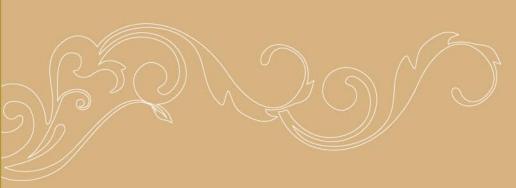


Women and HIV in the Asia-Pacific Region

A Development Practitioner's Guide





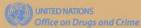




















Women and HIV in the Asia-Pacific Region

A Development Practitioner's Guide



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Foreword

One of the biggest challenges in addressing HIV in the Asia Pacific region is the complex intersection between women's vulnerability to HIV infection, coupled with the acute and disproportionate impact of the epidemic on women.

Increasingly, women living with HIV in Asia have been infected by their partners. According to the report of the Commission on AIDS in Asia, an estimated 50 million women in the region are at risk of HIV infection from their regular partners, who, in turn, have been infected either during paid sex or drug injection. Women now constitute up to 26% of new infections, representing a 7% rise since 2000.

In Asia and the Pacific, the impact of HIV is most evident at the household level, where once again, women are at the fore. Women, as caregivers, workers and surviving spouses, generally bear the brunt of the often devastating consequences of HIV.

Addressing the specific gender concerns of HIV, is one of UNDP's key priority areas requiring joint and collaborative efforts by governments, civil society, UN agencies and most importantly, people living with HIV. In attempting to disaggregate the vulnerabilities faced by women and in searching for ways in which to mitigate the impact of HIV on women, UNDP in partnership with key stakeholders, has developed a practitioners guide that builds on experience from the region in addressing issues of women and HIV. The guide offers evidence-based suggestions for policy and programmatic direction, and provides examples of promising practices from around the region to stimulate thinking and trigger effective responses.

It is our intention that this guide will be a living document that will continue to be informed by policy and action on the ground in the region.

Ajay Chhibber

Assistant Secretary General
Assistant Administrator and Director
UNDP Regional Bureau for Asia and the Pacific

t Chlibber

Acknowledgements

This Development practitioners guide is the result of an in-depth collaborative process with contributions from many institutions and individuals, largely from the region. Numerous background papers, studies, guidance notes and reports covering the work of gender, women and HIV in the region and beyond, have informed this guide. It most significantly draws on the Report of the Commission on AIDS in Asia "Redefining AIDS in Asia", the UNAIDS guidance notes on working with most at risk populations and Global UNAIDS policy guidelines on gender.

Taking into account the Global UNAIDS technical division of labour among co-sponsors, extensive consultations were held with other UN agencies including: UNODC on working with injecting drug users, UNFPA on sex work, UNICEF on care and support to orphans and vulnerable children and prevention of parent to child transmission, and UNAIDS on information and knowledge sharing, advocacy, and monitoring and evaluation. UNDP has also worked in close collaboration with UNIFEM SARO on the finalization of this guide.

The lead authors provided invaluable contribution to the writing of this report. In particular, we would like to gratefully acknowledge: Sarah Kambou, Jessica Ogden and Linda Sussman from International Centre for Research on Women (ICRW) global and Hema Swaminathan from Indian Institute of Management (IIM), Bangalore, on updates and editing support.

The guide benefited from excellent specific contributions which were received from: James Lang for the chapter on involving men and boys, Wing Sei for the chapter on HIV and education, Véronique Maeva Fages for the chapter on HIV and Women in conflict areas, Kazuyuki Uji for the section on HIV, women, migration and trafficking, Caitlin Wiesen and Revati Chawla for the chapter on women's inheritance and property rights, Jenny Butler, Garimela Giridhar, and Chaiyos for the section on HIV, sex work and women's reproductive and sexual rights.

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Caitlin Wiesen-Antin

Caiti Wies

Regional HIV/AIDS Practice Leader & Programme Coordinator Asia & Pacific UNDP Regional Centre, Colombo

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CHAPTER

01

PURPOSE OF THE GUIDE AND ROADMAP FOR USERS





PURPOSE OF THE GUIDE AND ROADMAP FOR USERS

This guide is intended for development practitioners in the Asia-Pacific region who are committed to taking meaningful action to reduce the HIV vulnerabilities women face and empower women to cope with the impact of the epidemic. It covers specific ways in which gender imbalances and gender-related injustices fuel the epidemic. The Guide offers evidence-based suggestions for policy and programmatic direction, and examples of promising practices from around the region to inspire thinking and trigger more effective responses on the ground.

The document is called a guide because it is intended to offer suggestions and give direction. With an issue as complex and culture-specific as women and HIV, and a region as diverse as Asia-Pacific, prescriptive blueprints are neither feasible nor desirable. Rather, the purpose of this Guide is to stimulate thinking on the issues and to act as a catalyst for further dialogue, consultation and context-specific policy and programme development. Though of late, the gender discourse has been broadened to include the gender expressions of gay and lesbian people, feminized men, transsexuals and transgendered populations, they have been left out of this guide with the intention of developing a separate guide in dealing with this population sub set. We hope readers will learn from the evidence presented on the ways gender imbalances drive the epidemic, and be inspired by the people and programmes behind the promising practices included in each section. Key resources are included for reference and further research.

The Guide recognizes that practitioners have many demands on their time. It is not a narrative and is not intended to be read cover-to-cover. Part 1 outlines the purpose and how to use the guide. Part 2 provides an overview of the issues that affect women and HIV and AIDS in the region. Part 3 presents suggested directions for policy and programmes for each topic that is covered in Part 4 of the Guide. Part 4 is composed of 13 sections on key topics related to women and HIV

and AIDS. Each of these sections is intended to function as a stand-alone module. Readers are encouraged to identify those sections that are the most relevant to their work, following cross-references to other sections as necessary.

TOPICS COVERED INCLUDE:

HIV and Prevention;

HIV and Women's Issues in Treatment;

HIV and Education;

HIV and Care-giving;

HIV and Violence Against Women;

HIV and Reproductive and Sexual Rights;

HIV and Property Rights;

HIV and Economic Empowerment;

HIV and Women in Highly Vulnerable Populations Including:

HIV and Sex work;

HIV, Women and Injecting Drug Use;

HIV, Women, Migration and Trafficking and

HIV and Women in Conflict Areas.

Engaging Men and Boys for Effective Responses to the Epidemic

Each topic in the Guide was selected on the basis of its relevance to the epidemic and its importance to policy and programme development. The discussion for each topic begins with an overview of the issue, followed by suggestions for policy and programming, examples of promising practices, resources and references for further information.



CHAPTER

02

OVERVIEW: HIV AND WOMEN IN THE ASIA-PACIFIC REGION





OVERVIEW: HIV AND WOMEN IN THE ASIA-PACIFIC REGION

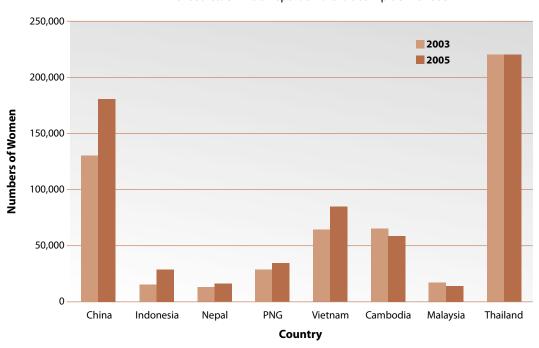
INTRODUCTION

According to UNAIDS, there were approximately 5 million people living with HIV in Asia and the pacific in 2007 including 395,000 new infections in that year. AIDS-related mortality in 2007 was approximately 380,000 and was the largest disease related cause of mortality and morbidity among 15-44 year old adults (Commission on AIDS in Asia, 2008). HIV prevalence is increasing in some countries, notably China, Indonesia, Papua New Guinea and Viet Nam, and there are signs of HIV increases in Bangladesh and Pakistan (UNAIDS, 2007). Nonetheless, some more positive trends are emerging in the Asia and Pacific region. HIV prevalence has been declining among pregnant women in four states in India, including Tamil Nadu where prevention efforts were scaled up in the late 1990s. Cambodia, Myanmar and Thailand, are also experiencing declines in HIV prevalence.

The Report of the Commission on AIDS in Asia (2008) identifies that the spread of HIV in Asia is driven by three high-risk types of behaviour: unprotected commercial sex, injecting drug use, and unprotected sex between men. Of these,

men who buy sex are the single largest group and are important in understanding the future of Asia's epidemic. According to the Report, at least 75 million men buy sex regularly and many are either married or likely to get married and thus, exposing their wives to the risk of infection. Approximately, another 20 million men are at risk through injecting drug use and unsafe sex among men. However, the limiting factor for the transmission of the HIV epidemic in Asia is the sexual behaviour of women outside of commercial sex work. The majority of women in Asia report only one sexual partner making it unlikely that the infection will continue to spread to the general population, independent of the high risk behaviours described above. Given this, the Commission proposes a classification scheme that is derived from the risk behaviour rather than the traditional scheme based on national HIV prevalence rates. The four suggested categories are Latent, Expanding, Mature, and Declining. According to the Commission, this new method of categorization can also help in prioritizing interventions. HIV prevention is far more cost effective than providing treatment, care, and livelihood support for an HIV positive individual. Investing only 1 USD in prevention services can save up to 8 USD in treatment services in countries that are experiencing expanding epidemics (Commission on AIDS in Asia, 2008).

FIGURE 1 ESTIMATED NUMBERS OF WOMEN 15+ LIVING WITH HIV Source: UNAIDS Report on the Global Epidemic 2006



WOMEN AND HIV

Indeed in this region, as elsewhere in the world (most notably sub-Saharan Africa) women and girls are increasingly at the centre of the epidemic. While the prevalence among men is still higher than among women in most populations in Asia-Pacific, this is beginning to change. The percentage of HIV positive women has risen from 19 percent in 2000 to 24 percent in 2007 (Commission on AIDS in Asia, 2008). In China, HIV prevalence among women has grown from 25 percent in 2002 to 39 percent in 2004, and exceeds one percent among pregnant women (UNAIDS, 2006). Most of the HIV positive women were infected by their husbands or boyfriends. Others were infected while working in commercial sex or while injecting drugs. In Thailand, approximately one-third of new infections in 2005 were among married women. In India, for 90 percent of HIV positive women, marriage was their risk factor. Women are now sharing a greater percentage of the burden relative to men of similar ages. For example, in Thailand, around 70 percent of young people now living with HIV are girls and women between the ages of 15-24 (UNICEF, 2005). Since 2003, 47 percent of the new infections in Fiji are among women, according to the Ministry of Health. Recent data from India indicate that 40 percent of people living with HIV are women (NACO, 2006).

Not only are women more vulnerable to HIV infection, they also largely bear the devastating impacts of HIV and AIDS. In addition to their existing workloads, women are burdened by the care giving responsibilities within the household. They often are unable to access treatment services for themselves, face extreme stigma and discrimination, and in many situations are deprived of their property and inheritance rights.

Now, before the epidemic takes firmer hold in the Asia-Pacific region, is an opportune time for development practitioners to assess the role of gender inequalities in the epidemic and design policies and programmes that squarely address the particular vulnerabilities that women face.

CRITICAL GENDER RELATED ISSUES FOR THE REGION

Norms and Attitudes About Gender and Sexuality

Gender norms are a critical part of the social context that frames the vulnerability of both women and men in the epidemic. Women are, in part, made vulnerable to HIV due to social norms and values that: (1) devalue their contributions to society; (2) persist in casting them in the role of upholders of moral traditions and family honour; (3) limit their identity options to wife, mother and respectable housewife; and (4) fail to recognize their sexuality, or cast it as immoral, deviant and decadent.

In many societies in the region (as elsewhere in the world), a culture of silence surrounds sex, and the implicit assumption is that "good" women should be ignorant about sex and passive in sexual interactions. This makes it difficult for women to be informed about risk reduction or be proactive in negotiating safer sex (Carovano, 1992). Cultural norms that restrict the mobility of women and their ability to access resources, can limit their access to prevention, testing and treatment services.

In many parts of Asia gender roles within marital relationships are rigid and based on traditional philosophies that give guidance on morality and the role of women within marriage, the family and the community. Integral to these moral codes is tolerating multiple partners and sexual experience for men, while protecting the virginity of women. Gender norms that reinforce the belief that multiple sexual partners is an essential expression of masculinity and that men must seek multiple partners for sexual gratification are at odds with prevention messages that call for abstinence and being faithful in partnerships or a reduction in the number of sexual partners. Another important dimension of masculinity in the region is the underlying belief that force or coercion in sex is unavoidable as a good woman can never say yes to sex. In a study of men in India, a majority of men said that force in sex was a marker of their ability to satisfy their wives sexually (Duvvury, Nayak and Allendorf, 2002).

Child marriage, a frequent practice in South Asia, increases the vulnerability of very young girls who lack power to negotiate the terms of their sexual life. Although research connecting child marriage to HIV infection is limited in Asia, several studies from sub-Saharan Africa provide evidence of greater HIV risk for younger married women versus their unmarried peers. In a study in Kenya and Zambia, married girls were 75 percent more likely to have HIV than unmarried girls of the same age (Clark, 2004). In this same study, married girls were more likely than unmarried girls to stop having sex after learning of HIV risk (Clark, 2004). Girls are less likely to be informed about HIV and how to protect themselves or to assess their risk, much less have the power to insist on condom use or to refuse unwanted sex within marriage. Lack of education or limited education and low socioeconomic status are risk factors for child marriage (UNICEF 2005). Adolescent women who are not in school seem particularly vulnerable to the effects of gender inequality (Beegle and Özler 2007). The common myth in the Asia region that having sex with virgin girls will protect a man or cure him from sexually transmitted diseases and HIV also increases demand for sex with younger girls (Huda, 2006).

Stigma also affects women more intensely than men, preventing them from accessing treatment, information and prevention services. The construct of 'social evils', common in much of South Asia, creates stigma and produces greater discrimination towards women because HIV is closely associated with behaviours considered immoral, such as sex work. This compounds the stigma experienced by women with HIV.

Disparities in Education

The association between education and HIV is likely a complex relationship that changes over time (Hargreaves, et al., 2008). In some countries, higher education has been associated with higher HIV prevalence, but over the last decade (Herz and Sperling, 2004) more recent evidence has shown increased education to be related to decreased HIV prevalence. In a recent literature review, several large cohort studies among Thai army conscripts showed a significant, consistently negative correlation between

HIV prevalence and higher levels of education between 1990 and 1995 (Hargreaves and Glynn, 2002). Girls' schooling has been found to be associated with several factors linked to HIV reduction. In India, women receiving secondary education were less likely to experience violence and had greater ability to leave violent situations compared to women with only primary education (Jejeebhoy, 1998). Education has been shown to be a significant factor in delaying age at marriage (Mathur, Greene and Malhotra, 2003). Girls are also thought to gain autonomy and important life skills useful in negotiations related to the timing of marriage through education (Lloyd and Mensch, 1999).

South Asia is still experiencing a gender gap in primary education enrolment, although girls' gross enrolment rates did increase nearly 20 percent between 1990 and 2000 – from 79.5 percent to 96.6 percent (UNESCO, 2004). While this trend is positive, the picture is less hopeful for primary school *completion* – a better indicator of educational status. In 1990 in South Asia, boys' primary school completion rates were 94.9 percent compared to 81.0 percent for girls (UNESCO, 2004).

The gender gap is much wider in secondary education. In South Asia, the gross enrolment rate for girls in secondary schools is only 50 percent. This is important because statistics show that it is secondary or higher levels of schooling that are associated with improved opportunities and outcomes for women (Malhotra et al., 2003). Secondary education is more consistently and strongly associated with increased decisionmaking and mobility for women than schooling at the primary level. Studies have found that only at secondary or higher levels of schooling does education have a significant beneficial effect on women's own health outcomes and risk of disease. Higher levels of schooling are strongly associated with higher age at marriage. Studies of HIV in sub-Saharan Africa and Latin America have found that while primary education increases girls' and women's ability to discuss HIV with a partner and negotiate safe sex or condom use with a partner, secondary education has an even greater positive impact. Girls who attend secondary school are far more



likely to understand the costs of risky behaviour and know effective refusal tactics in difficult sexual situations (Hargreaves & Boler, 2006).

The HIV vulnerability among young girls is a considerable concern, particularly in countries where young girls are twice as likely to have HIV as their boy peers, (Pettifor, et al., 2004). Although this pattern has not yet emerged in the Asia-Pacific region, keeping girls in school can help provide them with essential knowledge and skills to protect themselves.

Socio-economic Vulnerabilities

Economic strain in settings that involve gender inequality contributes dramatically to women's HIV vulnerability. Treatment of women as inferior to men, fewer economic opportunities and less power to ensure respect of their rights and social protections, including risk of child marriage and sexual violence are all factors that contribute to increased HIV vulnerability among women and girls. Women's economic vulnerability and their economic dependency on men make it less likely that women will succeed in negotiating condom use or fidelity with a partner. It also makes it less likely that they will leave a relationship that they perceive to be risky because they lack bargaining

power and fear abandonment and destitution (Heise & Elias, 1995; Mane, Rao Gupta, & Weiss, 1994; Weiss & Rao Gupta, 1998). Poverty and a lack of economic alternatives repeatedly have been identified as the reasons that many adult women and children become sex workers. In conditions of extreme poverty, many women and girls fall into sex work either because they are trafficked into the sex industry or because they feel they have no viable option to support themselves and their children (Wojcicki, 2002; Dunkle et al., 2004a; Harcourt & Donovan, 2005). A forthcoming report by Beegle and Özler found that gender inequality itself puts women, particularly young women, at risk of HIV, because it entitles men to have multiple partners in some settings.

Poverty is also directly related to child marriage which increases girls' HIV risk. Poor families have fewer options to send girls to school or offer other alternatives; thus marriage becomes a way out of poverty. Globally, nations with the lowest gross national product rates also have higher rates of child marriage (Mathur, Greene and Malhotra, 2003). Families may also obtain higher bride prices for daughters they marry off at a younger age (Mathur, Greene and Malhotra, 2003). In contrast, if a girl earns an income it

appears to protect her from child marriage as families delay marriage because of the income (Jejeebhoy, 1995). In Bangladesh, a study showed that only 31 percent of girls who worked in a factory married before age 18, as opposed to 71 percent of those who remained in their village (Amin, Diamond, Naved and Newby 1998).

Women's lack of access to and control over economic assets such as land and housing makes them particularly vulnerable in the AIDS epidemic and can fuel a vicious intergenerational cycle of disease and death. Without a guarantee of property and inheritance rights, a widowed woman is at risk of losing her home, inheritance and possessions either because the law does not give her the right to own or inherit land or housing, or because of dispossession with no accessible legal recourse to regain ownership. Thrust into these difficult economic situations, women and girls may be forced into risky and unsafe sexual behaviours just to meet their own and their children's or siblings' basic needs. They may also fall prey to sexual predators (Strickland, 2004). In a recent study in India, loss of property rights was acutely apparent among widows where 90 percent of HIV-positive widows stopped living in their marital homes after the death of their husband (UNDP, NCAER, NACO 2006).

The association between property rights and HIV came to light when many HIV-positive widows became dispossessed of their property after their husbands' death. One of the few studies exploring the link between property rights and HIV in South Asia found that women's insecure property rights exacerbated the impact of HIV. Women interviewed in this study were frequently asked to leave the marital home when their HIVpositive husband died or were forced to leave due to continued abuse by husbands' relatives. After dispossessing the widow, relatives often sold off all assets and kept the cash: which is more difficult for widows to recover (Swaminathan, Bhatla, and Chakraborty, 2007). This study also revealed that being female, HIVpositive and widowed exposed the women to very high rates of stigmatization. These women's stories were brought to light during the 8th International Congress on AIDS in Asia and the Pacific (ICAAP) in 2007 in a women's "court" held to hear cases of property and inheritance loss among HIV-positive women in the region. The court brought together 20 HIV-positive women from 11 nations who shared their experiences of struggle and overcoming dispossession of property and denial of inheritance rights (http://www2.undprcc.lk/resource_centre/rcc_publications.php?c_id=1002).

Women's ownership of immovable assets, particularly a house, has also been associated with reducing violence against women, and thus indirectly reducing HIV risk. Property ownership was found to not only protect against violence $and \, but \, also \, to \, provide \, an \, exit \, strategy for \, women \,$ to leave violent situations (Bhatla, Duvvury, and Chakraborty, 2006). For example, among women interviewed in West Bengal, 57 percent of women without property experienced violence as compared to only 35 percent of women with property. Research in Kerala, India, found that 49 percent of women with no property reported physical violence compared to only 7 percent women property owners (Panda, 2002). Owning property may also help mitigate economic and health shocks, including HIV, by providing assets that can be liquidated to meet resulting financial needs. Among households surveyed in six high prevalence states in India, 39 percent resorted to selling off assets when a household member became HIV-positive, and 57.2 percent of households with a widow sold off assets (UNDP, NCAER, NACO 2006).

Sexual and Reproductive Rights and Health of HIV-positive Women

Women's sexual and reproductive rights are enshrined in a number of international agreements and treaties, including the Cairo Declaration, the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Declaration of Commitment on HIV/AIDS passed at the 2001 United Nations General Assembly Special Session on HIV/AIDS (often known as UNGASS), and the 1994 Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA) Principle. These instruments are all geared toward upholding the right of women everywhere to reproductive and sexual freedom, health and dignity. Due to

the gender and social norms that circumscribe women's options and behaviour in much of the region, however, it is not uncommon for the sexual and reproductive rights of HIV-positive women to be abused. Abuses include: forced abortion and sterilization of HIV-positive women; denying positive women access to labour and delivery and other health care services; denying positive women access to contraception including barrier methods; an ongoing lack of female-controlled HIV prevention methods; and community disapproval for having sexual relationships and/or bearing children when HIV-positive (http://www.icw.org/files/SRHR-ICW%20 fact%20sheet-06.doc).

The Inter-agency Task Team on the Prevention of HIV Infection in Pregnant Women, Mothers and Children developed a global strategy for universal access to prevention of parent to child transmission (PPTCT). The strategy provides guidance on the standard of care for providing these services, urging the adoption of a comprehensive package of care based on the United Nation's four elements strategy that links and integrates maternal, newborn and child health care services. It gives priority to HIV-positive pregnant women needing access to these services. It also notes the importance of male involvment in protecting these rights. It encourages couples counselling as a means to improve the use of family planning, increase HIV testing and counselling, facilitate disclosure of HIV status, and improve adherence to treatment. This is a critical element in family centered care, which integrates care for the benefit of the family and includes services such as nutritional support, child health, and family planning services (The Inter-agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and Children, June 2007).

Mobility and Trafficking

Various factors contribute to women's increased vulnerability to HIV resulting from mobility and trafficking in the Asia-Pacific region. Generally speaking, economic need drives labor trafficking and internal migration (Azad, n.d.). Push and pull factors account for the high prevalence of trafficking and sex work in Asia. Impoverished or, abused women may be lured or *pulled* from

rural areas to urban centres for opportunities in employment, education, or simply a better life. On the other hand, some women are *pushed* into mobility to escape an unstable home life, to support or supplement their families' income, or to avoid an impending forced marriage.

Girls who are 12 or 13 years old have told interviewers they were lured by promises of jobs and marriage (Jafri, 2002). According to the Institute of Migration, women account for almost 50 percent of all migrants globally (IOM, 2006). Furthermore, women from Asia make up the largest percentage of unskilled migrants in those countries that receive labour (You and AIDS, 2006). In South and Southeast Asia, members of society most affected by trafficking are those occupying the lowest rungs of the societal ladder (Shah, Brar & Rona, 2002).

Although women and girls are trafficked for various purposes such as marriage, sweat shop labour, factory work, domestic work, and construction work, sexual exploitation remains the single largest category of trafficking crime throughout the region. Being in an unfamiliar environment, they are less likely to be able to exert control over protective behaviours such as engaging in sex, choice of partner, and whether a condom or other protection is used. Forced or voluntary removal from home can expose women and girls to more violence, including sexual violence, and other forms of unprotected sex, which in turn increases their vulnerability to HIV (UNAIDS, 2001; UNIFEM, 2004).

Though lack of adequate data remains one of the fundamental weaknesses in exploring the linkages between trafficking and mounting appropriate responses, recent study (Jay Silverman et al, 2007) by Harvard School of Public Health in Katmandu show a very strong association between trafficking, HIV and multiple layers of gender inequality. The study showed that about 38 per cent of women trafficked into sex work were found to be HIV-positive.

Furthermore, more than 60 per cent of the girls trafficked into sex work before the age of 15 were found to be HIV positive, demonstrating the high vulnerability of young girls to HIV and trafficking.

The research also showed that girls trafficked as minors spent longer term in brothels compared to other sex workers and were at a higher risk of HIV infection. It was found that each additional month of captivity in brothels increased their risk of HIV infection by 3 to 4 %.

Similarly a regional rapid assessment study by UNDP in South Asia (HIV and Human Trafficking, UNDP 2007) showed an alarming trend in trafficking of girls and women, and HIV. In particular, the study recommends greater dialogue and collaboration between the antitrafficking community and AIDS community, as HIV and human trafficking share many common contextual as well as consequential factors. It also addresses the need for laws, policies and programmes that address both human trafficking and HIV-related issues in a comprehensive, gender-responsive and rights-based manner.

Injecting Drug Use and Partners of Injecting Drug Users

Injecting drug users contract HIV mainly by sharing contaminated needles and other drug equipment. To understand the HIV epidemics in the Asia-Pacific region, it is critical to understand the nexus between injecting drug use (IDU), sex work, high numbers of concurrent sexual partnerships and the use (or non-use) of condoms. While drug use brings a risk of HIV infection separate from the risk of HIV transmission though unsafe sex, the nexus between IDU and unsafe sex is thought to be a key driver of the epidemic in China, Indonesia, Malaysia and Viet Nam, as well as parts of India. In all of these countries there is an overlap between injecting drug use and sex work, such that male drug users are frequently buyers of sex, female drug users are increasingly selling sex to support their drug use and female sex workers are increasingly injecting drugs (UNAIDS, 2006). Adding fuel to this potentially explosive situation is the infrequent use of condoms in these relationships and the sometimes extreme stigmatization of sex workers and injecting drug users in many, if not most, countries in the region and the criminalization of these behaviors.

Harm reduction programmes, including opioid substitution therapy and the exchange of used needles and syringes for clean ones, have been shown to be effective in reducing HIV transmission (Van Den Berg, et al. 2007). For example, Viet Nam is pilot testing a methadone programme for future scaling up. Harm reduction programmes have been acknowledged as an appropriate approach in several countries in the region including India, Laos, Pakistan and Viet Nam. However, budget limits and competing issues prevent widespread application.

The illegality of both sex work and IDU presents enormous challenges for meeting the treatment and support needs of injecting drug users living with HIV and their partners. Yet data highlighting the urgency of the problem, and the need to make sex workers who inject drugs a major focus of HIV prevention activities is still inadequate.

Sex Work

In some countries, as many as 15 percent of men in the general population and 44 percent of men in mobile populations reported buying sex in 2004 (MAP, 2005). The recent Commission on AIDS in Asia report (2008) estimates that on average, in Asia, there are ten male clients for every sex worker. This means that the number of clients of sex workers is ten times more than the number of actual sex workers. Given these rates and the relatively high HIV rates among sex workers in the region, a significant proportion of new HIV infections are contracted during paid sex. According to the 2006 UNAIDS annual report, HIV prevalence among female sex workers in Viet Nam increased from 0.06 percent in 1994 to six percent in 2002. In Indonesia, according to the report, the rate of HIV infection among female sex workers is 3.1 percent nationally but varies significantly from region to region; in Jakarta, for example, prevalence reached 6.3 percent in 2003. In China it is estimated that sex workers and their clients account for around 20 percent of the total number of people living with HIV (UNAIDS, 2006). Rates among male sex workers are less well known, since this activity is even more stigmatized and criminalized, but in one city in China health authorities claim that HIV prevalence among male sex workers is as high as five percent.

As noted above, the increasing use of injecting drugs by sex workers in the region and their clients makes sex workers more vulnerable to HIV. Sex workers also experience relatively high rates of sexually transmitted infections. For example, in Dili one quarter of sex workers surveyed in 2003 had gonorrhoea or Chlamydia infections, and 60 percent carried herpes simplex virus 2 (UNAIDS, 2006). Sexually transmitted infections facilitate HIV infection and are often used as proximate indicators for HIV. Violence is also part and parcel of the sex trade for many women. Sex workers in Papua New Guinea regularly experience gang rape – or *line ups* – at the hands of clients or the police.

There is important evidence that HIV prevention programmes for sex workers are effective, and that sex workers can be active participants in these programmes. Examples of effective programmes in the region include the Thai 100% Condom Use programme, which has been replicated in a number of countries in the region. The famous Sonagachi project in Kolkata, India also shows how working with sex workers, supporting them to organize to protect each other and themselves, can have a big pay-off in terms of infections prevented (UNAIDS, 2000).

Violence

Violence is the most extreme form of gender inequality and often stems from gender norms that make male violence against women a socially acceptable way to control an intimate partner. In the context of the HIV epidemic, gender-based violence makes women and others (for example men who have sex with men, in some settings) more vulnerable to infection, reduces their capacity to protect themselves, and reduces their ability to access treatment, care and support. A WHO-sponsored study with data from more than 24,000 women interviewed in 15 sites in 10 countries found that 15 to 71 percent of women reported having experienced physical and/or sexual violence by an intimate partner. Women living in more rural settings in Bangladesh, Ethiopia, Peru and Tanzania reported the greatest levels of violence (WHO, 2005). In India, 40 percent of women have experienced violence, and half of the 26 percent of women who suffer severe physical abuse report being beaten

during pregnancy (ICRW 2001). In Bangladesh, 40 percent of women reported sexual violence by a sexual partner (ICRW, 2002).

Violence contributes directly and indirectly to women's vulnerability to HIV (Maman, 2000; WHO, 2005). Individuals who have been sexually abused are at immediate risk of HIV infection, but they are also more likely to engage in unprotected sex, have multiple partners, and trade sex for money or drugs (Heise, Ellsberg, and Gottemoeller 1999). A Cambodian study found that among 1,000 female and transgendered sex workers, more than 50 percent had experienced violence - mostly in the form of rape - at the hands of law enforcement officials (Jenkins et al., 2005). Many of these rapes occurred without the use of a condom, exposing both the perpetrator and victim to higher risk of HIV transmission. In Cambodia, few rapes are reported by victims, often because of fear that the perpetrator might retaliate (LICADHO, 2006). Despite increased recognition of the relationship between HIV and gender-based violence in Cambodia, more emphasis is needed on the relationship between gender-based violence and HIV within the context of marriage (Duvvury & Knoess, 2005). A small Bangladeshi study that examined vulnerability to HIV infection found that in half of the 48 non-sex worker IDUs interviewed for the study, about 20 percent reported having been raped. In half of those cases the perpetrator was their husband (Azim et al., 2006).

Violence is thought to be an important contributorto the HIV epidemic in Papua New Guinea, where violence and fear are part of everyday life for many of the poor, particularly in Port Moresby. According to a recent report (Tobias, 2007), sexual violence and rape - particularly of young women - is extremely common, in part due to the low status of women, leading to an HIV rate among young women aged 15-19 that is four times higher than the rate among boys in the same age group. The National AIDS Council in Papua New Guinea reports that "patterns of male sexual behaviour, including a high incidence of rape, line ups [gang rape], sexual assault and weak law enforcement" are important contributors to the epidemic (Human Rights Watch, 2005, cited in Tobias, 2007: 10).

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CHAPTER 03

SUGGESTED DIRECTIONS FOR POLICY AND PROGRAMMES



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SUGGESTED DIRECTIONS FOR POLICY AND PROGRAMMES

HIV is a complex problem of global importance; a problem that deeply affects health, economic stability and the social and psychological wellbeing of individuals, families and communities. To effectively prevent the spread of HIV and to mitigate the consequences of living with HIV, it is critical to adopt a holistic approach and comprehensively address the factors that increase vulnerability to HIV and to do so on multiple levels and with multiple interventions. There are many opportunities to build on current efforts and create new strategies to improve prevention, care and treatment programmes, policy and research. This section is a compilation of all of the suggested directions for genderresponsive efforts in the Asia-Pacific region that are included in the each of the key topic discussions in Part 4 of the Guide. The number in parentheses after the topic indicates the location of the detailed discussion in Part 4.

PREVENTION (4.1)



Creating an Enabling Environment

Work towards changing gender norms and invest in gender transformative interventions that tackle gender inequality. These include HIV prevention education programmes using community-based, participatory processes that allow for critical analysis and reflection among community members in order to trigger transformations in gender roles and norms.

- Systematic, wide-scale programming using proven techniques such as Stepping Stones or other participatory learning and action methodologies to engage communities in meaningful, resolutionoriented debate on the issues (Jewkes et al., 2007). Other examples include the DISHA project, which works directly with youth and communities to transform gender norms and empower young women and young men to live more productively and safely (International Center for Research on Women, 2004). Another example is the Inner Spaces Outer Faces Initiative (ISOFI) which worked with staff designing and implementing programmes at various levels, and uses reflective practices and participatory learning and action (Kambou et al., 2007). Community Capacity Enhancement (CCE) is another example of participatory action and learning metrologies with proven success in PNG and Cambodia.
- Programmes working specifically with men of various ages to shift expectations and norms around gender and the treatment of women. Two excellent examples are Program H, first developed in Brazil and now adapted for use in India (Pulerwitz et al., 2006); and Men as Partners, developed and tested in South Africa to combat the dual and synergistic epidemics of gender-based violence and HIV (White et al., 2003). These programmes have fostered constructive roles for men in sexual and reproductive health. The challenge now is to take the principles behind these successes and replicate them effectively on a large scale (see Section 4.10 for a fuller discussion of this issue).
- Prepare for the introduction of new prevention technologies such as microbicides and vaccines. Demand-side issues: consider marketing microbicides as health and hygiene products rather than putting the emphasis on disease prevention. Supply-side issues: anticipate and plan how to overcome upstream resistance to these products, relating to policy-maker and health

- provider concerns about efficacy, and also their potential resistance to the empowering impact on women these products could have.
- Encourage the use of female initiated HIV prevention methods such as the use of the **Female Condom**. Encourage additional research into improving the products usability or bringing down its cost.
- Encourage and fund greater data collection and analysis. There is a need to synchronize data collection efforts among all agencies, improve and expand the scope of collecting data and conduct rigorous analysis to improve the understanding of the epidemic to promote formulations of evidence based policies and programmes.

Suggested Directions for Policy and Programmes

- The Global HIV Prevention Working Group recommends a **combination approach to prevention**, using a range of evidence-based strategies. By employing all appropriate tools-from delayed sexual activity to condom promotion, from voluntary counselling and testing to programmes for injecting drug users-combination prevention can help reduce new HIV infections and help stop the epidemic. Based on its analysis of the gap between current access to HIV prevention and the level of resources required to reverse the global epidemic, the Working Group has specifically recommended that:
 - Funding: In 2007, the Working Group suggested that 56 percent of the funding needed to provide a comprehensive response to HIV be spent on prevention efforts. For 2008, estimates now indicate \$22 billion is needed to scale-up a global, comprehensive response to HIV. Although global spending has increased 12 percent since 2006, the Working Group predicts that only \$10 billion will be made available for HIV programs in developing countries (Global HIV Prevention Working Group, 2007).

