbabwe Widows and Orphans Trust
ZWRCN	Zimbabwe Women Resource Centre and Network

APPENDIX II: AFRICAN HIV/AIDS-RELATED ORGANIZATIONS

Abantu for Development, P. O. Box 2389, Nairobi, 00200 Kenya (www.abantu.org)
ABC Ulwazi, P. O. 32402, Braamfontein 2017, South Africa (www.abculwazi.org.za)
ACACIA (Communities and the Information Society in Africa), 150 Kent Street, P. O. Box 8500 Ottawa, Ontario, K1G 3H9 Canada
Acres of Love, 4695 MacArthur Court, 11th floor, Newport Beach, CA 92660
ActALIVE Arts Coalition, 6 Echo Drive, Barrington, Rhode Island 02806 (www.actalive.org)
ActionAid International, Kenya, P. O. Box 42814 Nairobi, 00100, Kenya (www.actionaid.org)
Advance Africa Headquarters, 4301 North Fairfax Drive, #400, Arlington, VA 22203
Advisory Support, Information Services and Training for Labour-based Infrastructure Programme (ILO/ASIST), P. O. Box 39493, Nairobi, Kenya (asist@itdg.or.ke)
Africa Action, 1634 Eye Street, NW, #810, Washington, DC 20006 (www.africaaction.org)
Africa Alive, P. O. Box 16258, Nairobi, Kenya (www.africaalive.org)
Africa Consultants International (ACI), Villa 4346, Sicap Amitie, BP 5270, Dakar-Fann, Senegal (www.acibaobab.org)
Africa Files, Bloor Street United Church, Room 21, 300 Bloor Street West, Toronto, ON M5S 1W3 Canada (www.africafiles.org)
Africa Gender Institute (AGI), All Africa House, Middle Campus, off Stanley Road, Rondebosch 7700 (http://web.uct.ac.za/org/agi)
Africa Media Review/Revue Africaine de Media, CODESRIA, Avenue Cheikh Anta Diop, X Canal IV, BP 3304, Dakar, Senegal
Africa Regional Sexuality Resource Centre (ARSRC), 17 Lawal Street, Off Oweh Street, Jibowu, Lagos, Nigeria (www.arsrc.org)
Africa Renewal, Rom S-955, United Nations, New York, NY 10017 (www.un.org/AR)
Africa Training and Research Centre for Women, Economic Commission for Africa, P.O. Box 3001, Addis Adaba, Ethiopia
AfricaWoman, 3rd floor, Rm 324, Hurlingham Medicare Plaza, Argwings Kodhek Road, Nairobi, Kenya (http://www.africawoman.net)
African Centre for Democracy and Human Rights Studies (ACDHRS), Kairaba Avenue, K.S.M.D., The Gambia
African Connection, P. O. Box 1234, Halfway House, Midrand, 1685, 1258 Lever Road, Headway Hill, South Africa (www.africanconnection.org)
African Gender Institute (AGI), University of Cape Town, Private Bag, Rondebosch 7701, South Africa (http://web.uct.ac.za/org/agi)
African Human Rights Resource Center (http://www1.umn.edu/humanrts/africa)
African Leaders and AIDS (www.africpolicy.org)

African Medical and Research Foundation (AMREF), Langata Road, P.O. Box 27691-00506, Nairobi, Kenya (www.amref.org)

African Microenterprise AIDS Initiative, Opportunity International, 2122 York Road, Suite 340, Oak Brook, IL 60523 (http://www.microcreditsummit.org/press/Africanmicro.htm)

African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN), P. O. Box 46516, Nairobi 00100, Kenya (www.anppcan.org)

African News Online (http://africanews.org)

African Population Advisory Council (APAC), Valley Road, Chancery 4th floor, P. O. Box 10569, 00100 Nairobi GPO, Kenya

African Resource Centre, 1719 Bank Suite 301, Ottawa K1V 724, Ontario, Canada

African Rights (http://africa.oneworld.net)

African Studies, Central Connecticut State University, 1615 Stanley Street, New Britain, CT 06050 (www.ccsu.edu/afstudy)

African Studies Association, Rutgers, The State University of New Jersey, 132 George Street, New Brunswick, NJ 08901-1400 (www.africanstudies.org)

African Woman and Child (AWC) Feature Service, P. O. Box 48197 GPO Nairobi, 00100 (www.awcfs.org)

African Women's Development & Communication Network (FEMNET), Off Westlands Road, P. O. Box 54562, 00200 Nairobi, Kenya (www.femnet.org.ke)

African Women's Development Fund (AWDF), 25 Yiyiwa St. Abelenkpe, Accra, Ghana (www.awdf.org)

Africare, 440 R Street, N.W., Washington, D C 20001 (www.africare.org)

AfricaWoman, 3rd floor, Hurligham Medicare Plaza, Argwings Kodhek Rd, Nairobi, Kenya (http://www.africawoman.net)

Afrol News, Postboks 13, N-3537 Kroderen, Norway (www.afrol.com)

Afro-Net, 30 California Street, Watertown, MA 02472 (www.healthnet.org)

Agence pour la Promotion des Activities de Population—Senegal (APAS), 1er Etage Immeuble Abdoulaye Diaw, Route des Mamelles, Ouakam, B. P. 16292, Dakar-Fann, Senegal

AIDoS, Via dei Giubbonari 30, 00186 Rome, Italy

Aids & Africa, 3720 College Avenue, Ellicott City, MD 21043 (www.aidsandafrica.com)

AIDS Control and Prevention Project (AIDSCAP) Women's Initiative, Family Health International, 2101 Wilson Blvd, Suite 700, Arlington, VA, 22201 (http://www.fhi.org)

AIDS Counselling Trust, Box 7225, Harare, Zimbabwe

AIDS Information Centre, Baumann House, 7 Parliament Avenue, PO Box 10446, Kampala, Uganda

AIDS Foundation of South Africa, P.O. Box 50582, Musgrave, Durban, 4062 South Africa

AIDSMark, Population Services International, 1120 19th Street NW, Suite 600, Washington, DC 20036-3609 (www.aidsmark.org)

AIDS Resource Center (ARC), P. O. Box 26171, Code 1000, Addis Ababa, Ethiopia (www.etharc.org)

Akina Mama Wa Africa, 4 Wild Court, Kingsway, London WC2B 4AU, United Kingdom

Amakhosi Cultural Centre, P. O. Box 2370, Bulawayo, Zimbabwe

Amnesty International Benin, BP 01 3536, Cotonou, Benin

Amnesty International Cote d'Ivoire, 04 B.P. 895, Abidjan 04, Cote d'Ivoire

Amnesty International: FGM (http://www.amnesty.org/alilib/intcam/femgen/fgm1.htm)

Amnesty International Mali, BP 2804, Bamako, Mali

Anti-Slavery International, Thomas Clarkson House, The Stableyard, Broomgrove Road, London SW9 9TL, United Kingdom

Appropriate Health Resources & Technologies Action Group (AHRTAG), 1 London Bridge Street, London SE1 9SG, United Kingdom

The Ark Foundation of Africa (AFA), 1002 Maryland Avenue, NE, Washington, DC 20002 (www.arkafrica.org)

Article 19, 6-8 Amwell Street, London EC1R 1UQ, United Kingdom (www.article19.org)

Asociacion de Comunicadores Sociales Calandria, Jr. Cahuide 752, Jesus Maria, Lima 11, Peru (http://www.calandria.org.pe)

Association Femme, Enfant, Lutte contre la Pauvrete, Sicap Mermoz, Imm. D, Local 7545-2e porte, Dakar, Senegal (afelp@hotmail.com)

Association for Women's AIDS Research & Education (Project AWARE), 3180 18th Street, Suite 205, San Francisco, CA 94110

Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles (AMSOPT) P.B. 1543, Bamako, Mali

Association Mondiale des Radiodiffuseurs Communautairs (AMARC)/Africa, Suite 22, Private Bag X42, Braamfontein 2017, Johannesburg, South Africa

Association of African Women Scholars (AFWOSCHO), Women's Studies, Cavanaugh Hall, Suite 540, Indiana University, 425 University Boulevard, Indianapolis, IN 46202 (www.iupui.edu)

Association of African Universities (AAU), P. O. Box AN5744, Accra-North, Ghana (www.aau.org)

Association of Concerned Africa Scholars (ACAS), Michigan State University, 344 Baker Hall, East Lansing MI 48824 (www.concernedafricascholars.org)

Association of Media Women in Kenya (AMWIK), 3rd floor, Hughes Building, PO Box 10327, 00100 Nairobi, Kenya (www.amwik.org)

Association Panafricaine des Femmes Dans la Luttle Contre Le Sida (see SWAA)

Association for Progressive Communications (APC-Africa-Women), P.O. Box 29755, Melville, 2109 South Africa (www.apcafricawomen.org)

Association pour le Progres et la Defense des Droits des Femmes Maliennes (APDF)/The Coalition Against Trafficking in Women (CATW), BP 1740 Bamako Mali (www.catwinternational.org)

AVERTing HIV and AIDS, 4 Brighton Road, Horsham, West Sussex, RH13 5BA, United Kingdom (www.avert.org)

Awassa Children's Center, Box 1224, Awassa, Ethiopia (www.awassachildrensproject.org)

Babiker Bedri Association Scientific Association for Women's Studies (BBSAWS), Ahfad University for Women, PO Box 167, Omudurman, Sudan

Beyond Awareness Consortium, P. O. Box 408, Auckland Park, 2006, South Africa

British Broadcasting Corporation World Service Trust (BBC WST), Bush House, Room 301 NE, Strand, London WC2B 4PH, United Kingdom (http://www.bbc.co.uk)

British Medical Association, BMA House, Tavistock Square, London Wc1H 9JP, United Kingdom (info.northtrans@bma.org.uk)

The Brookings Institution (www.brookings.edu)

Bureau de l' Organisation Internationale du Travail à Alger, Rue Emile Payen 9A, BP 226, Algeria (registry@alger.ilo.sita.net)

Bureau de l' Organisation Internationale du Travail à Yaoundé, Boîte postale No. 13, Yaoundé, Cameroon (emac@ilo.org)

Bureau de l' Organisation Internationale du Travail à Kinshasa, Building Losonia 3ème étage, Boulevard du 30 Juin, B.P. 7248, Kinshasa I, Democratic Republic of the Congo (oit.kin@undp.org)

Bureau régional de l' Organisation Internationale du Travail pour l'Afrique, Boulevard Lagunaire, Commune de Plateau, 01 B.P. 3960, Abidjan 01, Cote d'Ivoire (abidjan@ilo.org)

Bureau de l' Organisation Internationale du Travail à Antananarivo, Maison Commune des Nations Unies, Rue Dr. Raseta, Galaxy Andraharo, Route de Majunga, Antananarivo 101, Madagascar (antananarivo@ilo.org)

Bureau de l' Organisation Internationale du Travail à Dakar, Rue El Hadj Amadou Assane N'Doye 22, B.P. 414, CP 18524, Dakar, Senegal (dakar-registry@ilo.org)

Cairo Institute for Human Rights Studies, 9 Rustom Street, Garden City, PO Box 117, Maglis Al Shaab, Cairo, Egypt

Canadian International Development Agency (CIDA), 200 Promenade du Portage, Gatineau, Quebec K1A 0G4 (http://www.acdi-cida.gc.ca)

Care, 151 Ellis Street, NE,Atlanta, GA 30303 (www.care.org)

The Carter Center, One Copenhill, 453 Freedom Parkway, Atlanta, GA 30307 (www.cartercenter.org)

Catholic Justice and Peace Commission, P.O. Box 14930 Nairobi 00800, Kenya

Centre for AIDS Development, Research and Evaluation (CADRE), P. O. Box 30829, Braamfontein 2017, South Africa (www.cadre.org.za)

Center for Communications Programs (CCP), Johns Hopkins University, 527 St. Paul Place, Baltimore, MD 21202 (www.jhuccp.org)

Center for Domestic Violence Prevention (CEDOVIP), Raising Voices, Plot 16 Tufnell Drive, Kamwokya, P. O. Box 6770, Kampala, Uganda (www.raisingvoices.org/cedovip.php)

Centre for African Family Studies (CAFS), Pamstech House, Woodvale Grove, Westlands, P. O. Box 60054, Nairobi, Kenya (www.cafs.org)

Centre for HIV/AIDS and STD Research, 21 Warehouse Road, Apapa, Lagos, Nigeria (www.nigeria-aids.org/eforum.cfm)

Centre for Law and Research International (CLARION), P. O. Box 46991, Nairobi 00100 Kenya (www.clarionkenya.org)

Center for Partnership Studies (CPS), c/o Riane Eisler, President, P. O. Box 51936, Pacific Grove, CA 93950 USA (www.partnershipway.org)

Center for Reproductive Law and Policy (CRLP), 120 Wall Street, New York, NY 10005 (www.crlp.org)

Centre for Rights, Education and Awareness (CREAW), P. O. Box 11964 Nairobi, 00100 Kenya (www.creaw.org)

Center for Women Policy Studies, 2000 P Street, NW, Suite 508, Washington, DC 20036

Centre for Democratic Development, Research and Training (CEDDERT), Hanwa, P.M.B. 1077, Zaria, Kaduna, Nigeria (www.ceddert.com)

Centre for Development and Population Activities (CEDPA), 1400 16th Street NW, Washington, DC 20036 (http://www.cedpa.org)

The Child Rights Advisory Documentation and Legal Centre (CRADLE), P. O. Box 10101 Nairobi 00100, Kenya (www.thecradle.org)

Children's Legal Action Network (CLAN), P. O. Box 1768 Nairobi, 00200, Kenya (www.anppcan.org/new/projects/clan/home)

Christian Aid, 35 Lower Marsh, Waterloo, London SE1 7RT, United Kingdom

Christian Partners Development Agency (CPDA), P.O. Box 13968 Nairobi, 00100, Kenya

