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Working To Empower

HIV/AIDS Education Worldwide

Bringing HOPE

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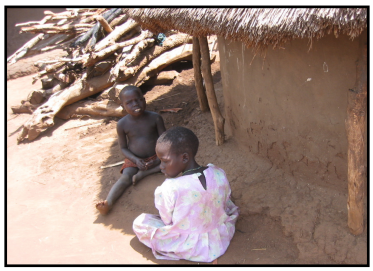

Children "play" in an IDP camp in northern Uganda.

In this Issue

WORKING TO EMPOWER

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Working to Empower, is a Canadian NGO based in Victoria, B.C. committed to fighting HIV/AIDS pandemic especially in Africa. For additional information please visit:

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HIV/AIDS: "Why Africa"?

The visit of the former Zambian President, Dr. Kenneth Kaunda this year in Yenegoa, Bayelsa State, Nigeria, left every person who attended to his visit crying as he asked what critics called a million dollar question. "Why Africa"?

The mud huts of an IDP camp in northern Uganda.

Kaunda charged the government and acknowledged the efforts of non-governmental organizations in fighting the scourge to see they attain a point of no movement of the virus.

Amidst sob, Dr. Kaunda commented the government must pay maximum task to what her citizens eat as food, because malnutritioned people cannot fight the disease when contracted.

Kaunda's visit was because of a road walk organized by Governor Goodluck Jonathan of Bayelsa State to help fight against the spread of HIV. Kaunda and President Olusegun Obasanjo of Nigeria commended Bayelsa State government for such a programme.

In President Obasanjo's remarks he described the road walk as "significant event demonstrating the commitment of the government of Bayelsa to fight HIV/AIDS".

> "...because malnutritioned people cannot fight the disease when contracted." - *Dr. Kaunda*

Professor Eyitayo Lambo, Minister of health who represented Mr. President said that the percentage of people living with HIV/AIDS had dropped following a 2005 survey. Though this assertion was not celebrated because according to Lambo it was not yet uhuru because the "fight against the disease must assume a multi-sectoral approach".

Apart from comments from other dignitaries who attended the road walk, Kaunda, Senate President, Ken Nnamani; Governor Goodluck Jonathan, Prof. Eyitayo Lambo and deputy governors of some states had a road walk earlier in the day to fight against the virus.

Odimegwu Onwumere, Nigerian Director WTE

The economic impact of HIV & AIDS on Africa

By- Parul Sharma

HIV and AIDS have already had a significant impact and caused a vast amount of human suffering in Sub-Saharan Africa, the region of the world that is most heavily affected by the AIDS pandemic. Nearly two-thirds of all HIV positive people live in this region, although it contains little more than 10% of the world's population. The existing literature on health and development contains increasing numbers of assessments of relations between health conditions of countries and their per capita GDP, but it has not assessed health as an aspect of economic welfare. Between 1960 and 1990 life expectancy in Africa increased by a very substantial 9 years. The impact was to add between 1.7% and 2.7% per annum to the growth rate of per capita GDP in generating a more inclusive measure of change in economic welfare. The AIDS epidemic, however, is more than reversing these gains: for Africa as a whole the AIDS-induced decline in economic welfare was about 1.7% per annum, leading to an overall growth rate of welfare of –2.6% .

In countries heavily impacted by AIDS, during 2005 alone, an estimated 4 million adults and children died as a result of AIDS in Sub-Saharan Africa. Since the beginning of the epidemic more than 15 million Africans have died from AIDS.

The Economic Impact

AIDS has marked a vital impact on the labour force, households and enterprises and has played a more significant role in the reversal of human development than any other single factor. One major aspect of this restricted development has been the damage that the epidemic has done to the economy, which, in turn, has made it more difficult for countries to respond to the crisis.

One way in which HIV and AIDS affect the economy is by reducing the labour supply through increased mortality and illness. Amongst those who are able to work, productivity is likely to decline as a result of HIV-related illness. Government income also declines, as tax revenues fall and governments are pressured to increase their spending to deal with the rising HIV prevalence.