- Scale-Up: Prevention scale-up must be a central priority, focusing on cost-effective, high-impact interventions, including behaviour change programmes, voluntary counselling and testing, STI control, condom promotion and prevention of parent-to-child transmission, among other proven strategies.
- Prevention and Treatment: Prevention and treatment programmes should be carefully integrated as they are brought to scale.
- Capacity Building: In addition to funding for prevention interventions, donors should provide extensive additional support to build long-term human capacity and infrastructure.
- Policy Reforms and Aid: Policy reforms and international aid should address the social and economic conditions-such as gender inequality, stigma, and povertythat increase vulnerability to, and facilitate the rapid spread of, HIV.
- Prevention Research: Research into new prevention strategies and technologies should be significantly accelerated.

The Commission on AIDS in Asia (2008) classifies all interventions as (i) high-cost/high-impact, (ii) low-cost/ high-impact, (iii) low-cost/low-impact, and high-cost/low-impact. The Commission further recommends prioritizing interventions that are proven to be highly effective. Examples of high impact prevention activities include interventions aimed at high-risk behaviour groups and policies/programmes aimed at preventing mother-to-child transmission as well as limiting exposure to HIV risk for women in stable relationships. It is estimated that focussing on these groups can prevent over 80 percent of new HIV infections (Commission on AIDS in Asia, 2008).

The integration of PPTCT into sexual, reproductive, maternal and child health and home-based care programmes is the best way to use existing services and providers, and reach the maximum number of people living with or affected by HIV. Comprehensive, quality facility services are the foundation of a successful PPTCT programme. However, they must be linked to community-based resources and initiatives for maximum coverage and impact-especially home-based care, faith-based programmes, traditional practitioners, PLWHA support groups and adolescent-friendly services and information

Prevention of parent to child transmission:

 Preventing infection in women of reproductive age;

(Israel & Kroeger, 2003). The United Nations recommends a three-pronged approach for

effective PPTCT:

- Preventing unwanted pregnancies in HIV-positive women; and
- Offering PPTCT prevention interventions to women who are both HIV-infected and pregnant.
- **Tailor HIV prevention messaging and programming** to meet actual needs and match actual behaviour with a focus on 'healthy sexuality' rather than disease prevention, including:
 - Peer education on safer sexuality, geared toward frank, open and honest discussion around sex and how to make it safer; and
 - Peer groups including heterosexual women, heterosexual men, as well as groups of self-identified homosexual men and women, and other sexual minorities.

HIV AND WOMEN'S ISSUES IN TREATMENT (4.2)



Creating an Enabling Environment

- Enact legislation that ensures universal access to counselling, testing, treatment and support regardless of how the person acquired or is thought to have acquired HIV. Governments also need to ensure that ARV drugs, both first and second-line, are available to those who need it. Special measures may need to be taken to reach marginalized and poor populations such as subsidizing transport costs, compensating loss of income or wages and other hidden costs in accessing treatment centres.
- Support all efforts, policies and interventions that seek to address the root causes of gender inequality, including zero tolerance for violence, reducing stigma and discrimination, information and access to legal rights including property and inheritance rights, and right to healthcare for all.
- Engage in vigorous, widespread and ongoing stigma reduction to ensure that a positive test result and/or being on treatment does not result in other negative outcomes for women or their families.
- Revise the nursing and medical school curricula to go beyond health issues and facilitate understanding of the wider context of HIV-positive women's lives including issues around stigma and discrimination. The need to respect the human rights of HIV-positive women should be a core component of the curricula. Health staff who have already qualified should receive this information as part of their ongoing job training.

Suggested Directions Programmes

- Consult HIV-positive women and girls about appropriate locations for service provision, and set up decentralized, mobile health care facilities based on their suggestions. Promote access for women and girls through the integration of HIV counselling, testing and treatment services with other sexual and reproductive health services. Involve positive women in design, implementation and monitoring of such services.
- **Undertakeagenderassessmenttoascertain** the particular treatment and care barriers faced by women and socially marginalized groups of women living with HIV, including: lesbians, bisexual women and transgender people; sex workers; injecting drug users; female prisoners; women with disabilities; people; indigenous undocumented immigrants, refugees and internally displaced people; and women in conflict situations and support these groups to mobilize regular and reliable access to ARVs, adequate training of health care workers who work with HIVpositive women, improved reproductive health services, and the need to include HIVpositive women in the development of HIV prevention, care and treatment programmes.
- Develop programmes that reach out to women for counselling, testing and treatment. For example, offer HIV-testing and counselling in a range of settings aside from antenatal clinics such as workplaces, universities and prisons.
- Train and employ HIV-positive women and girls, and positive women's organizations, to promote and distribute ART, and to become pre and post-test counsellors.
- Link up testing and treatment facilities with existing support groups or encourage new groups to form so that people who test positive can join a group and get support from the start.

? Counselling and Testing:

- Provide training in pre-and post-test counselling to health personnel in all locations where HIV testing takes place (including prisons).
- Ensure that women and girls have opportunities for counselling and testing conducive to the exercise of their right to informed consent by reaching out to women and girls in communities and health care settings outside of the labour and delivery ward.
- Create the opportunities and vigorously promote couples counselling and testing.
- Ensure that HIV testing is based on the provision of non-judgmental information and support so that women can make informed and voluntary decisions about whether or not to be tested.

HIV AND CARE GIVING (4.3)



Creating an Enabling Environment

- Support family care providers and ensure that women and girls do not lose opportunities for education, social life and employment due to the cultural imperative that they alone should provide care for family members sick and dying due to AIDS. Policies can support creative public-private partnerships and linkages (formal or informal) with community-based organizations and/or networks of HIV-positive people. In addition, programmes have been developed to encourage men to engage more actively in the care of family members living with HIV (e.g. Esu-Williams, 2004).
 - Nurture emergence and support continuation of community home-based care programmes. Draw on best practices from the region (notably Cambodia and Thailand) and Africa, where successful partnerships have been forged between the public healthcare services and community-based or faith-based organizations to provide a continuum of care to clients and their families.
 - Ensure linkages between testing, treatment and home-based care.
 - Ensure home-based care programmes are working with and supporting family caregivers, linking them to available information, prevention education and equipment.

- Ensure that home-based care is providing the support necessary so that educational opportunities for children – especially girl children – are not lost.
- Foster the participation of men and boys in home-based care, within the family and the community.
- Promote and protect the property and inheritance rights of women affected by HIV and AIDS. Property and asset ownership and control have an empowering effect on women living with and affected by HIV, enhancing their resilience and ability to manage their lives effectively despite their desperate circumstances. Securing women's property rights can help positive people live with dignity and contain the spread of HIV.
- In countries where national social security schemes exist, ensure it reaches marginalized populations, including those infected and affected by HIV.
- Addressgendernorms. Developand provide age-specific HIV education programmes that teach boys (in home, school, and religious settings) about:
 - Positive and negative aspects of existing concepts of masculinity and femininity;
 - Gender and age-specific HIV risks and vulnerabilities; and
 - Support groups and clubs that provide context-specific messages and opportunities for networking and involvement in community prevention and care activities.

Suggested Directions for Programmes

Linkfemale caregivers to home-based care and treatment programmes. Most Asian countries continue to lag behind African settings in providing home-based care for people living with HIV. In-depth analysis of the burden of care borne by women in HIV-affected households indicates that these

women require material, emotional and physical support to meet the obligation to care for a spouse, in-law or child living with HIV (Pradhan & Sundar, 2006).

- Integrate livelihood options, vocational training, and other income generating options in programmes catering to /HIV affected and infected women.
- Engage men and boys in caregiving. Lessons learned from an Expert Group Meeting on "The role of men and boys in achieving gender equality" in 2003 in Brazil include (UNDAW/UNAIDS/ILO/UNDP, 2003):
 - Present men as potential partners capable of playing a positive role in the health and well-being of their partners, families and communities;
 - Support men to recognize and address their own health needs as a first step;
 - Create opportunities for men to learn the skills necessary to provide care and support to people living with HIV;
 - Encourage men to play an active role in the prevention of parent to child transmission of HIV and use PPTCT services as an intervention point for men.

HIV AND EDUCATION (4.4)



Creating an Enabling Environment

P Enhance and Improve the Curriculum:

- Build HIV prevention and reproductive health information into existing school health programmes;
- Develop and implement life skills curricula; and
- Use a life-long learning approach.

P Enhance Capacities of Teachers:

- Promote and facilitate the provision of comprehensive sex education (knowledge of sexual and reproductive health, including ways to prevent unwanted pregnancy, STI and HIV);
- Train teachers in the importance of challenging gender stereotypes and correcting misinformation about sex and gender; and
- Enable teachers to train girls in skills that can provide economic opportunities.

Promote Girls' Education:

- Lobby national and local governments to create incentives and decrease barriers to educating girls;
- Encourage nutrition and health projects to offer sessions for mothers on the importance of girls' education at the same time they are providing their other services at community centres;

- Ensure that local government and community-based organizations monitor enrolment and school completion rates of girls; and
- Ensure that local administrations ensure that schools are safe and provide a conducive environment for girls to learn.

Suggested Directions for Programmes

- Implement comprehensive sexual and reproductive health education to youth:
 - Provide comprehensive HIV and pregnancy prevention information, including information about safer sexual practices and condom use as well as the risks and benefits of other forms of birth control:
 - Create space for peer-based gender norm debates and discussion geared toward challenging norms that disadvantage girls, condone violence against girls and women, and put boys at increased risk of HIV infection;
 - Provide life skills training to support youth self-esteem, enhance negotiation skills, and build capacity for safer adulthood behaviour (e.g, the DISHA project in India (see ICRW 2004));
 - Create income generation opportunities for girls – particularly in areas of extreme poverty, low education and few employment options.

Promote Girls' Education:

- Facilitate community-based advocacy for promoting girls education;
- Work with parents and communities to instil importance of educating their girls and young women;

HIV AND VIOLENCE AGAINST WOMEN (4.5)



Creating an Enabling Environment

- Advocate with governments to adopt national legislation on domestic violence, and to ensure governance systems and adequate resources for effective implementation and sensitization of law enforcement agencies.
- Encourage research to collect reliable empirical data to (i) provide evidence on the links between vulnerability to HIV violence, and trafficking, (ii) provide an estimate of the social and economic costs of HIV and violence to households, communities and national economies, and (iii) develop rigorous monitoring and evaluation systems to track the integration of violence components within HIV programmes.
- Enlist the support of influential community leaders at various levels of government to raise awareness against the twin burden of HIV stigma and gender-based violence.
- Puild gender capacity within civil society organizations working on HIV to recognize the links between gender-based violence and HIV, and build capacity of organizations to engage with families and communities in transformative processes to shift gender norms.
- Evolve specific methodologies on HIV stigma and violence reduction to generate dialogue with men and women as well as other specific communities such as high risk groups, health care providers and

counsellors on adoption of safe sex practices within long-term intimate relationships, sexuality, gender norms, and violence. These should be undertaken at a community level rather than individual to help break the silence around violence.

Encourage adaptation, replication and scale-up of best practice models that address gender-based violence effectively such as one-stop violence crisis centres, zero tolerance for violence zones and community level alternate dispute resolution and mediation. All of these models hinge on developing a comprehensive support system across various sectors such as health, education, judiciary, law enforcement agencies, and they must be implemented in conjunction with systems of local self-governance.

Suggested Directions for Programmes

- Integrate violence reduction into all programmes addressing HIV stigma, reproductive health and sexuality education with adolescents. Create safe spaces and platforms such as youth collectives and clubs to dialogue on issues of sexuality, expression, gender roles, conflict resolution and respectful relationships; and encourage sharing of experiences of positive personal change.
- Educate and equip young people with skills to minimize the consequences of violence such as increased risk-taking behaviours and teenage pregnancy.
- Engage men and boys to understand conception of male identity, the need to prove themselves to peers, and other pressures experienced by them due to gender stereotyping.
- Sensitize the healthcare system and HIV counsellors on gender-based violence. Encourage use of models for systematic screening and develop a comprehensive service delivery and referral system to address the issue. Focus particularly on the

frontline healthcare providers, antenatal and voluntary counselling and testing (VCT) clinics. Equip the system to recognize and deal with violence as a barrier impacting access to services, HIV status disclosure and negotiation of safe sexual relationships.

Provide adequate referral support networks and safe shelter for survivors of violence and similarly for women infected and affected by HIV.

HIV AND WOMEN'S REPRODUCTIVE AND SEXUAL RIGHTS (4.6)



Creating an Enabling Environment

- Fulfill obligations as signatories to international conventions. Through a consultative process that involves relevant entities including government and religious institutions, create legal measures that support fulfilment of the international commitments.
- Create or expand the scope of punitive measures for sexual offenses such as marital rape and incest. Conversely, reduce or eliminate similar measures for possession or distribution of contraceptives and prophylactics.
- Advocate for the integration of PPTCT and antenatal services with reproductive health and family planning services to ensure continuity in maternal treatment and care.
- Provide funding through NGO or statesupported interventions to offer to women and girls **opportunities to increase skills** that build self-esteem and facilitate empowerment, contributing to, for example, increased ability to negotiate condom use.
- Integrate sex education into school curricula to generate greater awareness, among young men and women, about sexual and reproductive health. This can help them avoid risky behaviour and make safe choices.
- Include HIV-positive women in clinical trials for contraceptive technologies to ensure product applicability to women of sero-positive status.

Suggested Directions for Programmes

- ♀ Educate providers of HIV-positive patients on rights affecting people living with HIV in order to ensure good quality of care. Training should include how to address layered stigma (additional discrimination on top of existing HIV-related stigma and discrimination) and the influence of gender.
- Create and support programming that ensures women have adequate access to information that appropriately educates them on, or expands their knowledge about, reproductive options. Utilize "edutainment" activities as a means to expand girls' awareness of their sexual and reproductive rights.
- Ensure that youth-friendly sexual and reproductive health services are provided to those in need. If services are designed and delivered from a youth perspective, young women can be empowered to take an active role in asserting their right to decision making on family planning methods.
- Promote male involvement in programmes that provide information about sexual and reproductive rights. Offer informational programmes to law enforcement officers and other people in positions of authority in this field to educate them on their roles in upholding a woman's sexual and reproductive rights.

HIV AND WOMEN'S PROPERTY RIGHTS (4.7)



Creating an Enabling Environment

- Review and harmonize laws that impinge on women's property and inheritance rights. Efforts should be made to harmonize land, marriage, and inheritance laws, and to ensure consistency between those laws, the provisions of the national constitution, and the obligations of the state with respect to international human rights treaties. Finally, legislation promoting the registration of all marriages and joint titling should be areas targeted for reform.
- Advocateforadoption of Gender-Sensitive Legislative Frameworks, Promoting Judicial Capacity and Effective Litigation. Even where laws are favourable to women's concerns, inadequate interpretation and enforcement renders them ineffective. Correcting this situation requires working with those who implement these laws and deliberate legal matters and as well as enhancing the accessibility and effectiveness of the judicial system itself.
- Invest in public awareness and building understanding of the issue. Sound laws and gender-sensitive judicial systems must go hand in hand with a high level of public awareness of women's property and inheritance rights and of how national law or international human rights frameworks can protect and promote those rights. Women themselves often lack adequate knowledge about courts and other legal mechanisms available to defend their rights, as well as the means to employ such mechanisms when needed. Raising awareness of women's

- property and inheritance rights is the first step in creating an environment in which women can actively engage with both customary and formal structures to realize and protect their rights.
- Invest in creating temporary shelters and accommodation for women and children who are evicted or who may want to leave their residence. This should be done on a priority basis by governments as the need for a safe place to stay makes women vulnerable and open to exploitation.

Suggested Directions for Programmes

- Replicate and scale up programmes such as community-based paralegal services to help women access and realize their rights. Securing property rights for women requires innovative, comprehensive strategies that address economic security and social support, and combine mutually reinforcing strategies of policy/legal, familial and community responses. A range of HIV/ AIDS organizations, positive networks, and property rights organizations have already implemented programs providing paralegal and legal aid services to women. To carefully and comprehensively replicate and scale up these programmes, it is critical to:
 - Build awareness among a broad range of HIV organizations on the links between HIV and property rights, among women of their legal rights, and among communities of the laws and regulations related to women's property and inheritance rights. Such services operate at the frontier between statutory and customary law and often represent the strongest resource for women seeking to defend their property claims from discriminatory customary practices. Women also need access to legal resources for advice on their legal options and support in taking action. Additionally, women need tools to prepare wills that are accepted by the informal and formal legal structures;

- Strengthen the capacity of positive networks and other organizations working in the area of HIV and AIDS to understand and undertake interventions on property rights (such as providing legal literacy training for community paralegals, developing alternative dispute mechanisms, decreasing stigma and discrimination, and involving men and boys);
- Create networks to bring together HIV/AIDS organizations, positive networks, and women's property rights organizations to encourage awareness of their overlapping interests, goals and activities, peer learning and exchange of strategies and ideas, and form strategic alliances for effective implementation and advocacy.
- Undertake further research and documentation to highlight the urgency of investing in this issue in the region. Examples of areas for research include: documentingcustomarylandtenuresystems; identifying the impact of the AIDS epidemic on land, property and inheritance rights in countries where such studies have not been done; developing gender disaggregated indicators at the national and local level that measure progress toward equity for women in land rights.

WOMEN, HIV AND ECONOMIC EMPOWERMENT (4.8)



Creating an Enabling Environment

- Advocate for ratification and full compliance with international conventions protecting women's property and inheritance rights; rights to education and economic opportunities, and human rights protections for people living with HIV and AIDS.
- Reform and strengthen national laws relating to women's property and inheritance rights.
- Support advocacy for the recognition of women's caregiving responsibilities as work.
- Promote micro-finance programmes and strengthen women's property ownership efforts that strive to support women's financial independence and make permanent, sustainable improvements in their economic status. Look for ways to include young women and adolescent girls. Use the microfinance platform to provide a range of training and educational services to participating women that provide skills building and challenge gender norms.
- Cobby national and local governments to create incentives and decrease barriers to educating girls and young women;

Suggested Directions for Programmes

- Develop strategies to provide vocational and technical training and employment opportunities for young women.
- Involve HIV-positive people in designing and implementing gender-equitable HIV workplace policies and awareness programmes that promote the retention and employment of HIV-positive staff and provide a range of appropriate care and support.
- Educate employers about HIV-positive workers' rights and eliminate discriminatory employment practices based on a worker's HIV status.
- Support self-help and support groups as they often help women discover livelihood opportunities and provide space to challenge gender inequality.
- Promote girls' education through:
 - Facilitating community-based advocacy for promoting girls education and vocational training; and
 - Working with parents and communities to instil the importance of girls education.

HIV AND WOMEN IN HIGHLY VULNERABLE POPULATIONS (4.9)

HIV AND SEX WORK (4.9.1)



Creating an Enabling Environment

Follow principles of harm minimization. Successful action to reduce HIV transmission that is a consequence of sex work will not *eliminate* sex work, but rather minimize the harms associated with it.

Remove or revise laws that criminalize sex work. Policyies that encourage decriminalization help to ease the way for the provision of HIV information and services for those involved. These measures should pave the way for an increase in condom use by clients, thereby dramatically reducing the onward transmission of HIV to non-sex worker clients.

Promote greater condom use by empowering sex workers and by involving other actors in the sex industry. Many past efforts to encourage condom use by sex workers have targeted information and commodities at the sex workers themselves. This approach can have some success, but given that the ultimate decision about whether or not to use a condom often resides with the male client, condom promotion efforts need to also be targeted directly to the clients themselves. This is especially relevant in countries such as Indonesia and Myanmar where women can be arrested for possession of a condom and in red light areas that experience high turn over of sex workers. Great success has been achieved in some countries in the region

(famously Thailand, but also West Bengal) through incentives to brothel owners who require patrons to use condoms.

P Ensure regular screening and treatment for sexually transmitted infections. Sexually transmitted infection (STI) rates are extremely high among sex worker populations, and effective screening and prompt treatment of these infections can have a significant impact on HIV transmission risk. It is likely that in the Philippines, for example, widespread, routine STI screening and associated HIV services for sex workers has contributed to slowing the growth of the epidemic there (MAP 2005). The provision of STI services to sex workers provides the additional opportunity of making HIV testing and counselling (including prevention counselling) available.

Suggested Directions for Programmes

Respond to the needs of injecting drug users within HIV programming for sex workers. Typically programmes to reduce needle-related HIV transmission and sex-related HIV transmission have been developed and implemented separately, or in parallel. However, because there is such an important overlap between these activities, particularly in the Asia-Pacific region, and because of the importance of this overlap as a driver of the epidemic here, it is necessary to develop programmes and policies to address the HIV risks associated with these behaviours together.

Readers and practitioners in particular may also find the recent guidance from UNAIDS (2007) useful for planning: (Please refer page 133 for full guidance note)

WOMEN, HIV AND INJECTING DRUG USE (4.9.2)



Suggested Directions for Policy and Programmes

- **Implement** comprehensive harm reduction **UNAIDS** programming: advocates a "comprehensive, integrated and effective system of measures. "Within a comprehensive approach, consider including specific outreach to women and girls who inject drugs and the female partners of men who inject. Also needed is a mapping of this population and expansion of programmes reaching male injectors and their female partners. The package recommended here encompasses delivery through peer outreach, and includes the following elements:
 - Raising awareness and increasing knowledge;
 - Needle and syringe exchange and safe disposal programmes;
 - Condom use;
 - Specialized gender-responsive drug dependence treatment including substitution treatment and detoxification measures;
 - Provision for abscess management and overdose management;
 - Voluntary and confidential counselling and testing for HIV and post-test services including HIV prevention education, HIV treatment, care and support for those infected and their partners;

- Services targeted to partners of IDUs that include stigma management and stigma reduction, HIV prevention, treatment, care and support where necessary and especially additional support for family caregivers of HIV-positive IDUs;
- Gender responsive services with a comprehensive approach addressing specific needs of women including peer outreach by female peer educators, gender-sensitive HIV/AIDS prevention and care materials;
- Collectives/solidarity groups of spouses of IDUs. (For example, in Manipur, a self help group was formed for the spouses/ widows of IDUs named "Unity is Strength". Through this group, the women help themselves to lead meaningful and productive lives in the society); and
- Increased and expanded baseline health and behaviour data collection and continued surveillance.
- Sensitize the legal, judicial, and health systems to the realities of the lives of injecting drug users and to work with them in a non-discriminatory manner.
- Encourage greater involvement by the injecting drug users themselves in the planning and design of programs and campaigns.

HIV, WOMEN, MIGRATION AND TRAFFICKING (4.9.3)



Creating an Enabling Environment

- P Develop policies and laws to make it safer for women to move and work. This policy development and strengthening of international and national laws and conventions, and national policies will need to involve international agreements and understandings about cross-border movement of people, migration control and regulation. The conditions under which many women move leave them vulnerable to sexual exploitation. Greater access to social protection and legal recourse are needed to ensure safe migration. (Women who migrate for work are often assumed to be engaged in transactional sex and therefore experience stigma and discrimination. Reducing stigma related to women's mobility should be addressed.)
- In creating stronger policies and laws aimed at ending human trafficking, draw on international conventions and national policies, and involve international agreements and understandings about the cross-border movement of people, its control and regulation. The resulting laws must include provisions to ensure women's sexual and reproductive rights and protect survivors of trafficking from involuntary repatriation.

Suggested Directions for Programmes

- Multi-sectoral approaches to reduce HIV and trafficking of women and young girls. Because of the complexity of the issue, policies and programmes around trafficking need to be multi-sectoral, integrated and holistic (Shah et al., 2002). They need to address both the issues that drive illegal human trafficking, and the effects of migration that compromise the safety of women. Interventions need to be grounded in legal provisions and macro-economic and social policies that protect human rights and provide poor women (and their families) with assets and legal protections. Programmes must include:
 - Empowerment of sex workers in the identification of those who have been trafficked
 - Empowerment of trafficked survivors to prevent their re trafficking
 - Improved access to legal protection and social services, including health and education;
 - Facilitation of safer mobility through norm change and rights education;
 - Alleviation of poverty in affected communities;
 - Work in source communities to raise awareness, promote zero tolerance for trafficking, and cultivate alternative options for girls and their families; and
 - Advocacy and information dissemination for ending trafficking in both source and recipient countries.

A study exploring the vulnerabilities and responses to human trafficking and HIV in South Asia (HIV and Human Traffikcing, UNDP 2007) provides some clear recommendations and interventions which can be divided into three general areas: Prevention; Treatment, care and support, and Advocacy.

Work with mobile groups and local communities together. Programmes to reduce the HIV vulnerabilities that result from mobility and trafficking must simultaneously work with mobile groups and the local communities with whom they interact. There is a risk that implementing programmes just for mobile populations can easily lead to stigma and discrimination against mobile people, while giving the false impression to those in local communities that they do not have to worry about HIV. The combined effect of these two unintended consequences is an environment in which HIV is more likely to be transmitted.

HIV AND WOMEN IN CONFLICT AREAS (4.9.4)



Suggested Directions for Policy and Programmes

- Institute gender sensitive national laws and policies. In post-conflict settings, addressing the lack of laws and a lack of enforcement of existing laws protecting women's rights is particularly important for meeting basic needs of women and their families.
- Strengthen international commitments to gender related issues affecting HIV in conflict zones. UN Security Council Resolution 1325 on the impact of armed conflicts on women, specifically called for action on this front:

"Requests the Secretary-General to provide to Member States training, guidelines and materials

on the protection, rights and the particular needs of women, as well as the importance of involving women in all peacekeeping and peace-building measures, invites Member States to incorporate these elements as well as HIV/AIDS awareness training into their national training programmes for military and civilian police personnel in preparation for deployment, and further requests the Secretary-General to ensure that civilian personnel of peacekeeping operations receive similar training."

- **Train military** conscripts in basic HIV prevention and transmission and provide access to condoms and STI treatment; train military conscripts in gender sensitivity in an effort to reduce aggressive behaviour including rape and sexual abuse of women;
- Train UN peacekeepers in gender sensitivity, making specific achievements part of the work performance review system; and
- Support economic and political empowerment of women in post-conflict settings. The following four recommendations are results of a symposium organized in sub-Saharan Africa by the Payson Center for International Development and Technology Transfer of Tulane University:
 - Provide multi-sector, integrated and gendered approach to HIV prevention and psychosocial and economic rehabilitation in post conflict societies.
 - Ensure that programs are gender and culturally sensitive in order to deal effectively with the disadvantages women face due to conflict (e.g., the creation of women-only clinics like the Polyclinic of Hope in Rwanda).
 - Address stigma and shame associated with rape and sexual violence by providing organization and social support to women living with HIV and to women who have experienced rape or other forms of violence (e.g., the Kenya Network of Women with AIDS).

• Incorporate conflict resolution and peace-building themes into HIV and AIDS programmes that are specifically tailored to women and into more general programmes in post-conflict societies (e.g., the Community Responses to Refugee Crisis: A Better Way to Cope project of the Society for Women and AIDS in Zambia).

UNDERSTANDING MASCULINITIES AND WORKING WITH MEN AND BOYS (4.10)



Suggested Directions for Programmes

- Move towards multi-sectoral and integrated programmes for men and boys; encourage programmes working on violence, health, asset creation and HIV to incorporate specific strategies to reach out and involve boys and men.
- Integrate HIV services within the larger family planning and health services, and specifically involve men in prevention efforts of transmission of HIV to their children and/or in the care of HIV-positive children.
- ♀ Engage men and women and boys and girls. Research shows the importance of sometimes engaging men and women separately, addressing and discussing their gender-specific needs, and then in other instances bringing them together.
- Use creative strategies to recruit or attract men and boys. Creating comfortable environments to engage men and boys is important. Reaching men and boys where

they gather, work and hang out is a good practice, along with outreach messages to which boys and men can identify.

- Engage with influence men in communities. Prevention efforts should pay attention not only to gender transformative messages for men and boys - but also who conveys the message. Whenever possible, men should talk to other men from the same communities, having some shared experiences. It may also be beneficial to engage role models who have an influence on men and boys such as peers, mothers, fathers, grandparents, community members and celebrities in programmes for change
- Provide safe spaces for boys and men where they can talk about their personal lives, sexuality and sexual health, experiences and use of violence, their frustrations, desires and challenges. Contrary to common beliefs about them, many boys and men are interested in talking about such issues.
- Engage boys from the earliest ages and use a lifecycle approach. The social reproduction of gender norms starts from the earliest ages when developing children construct their view of the world, their expectations, imitate the behaviour of men (if they are boys) and women (if they are girls), but can also and do transgress. The lifecycle approach refers to the idea of engaging individuals according to the changing needs and realities over the lifecycle, and a focus on key moments, opportunities, social institutions, socializing forces that can and should be drawn into questioning masculinities and gender privilege.
- Fatherhood, paternity leave, educating boys in how to care for others (informally and formally) is perhaps the "low lying fruit" in terms of engaging men in HIV prevention it may be the easiest place to start. Many men and boys can see immediate benefits and satisfaction to themselves by caring for others, including those living with HIV.

Suggested policy recommendations

- Invest in scaling up, sustainability and replication of successful programme interventions through a conducive environment
- Reduce the imbalance in power between women and men by ensuring policies that empower women such as decrease the gender gap in education, improve women's access to economic resources, increase women's political participation, and protect women from violence.
- Establish coalitions between the HIV/
 AIDS community and the international
 women's community to work together
 and hold governments accountable
 for the development, ratification and
 implementation of international relevant
 agreements.



CHAPTER O 4

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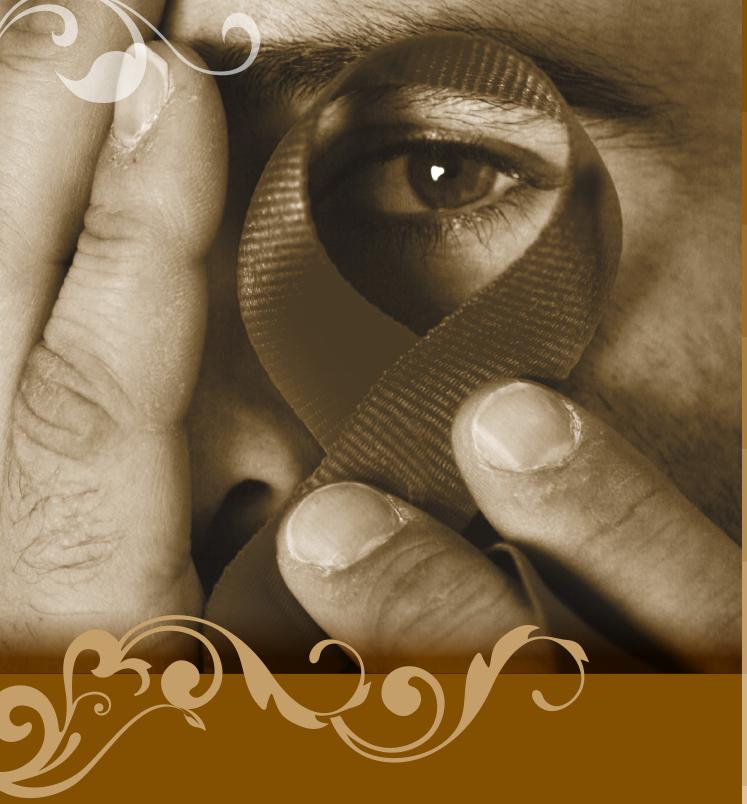




4.7 HIV and Women's Property Rights

4.8 HIV and Economic Empowerment

4.9 HIV and Women in Highly Vulnerable Populations



4.1 | HIV AND PREVENTION



4.1 HIV AND PREVENTION

"Only an exceptional response will suffice - a response that hinges on significant changes being made in the way poor and marginalised people are treated, in the relationship between rich and poor countries, in the way governments work." (Peter Piot, remarks at the London School of Economics, February 15, 2005)

INTRODUCTION

Women account for an increasing number of all HIV infections in the Asia-Pacific region. In 2007, women accounted for 24 percent of all HIV positive individuals in Asia, an increase from 19 percent in 2000. As indicated in the 2006 UNAIDS annual update, some promising developments have been made in the fight against the global HIV epidemic, including scaling up the availability of anti-retroviral treatment in some of the world's poorest countries, yet little progress has been made overall in reducing the spread of HIV in Africa or Asia (UNAIDS, 2006). UNAIDS estimates that only 10 percent or fewer of injecting drug users and other vulnerable populations are benefiting from current prevention interventions in Asia. (Global HIV Prevention Working Group, 2003).

Significant structural and socio-economic factors across the region increase women's vulnerability to HIV infections. These factors include:

- High poverty levels, with more than 35 percent of the population living below the poverty line;
- Low levels of literacy;
- Porous borders that facilitate migration and contribute to human trafficking;
- High degrees of stigma regarding sex, sexuality and HIV;
- Commercial sex and unprotected sex with multiple concurrent partners;

- Male resistance to condom use;
- High prevalence of sexually transmitted infections and low status of women, leading to an inability to negotiate safe sex (World Bank, 2007).

While the Asia-Pacific region is experiencing various levels of an AIDS epidemic certain patterns of HIV transmission are emerging. For example, HIV infection rates among women across the region are rising and being married is emerging as a key risk factor in many countries (United Nations, 2004). As of early 2003, the most common form of HIV transmission in Indonesia has been from HIV-infected persons (regardless of how they acquired their infection) to their spouses or regular sex partners, and this is likely to continue as the predominant pattern of HIV transmission there (World Health Organization, 2003). India, which bears a staggering HIV burden with an estimated 2.5 million people living with the virus, shows a similar pattern: a large proportion of women with HIV in India appear to have acquired the virus from regular partners who were infected during paid sex. In Nepal, the HIV infection rate among housewives between 2005 and 2006 had risen by 100 percent according to Nepal's National Centre for AIDS and STDs. In other countries in the region such as Bangladesh, Pakistan, Viet Nam, Laos, Cambodia, and Sri Lanka, prevalence is low among the general population but significantly higher among those who engage in high-risk behaviours such as injecting drug use and sex work.

As HIV prevalence rises among women of reproductive age in Asia-Pacific, an increasing number of their infants are contracting HIV through parent-to-child transmission. Indeed, the increasing number of children infected with HIV in Asia and the Pacific is alarming: at the end of 2005, there were an estimated 16,000 children living with HIV in Thailand (UNAIDS, WHO, UNICEF, 2006). According to UNICEF, 30,000 babies are born HIV-positive each year in India (UNICEF, 2003). Yet the availability of financial resources, human resources, and health system infrastructure available to promote prevention of parent-to-child transmission (PPTCT) varies greatly across the region (Preble & Piwoz, 2002).



More and more women in the Asia-Pacific region are infected with and affected by HIV. The epidemiological patterns showing the vulnerability of women in long-term unions and their children suggest that gender roles and gender dynamics play a key role in the epidemic. Dominant gender norms that privilege men's pleasure, regard sexual violence as normal, and encourage multiple concurrent sexual partnerships as a key expression of masculinity, leave both women and men vulnerable. Thus, any measure to contain the spread of HIV and deal with its effects for both women and men must be based on a critical understanding of gender dynamics, and be prepared to tackle these dynamics head on. Gender-related vulnerabilities must be understood in the broader context of deeply embedded social norms that lie at the heart of women's inability to deal effectively with the risks and needs created by the epidemic.

The role of effective prevention policies cannot be over emphasised. Prevention of HIV infection is far more cost effective for countries than providing treatment and other services to HIV positive individuals and their families. Investing 1 USD in prevention can save up to 8 USD on treatment (Commission on AIDS in Asia, 2008). The Report also emphasises that prevention interventions should target particular high risk groups (commercial sex workers, men having sex with men, and injecting drug users) to maximise the impact of the interventions on preventing further transmission of HIV.