Clinton Global Initiative (CGI), 1301 Avenue of the Americas, 37th Floor, New York, NY 10019-6022 (www.cgiu.org)

Clowns Without Borders, 540 Alabama #215, San Francisco, CA 94110 (www.clownswithoutborders.org)

Coalition On Violence Against Women (COVAW), P. O. Box 10658 GPO, Nairobi, 00100 Kenya (www.covaw.org.ke)

Collaborative Centre for Gender and Development, P. O. Box 4869 Nairobi, 00500 Kenya (http://kenya.fes-international.de/ccgd.shtml)

Comite National pour la Sante des Femmes et des Sockode, Tchaoudjo, Togo

Comite National Senegalais contre les Pratiques Traditionnelles Nefastes (COSEPRAT), Hopital Le Dantec, B.P. 3001, Dakar, Senegal

Commission Internationale pour l'Abolition des Mutilations Sexuelles (CAMS) B.P. 11.345, Institute Fundamental D'Afrique, Cheikh Anta Diop, Dakar, Senegal

Commission on Gender Equality, 2 Kotze Street, Old Women's Jail, East Wing, Constitution Hill, Braamfontein, Johannesburg, South Africa (www.cge.org.za)

Commission pour l'abolition des Mutilations Sexuelles (CAMS), 6 Place Saint-Germain-des-Pres, 75006 Paris, France
Commonwealth Foundation, Marlborough House, Pall Mall, London SW1Y 5HY, United Kingdom (www.commonwealthfoundation.com)
Communication for Social Change (CFSC) Consortium, 14 South Orange Avenue, #2F, South Orange, NJ 07079 (http://www.communicationforsocialchange.org) Contact: Denise Gray-Felder, president and CEO
The Communication Initiative, 5148 Polson Terrace, Victoria, British Columbia, Canada V8Y 2C4 (www.comminit.com)
Communications Consortium Media Center, 1200 New York Avenue NW, #300, Washington, DC 20005
Communication Team, Economic Commission for Africa, P. O. Box 3001, Addis Ababa, Ethiopia (www.uneca.org)
Community Law Centre (CLC), South Africa, (www.communitylawcentre.org.za)
Community Media for Development, PO Box 66193, Broadway 2020, Johannesburg, South Africa
Community Peace Building and Development Project (CPBD), 1825 Connecticut Avenue NW, Washington, D. C. 20009open society initiative for
CompuTainer Pty Ltd, P.O. Box 808, Witkoppen, 2068, South Africa (www.computainer.com) Contact: Mark Van der Merwe
Copperbelt Health Education Project, PO 23567, Kitwe, Zambia
Council for the Development of Social Science Research in Africa (CODESRIA), Avenue Cheikh Anta Diop x Canal IV, BP 3304, Dakar, Senegal (www.codesria.org)
Crisis Pregnancy Ministries (CPM), P. O. Box 66633, Nairobi, 00800 Kenya
Defense for Children International/Dutch section, PO Box 75297, NL-1070 AG Amsterdam, The Netherlands
Department for International Development (DFID), 1 Palace Street, London SW 1E 5HE, United Kingdom (http://www.dfid.gov.uk)
Development Through Media (DTM), P. O. Box 34696, Nairobi, Kenya (www.dtmafrica.com)
The Digital Education Enhancement Project, The Open University, Faculty of Education and Language Studies, Stuart Hall Building, Walton Hall, Milton Keynes, MK7 6AA, United Kingdom (www.open.ac.uk/deep)
Doctors Without Borders (Medecins Sans Frontieres), 333 Seventh Avenue, 2nd floor, New York, NY 10001-5004 (www.doctorswithoutborders.org)
DramAidE Office, University of Zululand, Private Bag X10001, KwaDlangezwa 3886, South Africa (www.dramaide.co.za)
East African Development Communication Foundation (EADCF), Box 2065, Patel Building, 4th floor, Dar es Salaam, Tanzania
Economic Commission for Africa, P. O. Box 3001, Addis Ababa, Ethiopia (www.uneca.org)
The Economic Society of South Africa (ESSA), P O Box 73354, Lynnwood Ridge 0040, South Africa (www.essa.org.za)
Education Centre for Women in Democracy (ECWD), P. O. Box 62714, Nairobi, 00200 Kenya (www.ecwd.org)
The Education With Enterprise Trust (EWET), PO Box 150, Harrismith, 9880, South Africa (www.ewet.org.za)
The Egyptian Center for Women's Rights, 135 Misr Helwan El-Zeraay 2nd floor, Suite 3, El Maadi, Cairo, Egypt (http://www.ecwronline.org)
Egyptian Organization of Human Rights, 10th floor Mathaf El0Manyal Street, Manyal Er-Roda, Cairo, Egypt
Egyptian Society for the Care of Children and Prevention of Traditional Practices Harmful to Women and Children (ENC), 25 Kadri Street, Sayeda, Zeinab, Cairo, Egypt

Eldis Programme, Institute of Development Studies, University of Sussex, Brighton BN1 9RE, United Kingdom (www.eldis.org/gender/index.htm)

Elimu Yetu Coalition (Kenya chapter of the Africa Networks Campaign on Education for All—ANCEFA), P.O. Box 42814 Nairobi, 00100 Kenya (www.ancefa.org)

enda third world, 4 & 5 rue Kléber, BP 3370, Dakar, Senegal (www.enda.sn)

Environment & Development in the Third World, Women & Development Synergy Network, BP 3370, Dakar, Senegal

Equality Now, PO Box 20646, Columbus Circle Station, New York, NY 10023 (http://www.equalitynow.org)

Ethiopian Economic Association (EEA), P.O. Box 34282, Addis Ababa, Ethiopia (www.eeaecon.org)

Experiment in International Living, AIDS Education & Control Project, PO Box 9007, Kampala, Uganda

Fahamu, 51 Cornmarket Street, Oxford OX1 3HA, United Kingdom (www.fahamu.org)

Famafrique, Synergie Genre et Developpement, BP 3370, Dakar, Senegal (www.famafrique.org)

Famedev, Liberte V1, Immeuble 48B, Dakar, Senegal (www.famedev.org)

Family Health International (FHI), HIV and AIDS Prevention and Care, P. O. Box 38835, Nairobi, 00623 (www.fhi.org)

Family Life Association of Swaziland (FLAS), P. O. Box 1051, Manzini Headquarters, Swaziland (www.flas.org.sz)

Family Planning Association of Kenya (FPAK), P. O. Box 30581, Nairobi, Kenya (www.fpak.org)

Fantsuam Foundation, No.1 Fantsuam Close, P. O. Box 58 Bayan Loco, Kafanchan, Kaduna State, Nigeria (www.fantsuam.org)

The Federation of Female Nurses and Midwives of Nigeria, 22 Bajulaiye Road, Shomolu, Lagos, Nigeria

Feminia, P. O. Box 13187, Yaoundé, Cameroon (www.feminia.org)

Femmes Africa Solidarité (FAS), Stele Mermoz Immeuble Rose, No 31C, P. O. Box 45077 Fann, Dakar, Senegal (www.fasngo.org)

FGMnetwork: Education and Networking (http://www.fgmnetwork.org)

FilmAid International Headquarters, 24 West 23rd Street, 4th floor, New York, NY 10010 (http://filmaid.org)

the Firelight Foundation, 740 Front Street, #380, Santa Cruz, CA 95060

First Voice International, 2400 N Street, NW, Washington, DC 20037 (www.firstvoiceint.org)

Focal Point for Human Rights of Women, United Nations Centre for Human Rights, Palais des Nations, CH-1211 Geneva 10, Switzerland

Food and Agriculture Organization (FAO), Viale delle Terme di Caracalla 00100 Rome, Italy (http://www.fao.org)

Ford Foundation, 320 East 43rd Street, New York, NY 10017 (http://www.fordfound.org)

Forest Action Network (FAN), P. O. Box 380, Nairobi, 00517, Kenya (www.fanworld.org)

Forum for African Women Educationalists (FAWE), P. O. Box 21394, Nairobi, 00505 Kenya (www.fawe.org)

Forward USA, 1046 West Taylor Street, Suite 204, San Jose, California 95126 (http://www.forwardusa.org)

Foundation for Female Photojournalists (FFP), P. O. Box OS 1826, Osu Accra, Ghana (http://ffpnet.blogspot.com)

Foundation for Women's Health, Research and Development (FORWARD), 40 Eastbourne Terrace, London W2 3QR, United Kingdom (www.forward.dircon.co.uk)

Francophone Africa Research Group/Groupe de Recherches sur l'Afrique Francophone (GRAF), 270 Bay State Road, Boston University, Boston, Massachusetts 02215 (www.bu.edu/africa)

Fraunhofer Institute for Media Communication, Schloss Birlinghoven, 53754 Sankt Augustin, Germany (www.fraunhofer.de)
The Freedom of Expression Institute, P. O. Box 30688, Braamfontein 2017, South Africa (www.fxi.org.za)
Freeplay Foundation, Unit 12 M5 Business Park, Maitland 7405, Cape Town, South Africa
Friedrich-Ebert Stifting Media Project Southern Africa, P. O. Box 23652, Windhoek, Namibia (www.fesmedia.org.na)
Fundacion Nuevo Periodismo Iberoamericano (FNPI), Centro, Calle San Juan de Dios #3-121, Cartagena de Indias, Columbia (http://www.fnpi.org)
The Bill and Melinda Gates Foundation (www.gatesfoundation.org)
GBV Prevention Network, P. O. Box 6770, Kampala, Uganda (www.preventgbvafrica.org)
The Gender and Media Southern African Network (GEMSA), 9 Derrick Avenue, Cnr Marcia St, Johannesburg, South Africa (www.gemsa.org.za)
Gender and Women's Studies for Africa's Transformation, African Gender Institute, University of Cape Town, Private Bag, Rondebosch, Cape Town 7701 (http://www.gwsafrica.org)
Gender Links (GL), 9 Derrick Avenue, Cnr Marcia Avenue, Cyrildene, 2198, Johannesburg, South Africa (www.genderlinks.org.za)
Ghanian Association for Women's Welfare (GAWW), PO Box 9582, Airport, Accra, Ghana
Global AIDS Alliance (GAA), 1413 K Street NW, 4th Floor, Washington, DC 20005 (www.globalaidsalliance.org)
Global AIDS Policy Coalition, Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02115 USA
The Global Business Council on HIV/AIDS (www.nat.org.uk)
Global Catalyst Foundation, 255 Shoreline Drive, Suite 520, Redwood City, CA 94065
Global Dialogues, 06 B.P. 9342, Ouagadougou, Burkina Faso (www.globaldialogues.org)
(UK Office: c/o SJS, 7 Allison Court, Metro Centre, Gateshead NE11 9YS, United Kingdom)
The GlobalGiving Foundation, 1816 12th Street NW, Washington, DC 20009 (www.globalgiving.com)
GOLD Peer Education Development Agency, 22 Station Road, Rondebosch 7700, Cape Town, South Africa (www.goldpe.org.za).
Grassroots Organizations Operating Together in Sisterhood (GROOTS), P. O. Box 10320-GPO, Nairobi, Kenya (www.groot.org)
The Green Belt Movement, Hughes Building, 1st Floor, Muindi Mbingu Street, Kenyatta Avenue Wing, P.O. Box 67545-00200, Nairobi, Kenya (www.greenbeltmovement.org)
GreenNet Educational Trust, Catherine House, 56-64 Leonard Street, London, United Kingdom EC2A 4JX, United Kingdom (http://www.apcwomen.org)
Group Femmes pour l'Abolition des Mutilations Sexuelles (GAMS), 66 rue de Grand Champs, 75020 Paris, France
The Alan Guttmacher Institute, 120 Wall Street, New York, NY 10005
Harvard School of Public Health AIDS Initiative, 651 Huntington Avenue, Boston, MA 02115 USA (www,hsph.harvard.edu)
Health Information Project (HIP)—Tanzania, c/o EADCF, Box 2065, Patel Building, 4th floor, Dar es Salaam, Tanzania
Healthlink Worldwide, 56-64 Leonard Street, London Ec2A 4 LT, United Kingdom (http://www.healthlink.org.uk)
Healthy Tomorrow, 14 William Street, Somerville, MA 02144 USA (http://www.stopexcision.net)
Heartlines, P. O. Box 1290, Houghton, South Africa (www.heartlines.org.za)
HelpAge International, Africa Regional Development Centre, P. O. Box 32832, London N1 9ZN, United Kingdom (www.helpage.org)