The impact that AIDS has had on the economies of African countries is difficult to measure. The economies of the worst affected countries were already struggling with development challenges, debt and declining trade before the epidemic started to affect the continent. AIDS has combined with these factors to further aggravate the situation. It is thought that the yearly impact of AIDS on Sub Saharan Africa's gross domestic product (GDP) is -1%. While this is a relatively modest effect, it will build in significance over time, especially in countries where HIV prevalence is rising. One way in which this impact can be reduced is through the provision of antiretroviral drugs to people living with HIV. A recent study in South Africa suggested that, if the proportion of those in need of ARVs who are receiving them increased to 50%, the effect of the epidemic on economic growth would be reduced by 17%.

AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies.

In countries heavily impacted by AIDS, during 2005 alone, an estimated 4 million adults and children died as a result of AIDS in Sub-Saharan Africa. Since the beginning of the epidemic more than 15 million Africans have died from AIDS.

The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be

much larger than the absolute number of AIDS deaths indicates Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

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The economic impact of HIV & AIDS on Africa

Continued from page 2

Reduced labour supply

The HIV/AIDS pandemic has an impact on labour supply, through increased mortality and morbidity. This is compounded by loss of skills in key sectors of the labour market. In South Africa, for example, around 60% of the mining workforce is aged between 30 and 44 years; in 15 years this is predicted to fall to 10% (R Elias, University of Botswana, personal communication, 2000) (figure). In the South African healthcare sector 20% of student nurses are HIV positive.

Reduced labour productivity

The long period of illness associated with AIDS reduces labour productivity. One review reported that the annual costs associated with sickness and reduced productivity as a result of HIV/AIDS ranged from $17 (£12; €19) per employee in a Kenyan car manufacturing firm to $300 in the Ugandan Railway Corporation. These costs reduce competitiveness and profits. Government incomes also decline, as tax revenues fall, and governments are pressured to increase their spending, to deal with the rising prevalence of AIDS, thereby creating the potential for fiscal crises.

Reduced exports and increased imports

Lower domestic productivity reduces exports, while imports of expensive healthcare goods may increase. The decline in export earnings will be severe if strategic sectors of the economy are affected, such as mining in South Africa. Consequently the balance of payments (between export earnings and import expenditure) will come under pressure at the same time that government budgets come under pressure. This could cause defaults on debt repayments and require economic assistance from the international community.

Measures that could be applied:

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

Prevent new infections.

An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.

Design major development projects appropriately.

Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in projects such as mines or new ports where commercial sex might be expected to flourish.

Mitigate the effects of AIDS on poverty.

The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses.

A strong political commitment to the fight against AIDS is crucial. Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.

LRA Profile

By: Taylor Whelan

There is a conflict in the north of Uganda that, since 1988, has taken thousands of lives, displaced millions of people, and seen whole armies created from the children of slaughtered villagers. The main instigator of this insurgency is the Lord's Resistance Army (LRA), a rebel group founded on less than clear ideologies and employing brutal tactics. The LRA is led by Joseph Kony, an enigmatic figure who seems to justify the actions of his organization through a combination of spiritual beliefs and the Ten Commandments, and who, in 2005, was indicted by the International Criminal Court on thirty three charges, including war crimes and crimes against humanity. Negotiations between the LRA and Ugandan government are ongoing, but progress has been slow due to resistance to any real commitments from either side.