OVERVIEW OF THE ISSUE

Research in the early 1990s by the International Center for Research on Women and others showed clearly that gender inequality is a central factor in increasing women's vulnerability to HIV: it greatly affects the way women can protect themselves from infection, cope with illness once infected, or care for those who are infected (Weiss & Gupta, 1998). In most societies, gender norms make men responsible for productive activities outside the home while women are expected to be responsible for reproductive and productive activities within the home. Over 25 years of research on women's roles in development also demonstrates that women have less access to and control over productive resources than men, as evidenced through persistent gender gaps in education, employment, income, ownership of land and

housing, and access to credit (UN Millennium Project, 2005).

Predictably, the inequality that characterizes the social and economic spheres of society is often mirrored in sexual interactions, creating an unequal balance of power in sexual relations. As a result, many women have less control than men over whether, when, where, why, with whom and how sex takes place. This inequality in sexual decision-making is perpetuated by gendered norms of femininity and masculinity that curtail women's sexual autonomy and expand men's sexual privilege, place greater emphasis on male pleasure over female pleasure, and cast women in the role of passive recipient rather than active agent. The complex interplay of social and economic gender differences and inequalities, combined with the unequal balance of power in sexual relations that favours men, significantly increases both women's and men's vulnerability to HIV.

For adolescent girls, age compounds this inequality and the impact of gender norms. In most societies young people have less power to shape their destinies than their older counterparts. Girls are at the bottom of the power totem pole, just when they are experiencing key life transitions such as marriage, initiation into sexual activity (often with older men) and motherhood.

Four key gender-related structural factors contribute to women's and girls' vulnerability to HIV infection.

Prevailing norms of femininity and masculinity

In many societies in this region, the ideal of feminine identity and sexuality is to be ignorant about sex, passive in sexual interactions, and to be either virgins or mothers - making it difficult for women to be informed about risk reduction or to proactively negotiate safer sex (Carovano, 1992), and placing them at increased risk of sexual violence (Weiss & Gupta, 1998; Heise & Elias, 1995). Similarly, norms of masculinity that require men to be more knowledgeable

and experienced about sex put men, particularly young men, at risk of infection. These norms prevent them from seeking information or admitting a lack of knowledge about sex or protection, and pressure them into experimenting with sex in unsafe ways to prove their manhood (UNAIDS, 1999).

2. Gaps in Education and Access to Information

Gender gaps in education, which favour boys in most regions of the world and persist at both the primary and secondary school levels throughout the Asia-Pacific region, are of grave concern in general, and particularly in relation to HIV vulnerability. Recent analysis of survey data among 6,700 respondents in Karnataka in southern India showed that post-secondary education significantly correlated with lower HIV prevalence among girls and women (Becker, ML, et al. 2007). Access to comprehensive information on sex and HIV prevention is also critical, and girls are generally less likely to have access than boys. For example, analysis of data from 23 developing countries found that levels of knowledge about HIV are almost always higher among men than among women, with 75 percent of men on average having accurate knowledge of HIV transmission routes and prevention as compared to roughly 65 percent of women (Gwatkin & Deveshwar-Bahl, 2001).

3. Economic Vulnerability

Women's lack of access to and control over economic assets, such as land and housing, makes them particularly vulnerable in the AIDS epidemic and can fuel a vicious intergenerational cycle of disease and poverty. Without a guarantee of property and inheritance rights, a woman widowed by the AIDS-related death of her partner is at risk of losing her home, inheritance and possessions either because the law of her land does not give her the right to own or inherit land or housing, or because of "property grabbing" by relatives and community members. Thrust into these difficult economic situations, women and girls may be forced into unsafe sexual behaviours to

meet their own and their children's or siblings' basic needs. Control over land and housing can give women greater bargaining power within households, which may translate into greater leverage to negotiate HIV prevention behaviours. In addition, control over land and housing protects women against the risk of domestic violence, thereby indirectly reducing vulnerability to HIV (Panda, 2002).

4. Violence Against Women

Violence against women is pervasive (WHO, 2005) and contributes both directly and indirectly to women's vulnerability to HIV (Maman, 2000). Individuals who have been sexually abused are at immediate risk of HIV infection and are also more likely to engage in unprotected sex, have multiple partners and trade sex for money or drugs (Heise, Ellsberg, & Gottemoeller, 1999). A recent national survey in Bangladesh showed that among married men, those who reported physically abusing their wives were significantly more likely to have reported STI symptoms or diagnosis in the past year than men who did not report violence (Silverman et al., 2007). More importantly, data from around the world also show a significant association between the experience of partner violence and HIV infection. A recent study among women visiting a VCT (voluntary counselling and testing) centre in Bangalore, India found that among those women reporting violence, a majority (67 percent) also reported testing HIV-positive (Chandrasekaran, et al. 2007). These findings corroborate other studies from Africa. Data from a Tanzanian study suggest that for some women, the experience of partner violence could be a strong predictor of HIV. Maman and colleagues (2002) found that among women who sought services at a VCT centre, those who were HIV-positive were 2.6 times more likely to have experienced violence in an intimate relationship than those who were HIV negative.

GENDER-BASED RESPONSES TO HIV PREVENTION

"A gender-based response to HIV focuses on how different social expectations, roles, status and economic power of men and women affect and are affected by the epidemic. It analyses gender stereotypes and explores ways to reduce inequalities between women and men so that a supportive environment can be created, enabling both to undertake prevention and cope better with the epidemic" (UNAIDS, 2001)

There are three main models for HIV prevention: (1) behaviour change models, which include the controversial 'ABC' campaigns, as well as programmes that encourage safer injecting practices and replacement therapy among drug users; (2) structural models, which include mandating condom use in brothels, harm reduction programming including needle exchange, primary and secondary education for girls, and programmes addressing genderbased violence, gender norms and the economic empowerment of women; (3) medical or technical models, such as expanding HIV testing, adult male circumcision, HIV vaccines and the development of female-controlled methods such as vaginal microbicides. Evidence suggests that the most effective programmes employ a range of these models in strategic combination, based on the specific epidemiological, cultural and social context in question.

Behaviour **Behaviour** change models. change HIV prevention programmes can target individuals, families, communities, entire societies or, ideally, a combination of these levels. Programmes based on these models tend to be message based - providing information to key populations (or the general population, depending on the nature of the epidemic) to enable people to make healthier behaviour choices. Such programmes should seek to generate individual motivation to avoid risky behaviour, build skills to use prevention commodities appropriately and to negotiate for safer sex or injecting practices of intimate

partners. They may work at a community level to generate frank and open discussion about sexuality and drug use, and seek to influence gender norms. The social structure factors mentioned above can limit the effectiveness and reach, so they are most effective when used in combination with structural models (HIV Prevention Working Group, November 2007).

Structural models. In 2000, the journal AIDS dedicated an entire issue to structural factors, defined as "physical, social, cultural organizational, community, economic, legal or policy aspects of the environment that impede or facilitate persons' efforts to avoid HIV infection" (Sumartojo et al., 2000). The same volume suggested that structural factors may act "as barriers to or facilitators of an individual's HIV-prevention behaviours" and have a direct bearing on "an individual's ability to avoid exposure to HIV" (Sumartojo, 2000). Such models can remove barriers or constraints to protective action or, conversely, erect barriers to risk-taking. Examples of the former approach are condom distribution and needle and syringe exchange programmes; examples of the latter include policies requiring condom use in brothels and other sex establishments. A structural emphasis can also be found in what are sometimes described as "transformative approaches" to HIV prevention. Instituto Promundo in Brazil, for example, has worked to change gender norms and attitudes among socially marginal groups of boys (Horizons, 2004); and the 'Stepping Stones' project in sub-Saharan Africa has worked with groups of young people to elicit change in gender relations.

Medical or technical models. Given the AIDS epidemic's disproportionate impact on women, there is a critical need to develop prevention options that women can use with, or when necessary without, their partner's knowledge. Improving prevention options for women requires both broadening current prevention strategies and developing new technologies that enhance women's ability to protect themselves. As part of a comprehensive prevention package, microbicides and expanded access to improved female condoms would dramatically enhance women's ability to protect themselves from HIV (Global Coalition on Women and AIDS, 2005).

There have been recent trials and discourses on using male circumcision in the prevention of HIV, and WHO and UNAIDS recommend that circumcision be added to the current list of interventions to reduce the spread of HIV, particularly in the context of a generalized or generalizing epidemic (perhaps less relevant in those Asia/Pacific countries where the epidemics remain concentrated) (WHO/UNAIDS, 2007). Given the global health imperative of curbing the AIDS epidemic, it is especially vital to rapidly introduce new HIV prevention methods after they prove effective in trials, and avoid delays in making lifesaving health interventions available to those who need them in poor countries (Global HIV Prevention Working Group, 2006).

HIV testing plays a critical role in comprehensive HIV prevention programming by linking behavioural interventions (and other HIV prevention services) with HIV and AIDS care and treatment. HIV counselling and testing and referral programmes need to be integrated as part of a comprehensive strategy for HIV prevention (Asian and Pacific Islander American Health Forum, 2003). The expansion of HIV testing is increasingly heralded as an important innovation in HIV prevention, often linked to programmes offering provider-initiated testing, as opposed to client-initiated efforts (WHO/ UNAIDS, 2007). The gender effects of providerinitiated testing are not yet known, and need further investigation as such programmes roll out, but could include positive and negative effects. Potential positive effects would include more men being tested – and being tested before their wives or long-term partners. This could benefit women, who otherwise are often the first to be tested (often in the context of antenatal care) and consequently are often blamed for 'bringing' the infection into the home. However, there is a danger that if provider-initiated testing programmes do not include comprehensive, one-on-one counselling with these men, they could increase negative consequences for women, such as violence, abandonment and stigmatization.

A common theme among communities and nations that have recorded prevention successes is the necessity of a 'combination' approach; this means multiple interventions and modalities,

including interventions targeting those at high risk and broad campaigns for general awareness (Valdiserri et al., 2003).

CREATING AN ENABLING ENVIRONMENT

- Work towards changing gender norms and invest in gender transformative interventions that tackle gender inequality. These include HIV prevention education programmes using community-based, participatory processes that allow for critical analysis and reflection among community members in order to trigger transformations in gender roles and norms.
 - Systematic, wide-scale programming using proven techniques such as Stepping Stones or other participatory learning and action methodologies to engage communities in meaningful, resolutionoriented debate on the issues (Jewkes et al., 2007). Other examples include the DISHA project, which works directly with youth and communities to transform gender norms and empower young women and young men to live more productively and safely (International Center for Research on Women, 2004). Another example is the Inner Spaces Outer Faces Initiative (ISOFI) which worked with staff designing and implementing programmes at various levels, and uses reflective practices and participatory learning and action (Kambou et al., 2007). Community Capacity Enhancement (CCE) is another example of participatory action and learning methodologies with proven success in PNG and Cambodia.
 - Programmesworkingspecificallywithmen of various ages to shift expectations and norms around gender and the treatment of women. Two excellent examples are Program H, first developed in Brazil and now adapted for use in India (Pulerwitz et al., 2006); and Men as Partners, developed and tested in South Africa to combat the dual and synergistic epidemics of genderbased violence and HIV (White et al., 2003). These programmes have fostered constructive roles for men in sexual and reproductive health. The challenge now

- is to take the principles behind these successes and replicate them effectively on a large scale (see Section 4.10 for a fuller discussion of this issue).
- Prepare for the introduction of new prevention technologies such as microbicides and vaccines. Demand-side issues: consider marketing microbicides as health and hygiene products rather than putting the emphasis on disease prevention. Supply-side issues: anticipate and plan how to overcome upstream resistance to these products, relating to policy-maker and health provider concerns about efficacy, and also their potential resistance to the empowering impact on women these products could have.
- PEncourage the use of female initiated HIV prevention methods such as the use of the Female Condom. Encourage additional research into improving the products usability or bringing down its cost.
- Encourage and fund greater **data collection and analysis**. There is a need to synchronize data collection efforts among all agencies, improve and expand the scope of collecting data and conduct rigorous analysis to improve the understanding of the epidemic to promote formulations of evidence based policies and programmes.

SUGGESTED DIRECTIONS FOR POLICY AND PROGRAMMES

The Global HIV Prevention Working Group recommends a combination approach to prevention, using a range of evidence-based strategies. By employing all appropriate tools-from delayed sexual activity to condom promotion, from voluntary counselling and testing to programmes for injecting drug users-combination prevention can reduce new HIV infections and help stop the epidemic. Based on its analysis of the gap between current access to HIV prevention and the level of resources required to reverse the global epidemic, the Working Group has specifically recommended that:

- Funding: In 2007, the Working Group suggested that 56 percent of the funding needed to provide a comprehensive response to HIV be spent on prevention efforts. For 2008, estimates now indicate \$22 billion is needed to scale-up a global, comprehensive response to HIV. Although global spending has increased 12 percent since 2006, the Working Group predicts that only \$10 billion will be made available for HIV programs in developing countries (Global HIV Prevention Working Group, 2007).
- Scale-Up: Prevention scale-up must be a central priority, focusing on cost-effective, high-impact interventions, including behaviour change programmes, voluntary counselling and testing, STI control, condom promotion and prevention of parent-to-child transmission, among other proven strategies.
- Prevention and Treatment: Prevention and treatment programmes should be carefully integrated as they are brought to scale.
- Capacity Building: In addition to funding for prevention interventions, donors should provide extensive additional support to build long-term human capacity and infrastructure.
- Policy Reforms and Aid: Policy reforms and international aid should address the social and economic conditions-such as gender inequality, stigma, and poverty-that increase vulnerability to, and facilitate the rapid spread of, HIV.
- Prevention Research: Research into new prevention strategies and technologies should be significantly accelerated.

CLASSIFYING HIV INTERVENTIONS BY COST AND IMPACT

The Commission on AIDS in Asia (2008) classifies all interventions as (i) high-cost/ high-impact, (ii) low-cost/high-impact, (iii) low-cost/low-impact, and high-cost/ low-impact. The Commission further recommends prioritizing interventions that are proven to be highly effective. Examples of high impact prevention activities include interventions aimed at high-risk behaviour groups and policies/ programmes aimed at preventing mother-to-child transmission as well as limiting exposure to HIV risk for women in stable relationships. It is estimated that focussing on these groups can prevent over 80 percent of new HIV infections (Commission on AIDS in Asia, 2008).

Prevent parent to child transmission:

The integration of PPTCT into sexual, reproductive, maternal and child health and home-based care programmes is the best way to use existing services and providers, and reach the maximum number of people living with or affected by HIV. Comprehensive, quality facility services are the foundation of a successful PPTCT programme. However, they must be linked to community-based resources and initiatives for maximum coverage and impact-especially home-based care, faith-based programmes, traditional practitioners, PLWHA support groups and adolescent-friendly services and information (Israel & Kroeger, 2003). The United Nations recommends a three-pronged approach for effective PPTCT:

- Preventing infection in women of reproductive age;
- Preventing unwanted pregnancies in HIV-positive women; and
- Offering PPTCT prevention interventions to women who are both HIV-infected and pregnant.

- **Tailor HIV prevention messaging and programming** to meet actual needs and match actual behaviour with a focus on 'healthy sexuality' rather than disease prevention, including:
 - Peer education on safer sexuality, geared toward frank, open, honest and fun
- discussion around sex and how to make it safer; and
- Peer groups including heterosexual women, heterosexual men, as well as groups of self-identified homosexual men and women, and other sexual minorities.

PROMISING PRACTICES

WORKING WITH MEN FOR HIV PREVENTION AND CARE: UNAIDS BEST PRACTICE COLLECTION

- **Project Papai**, worked with young men in Brazil to promote participation in health, education and child-rearing.
- Adolescent reproductive health and development programme in Zimbabwe, to promote sexual reproductive health and increase youth friendly services.
- Filipino men and domestic violence project to improve understanding of male violence and to reduce its rates.
- Men, sex and AIDS project in Botswana, to encourage discussion among men of issues relevant to sexual reproductive health.
- Healthy highways project in India, worked with truck drivers, their crews and paid sexual partners
- Mathare youth sports association AIDS awareness programme in Kenya increased AIDS awareness among slum dwelling men and women.
- ILPES in Costa Rica worked with prisoners and prison officers on HIV and human rights.
- Amigos Siempre Amigos worked with MSM with a range of activities.
- Faith, hope and love in Ukraine worked with IDUs.
- AIDS support organization worked on quality of life for HIV-positive people.
- Royal Thai Army initiative was a study of prevalence and incidence of HIV-1 among eligible Thai
 men

UNAIDS. 2001. Working with men for HIV prevention and care: UNAIDS Best Practice Collection, UNAIDS. Geneva, September. 2001.

INNER SPACES OUTER FACES INITIATIVE (ISOFI) - GENDER NORMS AND TRANSFORMATIONS

ISOFI was designed to find more effective ways to address inequities in ongoing programmes, beginning with a pilot phase in India and Viet Nam. Project staff worked at several levels. First, staff examined their own personal beliefs and attitudes about gender and sexuality. Many times, programme staff's personal beliefs (Inner Spaces) were not in line with their professional duties (Outer Faces). The second phase, currently underway, is research testing the hypothesis that systematic integration on gender and sexuality improves sexual and reproductive health outcomes.

http://www.icrw.org/html/projects/projects_hivaids.htm#ISOFI

STEPPING STONES PROGRAM - GENDER NORMS AND TRANSFORMATIONS

Stepping Stones is a life skills, communication and relationships training package designed in 1995 for use with communities in sub-Saharan Africa. It has since been adapted to the needs of populations in a variety of settings throughout the world.

http://www.steppingstonefeedback.org

RESOURCES

Global HIV Prevention Working Group 2007
Report. Bringing HIV Prevention to Scale: An Urgent Global Priority. This report discusses the importance of greatly expanding coverage of evidence-based HIV prevention, provides examples of successful scale-up of prevention programmes and offers recommendations for action. http://www.globalhivprevention.org/pdfs/PWG-HIV_prevention_report_FINAL.pdf

Stepping Stones Manual, Adaptations and Information. This well known manual and related materials have been used across several contexts with the aim of creating community awareness and improving prevention outcomes. http://www.steppingstonesfeedback.org/

Engaging Men and Boys in Changing Genderbased Inequity in Health: Evidence from programme interventions. A recent report detailing evidence from programme interventions working with men and boys to change gender-based inequities in health. Written by G. Barker, C. Ricardo and N. Nascimento, published by the World Health Organization 2007. http://www.who.int/gender/documents/Engaging_men_boys.pdf

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Women and HIV in the Asia-Pacific Region - A Development Practitioner's Guide



4.2 | HIV AND WOMEN'S ISSUES IN TREATMENT



4.2 HIV AND WOMEN'S ISSUES IN TREATMENT

INTRODUCTION

The increasing availability of anti-retroviral drugs (ARVs) in many resource-poor settings provides a critical opportunity to prolong the lives of HIV-positive people, while also encouraging others to find out their HIV status. As HIV treatment programmes are strengthened, it is important to put them in the wider context of HIV/AIDS management that integrates the continuum of HIV prevention, testing and counselling, and care and treatment (including treatment of opportunistic and other common infections, care, and support). This will create a comprehensive package that responds to the needs of both HIV-positive and HIV-negative women and men. People using these programmes should also be assured of accurate information and training on positive living. Similarly, the integration of treatment with primary care, STI diagnosis and treatment, family planning and other reproductive health services forms part of a comprehensive package that in turn responds to the multiple needs of men and women and helps remove the stigma of stand-alone services. Where integration of services is not possible, referral systems can be made linking primary care (including antenatal, family planning and general outpatient clinics) to VCT and other relevant HIV/AIDS services.

OVERVIEW OF THE ISSUE

Indeed in this region, as elsewhere in the world, women and girls are increasingly at the centre of the epidemic. While the prevalence among men is still higher than among women in most populations in Asia-Pacific, this is beginning to change. The percent of HIV positive women has risen from 19 in 2000 to 24 in 2007 (Commission on AIDS in Asia, 2008). In China, HIV prevalence among women has grown from 25 percent in 2002 to 39 percent in 2004, and exceeds one percent among pregnant women (UNAIDS, 2006). In Thailand, around 70 percent of the

young people now living with HIV are girls and women between the ages of 15-24 (UNICEF, 2005). Since 2003, women account for 47 percent of the new infections in Fiji, according to the Ministry of Health. Recent figures from India indicate that 40 percent of people living with HIV in India are women (NACO, 2006).

The increasing number of women living with HIV underscores the critical need to ensure access to healthcare and HIV-specific treatment for women and girls, including counselling and testing, and anti-retroviral treatment (ART). WHO's 2001 announcement of its global "3 by 5" initiative (to provide ART to three million people living with HIV by 2005), marked the beginning of treatment scale-up in many countries. Thailand, which began a large-scale ART programme in 2000, is on its way to universal access to treatment. In April of 2004 the Government of India launched a free ART programme and phased scale-up has begun. In Indonesia and Myanmar, there is high political and administrative commitment to start ART programming, and treatment programmes are rolling out. Viet Nam, which is one of the 15 priority PEPFAR countries¹, currently has 10,500 people on ART, and an additional 700 women receiving treatment to prevent parent-to-child transmission of HIV (see http://www.pepfar.gov/ pepfar/press/81650.htm for PEPFAR's Viet Nam country profile).

Review of the gains and limitations of the 3 by 5 campaign led to the current 'Universal Access' initiative. In September 2005, the UN General Assembly member states committed to develop and implement national HIV/AIDS plans leading to universal access to treatment by 2010. The main objective of the Universal Access initiative is to formulate comprehensive, integrated plans for the scale-up of prevention, treatment, care and support.

Despite these initiatives, WHO estimates there is a huge gap between the need and availability of ART in the Asia-Pacific region. According to one report, nearly 900,000 people living with HIV in the Southeast Asia sub-region urgently need antiretroviral treatment but barely seven

PEPFAR stands for the President's Emergency Plan for AIDS Relief, the largest HIV/AIDS aid programme in the world. It was first described in the 2003 State of the Union Address in which President G.W. Bush asked Congress to "commit \$15 billion over the next five years, including nearly \$10 billion in new money, to turn the tide against AIDS..." The program, which strongly emphasizes treatment, has 15 focus countries, mostly in sub-Saharan Africa, but also including Guyana, Haiti and Viet Nam. See www.pepfar.gov for more information.

percent of them are receiving it. Four countries, namely India, Indonesia, Myanmar and Thailand, account for an overwhelming majority of the antiretroviral treatment gap (WHO, 2004).

Access to ART varies significantly across the region and between men and women. It is estimated that, on average, women make up less than 40 percent of those accessing ART in the region (UNAIDS, 2006). However, the number of new infections among women is steadily rising. As long as access to ART is not universal, diligence will be necessary to ensure that the number of women receiving ART corresponds to the percentage they represent in the population of people requiring that treatment. Gender inequalities underlie many of the factors that constrain women's access to treatment. These are highlighted below.

HIV testing is the gateway to treatment, and yet testing is fraught with complications and dangers for many women. In the Asia-Pacific region, women are most often tested in the context of antenatal care, and are often the first member of the family to obtain an HIV test result. In many countries antenatal HIV testing is considered part of routine medical care. Therefore, the test may take place without counselling or the consent of the woman involved. If the test result is positive, the woman may be blamed for bringing HIV into the family. This is the case even when the husband is known to be positive. This can result in rejection or violence towards women by their spouses or in-laws (Paxton & Welbourn, 2004). Fear of their partner's reaction was reported by women in Tanzania as the most common barrier to disclosure (Maman et al., 2001). A recent study on the links between women's property rights and HIV in South Asia (Swaminathan, Bhatla & Chakraborty, 2007) documented that disclosure of status often results in both violence in the marital home and the eviction of HIV-positive women.

Gender-related differences in health seeking behaviour between men and women can also affect treatment access. Such differences have been reported from a survey on the socioeconomic impact of HIV and AIDS in India (UNDP, NACO, NCAER, 2006). With regard to opportunistic infections, men reported more episodes of illness being treated than did women. Only 4.4 percent of the illness episodes in men were left untreated, while for women the rate was double, at 9.7 percent. The same study reported that the primary reason women did not seek treatment was financial constraints, followed by lack of family support for seeking treatment. Constraints on women's mobility also limit their ability to access even free treatment. Women may be required to obtain permission (and often accompaniment) from a husband, inlaw or parent in order to seek health care, a task especially difficult if women have not disclosed their HIV status (ICW, 2004).

Efforts to improve access and adherence to treatment will also require tackling prevailing gender norms that create the barriers to access, particularly the stigmatization of HIV-positive women. Research in India and Viet Nam has revealed that stigma and discrimination against HIV-positive people and those perceived to be infected are common in hospitals and act as a barrier to seeking and receiving critical treatment and care services (UNAIDS 2001; HORIZONS 2007). Particularly vulnerable to stigma are marginalised groups such as sex workers and injecting drug users. Research on the services available for HIV-positive drug users found that women reported that available services did not adequately support their specific needs. Many expressed feelings of being invisible and discriminated against, even within the community of people living with HIV. These women also articulated their concerns about disclosing their HIV status and drug use to existing or new partners, family and friends, their children, colleagues and employers (ICW, 2006).

Prevention of parent-to-child transmission (PPTCT) is, or should be, an important component of any HIV treatment programme. An unfortunate consequence of this is that women living with HIV have been reproached as 'vectors of HIV transmission' (De Bruyn 2002). They sometimes experience pressure from health care providers not to become pregnant, and those who do, may be coerced into having abortions, or may feel pressure to use PPTCT measures such as giving birth via a caesarean section and not breastfeeding their babies.

Yet in communities where breastfeeding is the norm, women may fear that if they avoid breastfeeding, others will assume that they are HIV-positive. This perception often prohibits women from adhering to PPTCT regimes.

Efforts to integrate general reproductive health care services with PPTCT efforts are increasingly seen as a way to improve access to treatment. Access to treatment involves not only access to ARVs, but also empowering women with knowledge about their rights, choices around contraception, condom negotiation and safe delivery practices- all of which are key goals of enhanced reproductive health. A recent WHO press release on the situation in the Asia-Pacific region, quoted a UNFPA HIV adviser as saying:

"Linking HIV prevention efforts with reproductive healthcare can strengthen and improve access to both. Millions of women who don't know their HIV status have an unmet need for effective contraception. Integrated services would enable them to protect themselves and also reduce HIV transmission to their children." http://www.wpro.who.int/media_centre/press_releases/pr_20061106.htm

Linking PPTCT to other parts of the public health system will not only help reduce stigma and improve access, but could also ensure mothers and their children receive a comprehensive package of services. The annual Asia-Pacific task force on PPTCT has recognized universal access cannot be achieved unless HIV prevention, treatment and care are integrated with other services in the health-care system. Achieving universal access will also require strengthening of the broader health care system, improving training for providers and providing them with the necessary commodities and equipment. Ensuring that men play a more positive role in women's efforts to access needed services will also be key (Askew & Marge, 2003). Other factors also create significant barriers to effective access. For example, food security is an important aspect of treatment because many anti-retroviral (ARV) medications must be taken with food and because good nutrition is critical for maintaining overall good health. Poor health associated with opportunistic infections and other health problems related to having HIV force many women to abandon or decrease income generation activities. Transportation to and from health care visits often presents a difficult hurdle for women in need of treatment. These economic constraints create formidable barriers to adherence to treatment regimens among women.



In a cultural context where it is often unacceptable for women to address a man directly, as is common across the Asia-Pacific region, particular consideration of these issues in providing treatment services in a manner that meets the needs of women is critical. Women often are not asked for their consent before HIV testing and sometimes do not even know they are being tested for HIV or are not given their test results. A study in India on HIVrelated discrimination, found that many women experienced discrimination in health care settings. Over half of the women interviewed said they did not receive counselling before testing for HIV, and those who were coerced into testing were more likely to be denied care (Paxton et al., 2005).

MOVING TOWARD GENDER-EQUITABLE TREATMENT

PPTCT programmes and integrating HIV/AIDS services with other public health services, including reproductive and sexual healthcare, are two important components of an effective gender-responsive treatment programme. Such programmes must also address the gender-

related barriers and stigma that continue to stand in the way of women's access to testing and treatment.

Governments, health facilities, NGOs and faithbased or ganizations now have access to a numberof successful strategies^{2,3} and tools⁴ to address stigma and, with the involvement of people living with HIV and AIDS (PLWHA), to take these efforts to scale. These strategies reduce stigma by addressing the three drivers of stigma that are consistent across contexts and susceptible to immediate action: (1) lack of awareness and knowledge about stigma and discrimination and their harmful effects; (2) fear of HIV infection through casual contact with infected people because of lack of information and knowledge about the real means of transmission; and (3) the mindset that links HIV positive people with behaviours considered improper or immoral. Incorporating stigma reduction activities in HIVrelated programming is likely to enhance the effectiveness of prevention, care and treatment efforts.

STIGMA, DISCRIMINATION AND TREATMENT ACCESS

In Asia, stigma reduction interventions using these methodologies have been conducted in India⁵ and Viet Nam at both the institutional and community levels. The interventions have demonstrated that it is possible to improve attitudes towards people living with HIV and AIDS and decrease discriminatory behaviours.

In addition to addressing stigma, it is also important to provide counselling at all stages (including at the beginning of ARV treatment), to inform clients of their rights and obligations, and

to help support effective long-term adherence (Attawell & Mundy, 2003; CHANGE, 2004).

Sensitization and meaningful involvement of the community will also be critical in ensuring access and adherence to treatment. WHO and UNAIDS have highlighted the need for community preparedness for ART (Obermeyer, 2003), emphasizing that, unless approaches are informed by local conditions and an understanding of community culture, beliefs and behaviours related to illness, programmes could face unanticipated community responses. Myths, misperceptions and fears about ART generated within a community can spread quickly, resulting in low treatment uptake, adherence problems and/or people dropping out of treatment programmes. These myths and misperceptions may especially impact women, as has been shown in relation to uptake of PPTCT efforts in Botswana and Zambia (Rutenbery et al., 2002).

Communication about all aspects of HIV, including treatment options, is essential. Women and men must understand how HIV is transmitted and where they can go for testing and treatment. Information, communication and education must take into account gender differences in both message content and the strategies and media used to deliver those messages.

Women tend to have lower levels of literacy and education than men, and this can limit their access to health information and to comprehensive information about HIV prevention and treatment. Where illiteracy is high, particularly among women, written materials may be of limited use; and other means of communication, such as radio programmes, drama, puppet shows and storytelling, can help transmit information and knowledge more effectively. Age-sensitive

Ogden, J. and L. Nyblade, Common at Its Core: HIV-Related Stigma Across Contexts. 2005, International Center for Research on Women: Washington, DC.

³ DFID, Taking Action Against HIV Stigma and Discrimination: Guidance Document and Supporting Resources. Crown copyright 2007.

⁴ The *Understanding and Challenging HIV Stigma toolkit*, can be used to reduce stigma and discrimination with multiple audiences. *The PLHA-friendly Achievement Checklist* is available to help healthcare institutions reduce discrimination. The People Living with HIV Stigma Index – developed by and for people with HIV – is available to assess common forms of discrimination faced by people with HIV. For further information on the PLHIV Stigma Index, contact K. Thomson, UNAIDS Geneva, *thomsonk@unaids.org*.

⁵ Duvvury, Nata and Nandini Prasad. Information Bulletin: Reducing HIV/AIDS Stigma, Discrimination and Gender-based Violence among Health Care Providers in Andhra Pradesh, India. August 2006. Washington, DC: ICRW. http://www.icrw.org/docs/2006_ibreducingviolenceandstigma.pdf

communication that addresses specific concerns of young boys and girls may also be necessary to reach adolescents. Partnerships with local organisations such as women's groups, NGOs, AIDS Service Organisations (ASOs), youth groups and HIV-positive people can be very helpful in organising these activities. Another issue is that because they are faithful to one partner, many women do not consider themselves to be 'at risk' for HIV and so will not necessarily connect with messages. These factors can lead to delays in accessing testing, treatment, and also have implications for adherence to treatment regimens



CREATING AN ENABLING ENVIRONMENT

- Enact legislation that ensures universal access to counselling, testing, treatment and support regardless of how the person acquired or is thought to have acquired HIV. Governments also need to ensure that ARV drugs, both first and second-line, are available to those who need it. Special measures may need to be taken to reach marginalized and poor populations such as subsidizing transport costs, compensating loss of income or wages and other 'hidden costs' in accessing treatment centres.
- Support all efforts, policies and interventions that seek to address the root causes of gender inequality, including zero tolerance for violence, reducing stigma and discrimination, information and access to legal rights including property and inheritance rights, and right to healthcare for all.

- Engage in vigorous, widespread and ongoing stigma reduction to ensure that a positive test result and/or being on treatment does not result in other negative outcomes for women or their families.
- Revise the nursing and medical school curricula to go beyond health issues and facilitate understanding of the wider context of HIV-positive women's lives including issues around stigma and discrimination. The need to respect the human rights of HIV-positive women should be a core component of the curricula. Health staff who have already qualified should receive this information as part of their ongoing job training.

SUGGESTED DIRECTIONS PROGRAMMES

- Consult HIV-positive women and girls about appropriate locations for service provision, and set up decentralized, mobile health care facilities based on their suggestions. Promote access for women and girls through the integration of HIV counselling, testing and treatment services with other sexual and reproductive health services. Involve HIV positive women in design, implementation and monitoring of such services.
- Undertake an assessment to ascertain the particular treatment and care barriers faced by women and socially marginalized groups of women living with HIV, including: lesbians, bisexual women and transgender people; sex workers; injecting drug users; female prisoners; women with disabilities; indigenous peoples; undocumented immigrants, refugees and internally displaced people; and women in conflict situations and support these groups to mobilize regular and reliable access to ARVs, adequate training of health care workers who work with HIVpositive women, improved reproductive health services, and the need to include HIVpositive women in the development of HIV prevention, care and treatment programmes.
- Develop programmes that reach out to women for counselling, testing and

treatment. For example, offer HIV-testing and counselling in a range of settings aside from antenatal clinics such as workplaces, universities and prisons.

- Train and employ HIV-positive women and girls, and positive women's organizations, to promote and distribute ART, and to become pre and post-test counsellors.
- Link up testing and treatment facilities with existing support groups or encourage new groups to form so that people who test positive can join a group and get support immedeatly.

? Counselling and Testing:

- Provide training in pre-and post-test counselling to health personnel in all locations where HIV testing takes place (including prisons).
- Ensure that women and girls have opportunities for counselling and testing conducive to the exercise of their right to informed consent by reaching out to women and girls in communities and health care settings outside of the labour and delivery ward.
- Create the opportunities and vigorously promote couples counselling and testing.

Ensure that HIV testing is based on the provision of non-judgmental information and support so that women can make informed and voluntary decisions about whether or not to be tested.

PROMISING PRACTICES

The importance of involving the community in ensuring access to treatment and moving towards a supportive environment has been tried in certain programmatic efforts. UNDP has rolled out a large-scale effort in Cambodia. This effort works with 44 communes to mainstream HIV in partnership with the provincial rural development committee, improve delivery of services to those with HIV and sexually transmitted infections (STI), develop outreach health and HIV services, and train communities and groups to provide services. As part of Cambodia's Leadership for Results programme, groups tried several approaches to support treatment efforts. One group set up support visits to a village of 60 people, which is made up only of people living with HIV (UNDP 2004). Another group organized an inter-regional ARV referral system for provinces where these drugs are not available, and set up a housing system for people who travel to Siem Reap for treatment. This programme treated over 150 people at its inception. The box below gives details of a programme in which communities reached out to people living with HIV, reducing stigma, increasing acceptance and enabling treatment.