The Hesperian Foundation, 1919 Addison, Suite 304, Berkeley, CA 94704-1144 USA
Hivos, Raamweg 16, P. O. Box 85565, 2508 CG The Hague (www.hivos.nl)
Hope for African Children Initiative (HACI), P. O. Box 76154-000508, Nairobi, Kenya
Human Rights Watch (HRW), 350 5th Avenue, 34th floor, New York, NY 10118-3299 (www.hrw.org)
The Human Rights Trust of Southern Africa (SAHRIT), 12 Ceres Road, Avondale, P. O. Box CY2448, Causeway, Harare, Zimbabwe (www.sahrit.org)
Hunt Alternatives Fund, 625 Mount Auburn Street, Cambridge, MA 02138 USA (www.huntalternatives.org)
Icon Partners and Associates, Office No. 3 Kisozi Complex, P. O. Box 5388, Kampala, Uganda (www.iconug.net)
id21, Institute of Development Studies, University of Sussex, Brighton BN1 9RE, England
The Ikhaya Lobomi Organisation, P. O. Box 583, Bothas Hill, 3660, South Africa (www.homeoflife.org.za)
ILO Office in Abuja, United Nations House, Plot 617/618, Central Area District, PMB 2851 Garki, Abuja, Nigeria (familoni@ilo.org)
ILO Office in Addis Ababa, Africa Hall, 6th floor, Menelik II Avenue, P. O. Box 2788 Addis Ababa, Ethiopia (addisababa@ilo.org)
ILO Office in Cairo, 9 Taha Hussein Street, 11561, Zamalek, Cairo, Egypt (cairo@ilo.org)
ILO Area Office in Dar es Salaam, 76/27 and 105/27 Maktaba Street, P. O. Box 9212, Dar es Salaam, United Republic of Tanzania (daressalaam@ilo.org)
ILO Office in Lusaka, 3rd Floor, Superannuation House, Ben Bella Road, P. O. Box 32181, ZA 10101 Lusaka, Zambia (lusaka@ilo.org)
ILO Office in Pretoria, 347 Hilda Street,. Corner Arcadia St. , P. O. Box 11694, Hatfield 0028, Pretoria, South Africa (pretoria@ilo.org)
ILO Southern Africa Multidisciplinary, Advisory Team (ILO/SAMAT), 8 Arundel Office Park, Norfolk Rd, Mt. Pleasant, P. O. Box 210, Harare, Zimbabwe (harare@ilo.org)
Institute for African Alternatives (IFAA), Sable Centre, 41 de Korte Street, 4th floor, Braamfontein, Johannesburg 2001, South Africa
Institute for Education in Democracy (IED), P. O. Box 43874 Nairobi 00100, Kenya (www.iedafrica.org)
Institute for War & Peace Reporting (IWPR), 48 Grays Inn Road London WC1X 8LT, United Kingdom
Integrated Regional Information Networks (IRIN), P. O. Box 30218-00100, Nairobi, Kenya (http://www.irinnews.org)
Inter-African Committee on Traditional Practices (IAC), 147 rue de Lausanne, 1202 Geneva, Switzerland
Inter-African Committee on Traditional Practices, PO Box 3001, Addis Adaba, Ethiopia
Inter-African Network for Women, Media, Gender and Development (FAMEDEV), B. P. 32-343, Dakar-Ponty 15-523, Senegal (www.famedev.org)
Interagency Gender Working Group (http://www.igwg.org)
Inter-American Development Bank (IDB), 1300 New York Avenue NW, Washington, DC 20577 (http://iadb.org)
International AIDS Economics Network (IAEN) (www.iaen.org)
International Center for Research on Women (ICRW), 1717 Massachusetts Avenue NW, Suite 302, Washington, DC 20036 (http://www.icrw.org) and Plot 7, Wampewo Avenue, P. O. Box 7289, Kampala, Uganda
International Centre for the Legal Protection of Human Rights (http://www.interights.org)
International Confederation of Midwives, Eisenhowerlaan 1382517 KN The Hague, The Netherlands (Intlmidwives@compuserve.com)

International Commission of Jurists (ICJ), P. O. Box 59743, Nairobi, Kenya (www.icj-kenya.org)

The International Community of Women Living with HIV/AIDS (ICW), Unit 6, Building 1, Canonbury Yard, 190a New North Road, London N1 7BJ, United Kingdom (www.icw.org)

International Federation of Journalists, IPC-Residence Palace, Bloc C, Rue de la Loi 155, B-1040 Brussels, Belgium (www.ifj.org)

International Federation of Red Cross and Red Crescent Societies, PO Box 372. 17, Chemin des Crets, Petit Saconnex, 1211 Geneva 19, Switzerland

International Information Centre and Archives for the Women's Movement (IIAV), Obiplein 4, 1094 RB Amsterdam, The Netherlands (http://www.iiav.nl)

International Institute of Communication and Development (IICD), Raamweg 5, 2596 HL, The Hague, Netherlands (http://www.iicd.org)

International Organization for Migration (IOM), P. O. Box 55391, Arcadia 0007, Pretoria, South Africa (www.iom.int)

International Planned Parenthood Federation, AIDS Prevention Unit, Regents College, Inner Circle, Regents Park, London NW1 4NS, United Kingdom (http://www.ippf.org)

International Press Centre, 42 Itaye Road, Ogba-Ikeja, Lagos, Nigeria

International Refugee Rights Initiative (IRRI), 18A Kyadondo Road, Nakasero Hill, P. O. Box 7785, Kampala, Uganda (www.refugee-rights.org)

International Rescue Committee, 122 East 42nd Street, New York, New York 10168-1289 (www.theirc.org)

International Women's Health Coalition, 24 East 21st Street, 5th floor, New York, NY 10010

International Women's Media Foundation (IWMF), 1625 K Street NW, Washington, DC 20006 (www.iwmf.org)

International Women's Tribune Centre (IWTC), 777 United Nations Plaza, New York, NY (www.iwtc.org)

Intersex Society of North America (ISNA), PO Box 301, Petaluma, CA 94953 (www.isna.org)

Islamic Medical Association of Uganda (IMAU), P. O. Box 2773, Kampala, Uganda (www.imauganda.org).

IWPR/Africa, 1st Floor, 5 Wellington Road, Parktown, 2193, Johannesburg, South Africa

IWPR/Europe, 48 Gray's Inn Road, London WC1X 8LT, United Kingdom

IWPR/US, 1325 G Street, NW, Suite 500, Washington, DC 20005, USA

Jacaranda Foundation, 11734 Wilshire Blvd, #C913, Los Angeles, CA 90025 (www.jacarandafoundation.org)

Jambo Tanzania, Inc., 78 Maple Street, Springfield, MA 01105 USA

Jenda: A Journal of Culture and African Women Studies (http://www.jendajournal.com) Contact: Nkiru Nzegwu, Binghamton University, Department of Africana Studies, Vestal Parkway, Binghamton, NY 13902-6000 USA (jen-editors@africaresource.com)

Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, 111 Market Place, Suite 310, Baltimore, MD 21202 (http://www.jhuccp.org)

Joint United Nations Programme on HIV/AIDS (UNAIDS), UNAIDS Secretariat, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland (www.unaids.org)

Journ-AIDS, HIV/AIDS and the Media Project, Journalism Programme, University of the Witwatersrand, Private Bag 3, WITS 2050. South Africa

Journalists Against AIDS Nigeria (JAAIDS), P. O. Box 56282, Falomo, Lagos, Nigeria (www.nigeria-aids.org)

Journalists for Human Rights (JHR), Hse. No. F732/1, Near Duncan's Bar, Osu RE, Accra, Ghana and 47 John Street, Central Freetown, Sierra Leone (www.jhr.ca)

Justice for Widows and Orphans Project (JWOP), House #6, Nyati Close, P. O. Box 34777, Lusaka, Zambia (www.jwop.org.zm)

Kabissa, 1519 Connecticut Ave, NW, Suite 200, Washington, D. C. 20036 (www.kabissa.org)

The Henry J. Kaiser Family Foundation (KFF), 2400 Sand Hill Road, Menlo Park, CA 94025 (www.kaisernetwork.org)

W. K. Kellogg Foundation, One Michigan Avenue East, Battle Creek, MI 49017-4012 (http://www.wkkf.org)

Kenya AIDS Intervention Prevention Project Group (KAIPPG), P.O. Box 40, Butere, Kenya (www.kaippg.org)

Kenya AIDS NGOs Consortium (KANCO), P. O. Box 69866, Nairobi, 00400 Kenya (www.kanco.org)

Kenya AIDS Watch Institute (KAWI), P. O. Box 10013 GPO, Nairobi, 00100 Kenya (www.kenyaaidsinstitute.org)

Kenya Alliance for the Advancement of Children (KAACR), P. O. Box 73637 Nairobi, 00200 Kenya (www.kaacr.com)

Kenya Female Advisory Organisation (KEFEADO), P. O. Box 6025, Kisumu, Kenya 40103 (www.kefeado.co.ke)

Kenya Human Rights Commission (KHRC), P. O. Box 41079 Nairobi, 00100, Kenya (www.khrc.org.ke)

Kenya Network of Women With AIDS (KENWA), P. O. Box 69866, Nairobi, 00400 Kenya (www.kenwa.org)

Kenyan National Council on Traditional Practices, PO Box 7850, Nairobi, Kenya

Kivulini, P. O. Box 11348 Mlangommoja, Near Newpack Hotel, Baganda Street, Mwanza, Tanzania (www.kivulini.org)

Konrad Adenauer Stiftung Media Programme, P. O. Box 1383, Houghton 2041, South Africa (www.kasmedia.org)

Kubatana Trust of Zimbabwe P.O.Box GD376, Greendale, Harare (www.kubatana.net)

Kwacha Kum'mawa, P. O. Box 511135, Chipata, Zambia

Legal and Human Rights Centre (LHRC), P. O. Box 75254, Dar es Salaam, East Africa (www.humanrights.or.tz)

Legal Assistance Center, P. O. Box 604, Windhoek, Namibia (www.lac.org.na)

Stephen Lewis Foundation, 260 Spadina Avenue, Suite 501, Toronto, Ontario M5T 2E4 Canada (www.stephenlewisfoundation.org)

Liberia Institute of Journalism (www.lij.kabissa.org)

Liberia Media Project, P. O. Box 3840, Monrovia 1000 Liberia (liberiamediaproject@yahoo.com)

Liberian Community Peace Building and Development Project (CPBD)

London Black Women's Health Action Project (LBWHAP), Cornwall Avenue, Community Centre, 1 Cornwall Avenue, London E2 OHW, United Kingdom

Lusophone African Studies Organization (LASO), 310 Auditorium Building, Michigan State University, East Lansing, MI 48824 (www.h-net.org/~lusoafri)

Maendeleo Ya Wanawake Organisation (MYWO), P. O. Box 44412 GPO Nairobi, 00100 Kenya (www.maendeleo-ya-wanawake.org)

The Maghreb Center: Fostering Understanding and Development of the Maghreb, 3528 S Street, NW, Washington DC 20007

Maji na Ufanisi, P. O. Box 58684 Nairobi, 00200, Kenya (www.maji-na-ufanisi.org)

Malawi Human Rights Resource Centre (MHRRC), Area 9 (Plot No. 9/190), P. O. Box 891, Lilongwe, Malawi (www.sdnp.org.mw/mhrrc)

Management Sciences for Health, 165 Allandale Road, Boston, MA 02130 (http://www.msh.org)

MEASURE Communications, 1875 Connecticut Avenue NW, #520, Washington, DC (www.measurecommunication.org)

Media Diversity Institute, 43-51 Great Titchfield Street, London W1W 7DA, United Kingdom (www.media-diversity.org)

Media Foundation for West Africa (MFWA), P. O. Box LG 730, Legon, Ghana (www.mediafoundationwa.org)

MediaHouse, PO Box 77, Maadi, Cairo, Egypt (www.mediahouse.org)

Media Institute of Southern Africa (MISA), 21 Johann Albrecht Street, Private Bag 13386, Windhoek, Namibia (www.misa.org)

Media Resource and Advocacy Centre (MRAC), 40 Johnson Street, Off Bode Thomas Street, Surulere Lagos, Nigeria

Media Stream, 15 Mountain Road, Kommetjie, Western Cape, South Africa (www.mediastream.co.za)

Mediterranean Institute of Gender Studies (MIGS), 46, Makedonitissas Avenue, P. O. Box 24005, 1703 Nicosia, Cyprus (http://medinstgenderstudies.org)

Men's Network for Gender Equality, Kenya, P.O. Box 54562 Nairobi, 00200 Kenya (www.femnet.org.ke)

The Mifumi Project, P. O. Box 274, Tororo, Uganda (www.mifumi.org)

Ministry of Information and Broadcasting, Private Bag 13344, Windhoek, Namibia

Minority Rights Groups International, 379 Brixton Road, London SW9 7DE United Kingdom

Miss Koch Initiative, Davide Okoth Ayieko, PO box 47714, Nairobi, Kenya

Moments Entertainment/CBFA, 72 Keurboom Street, Atholl 2196, South Africa

Most United Knowledgeable Artists (MUKA) project, P. O. Box 1281, Johannesburg 2000, South Africa

Mothertongue, P. O. Box 12531, Mill Street 8010, Cape Town, South Africa (www.mothertongue.co.za)

Movement for the Eradication of Female Genital Mutilation (MEFEGM), 90 Sanders Street, Freetown, Sierra Leone

Muslim AIDS Intervention Prevention Project Group (MAIPPG), P.O. Box 40, Butere, Kenya

The Naledi3D Factory, PostNet Suite 213, Private Bag X844, Silverton 0127, South Africa (www.naledi3d.com)

National AIDS Control Council (NACC), P. O. Box 61307 Nairobi (www.nacc.org.ke)

National AIDS & STDs Control Programme (NASCOP), P. O. Box 19361 Nairobi, 00202 Kenya (www.ministryofhealth.gov.ke)

National Association of Nigeria Nurses and Midwives (NANNM), PO Box 3857 Ikeja Post Office, Lagos, Nigeria

National Committee on Traditional Practices Uganda (NCTPU), PO Box 7296, Kampala, Uganda

National Electronic Media of South Africa (NEMISA), P. O. Box 545, Auckland Place, 2006, Johannesburg, South Africa (www.nemisa.co.za)

National Organization of Circumcision Information Resource Centers (NOCIRC) FGM Awareness and Education Project, PO Box 2512, San Anselmo, CA 94979-2512

National Organisation for Peer Educators (NOPE), P. O. Box 10498, Nairobi 00100 Kenya (www.nope.org.ke)

National Women's Health Information Center, U. S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201 (www.4woman.gov)

National Women's Health Network, 1325 G Street NW, Lower level B, Washington, DC 20005

Nelson Mandela Children's Fund (NMCF), 21 Eastwold Way, Saxonwold, P. O. Box 797, Highlands North, 2037, South Africa (www.nmcf.co.za) (www.nelsonmandelachildrensfund.com)

The Nelson Mandela Foundation (NMF), Mandela House, 107 Central Street, Houghton 2198, South Africa (www.nelsonmandela.org)

Network of Sex-Work Related HIV/AIDS Projects, c/o AHRTAG, 1 London Bridge Street, London SE1 9SG, United Kingdom

Networked Intelligence for Development (NID), 461 Roncesvalles Avenue, Suite D, Toronto, Ontario, Canada M6R 2N4 (www.networkedintelligence.com)