The LRA takes its roots in the revolutionary upheaval that took place in Uganda in the mid-eighties. In 1985 Tito Okello, an Acholi from the north of Uganda, overthrew Milton Obote's government. Six months later, the newly installed government was overthrown again, and Yoweri Museveni, the current president of Uganda and former head of the National Resistance Army, seized power. When Okello had been in power, he had treated the people in the south of Uganda with very little respect, so when Museveni came to power, the Acholi feared retribution. It was at this point that a resistance developed in northern Uganda, under the leadership of an Acholi named Alice Auma (aka Alice Lakwena), who claimed to be a spirit medium, receiving messages from the dead. These spirits instructed her to lead a rebellion against Museveni. The rebellion was eventually defeated and Auma fled the country, leaving a power vacuum in the north. Into this vacuum stepped Joseph Kony who, in 1987, formed the Lord's Resistance Army.

The Lord's Resistance Army is known to commit acts of brutal violence. Reports from those who have escaped from the LRA tell of villages being raided during the night, and children being kidnapped and inducted into the LRA. Often these children are sent back to the villages to kill their own parents so that if they escape, they have no one to return home to. According to the UN, over 25,000 children have been abducted and forced to fight against the Uganda People's Defense Force (formerly the National Resistance Army), or raid villages kidnapping other children. The boys are forced to fight, the girls are used as sex slaves; Joseph Kony himself reportedly has over 60 concubines, taking his pick of the young girls abducted from the villages. The children are told that if they run away, the Ugandan army will poison them, and failed escapes usually end with the beating and execution of the children at the hands of LRA commanders. It should be noted that the LRA is not alone in enlisting children. The Uganda People's Defense Force (UPDF), the government's army, has been known to recruit children as young as twelve to fight the LRA.

The LRA is composed almost eighty percent of child soldiers and the bulk of the LRA forces, and essentially all of the children, are forced to fight with machetes, knives, and clubs. In fact, the UN estimates that the LRA only has modern weapons (i.e. guns) to equip 200 soldiers. The LRA acquires most of its resources from pillaging the villages of northern Uganda, which brings a sense of insecurity to the population. During the last few years over 1.6 million people were driven into IDP camps from fear or the LRA, but as peace talks have carried on, around 300,000 have returned to their villages. The LRA does not acquire resources only by stealing them. Their main source of external funds is Southern Sudan.

In 2005 the International Criminal Courts at The Hague indicted Kony and four of his lieutenants for war crimes and crimes against humanity. Although the UPDF claims to have killed one of these lieutenants in August of 2006, the rest, including Kony, remain at large. Kony has told reporters in the past that he would refuse to stand trial at the ICC because he had done nothing wrong. The indictments have also put a strain on peace talks taking place in Juba, South Sudan, which Kony has refused to attend, reportedly for fears of being apprehended. Many have called for the charges to be dropped, hoping that this move may benefit the peace talks, but the International community has largely ignored these calls. With no incentives for Kony to end the war and sign a peace agreement, most people in northern Uganda agree that rapid progress is unlikely.

Since peace talks resumed in the summer of 2006, a certain amount of stability has returned to the region, but little has been accomplished. Most recently the LRA has refused to continue negotiating with Museveni's government in South Sudan, where the talks have been held, asking for the process to be moved to Kenya or South Africa, who are seen as more neutral. The ongoing jockeying by both parties gives little hope to those living in north Uganda who wish to finally see a resolution to the conflict, and although fighting has declined, the lack of an agreement between the government and the LRA has left a cloud of uncertainty hanging over the people.

Refugee women, girls in sub-Saharan Africa among hardest hit by HIV/AIDS crisis

By - Janet Otsuki

Women and girls in sub-Saharan Africa are the face of the HIV/AIDS epidemic. It's known that gender inequality renders females disproportionately more vulnerable to infection. Less publicized, however, is the plight of refugee women and girls of the sub-region. The human rights abuses they suffer during conflict and displacement put them at enormous risk for contracting HIV.

Women in sub-Saharan Africa represent a large portion of the global refugee population. The United Nations Development Fund for Women (UNIFEM) reports that women and children make up roughly 75 percent of the more than 35 million people made refugees or displaced by conflict globally. Meanwhile, five of the top ten largest refugee populations in the world originate from sub-Saharan African countries, according to UNHCR-The UN Refugee Agency.