COMMUNITIES REACHING OUT TO PLWHA: EXPERIENCES FROM CAMBODIA

In Cambodia, where people are still recovering from the trauma of the Khmer Rouge regime, community conversations enhancement (CCE) have brought villagers together to provide emotional support for each other in the face of another crisis: HIV/AIDS. For people who are still learning to trust each other again, who formerly regarded HIV/AIDS as a shameful, taboo subject, and who were not accustomed to speaking openly about sex and gender, CCE has produced an enormous shift in attitudes. It has been implemented in seven provinces so far, and plans are underway to bring the methodology to twice as many communities and to incorporate it into the national strategy on HIV/AIDS. Reacting on Cambodia's greatest successes, Daouda Diouf, who helped implement CCE there, spoke of a new link between communities and health care providers. People in villages where community conversations have taken place are now asking themselves, "What can we do to help people who are undergoing treatment for HIV and AIDS?" With the help of health care workers who have participated in the conversations, these communities have set up support systems for villagers returning from hospitals to help them remain vigilant in taking their ARV medications. According to Diouf, this is an important achievement, because many people who formerly shunned PLWHA now actively support them. Support for PLWHA has taken many forms. In Battambang, a monk's temple is being used as a centre for care and support. In addition to food and counselling, monks offer spiritual support, an important element in this deeply religious country. Furthermore, in every community Diouf encountered villagers contributed money after the sessions to support PLWHA and their families or to pay for testing. Finally, and perhaps most important, in places where revealing one's positive status formerly meant encountering stigma and discrimination, community members now reach out to HIV-positive people–literally. "People were hugging them," said Diouf, referring to a meeting at which several HIV-positive individuals came forward to tell their stories. Communities are also ensuring that future generations and neighbouring villages can learn from their successes. They have developed their own methods of documenting the community conversations process, including written stories, songs and maps of the changes they have undergone. By tracking this evolution, they preserve a record for themselves and provide important lessons for other communities. This documentation also provides a basis for scaling up the process to other communities and regions. Cambodians participating in CCE have also gained insight into what they can accomplish: they plan to reach twice as many communities next year, using the same amount of money they previously allocated for the initial programme. These stories of success have shown that, one community at a time, Cambodians are making a difference in raising the standard for care and taking a stand against stigma and discrimination.

For details see UNDP, Transformation Across Borders: Addressing HIV/AIDS in the Asia-Pacific Region, 2004

BRINGING TREATMENT HOME

Every morning and evening, a group of women and a few men, many of them HIV-positive, fan out over the villages of the central region of Haiti to bring ART to more than 650 AIDS patients. These 'accompagnateurs' distribute twice-daily dosages of antiretroviral drugs and other medications, some food and a shoulder to lean on. For many patients, it is their first experience of sustained health care. Although renewed conflict and natural disasters in Haiti may make it more difficult to reach patients, the *accompagnateurs* continue to make their rounds as part of the HIV Equity Initiative (HEI), a joint programme between Haitian and US NGOs. Based on the DOTS (directly observed therapy, short-course) method, first developed for tuberculosis patients, the accompagnateur system brings health care to the patient rather than the other way around. Fuelled as much by hope as by money, the Initiative provides treatment for opportunistic diseases to the overwhelming majority of its 6,500 HIV patients and ART to the 10 percent with AIDS. Lacking money for more sophisticated testing, the Initiative's protocol for providing ART is also based primarily on direct observation: patients with visible conditions such as wasting or severe diarrhoea receive therapy.

The accompagnateurs factor women's caring responsibilities into their treatment in various ways, including by providing money to help pay school fees when possible. They also try to be aware of the circumstances under which the women became infected. "We realize that gender inequality is at the root of a lot of infectious diseases, including HIV/AIDS, because of the limited ways women can protect themselves," said Dr. Joia Mukherjee of Partners in Health, the US NGO that, along with the Haitian organization Zanmi Lasante, runs HEI. "Many women we see were domestic servants when they were young girls and were abused by their employers. Others had to do sex work for food or security," said Dr. Mukherjee. Many of them came home to their villages to die, she added, but thanks to HEI, they are still alive.

From: Women and HIV/AIDS: Confronting the Crisis, a joint report by UNAIDS, UNFPA and UNIFEM, 2004.

RESOURCES

TREAT Asia (Therapeutics Research, Education, and AIDS Training in Asia) is a network of clinics, hospitals and research institutions working with civil society to ensure the safe and effective delivery of HIV/AIDS treatments throughout Asia and the Pacific. Facilitated by amfAR, TREAT Asia seeks to strengthen HIV/AIDS care, treatment and management skills among health care professionals through education and training programmes developed by experts in the region. TREAT Asia: http://www.amfar.org/cgi-bin/iowa/asia/about/index.html

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Stigma Resources:

a. EngenderHealth has produced a toolkit entitled Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. This two-volume curriculum offers a unique

training opportunity for health workers in countries hardest hit by the AIDS pandemic. The training course guides health workers through an investigation of the root causes of stigma and discrimination while helping them to understand their own attitudes about HIV and individuals affected by these conditions and how these attitudes might affect the care they offer. The training also provides a review of clients' rights in receiving health care services, information about the use of standard precautions and proper infection prevention techniques to help minimize the risk of occupational exposure to HIV, and guidance in developing action plans to help the participants put what they have learned into practice at their service settings. The curriculum consists of a participant's handbook and a trainer's manual. http://www.engenderhealth.org/ res/offc/hiv/stigma/index.html#stigma

This toolkit has been used and adapted in a number of contexts in Asia, including India (see http://www.popcouncil.org/pdfs/horizons/inplhafriendly.pdf) and Viet Nam (see http://www.popcouncil.org/horizons/projects/Vietnam_HospitalStigma.htm)

b. The International Center for Research on Women, the International AIDS Alliance, the Academy for Educational Development and their partners have developed a toolkit for addressing HIV-related stigma in the community. Understanding and Challenging HIV Stigma⁶ is the most comprehensive toolkit presently available to address stigma among different audiences. It takes a participatory approach, providing a wide range of interactive exercises to help people understand stigma (what it means, why it is an important issue, its root causes) and develop strategies to challenge stigma. The toolkit has a flexible menu of modules and can be used to engage a range of audiences, including health workers, business leaders, educators, policy-makers, religious leaders, and the media. People living with HIV can be both audience members and implementers of the toolkit. Knowing stigma from the "inside," this group can play an important role as stigma trainers. At the same time they need help to cope with stigma and self-stigma; one of the chapters in the toolkit addresses that need with exercises to strengthen their understanding of stigma and empower them to challenge stigma. The toolkit has been translated into a number of languages including Amharic, French, Portuguese, and Swahili, and adapted versions of the toolkit have been translated into Telugu and Vietnamese. Given its wide applicability and field-based content, the toolkit provides a cost-effective way for addressing stigma.

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⁶ Available at: http://www.icrw.org/html/issues/hivaids.htm

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4.3 HIV and Care-giving 4.4 HIV and Education 4.5 HIV and Violence

4.8 HIV and Economic Empowerment



4.3 | HIV AND CARE-GIVING



4.3 HIV AND CARE-GIVING

INTRODUCTION

This section focuses on women as providers of care to people sick and/or dying due to AIDS, including their spouses, children and other family members. The societal expectation is that women will provide this care regardless of the personal costs. This assumption is also built into many health systems and care programmes. There is an urgent need to better understand the needs of informal women caregivers in order to ensure that they are supported and linked into comprehensive care and treatment programming, and given the material and emotional supports and resources they need. Approaches that combine these strategies with efforts to redress imbalances in gender norms, foster the participation of men and boys in care giving, and seek to empower women economically will have the greatest and most sustained impact.

OVERVIEW OF THE ISSUE

The challenges for women and girls in the HIV epidemic do not stop at the risk of infection. Equally profound and intractable are the myriad impacts the epidemic has on women whose partners, family members and/or children are sick, dying or deceased as a result of AIDS and related opportunistic infections. When HIV enters the household, women and girls provide the care. Globally, up to 90 percent of care related to illness is provided in the home by women and girls. This is in addition to the many tasks they already perform, such as taking care of children and the elderly, cooking, cleaning and, in subsistence areas, fetching water and firewood (Global Coalition on Women and AIDS, 2004). The statistics speak for themselves. The UN Secretary-General's Task Force on Women and AIDS in Southern Africa, for example, found that two-thirds of caregivers in the households surveyed were female, and almost a quarter of them were over 60 years old (UNAIDS, 2004). In Vietnam, women and girls make up 75 percent of caregivers for people living with HIV (Ogden, Esim & Grown, 2006). Traditionally, women in Papua New Guinea, as in most other societies, provide most of the care for children, the infirm and the sick. They are also recognized as the main caregivers, within families, for people with HIV (Luker, 2004). In Thailand, elderly mothers serve as the primary caregivers for a large proportion of people living with HIV. (Wassana, 2004).

These women, many of whom will themselves live with HIV and AIDS, frequently face at least three types of stigma: the stigma of being female, the stigma of being a widow, and the stigma of living with or being closely-associated with HIV. They also bear their burden of care with an everdwindling base of economic and social resources. A UNAIDS study of Bangalore and Mumbai, two Indian cities with high HIV prevalence, found that issues such as inheritance, housing and care-giving were particularly fraught with problems for women with HIV. In addition, as the epidemic spreads, female responsibility for caregiving reduces girls' and women's participation in productive and economic activities (including education). This in turn further constrains women's social and economic opportunities, thrusting these women into a cycle of poverty, disempowerment and vulnerability to infection (World Bank, Gender and Development Group, 2004; Ogden, Esim & Grown, 2006).

An analysis of the intersection of gender roles, and care and support activities is important because it sheds light on the debilitating and disproportionate burden borne by women. It is also important because it draws attention to the ways in which contemporary gender roles in the context of the epidemic compromise women's ability to care for themselves and, in many instances, their children. The 2004 joint report by UNAIDS, UNFPA and UNIFEM, 'Women and HIV/AIDS: Confronting the Crisis, articulates that in addition to the many tasks women already perform in the home, women are also deeply involved in work at the community level, often as volunteers. This has been dubbed the 'care economy' (Elson 2002) because of the role it plays in underpinning and enabling other family members to participate productively in the market economy. Despite its critical contribution to the overall national economy and society in general, however, the value of the time, energy and resources required to perform this unpaid work is rarely recognized by governments or communities.

The devastating effect of HIV on women's work is even less recognized. Poverty reduction strategies and national AIDS plans seldom take women's caregiving into account; it remains unpaid and therefore undervalued in economic terms. Even as prevalence rates come down in countries such as Thailand or Uganda, the impact of HIV will continue for years afterwards in terms of the large number of orphans, wages lost to caregiving and death, and resources spent on health care. The social services that will ease some of this burden are a critical complement to HIV/AIDS treatment.

CREATING AN ENABLING ENVIRONMENT

- Support family care providers and ensure that women and girls do not lose opportunities for education, social life and employment due to the cultural imperative that they alone should provide care for family members sick and dying due to AIDS. Policies can support creative public-private partnerships and linkages (formal or informal) with community-based organizations and/or networks of HIV-positive people. In addition, programmes have been developed to encourage men to engage more actively in the care of family members living with HIV (e.g. Esu-Williams, 2004).
 - Nurture emergence and support continuation of community home-based care programmes. Draw on best practices from the region (notably Cambodia and Thailand) and Africa, where successful partnerships have been forged between the public healthcare services and community-based or faith-based organizations to provide a continuum of care to clients and their families.
 - Ensure linkages between testing, treatment and home-based care.
 - Ensure home-based care programmes are working with and supporting family caregivers, linking them to available information, prevention education and equipment.

- Ensure that home-based care is providing the support necessary so that educational opportunities for children – especially girl children – are not lost.
- Foster the participation of men and boys in home-based care, within the family and the community.
- Promote and protect the property and inheritance rights of women affected by HIV and AIDS. Property and asset ownership and control have an empowering effect on women living with and affected by HIV, enhancing their resiliency and ability to manage their lives effectively despite their desperate circumstances. Securing women's property rights can help positive people live with dignity and contain the spread of HIV.
- In countries where national social security schemes including employment guarantee schemes exist, ensure it reaches marginalized populations, including those infected and affected by HIV.
- Address gendernorms. Develop and provide age-specific HIV education programmes that teach boys (in home, school, and religious settings) about:
 - Positive and negative aspects of existing concepts of masculinity and femininity;
 - Gender and age-specific HIV risks and vulnerabilities; and
 - Support groups and clubs that provide context-specific messages and opportunities for networking and involvement in community prevention and care activities.

SUGGESTED DIRECTIONS FOR PROGRAMMES

Linkfemale caregivers to home-based care and treatment programmes. Most Asian countries continue to lag behind African settings in providing home-based care for people living with HIV. In-depth analysis of the burden of care borne by women in HIV-

- affected households indicates that these women require material, emotional and physical support to meet the obligation to care for a spouse, in-law or child living with HIV (Pradhan & Sundar, 2006).
- Integrate livelihood options, vocational training, and other income generating options in programmes catering to /HIV affected and infected women.
- Engage men and boys in caregiving. Lessons learned from an Expert Group Meeting on "The role of men and boys in achieving gender equality" in 2003 in Brazil include (UNDAW/UNAIDS/ILO/UNDP, 2003):

- Present men as potential partners capable of playing a positive role in the health and well-being of their partners, families and communities;
- Support men to recognize and address their own health needs as a first step;
- Create opportunities for men to learn the skills necessary to provide care and support to people living with HIV;
- Encourage men to play an active role in the prevention of parent to child transmission of HIV and use PPTCT services as an intervention point for men.

PROMISING PRACTICES

COMFORT AND HOPE - SIX CASE STUDIES ON MOBILIZING FAMILY AND COMMUNITY CARE FOR AND BY PEOPLE LIVING WITH HIV/AIDS, (UNAIDS, 1999).

- Project Hope, Brazil has created effective systems contributing to the organization's sustainability
 permitting the project to create and maintain a strong corps of volunteers and supporters in its community. It negotiated secure funding from outside sources and linkages with government and non-governmental institutions and groups working in the same field.
- The Diocese of Kitui HIV/AIDS Programme, Kenya exemplifies action that can be undertaken to improve the quality of life for infected/affected persons.
- The IKHLAS Community Centre Project, Pink Triangle, Malaysia highlights the community mobilization value of participation by persons living with HIV. The participation of infected persons from the IDU community is probably essential in order to reach this group, which is highly marginalized both socially and legally.
- Tateni Home Care Services, South Africa exemplifies the community mobilization value of synergy achieved through shared planning and day-to-day collaboration between CBOs, local institutions and government.
- The **Sanpatong Home-based Care Project, Thailand** emphasizes participation and involvement of families in caring for people living with HIV to the benefit of the individuals and the public health system.
- The **Chirumhanzu Home-based Care Project, Zimbabwe** demonstrates the community mobilization value of participation by infected and affected persons in their own care, and shows how this provides a guarantee of a project's ethical soundness.

UNAIDS. (1999). Comfort and Hope: Six case studies on mobilizing family and community care for and by people with HIV/AIDS. UNAIDS Best Practice Collection. Geneva: UNAIDS.

COMMUNITY-BASED, FAITH-BASED ORGANIZATIONS

The **India HIV/AIDS Alliance** supports NGOs that provide community-based care for people living with HIV and children affected by AIDS. The programme provides psychosocial support, health care, voluntary counselling and testing, economic and food support, and skills training. Home-based care programmes in Asia operated by community-based organization (CBOs) or faith-based organizations (FBOs) are relatively small in scale. Some of the more effective programmes are those that run through HIV support groups.

An example is the **Ashar Alo Society in Dhaka, Bangladesh**. Among it activities to support those living with HIV and their families are efforts to scale-up care and support programmes. **Cheyutha**, based in Andhra Pradesh, is a similar CBO in India. Among other services, this health and development organization offers clinical and psycho-social home-based care. The **Salvation Army in India** also has good coverage of home-based care for AIDS. In Andhra Pradesh, **Vasavya Mahila Mandali** has innovative programming to empower grandmothers raising their grandchildren orphaned by AIDS.

India HIV/AIDS Alliance. (2004). *Integration: A Sustainable Approach, Experience from a community based HIV/AIDS care and support programme.*

REACHING OUT, SCALING UP - EIGHT CASE STUDIES OF HOME AND COMMUNITY CARE FOR AND BY PEOPLE LIVING WITH HIV (UNAIDS, 2001).

- Cambodia's Home Care Programme, Phnom Penh exemplifies home care teams made up of government staff and NGOs, which created strong links with traditional and faith leaders. Referral systems linked the teams with health centres/hospitals. The programme was piloted in Phnom Penh and extended to other parts of the country.
- Centre for Socio-Medical Assistance (CASM), Abidjan, Côte d'Ivoire is an outpatient clinic for persons with HIV.
- **Programme for AIDS Initiatives, Ecuador** provides no direct services, but funds, trains, links and supports community HIV prevention and care programmes.
- Continuum of Care Project, Manipur, India developed a series of discussions and workshops with state government and the National AIDS body (NACO) and national and international NGOs. Among other innovations, it created multi-disciplinary 'core groups' within hospitals, NGOs and communities to improve quality of services.
- Kariobangi Community-based Home Care and Home-based AIDS Care Programme,
 Nairobi, Kenya operates in a large, extremely poor area. It grew out of a community health programme and delivers many of its services though volunteers supervised by trained staff.
- **Bambisanani, Eastern Cape, South Africa** is a health programme established by government, NGOs and the private sector. Along with care and prevention, income generation activities and community capacity building are emphasized.
- Mildmay Centre for Palliative HIV/AIDS Care, Uganda offers a range of specialist referral services and acts as a regional centre of excellence.
- Partnership for Home-based Care in Rural Areas, Uganda brings together different expertise of NGOs to improve AIDS home care.

UNAIDS. (2001). Reaching out, scaling up: Eight case studies of home and community care for and by people with HIV/AIDS with HIV/AIDS. UNAIDS Best Practice Collection. Geneva: UNAIDS.

VIETNAM WOMEN'S UNION

The Vietnam Women's Union (VWU) works with older women caregivers affected by AIDS. Through the establishment of "Empathy Clubs" – self-managed organizations that encourage and support older women caregivers in their communities – the VWU has profoundly improved the lives caregivers and their families.

In May 2002, a group of older people in Hanoi participated in a consultation on their role as caregivers and the impact of HIV/AIDS on their lives. They found the experience so useful that, with the help of the VWU, they have since then established an older people's club in Thai Nguyen. The change for these older people has been tremendous. The local leaders plan to start similar clubs in other villages.

Source: Older Women Leading the Way: Replicable model of community-based HIV/AIDS response by Older Women Carers, The Experience of the Vietnam Women's Union in Viet Nam. (2005).

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4.3 HIV and Care-giving 4.4 HIV and Education 4.5 HIV and Violence

4.8 HIV and Economic Empowerment

4.9 HIV and Women in Highly Vulnerable Populations



4.4 | HIV AND EDUCATION



4.4 HIV AND EDUCATION

OVERVIEW OF THE ISSUE

The association between education and HIV is a complex relationship that changes over time (Hargreaves, et al., 2008). In some countries, higher education had been associated with higher HIV prevalence, but over the last decade recent evidence has shown that increased education is related to decreased HIV prevalence (Herz and Sperling, 2004). A recent review of several large cohort studies among Thai army conscripts showed a significant, consistently negative association between HIV prevalence and higher levels of education between 1990 and 1995 (Hargreaves and Glynn, 2002).

Girls' schooling has been found to be associated with several factors linked to HIV reduction. In India, women receiving secondary education were less likely to experience violence and had greater ability to leave violent situations as compared to women who received only primary education (Jejeebhoy, 1998). Education has also been shown to be a significant factor in delaying marriage (Mathur, Greene and Malhotra, 2003). Girls are also thought to gain autonomy and important life skills useful in negotiation of decisions related to the timing of marriage through education (Lloyd and Mensch, 1999). School attendance can provide opportunities for boys and girls to access information about sexual and reproductive health including critical information on HIV transmission and prevention.

Across the Asia-Pacific region, education of girls lags behind that of boys. South Asia, despite a nearly 20 percent increase in girls' gross enrolment rates between 1990 and 2000 – from 79.5 percent to 96.6 percent (UNESCO, 2004) – is still experiencing a gender gap in enrolment in primary education. While this trend is positive, the picture is less hopeful for primary school *completion*, which is a better indicator of educational status. In 1990, primary school completion rates among South Asian boys was 94.9 percent as compared with 81.0 percent for girls (UNESCO, 2004).

The gender gap is much wider in secondary

education. In South Asia the secondary school gross enrolment rate for girls is only 50 percent. Globally, only 17 percent of girls are enrolled in secondary school and the gender parity ratios for gross enrolment rates are lower than 0.90 in all developing country regions except Latin America and the Caribbean. Completion rates, where available, are even lower. For the 19 middle-income countries for which this data is available, completion rates for girls at the secondary level are below 50 percent (UNESCO, 2004).

Secondary education appears to be especially protective. It is more consistently associated with increased decision-making and mobility for women than schooling at the primary level, and studies have found that only at secondary or higher levels of schooling does education have a significant beneficial effect on women's own health outcomes and risk of disease. Studies of HIV in sub-Saharan Africa and Latin America find that while primary education increases girls' and women's ability to discuss HIV with a partner, ask for condom use or negotiate sex with a spouse, secondary education has an even greater impact. Girls who attend secondary school are far more likely to understand the costs of risky behaviour and are better able to safely navigate difficult sexual situations (Hargreaves & Boler, 2006).

There are several factors determining girls' educational opportunities. Early marriage excludes girls from education. In South Asia, 30 percent or more of girls aged 15–19 are already married. In Bangladesh, the rate is very high (65 percent), in India moderately high (48 percent), and relatively low in Sri Lanka (14 percent) (Mathur et al., 2003). Other reasons girls are excluded from education in the region include the following:

- Many families do not understand the benefits of educating girls, whose role is often narrowly viewed as being prepared for marriage, motherhood and domestic responsibility;
- Girls in many countries are already disadvantaged in terms of social status, lack of time and resources, a high burden of domestic tasks and sometimes even lack of food; and

iii. Girls, rather than their brothers, tend to bear the burden of care for ill parents and younger siblings, jeopardizing their ability to attend school. (Global Coalition on Women and AIDS, http://womenandaids. unaids.org/issues_education.html)

Quality of education is also relevant. Limited access to comprehensive information on sex and HIV prevention further compounds women's risk. Because of the culture of silence that surrounds matters of sexuality, women and girls, particularly unmarried girls, are often uninformed about sexual matters. A study in southeast Nigeria, for example, found that the stigma attached to premarital sex limited the availability of and access to contraceptive information and services by single women (Ozumba, Obi, & Ijioma, 2005). Data from 23 developing countries found that levels of knowledge about HIV and AIDS are almost always higher among men than among women, with 75 percent of men on average having accurate knowledge of HIV transmission routes and prevention as compared to roughly 65 percent of women (Gwatkin & Deveshwar-Bahl, 2001).

Fears that providing comprehensive sex education to adolescents may lead to early sexual debut and increased sexual activity have often led to restrictions being imposed on the type and level of information on sex and HIV prevention that adolescents receive. Contrary to those fears, a review of 83 studies conducted in developed and developing countries showed that comprehensive sex education programmes that include information on abstinence, contraception, pregnancy and sexually transmitted infections (STI), including HIV, do not increase sexual activity. In fact, of the 52 studies that specifically looked at the timing of initiation of sex, all but one found that the programmes either delayed sexual initiation or had no impact (Kirby et al., 2005). Hence, there is little evidence to support the belief that sexuality and/or HIV education promote promiscuity (Grunseit et al., 1997).

In order to be an agent for sustained transformative change, educators also need to find ways to actively engage students in dialogue about unequal gender norms. While well-implemented, school-based HIV prevention programmes are a vital part of reducing HIV risk, these programmes can be greatly enhanced when they go beyond just providing information, and help young people develop the knowledge, attitudes and life skills needed to protect themselves against HIV. HIV education should include discussions of gender roles, rights and responsibilities to help boys and girls understand and address stereotypes, gender bias, power relations and discrimination. Skills-based HIV education uses participatory approaches to involve both children and young people in active learning experiences that can go well beyond HIV to include other health and personal development (http://www.unicef.org/lifeskills/ index_8657.html). In addition, students (especially girls) may benefit from livelihood skills education and training to help ensure access to wage-earning opportunities for young girls and women, thus reducing their economic dependence on others once they are out of school.

These recommendations require significant changes in school curricula and, by extension, in teacher training and capacity-building. Teachers must understand and be willing to discuss HIV and AIDS before they can properly teach about it. In traditional societies, teaching about the sexual dimension of HIV and AIDS presents special problems, and teachers may need to acquire specific skills to address this role effectively. (World Bank, 2006).

Investments in education often need to be accompanied by investments in conditions that will facilitate the role of education in maxmizing the benefits for girls and women. This requires improvement in provision of services and opportunities, and more fundamentally, shifts

in social and economic structures and gender norms.

Many of these factors can be readily addressed by policy shifts and programmatic action, given the necessary political will. To improve health outcomes, for example, policies and programmes to educate girls must be accompanied by efforts that improve services and create an enabling environment for women to use these services. In order to have an impact on HIV prevalence, it is clear that although improving education levels can help, other key risk factors in the population must also be addressed concurrently. Similarly, in the economic sphere, policy efforts at educating girls should go hand-in-hand with efforts that increase economic opportunities.

MOVING FORWARD WITH GIRLS' EDUCATION

There are four key lines of action in the education response to the challenge of HIV and its effects on girls (adapted from http://www.unicef.org/lifeskills/index_8657.html):

- Get girls into school and ensure a safe and effective environment that can keep them at school and learning.
- Ensure quality of content so that girls and boys receive comprehensive sexual education, comprehensive HIV prevention information and life skills training;
- Ensure schools are safe havens so that girls and young women do not face sexual predation and harassment while at school (UNICEF, 2004). Special security measures and behaviour protocols must be ensured to protect the rights of children and young people in education systems.
- Ensure special measures for those not in schools – including extending the definition of education well beyond that which is delivered in schools. and considering the needs of working children, street children, and those who are exploited or made vulnerable by poverty.



CREATING AN ENABLING ENVIRONMENT

P Enhance and Improve the Curriculum

- Build HIV prevention and reproductive health information into existing school health programmes;
- Develop and implement life skills curricula; and
- Use a life-long learning approach.

Part of Teachers Properties of Teachers

- Promote and facilitate the provision of comprehensive sex education (knowledge of sexual and reproductive health, including ways to prevent unwanted pregnancy, STI and HIV);
- Train teachers in the importance of challenging gender stereotypes and correcting misinformation about sex and gender; and
- Enable teachers to train girls in skills that can provide economic opportunities.

Promote Girls' Education

- Lobby national and local governments to create incentives and decrease barriers to educating girls;
- Encourage nutrition and health projects to offer sessions for mothers on the importance of girls' education at the same time they are providing their other services at community centres;
- Ensure that local government and community-based organizations monitor enrolment and school completion rates of girls; and
- Ensure that local administrations ensure that schools are safe and provide a conducive environment for girls to learn.

SUGGESTED DIRECTIONS FOR PROGRAMMES

Implement comprehensive sexual and reproductive health education for youth

- Provide comprehensive HIV and pregnancy prevention information, including information about safer sexual practices and condom use as well as the risks and benefits of other forms of birth control;
- Create space for peer-based gender norm debates and discussion geared toward challenging norms that disadvantage girls, condone violence against girls and women, and put boys at increased risk of HIV infection;
- Provide life skills training to support youth self-esteem, enhance negotiation skills, and build capacity for safer adulthood behaviour (e.g, the DISHA project in India (see ICRW 2004));
- Create income generation opportunities for girls – particularly in areas of extreme poverty, low education and few employment options.

Promote Girls' Education

- Facilitate community-based advocacy for promoting girls education;
- Work with parents and communities to instil importance of educating their girls and young women;

PROMISING PRACTICES

DISHA - LIFE SKILLS EDUCATION IN INDIA: The International Center for Research on Women (ICRW) is leading a large-scale, collaborative initiative known as DISHA (which means "direction" in Hindi) to improve the reproductive health and well-being of young people in the states of Bihar and Jharkhand, India. Launched in 2003, DISHA is being implemented over a four- to five-year period in partnership with six organizations in Bihar and Jharkhand. Each of the partners has an extensive presence in the local community, is committed to youth well-being and development, and brings a wide range of expertise and experience to the project, ranging from community mobilization to corporate linkages. Partners in Bihar are CENCORED, the Daudnagar Organization for Rural Development and the Integrated Development Foundation. In Jharkhand, partners are Alternative for India Development, the Badlao Foundation and the Tribal Culture Society (TCS). This work is supported by the David and Lucile Packard Foundation.

Assessments by ICRW and local and national stakeholders indicate that existing programmes for delivering reproductive health information and services are too narrow and inadequate to address youth reproductive health concerns in Bihar and Jharkhand. DISHA takes a more comprehensive, multi-sectoral and integrated approach that addresses not only the health, but also the socio-cultural and economic factors that have an impact on youth reproductive health. It seeks to build the capacity of youth-serving organizations to implement and evaluate high-quality programmes, while building leadership and widespread commitment to address the needs of youth.

DISHA is designing and implementing six new, innovative programmes that incorporate best practices and lessons learned on integrated youth programmes. Taken together, these programmes will reach over 200 communities and 7,000 to 9,000 youth. The programmes in each area also target community leaders, parents and service providers. Through both direct and indirect outreach, the DISHA project is likely to reach approximately 30,000 to 40,000 young people.

For more information on DISHA go to www.icrw.org

LIFE SKILLS EDUCATION IN NEPAL: As part of the national five-year education plan, a life skills based education programme for grades 1-10 is being developed and piloted in 10 districts. Three key preparatory activities have helped guide the development of the programme: (i) a survey of teenagers in Nepal that provides a basis for life skills development and HIV prevention programme development; (ii) an assessment of the impact of HIV on the education sector in Nepal; and (iii) a review of the grades 1-10 health and social studies textbooks and teacher training manuals for substance/drug abuse and HIV prevention education (World Bank, 2006).

SRI LANKA: A life skills based education programme was introduced into the school curriculum for grades 7-9 in 1997. The key focus areas are values, reproductive health, preventing HIV, preventing substance abuse, gender issues, and related topics of violence prevention and conflict resolution. More recent discussions have emphasized the need to also address HIV prevention within the context of overall school health and well-being, including improved nutrition. Stronger synergy between the work undertaken by the Health and Education sectors is being developed (World Bank, 2006).

INDIA: The Ministry of Human Resource Development and the National AIDS Control Organization (NACO), in collaboration with development partners, are scaling up programmes to educate adolescents about HIV and AIDS. The plans call for training teachers and peer educators in conducting courses and leading study groups on HIV awareness and prevention. The programmes aim to reach at least 33 million students in secondary schools over three years.

PAKISTAN: A project run by a UNICEF partner AMAL Human Development Network Pakistan is working with Pakistan's top pop group "Strings" to reach the most vulnerable and isolated children. The project uses music to provide children and young people who are out of school and often working or living on the street with access to life skills, non-formal education, basic health information and hygiene training.

LEADERSHIP AND CAPACITY-BUILDING IN CAMBODIA: After years of conflict and instability, Cambodia went through a period of massive reconstruction in the late 1980s. With dropping school enrolment and rising HIV rates, Cambodia adopted the sectoral mainstreaming approach to integrate HIV concerns into both policy and technical levels of development activities. This approach allowed HIV programming to shift from a strictly public health focus to a cross-cutting approach across all government sectors. Rather than doing this in a top-down manner, the approach sought to determine how HIV programming could improve each sector as a whole and contribute to the overall national goal of poverty reduction. This was useful in targeting specific groups for tailored HIV programming and for linking HIV to specific development activities and goals of the sector. This in turn allowed HIV programming to have a more fundamental effect on the education sector and resulted in HIV education to in-school and out-of-school youth, and in the workplace. HIV mainstreaming in the education sector is part of the national budget and all pre-service teachers are systematically trained in HIV. About 80,000 teachers who are in service are also trained on HIV. HIV is also part of the minimum standards for students' performance and national examination plans. For out-of-school children, peer-to-peer education is encouraged (Mainstreaming HIV in the Education Sector in Cambodia, Patrick Duong presented at the UNDP Global Mainstreaming Consultation, New Delhi, 4-7 November 2008)

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4.5 | HIV AND VIOLENCE AGAINST WOMEN



4.7 HIV and Women's Property Rights

4.8 HIV and Economic Empowerment

4.9 HIV and Women in Highly Vulnerable Populations



4.5 HIV AND VIOLENCE AGAINST WOMEN

INTRODUCTION

Violence against women is one of the most prevalent and pervasive risks faced by women across the world in their daily lives. It remains the most fundamental and extreme form of gender inequality and a poignant manifestation of the low status and specific disadvantage that women face. A WHO-sponsored study, including data from more than 24,000 women interviewed in 15 sites in 10 countries, found that from 15 to 71 percent of women reported having experienced physical and/or sexual violence by an intimate partner. Women living in more rural settings in Bangladesh, Ethiopia, Peru and Tanzania reported the highest levels of violence (WHO, 2005). In India, 40 percent of women report experiencing physical violence at the hands of their husbands, and half of those who had suffered severe physical abuse reported being beaten during pregnancy (ICRW, 2001). At a global level, the health burden from genderbased victimization among women age 15 to 44 is comparable to that posed by other risk factors and diseases already high on the world agenda, including HIV, tuberculosis, sepsis during childbirth, cancer and cardiovascular disease (World Bank, 1993).

OVERVIEW OF THE ISSUE

Violence needs to be recognized as not only as a human rights violation or health issue, but as also an issue that impacts the development process as a whole. Researchers argue that violence obstructs participation in development processes and contradicts the very goals of development (Burton, Duvvury & Varia, 2000). In addition, violence against women and HIV need to be viewed as twin pandemics that feed into and off of each other, with violence being both a cause and a consequence of HIV. Data from a study in Tanzania (Maman et al., 2000) suggests that for some women, the experience of violence or being the victim of a violent act is a strong predictor of future HIV infection. The fear of violence also acts as a barrier to women's ability to access HIV prevention tools and services,

including testing and counselling (Maman et al., 2001), and health providers are often at a loss concerning how to help victims of violence.

Violence against women directly contributes to HIV-related vulnerability in a number of ways. Firstly, actual or threatened violence limits women's ability to negotiate safe sexual behaviour in their intimate relationships. Research shows that violence and fear of abandonment act as significant barriers for women who have to negotiate use of condoms, discuss fidelity with their partners or leave relationships that they consider risky (Mane, Rao Gupta, & Weiss, 1994; Weiss & Rao Gupta, 1998; Dunkle et al., 2003). Condom use in intimate relationships is often viewed as an indicator that norms of sexuality and fidelity have been breached by one or both partners. So it is not surprising that even spouses of individuals at high risk for HIV (such as truckers) often report no condom use with their husbands (ICRW, 2005). Even women sex workers who report increased ability to negotiate condom use with their clients, report high levels of sexual violence with their regular intimate partners, including being beaten for requesting condom use and being forced to have sex without condoms (ICRW, 2005; Jenkins, 2000; guoted in 'Policy Document on Positive Sex Workers' Durbar Mahila Samanwaya Committee). Studies also suggest that intimate partner violence is associated with an increased risk that the abusive male partner is HIV-positive (Dunkle et al., 2003) or is himself at increased risk for infection (Martin & Curtis, 2004).

Secondly, sexual violence is related to HIV vulnerability both at the time of abuse and in predicting future high-risk behaviour. Individuals who have been sexually abused are more likely to engage in unprotected sex, have multiple partners, report non-use of condoms and involvement in transactional sex such as trading sex for money or drugs (Heise, Ellsberg, & Gottemoeller, 1999; Dunkle et al., 2003; several studies quoted in Ellsberg, 2005). A study in Cambodia concluded that more emphasis must be placed on the relationship between genderbased violence and HIV and AIDS within the context of marriage (Duvvury & Knoess, 2005). A small Bangladeshi study that examined vulnerability to HIV infection found that among



the 48 non-sex worker IDUs interviewed for the study, about 20 percent reported having been raped. In half of those cases the perpetrator was their husband (Azim et al., 2006). With increasing recognition of the spread of HIV among married women in the Asia-Pacific region, there is need to gather more data to better understand this association.