Nigeria Internet Law Reports (http://www.nigeria-law.org/LawReporting.htm)

NISAA Institute for Women's Development, P. O. Box 1057, Lenasia 1820, Johannesburg, South Africa (www.nisaa.org.za)

Ntengwe for Community Development Trust, Zimbabwe, (www.wearetheorphans.org)

Nurturing Orphans of AIDS for Humanity (NOAH), Box 4043, Rivonta, Gauteng, South Africa

Office of the Special Adviser on Gender Issues and Advancement of Women, United Nations, Tow United Nations Plaza, 44th Street, 12th Floor, New York, NY 10017 (http://www.un.org/osagi)

Ombetja Yehinga Organisation (OYO), P. O. Box 97217, Maerua Park, Windhoek, Namibia (http://ombetja.org)

Open Society Foundation for South Africa, PO Box 23161, Claremont, South Africa, 7735 (admin@ct.osf.org.za)

The Open Society Institute (OSI), 400 West 59th Street, New York, NY 10019 (www.soros.org)

The Open Society Initiative for Southern Africa (OSISA), 12th Floor Braamfontein Centre, 23 Jorissen Street, Braamfontein 2017, PO Box 678, Wits 2050, Johannesburg, South Africa (www.osisa.org)

The Organization for Social Science Research in Eastern and Southern Africa (OSSREA), P. O. Box 31971, Addis Ababa, Ethiopia (www.ossrea.net)

Organization of Women Writers of Africa, Inc (OWWA), P. O. Box 652, Village Station, New York, NY 10014 (www.owwa.org)

Pan-African Action-Research Network, c/o Brooke Schoepf, 13 Spencer Baird Road, Woods Hole, MA 02543 USA

Pan American Health Organization (PAHO), 525 23rd Street NW, Washington, DC 20037 (http://www.paho.org)

The Panos Institute, AIDS Unit, 9 White Lion Street, London N1 9PD, United Kingdom (www.panos.org)

Partnership in Development Research, American University in Cairo Social Research Center, 11th Floor, Cairo Center, 106 Kasr Al-Aini Street, Cairo, Egypt (www.aucegypt.edu/pdr)

PATH, P. O. Box 76634-00508, Nairobi, Kenya (www.path.org)

Pathfinder International, P. O. Box 48147, Nairobi 00100, Kenya (www.pathfind.org)

The Pendulum Project, 1770 Mass Avenue, Box 625, Cambridge, MA 02140 Plan, West Africa Regional Office, 136 Sotrac Mermoz, Dakar, Senegal

Policy Project, The Futures Group International, 1050 17th Street, Suite 1000 NW, Washington, DC 20036 (www.policyproject.com)

Population Action International (PAI), 1120 19th Street, NW, Suite 550, Washington, DC

Population Council, One Dag Hammarskjold Plaza, New York, NY 10017 USA (www.popcouncil.org)

The Population Council, 258, Rue 13.21—Zone du Bois, 01 B.P. 6250-Ouagadougou 01, Ouagadougou, Burkina Faso

Population, Development and Reproductive Health, Norman Shaw South, Room 301, Victoria Embankment, London SW1A 2H2, United Kingdom

Population Media Center, PO Box 547, Shelburne, VT 05482 Contact: Kriss Barker

Population Reference Bureau, MEASURE Communication, 1875 Connecticut Avenue, NW, Suite 520, Washington, DC 20009 (www.measurecommunication.org)

Population Services International (PSI), 1120 19th Street NW, #600, Washington, D. C. 20036

Positive Muslims, 5 Drake Road, Observatory, Cape Town 7925, South Africa

Positively Women of Kenya, PO Box 76618, Nairobi, Kenya Program for Appropriate Technology in Health (PATH), 1455 NW Leary Way, Seattle, WA 98107 (http://www.path.org)

Program on Critical Issues in Reproductive Health and Population, The Population Council, 1 Dag Hammarskjold Plaza, New York, NY 10017 USA
Progressive Primary Health Care Network, 9th floor, Cavendish Chambers, 183 Jeppe Street, Johannesburg 2001, South Africa
Project San Francisco/Kigali, c/o Center for AIDS Prevention Studies, University of San Francisco, 74 New Montgomery, Suite 600, San Francisco, CA 94105 USA
Radda Barnen (Swedish Save the Children), S-107 88 Stockholm, Sweden
Radio Apac, PO Box 4005, Kampala, Uganda
Radio Dialogue, 9th floor Pioneer House, Bulawayo, Zimbabwe
Rainbo Kenya, Box 10658-00100 GPO, Nairobi, Kenya
Rainbo Sudan, Elgezeira Street, Building # 3, Square 2WE, Khartoum, Sudan
Rainbo UK, Queens Studios, 121 Salusbury Road, London NW6 6RG, United Kingdom
Rainbo USA, 275 Madison Avenue, 6th Floor, New York, NY 10016
Raising Voices, Plot 16 Tufnell Drive, Kamwokya, P. O. Box 6770, Kampala, Uganda (www.raisingvoices.org)
The Read Organisation, P. O. Box 30994, Braamfontein, 2017 Johannesburg, South Africa (www.read.co.za)
Refugee Studies Centre, Department of International Development, 3 Mansfield Road, Oxford OX1 3TB, United Kingdom (www.fmreview.org)
Research, Action and Information Network for Bodily Integrity of Women (RAINBO), 915 Broadway, Suite 1603, New York, NY10010–7108 (www.rainbo.org)
Resource Conflict Institute (RECONCILE), P. O. Box 7150 Nakuru, 20110, Kenya (www.reconcile-ea.org)
Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN), Suite 87, Private Bag X12, Tokai, Cape Town 7966, South Africa (www.rapcan.org.za)
Right To Play International, 65 Queen Street West, Thomson Building, Suite 1900, Box 64, Toronto, Ontario, M5H 2M5, Canada (www.righttoplay.com)
The Rockefeller Foundation, 420 Fifth Avenue, New York, NY 10018 (http://www.rockfound.org)
Royal College of Midwives, 15 Mansfield Street, London W1M 0BE, United Kingdom (www.rcm.org.uk)
Royal Tropical Institute, Department of Information & Documentation, Mauritskade 63, 1092 AD Amsterdam, The Netherlands
Rusappe Girls Empowerment Village, P. O. Box CZA239, Chitungwiza, Zimbabwe
Rwanda Women's Network (RWN), Rwanda, (www.rwandawomennetwork.org)
Sankofa Center for African Dance and Culture (SCADC), P. O. Box 6581, Santa Ana, CA 92706 (www.sankofacenter.org)
The Sara Communication Initiative (SCI), UNICEF-ESARO, P. O. Box 44145, 00100, Nairobi, Kenya
Save the Children, 54 Wilton Road, Westport, CT 06880 (www.savethechildren.org)
Search for Common Ground, Rue Belliard 205, 1040 Brussels, Belgium
Service Allemand de Developpement (DED), BP 11895, Niamey, Niger (http://niger.ded.de)
Sesame Workshop, 1 Lincoln Plaza, New York, NY 10023 (www.sesameworkship.org)
Sexual Violence Research Initiative (SVRI), c/o Gender and Health Research Unit, Medical Research Council, South Africa, Private Bag 385, 001 Pretoria, South Africa (www.svri.org)
Sierra Leone Association on Women's Welfare (SLAWW), PO Box 1069, Freetown, Sierra Leone
Sisi kwa Sisi, P. O. Box 2869, Mbeya Tanzania
Socialstyrelsen, The National Board of Health and Welfare, 106 30 Stockholm, Sweden (socialstyrelsen@sos.se)
Society for AIDS Families and Orphans, 228 Smit Street, Johannesburg 2195, South Africa

The Society for Family Health, Awaye House, Lagos Badagry Road, Orile Iganmu, Lagos, Nigeria
Society for Women and AIDS in Africa (SWAA), Sicap Sacre Coeur 11, Villa No. 8608F, B.P. 16-425, Dakar-Fann, Senegal (www.swaainternational.org)
Society for Women and AIDS in Kenya (SWAK), P. O. Box 21526, Nairobi 00505, KenyaSociety of Research on African Cultures (SORAC), French Department, Montclair
State University, 1 Normal Avenue, Upper Montclair, New Jersey 07043 (www.chss.montclair.edu)
Somali Association for Relief and Development (SAFRAD), 95 West 95th Street, Suite 25E, New York, NY 10025
The Soros Foundation, 400 West 59th Street, New York, NY 10019 (www.soros.org)
Soul Beat Africa, P.O. Box 413342, Hyde Park 2024, South Africa
Soul City Institute for Health and Development Communication, PO 1290, Houghton 2041, South Africa (www.soulcity.org.za)
South African Media and Gender Institute, 4th floor Dumbarton House, 1 Church Street, Cape Town, South Africa 8001 (www.womensmediwatch.org.za)
South African Regional Poverty Network, P. O. Box 11615, Hatfield 0028, South Africa (www.sarpn.org.za)
Southern Africa Communications for Development (SACOD), P. O. Box 30609, Braamfontein 2017, South Africa (http://sacod.krazyboyz.co.za)
Southern African AIDS Information Dissemination Service (SAfAIDS), P. O. Box A509, Avondale, Harare, Zimbabwe (http://www.safaids.org)
Stepping Stones, Gender and Health Research Unit, Medical Resource Council, Private Bag X385, Pretoria 001, South Africa
Story Workshop, P. O. Box 266, Blantyre, Malawi (www.storyworkshop.org)
Strategies For Hope Trust, 93 Divinity Road. Oxford, Oxon OX4 1LN, United Kingdom (www.stratshope.org)
Straight Talk, P. O. Box 55472-00200, Nairobi, Kenya (www.straighttalk.or.ke)
Sudan National Committee on Traditional Practices (SNCTP), PO Box 10418, Khartoum, Sudan
Supreme Court of Appeal of South Africa (www.server.law.wits.ac.za)
Swaziland Action Group Against Abuse-Ingungu Yematsemba (SWAGAA), P. O. Box 560, Matsapha, Swaziland (www.swagaa.org.sz).
Swiss Agency for Development and Cooperation (SDC), Freiburgstrasse 130, 3003 Berne, Switzerland (http://www.deza.ch)
TackleAfrica, 31 Ferndale, Tunbridge Wells, Kent, TN2 3PD, United Kingdom (www.tackleafrica.org)
Tahirih Justice Center, 6066 Leesburg Pike, Suite 220, Falls Church, VA 22041 (http://www.tahirih.org)
Tanzania Media Women's Association, PO Box 6143, Dar es Salaam, Tanzania
Teaching aids at low cost (TALC), P. O. Box 49, St. Albans, Herts AL2 5TX, United Kingdom (www.talcuk.org)
Teenage Life Program (TELIP), Uhuru Street, Ilala, P. O. Box 31891, Dar es Salaam, Tanzania (www.teenagelife.4t.com)
The AIDS Service Organization (TASO), PO Box 10443, Kampala, Uganda
Third World Network, 131 Jalan Macalister, 10400 Penang, Malaysia (www.twnside.org.sg)
Tostan Africa, BP 29371, Dakar-Yoff, Senegal (www.tostan.org)
Treatment Action Campaign (TAC), 34 Main Road, Mulzenberg, 7945, South Africa
UK NGO AIDS Consortium for the Third World, Fenner Brockway House, 37/39 Great Guildford Street, London SE1 OES, United Kingdom

UK Consortium on AIDS and International Development, Grayston Centre, 28 Charles Square, London N1 6HT (info@aidsconsortium.org.uk)
UN Centre for Human Rights, Palais des Nations, 8/40 Avenue de la Paix, 1211 Geneve 10, Switzerland
UN Division for the Advancement of Women, United Nations, Room DC2-1220, New York, NY 10017
UN Working Group on Traditional Practices, UN Human Rights Centre, Palais des Nations, CH-1202 Geneva, Switzerland
UNFPA (UN Fund for Population Activities), 220 East 42nd Street, New York, NY 10017
UNFPA: The Fistula Campaign, Resource Mobilization Branch, 220 E. 42nd Street, New York, NY 10017 (fistulacampaign@unfpa.org)
UNHCR (UN High Commissioner for Refugees), PO Box 2500, 1211 Geneva 2, Switzerland
UNICEF Mozambique, P. O. Box 4713, Maputo, Republic of Mozambique (www.unicef.org/mozambique)
UNIFEM (UN Development Fund for Women), 304 45th Street, 6th floor, New York, NY 10017 (http://www.unifem.undp.org)
United Nations Children's Fund (UNICEF), 3 United Nations Plaza, New York, NY 10017 (www.unicef.org)
United Nations Development Programme (UNDP), 304 East 45th Street, 10th floor, New York, NY 10017 (www.undp.org)
UN World Food Programme, Via C. G.Viola 68, Parco dei Medici 00148, Rome, Italy (www.wfp.org)
United States Agency for International Development (USAID), Information Center, Ronald Reagan Building, Washington, DC 20523-1000 (http://usaid.gov)
US Committee for UNICEF, 333 East 38th Street, 6th floor, New York, NY 10016 USA
Bernard van Leer Foundation, PO Box 82 334, 2508 EH The Hague, Netherlands (http://www.bernardvanleer.org)
Village Life Panorama Projects, Grassroots Mobilization for Rural People, PO Box 15, AWGU, Enugu State, Nigeria
Waliokatika Mapambano Na AIDS Tanzania (WAMATA), PO Box 35133, University of Dar es Salaam, Dar es Salaam, Tanzania
Well Women Project, Health Unlimited, Prince Consort House, 27–29 Albert Embankment, London SE1 7TS
West Africa Review (http://www.westafricareview.com/war/vol2.1/2.1war.htm)
West African Research Association (WARA), African Studies Center, Boston University, 270 Bay State Road, Boston, MA 02215
Westly-Electronic Journal of Africana Bibliography (http://www.lib.uiowa.edu/proj/ejab/4/index.html)
WHO Africa Region, PO Box 6, Brazzaville, Congo
Widows and Orphans Welfare Society of Kenya (WOWESOK), P.O. Box 74609, Nairobi, 00200 Kenya (www.wowesok.org.ke)
Wola Nani, P. O. Box 13890, Mowbray 7705, South Africa (www.wolanani.co.za)
Women & AIDS Support Network, PO Box 1554, Harare, Zimbabwe
Women Connect, Community Development Foundation, 60 Highbury Grove, London N5 2AG, United Kingdom (www.womenconnect.org.uk)
Women Fighting AIDS in Kenya (WOFAK), P. O. Box 35168, Nairobi, 00200, Kenya
Women for Women International, 4455 Connecticut Avenue NW, Suite 200, Washington, D. C. 20008 (www.womenforwomen.org)
Women Writing Africa, The Feminist Center at CUNY, The Graduate Center, 365 Fifth Avenue, Suite 5406, New York, NY 10016 (www.feministpress.org)
Women's Action Group, Health Information Programme, Box 135, Harare, Zimbabwe