Sub-Saharan Africa accounts for almost two-thirds of global HIV infections, with women making up 59 percent of these cases, according to the 2006 epidemic update from The Joint United Nations Programme on HIV/AIDS (UNAIDS). Young women and girls are at particular risk: the prevalence of HIV in young sub-Saharan African women ages 15 to 24 is three times higher than in their male counterparts, according to The Alliance for Microbicide Development.

Displaced women in conflict situations face a number of gender-related factors that contribute to the spread of HIV. According to UNIFEM, these include a breakdown of family, social and community structures; lack of access to health care and social services; increased sexual and gender-based violence; and increased sexual interaction between civilians and combatants. Additionally, refugees and returnees suffer stigma, discrimination and other human rights abuses that feed the cycle.

"Survival" sex

Transactional or "survival sex" is a huge problem among this population. Women and girls are propositioned or forced to trade sex with soldiers, police, or peacekeeping forces in exchange for food, water, shelter, protection, money and other highly sought-after commodities.

"Damaged clinics, untested blood

Civilian populations may lack access to social services, healthcare and a safe blood supply during conflict. Damage to health facilities, loss or looting of medical supplies and equipment, and difficulty reaching service locations are all challenges for displaced persons. War casualties become the primary concern, not the routine health needs of refugees.

Rampant gender-based violence

Gender-based violence is one of the most significant risk factors for HIV transmission to women, and sexual violence is rampant in all stages of conflict. Violent sex greatly increases a female's risk of viral contraction.

Refugee stigma, discrimination

Refugee women and girls suffer stigma and discrimination on a number of fronts. According to UNHCR, they are often stigmatized just for being refugees by the society of their asylum due to their poverty and ethnicity. Women and girls face a third factor: discrimination based on gender.

Also, refugees are falsely accused of bringing and spreading HIV within their country of refuge. On the flipside, returnees are accused of being infected when they repatriate to their home countries.

Prevention, awareness efforts

According to UNHCR, international aid organizations both large and small are conducting HIV/AIDS prevention and awareness activities in sub-region refugee and returnee settings. These include schools, antenatal care clinics, outpatient clinics, youth centers and food distribution sites.

"...the prevalence of HIV in young sub-Saharan African women ages 15 to 24 is three times higher than in their male counterparts.

Young refugees are trained as peer educators and encouraged to speak openly about sexual and reproductive issues and the importance of testing and counseling. Public talks, dramas, dance performances, videos, brochures, and cartoons all communicate HIV-related information. Condoms are also distributed.

Hope for the future

The medical community recognizes that women lack full control of the preventative measures that can protect them from HIV, and it is currently developing topical microbicides that could reduce HIV transmission. These substances would be applied topically to female genital mucosal surfaces, putting preventative control squarely in women's hands. This technology could become available within an estimated five to ten years.

Refugee women and girls in sub-Saharan Africa have responded to HIV/AIDS with leadership, courage and determination. Their example can inspire the necessary political, economic and social changes to begin reversing this crisis.

Killer AIDS and orphans in Sub-Saharan Africa: An eyewitness's viewpoint

Priyank Nandan

Interview

We are all aware of the deep rooted damage that AIDS has caused in Africa, specifically the sub-Saharan region. One of the most devastating affects of this epidemic has been the millions of children it has orphaned. The statistics clearly reflect the level of damage this demon has caused. According to the United Nations there are no less than fourteen million orphans because of HIV/AIDS. Eight out of every 10 children in the world whose parents have died of AIDS live in sub-Saharan Africa. During the last decade, the proportion of children who are orphaned as a result of AIDS has risen from 3.5% to 32% and will continue to increase exponentially if the disease spreads unchecked.

Mihret is an Ethiopian orphan, not only did her parents carry the HIV and die of AIDS, but they passed the virus onto her, probably during the birthing process. Unlucky in that respect, Mihret is blessed in that she has access to treatments that will allow her to live beyond her tenth birthday – something many other children living with the virus will not have an opportunity to do.