In addition to evidence on forced sex and sexual violence among married adult women, there is also growing evidence of the magnitude of this trend among young adults, male and female, married and unmarried. A survey conducted by UNFPA in the Caribbean reported that 21 percent of boys and 18 percent of girls were sexually abused before the age of sixteen (World Bank, 2000). A review of thirteen studies (mostly small sample sizes) found that between two and 20 percent of girls and fewer than 15 percent of boys, generally aged from 15-19, reported having experienced sexual coercion. When asked about forced first sexual experience, about 15 to 30 percent of sexually active girls and fewer than 10 percent of boys reported coercion (Jejeebhoy et al., 2003). Studies conducted in schools highlight that sexual coercion and abuse are part of the educational experience for many young people (UNICEF, 2006).

Conflict or violence experienced outside of the home compounds women's vulnerability to HIV. A Cambodian study found that among 1,000 female and transgendered sex workers, over 50 percent had experienced violence at the hands of law enforcement personnel (Jenkins et al., 2005). In addition to being a violation of basic human rights, many of these rapes occurred without the use of a condom, therefore involving some level of HIV transmission risk. In Cambodia, few rapes are reported by victims, often because victims fear that the perpetrator might retaliate (LICADHO, 2006). Violence is thought to be an important contributor to the HIV epidemic in Papua New Guinea, where violence and fear are part of everyday life for many of the poor, particularly in Port Moresby. According to a recent report (Tobias, 2007), sexual violence and rape – particularly of young women – is common, in part due to the extremely low social status of women, leading to an HIV incidence rate among young women aged 15-19 that is four times higher than the rate among boys in the same age group. The National AIDS Council in Papua New Guinea reports that "patterns of male sexual behaviour including a high incidence of rape, line-ups (gang rape), sexual assault and weak law enforcement" are important contributors to the epidemic (Human Rights Watch, 2005

cited in Tobias, 2007). Another study documents the extent of violence perpetrated by armed forces and other politically motivated agents in Bangladesh, Myanmar and Thailand (Priyakamon et al., 2004). A form of gang rape referred to as "bauk" has also been observed in Cambodia among young students raping sex workers for male bonding because they consider the sex workers "less than human" (Duvvury and Knoess, 2005)

Gender-based violence is also a consequence of HIV. Disclosure of status is often accompanied by violence perpetrated at the hands of the husband, family and community. The most common barrier to disclosure reported by women was related to fear of partner's reaction (WHO, 2004). A recent study on the links between women's property rights and HIV in South Asia (Swaminathan, Bhatla & Chakraborty, 2007) documented that violence in the marital home following disclosure of status often results in the positive women being evicted. Narratives collected as part of this study highlight yet another, but relatively unexplored, form of violence: violence by HIV-positive husbands towards their wives who are not HIVpositive. Affected women speak of the extreme violence perpetrated on them as a result of the anger and frustration their husbands feel when the husband learns of his own HIV status, as if wanting to ensure that he passes on the infection to his wife.

Both stigma and violence are rooted in and enacted through gender inequalities. Deeprooted gender stereotypes and social norms that sanction certain behaviours in intimate relationships and encourage certain types of masculinity and femininity are fundamental in perpetuating violence. Research studies and interventions now increasingly recognize that the unequal power balance in gender relations places not only women at greater risk of HIV infection, but also increases men's vulnerability. Traditional norms of masculinity dictate that men should be sexually knowledgeable, experienced and "in control" - norms that coerce them into experimenting with sex at a young age in unsafe ways (UNAIDS, 1999) and challenge the effectiveness of prevention messages built around fidelity and partner reduction (Heise & Elias, 1995). Therefore, interventions that do not incorporate methodologies to create dialogue with the larger community on challenging these gender norms and breaking the silence around perceived 'private' matters only partially address the issue. Efforts to address violence require not only direct interventions but also strategic associated interventions such as work with men on notions of gender, sexuality and violence; sensitization of communities and specific groups such as health care providers and counsellors; and sensitization of other key stakeholders (e.g. teachers, parents, faith and community leaders) in the lives of adolescents who have the power to shape their notions of gender and sexuality.

CREATION OF GENDER-EQUITABLE NORMS

Violence against women and HIV share certain characteristics that have programmatic implications: both are associated with shame and blame; both are regarded as private matters; both are fuelled by unequal power relations; and both can only be effectively addressed through ensuring the creation of gender-equitable norms within communities and families. Thus, programmes that have been effective in addressing violence include elements that focus on more than one characteristic at a time, tackling both the structural drivers of violence and the programmatic impacts.

CREATING AN ENABLING ENVIRONMENT

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- Advocate with governments to adopt national legislation on domestic violence, and to ensure governance systems and adequate resources for effective implementation and sensitization of law enforcement agencies.
- Encourage research to collect reliable empirical data to (i) provide evidence on the links between vulnerability to HIV violence, and trafficking, (ii) provide an estimate of the social and economic costs of HIV and violence to households, communities and

national economies, and (iii) develop rigorous monitoring and evaluation systems to track the integration of violence components within HIV programmes.

- Parallel Enlist the support of influential community leaders at various levels of government to raise awareness against the twin burden of HIV stigma and gender-based violence.
- ➡ Build gender capacity within civil society organizations working on HIV to recognize the links between gender-based violence and HIV, and build capacity of organizations to engage with families and communities in transformative processes to shift gender norms.
- Evolve specific methodologies on HIV stigma and violence reduction to generate dialogue with men and women as well as other specific communities such as high risk groups, health care providers and counsellors on adoption of safe sex practices within long-term intimate relationships, sexuality, gender norms, and violence. These should be undertaken at a community level rather than individual to help break the silence around violence.
- Encourage adaptation, replication and scale-up of best practice models that address gender-based violence effectively such as one-stop violence crisis centres, zero tolerance for violence zones and community level alternate dispute resolution and mediation. All of these models hinge on developing a comprehensive support system across various sectors such as health, education, judiciary, law enforcement agencies, and they must be implemented in conjunction with systems of local self-governance.

SUGGESTED DIRECTIONS FOR PROGRAMMES

Integrate violence reduction into all programmes addressing HIV stigma, reproductive health and sexuality education with adolescents. Create safe spaces and platforms such as youth collectives and clubs to dialogue on issues of

- sexuality, expression, gender roles, conflict resolution and respectful relationships; and encourage sharing of experiences of positive personal change.
- Educate and equip young people with skills to minimize the consequences of violence such as increased risk-taking behaviours and teenage pregnancy.
- Engage men and boys to understand conception of male identity, the need to prove themselves to peers, and other pressures experienced by them due to gender stereotyping.
- Sensitize the healthcare system and HIV counsellors on gender-based violence. Encourage use of models for systematic screening and develop a comprehensive service delivery and referral system to address the issue. Focus particularly on the frontline healthcare providers, antenatal and voluntary counselling and testing (VCT) clinics. Equip the system to recognize and deal with violence as a barrier impacting access to services, HIV status disclosure and negotiation of safe sexual relationships.
- Provide adequate referral support networks and safe shelter for survivors of violence and similarly for women infected and affected by HIV.

PROMISING PRACTICES

GOVERNMENT MINISTRIES AND BNWLA: BREAKING THE SILENCE

Bangladesh National Women's Lawyers' Association (BNWLA) works with different ministries to address Violence against Women and Children. BNWLA is a member of the National Task Force on CICR (Children Previously Involved in Camel Racing), the National Coordination Body for Acid Victims, and Special Cell to Monitor Violence against Women Cases. BNWLA has been involved with the National Task Force engaged in preparing the National Plan of Action for Women and Children. Additionally, BNWLA has been engaged with the Government run shelter homes to ensure that a minimum standard of care is maintained in the homes.

BNWLA has also been coordinating a national coalition "Citizens Initiative against Domestic Violence" that has brought together more than 40 national organizations working to establish the rights of women. One of the larger goals of the coalition is to finalize the proposed Bill on domestic violence by generating awareness and policy advocacy around the Bill.

WOMEN-INITIATED COMMUNITY LEVEL RESPONSES TO DOMESTIC VIOLENCE

Based on the finding that the most effective responses to inter-spousal violence are those in which the immediate family and community support the women and take responsibility to end violence, ICRW documented and evaluated five such programmes in India. Though operating in different socio-cultural contexts, all the programmes rely on a public dialogue or mediation to resolve the conflict through a face-to-face discussion among the people involved. A series of sessions takes place in the presence of the families, community and influential gate-keepers, which facilitate the emergence of a mutually agreeable solution.

This strategy works because a 'private' issue becomes a public concern. The arbitrators feel that this technique is effective because "it makes it very difficult to continuously justify a wrong behaviour in public". Additionally the fact that the decision is reached through public dialogue ensures that the community owns and is responsible for the decision. Not only is there a change in the levels of violence, but women also feel supported. They report increased confidence and ability to "exercise agency" – i.e., control outcomes affecting their lives. A democratic process, fear of public ostracism, and a backup threat of action by the local administrative authorities work together to make this an effective programmatic response to violence.

For details see www.icrw.org/docs/DVIndia_Report5_702.pdf.

POLICY-RELATED INTERVENTION, INDIA

The Indian government passed the Prevention of Women from Domestic Violence Act (PWDVA) in 2005. This law applies to all women in domestic relationships (relationships between a man and woman in a shared household) and includes physical, sexual, emotional, and economic abuse. One of the key features of the law is that provides women a right to residence in the household, i.e., she cannot be thrown out. In situations where she does not want to return to the house, the perpetrator has to provide for alternative accommodation.

For details see http://lawyerscollective.org/projects-and-activities

WORKING WITH MEN AND BOYS TO REDUCE VIOLENCE AGAINST WOMEN

Save the Children Sweden is working with men and boys in South and Central Asia to address violence against women. The initiative, which also includes a training program, incorporates the following components: perception of masculinities, gender relations and power, gender inequality, sexuality, life skills, self-reflections and gender socialization. Save the Children emphasizes the need to work with communities and create safe spaces for both sexes to discuss gender-related concerns.

For details see http://sca.savethechildren.se/en/sca/

RESOURCES

The urgent need to involve the community, key stakeholders and service providers in a dialogue to address the role of gender norms within the HIV epidemic has led to the creation of methodologies and evaluations of programmaticinterventions. Effective programmes have used strategies such as couple counselling, generating community ownership for issues of violence through community-based arbitration programmes and creative Behaviour Change Communication (BCC) programmes to challenge prevailing beliefs and norms. Interventions with women involved in sex work have also used comprehensive strategies of empowerment, such as formation of collectives as is the case for the Sonagachi project in West Bengal, India; setting up a care and support group, 'Asha', as part of a psychological rehabilitation programme for young women who have been trafficked (Sanlaap, Kolkata, India).

The following are toolkits that lay out methods to involve the community and specific stakeholders on issues of violence and stigma reduction:

- Stepping Stones manual This well known manual has been used across several contexts with the aim of creating community awareness in issues of gender-based violence. www.steppingstonesfeedback.org; www.stratshope.org/images/t-steppingstones.pdf
- HIV&AIDS-Stigma and Violence Reduction Intervention Manual This manual is a guide for community-based organizations to facilitate a community-led and -owned process that addresses stigma and gender-based violence in HIV prevention efforts. http://www.icrw.org/docs/2006_SVRI-Manual.pdf

- Stigma and Violence Reduction toolkit for health care providers- a project that lays out participatory interactive exercises to sensitize health care-providers to stigma and violence. (upcoming on www.icrw.org)
- Stigma: Toolkit for Action. Introduction and Module A: Using the Toolkit; and Naming the Problem -ICRW, the Academy for Educational Development and the International HIV/AIDS Alliance have recently released a revised stigma reduction toolkit to help fight HIV- and AIDS-related stigma. The toolkit is used to facilitate discussion about the rights of positive persons and issues around gender, sexuality and morality. http://www.icrw.org/docs/stigma-toolkit/intro-a.pdf

OTHER RESOURCES INCLUDE

- Community level women initiated interventions to end domestic violence – synthesis report of three studies (www.icrw. org/docs/DVIndia_Report5_702.pdf).
- Operational Guide on Gender and HIV/AIDS : A rights based approach -Prepared by the UN Interagency Task team on Gender and HIV. (www.unifem.org/resources/item_detail. php?ProductID=67)
- Examples of best practice in Addressing gender-based violence in the Latin American and Caribbean region: a critical review of interventions http://econ.worldbank.org/ files/39678_wps3438.pdf
- Integrated approaches to eliminate gender-based violence http://www.

thecommonwealth.org/shared_asp_files/uploadedfiles/%7bBC734E4C-36AC-482D-984A-593228DB5F8D%7d_gender%20violence.pdf

- UNGASS, Gender and Women's Vulnerability to HIV/AIDS in Latin America and the Caribbean. Pan- American Health Organization 2002.
- Women and HIV/AIDS: Confronting the CrisisA joint report by UNAIDS/UNFPA/UNIFEM
- Violence Against Women and HIV/AIDS Setting the Research Agenda. A meeting report. October 2000. WHO

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4.6 | HIV AND WOMEN'S REPRODUCTIVE AND SEXUAL RIGHTS



4.7 HIV and Women's Property Rights

4.8 HIV and Economic Empowerment

4.9 HIV and Women in Highly Vulnerable Populations



4.6 HIV AND WOMEN'S REPRODUCTIVE AND SEXUAL RIGHTS

OVERVIEW OF THE ISSUE

Sexual and reproductive rights can be defined as:

- the right to reproductive health care;
- the right to make decisions about their reproductive lives (CRR, 2005).

Sexual and reproductive rights are among the basic human rights that are enshrined in key international conventions and upheld by governments that commit to those conventions (CRR, 2005). Nations that signed and ratified international conventions establishing or recognizing pre-existing reproductive rights (i.e., the Convention on the Elimination of All Forms of Discrimination against Women [CEDAW]) must ensure that each woman in their country is free from gender inequalities that may constrain her ability to exercise those rights. When these rights are not upheld, they create ample opportunity for a woman to be abused, violated and exploited (CRR, 2005), and increase her vulnerability to poverty and disease, including HIV.

According to these conventions, a woman's reproductive and sexual rights must be upheld, regardless of her HIV status. Positive women specifically need to be afforded with the guarantee that they can freely access quality reproductive health care without HIVrelated stigma and discrimination and not be coerced into abortion or sterilization. HIVnegative women need to be assured that they can freely access reproductive health services and social supports that can reduce their HIV vulnerability as well as make decisions that do not compromise their reproductive health. Both groups of women need to be ensured that they can fully exert these rights on their own and at their own will.

Signing international conventions does not always guarantee the protection of sexual and reproductive rights (CRR, 2005). For example,

gendered norms that shape how childbearing decisions are made can affect how sexual and reproductive rights are defined and defended in the country context, as exemplified in India and Viet Nam. In both countries, women face enormous pressures to conceive once they are married and women may be coerced into childbearing by her husband/partner or a family member. In a Vietnamese qualitative study examining the socio-political attributes that facilitate the transmission of HIV, women reported that a woman's primary obligation is to provide her husband with a male heir (Phinney, n.d). In India, women in HIV-serodiscordant couples reported weighing the benefits of childbearing against becoming HIV-positive; a grave dilemma given that bearing children is an important aspect of feminine identity in India (Solomon, 2003).

Punitive measures in place in some Asia-Pacific countries create further obstacles to the realization of reproductive and sexual rights. These measures effectively punish women for exercising their sexual and reproductive rights, such as possession or distribution of condoms, an offence which in some countries (such as India and the Philippines) warrants either arrest on the suspicion of being involved in sex work or harassment from law enforcement (Paxton et al., 2004; Human Rights Watch, 2002 and 2004). In addition, sex workers have reported experiencing verbal harassment about their occupations from health providers at STI referral services, even in a context in which the necessary legal protections and referral systems were in place to ensure proper sexual health care (Amin, 2004).

Societies that lack punitive measures against the violation or infringement of sexual and reproductive rights create the opportunity for HIV vulnerability to increase. Women repeatedly exposed to violence or sexual abuse from a perpetrator who may be HIV-positive are highly vulnerable. Structural norms, particularly those that fail to provide legal protections against sexual violence within marriage, reinforce this effect. This vulnerability is compounded by women's inability to access medical care and the lack of legal options to seek justice against such incidents.



The shortcomings in upholding a woman's sexual and reproductive health rights appear to be further compounded when she is HIV-positive. $Women \, report \, being \, denied \, information \, on \, safer \,$ sex because of their sero-status, the assumption being that because she is positive she is no longer entitled to her reproductive rights (Esplen, 2007). In a study on HIV-related discrimination in the Asia-Pacific region, pregnant women reported being coerced by health professionals to take an HIV test (APN+, 2004). Upon learning of their positive HIV status, they were advised to have abortions, be sterilized (even in countries where abortion is illegal), or give their child up for adoption. Furthermore, when an HIVpositive woman is pregnant, the focus will be on preventing infection of her child, while her own rights to treatment and care may be ignored or neglected (Paxton et al., 2004; DeBruyn, 2006; PATH Convergence Project, 2007; Esplen, 2007).

In many parts of the Asia-Pacific region, sexual and reproductive rights often are in conflict with gendered norms prescribed by religious institutions and value systems that have been in existence for generations. In a study examining policies and actions on women's reproductive rights across five Asia-Pacific countries, the rights

afforded to women were highly dependent on the religious context even though four of these five countries had ratified CEDAW (CRR, 2005). In addition, adolescents in this region report being consistently denied access to reproductive health services or unable to find youth resources that provide information about sexual and reproductive health, violence, HIV prevention, contraception and sexuality issues (CRR, 2005; APCRSH, 2003). Narrow definitions of rape, limited measures to protect women from sexual harassment, and criminalization of abortion are some of the measures that can stand in the way of women freely exercising their sexual and reproductive rights.

One positive example of progress in finding ways to encourage nations to ratify and comply with CEDAW comes from the UNDP Pacific Centre. UNIFEM, UNDP, regional governments and civil society have developed specific legislative indicators to assess the degree of ratification and compliance with CEDAW conventions among the nine countries of the Pacific region (UNDP 2007). CEDAW, the international bill of rights for women, is now the second most ratified treaty in the Pacific region. These indicators have been useful measures to

assess the degree of compliance and gaps in legislative compliance (de jure) versus how laws are applied routinely. For example, one nation in the region has legislation making solicitation of sex an offence for men and women, a step toward gender equality in legislation; however, full compliance with CEDAW requires that sex workers are not criminalised. Abortion is not an offence in four of the nine nations, but access to safe reproductive health care, including family planning, is an important issue in this region. Discrimination against women is technically still lawful in two countries in this region. All countries in the region have legislated against assault on women, but none of these countries have identified by law domestic violence as a form of discrimination. Laws designed to protect women against all forms of violence, including certain protections for girls aged 16 and over in cases of rape, are generally inadequate in countries in this region. These represent several examples of the type of detailed review these indicators can provide (UNDP, 2007).

The Inter-agency Task Team on the Prevention of HIV Infection in Pregnant Women, Mothers and Children has developed a global strategy for universal access to prevention of parent to child transmission which provides guidance on the standard of care for providing these services. This strategy calls for the adoption of a comprehensive package of care based on the United Nation's four elements strategy which links and integrates maternal, newborn and child healthcare services. Prioritization is given to HIV-positive pregnant women who need access to these services. Male involvment is also recognized as an important issue, as is couples counseling which encourages HIV testing and counseling, facilitates disclosure of HIV status, and improves use of family planning methods and adherence to treatment. This is a critical element in the continuum of family-centered care which integrates care for the benefit of the family including services such as nutritional support, child health, and family planning services (The Inter-agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and Children, June 2007).

In sum, sexual and reproductive rights are basic human rights and awareness must be raised affirming this. When a woman faces coercion or discrimination exercising such rights, her vulnerability to HIV can increase. It is important that all women, regardless of the status, are allowed to exercise these rights without being subjected to mistreatment from their partner, medical personnel or other people in positions of authority. Social structures that foster political or programmatic institutions that fail to uphold these rights need to be challenged and restructured.

CREATING AN ENABLING ENVIRONMENT

- Fulfil obligations as signatories to international conventions. Through a consultative process that involves relevant entities including government and religious institutions, create legal measures that support fulfilment of the international commitments.
- Create or expand the scope of punitive measures for sexual offenses such as marital rape and incest. Conversely, reduce or eliminate similar measures for possession or distribution of contraceptives and prophylactics.
- Advocate for the integration of PPTCT and antenatal services with reproductive health and family planning services to ensure continuity in maternal treatment and care.
- Provide funding through NGO or statesupported interventions to offer to women and girls **opportunities to increase skills** that build self-esteem and facilitate empowerment, contributing to, for example, increased ability to negotiate condom use.
- Integrate sex education into school curricula to generate greater awareness, among young men and women, about sexual and reproductive health. This can help them avoid risky behaviour and make safe choices.
- Include HIV-positive women in clinical trials for contraceptive technologies to ensure product applicability to women of sero-positive status.

SUGGESTED DIRECTIONS FOR PROGRAMMES

- Educate providers of HIV-positive patients on rights affecting people living with HIV in order to ensure good quality of care. Training should include how to address layered stigma (additional discrimination on top of existing HIV-related stigma and discrimination) and the influence of gender.
- Create and support programming that ensures women have adequate access to information that appropriately educates them on, or expands their knowledge about, reproductive options. Utilize "edutainment" activities as a means to expand girls' awareness of their sexual and reproductive rights.
- Ensure that youth-friendly sexual and reproductive health services are provided to those in need. If services are designed and delivered from a youth perspective, young women can be empowered to take an active role in asserting their right to decision making on family planning methods.
- Promote male involvement in programmes that provide information about sexual and reproductive rights. Offer informational programmes to law enforcement officers and other people in positions of authority in this field to educate them on their roles in upholding a woman's sexual and reproductive rights.

PROMISING PRACTICES

VASAVYA MAHILA MANDALI (INDIA)

Vasaya Mahila Mandali (VMM), an Indian NGO, targets women and children, raising awareness of HIV/AIDS and providing prevention, care and support services. Its intervention, "Community-Driven Approaches to Address the Feminization of HIV/AIDS in Andhra Pradesh", provides women with sexual/reproductive health (SRH) and HIV/AIDS education and community sensitization exercises on HIV/AIDS-related stigma and discrimination. It also includes day-to-day outreach on SRH, sexually transmitted infections (STIs), life skills and women's rights. Separate sessions for women and girls are held on a daily basis following a structured curriculum emphasizing STIs, contraceptive methods, condom demonstration and negotiation, menstrual hygiene, and other health related knowledge and health seeking behaviours. Increased STI referrals and treatment were documented, as well as increased deliveries in a hospital setting and more frequent contact with NGO staff/health providers inquiring about SRH issues. For more information see UNDP, NACO, NCAER (2006) Gender Impact of HIV and AIDS in India available at http://www.ncaer.org/downloads/lectures/gender.pdf

MAMTA, an Indian NGO, works to promote integrated health and development issues in the context of poverty, gender and rights with 'life cycle approach'. MAMTA started its activities in a Delhi slum in 1990 where it was providing clinical services to women and children to improve overall health and pregnancy outcomes. The organisation soon started working with young people and adolescents and initiated the Young People's Sexual and Reproductive Health and Rights (YRSHR) network across several states in India. MAMTA has used its findings from its projects to feed into national and international level advocacy and capacity building at the regional level. MAMTA has organized an Advanced International Training Program on Young People's Sexual and Reproductive Health and Rights South and South East Asian countries. The training programme aims at enhancing the capacities of individuals and institutions to work and network effectively, to address, act and advocate for young people's sexual and reproductive health and rights (YRSHR). The training programme expects to promote better regional understanding on YRSHR through experience sharing and thus support development of polices, programmes, strategies and interventions that are responsive to the health needs of young people. For more information on MAMTA and YRSHR see, http://www.mamta-himc.org/index.htm and http://www. yrshr.org/index.asp

RESOURCES

AIDSNET (2006). Synergising HIV/AIDS and Sexual and Reproductive Health and Rights – A Manual for NGOs.

Accessible at: http://www.aidsnet.dk/Default. aspx?ID=1493

 Provides guidance to HIV/AIDS programme staff including consideration of S/RH issues that are most relevant to HIV and AIDS

CHANGE, ICW, IPAS, and Pacific Institute for Women's Health. (2004). Fulfilling reproductive rights for women affected by HIV: A tool for monitoring achievement of Millennium Development Goals. CHANGE, Takoma Park, Maryland, USA.

Accessible at: http://www.genderhealth.org/pubs/MDGNov2004.pdf

 Provides benchmarks for NGOs and CBOS working on addressing HIV and AIDS in their communities and meeting the MDGs targeting HIV-positive women and their needs

ICW and GCWA (2007). Sexual and reproductive rights.

Accessible at: http://www.icw.org/files/SRHR-ICW%20fact%20sheet-06.doc

 Provides a quick overview of key issues and legislation that upholds a woman's sexual and reproductive rights, with particular focus on those affecting a woman who is HIV-positive

UNAIDS, UNFPA, UNODC, YouthNet, and WHO. (2004). *Protecting young people from HIV and AIDS: the role of health services*. Geneva: WHO.

Accessible at: http://www.who.int/child-adolescent-health/New_Publications/ADH/ISBN_92_4_159247_8.pdf

 Provides guidelines on strategies to integrate adolescent health services with interventions that address HIV/AIDS

WHO, UNFPA, UNAIDS, and IPPF (2005). Linking Sexual and Reproductive Health and HIV/AIDS: An Annotated Inventory. Geneva: WHO. Accessible at: http://data.unaids.org/Publications/IRC-pub06/in_sexualreproductivehealth%20and%20%20hiv%20aids_30nov05_en.pdf

Provides a multitude of resources that address sexual reproductive health and HIV and AIDS including – links to tools, methodologies, policy briefs, etc.-that target a range of users - policy makers, programme staff, research organizations, etc.

UNDP, UNIFEM (2007). Translating CEDAW into Law: DEDAW Legislative Compliance in Nine

Pacific Island Countries. Accessible at: http://regionalcentrepacific.undp.org.fj/HTML%20docs/CEDAWpublication.htm

Provides an example of governments, civil society and regional organizations in the UN family working together to ratify and implement CEDAW in the Pacific. National level indicators were developed to assess the degree to which national legislation is in compliance with CEDAW.

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ICW. (2004). *Positive women: Voices and choices.* Bangkok: Author.

PATH Convergence Project (January 2007). Convergence of HIV and SRH Services in India: Impact on and implications for key populations (A Literature review). New Delhi: Author.

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Phinney, H. (n.d.) 'Rice is essential but tiresome, you should get some noodles': The political-economy of married women's HIV risk in Ha Noi, Viet Nam. (Draft for the American Journal of Public Health) .Seattle: University of Washington.

Accessible at: http://www.sms.mailman.colum-bia.edu/cgsh/pdf/Phinney.pdf

Solomon, S., Buck, J., Chagaturu, S.K., Ganesh, A.K., and Kumarasamy, A. (2003). "Stopping HIV before it begins: Issues faced by women in India". *Nature Immunology 4*: 719-723.

UNAIDS. (2006). 2006 AIDS epidemic update. Geneva: Author.

UNDP, UNIFEM (May 2007). Translating CEDAW into Law: DEDAW Legislative Compliance in Nine Pacific Island Countries. UNDP: Suva, Fiji

Vasavya Mahila Mandali. (February 2007). "Community-driven approaches to address the feminization of HIV/AIDS in Andhra Pradesh." *Sahrudaya:7* (8). New Delhi: International HIV/AIDS Alliance in India.

WHO. (April 2007). *Strengthening linkages between sexual and reproductive health and HIV.* (HIV Technical Brief). Geneva: Author.

Accessible at: http://www.who.int/reproductive-health/hiv/hiv_tecbrief_srhhiv.pdf

WHO, UNFPA, UNAIDS, and IPPF (2005). Linking Sexual and Reproductive Health and HIV/AIDS: An Annotated inventory. Geneva: WHO. Accessible at: http://data.unaids.org/Publications/IRC-pub06/in_sexualreproductivehealth%20and%20%20hiv%20aids_30nov05_en.pdf



4.3 HIV and Care-giving 4.4 HIV and Education 4.5 HIV and Violence

4.8 HIV and Economic Empowement

4.9 HIV and Women in Highly Vulnerable Populations



4.7 | HIV AND WOMEN'S PROPERTY RIGHTS



4.7 HIV AND WOMEN'S PROPERTY RIGHTS

OVERVIEW OF THE ISSUE

Ensuring women's rights to ownership of property and control over productive assets is increasingly recognized as a critical step towards achieving the Millennium Development Goals (MDGs), particularly goal three - promoting gender equality and women's empowerment. The ability of women to access, own, and control assets has been considered pivotal to ensuring women's empowerment, social and economic security and well-being. Ownership of land, housing and other property provides direct and indirect benefits including a secure place to live, the means to a livelihood and a measure of wealth or capital by which additional economic resources can be leveraged (land can serve as collateral for credit, for instance). Land has long been recognized as a primary source of wealth, social status and power, providing the basis for shelter, food and economic activities (FAO 2002). The HIV epidemic amplifies the importance of property and asset ownership for women, as it can profoundly compromise a woman's financial, social and physical well-being. Property ownership may sustain livelihoods in the shortterm or the long-term and also serve as collateral for credit, enabling HIV- and AIDS-affected households to cope better with the personal and financial impacts of the disease (Strickland, 2004).

Unfortunately, women face many structural and community level barriers to their ability to access and own assets, claim inheritance, and access finance and credit, including male preference in inheritance practices, male privilege in marriage, gender in equality in the land market and male bias in state land redistribution programmes (Deere & Leon, 2001). Women in many countries may have access to property and other assets only through informal arrangements or traditional methods of household and communal decision-making. In India, of all rural women in the workforce, 85 percent are in agriculture (Agarwal, 2002). However, because land is primarily inherited through the male family line, some researchers estimate that women own less than 10 percent of land; others put the number at two percent (FAO, 2002).

In the context of the HIV epidemic, property rights encompass a broad spectrum of assets that can provide economic security. "Women define "property" as everything they receive from their birth family when they marry, and all they are entitled to as wives, including jewellery, dowry, furniture, insurance, pensions, bank accounts, fixed deposits, land, houses or any other asset their husbands acquired." (Swaminathan, Bhatla & Chakraborty, 2007)

Ownership of land has been linked to both economic and physical security. Research indicates that individuals who own land generate much higher rural, non-farm earnings from self-employment than people without land (Chadha, 1992). Asset control can also give women greater bargaining power within households and help protect against domestic violence, a key risk factor for HIV (see Section 4.5 for a fuller discussion of this relationship). Research in Kerala, India, for example, found that 49 percent of women with no property reported physical violence compared to only 7 percent of women who did own property (Panda, 2002). Research conducted by the International Center for Research on Women (ICRW, 2006) has also documented that ownership of immovable assets not only protects women from experiencing intimate partner violence, but also gives them a means of exiting violent situations. Property-owning women who are not experiencing violence rank higher on measures of empowerment such as greater self worth, confidence and an increased ability to make decisions, including financial decisions.

These findings suggest that women who own property or otherwise control assets may be better positioned to improve their lives and expand their capacity to manage crises. This empowering aspect of property-both economically and socially-is especially vital for women living with and affected by HIV or AIDS. Issues of property ownership have been forced into the open in Africa, where there is evidence that women's need for land for economic security and survival is deepening as the number

of female-headed and child-headed households grows due to the AIDS epidemic. Evidence from that region indicates that economic vulnerability and the lack of assets such as land significantly increase the likelihood that women will engage in a variety of risky sexual behaviours, including transactional sex and multiple, concurrent sexual contacts (Hallman, 2004; Weiser et al., 2006). A study in South Africa found that factors associated with increased likelihood of reporting transactional sex were partly related to insecure asset ownership and included living in substandard housing and ever reporting hunger in the household (Dunkle et al., 2004). Financial inequality in a relationship also has been found to be an independent predictor of sexual coercion. Women who are economically dependent on men are less able to negotiate safe sex behaviour such as condom use, and are less likely to leave relationships that they consider risky (Jewkes et al., 2003; Luke 2003; van der Straten, 1997).

HIV also exacerbates an additional economic vulnerability for women: dispossession and denial of property rights, mostly following death of a husband. Narratives given by a small sample of women, collected as part of a study exploring the links between HIV and property rights in three countries of South Asia (Swaminathan, Bhatla & Chakraborty, 2007), reveal that these women face the triple stigma of being female, widowed and, quite often, HIV-positive. The women report that while their husbands' HIVpositive status was deliberately withheld from them, they were nevertheless blamed for bringing HIV into the home. They were denied money for their own treatment, or denied a share of the matrimonial property on several pretexts such as: the marital family equating the money they spend on the husband's treatment to his share of the family inheritance; promises to transfer inheritance to their children, particularly if they are boys; or forcing or deceiving the women into signing legal documents to prevent them from claiming their share. The study also found that eviction is another form of property dispossession. A wife is often asked to leave her marital home after her husband's death and/or face disclosure of her HIV-positive status. Even if she is not immediately evicted, she frequently suffers abuse until she leaves of her own accord. After she is expelled from the marital home, the husband's family usually establishes control over any assets and sells them off for cash, which can make it more difficult for widows to recover their share. Such practices, fuelled by the stigma and discrimination commonly experienced by spouses of those who have died of AIDS, leave affected women (and sometimes their children) destitute and more vulnerable to further consequences of the epidemic (Drimie, 2002a; FAO, 2003; Human Rights Watch, 2003a). The study on the Gender Impact of HIV and AIDS in India (NACO, NCAER, UNDP 2006, page xxi) also supports this argument. The study shows that hardly 10 percent of widows are living with their husband's family and out of those who are not living with their husband's family; more than 90 percent had stopped living in their marital homes after the death of their husbands. In addition, 79 percent of the widows have complained that they were denied a share in their husband's property.

It is important to note that the potential benefits of asset ownership go beyond income. Evidence and preliminary findings from a study in South Africa and Uganda indicate that secure property rights and property ownership can help women mitigate harmful effects of HIV and AIDS. For example, the study results suggest that mitigation benefits from owning property were strongest for women in Uganda, where land and property are used both for housing and generating income. Women with property had a greater degree of economic independence because they used their property (land, livestock, etc.) for various agricultural activities, and could further supplement their income with a range of informal work, such as petty trading, sale of old clothes, sale of livestock-related products, and brewing and selling millet liquor. Moreover, the land itself could generate income via land rentals, and women could use labour-sharing arrangements to bridge labour shortages (ICRW, HSRC, AFD, 2008).

In sum, relevant economic processes by which property rights decrease HIV-related vulnerability include:

providing women with a secure place to live;

- serving as a site for economic activity and means of livelihood;
- reducing economic dependence on men and extended (marital) family; and
- serving as collateral for credit.

At the same time, property ownership empowers women and reduces their vulnerability by giving them:

- greater bargaining power at the household, individual (sexual) and community level;
- expanded social status in communities, and
- increased agency to control outcomes affecting their lives.