Women's Commission for Refugee Women and Children, 122 East 42nd Street, New York, NY 10168-1289 (www.womenscommission.org)

Women's eNews, 135 West 29th Street, Suite 1005, New York, NY 10001

Women's Global Network for Reproductive Rights, NWZ Voorburgwal 32, 1012 RZ Amsterdam, Netherlands

Women's Health in Women's Hands, 2 Carlton Street, Suite 500, Toronto, Ontario M5B 1J3, Canada

Women's Health Project, Centre for Health Policy, Department of Community Health, University of the Witwatersrand Medical School, 7 York Road, Parktown 2193, South Africa

Women's Health Research Network in Nigeria, c/o Centre for Social and Economic Research, Ahmadu Bello University, Zaria, Nigeria

Women's International Network Project, Kissidougou-Gueckedou Prefectures, B.P. Kissidougou, Salimatu Bah-Barrie Foundation, Bangura Village (Pita), Province of Fouta Djallon, Guinea

Women's International News Network (WINN), c/o Fran Hosken, 187 Grant Street, Lexington, MA 02173

Women, Media and Change (WOMEC), P. O. Box GP 14550, Accra, Ghana (www.womec.org)

Women'sNet, P. O. Box 62577, Marshalltown, South Africa (www.womensnet.org.za)

Women's Rights Awareness Programme (WRAP), P. O. Box 3006 Nairobi 00200 Kenya (www.wrapkenya.org)

Women's Voice, Malawi, (www.womens-voice.org.mw)

World Alliance for Breastfeeding Action (WABA), P. O. Box 1200, 10850 Penang, Malaysia (www.waba.org.my)

The World Association for Christian Communication (WACC), 308 Main Street, Toronto Ontario M4C 4X7, Canada (www.wacc.org.uk).

The World Bank and Africa (www.worldbank.org/afr/aids/paper.htm)

World Council of Churches, AIDS Working Group, PO Box 2100, 1211 Geneva 2, Switzerland

World Health Organization (WHO), WHO Global Programme on AIDS (GPA), Avenue Appia 20, 1211 Geneva 27, Switzerland (www.who.int)

World Learning, Kipling Road, PO 676, Brattleboro, VT 05302–0676 800/257–7751 (www.worldlearning.org)

World Vision Germany, Am Houiller Platz 4, 61381 Friedrichsdorf, Germany (www.worldvision.org)

Youth Association for Dissemination of Development Information (YADDI), P. O. Box 303, Butare, Rwanda

Youth Broadcasting Project, P. O. Box 44145, Nairobi, Kenya

Zimbabwe Widows and Orphans Trust (ZWOT), 114 Eastern Road, Greendale, Harare, Zimbabwe (www.zwot.com)

APPENDIX III: AFRICAN TERMS

Abayifo: Witches (Akan); (*Bayie* means witchcraft)
Al-Lah: God
Banda: Small African hut, especially designed for foreign tourists
Baraza: The balcony on a house where talking occurs, or a meeting place
Barika: Polygyny (Shona)
Bassia butter: Plant fat, used for cosmetics or medicinal purposes
Bayie: witchcraft
Bhang(i): Marijuana
Bid Dharas: Sugar Daddies
Boubou: Traditional coat worn by men in sub-Saharan Africa
Butiti: A string of beads that a woman wears around her waist
Chai: Tea, colloquial for a bribe
Daya: Traditional birth attendant (in Egypt and the Sudan)
Dibia: A traditional healer
Endwadde enganda: A "complicated disease," best cured by traditional medicine
Enkata: A grass or cloth cushion used for carrying heavy objects on the head
Fatwa: An authoritative religious decree
Foufou: A traditional dish of cassava, yam, and banana
Galabea: The long, while gown worn by Muslim men
Gedda: An old woman of the village
Grigri: Magic object or amulet said to protect against evil spirits
Griot: Oral historian, poet, story-teller
Haram: Something forbidden, sinful
Imam: Muslim religious leader
Inkanyezi: Glow worm (Xhosa)
Iseko: A widow's bad luck, losing up to three husbands
Jalabiya: A kaftan
Juliana: A cloth popular with Baganda women, it is the Tanzanian nick name for AIDS
Kabissa: Complete (Kiswahili)
Kachabale: Sexual arousal by means of rubbing the penis between vaginal lips
Kandooya: Torture treatment where elbows and ankles are bound behind a victim's back
Khanga: Rectangles of brightly colored cotton used for male and female dress
Kitenge: Colorful women's clothing, consisting of blouse, skirt, head-scarf
Kora: African musical instrument
Lihlombe lekukhalela: "shoulder to cry on", referring to community worker—Swaziland
Lobola: Brideprice (also, *roora* in Shona)
Lukasa: Beaded memory board

Magendo:	The middle-man smuggler on a black market
Makogo:	A Zambian beer ceremony after someone's death
Malaya:	A prostitute
Malwa:	Local beer, grain derivative
Marabout:	Islamic holy man
Matatu:	Public transportation
Matooke:	Green bananas, the staple in some countries
Mayembe:	(Evil) spirits
Misada:	Economic aid, or the Kenyan nickname for AIDS
Mudhira:	A "dealer," such as of foods or products
Mufti:	A senior religious leader
Muzungu:	A white person, usually meaning a European
Mzee:	An old man
Nana:	Respectful title for an African woman
Nkolola:	A local traditional initiation ceremony in Zambia
Nyana:	Grandmother (Swahili)
Obaakofo Mmu Man:	One man does not rule a nation
Olubugo:	a bark-cloth burial shroud
Qur'an:	Also known as the Koran, it is the Muslim holy book: the word of od revealed to the Prophet Mohammed
Pirogue:	Small boat propelled by a paddle or sail
Purdah:	Separating curtain in a house, segregating women
Salaam:	Peace (greeting)
Saluala:	Used clothing
Sambusa:	Deep-fried pastry triangle, filled with mincemeat or peas
Shamba:	A garden or agricultural plot
Shari'a (*Sharia*):	Islamic law
Sunna:	Practices based on traditions of the Prophet Mohammed
Tahur:	literally, purification
Tissu pagne:	Cloth used for women's long skirts
Tonto:	Local beer that is made from bananas
Tostan:	"breakthrough" (Wolof)
Toto:	A boy
Ubulawu:	Medicine worn by women to soften their husbands against ill-treatment
Ukusoma:	Non-penetrative sex (Zulu)
Ungefanyaje:	"What would you do?" (Swahili)
Uzwanamina:	A "husband love me" charm to keep husbands listening
Vidomegon:	Benin child maids
Wabenzi:	Rich, powerful men
Waragi:	Liquor made from bananas, cassava, or dates
Wazungu:	Europeans
Wola Nani:	"We embrace and develop one another" (Xhosa)

APPENDIX IV: AFRICAN HIV/AIDS-RELATED WEB SITES

Abantu for Development (www.abantu.org)
The Academic and Non-Fiction Authors' Association of South Africa (http://www.anfasa.org.za)
ActionAid International, Kenya (www.actionaid.org)
AfriBeat (www.afribeat.com)
AfricaBib (www.africabib.org)
Africa Action (www.africaaction.org)
The Africa Book Centre Ltd (http://www.africabookcentre.com)
Africa Consultants International (ACI) (www.acibaobab.org)
AfricaFiles (info@africafiles.org)
The Africa ICT Policy Monitor (http://africa.rights.apc.org)
African Gender Institute (AGI) (http://web.uct.ac.za/org/agi)
African Human Rights Resource Center (http://www1.umn.edu/humanrts/africa)
African Leaders and AIDS (www.africpolicy.org)
Africa Leadership Forum (ALF) (www.africaleadership.org)
Africa Film & TV News (www.africafilmtv.com)
African Medical and Research Foundation (AMREF) (www.amref.org)
African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN) (www.anppcan.org)
African News Online (http://africanews.org)
Africare (www.africare.org)
Africa Renewal (www.un.org/AR)
Africa Review of Books (http://www.codesria.org/Links/Publications/Journals/africa_review_books.htm)
AfricaWoman (http://www.africawoman.net)
Africana Librarians Council (ALC) (http://www.loc.gov/rr/amed/afs/alc)
Africana Libraries Newsletter (http://www.indiana.edu/~libsalc/african/aln/alnindex.html)
African Books Collective Ltd (ABC) (http://www.africanbookscollective.com)
African Bushmail Network (www.bushmail.co.za)
African Connection (www.africanconnection.org)
African Journals Online (http://www.ajol.info)
African Publishers Network (APNET) (http://www.apnet.org)
African Review of Books (http://www.africanreviewofbooks.com)
African Rights (http://africa.oneworld.net)
African Studies Association (www.africanstudies.org)
African Union (www.africa-union.org)
African Woman and Child (AWC) (www.awcfs.org)
African Women's Development & Communication Network (FEMNET) (www.femnet.org.ke)

African Women Global Network (AWOGNet) (www.osu.edu/org/awognet)
Africare (www.africare.org)
Afriline (www.afriline.net)
Afrilivres/Livres d'Afrique et des Disasporas (http://www.afrilivres.com)
Afrol News (www.afrol.com)
Afro-Net (www.healthnet.org)
Aids & Africa (www.aidsandafrica.com)
AIDS Analysis Africa Online (AAAO) (www.redribbon.co.za)
AIDS Control and Prevention Project (AIDSCAP) (http://www.fhi.org)
AIDS Media Center, World Bank (aidsmedia@worldbank.org)
AIDS Resource Center (ARC) (www.etharc.org)
allAfrica.com (http://allafrica.com)
Amnesty International: FGM (http://www.amnesty.org/alilib/intcam/femgen/fgm1.htm)
Appropriate Technology Library (www.green-trust.org)
Article 19 (www.article19.org)
Association Culture et Développement (http://www.culture-developpement.asso.fr)
Association for the Development of Education in Africa. (http://www.adeanet.org/workgroups/en_wgblm.html)
Association for the Study of Classical African Civilizations (ASCAC) (www.ascac.org)
Association of African Universities (AAU) (www.aau.org)
Association of African Women Scholars (www.iupui.edu)
Association of Concerned Africa Scholars (ACAS) (www.concernedafricascholars.org)
Association of Media Women in Kenya (AMWIK) (www.amwik.org)
Association for Progressive Communications (APC-Africa-Women) (www.apcafricawomen.org)
Association pour le Progres et la Defense des Droits des Femmes Maliennes (APDF)/(www.catwinternational.org)
Bending the Arc (www.bendingthearc.com)
Biblionef South Africa (http://www.biblionefsa.org.za)
The Binti Pamoja Center (www.bintipamoja.org)
Cairo International Book Fair/General Egyptian Book Organization (http://www.egyptianbook.org.eg/En)
Centre Africain de Formation à l'Edition et à la Diffusion (CAFED) (http://www.capjc.nat.tn/fr/cafed.asp)
Centre for AIDS Development, Research and Evaluation (CADRE) (www.cadre.org.za)
Centre for the Book (http://www.bdf.org.za/cms)
Center for Communications Programs (CCP) (www.jhuccp.org)
Centre for Development and Population Activities (CEDPA) (http://www.cedpa.org)
Center for Domestic Violence Prevention (CEDOVIP) (www.raisingvoices.org/cedovip.php)
Centre for African Family Studies (CAFS) (www.cafs.org)
Centre for Democratic Development, Research and Training (www.ceddert.com)
Centre for Law and Research International (CLARION) (www.clarionkenya.org)
Center for Partnership Studies (CPS) (www.partnershipway.org)
Center for Reproductive Law and Policy (CRLP) (www.crlp.org)
Centre for Rights, Education and Awareness (CREAW) (www.creaw.org)
The Centre of African Studies at The University of Edinburgh (www.cas.ed.ac.uk)
The Child Rights Advisory Documentation and Legal Centre, Kenya (CRADLE) (www.thecradle.org)
Children's Book Project of Tanzania (CBP) (http://www.cbp.or.tz)
Children's Legal Action Network (CLAN) (www.anppcan.org/new/projects/clan/home)
Children's Literature Research Unit, University of South Africa (http://www.childlit.org.za/clruindex.html)