IThe extent of damage can be visualized from the eyes of Logan Cochrane the founder of Working To Empower.

Priyank: *Hi Logan. tell us something about yourself and your work?*

Logan: Working To Empower works in many areas relating to HIV and AIDS, while our main focus is education. We train educators, create peer education teams, and offer community based education programs. However, education is sometimes not enough. Poverty can be viewed as a related factor for HIV prevalence and thus we also fund income generating projects and support orphans by paying their school fees. Speaking here about orphans, not only do we try and support those already orphaned but we also aim to prevent orphaning in the future through our education.

Priyank: *Can you explain the exact nature of problems you have worked on?*

Logan: Of course, every society and culture is different. Instead of only viewing this epidemic as a medical problem, WTE develops different programs and approaches according to each need, culture, and local dynamics. One of greatest problems today is funding, now that we have had very positive responses and successful programs many locally based organizations are contacting WTE requesting programs for their areas. WTE also works mostly with refugees or internally displaced persons, this adds components requiring additional concern, such as ongoing conflict or the impact of sexual violence.

Priyank: *What do you think can be done to improve the existing conditions?*

Logan: There is much to be done, and much that can be done. However, projects and ideas need to be very well thought out before implementation. WTE spends months planning their low-budget projects, interacting with local organizations, their ideas, needs, and demands. Some other projects are implemented by good-hearted well-intentioned individuals/groups and may not have the results that had been intended because there is a lack of this specificity for the local culture, needs, and dynamics.

Priyank: *How do you feel more and more people can get involved in this battle against AIDS? How can someone like me or others sitting far far away in the luxury of their homes contribute this cause?*

Logan: Getting involved with projects working in this area, who are having positive and successful results, is a great idea. This includes all types of projects from the funding of clinics in Malawi to peer education teams. Help can be offered from home through awareness raising, donations, event planning, and various other projects. WTE has over twenty volunteers who are connected together mostly through the internet doing these types of projects – we are always looking for new ideas and volunteers as well.

Priyank: *Can you give us some idea in how long you have been working in this area and what has been your primary motivation for the same?*

Logan: I began entering the field of HIV/AIDS by writing a teachers guide for HIV education. Later found myself designing culturally and socially focused programs for HIV/AIDS education, which coincided with the founding of Working To Empower. During 2005 we spent half the year planning programs and forming partnerships, as well as fundraising. Since that time, under recently, I was working with our partners with HIV/AIDS education (Lugufu refugee camp, Nyragusu refugee camp, Kmpoasse refugee camp, Agoro IDP camp, Baraka eastern Congo, and Cotonou, Benin). Currently I am helping to plan for the next project in the IDP camps of northern Uganda. My motivation is a love for the work.

Priyank: *What's your vision for WTE say 5 years down the line?*

Logan: WTE has had great success with its work regarding HIV/AIDS. We'd like to continue along this line, extending our success to additional regions. Currently we have requests to work in eight additional areas and could potentially be working with these newly proposed projects for the next five years, however funding is an issue we currently are trying to deal with. In addition to new projects, we are continuing and developing our current efforts. Peer education teams continue their work, resource centers are being built up, income generation projects are being started, and education sponsorship for orphans is an on-going work.

AIDS scenario in Cameroon

Lakshmi Ravindran

Located in Central and West Africa on the Bight of Biafra, Cameroon has been described as "*Africa in miniature*" as it exhibits all the major climatic and vegetative regions of the continent. Apart from its natural beauty and ethnic diversity (with more than 250 ethnic groups), Cameroon has enjoyed relative political stability, a youthful population, a high level of education and is one of the best endowed natural resource economies in sub-Saharan Africa. However despite all these advantages Cameroon's potential is literally being eaten into by an inefficient politico-administrative set up and a raging AIDS epidemic.