THE EMERGING RESPONSE

Responses to help HIV-positive women secure their economic conditions and property rights have only recently begun to emerge in the Asia-Pacific region., and they are uninformed and fragmented. This is due both to a limited understanding of how property rights could mitigate the impact of HIV, and lack of capacity, both technical and financial, to deal with the problem (Swaminathan, Bhatla & Chakraborty, 2007). A growing number of organizations have begun to experiment with employing HIV-positive women as staff, or are building vocational skills, offering loans or lobbying industry to employ HIV-positive people. However, these responses lack reach, may not be sustainable and often do not benefit the most vulnerable and unskilled. The challenge is to create strategies for sustained economic, social and health support that provide a safety net to prevent HIV-positive and/or affected women from continually slipping back into risky sexual behaviour, economic crisis and consequently worsened health status.

The legislative arena holds important promise. Laws favourable to women are a critical first step and are indicative of a policy environment that recognizes gender bias and seeks to amend it. In recent years, India and Nepal have amended their legislation, giving women equal inheritance rights, though what impact this is having on the lives of women has yet to be determined. In the context of HIV, the likelihood of realizing these rights becomes even more difficult due to the added layer of blame, shame and stigma alluded to above.

While personal stories of the despair faced by women abound, systematic and visible evidence is necessary to push this issue onto national policy agendas. To this end, the first ever Asia-Pacific Court of Women on HIV, Inheritance and Property Rights: From Dispossession to Livelihoods, Security and Safe Spaces was organized by UNDP Regional Office at the 8th International Congress on AIDS in Asia and the Pacific, held in Colombo in 2007. Testimonies from HIV-positive women and sex workers illustrated the violations of property rights that they faced (http://www2.undprcc.lk/ resource_centre/rcc_publications.php?c_id=1002) Participants from Sri Lanka, Nepal, Bangladesh, Pakistan, India, Cambodia, Viet Nam, Papua New Guinea, Thailand, Malaysia and even Ethiopia and South Africa presented testimonies at the Asia-Pacific Court of Women on HIV, Inheritance and Property Rights. The testimonials were presented before the eminent jury, which issued a public statement with policy recommendations on this issue at the end of the special court.

In terms of organizational responses, formal legal, family level mediation and communitybased arbitration are all potential strategies that can be used to help women access their rights (Swaminathan, Bhatla & Chakraborty, 2007). However, these may need to be used in conjunction with each other to create an environment where women can realize their rights. Women face obstacles such as legal systems insensitive to these issues, long and cumbersome arbitration processes, and practical constraints such as lack of awareness of rights and access to documents. In many instances, women hesitate to use the legal options as they want to maintain their family ties and relations, and also not lose face in the community for having dragged family matters into the open. Family and community level dialogue, mediation or even the formation of pressure groups may be needed to intervene and engage gatekeepers and shift norms around gender.



Recognizing the importance of communitydriven responses to HIV and AIDS, ICRW, in partnership with the Global Coalition on Women and AIDS and the FAO, implemented a grants programme to document and test community interventions to secure women's property and inheritance rights in the context of HIV. Programme results demonstrate the promise of interventions that harness local capacity and the synergy of networks to secure women's rights to property and inheritance. Findings also suggest practical ways for the international development and donor communities to support these pioneering initiatives and bring them to scale. Integrating these findings into new and current programmes will help fashion a more effective response to HIV (Welch, Duvvury, and Nicoletti 2007).

Most importantly, the Report of the Commission on AIDS in Asia "Redefining AIDS in Asia: crafting an effective response" clearly recommends that impact mitigation programmes, at a minimum, should have at least four components: one of which is laws to guarantee inheritance right especially for women. This component needs to be included in the national HIV responses and would cost about 300 million per year

at the current rate of infection in Asia. The report further emphasises that legal and other obstacles that prevent women (including those widowed by AIDS) from inheriting assets must be removed

CREATING AN ENABLING ENVIRONMENT

- Review and harmonize laws that impinge on women's property and inheritance rights. Most importantly, legal and other obstacles that prevent women (including those widowed by AIDS) from inheriting assets must be removed. Efforts should be made to harmonize land, marriage, and inheritance laws, and to ensure consistency between those laws, the provisions of the national constitution, and the obligations of the state with respect to international human rights treaties. Finally, legislation promoting the registration of all marriages and joint titling should be areas targeted for reform.
- Advocateforadoption of Gender-Sensitive Legislative Frameworks, Promoting Judicial Capacity and Effective Litigation. Even where laws are favourable to women's concerns, inadequate interpretation and

- enforcement renders them ineffective. Correcting this situation requires working with those who implement these laws and deliberate legal matters and as well as enhancing the accessibility and effectiveness of the judicial system itself.
- Invest in public awareness and building understanding of the issue. Sound laws and gender-sensitive judicial systems must go hand in hand with a high level of public awareness of women's property and inheritance rights and of how national law or international human rights frameworks can protect and promote those rights. Women themselves often lack adequate knowledge about courts and other legal mechanisms available to defend their rights, as well as the means to employ such mechanisms when needed. Raising awareness of women's property and inheritance rights is the first step in creating an environment in which women can actively engage with both customary and formal structures to realize and protect their rights.
- Invest in temporary shelters and accommodation for women and children who are evicted or who may want to leave their residence. This should be done on a priority basis by governments as the need for a safe place to stay makes women vulnerable and open to exploitation.

SUGGESTED DIRECTION FOR PROGRAMMES

Replicate and scale up programmes such as community-based paralegal services to help women access and realize their rights. Securing property rights for women requires innovative, comprehensive strategies that address economic security and social support, and combine mutually reinforcing strategies of policy/legal, familial and community responses. A range of HIV/ AIDS organizations, positive networks, and property rights organizations have already implemented programs providing paralegal and legal aid services to women. To carefully and comprehensively replicate and scale up these programmes, it is critical to:

- Build awareness among a broad range of HIV organizations on the links between HIV and property rights, among women of their legal rights, and among communities of the laws and regulations related to women's property and inheritance rights. Such services operate at the frontier between statutory and customary law and often represent the strongest resource for women seeking to defend their property claims from discriminatory customary practices. Women also need access to legal resources for advice on their legal options and support in taking action. Additionally, women need tools to prepare wills that are accepted by the informal and formal legal structures;
- Strengthen the capacity of positive networks and other organizations working in the area of HIV and AIDS to understand and undertake interventions on property rights (such as providing legal literacy training for community paralegals, developing alternative dispute mechanisms, decreasing stigma and discrimination, and involving men and boys);
- Create networks to bring together HIV/AIDS organizations, positive networks, and women's property rights organizations to encourage awareness of their overlapping interests, goals and activities, peer learning and exchange of strategies and ideas, and form strategic alliances for effective implementation and advocacy.
- Q Undertake further research and documentation to highlight the urgency of investing in this issue in the region. Examples of areas for research include: documentingcustomarylandtenuresystems; identifying the impact of the AIDS epidemic on land, property and inheritance rights in countries where such studies have not been done; developing gender disaggregated indicators at the national and local level that measure progress toward equity for women in land rights.

PROMISING PRACTICES

INCREASING WOMEN'S ACCESS TO LAND AND PROPERTY IN THE CONTEXT OF HIV; NEPAL

In the Asia Pacific Region, the UNDP Regional Programme on HIV in partnership with UNIFEM and UNAIDS embarked on a programme to increase women's access to land and property in the context of HIV.

In order to bring this issue to the attention of policy makers and incorporate it into the HIV response agenda of the region, a high impact large scale advocacy event was held in 2007: The Asia Pacific Court of Women on inheritance and property rights; from dispossession to livelihoods, security and safe spaces. A major partnership initiative between UNAIDS, AWHRC, ICRW, UNIFEM, lawyers Collective and FWLD, the Court hosted over 500 people, most important of whom were 22 women testifiers from 11 countries in the AP region; a five member eminent Jury comprising two Supreme Court judges from Sri Lanka and Nepal and five expert witnesses who set the context for the subject of the court.

The outcomes from court created the demand for country specific action on increasing women's access to land and property using a human rights framework. The first country level action started in Nepal, where women's land ownership has historically remained low, at only 1% according to the Nepal's National Women's Commission. Chief reasons for this have been the gender discriminatory provisions contained in the Civil Code. In 2002, after intense pressure from Women's groups and collectives of lawyers, the 11th amendment to the civil code was introduced, granting equal rights to ancestral property for daughters, full inheritance rights to widows and a wife's rights to her husband's property. However, even by 2007, the gap between progressive legislation and actual practice was still wide.

With the endorsement of Justice Kalayan Shrestha of the Supreme Court of Nepal and a Jury member of the regional court; and in partnership with the Forum for Women, Law and Development (FWLD) in Nepal¹, an innovative initiative involving rights holders and duty bearers, was rolled out in Nepal. This programme first brought together UNIFEM NGO partners working on gender issues, and UNDP NGO partners working on HIV, to the same platform. Using a mix of leadership development and community conversations methodology², the group was motivated to take community level innovative actions to change attitudes, norms and beliefs surrounding women's rights to land and property, one of the key barriers to increasing women's access to land. This resulted in, among other things, three HIV positive women claiming their rights to their deceased husband's properties from their in-laws. These successes were then showcased at a national consultation for duty bearers including representatives from the Ministries of Law, Justice and Parliamentary affairs; Women, children and social affairs; Health; Land Reform, Finance; and the Human Rights Commission in Nepal.

The programme resulted in a renewed commitment from policy makers to give priority to women's land rights in Nepal. During this same period, the government increased the percentage of rebate granted to people who registered property in the name of a woman from 10 % to 20%.

Initial reports from the Department of Land Reform and Management have shown a remarkable increase in women's land ownership. Now 25% of the total land registered in 13 different land revenue offices in Nepal are in the names of women³.

¹ Under the dedicated leadership of Advocate Sapana Pradhan Malla, a practicing lawyer before the Supreme Court of Nepal, and member of Nepal's Constituent Assembly.

² Leadership development and community conversations are part of UNDP's Leadership for Results program, designed to enhance the leadership, commitment and capacity of stakeholders involved in the response to the HIV epidemic

³ Women and land ownership: Maina Dhital, Kantipur daily, 26th January 2008

NAGORIK UDDYOG COMMUNITY-LEVEL DISPUTE RESOLUTION: ENSURING WOMEN'S REALIZATION OVER RIGHT TO PROPERTY (BANGLADESH)

Community-level dispute resolution can be more accessible and effective for poor women. In addition, long-term engagement with communities and working with community gatekeepers can shift gender norms to ensure sustainability of interventions. Nagorik Uddyog, a citizens' initiative in Bangladesh, uses the shalish, a traditional informal mechanism for dispute resolution. Because Nagorik Uddyog's main focus is to enhance women's access to justice, it has a concrete strategy to help women realize their property rights: (1) form shalish committees comprised of community members, with women making up at least one-third of the shalish; (2) provide education and training to the committee members on human rights and the legal framework including statutory, customary and religious laws; and (3) set up legal aid committees to monitor human rights in local areas and report on all shalish hearings to provide feedback to both the committees and Nagorik Uddyog staff. Women bring issues related to alimony, domestic violence, dowry harassment, desertion and land for dispute resolution to the shalish. When informal mediation fails, the organization provides legal aid. For example, Jahanara was deserted by her husband and he refused to pay child support for their son. Nagorik Uddyog, with the help of the local legal aid council, organized a shalish for her case. She and her husband agreed to formally separate and she was awarded Tk. 25,000 (\$ 390). With Nagorik Uddyog's help, she bought 0.36 acres of land and now earns about Tk. 6,500 (\$103) per month. She is happy about her ability to make a living and feels that she is a respected member of the community.

For details see Swaminathan, Bhatla & Chakraborty. (2007). Women's property rights as an AIDS response: Emerging efforts in South Asia. ICAAP8 edition International Center for Research on Women, Washington, DC and UNDP Regional Centre in Colombo.

KEY RESOURCES

For examples of programmes that seek to secure Women's Property and inheritance rights in the context of HIV/AIDS:

- 1. Voices and Visions: the Asia Pacific Court of Women on HIV, Inheritance and Property Rights, UNDP RCC, UNAIDS, UNIFEM and AWHRC, 2007
- Women's Property rights as an AIDS response- Emerging Efforts in South Asia. ICAAP8 edition Swaminathan, Bhatla and Chakraborty ICRW, UNDP, GCWA 2007 http://www.icrw.org/docs/2007-propertyrights-south-asia.pdf
- 3. Women's Property rights as an AIDS response- Lessons from Community interventions in Africa'. Welch, Duvvury and Nicoletti ICRW 2007 http://www.icrw.org/html/news/news.htm

4. Economy and Epidemic. Microfinance and HIV/AIDS in Asia. Stuart Mathison. The Foundation for Development Cooperation. 2004

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Swaminathan, H., Bhatla, N. & Chakraborty, S. (2007). *Women's Property rights as an AIDS response-Emerging Efforts in South Asia*. Washington, D.C.: International Center for Research on Women.

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4.3 HIV and Care-giving 4.4 HIV and Education

4.7 HIV and Women's Property Rights

4.8 HIV and Economic Empowerment

4.9 HIV and Women in Highly Vulnerable Populations



4.8 | HIV, WOMEN AND ECONOMIC EMPOWERMENT



4.8 HIV, WOMEN AND ECONOMIC EMPOWERMENT

OVERVIEW OF THE ISSUE

HIV and AIDS exploit the societal fault lines of gender-based inequalities and social norms entrenched in society. Persistent gender inequality, particularly in access to economic resources, greatly affects how women and girls can and cannot protect themselves from HIV, how they cope with HIV once infected and care for people living with the virus. Discriminatory practices have long kept women and girls from education, training and productive work, as well as from access to critical assets such as inheritance, land and housing. When they do find work in the formal sector, women often experience gender discrimination in hiring and payment practices.

Research clearly links between women's economic vulnerability and their vulnerability to HIV: economically vulnerable women are less likely to terminate a potentially dangerous relationship, less likely to have access to information regarding HIV and AIDS, less likely to use condoms, and more likely to resort to high-risk behaviours for a source of income (Weiss and Gupta 1998, Blanc 2001). A study in South Africa found that factors associated with an increased likelihood of reporting transactional sex were partly related to insecure asset ownership. These factors included living in substandard housing and even reporting hunger in the household (Dunkle et al. 2004). Financial inequality in a relationship has also been found to be an independent predictor of sexual coercion. Women who are economically dependent on men are less able to negotiate safe sex behaviour such as condom use, and are less likely to leave relationships that they consider risky (Jewkes et al. 2003; Luke 2003; van der Straten 1997). These women are also less able to cope with HIV and AIDS and its impact if they or their family members become infected (Drimie 2002, FAO 2003).

HIV infection and AIDS-related mortality generate and heighten both household level and women's personal economic vulnerability. Households slip deeper into poverty as people lose savings, land, housing tenure and employment as they struggle to meet the medical costs and other needs associated with care for the prolonged illness. Households may deal with the economic challenge by selling off assets, including livestock, furniture, and other consumer goods, in order to cover such costs as clinic visits, medical treatments, supplies and funerals. Profits from the sale of assets also help offset losses that result when household caregivers – often women and girls – are diverted from other income-generating activities to provide care for family members with HIV and AIDS. Some studies suggest a sequence of "asset liquidation" among AIDS caregivers to cope with the economic impact: first liquidating savings, then business income, then household assets, then productive assets, and finally land (Drimie 2002b). A recently concluded study on the socio-economic impact of HIV and AIDS at the household level in India found that HIV-affected households report both lower income and increased expenditure, especially on medical care, and decreased savings, as compared to non-HIV-affected households. The total loss of income (calculated as percentage of current household income) was found to be very high (around 66 percent) in households where people living with HIV are unable to work. The study found that almost 43 percent of the sample households had either borrowed or liquidated assets to cope with the financial burden after a member became HIV-positive (UNDP, NACO, NCAER, 2006).

When husbands or fathers die of AIDS, women and girls often lose their homes, inheritance, possessions and livelihoods – further threatening their economic situation. "Property grabbing" by relatives and community members or laws that do not support women's rights to own or inherit land or housing are widely documented in Africa and Asia. In some parts of South Asia, a wife is often sent out of the house after her husband's death and/or disclosure of her HIVpositive status. Even if she is not immediately evicted, she frequently suffers abuse until she leaves of her own accord. After she is expelled from the marital home, the husband's family usually establishes control over any assets and sells them off for cash, which make it more

difficult for widows to recover their share. Some families fear that if they transfer property to their daughter-in-law, it will be passed on to her natal family (Swaminathan, Bhatla, and Chakraborty 2007).

Married women, especially adolescent girls, who depend on their husbands for economic support, have less leverage to negotiate protection. In some parts of Asia, and in South Asia in particular, high rates of child marriage – triggered by poverty, lack of education and lack of viable alternatives – leave young wives with little power over their older husbands to influence sexual or other household decisions. Married girls who have complied with social expectations to marry and bear children are increasingly being infected with HIV.

ECONOMIC EMPOWERMENT AS AN AIDS-PREVENTION STRATEGY

Increasing women's economic stability is a goal of many development projects. Women's economic vulnerability may often be due to lack of education and training, and less access to high profit margin products and markets than men. Promoting economic empowerment through enforcing property and inheritance providing secondary rights, education, technical training and microfinance services can contribute to reducing their vulnerability to domestic violence, unsafe sex and other HIV risk factors. Economic security, through ownership of immovable assets such as ownership of land and house in some parts of South Asia, has been found to help protect women from the experience of domestic violence, and also cope better with violence should it arise (ICRW 2006). In addition, women who own property are much more likely to be involved in financial decision-making at the household level, as well as in matters related to their property. Education (Section 4.4) and property rights (Section 4.7) are discussed elsewhere in detail in this document.

Many organizations employ HIV-positive women as staff, or invest in building vocational skills, offer loans or lobby with certain industries and institutions to employ positive people. However, these efforts are often not sustainable and do not benefit the most vulnerable and unskilled

women. There are certain barriers to regular sustained employment in the context of HIV: lack of available, well-paying jobs; limited skills among the women; and the effect of HIV-related illness or fear of disclosure on employment (Swaminathan, Bhatla, and Chakraborty 2007). The challenge is to create strategies for sustained economic, social and health support that provide a safety net to prevent HIV-positive people from continually slipping back into risky sexual behavior, economic crisis and consequently worsened health status.

Livelihoods and Employment

In many countries efforts around care giving have focused on economic and social support strategies to facilitate livelihood development. For example, skill building and vocational trainings that help to secure employment or generate income are often coupled with formation of social support or peer groups. In Rwanda, NGOs and international agencies are providing vocational training and skill-building classes to youth (mainly girls) who are heads of households and helping to create support groups for them. In Uganda, where one family in four is looking after children not their own, the Uganda Women's Efforts to Save Orphans is working with girls who have become the main support of their families, providing training, paying school fees and helping them develop income-generating activities (UNAIDS/UNFPA/ UNIFEM, 2004, for details see www.uweso.org/)

SKILL DEVELOPMENT PROGRAMMES FOR GRANDMOTHERS

In an innovative example from India, grandmothers are being financially and emotionally equipped to take care of their grandchildren. Located in Andhra Pradesh, this programme was initiated by Vasavya Mahila Mandali in low income areas, where an estimated 10-15 persons die of AIDS related illnesses each year, resulting in a large number of orphans. Two prevailing patterns caused grave concern: first, that basic survival became a daily struggle as most people were wage earners; and second, that low earnings were resulting in a number of women supplementing household income through sex work. Skills development programmes were organized to help grandmothers become self-employed and self-sustaining by operating small businesses to support the household income. They also strengthened bonds between the generations, encouraged a sense of community and extended relationships to build a conducive environment (described in UNDP, NACO, NCAER, 2006).

Certain institutions have initiated programmes for securing economic rights as human rights, such as freedom from discrimination in housing and employment; and addressing the welfare needs of HIV-positive people. In Fiji, for example, access to housing grants and support allowances are being made available to people with HIV who are unemployed. Churches in Tonga, the Solomon Islands and Fiji and the Samoa AIDS Foundation have provided assistance in the form of housing and employment for people with HIV (Mid-Term Review Of the Pacific Regional Strategy on HIV and AIDS 2004-2008 Draft Report)

Microfinance

Microfinance, which provides savings, credit and other financial services for those excluded from the formal banking system, may play a role in reducing women's vulnerability to HIV and AIDS. Women have used microfinance services to generate income, develop skills and improve their families' standard of living. Several studies have documented positive outcomes of microfinance programme participation including: increases in social capital (Anderson, 2002; Quiniones 2000; and Rankin 2002); women's participation in decision-making within the household (Mahmud 2003; Amin 1998); and women's empowerment (Hashemi, 1996). Several studies in Bangladesh have also provided evidence of reduced economic vulnerability among microfinance programme participants, particularly women (Develtere, 2005; Kandkher, 2005).

A recent analysis on the role of microfinance in poverty alleviation indicates that while it is not a panacea, it has been a useful mechanism for changing the circumstances of women on an individual and small community basis. Limitations include the tendency of microfinance programmes to leave out younger women and adolescents. The report states that:

"the ability of a woman to transform her life through access to financial services depends on many factors – some of them linked to her individual situation and abilities, and others dependent upon her environment and the status of women as a group" (Urdang 2007:8).

There are other limitations as well, although these can be mitigated through careful programme planning. Some studies have shown increases in empowerment to be limited to within household arrangements only (Mahmud 2003) and to actually increase the experience of violence (Schuler 1998; Cheston, 2002). Some have viewed microfinance programmes as having failed to decrease poverty or affect real structural change to alleviate the causes of poverty (Buckley, 1997; Ahmad 2003; Elahi, 2004). Many microfinance programmes are kept at the level of small loans that do not allow growth and keep women "ghettoized" in microcredit. To make more permanent and sustainable

inroads into women's economic disadvantage, programmes that are committed to social change as a major goal could measure their success by the size of women's loans over time and whether a substantial proportion of women borrowers graduate from micro-credit to formal credit channels and from micro-enterprise to small- and medium-sized businesses. Access to a full complement of business development services and training, not just loans, would contribute to women's ability to building *equity*.

Some consider microfinance an important mechanism for providing economic safety nets for women and their households affected by HIV. (Mathison 2004, Parker 2005). However, little research has been conducted on whether microfinance is an effective intervention for preventing HIV. There is some evidence that microfinance programs mitigate the consequences of HIV. The most successful project to date that has used micro-finance in a group-based lending format to prevent HIV in a community is the Microfinance for AIDS and Gender Equity (IMAGE) study in South Africa (Pronyk, 2005). This project used a combination

of HIV and gender training and microfinance targeting women's groups. Study results showed a 55 percent decrease in intimate partner violence among program participants. There was also evidence of improved economic status within the household and empowerment among participants. The results did not show an effect on HIV incidence or condom use with non-spousal partners (Pronyk, 2005). In addition, access to microfinance programs can provide an opportunity and an audience for the delivery of information and education (for example, on HIV and other reproductive and sexual health issues) to otherwise hard-to-reach populations of poor women and girls.

HIV in the Workplace

A recent report by the International Labor Organization (ILO) calls for a concerted effort towards a comprehensive national response by Governments and individual organizations to secure social protection and work place policies for people who are HIV-positive. In 2001, ILO put forth a code of practice for HIV/AIDS in the world of work¹, key principles of which are:



 $^{1\}quad \text{Details available at } www.ilo.org/public/english/protection/trav/aids/code/languages/hiv_a4_e.pdf.$

- Recognition of HIV as a workplace issue, in that the workplace is part of the local community, with a role to play in the wider struggle to limit the effects and spread of HIV;
- Non-discrimination, with respect for the rights of people living with HIV;
- Gender equality, keeping in mind that women are more adversely affected by HIV and AIDS due to biology, sociocultural norms and economic forces;
- A healthy work environment, safe from the transmission of HIV and adapted to the capabilities of workers based on their physical and mental health;
- Social dialogue, with trust and cooperation between employers, workers, unions and governments, and with the active involvement of infected and affected workers;
- No screening for purposes of exclusion from employment or work processes;
- Confidentiality, as there is no justification for asking job applicants or workers to disclose their HIV status;
- Continuation of the employment relationship regardless of a worker's HIV status, as long as persons with AIDSrelated illnesses are able to perform their duties;
- Inclusion of culturally sensitive prevention programmes;
- Care and support, including affordable health services with the same high quality provided to other workers.

Business institutions must also be included in efforts for secure employment. A few organizations in India such as Positive Women's Network, Cheyutha and Amiche Aamche Sanshta enter into dialogue with industry either to seek potential employment of positive people, or to encourage them to pay dues to widows following a male employee's death

((Swaminathan, Bhatla, and Chakraborty 2007). However, a more proactive role can be played by introducing gender-equitable HIV workplace policies and implementing HIV awareness programmes throughout a company. The involvement of HIV-positive women in workplace policy development and implementation to ensure the retention and employment of HIV-positive staff, including women, is essential (ICW 2006b). Benefits to staff should provide a range of appropriate care and support options that include but go beyond the provision of treatment – such as counselling, and having in place complaints procedures for those who experience discrimination.

PWN -

Positive Women's Network (PWN+), Chennai has worked with the Tamil Nadu State AIDS Control Society (TNSACS) to place thirty three positive women as counsellors (PPTCT, ICTC, and ARV programs). TNSACS requires NGOs that are funded by them to employ at least one positive person in that project.

A large number of studies have repeatedly shown that investing in women is both the right thing to do (in moral terms) and the smart thing to do (in terms of economic and social pay-off (see, for example, Economist 2006; Quisumbing et al. 1995; Klasen 1999). That is why programmes that intend to promote and engender women's economic empowerment need to incorporate but also extend beyond the practical, short-term survival needs of women and their households. By addressing the longer-term, strategic (empowerment) interests of participants, such programmes can have a more meaningful and more sustainable impact - assisting not only individual women and girls, but by extension their households and communities.

The Women and Wealth Project – empowering HIV positive women economically and socially

Economic security is one of the most pressing priority needs for women living with and affected by HIV in Asia. Particularly they include women economically challenged with an ailing husband, widowed by AIDS, disowned by family, or denied the right to inheritance and property of their late husbands. In many cases, these women put up a final defence line against impoverishment of the entire household including children. However, strong stigma and discrimination, compounded by lack of skills and work experience, often stand in their way to getting a job or accessing credit.

In response to such emerging issues with a direct impact on human development and poverty, UNDP Regional HIV and Development Programme for Asia and the Pacific initiated the Women and Wealth Project (WWP) in late 2006, in partnership with a Thai NGO Population and Community Development Association (PDA) and UNDP country offices in Cambodia and India.

WWP takes a two-phased approach. The first phase is the development of sustainable social enterprises to provide employment and a sustainable flow of financial resource for the positive women's groups and also to finance the second phase.

The second phase is the implementation of a unique micro-credit programme specifically designed for people living with HIV called "the Positive Partnership Programme (PPP)," which is devised by PDA (PPP has been selected by UNAIDS for its 2007 Best Practice Collection).

Under the Women and Wealth Project, a women's wing of the Cambodia People Living with HIV Network (CPN+) established a small garment factory called Modern Dress Sewing Factory (MDSF). In India, the Positive Women Network (PWN+) started Social Light Communications (SLC), a design and printing company. Besides regular staffs, business managers of MDSF and SLC are women living with HIV, who are supported and trained by UNDP and PDA.

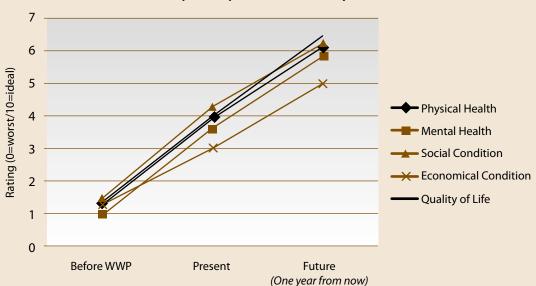
Key characteristics of WWP include the following:

- Economic empowerment both individually and collectively by creating livelihood opportunities and generating revenue for groups, respectively. Unlike individual micro loans, the business can continue despite a person falling sick, which is a real possibility and threat for HIV positive people with a compromised immune system.
- Social empowerment by reducing stigma and discrimination against positive women through business interactions, by making them income earners and "business owners" and by nurturing self-confidence and hope
- Providing a safe and mutually-supportive working environment for HIV positive women to openly discuss issues unique to them without fear of stigma and discrimination and getting fired
- All products produced by MDSF and SLC being marketed under the common brand "WE", which stands for "Women Empowered" and "Together WE can."
- Keeping a daily checklist to ensure all HIV positive workers are taking HIV medicines appropriately
- PPP (a unique micro-credit scheme) to distribute the benefits of the project to a greater number of HIV positive women across the country
- Revenues from the businesses to provide funding to support activities of their self-help groups

South-South cooperation through facilitating capacity transfer from Thailand (PDA) and interactions among the groups from Cambodia and India for cross-border mutual support among women living with HIV. For example, logos and label designs for the Cambodian group have been done by the Indian group.

An evaluation* revealed that HIV-positive women working at MDSF in Cambodia were experiencing both social and economic empowerment. Additionally, their response indicates that participating in the Women and Wealth Project helped improve their physical and mental health as well as the overall quality of life.

Self-assessment of positive women at MDSF (n=15, mean values)



*In this subjective assessment exercise, 15 HIV positive women working at MDSF were given a self-administered survey and asked to assess their various conditions at different timelines: (1) time before they participated in WWP, (2) present and (3) future, by giving ratings between 0 (worst) and 10 (ideal).

For more information visit (www.wwp-we.org)

CREATING AN ENABLING ENVIRONMENT

- Advocate for ratification and full compliance with international conventions protecting women's property and inheritance rights; rights to education and economic opportunities, and human rights protections for people living with HIV and AIDS.
- Reform and strengthen national laws relating to women's property and inheritance rights.

- Support advocacy for the recognition of women's caregiving responsibilities as work.
- Promote micro-finance programmes and strengthen women's property ownership efforts that strive to support women's financial independence and make permanent, sustainable improvements in their economic status. Look for ways to include young women and adolescent girls. Use the microfinance platform to provide a

- range of training and educational services to participating women that provide skills building and challenge gender norms.
- Cobby national and local governments to create incentives and decrease barriers to educating girls and young women;

SUGGESTED DIRECTIONS FOR PROGRAMMES

- Develop strategies to provide vocational and technical training and employment opportunities for young women.
- Involve HIV-positive people in designing and implementing gender-equitable HIV workplace policies and awareness programmes that promote the retention

- and employment of HIV-positive staff and provide a range of appropriate care and support.
- Educate employers about HIV-positive workers' rights and eliminate discriminatory employment practices based on a worker's HIV status.
- Support self-help and support groups as they often help women discover livelihood opportunities and provide space to challenge gender inequality.
- **Promote girls' education** through:
 - Facilitating community-based advocacy for promoting girls education and vocational training; and
 - Working with parents and communities to instil the importance of girls education,

PROMISING PRACTICES

SEWA BANK (INDIA)

In 1972 a group of self-employed women formed the Self Employed Women's Association (SEWA) in Gujarat. The main objective of SEWA is to "strengthen its members' bargaining power to improve income, employment and access to social security." SEWA sees itself not merely as a workers' organization, but also as a confluence of the labor, co-operative and women's movements. SEWA has an all India membership. It uses the dual strategy of struggle and development, thus enabling them to enter the mainstream of the economy. In this process, women have become more confident and autonomous. SEWA has helped workers organize around various issues, resulting in their being able to raise these with government and in the society in general.

Self employed women workers and producers are economically very active and contribute to economic growth. They are mainly involved in production, trading and the service sector. However, in spite of their hard work and their contribution to the country's gross domestic product, they lack access to financial services that would help them to upgrade their work and productivity. Self-employed women lack working capital and ownership of assets. As a result, a large portion of their income goes towards interest on working capital and on goods for their trade. Local money lenders exploit their circumstances and the formal banking sector tends to be unresponsive to their needs. SEWA was established to fill this gap: since its inception it has been providing banking services to poor, illiterate self-employed women and has become a viable financial venture. SEWA provides a range of banking and other social services to its members in both urban and rural areas.

For more information go to: www.sewabank.com

PLEASE CONTINUE TO THE NEXT PAGE >>

IMAGE (SOUTH AFRICA)

In 2006, the Intervention with Microfinance for AIDS and Gender Equity or IMAGE Project provided micro-loans to women and integrated a 10-part gender and HIV training programme called "Sisters for Life" into fortnightly loan repayment meetings over a six-month period in rural South Africa. More importantly, the IMAGE Project mobilized microfinance participants, who tended to be older women in the community (mean age of 41 years), to be agents of change in their households and communities. An assessment of te project found the intervention to be effective in a number of ways. Participants experienced improvements in assets, expenditures, membership in informal savings groups and in nine indicators of empowerment, including autonomy in decision-making, relationship with partner, challenging gender norms, and participation in collective action. Among participants, the risk of physical and/or sexual intimate partner violence in the past year dropped by 55 percent. The researchers who assessed the project concluded that "given the linkages between violence and HIV, we suggest that existing development initiatives, such as microfinance, may provide an important entry point for addressing HIV in areas where poverty and gender inequalities continue to confound prevention efforts." (Pronyk et al., 2006)

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4.3 HIV and Care-giving 4.4 HIV and Education

4.7 HIV and Women's Property Rights



4.9 | HIV AND WOMEN IN HIGHLY VULNERABLE POPULATIONS



4.9 HIV AND WOMEN IN HIGHLY VULNERABLE POPULATIONS

The Asian epidemic is largely driven by the high risk behaviour of populations most at risk of HIV infection including sex workers and their clients injecting drug users; and men who have sex with men (Commission on AIDS in Asia, 2008). In addition to identifying these groups, the Commission's report encourages governments and policy makers to focus on them to effectively contain the spread of HIV in the continent. The report contends that the epidemic cannot be sustained independently of the HIV transmission rates within these groups. This section further elaborates on the issues and needs of sex workers and the injecting drug users. It also considers the relations between HIV, migration and trafficking as well as the situation in conflict areas.

This sub-section provides an overview of the key linkages between migration, gender and HIV, and then focuses the lens on the issue of trafficking. It then provides several examples of promising practices, suggested course of actions and some key resources for further exploration.

4.9.1 HIV AND SEX WORK

OVERVIEW OF THE ISSUE

The purchase of sex by men in the Asia-Pacific region is believed to be an important factor driving the epidemic in the countries. According to UNAIDS, the percentages can be high: in some countries 15 percent among men in the general population and 44 percent of men in mobile populations reported buying sex in 2004 (UNAIDS, 2006). It is not surprising then, that quite a high proportion of new HIV infections are contracted during paid sex, and a relatively high prevalence of HIV has been found among sex workers across the region. Male sex workers and transgender sex workers also have relatively high prevalence rates although data is more limited. In Viet Nam, HIV prevalence among female sex workers increased from 0.06 percent in 1994 to six percent in 2002. In Indonesia, the rate of HIV infection among female sex workers is 3.1 percent nationally but varies significantly from region to region (UNAIDS, 2006). In Jakarta, for example, prevalence reached 6.3 percent in 2003. In South and Southeast Asian countries other than India, the United Nations estimates that sex workers and their clients accounted for almost half of all people living with HIV in 2005 (UNAIDS/WHO, 2006). There are fears that commercial sex is having an increasing influence on the AIDS epidemic in China (http://www. avert.org/aidschina.htm). China's AIDS epidemic is expanding, and demand for commercial sex is apparently growing (Tucker et al., 2005). The Chinese government estimates that in 2005, sex workers and their clients accounted for just under 20 percent of people living with HIV nationally (Ministry of Health People's Republic of China/UNAIDS, 2005). High HIV infection rates also continue to be detected among sex workers in India. The government estimates that 8 percent of sex workers nationally are infected with HIV, which is almost nine times higher than the overall HIV prevalence rate for Indian adults (NACO, 2006). And the rates are even higher in some specific cities. Studies have detected 44 percent HIV prevalence among sex workers in Mumbai, and 26 percent in Mysore (NACO, 2005).