Clowns Without Borders (www.clownswithoutborders.org)
Coalition On Violence Against Women (COVAW) (www.covaw.org.ke)
Collaborative Centre for Gender and Development, Kenya (http://kenya.fes-international.de/ccgd.shtml)
Commission on Gender Equality (www.cge.org.za)
The Communication Initiative (www.comminit.com)
Community Law Centre (CLC), South Africa (www.communitylawcentre.org.za)
Council for the Development of Social Science Research in Africa (CODESRIA) (www.codesria.org)
Doctors Without Borders (www.doctorswithoutborders.org)
DramAidE (www.dramaide.co.za)
East African Book Development Association (EABDA) (http://www.eabda.com)
The Economic Society of South Africa (www.essa.org.za)
Education Centre for Women in Democracy (ECWD) (www.ecwd.org)
The Education With Enterprise Trust (EWET) (www.ewet.org.za)
The Egyptian Center for Women's Rights (http://www.ecwronline.org)
Eldis Programme (www.eldis.org/gender/index.htm)
Elimu Yetu Coalition (www.ancefa.org)
enda third world (www.enda.sn)
Espace Afrique. Diffusion et Promotion du Livre Africain Francophone (http://www.espace-afrique.ch)
Ethiopia Reads (http://www.ethiopiareads.org/index.html)
Ethiopian Economic Association (EEA) (www.eeaecon.org)
Famafrique, Synergie Genre et Developpement (www.famafrique.org)
Family Health International (FHI) (www.fhi.org)
Family Life Association of Swaziland (FLAS) (www.flas.org.sz)
Family Planning Association of Kenya (FPAK) (www.fpak.org)
Fantsuam Foundation (www.fantsuam.org)
Feminia (www.feminia.org)
Femmes Africa Solidarite (FAS) (www.fasngo.org)
FGMnetwork: Education and Networking (http://www.fgmnetwork.org)
Food and Agriculture Organization (FAO) (http://www.fao.org)
Ford Foundation (http://www.fordfound.org)
Forest Action Network (FAN) (www.fanworld.org)
Forum for African Women Educationalists (FAWE) (www.fawe.org)
Foundation for Women's Health, Research and Development (FORWARD) (www.forward.dircon.co.uk)
The Freedom of Expression Institute (www.fxi.org.za)
GBV Prevention Network (www.preventgbvafrica.org)
The Gender and Media Southern African Network (GEMSA) (www.gemsa.org.za)
Gender and Women's Studies for Africa's Transformation (http://www.gwsafrica.org)
Gender Links (GL) (www.genderlinks.org.za)
Ghana Book Development Council (GBDC) (http://www.edughana.net/bookdevelopment.htm)
Ghana Book Trust (http://www.ghana-book-trust.org)
Global Dialogues (www.globaldialogues.org)
Global Rights (www.globalrights.org)
Grassroots Organizations Operating Together in Sisterhood (GROOTS) (www.groot.org)
The Green Belt Movement (www.greenbeltmovement.org)
GreenNet Educational Trust (http://www.apcwomen.org)
Groupe de Recherches sur l'Afrique Francophone (GRAF) (www.bu.edu/africa)
Healthlink Worldwide (http://www.healthlink.org.uk)
Heartlines (www.heartlines.org.za)
Hope for African Children Initiative (HACI) (www.hopeforafricanchildren.org)

Human Rights Watch (HRW) (www.hrw.org)
The Human Rights Trust of Southern Africa (SAHRIT) (www.sahrit.org)
IBBY SA. The International Board on Books for Young People-South Africa (http://www.ibbysa.org.za)
International Federation of Library Associations and Institutions. Africa Regional Section (http://www.ifla.org/VII/s25/index.htm#Newsletter)
Institute for Education in Democracy (IED) (www.iedafrica.org)
Inter-African Network for Women, Media, Gender and Development (FAMEDEV), (www.famedev.org)
Interagency Gender Working Group (http://www.igwg.org)
International AIDS Economics Network (IAEN) (www.iaen.org)
International Center for Research on Women (ICRW) (http://www.icrw.org)
International Centre for the Legal Protection of Human Rights (http://www.interights.org)
International Confederation of Midwives (Intlmidwives@compuserve.com)
International Commission of Jurists (ICJ) (www.icj-kenya.org)
The International Community of Women Living with HIV/AIDS (www.icw.org)
International Information Centre and Archives for the Women's Movement (IIAV), (http://www.iiav.nl)
International Institute of Communication and Development (IICD) (http://www.iicd.org)
International Organization for Migration (IOM) (www.iom.int)
International Planned Parenthood Federation (http://www.ippf.org)
International Women's Media Foundation (IWMF) (www.iwmf.org)
International Women's Tribune Centre (IWTC) (www.iwtc.org)
Jenda: A Journal of Culture and African Women Studies (http://www.jendajournal.com)
Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (http://www.jhuccp.org)
Joint United Nations Programme on HIV/AIDS (UNAIDS) (www.unaids.org)
Journalists Against AIDS Nigeria (JAAIDS) (www.nigeria-aids.org)
Journalists for Human Rights (JHR) (www.jhr.ca)
Justice for Widows and Orphans Project (JWOP) (www.jwop.org.zm)
Kabissa (www.kabissa.org)
Kenya AIDS Intervention Prevention Project Group (KAIPPG) (www.kaippg.org)
Kenya AIDS NGOs Consortium (KANCO) (www.kanco.org)
Kenya AIDS Watch Institute (KAWI) (www.kenyaaidsinstitute.org)
Kenya Alliance for the Advancement of Children (KAACR) (www.kaacr.com)
Kenya Female Advisory Organisation (KEFEADO) (www.kefeado.co.ke)
Kenya Human Rights Commission (KHRC) (www.khrc.org.ke)
Kenya Network of Women With AIDS (KENWA) (www.kenwa.org)
Kenya Publishers Association/Nairobi International Book Fair (http://www.kenyabooks.org/home/index.asp)
Kinderbuch Fonds Boabab/Baobab Children's Book Fund (http://www.baobabbooks.ch)
Kivulini (www.kivulini.org)
L'association Livres d'Afrique/Salon Livres d'Afrique (http://www.livresdafrique.com)
Law Africa (http://www.lawafrica.com)
Legal and Human Rights Centre (LHRC), East Africa (www.humanrights.or.tz)
Legal Assistance Center, Namibia (www.lac.org.na)
Stephen Lewis Foundation (www.stephenlewisfoundation.org)
Liberia Institute of Journalism (www.lij.kabissa.org)
Liberia Media Project (liberiamediaproject@yahoo.com)
Life Vanguards (LIVA) (www.nigeriavillagesquare.com)
Lusophone African Studies Organization (LASO), (www.h-net.org/~lusoafri)
Maendeleo Ya Wanawake Organisation (MYWO) (www.maendeleo-ya-wanawake.org)
Maji na Ufanisi (www.maji-na-ufanisi.org)

Malawi Human Rights Resource Centre (MHRRC) (www.sdnp.org.mw/mhrrc)
Management Sciences for Health (http://www.msh.org)
Media Diversity Institute (www.media-diversity.org)
Media Foundation for West Africa (MFWA) (www.mfwaonline.org)
MediaHouse, PO Box 77, Maadi, Cairo, Egypt (www.mediahouse.org)
Media Institute of Southern Africa (MISA) (www.misa.org)
Men's Network for Gender Equality, Kenya (www.femnet.org.ke)
The Mifumi Project, Uganda (www.mifumi.org)
Ministère de la culture et de la communication (http://www.culture.gouv.fr/culture/dll/misinter.htm)
National AIDS Control Council (NACC) (www.nacc.org.ke)
National AIDS & STDs Control Programme (NASCOP) (www.ministryofhealth.gov.ke)
National Book Development Council of Kenya (NBDCK) (http://www.nationalbook-council-kenya.org)
National Book Development Council of Tanzania/Baraza la Maendeleo ya Vitabu Tanzania (BAMVITA) (http://www.bamvita.or.tz/default.asp)
National Organisation for Peer Educators (NOPE) (www.nope.org.ke)
Nelson Mandela Children's Fund (NMCF) (www.nmcf.co.za)
The Nelson Mandela Foundation (NMF) (www.nelsonmandela.org)
Nigeria International Book Fair (http://www.nibf.org)
Nigeria Internet Law Reports (http://www.nigeria-law.org/LawReporting.htm)
NISAA Institute for Women's Development (www.nisaa.org.za)
The Noma Award for Publishing in Africa (http://www.nomaaward.org)
Ntengwe for Community Development Trust, Zimbabwe (www.wearetheorphans.org)
Online Publishers Association of South Africa (http://www.online-publishers.org.za)
Open Knowledge Network (www.dgroups.org)
Open Society Foundation for South Africa (admin@ct.osf.org.za)
The Open Society Initiative for Southern Africa (OSISA) (www.osisa.org)
The Organization for Social Science Research in Eastern and Southern Africa (OSSREA) (www.ossrea.net)
Organization of Women Writers of Africa, Inc (OWWA) (www.owwa.org)
Pan African Booksellers Association (http://www.panafricanbooksellersassociation.org/default.htm)
Pan American Health Organization (PAHO) (http://www.paho.org)
The Panos Institute, AIDS Unit (www.panos.org)
Pathfinder International (www.pathfind.org)
Policy Project (www.policyproject.com)
Population Action International (PAI) (www.popcouncil.org)
Print Industries Cluster Council (PICC)-South Africa (http://www.picc.org.za)
Professional Editors' Group (PEG)-South Africa (http://www.editors.org.za)
Program for Appropriate Technology in Health (PATH) (http://www.path.org)
Publishers' Association of South Africa (http://www.publishsa.co.za)
Raising Voices (www.raisingvoices.org)
READ Educational Trust (http://read.org.za)
Reading Association of South Africa (http://www.rasa.uct.ac.za)
Refugee Studies Centre (www.fmreview.org)
Reproductive Health Outlook (www.rho.org)
Research, Action and Information Network for Bodily Integrity of Women (RAINBO) (www.rainbo.org)
Resource Conflict Institute (RECONCILE) (www.reconcile-ea.org)
Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN), South Africa (www.rapcan.org.za)
Right To Play (www.righttoplay.com)
Royal College of Midwives (www.rcm.org.uk)

Rwanda Women's Network (RWN), Rwanda (www.rwandawomennetwork.org)
Safe Motherhood (www.safemotherhood.org) (www.matercare.org)
Sankofa: A Journal of African Children's and Young Adult Literature (http://jewel.morgan.edu/~english/english.htm)
Save the Children (www.savethechildren.org)
Secours populaire français (SPF) (www.secourspopulaire.fr)
Sexual Violence Research Initiative (SVRI) (www.svri.org)
Social Aspects of HIV/AIDS Research Alliance (SAHARA) (www.sahara.org.za)
Society for Women and AIDS in Africa (SWAA) (www.swaainternational.org)
Society of Research on African Cultures (www.chss.montclair.edu)
Soul City Institute for Health and Development Communication (www.soulcity.org.za)
South African Booksellers Association (SABA) (http://www.sabooksellers.com)
South African Children's Book Forum (SACBF) (http://www.sacbf.org.za/sacbfhome.html)
South African Book Development Council (SABDC) (http://www.picc.org.za/index)
Southern African Book Development Education Trust (SABDET) (http://www.sabdet.com)
South African Media and Gender Institute (www.womensmediwatch.org.za)
South African Regional Poverty Network (www.sarpn.org.za)
Southern African AIDS Information Dissemination Service (SAfAIDS), Harare, Zimbabwe (http://www.safaids.org)
Standing Conference on Library Materials on Africa (SCOLMA) (http://www.lse.ac.uk/library/scolma)
Supreme Court of Appeal of South Africa (www.server.law.wits.ac.za)
Swaziland Action Group Against Abuse (SWAGAA) (www.swagaa.org.sz).
TackleAfrica (www.tackleafrica.org)
UNIFEM (UN Development Fund for Women) (http://www.unifem.undp.org)
United Nations Children's Fund (UNICEF) (www.unicef.org)
United Nations Development Programme (UNDP) (www.undp.org)
United Nations Population Fund (www.unfpa.org)
United Nations World Food Programme (www.wfp.org)
United States Agency for International Development (USAID) (http://usaid.gov)
Watu Wa Watu (http://www.maaango.org/aids.html)
West Africa Review (http://www.westafricareview.com/war/vol2.1/2.1war.htm)
Westly-Electronic Journal of Africana Bibliography (http://www.lib.uiowa.edu/proj/ejab/4/index.html)
Widows and Orphans Welfare Society of Kenya (WOWESOK) (www.wowesok.org.ke)
Wola Nani (www.wolanani.co.za)
Women for Women International (www.womenforwomen.org)
Women, Media and Change (WOMEC) (www.womec.org)
Women'sNet, South Africa (www.womensnet.org.za)
Women's Rights Awareness Programme (WRAP) (www.wrapkenya.org)
Women's Voice, Malawi, (www.womens-voice.org.mw)
The World Association for Christian Communication (WACC) (www.wacc.org.uk).
World Bank and Africa (www.worldbank.org/afr/aids/paper.htm)
World Health Organization (WHO) (www.who.int)
Zimbabwe Widows and Orphans Trust (ZWOT) (www.zwot.com)
Zimbabwe International Book Fair Trust (http://www.zibf.org.zw)