Today with a population of 17.3 million and a GDP of USD 16.98 billion, Cameroon, while it fairs better than its neighbours in Sub Saharan Africa, still has very poor development indicators. It is 144th on the Human Development Index with 40.2% of its population below the poverty line and 17.1% living on less than $1 a day. The average life expectancy at birth is 51 years.

The AIDS epidemic in Cameroon has over the past two decades assumed overwhelming proportions. The Sub Saharan region of Africa, in which Cameroon is located, is the worst affected by the AIDS epidemic, with 25.8 million HIV positive people. The region has just over 10% of the world's population, but is home to two thirds of all people living with HIV. With 13.5 million women, 77% of all women with HIV live in this area. An estimated 2.4 million of the 3.1 million deaths out of HIV-related illnesses in 2005 were in this region, while 3.2 million of the total 4.9 million new infections were from this region. The region also has the highest rate of adult infections at 7.2%.

The first HIV AIDS case reported in Cameroon was in 1985. The rate of HIV sero-prevalence has since grown at an astronomical rate of more than 22 times in 15 years, from 0.5% in 1987 to 11.8% in 2002 in the sexually active population (adults from 15 to 49). The current estimate as per the WHO is 4.8 – 9.8% with the Demographic Health Survey reporting an overall population infection rate of 5.5%. Cameroon now finds itself in the 25 most infected countries in the world. Prevalence varies from one province to another: the epidemiological data from the surveillance activity for 2002 show that prevalence reaches 17% in Adamaoua province, as against 6% for the Western province. The prevalence of the disease is far higher among women than men, with 7% of women in Cameroon being infected with HIV, almost double the 4% rate among men, according to the latest Demographic and Health Survey (CDHS), conducted from February to August of 2004. The primary reason for this is the poor status enjoyed by women, as indicated by Cameroon's gender related development index rank of 109. The most vulnerable groups include sex workers, truck drivers, mobile populations and military personnel. Young people are highly affected – a third of Cameroonians infected are 15–29 years of age.

The main administrative structure in place for coordinating the HIV response at the national level is the National AIDS Control Committee (CNLS), which was established by decree in 1988. It is one of the three special directorates under the Ministry of Health. The CNLS is presided over by the Minister of Public Health and has representatives from technical ministries, NGO networks, associations of people living with HIV, partners in development, civil society representatives and representatives from religious groups. As a part of the decentralization effort there are agencies at the provincial, communal and local levels. The executing agencies are the Central Technical Group at the central level, the provincial technical groups in the ten provinces and the corresponding agencies at the communal level.

The government has sought to promote universal access to treatment through the creation of approved treatment centres, affiliated treatment centres and district management units across the country and by reducing the costs of testing, treatment and laboratory follow-up through subsidies. Cameroon has 166 district hospitals, health centres and clinics that provide treatment for sexually transmitted infections and opportunistic infections, HIV testing, psychosocial support to people living with HIV/AIDS and prevention counseling.

The country developed national treatment guidelines and a Multisectoral plan for decentralizing the provision of antiretroviral therapy in 2004–2005 in collaboration with the National AIDS Control Committee and WHO. This plan was to scale up antiretroviral therapy to 36 000 people by the end of 2005 in 83 treatment centres across the country. By September 2005, 1825 health workers and 486 community supporters had been trained to deliver antiretroviral therapy in accordance with international standards. Efforts have been made to expand voluntary counselling and testing, but the existing structures remain inadequate to meet the growing demand. As of September 2005, the number of HIV testing and counseling centres were 89. The Multisectoral plan also reinforces the UNAIDS "*three ones*" principles of *one agreed HIV/AIDS action framework that drives alignment of all partners; one national AIDS authority with a broad-based multisectoral mandate;* and *one agreed country-level monitoring and evaluation system*. Protocols for HIV surveillance have been developed.