Of growing concern in the region is rate of transmission from sex worker clients to their non-sex worker partners (e.g. wives and girlfriends). According to the Commission on AIDS in Asia (2008), it is the most important factor affecting the potential size of the HIV epidemic in most Asian countries. A recent study exploring this issue in Cambodia (Hor et al., 2005) found that 40 percent of the clients interviewed were having unprotected sex with non-sex worker partners, and that the rate of HIV among this group was over 9 percent - three times higher than the prevalence among police who were tested for the sentinel surveillance survey. Although the rate of reported condom use among sex workers was high (74.5 percent), it still fell below the 90 percent target set by the National AIDS Prevention programme. This study concluded that clients of sex workers are likely to be an important bridge for HIV transmission, and that condom promotion and HIV prevention programmes must urgently focus on non-sex worker sexual relationships. Because condoms are not normally considered appropriate for use in marriage, such programmes will need to address a range of issues related to gender norms and tackle issues around the reproductive expectations and needs of married couples.

Sex workers become vulnerable to HIV for a wide range of reasons. In some parts of the region, sex workers use drugs and share needles, an issue of particular salience in China, Indonesia and Viet Nam (UNAIDS, 2006; MAP, 2005). Studies often find higher rates of HIV infection amongst sex workers who inject drugs than amongst those who do not. For example, in Ho Chi Minh City, a 2003 study found that 49 percent of sex workers who injected drugs were HIV-positive, compared to eight percent of those who did not use drugs (MAP, 2005). Indeed, the overlap between drug use and sex work, particularly in Southeast Asia, parts of northern India and Indonesia, is of increasing concern. In all these countries there is an overlap between injecting drug use and sex work, such that male drug users frequently buy sex, female drug users are increasingly selling sex and female sex workers are injecting drugs.

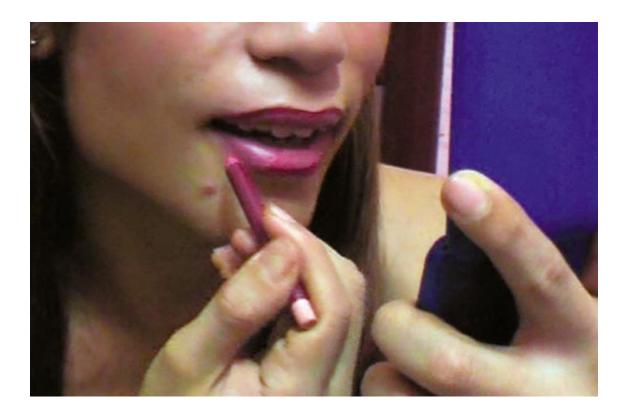
The infrequent use of condoms among sex workers and their clients is also cause for concern. Campaigns to encourage condom use among sex workers have met with a reasonable measure of success. For example, in Chennai, HIV prevalence among female sex workers fell from 8.2% in 2000 to 2.2% in 2006, a period during which 90 % of the clients claiming condom use during paid sex (Commission on AIDS in Asia 2008).

The extreme stigmatization of sex workers in many, if not most, countries in the region adds a further dimension to their vulnerability. As Meena Seshu of SANGRAM has remarked:

"Apart from the stigma already attached to [sex workers], society has further marginalized them as core transmitters of the HIV infection. It fails to understand and recognize that they are but links in the broad networks of heterosexual transmission of HIV. And that they constitute a community that bears and will continue to bear the greatest impact of the HIV epidemic." (http://www.avert.org/prostitution-aids.htm)

It is important to note that sex work is not a monolithic category. There are a great variety of forms in which sex work takes place, ranged along a continuum from relatively formalized (as with sex workers who are based in brothels) to extremely non-formalized (as with women who occasionally sell sex, or exchange sex for specific commodities such as food in times of great need). In between are street-based sex workers, "hostesses", and "flying" sex workers - women who may wander into a red light area to work for a time then disappear again without ever attaching themselves to a particular brothel or broker. Vulnerability to HIV is affected somewhat by where a woman is located (at any point in time) along this continuum, with the least formalized among them generally being more at risk of HIV infection. Vulnerability, however, is also mediated and shaped by a range of other factors such as age (with younger and older sex workers being particularly vulnerable), immigration status (women who are trafficked into sex work from another country being among the most vulnerable)¹, whether or not she injects drugs, her history of sexually transmitted infections, and whether her entry into sex work was on her own accord or coerced. This range of factors affects the extent to which a given woman will have access to health care services (including reproductive health care, treatment of sexual infections, and HIV prevention, care and treatment), prevention commodities (such as condoms and contraception), and HIV prevention information, which may be targeted to more formalized sex workers. It may also

¹ Silverman JG, Decker MR, Gupta J, Maheshwari A, Willis BM, Raj A. HIV prevalence and predictors of infection among sex trafficked Nepalese girls and women. Journal of the American Medical Association (JAMA) 2007; 298: 536-42.



influence that woman's ability to negotiate condom use and/or influence the nature of a sexual exchange, including whether or not violence is used and the nature of redress available should violence occur.

Women at the less formalized end of this spectrum tend to be at a particular disadvantage, as they are likely to be isolated, unprotected and quite vulnerable to exploitation, violence and discrimination - all risk factors for HIV. This is also a hidden population, about whom little is known and who therefore are difficult to reach with prevention information and commodities. Women who identify themselves as sex workers and work in a formalized sex work setting, may, in some instances, have their vulnerability mediated by the relative ease with which they are able to organize, network and provide safety nets for each other. They are also more visible, and therefore more easily reached by HIV and STI prevention programmes, treatment and care.

Indeed, throughout the epidemic, women who formally identify themselves as working in the sex industry have been among the most likely to respond well to HIV prevention campaigns. Prevention campaigns aimed at, and directly

involving the participation of, sex workers not only reduce the number of HIV infections that result from paid sex; they can also play a vital role in restricting the overall spread of HIV in a country. Proof of this can be seen in countries such as India, Bangladesh, Benin, Cambodia, the Dominican Republic and Thailand, where general reductions in the national HIV prevalence have been largely attributed to HIV prevention initiatives aimed at sex workers and their clients (UNAIDS, 2003). India's Sonagachi project, implemented by Durbar Mahila Samanwaya Committee (DMSC), which mobilizes sex workers in Kolkata's red light areas into supportive Self-Regulatory Boards, monitors and protects women and girls working in those areas, and lobbies for their rights. This type of project is a prime example of directly involving sex workers as agents of change (see UNAIDS, 2000; UNDP, 2003).

Within the Asia-Pacific region there is debate about whether HIV prevention will be more effective if sex work is criminalized or decriminalized. The HIV and AIDS community, however, has generally agreed that further criminalizing sex work will not only be ineffective, it may in fact exacerbate the epidemic (UNAIDS,

2007). By driving sex work further underground, criminalization makes it more difficult to ensure that these women have access to the necessary services, commodities and social protections they need to moderate their vulnerability to infection.

CREATING AN ENABLING ENVIRONMENT

- Follow principles of harm minimization.
 Successful action to reduce HIV transmission that is a consequence of sex work will not eliminate sex work, but rather minimize the harms associated with it.
- Remove or revise laws that criminalize sex work. Rather than drive this activity under-ground, policy should decriminalize it, easing the way for the provision of information, services and protections for those involved. These measures should pave the way for an increase in condom use by clients, thereby dramatically reducing the onward transmission of HIV to non-sex worker clients.
- Promote greater condom use by empowering sex workers and by involving other actors in the sex industry. Many past efforts to encourage condom use by sex workers have targeted information and commodities at the sex workers themselves. There are good examples where empowerment of sex workers organizations has led to increase in condom use as shown in Sonagachi, India. However, given that the ultimate decision about whether or not to use a condom resides with the male client, condom promotion efforts need to also be targeted directly to the clients themselves. This is especially relevant in countries such as Indonesia and Myanmar where women can be arrested for possession of a condom and in red light areas that experience high turn over of sex workers. Great success has been achieved in some countries in the region (famously Thailand, but also West Bengal) through incentives to brothel owners who require patrons to use condoms. (e.g., see Promising Practices in this section of the Guide).

P Ensure regular screening and treatment for sexually transmitted infections. Sexually transmitted infection (STI) rates are extremely high among sex worker populations, and effective screening and prompt treatment of these infections can have a significant impact on HIV transmission risk. It is likely that in the Philippines, for example, widespread, routine STI screening and associated HIV services for sex workers has contributed to slowing the growth of the epidemic there (MAP 2005). The provision of STI services to sex workers provides the additional opportunity of making HIV testing and counselling (including prevention counselling) available.

SUGGESTED DIRECTIONS FOR PROGRAMMES

Respond to the needs of injecting drug users within HIV programming for sex workers. Typically programmes to reduce needle-related HIV transmission and sex-related HIV transmission have been developed and implemented separately, or in parallel. However, because there is such an important overlap between these activities and because of the importance of this overlap as a driver of the epidemic here, it is necessary to develop programmes and policies to address the HIV risks associated with these behaviours together.

Readers, and practitioners in particular may also find the recent guidance from UNAIDS (2007) useful for planning:

UNAIDS GUIDANCE NOTE ON SEX WORK, PILLAR 2: EXAMPLES OF ACTIONS

Meeting the HIV prevention, treatment, care and support needs of sex workers and their clients requires a wide range of actions and the comprehensive integration of accessible and quality services.

Expanding our knowledge base:

- Country level mapping of sex work settings, including mobility and migration trends and their implications for service delivery, legal frameworks pertaining to sex work and their impact on the vulnerability of sex workers and clients to HIV infection, and the availability of services for sex workers as well as identification of gaps;
- Identify good practice examples of HIV treatment, care and support for sex workers living with HIV; and
- Improve data collection of HIV and sexually transmitted infections prevalence among sex workers at the country level.

Advocacy:

- Support the development and expansion of HIV prevention, treatment, care and support services for sex workers in primary health care settings, and through the owners and operators of sex work establishments, and the controllers of sex workers; and,
- Support programmes that address the stigma and discrimination experienced by sex workers.

Strategic partnerships:

- Provide technical support to national governments to reduce the risks associated with HIV and sex work, including the elimination of gender-based violence towards sex workers, through the establishment of national, regional and local partnerships between law enforcement, health, judicial and other government sectors, civil society organizations, and sex work networks and organizations; and,
- Engage police, brothel owners and managers of sex industry operations, local health authorities, and sex workers and clients in introducing codes of practice in sex work settings including: condom use; prevention, diagnosis and treatment of HIV and other sexually transmitted infections and other reproductive tract infections; the elimination of gender-based violence against sex workers; and appropriate behavioural standards for clients.

Enhancing service provision and uptake:

- Promote the integration of HIV services for sex workers into primary health care, sexually transmitted infections, tuberculosis, hepatitis, family planning, prevention of mother to child transmission, and sexual reproductive health services;
- Support initiatives enabling sex workers to refuse a client and negotiate safer sex practices and utilize other risk-reduction methods;
- Strengthen programmes which provide care and treatment for sex workers living with HIV, including antiretroviral therapy, when medically indicated, and treatment of opportunistic infections;

- Promote access to drug dependence treatment programmes and a comprehensive package of harm reduction interventions; and,
- Promote behaviour change communication initiatives with clients of sex workers in sex work settings.

Source: UNAIDS. (2007). *Guidance Note on HIV and Sex Work*. Geneva: UNAIDS. *http://www.aids.md/files/library/2007/1144/unaids-guidance-note-hiv-sex-work-apr-2007.pdf*

PROMISING PRACTICES

There has been a great deal of excellent work with sex workers across the region over the last two decades, and numerous examples of good practice to follow, of which only a few are mentioned here to stimulate thinking and

inspire further research. For additional examples, see UNAIDS (2000). Section 4.9.3 includes case studies of interventions aimed at women who have been trafficked into sex work (and see UNDP, 2003 for greater detail on these).

THAILAND'S 100% CONDOM PROGRAM

By the late 1980s, the government of Thailand was becoming alarmed at the high rates of HIV in sex workers and their clients, and sought ways to increase condom use in their interactions. In the early 1990s, it began a pilot programme responding to the finding that sex work establishments requiring condom use or sex workers insisting on condom use often lost clients and money to those that did not. Owners who promoted safer behaviour faced the risk of losing business because men could simply go to another establishment or to a sex worker who did not require condoms. Regional Communicable Disease Control officials realized that one solution was to require that all sex workers in the province use condoms in every sex act. This would assure owners and managers that they would not lose business by enforcing the policies requiring condom use, since clients could not go anywhere else to obtain unprotected sex. The officials initiated a collaborative effort among local authorities, public health officers, sex establishment owners and sex workers to ensure that clients could not purchase sexual services without condom use in the province. When this programme was implemented, the rates of sexually transmitted diseases (STIs) dropped quickly and significantly. Soon afterwards, the efforts were expanded with equally postive results in the surrounding provinces and several others in other parts of the country. In August 1991 the National AIDS Committee, chaired by the prime minister, issued a resolution to implement the 100% Condom Program on a national scale. The resolution stated:

The governor, the provincial chief of police and the provincial health officer of each province will work together to enforce a condom-use-only policy that requires all sex workers to use condoms with every customer. All concerned ministries will issue directives that comply with this policy.

By the middle of 1992, the 100% Condom Policy was in place nationally, and studies indicate a 90 percent compliance rate.

There are clear indications that these efforts have had an impact on HIV transmission at the national level. Nationwide monitoring of condom use in brothel-based sex work and of levels of reported STI among men has shown a strong relationship between the increase in condom use and the rapid decline in STI. Studies found a tenfold reduction in STI incidence and a fivefold reduction in HIV incidence among young Thai men between 1991 and 1993 (Celentano et al. 1998). In short, the 100% Condom Program has been an important contributor to large-scale reduction of HIV transmission throughout the country. (See UNAIDS1998)

[A UNAIDS evaluation of this programme, from which this box has drawn, can be found at http://data.unaids.org/Publications/IRC-pub01/JC275-100pCondom_en.pdf]

WORKING IN THE SEX WORKER'S WORLD

These small case studies show that key players within the sex industry, including sex workers themselves and the various power brokers that influence their lives, should be seen as part of the solution, not just part of the problem.

1) *Mamasans in HIV education for sex workers in Lao PDR* (from MAP Report 2005): There is a rapid turnover of women into and out of the sex industry in Lao PDR. Many women find themselves infected with a sexually transmitted infection within weeks of the first time they sell sex. Turnover at sex-selling establishments is high. Interventions that reach an establishment only every few months find that over half of the sex workers are new each time they go, making it difficult to provide the women with the needed ongoing services in a sustainable and cost efficient manner.

Mamasans are women who control business arrangements for sex workers. Operating in small drink shops, they are frequently the first point of contact for women beginning to sell sex in Lao PDR, and they may also be the most influential. One study showed that sex workers who received HIV education through their *mamsans* were up to 10 percent less likely to have unprotected sex with a client than similar sex workers who received information by any other form of intervention.

2) <u>Empowering sex workers in identifying trafficked women</u> (from "Challenges to Opportunities" Publication; UNDP 2003)

The NGO Durbar Mahila Samanwaya Committee's (DMSC) policy and practice have revolutionised existing approached to curbing trafficking and containing HIV/AIDS in the South Asian context. The active involvement and empowerment of sex workers in generating sustainable responses through the formation Of: Self-Regulatory Boards" has proven to be an invaluable best practice that is now being replicated globally, from Brazil to Thailand. The core elements of the project include strengthening networks and partnerships among sex workers' organizations and between state and non-governmental organizations; as well as targeting the community by involving sex workers themselves. One of the highlights, in terms of achievements of STD/HIV prevention was the rise in condom use in Sonagachi, from 2.7% in 1992, to a dramatic 60% in 1994, and 86% in 2005 (data from DMSC).

SOCIAL MARKETING OF CONDOMS IN A FEMALE STREET BASED SEX WORKERS INTERVENTION IN DHAKA, BANGLADESH.

SHAKTI, an HIV prevention project of CARE Bangladesh started working among street-based sex workers in early 1997 in Dhaka. Initially the peer educators were responsible for providing knowledge on STD/HIV/AIDS, condom use and the free distribution of condoms. The organization of sex workers, Durjoy Nari Shongo (Undefeatable Women's Committee) came into existence in February 1998. As the organization developed its capacity it was decided to hand over project activities to their organization in phased manner. Keeping in mind the sustainability of the project, it was decided to sell condoms through social marketing model and stop free distribution. The model was developed in 1999 together by the Durjoy Nari Shongo and peer educators. Durjoy Nari Shongo now purchases condoms in wholesale from a social marketing company and sells through women sellers at retailer price to sex workers. Initially, SHAKTI donated some condoms to seed the project. Subsequently, the profit from sale of condoms held create a revolving fund.

The volume of condom sales is affected by external factors like police arrest, violence, political unrest, religious issues, and so on. The monitoring survey showed a sharp increase in condom usage; at the end of December 1998, only 39% of all vaginal and anal sexual intercourse were reported to be covered by condoms, which increased to 52.4% at the end of December 1999 and 65.6% at the end of December 2000.

Involvement of sex workers' organization in social marketing of condoms appears to be a promising model for sustaining the safe sex intervention program.

RESOURCES

MAP Report (Monitoring the AIDS Pandemic). 2005. Sex work and HIV/AIDS in Asia. www. mapnetwork.org/docs/MAP_SW%20in%20 Asia%20Final%2004July05_en.pdf

Network of Sex Work Projects http://www.nswp.org . In 1991 an informal alliance of sex workers and organizations that provide services to sex workers formed as the Network of Sex Work Projects. NSWP is a legally constituted international organization for promoting sex workers' health and human rights. With member organizations in more than 40 countries, the Network develops partnerships with technical support agencies to work on independently-financed projects.

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4.9.2 HIV, WOMEN AND INJECTING DRUG USE

OVERVIEW OF THE ISSUE

To understand the HIV epidemic in the Asia-Pacific region and get a complete picture of women's vulnerabilities in these situations, it is critical to understand the nexus between injecting drug use, sex work, high numbers of concurrent sexual partnerships and the use (or non-use) of condoms. This nexus is thought to be a key driver of the epidemics in China, Indonesia, Malaysia and Viet Nam, as well as parts of India. The nexus is critical not least because the combined burden of HIV in these five countries is so tremendous. In all these countries there is an overlap between injecting drug use and sex work, such that male drug users frequently buy sex, female drug users increasingly are selling sex and female sex workers are injecting drugs. Adding fuel to this potentially explosive situation is the infrequent use of condoms in these relationships and the sometimes extreme stigmatization of sex workers and injecting drug users in many, if not most, countries in the region.

Some data from the 2006 UNAIDS Epidemic Update helps to illustrate the situation:

- In China, drugusers account for 44 percent of the approx 650,000 people living with HIV there. Almost half of injecting drug users (IDUs) in China is thought to share needles, and one in 10 engages in highrisk sex. Research has found that a large proportion of IDUs buy sex and at least half of female IDUs have at some stage sold sex (Liu et al. 2006; Yang et al. 2005). Sex workers who inject have a very high risk of HIV since they tend to have more partners, use condoms less, and are more likely to share injecting equipment than non-sex working injectors.
- In parts of India, the overlap between sex work and drug use is such that HIV prevalence among sex workers in Tamil Nadu is 50 percent.

- In Viet Nam, HIV prevalence among injecting drug users increased from nine percent in 1996 to 29 percent in 2002 and 32 percent in 2003. It is higher among IDUs in certain cities. In Hai Phong, for example, 66 percent of IDUs are HIVpositive (VAAC/FHI 2007 - reported on JVNET 2/28/07). Condom use is sporadic at best among this population, although the purchase of sex by injectors is common. According to various studies cited by UNAIDS, large proportions of sex workers also inject drugs (20 percent of street-based workers in Ho Chi Minh City and 43 percent in Hanoi), and they are least likely to use condoms when having sex. In Hanoi, a study found that HIV infection levels were 1.6 percent among non-injecting sex workers, compared with 33 percent among those who injected drugs (Tran et al. 2005).
- Drug use is also on the rise in **Pakistan**, where there is also a significant overlap between injecting drug use and sex work. Combined with very low levels of knowledge and awareness about HIV by those at greatest risk, this trend is especially troubling (one in four IDUs in Karachi had never heard of AIDS, while one in five female sex workers could not recognize a condom, and one in three had never heard of AIDS).
- The drug use/sex work nexus is also prevalent in parts of Indonesia, such as Papua, Jakarta, and Borneo.
- Injecting drug use is at the heart of the epidemic in **Malaysia**, and threatens to increase the currently low rates in **Bangladesh**, where HIV infection rates have increased from 1.7 percent in 2000-2001 to 4.9 percent in 2004-2005.

The fact that both sex work and injecting drugs are illegal activities presents enormous challenges for meeting the treatment and support needs of HIV-positive IDUs and their partners. Yet these data highlight the urgency of the problem, and the need to address it as a major focus of HIV prevention activities.

For women who inject drugs, the stigma of injecting drug use is added to other types of related stigma and discrimination. These factors combined can push women into behaviours that increase their risk of HIV. There is a higher likelihood that women drug users will: provide sex in exchange for housing, sustenance, and protection; suffer violence from sexual partners; and have difficulty insisting that their sexual partners use condoms. Women drug users may also rely on men to acquire drugs and injecting equipment and even to inject them - behaviours shown to increase the likelihood of injecting with contaminated equipment. Pregnant drug users are particularly vulnerable. They are less likely than other women to receive accurate information about the dangers of drug use during pregnancy or prevention of parentto-child transmission of HIV. In some countries pregnant drug users are rejected by healthcare providers, threatened with criminal penalties or loss of parental rights, or coerced into having an abortion or abandoning their newborns to the state. Poor access to medication-assisted treatment jeopardizes the pregnancies of opiate-dependent drug users (International harm Reduction Development Program, 2007).

Both injecting drug users and sex workers are potentially at great risk of contracting and transmitting HIV and other serious infections. Female sex workers who also inject drugs could therefore be at especially high risk. The close links between drugs and sex work have been known for many years. Many female sex workers in developed countries inject drugs and are HIV-positive (Gillies & Carballo, 1990). A study of injecting drug use and HIV infection among streetwalking sex workers in Ho Chi Minh City showed that those who also injected drugs had fewer years in sex work, more clients and more husbands/lovers who injected drugs (Nguyen et al., 2004). This study also showed that many of these women inject regularly, share injecting equipment, have a history of sexually transmitted diseases, and infrequently use condoms with both clients and partners (Nguyen et al., 2004). Another study in Viet Nam on drug use and sexual behaviours revealed that it is common for male drug users to partner with a specific sex worker – many of whom eventually begin to inject (Tran et al., 2004).



Women who are spouses of male injecting drug users are highly vulnerable to HIV given the risk of contracting HIV through sexual intercourse compounded by the low probability of condom use. A study with male injecting drug users in Nepal showed that injecting drug users tend not to use condoms with those they feel close to and think are healthy. They apply this principle to sex with their wives, girlfriends and even sex workers. Many of these men report having multiple sex partners and did not tend to reflect on the possibility that they themselves could transmit infections to their partners (Family Health International-Nepal, 2002). In Pakistan, approximately 50 percent of men who inject drugs are married and regularly engage in unprotected sex with their spouses a percentage that translates into an estimated 50,000 women being at high risk of acquiring HIV (Global AIDS Alliance, 2007).

It is important to note that these gender-related vulnerabilities are layered on top of vulnerabilities that relate directly and solely to drug use in the region. An Asian Harm Reduction Network report (2001) found that across the region drug users are made especially vulnerable to HIV (as well as to discrimination, criminalization and excessive punishment, including violence) by policies that are affected by strongly held beliefs about drugs and their adverse effects on society. Many countries in the region take an 'elimination' stance, as opposed to a 'harm reduction' stance. Elimination policies are aimed at reducing both supply and demand for drugs, with a focus on punishment. Stringent laws exist prescribing severe punishment for all drug-related offences, including not only drug use but also possession of drugs and drug-use paraphernalia (e.g. needles and syringes). Such a policy position can make it difficult to provide HIV-related services and support. Indeed, these penalties may actually forbid providing drug users with information or with the means to protect themselves against HIV infection. While widespread, this approach has not been successful in reducing either drug use or HIV prevalence associated with it. A harm reduction position recognizes the dangers of drug use, and seeks to create policies and programmes that eliminate the risks associated with the behaviour. Such an approach may involve some level of acceptance of drug use in order to provide or allow for the provision of, for example, constructive engagement with drug using communities and those serving them, provision of clean needles and/or replacement drug therapy to drug users. Harm reduction programming has had successes in reducing HIV transmissions among drug users, and from drug users to their non-using partners in many parts of the world, and is gaining ground in Asia as well (see, e.g. Viet Nam's new AIDS Law, at http://www.ahrn.net/Vietnam%20AIDS%20Law_ submitted%20to%20NA_21Jun2006.pdf). In order to move forward in reducing the vulnerabilities of women who inject, it will be necessary first to engage in the promotion of harm reduction principles and practices to policy makers and their constituencies.

SUGGESTED DIRECTIONS FOR POLICY AND PROGRAMMES

- **♀** Implement comprehensive harm reduction programming: UNAIDS advocates a "comprehensive, integrated and effective system of measures." Within a comprehensive approach, consider including specific outreach to women and girls who inject drugs and the female partners of men who inject. Also needed is a mapping of this population and expansion of programmes reaching male injectors and their female partners. The package recommended here encompasses delivery through peer outreach, and includes the following elements:
 - Raising awareness and increasing knowledge;
 - Needle and syringe exchange and safe disposal programmes;

- Condom use;
- Specialized gender-responsive drug dependence treatment including substitution treatment and detoxification measures;
- Provision for abscess management and overdose management;
- Voluntary and confidential counselling and testing for HIV and post-test services including HIV prevention education, HIV treatment, care and support for those infected and their partners;
- Services targeted to partners of IDUs that include stigma management and stigma reduction, HIV prevention, treatment, care and support where necessary and especially additional support for family caregivers of HIV-positive IDUs;
- Gender responsive services with a comprehensive approach addressing specific needs of women including peer outreach by female peer educators, gender-sensitive HIV/AIDS prevention and care materials;
- Collectives/solidarity groups of spouses of IDUs. (For example, in Manipur, a self help group was formed for the spouses/ widows of IDUs named "Unity is Strength". Through this group, the women help themselves to lead meaningful and productive lives in the society); and
- Increased and expanded baseline health and behaviour data collection and continued surveillance.
- Sensitize the legal, judicial, and health systems to the realities of the lives of injecting drug users and to work with them in a non-discriminatory manner.
- Encourage greater involvement by the injecting drug users themselves in the planning and design of programs and campaigns.

PROMISING PRACTICES

COMMUNITY AND PRISON HARM REDUCTION IN THE RUSSIAN FEDERATION.

This report examines best practice harm reduction for HIV prevention among IDUs in community and prison settings and Findings are derived from a survey of harm reduction programmes in Russia and findings from harm reduction programmes in prisons.

World Bank Human Development Network, HNP discussion paper. 2001. Burrows, D. A best practice model of harm reduction in the community and in prisons in Russian federation. Available at http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Burrows-ABestPractice-whole.pdf

DRUG DEMAND REDUCTION PROGRAM (CENTRAL ASIA)

Since 2002, Population Services International has implemented the Drug Demand Reduction Program in Central Asia, which focuses on educating at-risk youth, sex workers, drug-using sex workers and drug users on the risk of drug use, especially as it relates to risk of HIV transmission. This programme is a key component in Central Asian governments' programmes to address HIV transmission. It works with an array of risk groups including a regional network of Youth Power Centers in high-risk communities where heroin is readily available. Activities include peer education, mass media campaigns, targeting at-risk youth and simultaneously working with IDUs who may play a role in initiating youth drug use, to discourage their involvement in injecting initiation. This "Break the Cycle" program, first pioneered in the United Kingdom, is paired with Youth Power Centers in a totally new and unique model for reducing drug use and susceptibility to HIV.

Source: http://psi.org/where_we_work/cent-asia.html

HARM REDUCTION PROJECT, VIET NAM

Since 2005, Population Services International has run a harm reduction programme in Viet Nam, which aims to reduce HIV incidence among IDUs, through a high coverage strategy that uses outreach and peer education to promote safer injecting and sexual behaviours to IDUs. Trained interpersonal communicators and peer educators deliver messages related to key safer behaviours, including abstaining from commercial sex, promoting condom use, and enhancing the ability of IDUs to reduce their risk. The programme has also increased access to clean needles and syringes through vouchers redeemable at specially recruited pharmacies, especially those with extended business hours located in neighbourhoods where IDUs congregate. Communication materials convey messages that address needle/syringe sharing and barriers to condom use. The project also reaches IDUs at their homes and in tea stalls.

Source: http://psi.org/where_we_work/Vietnam.html

OTHER KEY RESOURCES

UNODC. 2006. HIV/AIDS prevention and care for female injecting drug users. http://www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf

Asian Harm Reduction Network website: http://www.ahrn.net/contains information about progress and obstacles to harm reduction programming in the region, and includes up-to-date information on current policies in practices in countries throughout the region, as well as links to current evidence and best practice.

The Asian Harm Reduction Network: Supporting Responses to HIV and Injecting Drug Use in Asia. UNAIDS Case Study. UNAIDS Best Practice Collection. May 2001. Geneva.

http://data.unaids.org/Publications/IRC-pub05/ JC477-AHRN_en.pdf

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Tran, Trung nam et al. (2004). Drug use, sexual behaviours and practices among female sex workers in Hanoi, Vietnam-a qualitative study. *International Journal of Drug Policy 15, 189–195*.

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UNODC. (2006). *HIV/AIDS prevention and care for female injecting drug users*. Vienna: United Nations.

4.9.3 HIV, WOMEN, MIGRATION AND TRAFFICKING

OVERVIEW OF THE ISSUE

According to the International Organization for Migration and UNFPA (UNFPA/IOM, 2006) the number of female migrants has steadily risen over the last 40 years, and currently female migrants constitute nearly half of all migrants worldwide. Migration data is largely not gender-specific, however, and female migrants are largely invisible in international migration statistics. This absence of gender-specific data hinders the understanding and appropriate assessment of women's role and needs in the migration process. Although much remains to be learned, it appears that while many women may migrate to be unified with family members living and working elsewhere, an increasing number of girls and women are forced to migrate. It also appears that women are increasingly migrating independently to meet their own economic needs and desires. This type of female migration may be a product of improvements in gender equality and an outcome of modifications in gender roles and women's status (UNFPA/IOM, 2006).

People may move from one place to another seasonally, periodically or permanently for a range of reasons, which can be categorized roughly as follows:

- 1. Voluntary and job-related mobility (e.g. truckers, traders, free-lance sex workers);
- 2. Legally required mobility (members of the military, deported immigrants);
- Coerced mobility (political refugees, persons trafficked for sexual or other forms of exploitation, persons displaced due to war-related population shifts); and
- 4. Distress mobility (due to extreme poverty and natural calamities).

Characteristics of work-related mobility that

enhance HIV vulnerability include repeated overnight travel away from home or community and imbalanced male-to-female population ratios (as among miners, for example), which increases the possibility that sex partners are shared. Migrants are also at enhanced risk because they tend to be poor and lack access to social support networks, health and other social services. Indeed, the link between internal and cross-border migration and HIV is strong: It is estimated that 5 million people are living with HIV/AIDS in the Asia-Pacific region (UNAIDS, 2007). More than half of the PLHIV are in South Asian countries, all of which are labor sending countries.

For a large number of people in the region, migration has become a key strategy to escape poverty. Migration is also an important development strategy for some countries, including Sri Lanka, Bangladesh and the Philippines, in which remittances from overseas migrant workers constitute a large percentage of national foreign exchange earnings. Economic need, including seasonal crop failures, is a primary driver of labor trafficking and internal migration for both women and men (Azad, Nandini).

The vulnerability of women in these situations is compounded by the lack of social, medical and legal services, the absence of support structures, and low levels of awareness and knowledge about HIV. While for many people "mobility is an important survival mechanism and a freedom," it also creates specific conditions of vulnerability that result from "long periods of separation from family, removal from familiar behavioural norms and expectations, social and cultural, isolation and lack of access to information and services" (UNDP, 2007). Therefore, the problem is not population mobility per se, but rather the unsafe conditions under which people move which increase their vulnerability to HIV. This could include increases in the number of sexual partners, the likelihood of unsafe sex and the connectivity of otherwise geographically delimited/closed sexual networks - all of which are related to the spread of HIV² In addition,

² Guest, P. 2002. "Migration and the spread of HIV/AIDS," Unpublished paper. Bangkok, Thailand: Population Council.; Skeldon, Ronald. 2000. "Population mobility and HIV vulnerability in South East Asia: An assessment and analysis," Bangkok, Thailand: UNDP.

there may be linkages between voluntary mobility and trafficking, as some may start out as migrants and end up being trafficked along the way.

Many women who are engaged in sex work are not necessarily trafficked but are extremely vulnerable to HIV given the illegal status of sex work in many countries in the region. A migration study in India among female sex workers found only five to 15 percent of women reported that they had been forced into sex work by trickery or coercion (personal communication, Ravi Verma, 2008)

In many parts of South Asia, families often prefer to send off girls and young women who may be considered a burden at home while waiting for marriage, or who may be widowed or separated, as they are seen to be more likely than young men to send their earnings back to the family. Lacking education, these girls and women have limited livelihood possibilities in their own immediate communities where the majority of the others are also poor and unable to provide employment.

While mobility increases the vulnerability of those who move, it can also increase the vulnerability of those who remain behind. For example, early in the HIV epidemics in Asia, long-distance truck drivers were identified as an important population to reach with prevention messages. It is estimated that there are over five million truck drivers in India, and they are threetimes more likely than other men to have sex with someone who is not a regular partner. The truck drivers also have a rate of HIV and other sexually transmitted diseases 10 to 20 percent higher than the average client of a sex worker (AVAHAN India AIDS Initiative, "Meeting the Challenge"). The wives of these truckers are at particular risk of HIV both because they are left alone in their villages for long periods of time and may themselves seek outside partners, and also because they have a much higher risk of exposure to HIV through unprotected sex with their husbands (condoms are not generally used with regular partners or spouses when their husbands return home). Violence against women is a further issue exacerbating HIV vulnerability for truckers' wives. One report (ICRW, 2005) found that 43 percent of truckers' wives in one district of Andhra Pradesh reported experiencing at least one form of physical violence in the previous 12 months, with sexual violence being particularly prevalent (see Section 4.5 on the links between violence and HIV). Women who travel abroad for work (whether for sex work or not, and whether the migration is voluntary or forced) also risk carrying HIV back with them to their husbands and partners at home. The situation is further exacerbated by HIV- and sex related stigma, which may lead women to conceal, their serostatus (see Hong et al., 2004). In this way, mobility can act as a bridge for HIV to move from mobile individuals into the general population.

HIV and Trafficking



Trafficking is a form of mobility and a phenomenon that substantially compounds HIV risk for those trafficked and their sexual contacts. The UN Protocol to Prevent, Suppress and Punish Trafficking in Persons (2000) defines trafficking as:

"The recruitment, transporting, transfer, harboring or receipt of persons, by means of a threat of use of force, or other forms of coercion, of abduction, of fraud, of deception of the abuse of power or of a position of vulnerability, or of giving or receiving payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation."

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Trafficking has been found to be integrally linked to the lack of secure livelihoods which forces large numbers of people to leave their homes seeking income to improve the living conditions of their families, often uninformed of potential risks including trafficking and HIV infection. Although the majority of children trafficked are girls, there is evidence of trafficking of boys in Asia for the purposes of labor, begging, camel jockeys, and to work in the sex industry (Archavanitkul, 1998).