APPENDIX V: AFRICAN EMBASSIES AND LIAISONS IN THE UNITED STATES

Embassy of the Peoples Republic of *Algeria*, 2118 Kalorama Road, NW, Washington, DC 20008
Embassy of the Republic of *Angola*, 2100-2108 16th Street, NW, Washington, DC 20009
Embassy of the Republic of *Benin*, 2737 Cathedral Avenue, NW, Washington DC 20008
Embassy of *Botswana*, 3400 International Drive, NW, Suite 7M, Washington DC 20008
Embassy of *Burkina Faso*, 2340 Massachusetts Avenue, NW, Washington DC 20008
Embassy of the Republic of *Burundi*, 2233 Wisconsin Avenue, NW, Suite 212, Washington DC 20007
Embassy of the Republic of *Cameroon*, 2349 Massachusetts Avenue, NW, Washington DC 20008
Consulate General of *Cape Verde*, 607 Boston St. 4th. Floor, Boston, Mass. 02116
Embassy of the *Central African Republic*, 1618 22nd Street, NW, Washington DC 20008
Embassy of the Republic of *Chad*, 32002 R Street, NW, Washington DC 20009
Embassy of the *Democratic Republic of Congo*, 1800 New Hampshire Avenue, NW, Washington DC 20009
Embassy of the *Republic of Congo*, 4891 Colorado Avenue, NW, Washington DC 20011
Embassy of the Republic of *Cote d'Ivoire*, 2424 Massachusetts Avenue, NW, Washington DC 20008
Embassy of *Djibouti*, 1156 15th Street, NW, Suite 515, Washington DC 20005
Embassy of the Arab Republic of *Egypt*, 3521 International Ct. NW, Washington, DC 20008
Embassy of *Equatorial Guinea*, 2020 16th Street NW Washington 20009
Embassy of *Ethiopia*, 3506 International Dr. NW Washington, DC 20008
Embassy of *Gabon*, 2034 20th Street, NW, Suite 200, Washington DC 20009
Embassy of the *Gambia*, 1155 15th Street, NW, Suite 1000, Washington DC 20005
Embassy of *Ghana*, 3512 International Drive NW, Washington DC 20008
Embassy of the *Republic of Guinea*, 2112 Leroy Place, NW, Washington DC 20008
Diplomatic Mission of *Guinea-Bissau*, 918 16th Street, NW, Washington DC 20006
Embassy of *Kenya*, 2249 R. Street, NW, Washington DC 20008
Embassy of the Kingdom of *Lesotho*, 2511 Massachusetts Avenue, NW, Washington DC 20008
Embassy of *Liberia*, 5201 16th Street, NW, Washington DC, 20011
Mission of *Libya* to the UN, 309 East 48th Street, New York, New York 10017
Embassy of *Madagascar*, 2374 Massachusetts Avenue NW, Washington, DC 20008
Embassy of *Malawi*, 2408 Massachusetts Avenue, NW, Washington DC 20008
Embassy of the Republic of *Mali*, 2130 R Street, NW, Washington DC 20008

Embassy of the Islamic Republic of *Mauritania*, 2129 Leroy Place, NW, Washington, DC 20008
Embassy of *Mauritius*, 4301 Connecticut Avenue, NW, Suite 441, Washington, DC 20008
Embassy of the Kingdom of *Morocco*, 1601 21st Street, NW, Washington DC 20009
Embassy of the Republic of *Mozambique*, 1990 M Street, NW, Suite 570, Washington DC 20036
Embassy of the Republic of *Namibia*, 1605 New Hampshire Avenue, NW, Washington DC 20009
Embassy of the Republic of *Niger*, 2204 R Street, NW, Washington, DC 20008
Embassy of the Federal Republic of *Nigeria*, 3519 International Court, NW, Washington, DC 20008
Embassy of the Republic of *Rwanda*, 1714 New Hampshire Avenue, NW, Washington DC 20009
Embassy of the Republic of *Senegal*, 2112 Wyoming Avenue, NW, Washington DC 20008
Embassy of the Republic of *Seychelles*, 800 2nd Avenue, Suite 400, New York, NY 10017
Embassy of *Sierra Leone*, 1701, 19th Street, NW, Washington, DC 20009
Embassy of the Republic of *South Africa*, 3051 Massachusetts Ave, NW, Washington, DC 20008
Embassy of the Republic of the *Sudan*, 2210 Massachusetts Ave. NW, Washington, DC 20008
Embassy of the United Republic of *Tanzania*, 2139 R. Street, NW, Washington, DC 20008
Embassy of the Kingdom of *Swaziland*, 1712 New Hampshire Avenue NW, Washington, DC 20009
Embassy of the Republic of *Togo*, 2208 Massachusetts Avenue, NW, Washington DC 20008
Embassy of the Republic of *Tunisia*, 515 Massachusetts Avenue, Washington DC 20005
Embassy of the Republic of *Uganda*, 5911 16th Street NW, Washington DC 20011
Embassy of the United Republic of *Zambia*, 2419 Massachusetts Avenue, NW, Washington, DC 20008
Embassy of *Zimbabwe*, 1608 New Hampshire Ave NW, Washington DC 20009

APPENDIX VI: AFRICAN MEDIA

24 Heures (Abidjan, Cote d'Ivoire): (http://www.24heuresci.com)
Accra Mail (Accra, Ghana): (http://www.accra-mail.com)
Addis Fortune (Addis Ababa, Ethiopia): (http://www.addisfortune.com)
AfriBeat: (www.afribeat.com)
AfricaFiles: (info@africafiles.org)
Africa Film & TV News: (www.africafilmtv.com)
AfricaFocus (Washington, DC): (http://www.africafocus.org)
African News Online: (http://africanews.org)
African Journals Online: (http://www.ajol.info)
African Publishers Network (APNET): (http://www.apnet.org)
African Review of Books: (http://www.africanreviewofbooks.com)
AfricaWoman: (info@africawoman.net)
Afrol News: (www.afrol.com)
Afro-Net: (www.healthnet.org)
Agence Net Press (Bujumbura, Burundi)
Alliance for a Green Revolution in Africa (Nairobi, Kenya): (http://www.agra-alliance.org)
Agencia de Informacao de Mocambique (Maputo, Mozambique): (http://www.sortmoz.com/aimnews)
Altervision (Abidjan, Cote d'Ivoire)
Aminata.com (Conakry, Guinea): (http://www.aminata.com)
The Analyst (Monrovia, Liberia): (http://www.analystnewspaper.com)
Angola Press Agency (Luanda, Angola): (http://www.angolapress-angop.ao)
Agence de Presse Sénégalaise (Dakar, Senegal): (http://www.aps.sn)
Cape Argus (Cape Town, South Africa): (http://www.capeargus.co.za)
Rwanda News Agency/Agence Rwandaise d'Information (Kigali, Rwanda): (http://www.ari-rna.co.rw)
Arusha Times (Arusha, Tanzania): (http://www.arushatimes.co.tz)
L'Aurore (Conakry, Guinea): (http://laurore.press-guinee.com)
Balancing Act (London): (http://balancingact-africa.com)
Le Bénin Aujourd'hui (Cotonou, Benin)
Biz-Community (Cape Town, South Africa): (http://www.bizcommunity.com)
Burundi Réalités (Bujumbura, Burundi): (http://www.burundirealite.org)
Business Daily (Nairobi, Kenya): (http://www.bdafrica.com)
Business Day (Johannesburg, South Africa): (http://www.bday.co.za)
Business in Africa (Johannesburg, South Africa): (http://www.businessinafrica.net)
Cameroon Tribune (Yaoundé, Cameroon): (http://www.cameroon-tribune.net)
The Citizen (Dar es Salaam, Tanzania): (http://www.thecitizen.co.tz)
Concord Times (Freetown, Sierra Leone)
Daily Champion (Lagos, Nigeria): (http://www.champion-newspapers.com)
The Daily Monitor (Addis Ababa, Ethiopia)
The Daily Observer (Banjul, the Gambia): (http://www.observer.gm/enews)
Daily Trust (Abuja, Nigeria): (http://www.dailytrust.com)

East African Business Week (Kampala, Uganda): (http://www.busiweek.com)
The East African Standard (Nairobi, Kenya): (http://www.eastandard.net)
The East African (Nairobi, Kenya): (http://www.nationmedia.com/eastafrican/current)
The Ethiopian Herald (Addis Ababa, Ethiopia): (http://www.ethpress.gov.et/Herald/articlefront.asp)
L'Express (Port Louis, Mauritius): (http://www.lexpress.mu)
L'Express de Madagascar (Antananarivo, Madagascar): (http://www.lexpressmada.com)
Fahamu (Oxford, UK): (http://www.fahamu.org)
Financial Gazette (Harare, Zimbabwe): (http://www.fingaz.co.zw)
Focus Media (Kigali, Rwanda)
FOROYAA Newspaper (Serrekunda, The Gambia)
Fraternité (Cotonou, Benin): (http://www.fraternite-info.com)
Fraternité Matin (Abidjan, Cote d'Ivoire): (http://news.abidjan.net/presse/fratmat.htm)
Freedom Newspaper (The Gambia): (http://www.freedomnewspaper.com)
Gabonews (Libreville, Gabon): (http://www.gabonews.ga)
Garowe Online (Garowe, Somalia): (http://www.garoweonline.com)
Ghanaian Chronicle (Accra, Ghana): (http://www.ghanaian-chronicle.com)
The Herald (Harare, Zimbabwe): (http://www.herald.co.zw)
The Independent (Freetown, Sierra Leone)
Infos Plus Gabon (Libreville, Gabon): (http://www.infosplusgabon.com)
The Inquirer (Monrovia, Liberia): (http://www.theinquirer.com.lr)
L'Intelligent d'Abidjan (Abidjan, Cote d'Ivoire): (http://www.lintelligentdabidjan.org)
Inter Press Service (Johannesburg, South Africa): (http://www.ipsnews.net/africa)
UN Integrated Regional Information Networks (Nairobi, Kenya): (http://www.irinnews.org)
Jenda: A Journal of Culture and African Women Studies: (http://www.jendajournal.com)
Leadership (Abuja, Nigeria): (http://www.leadershipnigeria.com)
Les Echos (Bamako, Mali): (http://www.jamana.org/lesechos/index.html)
Libération (Casablanca, Morocco): (http://www.liberation.press.ma)
Liberia Institute of Journalism: (www.lij.kabissa.org)
Liberia Media Project: (liberiamediaproject@yahoo.com)
L'Autre Quotidien (Cotonou, Benin): (http://www.lautrequotidien.com)
Le Messager (Douala, Cameroon): (http://www.lemessager.net)
Midi Madagasikara (Antananarivo, Madagascar): (http://www.midi-madagasikara.mg)
Mmegi/The Reporter (Gaborone, Botswana): (http://www.mmegi.bw)
The Monitor (Kampala, Uganda): (http://www.monitor.co.ug)
Namibia Economist (Windhoek, Namibia): (http://www.economist.com.na)
The Namibian (Windhoek, Namibia): (http://www.namibian.com.na)
The Nation (Nairobi, Kenya): (http://www.nationmedia.com/dailynation)
New Era (Windhoek, Namibia): (http://www.newera.com.na)
The New Times (Kigali, Rwanda): (http://www.newtimes.co.rw)
New Vision (Kampala, Uganda): (http://www.newvision.co.ug)
The NEWS (Monrovia, Liberia): (http://www.thenews.com.lr)
Nord-Sud (Abidjan, Cote d'Ivoire): (http://www.nordsudmedia.info)
Notre Voie (Abidjan, Cote d'Ivoire): (http://www.notrevoie.com)
Le Nouveau Réveil (Abidjan, Cote d'Ivoire): (http://www.lenouveaureveil.com)
La Nouvelle Relève (Kigali, Rwanda)
L'Observateur Paalga (Ouagadougou, Burkina Faso): (http://www.lobservateur.bf)
Liberian Observer (Monrovia, Liberia): (http://liberianobserver.com)
Online Publishers Association of South Africa: (http://www.online-publishers.org.za)
Le Patriote (Abidjan, Cote d'Ivoire): (http://lepatriote.net)
Le Pays (Ouagadougou, Burkina Faso): (http://www.lepays.bf)
Le Phare (Kinshasa, Congo): (http://www.lepharerdc.com)
PlusNews (Johannesburg, South Africa): (http://www.plusnews.org)
The Post (Buea, Cameroon): (http://www.postnewsline.com)

Le Potentiel (Kinshasa, Congo): (http://www.lepotentiel.com)
La Presse (Tunis, Tunisia): (http://www.lapresse.tn)
La Prospérité (Kinshasa, Congo): (http://www.laprosperiteonline.net)
Public Agenda (Accra, Ghana): (http://www.ghanaweb.com/public_agenda)
Le Quotidien Mutations (Yaoundé, Cameroon): (http://www.quotidienmutations.info)
The Reporter (Addis Ababa, Ethiopia): (http://www.ethiopianreporter.com)
Republic of Togo (Lomé, Togo): (http://www.republicoftogo.com)
San Finna (Ouagadougou, Burkina Faso): (http://www.sanfinna.com)
Shabait.com (Asmara, Eritrea): (http://www.shabait.com)
Shabelle Media Network (Mogadishu, Somalia): (http://www.shabelle.net/news/english.htm)
Sidwaya (Ouagadougou, Burkina Faso): (http://www.sidwaya.bf)
Le Soleil (Dakar, Senegal): (http://www.lesoleil.sn)
SouthScan (London): (http://southscan.gn.apc.org)
Sud Quotidien (Dakar, Senegal): (http://www.sudonline.sn)
SW Radio Africa (Zimbabwe): (http://www.swradioafrica.com)
This Day (Lagos, Nigeria): (http://www.thisdayonline.com)
The Times of Zambia (Ndola, Zambia): (http://www.times.co.zm)
TOMRIC News Agency (Dar es Salaam, Tanzania)
La Tribune (Algiers, Morocco): (http://www.latribune-online.com)
Tunisia Online (Tunis, Tunisia): (http://www.tunisiaonline.com)
UN News Service (New York): (http://www0.un.org/apps/news/region.asp?Region=AFRICA)
Vanguard (Lagos, Nigeria): (http://www.vanguardngr.com)
The Voice (Francistown, Botswana): (http://www.thevoicebw.com)
Wal Fadjri (Dakar, Senegal): (http://www.walf.sn)
The Weekly Observer (Kampala, Uganda): (http://www.ugandaobserver.com)
Weekly Trust (Abuja, Nigeria): (http://www.dailytrust.com/weekly/home.htm)
Westly-Electronic Journal of Africana Bibliography: (http://www.lib.uiowa.edu/proj/ejab/4/index.html)
Zimbabwe Independent (Harare, Zimbabwe): (http://www.thezimbabweindependent.com)
Zimbabwe Standard (Harare, Zimbabwe): (http://www.thezimbabwestandard.com)

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APPENDIX VII: AFRICAN HIV/AIDS-RELATED BILLBOARDS

"AIDS is preventable. Apathy is lethal."
(ARVs): "All by 2010."
"Beware of Sugar Daddies!"
"Choose life, be faithful."
"Drop the debt, donate the dollars, treat the people."
"Everyone he's slept with, is sleeping with you."
"Fight against HIV/AIDS in Africa."
"Generic AIDS drug for the poor countries now."
"Helping each other, act responsibly together."
"HIV stops with me."
"I want to finish my education. Sex can wait."
"If you have to . . . play it safe, use a condom."
"No sex please, we are students."
"A planned family is a happy one."
"Know your status."
"Stop AIDS before it stops the world."
"Saving yourself for marriage is the right thing to do."
"Sex=AIDS=death."
"Sex thrills, but AIDS kills."
"Sugar Daddy + Young Girl=Danger."
"Stop AIDS. Keep the promise."
"Value your body, respect yourself."
"We all have AIDS."
"Weapons of mass instruction."
"Your girlhood is your pride . . . preserve it."
"Your lover will kill you."