In 2002, the Government reduced the cost of antiretroviral therapy by 53% through a subsidy totaling US$ 1 230 770, reducing the average treatment cost from US$ 73 to US$ 34 per person per month. The cost of antiretroviral drugs further declined from US$ 42 per person per month at the beginning of 2004 to US$ 10 per person per month in October 2004.

Yet despite all these efforts the problem still looms large. The key link to the HIV problem in Cameroon is the need for greater *awareness* and to build a *stronger health system*.

Partnering with local communities to spread awareness, removing taboos and ensuring greater monitoring and surveillance, is other need to fight the stigma in country.

Make a difference

New Projects

Help us build a new house for deserving kids in Ethiopia!

Ethiopia is one of the world's poorest nations according to GDP per capita, however its economic lacking is balanced with a family-centered kindness, an always open-door policy of welcoming people, a deep history with monuments world-renowned, and much more. The poverty however has brought problems upon its people, related to this is the spread of HIV, which has now orphaned nearly one-million children. Other sicknesses, such as TB and Malaria, the boarder conflict with Eritrea, and extreme poverty have orphaned an additional three million Ethiopian children.

Working To Empower has joined with Artists For Charity (AFC) in a partnership to help run this home, our goal for 2007 is to build a new house for our children, to date the house has been rented.

To **Donate** for these kids and for details, visit: http://www.givemeaning.com/project/kidshome

Ugandan IDP camp HIV education

Working to Empower (WTE) proposes an HIV/AIDS Education and Awareness Project within the Kitgum district in northern Uganda, with a duration of approximately four months spanning from April until August 2007. Three internally displaced regions will be targeted. In each region, we will conduct seminars, create peer education networks by offering monthly incentives, develop community-based sensitization programs in the short and long-term and create locally-run resource centres for HIV/AIDS information.

The project will run in collaboration with Agoro Community Development Association (ACDA), a locally based non-governmental organization (NGO).

To **Donate** and for more information about project, please visit:

http://www.givemeaning.com/project/empower

AIDS POEM

Marta (Seven year old Kenyan girl)

AIDS, AIDS.
AIDS is a killer disease
Oh, killing all young and old, rich and poor
so you parents be careful.
Look at me now I have got no parents,
I sleep on the floor,
I eat from the gardens,
No one to care for me,
No one to love me,
so you parents be careful.
AIDS is a killer disease,
AIDS is a killer disease,
AIDS is a killer disease,
What shall I do about it?
We are, we are the children
from Mathare,

After The Death

Her problem started
After her hubby died
Of HIV/AIDS complications;
After few months
Her adolescent child followed.

She was emotionally electricuited
But had to hold onto her other kid
Left with tears and grieves.

Her in-laws, instead of consolation,
Took to insulting her as though
A player could turn the ball in a pitch
Because they knew she would also be a carrier.

They even said it in the open
That she would soon die of HI/AIDS
As their son, her hubby had died.

But was this a threat? Hatred?
Envy? Or what? Even to their son?

Even, her father-in-law
Saw his child's death, her hubby,
As a shame to the family;
He brought out the corpse in the open
Against the tradition of them
And cursed the corpse, contempt the corpse...
Because "He died of AIDS"?

She was frail and ashamed
But this act propelled her
To emboldened up and reveal her status
In the air, newspapers and Internet.

This act by her father-in-law
Moved her spirit from death
To begin to do things
She knew she couldn't do on her own,
God was on her strength.

But she was not left without tears,
Fears, shame, thoughts, insults...
But one looking at her
She looked hale and hearty.

She advised carriers to marry carriers;
Such insult from her father-in-law
Was why many afflicted by the virus
Cannot come out to say their statuses.

Odimegwu Onwumere
Nigerian Director WTE

WORKING TO EMPOWER

Get Involved (volunteer): www.workingtoempower.org

Working to Empower, is a Canadian NGO based in Victoria, B.C. committed to fighting HIV/AIDS pandemic especially in Africa. For additional information please visit: www.workingtoempower.org Email: workingtoempower@yahoo.com