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APPENDIX VIII: AFRICAN AIDS-RELATED FILMS

Legends: P: Producer, F: French, ND: No date

Year	Title	Director	Country
ND	*AIDS: A Race Against Time*	a	Nigeri
ND	*AIDS Is Not Only for the Others*	Torber Rasmussen et al. (P)	Zimbabwe
ND	*Condoms, Fish & Circus Tricks*	Robert Rooney	Malawi, South Africa, Zambia
ND	*Heavy Traffic*	Kgomotso Matsunyane	South Africa
ND	*Images of HIV/AIDS Around the World*	Deborah Johnson (P/D)	Burkina Faso, Ghana, Cote d'Ivoire, etc.
ND	*It's My Life* (Zackie Achmat)	Brian Tilley	South Africa
ND	*La Memoire et Le Verbe* (F)	Missa Hebie, Rodrique Barry	Burkina Faso
ND	*Life Must Continue*	Stephen Makau (P/D)	Kenya
ND	*Open Secret*		Uganda
ND	*Sida, Faits et Realities en Cote d'Ivoire* (F)	Celestin Digbeu Kalet	Cote d'Ivoire
ND	*Talking AIDS*	Copperbelt Health Ed Project	Zambia
ND	*Zviripo Maererano ne AIDS*	Ann Holmes	Zimbabwe
1991	*It's Not Easy*	Faustin Misanvu	Uganda
1991	*Karate Kids*	Derek Lamb	(Animation)
1992	*Just a Little Playing Around*	Gabe Reynaud	Papua, New Guinea
1992	*Kinderen van Afrika*	—	Zambia
1992	*Living Positively with AIDS*	Jamie Hartzel	United Kingdom (TASO)
1992	*Mashambanzou: Dawn of a New Life*	—	Zimbabwe
1992	*La Memoire et le Verbe* (F)	Missa Hebie, Rodrigue Barry	Burkina Faso
1992	*More Time*	Isaac Mabhikwa	Zimbabwe
1992	*Need to Blame*	Edwina Spicer	Zimbabwe
1992	*No Longer Alone*	Ann Holmes	Zimbabwe
1993	*AIDS Education in a Positive Light*	Mark A. Reyes	
1993	*A Future with AIDS*	—	Zambia/India/Brazil
1993	*Gospel of AIDS* (F)	Gil Courtemanche	Rwanda
1993	*Hama Ndedzedu: The Terminally Ill*	Ann Holmes	Zimbabwe
1993	*HIV/AIDS: Preventing the Worst*	—	India/Zambia
1993	*Il Faut que Je Me Soigne* (F)	Collectif Des Burundais	Burundi
1993	*No Need to Blame*	—	Zimbabwe

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Appendix VIII Continued

Year	Title	Director	Country
1993	*The Orphan Generation*	Small World Productions (P)	Uganda
1993	*A Place Called Home*		Nigeria
1993	*Puppets Against AIDS—Township to Tundra*	—	South Africa
1993	*Religion and AIDS*		Eastern Mediterranean
1993	*Sida, Faits et Realities en Cote d'Ivoire* (F)	Celestin Digbeu Kalet	Cote d'Ivoire
1993	*Le Sida au Cameroon* (F)	Lucien Mailli	Cameroon
1993	*Sida dans la Cite* (F)	Franck Amblard	Cote d'Ivoire
1993	*Side by Side: Women against AIDS in Zimbabwe* Peter Davis		Zimbabwe
1993	*The Way of the Cross*	—	Uganda
1993	*What Is It With This AIDS?*	Eye to Eye (P)	Swaziland
1993	*Zviripo Maererano ne AIDS*	Ann Holmes	Zimbabwe
1994	*Femmes Aux Yeux Ouverts* (F)	Anne-Laure Folly	Togo
1994	*Rue Princesse* (F)	Henri Duparc	Cote d'Ivoire
1994	*Tufanye Nini*	—	Tanzania
1995	*Afrique, mon Afrique* (F)	Idrissa Ouedraogo	Burkina Faso
1995	*Born in Africa* (Philly Bongoley Lutaaya)	—	Uganda
1995	*Sai Sai by—dans les Tapats de Dakar*	Bouna Medoune Seye	Senegal
1995	*Stepping Stones*	Small World Productions (P)	Uganda
1995	*Talking AIDS*	—	Zambia
1996	*Another Messenger* (Puppets against AIDS)	—	Namibia
1996	*Challenges in AIDS Counselling*	—	Zambia
1996	*Une Conversation* (F)	Christopher Sands	(Muslim community)
1996	*Everyone's Child*	Tsitsi Dangarembga	Zimbabwe
1996	*The Faces of AIDS* (F)	Frances Reid	Cameroon, Zimbabwe
1996	*Facts about AIDS*/Sviripo maererano ne AIDS	—	Zimbabwe
1996	*Sangoma*	Peter Davis	
1997	*Dakan* (Destiny) (F)	Mohamed Camara	Guinea
1998	*Woubi Cheri* (F)	Philip Brooks, Laurent Bocahut (P)	Cote d'Ivoire
1999	*The Silent Killer/AIDS in South Africa*	Marika Griehsel (P/D)	South Africa
1999	*Time to Care: Let's Face It*	Pathfinder, JHU/DISH (Ps)	Uganda
1999	*Under the Mupundu Tree*	Chris Mahoney (P/D)	Zambia
2000	*Promise of Love*	Anne G. Mungai, Johnny Umukoro	Kenya
2000	*Shared Concern*	Abraham Laryea	Ghana
2000	*Yellow Card*	John Riber	Zimbabwe
2001	*An Account of a Catastrophe Foretold*	Philip Brooks	France
2001	*Amah Djah-foule*	Project Retro-CI (P)	Cote d'Ivoire
2001	*The Ball*	Orlando Mesquita	Mozambique
2001	*Bushfire*	Stephen Makau (P/D)	Kenya
2001	*Body and Soul*	Melody Emmett	
2001	*Choose Life*	Dorothy Brislin Ntone	Mozambique

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Appendix VIII Continued

Year	Title	Director	Country
2001	*Comic Relief Dead Serious: Rwanda—A Hope in Hell*	Kate Broome	United Kingdom
2001	*Dancing on the Edge*	Karen Boswall	Mozambique
2001	*Dreams of a Good Life*	Bridget Pickering	South Africa
2001	*Dunia ni Mbaya*	Kibara to Kaugi	Kenya
2001	*Face to Face*	Godwin Mawuru	Zimbabwe
2001	*Guilty/The Moment*	Siyabonga Makhatini	
2001	*House of Love*	Cecil Moller	Namibia
2001	*Imiti Ikula*	Sampa Kangwa Wilkie	Zambia
2001	*I Promise Africa*	Jerry Henry (P/D)	Kenya
2001	*Let's Talk About It*	Lizo Kalpa	South Africa
2001	*Looking for Busi*	Robyn Hofmeyr	South Africa
2001	*A Luta Continua* (The Struggle Continues)	Jack Lewis	
2001	*A Miner's Tale*	Nic Hofmeyr	Mozambique
2001	*Patience and Pinkie: Mother to Child*	Jane Thandi Lipman	South Africa
2001	*Patient Abuse*	Jack Lewis	South Africa
2001	*A Red Ribbon Around My House*	Portia Rankoane	South Africa
2001	*6000 A Day*	Philip Brooks	
2001	Scenarios from the Sahel:		
	A Ring on Her Finger	Fanta Regina Nacro	Burkina Faso, Senegal
	Iron Will	Fanta Regina Nacro	Burkina Faso, Senegal
	My Brother	Cheick Oumar Sissoko	Mali, Senegal
	Shared Hope	Cheick Oumar Sissoko	Burkina Faso, Mali
	The Voice of Reason	Fanta Regina Nacro	Burkina Faso, Senegal
	To the Rescue	Cheick Oumar Sissoko	Burkina Faso, Senegal
2001	*Simon & I*	Beverley Palesa Ditsie, Nicky Newman	South Africa
2001	*The Sky In Her Eyes*	Ouida Smit, Madoda Ncayiyana	South Africa
2001	*That's Me*	Sasha Wales-Smith	Zimbabwe
2001	*Together We Can*	Jacqui Fox	South Africa
2001	We All Share Some Responsibility	Berni Goldblat, Daphne Serelle	Burkina Faso
2002	*Coming to Say Goodbye*	—	Kenya, Tanzania
2002	*Night Stop*	Licinio Azevedo	Mozambique
2002	*Shooting Silent*	Renee Rosen	South Africa
2002	*Speaking Out: Women, AIDS and Hope in Mali*	Joanne Burke (P/D)	Mali
2003	*AIDS—Life at Stake*	Heather Edmundson	Kenya
2003	*AIDS Warriors*	Andrew Young, Micah Fink	Angola
2003	*A Closer Walk*	Robert Bilheimer (D/P)	South Africa
2003	*Beat It! AIDS Treatment Literacy Series*	Jack Lewis (P)	South Africa
2003	*Beat the Drum*	David Hickson	South Africa
2003	*Fire and Hope*	Shannon Walsh	South Africa
2003	*Haba na Haba* (Little by Little)	Kimani Njogu	Kenya
2003	*Let's Talk About It . . . Harriet*	Carol Duffy Clay	Zambia
2003	*Makaburi Yatasema* (Only Stones are Talking)	Chande Omar Omar	Tanzania
2003	*State of Denial*	Elaine Epstein	South Africa

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Appendix VIII Continued

Year	Title	Director	Country
2004	*AIDS—The Woman's Story*	Vanessa Noordervliet	Kenya, Brazil, Thailand
2004	*Darwin's Nightmare*	Hubert Sauper	Tanzania
2004	*Hidden Tears*	Kidane Yilak	Ethiopia
2004	*Hotel Rwanda*	Terry George	Rwanda
2004	*Moolaade*	Ousmane Sembene (W/D)	Senegal
2004	*The Origins of AIDS*	Peter Chappell, Catherine Peix	Dem. Rep. of Congo
2004	*The Orphans of Nkonola*	Brian Woods	South Africa
2004	*Siwir Enba* (Hidden Tears)	Kidane Yilak	Ethiopia
2004	*The Three Amigos*	Firdaus Kharas, Brent Quinn	Canada
2004	*The Value of Life: AIDS in Africa Revisited*	Judy Jackson	—
2005	*A Child Is a Child*	Madoda Ncayiana	South Africa
2005	*The Children They Are Left With*	Peter Jordan	Zimbabwe
2005	*The Constant Gardener*	Fernando Meirelles	Kenya
2005	*Dear Francis*	Jason Djang, Brent Gudget	Swaziland
2005	*Duara* (& Sound the Drum)	Richard Ndunguru	Tanzania
2005	*500 Years Later*	Owen Alik Shahadah	—
2005	*God Sleeps in Rwanda*	Kimberlee Acquaro, Stacy Sherman	Rwanda
2005	*iThemba* (Hope)	Keefe Murren, Nelson Walker 111.	South Africa
2005	*Nkosi*	Liza Aziz	South Africa
2005	*Scratching the Surface: A Journey with H.E.A.R.T.*	Jason Bortz	Kenya
2005	*Sometimes in April*	Raoul Peck	Rwanda
2005	*Their Brothers' Keepers: Orphaned by AIDS*	Catherine Mullins	Zambia
2005	*Tikambe* (Let's Talk About It)	Carol Duffy Clay (P)	Zambia
2005	*Tracking the Monster*	Matthew Ginsburg	Kenya, Madagascar, S. Africa
2005	*Tsotsi*	Gavin Hood	South Africa
2005	*We Will Not Die Like Dogs*	Lisa Russell	Nigeria, Uganda, Burkina Faso, and Zambia
2005	*Yesterday*	Darrell Roodt	South Africa
2006	*Darfur Diaries*	Aisha Bain, Jen Marlowe	Sudan
2006	*Gem Slaves: Tanzanite's Child Labour*	IRIN Films (P)	Tanzania
2006	*Nkosi Johnson*	Charlize Theron (P)	South Africa
2006	*Orphans of Nkandla*	Brian Woods, Deborah Shipley	South Africa
2006	Seeds of Hope	Concentric Media (P)	
	Breaking the Silence: Lifting the Stigma of HIV/AIDS in Ethiopia		Ethiopia
	From Risk to Action: Women & HIV/AIDS in Ethiopia		Ethiopia

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Appendix VIII Continued

Year	Title	Director	Country
	HIV/AIDS Awareness in Ethiopia: Approaches to Prevention		Ethiopia
	Stepping forward: Men teaching and learning about HIV/AIDS		Ethiopia
	Whose children are they now? AIDS Orphans in Ethiopia		Ethiopia
2007	*AIDS, Inc.*	Gary Null (W/D)	
2007	*Beyond the Gates*	Michael Caton-Jones	Rwanda
2007	*Darling! The Pieter-Dirk Uys Story*	Julian Shaw	South Africa
2007	*Dreams of Change*	Ditte Haalov-Johnsen	Mozambique
2007	*Egoiste: Lotti Latrous*	Stephan Anspichler	Cote d'Ivoire
2007	*A Little Bit of Love: Making of a Message*	Scott Hatfield	Uganda
2007	*Ndizvo Zvandiri*	EGPAF (Elizabeth Glaser)	Zimbabwe

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