Both HIV transmission and trafficking thrive in contexts of grave gender power disparity – that is, where a woman's worth is perceived as being low, where women have little autonomy relative to men, and where human rights are not accorded equally to women and men nor protected by the government. This situation results in the economic dependency of women on men, gender-based violence, unequal access to resources and many forms of exploitation – all key factors that have been strongly linked to HIV vulnerability and are associated with trafficking.

Though lack of adequate data remains one of the fundamental weaknesses in exploring the linkages between trafficking and mounting appropriate responses, a recent study in Kathmandu by the Harvard School of Public Health shows a very strong association between trafficking, HIV and multiple layers of gender inequality (Silverman, 2007). The study found that about 38 percent of women trafficked into sex work were HIV-positive. Furthermore, the same study found that more than 60 percent of the girls trafficked into sex work before the age of 15 were HIV-positive, demonstrating the high vulnerability of young girls to HIV in trafficking.

The research also showed that girls trafficked as minors spent longer amounts of time in brothels compared to other sex workers, extending their exposure to the virus and therefore putting them at a higher risk of HIV infection. It was found that each additional month of captivity in brothels increased their risk of HIV infection by 3 to 4 percent (Silverman et al., 2007).

A great deal of trafficking occurs between countries in the Asia-Pacific region. For example, the Coalition against Trafficking in Women (CATW) Fact Book estimates that thousands of Burmese women are trafficked into Thailand for the purposes of sexual exploitation through abduction, with the promise of good jobs, or through the sale of girls from hill tribes (http://www.catwinternational.org/factbook). It is estimated that 50-70 percent of these women become infected with HIV. CATW reports that Vietnamese women and girls are trafficked to both China and Cambodia through abduction, promise of jobs or tourist trips, and matchmaking with foreigners who often sell and resell the women abroad. Japan, CATW reports, is the largest sex industry market for Asian women, with over 150,000 non-Japanese women in prostitution, more than half of whom are Filipinas and 40 percent of whom are Thai. These women and girls, far removed from their families and friends, with no power and fewer resources of their own, are exposed to HIV through repeated unprotected sexual contacts, which may include violence and other forms of exploitation as well. Indeed, studies show that brothel-based sex workers are most likely to become infected during their first six months of work (e.g. Kilmarx et al., 1998) - precisely the time when their bargaining power is at its lowest, when they may be forced to 'service' more customers, are less likely to be able to insist on condom use, and may be subjected to additional violence to be "broken in" (UNDP, 2003).

As UNDP (2003) explains, trafficking often includes sexual exploitation, and may also involve domestic servitude, unsafe agricultural labor, sweatshop labor, construction or restaurant work. Trafficked women and girls are made vulnerable to HIV infection both by being cast adrift from the networks of social support and reciprocity that may have been available to

protect them in their home areas, and through potential exposure during multiple, concurrent, unprotected and often violent sexual contacts.

The UN Office on Drugs and Crime (UNODC) recently reported that India has become a leading destination for human trafficking, with over 35,000 young girls and women from Bangladesh and Nepal being brought into the country every year, primarily for prostitution and slavery (http://www.giftasia.org). Meanwhile, the age of those being trafficked is dropping. According to the UNODC, in the 1980s, trafficked girls were mostly 14-16 years old. By 1994, the average age was between the ages of 10-14, and by 2006, girls 10 and younger were being forced into the trade. It is possible that the fear of HIV infection is driving traffickers to seek out younger and younger women under the assumption that they would be less likely to be HIV-positive or it could be due to the prevailing "virginity myth" among clients of sex workers (UNDP, 2003). As UNDP explains, "Asia is facing a double emergency – a trafficked child or woman has greater chances of contracting HIV/AIDS because s/he is placed in the most vulnerable of situations with absolutely no control over his/ her choices" (UNDP, 2003, 6).

HIV, Migration, and Trafficking

The lack of safe, secure and legal channels for migration, drive unsuspecting and uninformed women and girls into the hands of unscrupulous agents and traffickers who promise them "good jobs" and "safe travel" to work sites. Taking advantage of the increasing number of people in such vulnerable and often desperate situations, human trafficking has become the third most profitable organized crime business following arms and illicit drug trafficking, with an estimated market value of U.S.\$32 billion (UNODC, 2007). An estimated 250,000 women and girls are trafficked from South Asia and 200,000 from South East Asia annually (UNDP Regional Programme for Asia and the Pacific 2008-2011).

Women and girls trafficked into sex work have extremely unequal power relations with their 'buyer' or brothel owner. This makes them highly vulnerable to HIV infection. They are exposed to HIV through repeated unprotected sexual contacts, which may include violence and other forms of exploitation as well. A large majority of female sex-workers face extreme forms of violence at the hands of police and



clients. Women trafficked for sexual exploitation may become totally powerless and subject to greater violence and dangers, including forced sex without condoms." It is estimated that more than two-thirds of female sex-work is non-brothel based in some settings, particularly in South Asia. And about one-third of all female sex-workers are mobile for the reasons of safety and business.

Over the last 15 years, there have been a number of approaches to addressing the gender-related risks of mobility and trafficking. Approaches include finding trafficked women and girls and providing safe havens and alternative incomegenerating options for them (also known as the 3 R's or Recovery, Rehabilitation/Repatriation (if applicable) and Reintegration); reducing the demand for trafficked women and girls by cracking down on traffickers and their contacts, such as "madams" and pimps; reducing the need for mobility by increasing the resiliency and capacities of sending communities; and making migration safer for those involved. Some efforts utilize more than one of these approaches at a time.

There remains considerable debate about whether and to what extent such efforts can and should involve law enforcement agencies. This debate often centres on the fact that victims of trafficking are themselves sometimes criminalized, whether as being illegally present in the receiving country, or due to the activities in which they are involved such as sex work. In Pakistan, for example, trafficked women in sex work are criminalized and imprisoned as having committed zina, or unlawful sexual intercourse outside of marriage (UNDP, 2003). In addition, law enforcement may prioritize the repatriation of trafficked women over ensuring their well-being and respecting whether they want to return home. Many of these women (the vast majority of whom have left their country without passports) will be subsequently rejected at their home country borders, unable to prove citizenship. Making a determination as to whether and how to involve law enforcement in rescue and reintegration efforts will depend to a great degree on the policy and legal context and the ability of the implementing agency to influence the behaviour and actions of the

law enforcement personnel involved. Some organizations, such as Lawyers for Human Rights and Legal AID (LHRLA) in Pakistan, work closely with the media to raise awareness of policy makers and the community, and to advocate for policy change.

Even when girls and women trafficked for sexual exploitation are rescued from captivity, they often face another layer of gross human rights violations and vulnerability. They are in some cases harassed and treated as criminals by the police due to the fact that they were engaged in sex work, forced into HIV testing without proper counselling, and detained or deported when they do not have legal documents. Furthermore, girls and women trafficked for sexual exploitation are often labelled as tainted and not accepted by their own family and community. Social sanctions against them are further compounded if they are infected with HIV.

With few livelihood options and little social support, many are forced to re-enter into sex work, exchange sex for food and survival or become an easy prey for re-trafficking. Research conducted by the National Human Rights Commission in India (NHRC, 2004) reveals that about 25 percent of 561 respondents who were trafficking survivors for sex work were victims of re-trafficking. Eighty percent of these re-trafficking survivors cited the lack of alternative jobs back home as the major reason for becoming re-trafficked.

A regional rapid assessment study by UNDP in South Asia calls for greater dialogue and collaboration between the anti-trafficking community and AIDS community, as HIV and human trafficking share many common contextual as well as consequential factors (UNDP, 2007). The report also emphasizes the need for laws, policies and programmes that address both human trafficking and HIV-related issues in a comprehensive manner.

The need for attention to this issue has clear international backing. For example, the UN General Assembly Special Session on HIV/AIDS (UNGASS) Declaration calls for governments "to strengthen legal, policy, administrative and other measures for the promotion and

protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls" (emphasis added).

CREATING AN ENABLING ENVIRONMENT

- Develop policies and laws to make it safer for women to move and work. This policy development and strengthening of international and national laws and conventions, and national policies will need to involve international agreements and understandings about cross-border movement of people, migration control and regulation. Women who migrate for work are often assumed to be engaged in sex work and therefore experience stigma and discrimination. Reducing stigma related to women's mobility should be addressed.
- In creating stronger policies and laws aimed at ending human trafficking, draw on international conventions and national policies, and involve international agreements and understandings about the cross-border movement of people, its control and regulation. The resulting laws must include provisions and take care that their implementation ensures and protects survivors of trafficking from involuntary repatriation. Great caution must be exercised in interpreting and implementing relevant laws. In March 2008, anti-trafficking legislation was enacted in Cambodia. However, it was used by the law enforcement authority to equate sex workers with traffickers, resulting in massive brothel raids and arrests of sex workers. The crackdowns have driven sex workers underground, often more dangerous working environment hardly accessed by HIV prevention . Sex workers are now afraid of carrying condoms for fear of arrest, putting the country's 100% condom campaign in serious jeopardy.

SUGGESTED DIRECTIONS FOR PROGRAMMES

- Multi-sectoral approaches to preventing HIV and trafficking of women and young girls. Because of the complexity of the issue, policies and programmes around trafficking need to be multi-sectoral, integrated and holistic (Shah et al., 2002). They need to address both the issues that drive illegal human trafficking, and the effects of migration that compromise the safety of women. Interventions need to be grounded in legal provisions and macro-economic and social policies that protect human rights and provide poor women (and their families) with assets and legal protections. Programmes must include:
 - Empower sex workers in the identification of those who have been trafficked
 - Empowerment of trafficked survivors to prevent their re trafficking
 - Improved access to legal protection and social services, including culturally and linguistically appropriate health services and education:
 - Facilitation of safer mobility through norm change and rights education;
 - Alleviation of poverty in affected communities;
 - Work in source communities to raise awareness, promote zero tolerance for trafficking, and cultivate alternative options for girls and their families; and
 - Advocacy and information dissemination for ending trafficking in both source and recipient countries.
- Work with mobile groups and stable communities together. Programmes to reduce the HIV vulnerabilities that result from mobility and trafficking must simultaneously work with mobile groups and the stable communities with whom they interact. There is a risk that implementing programmes just for mobile populations can easily lead to stigma and discrimination against mobile

people, while giving the false impression to those in stable communities that they do not have to worry about HIV. The combined effect of these two unintended consequences is an environment in which HIV is more likely to be transmitted.

PROMISING PRACTICES

LAWYERS FOR HUMAN RIGHTS AND LEGAL AID (LHRLA), PAKISTAN

LHRLA was formed to meet the ever-growing demands of those who cannot afford the expenses of litigation. LHRLA provides direct legal aid by approaching law enforcement agencies, the police, the Home Secretary, the provincial governor and other highly placed officials with reports, petitions and statistics. The organization welcomes all cases where there has been an infringement of human rights. It focuses primarily on cases of woman and child abuse, trafficking, illegal detention, rape, torture, dissolution of marriage, child custody, the juvenile justice system, jail reforms and public interest litigation. LHRLA's primary activities involve advocacy for policy change, working with the media to raise awareness about trafficking and its relationship to legislation and policy, both within Pakistan and elsewhere in the region. Through this mechanism, LHRLA seeks to generate public debate and ultimately pressure governments to change laws and constructively address issues.

For more information, see: www.lhrla.com and UNDP 2003. From Challenges to Opportunities: responses to trafficking and HIV/AIDS in South Asia. United Nations Development Program. Available at: http://www.undprcc.lk/Our_Work/HIV_and_Development.asp

MAITI, KATHMANDU, NEPAL

Maiti Nepal's name is synonymous with care and support. Set up in 1993 by a group of socially committed professionals to combat trafficking in women and children, it has done exemplary work in providing sustained and transformative care and support services to both the survivors of trafficking, including those who are HIV-positive, and to the communities where rescued girls are reintegrated. In the sprawling shelter home that Maiti runs, every woman and child in distress finds a place she can call her own. The organization has reached out to those marginalised and has shaped public consciousness on trafficking and HIV/AIDS issues.

Maiti's uniqueness lies in its approach to care, support and reintegration of survivors of trafficking and HIV positive women and children.

At the core of the care and support structures is a safe shelter where women who have been severely traumatised by the experience of being trafficked can seek refuge. But as they recover and move towards normalcy, they are offered access to many other mechanisms, which contribute towards reintegration. Medical care, psychological counselling, health and hygiene education along with awareness about HIV/AIDS, vocational training, non-formal education, assistance in finding job are among the services provided by the care and support programme. Among the international agencies and NGO's that support Maiti's programmes and projects are the UNDP, UNICEF, UNIFEM, Save the Children UK, Terre des Hommes, Save the Children Norway, The Asia Foundation and ILO. Maiti has entered into partnerships with South Asian NGOs such as STOP (Delhi, India), SANLAAP(Kolkata, India), Childline, Varanasi, and Maiti Mumbai, for better coordination of its efforts to rescue and repatriate trafficked women and children. (Source: From Challenges to Opportunities: Responses to trafficking and HIV/AIDS in South Asia, UNDP 2003)

For more information about Maiti, go to http://www.maitinepal.org/

SANLAAP, KOLKATA, INDIA

SANLAAP is a development organization that has been working on the issue of human trafficking for two decades. Over the years, the organization has gathered knowledge and information from the children and women in the red light areas, with whom SANLAAP started its journey. Thousands of women and children are trafficked for the purposes of commercial sexual exploitation, cheap domestic labor, beggary, organ transplant, and to work in the circus and entertainment industry across the country. In response, SANLAAP partnered with the police and helped identify minors who are forced into labour and sex work.

SANLAAP is involved in awareness raising, sensitization and training for law enforcement and the broader community. A key part of SANLAAP's work involves providing shelter for young women and girls who have been victims of trafficking or who are the children of sex workers in the community. There are currently 250 girls being sheltered by SANLAAP in 4 homes across the city. These girls receive education, skills building, psychosocial and mental health support, and access to legal aid. Since 2003 SANLAAP has been one of the major organizations in India giving training to the police on gender, trafficking laws and legislation and dealing with victims of trafficking. In 1996 SANLAAP created a process to repatriate Bangladeshi girls. In 2006 it became the standard operating procedure, and, with the help of UNICEF and the Government of India, will soon become the subject of a bilateral agreement between the two countries.

For more information about SANLAAP, go to http://www.sanlaapindia.org/

DURBAR MAHILA SAMANWAYA COMMITTEE (DMSC) KOLKATA

Durbar Mahila Samanwaya Committee's (DMSC) policy and practice have revolutionised existing approaches to curbing trafficking and containing HIV/AIDS in the South Asian context. The active involvement and empowerment of sex workers in generating sustainable responses through the formation of 'Self-Regulatory Boards' has proven to be an invaluable best practice that is now being replicated globally, from Brazil to Thailand. DMSC see sex work as a 'contractual service negotiated between consenting adults and is committed to decriminalization of sex workers and their children.

DMSC's work with trafficked women grew out of the innovative approach they developed for providing sex workers in Kolkata's red light district of Sonagachi, with treatment for sexually transmitted infections. In around 1996 DMSC helped with the creation of Self-Regulatory Boards, which were a way for sex workers to organize amongst themselves to control the exploitative practices within the trade, prevent the entry of minors, regulate the rules and practices, and institute social justice measures for sex workers and their children. Their objectives included mitigation of violence, establishing channels of information within red-light areas to identify minors being trafficked therein, providing trauma counselling and health care to trafficked women and children, repatriation of those rescued, and keeping in touch with those who are repatriated to ensure they remain safe and not re-trafficked. In the context of trafficking, DMSC use the self-regulatory boards to identify minors who have been trafficked into the sex trade, and to help them out of their situation. A key innovation of this work is the involvement of 'babus' (or regular clients) who keep an eye out for 'new faces', which they can then report to the SRBs for further investigation.

For more information about DMSC, go to http://www.durbar.org/ and see also http://www.undprcc.lk/Our_Work/HIV_and_Development.asp

TRAFFICKING AND HIV PREVENTION PROJECT: CARE BANGLADESH

CARE Bangladesh initiated a pilot project on trafficking and HIV prevention in the border areas of Bangladesh and India in 2003. The projected targeted about twenty thousand people in six villages of Benepole Check Post including gram police, black marketers, police, port labors, transport labors, dalals (brokers), school teachers, students and imams, madrasha students & teachers, local club members, casual sex workers, migrant population and trafficked victims. The major project activities were education and awareness raising among concerned stakeholders, advocacy with key government officials and opinion leaders and networking for identification, referrals and re-integration of the trafficked survivors with local service providers

The strength and unique quality of this project was its ability to mobilize and strengthen the capacity of sex workers organizations at the border to actually intervene effectively in order to (i) reduce the vulnerability of the women being trafficked in the sex trade and (ii) provide practical assistance to the women and girls affected by trafficking into the sex trade through promoting sexual health and appropriate repatriation and reintegration. This project also sought to strengthen this network of sex workers and their anti-trafficking activities by eliciting the active collaboration of NGOs, GOs and other relevant bodies and institutions which were either directly or indirectly involved with addressing the problems associated with trafficking.

For more information, see resource, "Trafficking and HIV Prevention Evaluation Report".

RESOURCES

<u>Reducing girls' vulnerability to HIV/AIDS: the Thai</u> <u>approach. A UNAIDS Case Study. July 1999.</u>

This case study is in the UNAIDS Best Practice Collection. It provides a succinct and helpful overview of the issues of sex work among young women in Thailand, relates this to their HIV vulnerabilities, and highlights several organizations and projects that are addressing these issues.

http://data.unaids.org/Publications/IRC-pub05/ JC466-GirlsVuln_en.pdf

<u>Toolkit for HIV prevention among mobile</u> <u>populations in the Greater Mekong Sub-region.</u> 2002.

This is a toolkit for managers and implementers of HIV prevention programmes in locations where there is an association between mobility and HIV vulnerability. It outlines how HIV transmission can be prevented among mobile people as well as among people who live in stable communities affected by mobility. The toolkit should be used by people who already have some experience in HIV prevention and are now ready to address

the specific challenges of working with mobile populations. It is not a complete textbook for people new to HIV prevention. It assumes that programme managers already know about HIV, know how to facilitate participative educational processes, and know how to work with people in local communities. For these programme managers, the toolkit presents useful guidelines that will help them to ensure that all aspects of effective HIV prevention programmes are occurring in their location.

http://www.burnet.internationalhealth.edu.au/ freestyler/gui/files/toolkit_part1.pdf

<u>United Nations Development Program. From Challenges to Opportunities: responses to trafficking and HIV/AIDS in South Asia. 2003</u>

This publication includes brief analyses of the work of several organizations whose work focuses on reducing the vulnerability of women in the context of trafficking and provides a useful overview of key domains and approaches for intervention.

http://www.undprcc.lk/Our_Work/HIV_and_ Development.asp

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4.9.4 HIV AND WOMEN IN CONFLICT AREAS

OVERVIEW OF THE ISSUE

Conflict as it is used here is defined as armed political or ethnic unrest that has led to or has the great potential to lead to internal displacement of families and individuals. The conflict situation in the Asia-Pacific region is best described along a continuum from the relatively peaceful societies such as Malaysia and Viet Nam on one end, to countries characterized by long-term political control with forceful silencing of government opposition (such as the violence which occurred recently in Myanmar), to the ethnic and political tensions that have long smouldered and recently erupted in East Timor and Nepal. Natural disasters are also included here as they face similar issues related to displacement and disruption of services and legal and economic structures.

While there is little peer-reviewed literature on gender issues related to HIV in conflict zones, recent research has challenged previous assumptions that armed conflict automatically increases HIV prevalence (Spiegel, 2004).

HIV rates among displaced populations are often lower than rates in the more stable host countries. Increases in HIV rates in conflict areas are influenced by various factors including HIV prevalence in the host country and among the displaced population, the level of isolation of the displaced population, the length of the conflict, and the presence of international military or peacekeeping soldiers. Where HIV prevalence rates are higher in the host country, HIV is more likely to increase among the displaced population. If the group or population affected by the conflict is relatively isolated and the HIV prevalence rate is not high, the rate of HIV infection does not necessarily increase. The use of rape and sexual abuse as a weapon of war has been well documented in conflict areas worldwide. Yet even in Sierra Leone, where there was a very high incidence of rape and sexual abuse, the post-conflict HIV prevalence rate was reportedly less than one percent - lower than in surrounding countries for which there is HIV prevalence data (Kaiser et al., 2002). However, in the Democratic Republic of Congo, where there was a high level of sexual violence and a UN peacekeeping presence, HIV prevalence rates in eastern districts were between 15-24 percent, higher than surrounding areas (Save the



Children, 2001). Thus, the relationship between HIV and conflict is highly context specific.

Regardless of whether conflict causes an increase in HIV infections, conflict undeniably creates a situation of HIV vulnerability for women and young girls. The UNHCR estimates that 80 percent of refugee and internally displaced populations worldwide are women and children. Rape and sexual violence against women are well documented weapons of war. Women are raped in refugee camps as they go out for firewood, or are raped by paramilitary groups to intimidate or maintain control of a geographic area. Women who are raped and become pregnant or HIV-positive rarely have access to health care services. Experience from Rwanda and Sierra Leone indicates that these women are often treated as social outcasts in refugee or internally displaced persons (IDP) camps, are socially isolated and even raped again inside the camps (Benjamin, 2001).

In societies with existing gender inequalities, the economic and social disruption of conflict enhances unequal access to resources for women. This puts them at greater risk for transactional sex for basic needs such as food, shelter, protection and money. Conflict may cause separation of families, leaving women without the social protections of the extended family and friends. Women are also more vulnerable to weak or unenforced legal protections and if they have to leave their home country may by at increased risk for violence or other abuses. Land and property rights are also critical issues in post-conflict and reconstruction areas, and disproportionately affect women (UNCHS, 1999). In Banda Aceh Indonesia, the Indian Ocean tsunami destroyed land records and women who lost their husbands also faced enormous challenges in claiming rights to marital land and property (IDLO, 2007).

Several other specific factors associated with conflict also exacerbate the HIV-related vulnerability of women. First, during conflict, public health infrastructures become inaccessible, particularly for complex services such as PPTCT or ART. Women must rely on breastfeeding where there is no access to infant formula, thus increasing the risk of mother

to child transmission through breast milk. Second, the presence of international military, paramilitaries or other armed groups has also been associated with HIV infection among young girls and women in conflict zones. HIV rates among military conscripts have been found to be higher than in the civilian population (McGinn et al., 2001, as cited in Spiegel, 2004; Smith, 2002, as cited in Spiegel, 2004) and peacekeeping troops often come from countries with high HIV prevalence rates.

In a recently concluded rapid assessment on the HIV risks and vulnerabilities of conflict-affected populations in Sri Lanka, it was found that vulnerabilities relating to HIV infection include poverty and lack of livelihoods, migration, displacement, disruption of families, food insecurity, gender based violence, and alcohol and substance misuse; all of which particularly increased the HIV vulnerability of women affected by conflict. (Joint HIV Assessment Mission of Conflict-affected Populations in Sri Lanka, 2008 UNHCR, UNAIDS, UNICEF, UNDP Regional Centre, UN Resident Coordinator's Office, IOM, FPA-Colombo, OfERR, World Vision, HelpAge,)

In South Asia, the history of opiate drug use adds another dimension to women's HIV vulnerability. Conflict can create fluctuations in drug supply and pricing. One example is in the community associated with injecting drug use in the region of Afghanistan, India and Pakistan known as the Golden Crescent. While men account for most of the injecting drug use, their behaviour also puts women sex partners at risk of HIV infection through unprotected sex. During the Afghan war, the Taliban restrictions and military presence created increased prices and limited heroin supply in Pakistan. Among drug users who breathe the fumes of heroin (known as "chasing the dragon"), more switched to injecting synthetic opiates such as buprenorphine, which were less expensive and widely available in local pharmacies (Strathdee et al., 2002). Hankins et al. (2002) also point out that fluctuations in drug supply can create increased drug use where drugs may be used as in-kind payment for food or other necessities in conflict zones and bring in other drugs which are injected with higher frequency. Access to clean injecting equipment may also be suspended.

SUGGESTED DIRECTIONS FOR POLICY AND PROGRAMMES:

- Institute gender sensitive national laws and policies. In post-conflict settings, addressing the lack of laws and a lack of enforcement of existing laws protecting women's rights is particularly important for meeting basic needs of women and their families. (For example, after the conflict in Rwanda, laws governing property ownership by women were strengthened)
- Strengthen international commitments to gender related issues affecting HIV in conflict zones. UN Security Council Resolution 1325 on the impact of armed conflicts on women, specifically called for action on this front:

"Requests the Secretary-General to provide to Member States training, guidelines and materials on the protection, rights and the particular needs of women, as well as the importance of involving women in all peacekeeping and peacebuilding measures, invites Member States to incorporate these elements as well as HIV/AIDS awareness training into their national training programmes for military and civilian police personnel in preparation for deployment, and further requests the Secretary-General to ensure that civilian personnel of peacekeeping operations receive similar training."

- Train military conscripts in basic HIV prevention and transmission and provide access to condoms and STI treatment; train military conscripts in gender sensitivity in an effort to reduce aggressive behaviour including rape and sexual abuse of women;
- Train UN peacekeepers in gender sensitivity, making specific achievements part of the work performance review system; and

Support economic and political empowerment of women in post-conflict settings.



The following four recommendations are results of a symposium organized in sub-Saharan Africa by the Payson Center for International Development and Technology Transfer of Tulane University:

- Provide multi-sector, integrated and gendered approach to HIV prevention and psychosocial and economic rehabilitation in post conflict societies.
- Ensure that programs are gender and culturally sensitive in order to deal effectively with the disadvantages women face due to conflict (e.g., the creation of women-only clinics like the Polyclinic of Hope in Rwanda).
- Address stigma and shame associated with rape and sexual violence by providing organization and social support to women living with HIV and to women who have experienced rape or other forms of violence (e.g., the Kenya Network of Women with AIDS).
- Incorporate conflict resolution and peace-building themes into HIV and AIDS programmes that are specifically tailored to women and into more general programmes in post-conflict societies (e.g., the Community Responses to Refugee Crisis: A Better Way to Cope project of the Society for Women and AIDS in Zambia).

PROMISING PRACTICES

TRAINING AND STRUCTURAL CHANGE FOR MILITARY PERSONNEL

There are few examples of HIV interventions that address gender issues related to HIV in conflict zones in South Asia. An intervention conducted among conscripts in the Royal Thai Army did not directly involve a conflict zone, however, it is an example of an HIV intervention that effectively reduced HIV incidence among military personnel. The Social Mobility and Sexual Behaviour (SOMSEX) programme in Northern Thailand may provide a model for developing effective HIV interventions for other military conscripts. The model was multisectoral and established clear policies for the military regarding HIV. Several epidemiological studies were conducted to establish a databank on military conscripts for surveillance activities. Training was provided using a peer education approach with educational sessions, condom distribution, and improved recreational facilities on military bases to prevent boredom. (UNAIDS, 2004).

TRAINING FOR UN PEACEKEEPERS

Refugees International provided an in-depth study with the aim of developing a set of policy recommendations for increasing gender sensitivity among UN peacekeeping forces. These recommendations include mainstreaming gender, using personnel performance appraisals as a mechanism for instituting attitude changes within the organization, focusing on civilian personnel, training peacekeeping troops, improving access to the UN complaint system, and empowering women post conflict (Martin, 2005).

POST CONFLICT CAPACITY BUILDING

Ethnic conflict in Sri Lanka has raged for twenty years and internally displaced 800,000 people. A Sri Lankan NGO provides an example of social change programming that takes advantage of conflict to transform gender relationships. The Suriya Women's Development Centre, founded by a group of displaced Tamil women, integrates prevention of violence against women into all of their projects. Women educate the public about violence against women through street dramas, posters and songs. The group also coordinates the Eastern women's NGO forum where NGOs come together to share ideas. Suriya also uses development of video to help women express their experiences and recovery to women who are on the "other side". Through this exchange of video from both sides, the group hopes to provide a "visual evidence of the peace-making process..." (www.oxfordresearchgroup.org.uk)

Violence against women is often intensified after natural disasters or periods of ethnic or political conflict. PRADET, a nongovernmental organization in East Timor, operates the Safe Room project which provides specialized medical and counseling care for people who have experienced domestic violence, sexual assault or child abuse. Safe Room is housed in a small building on the grounds of the National Guido Valadares Hospital in Bidau, Dili, which is open seven days a week during all daylight hours. PRADET has developed a forensic protocol for medical examinations in which injuries are recorded systematically so that this medical evidence can be used later if a legal case is prosecuted. A mental assessment and counseling is also provided. Staff follow up with patients to monitor their mental and physical health. For more information, see http://timor-leste_genderprofile_English.pdf.

The International Development Law Organization has produced a guidebook and a video to raise awareness and provide information on key legal concerns around land, inheritance and guardianship and on the processes through which issues related to these concerns can be resolved. The guidebook is based on previous literature and original data collected among 12 tsunami-affected villages in Banda Aceh and Aceh Besar (IDLO, 2007).

In Sri Lanka, the Suriya Women's Development Centre is a group of displaced Tamil women who have successfully integrated gender into their development programming. Suriya uses song and street drama to educate the community about violence against women (see Bell, E. et al., 2003).

The Canadian NGO, World University Service (WUSC), supports projects in Sri Lanka including courses on welding, bicycle repair, carpentry and mechanics in both mixed classes for men and women and in classes for women only. Gender training is included in all classes (Bell et al., 2003).

Experiences in Africa have made clear that regional coordination is essential for providing continuity of care in HIV prevention, care and treatment services, particularly for complex medical care such as anti-retroviral therapy and prevention of parent to child transmission. Three examples of such regional coordination are the Great Lakes Initiative on AIDS (GLIA), the Oubangui-Chari HIV/AIDS Initiative, and the Mano River Union Initiative on HIV/AIDS (UNAIDS and UNHCR, 2005). A recent UNHCR review indicated that regional programmes may help to provide continuity of services across countries, ensure similar HIV testing algorithms and treatment, improve programmes efficiency and lower costs for prevention and treatment services (UNAIDS and UNHCR, 2005).

Dr. Kamran Lankarani, Minister of Health and Medical Education, Islamic Republic of Iran

It is estimated that today about 2 million refugees are living in Iran. They are mostly from Afghanistan-the large majority of them are women and children. The Government of Iran has always made, and will continue to make available, all health interventions including HIV prevention, treatment and care for our refugee populations 'Without discrimination against them.

So far, all HIV prevention and care programmes including methadone maintenance therapy and other harm reduction measures, have been provided free of charge to all refugees living in Iran. The Government is also providing them with antiretroviral medicines, based on national care and treatment protocols.

The country's HIV policy, developed recently with the participation of all stakeholders, devotes a chapter to HIV prevention among refugees and migrant populations.

In order to respect the dignity of the individual and uphold human rights, which in our constitution includes the right to health, and considering also that refugees are integrated within our host populations, Iran is committed to maintaining and promoting the health of its refugees.

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4.3 HIV and Care-giving 4.4 HIV and Education

4.5 HIV and Violence Against Women

4.7 HIV and Women's Property Rights

4.8 HIV and Economic Empowement

4.9 HIV and Women in Highly Vulnerable Populations



4.10 | ENGAGING MEN AND BOYS FOR EFFECTIVE RESPONSES



4.10 UNDERSTANDING MASCULINITIES AND INVOLVING BOYS AND MEN FOR EFFECTIVE RESPONSES TO THE EPIDEMIC

INTRODUCTION

This section reviews the relationship between prevalent gender norms for men and HIV vulnerability, and offers recommendations for involving men and boys in HIV prevention, care and the longer the term process of changing those norms.

There are clear connections between men's behaviours and attitudes related to sexuality and gender relations and the spread of HIV in Asia. The 2008 Report of the Commission of Aids in Asia reports that:

- HIV transmission in Asia is driven primarily by three high-risk behaviours: unprotected commercial sex, injecting drug use and unprotected sex between men.
- Most women living with HIV in Asia have been infected by their husbands and boyfriends who currently or in the past have engaged in paid sex work or drug injecting
- The numbers of men who buy sex and the turnover of clients visiting sex workers are the main determinants of the speed and level of most Asian epidemics
- Relatively few women in Asia have sex with more than one partner, and HIV-infected women are unlikely to transmit the virus to someone else (except during childbirth)

Given these factors, prevention responses to the epidemic will include engaging with boys and men around complex issues such as condom use, MSM and other sexual practices, gendered attitudes and behaviours. Yet, working with boys and men is not a discrete or "stand alone" approach to HIV prevention, treatment or care. Understanding the varying positions of boys and men, and the effects of prevalent gender norms on men in Asian societies, is part and parcel of any analysis of factors behind the spread of the epidemic and for any proposed strategies

for prevention. Following from such a gender analysis, project approaches of "involving boys and men" take different forms. These can be categorised in different ways, however these are fluid and overlapping categories, not distinct domains. These categories include:

- targeted projects and service provision that address issues and needs specific to boys and men, or are shaped to be more responsive to boys and men and the complexity of their lives. These are sometimes referred to as "men's health" projects.
- Projects that involve men as partners with a goal of strengthening women's health and safety (women's empowerment projects)
- projects that involve both women and men (boys and girls) and consider the effects and consequences of gendered behaviours, roles and relations on society (gender equality)
- longer term prevention initiatives that aim to transform harmful gender norms for boys and men for the health and safety of all (gender transformative)

Like women and girls, boys and men are not a homogenous group. The experiences, positions and attitudes of boys and men do vary widely, even among men in the same community. Men are fathers and sons, friends and co-workers, young and old, leaders and followers, husbands and boyfriends, and these roles have different shades of meaning across the region. Despite the diversity of individual boys and men, there are prevalent gender norms for men, or masculinities, that dictate a very limited, and often harmful, set of roles and behaviours for men.

GENDER NORMS AND MASCULINITIES

Gender norms are the generally accepted definitions for being a woman and a man - what is considered 'normal' for the different sexes - by a given society or group. Gender norms are taught, modelled and enforced in complex ways - through friends and families, institutions and schools, through laws (civil, customary and



religious), through art and literature, the media and cultural activities. All of us, girls and boys, women and men, learn, try out, teach, and even enforce gender norms.

The term masculinities describes gender norms for men. They are how societies define what men should be, do and not do because they are men. They are commonly held ideologies about men and how they ideally should behave in a given setting. The plural form conveys that there are many definitions for- and ways of being - a man, and that these do change over time, lifecycles and from place to place. The plural form also hints towards the hierarchies that stratify different types of men, characterised by different types of masculinity along a spectrum of powerful and dominant to disempowered and marginalised. At its core, understanding work with men for gender equality and HIV prevention hinges on understanding the dominant gender norms for men and women, how they are entrenched in societies, and how these norms help divide power and resources between women and men and among different groups.

It is striking how the same dominant notions of manhood are so often repeated. No matter where dominant norms are identified or by whom, the answers are surprisingly the same. The common denominators are gender norms that describe men who are: strong and brave, breadwinners, attractive, protector, leaders, decision makers, heterosexual and sexually active and experienced. Dominant masculine norms dictate that men are entitled to privileges over women and their bodies - higher pay, more access to jobs, resources and political participation, as well as unpaid services and pleasure from women. As a study on masculinity in India puts it more simply, "Men's roles and responsibilities were largely understood through three main roles: those of provider, protector and procreator"1.

There is nothing inherently wrong with many masculine norms, and all societies have positive examples of safe and healthy ways to be men. However dominant masculine norms become problematic when they are narrowly and strictly interpreted. Simply put, dominant

¹ Kumar, Ch. Satish, S.D. Gupta, George Abraham, Masculinity and Violence against Women in Marriage: An Exploratory Study in Rajasthan, p. 8. Indian Institute of Health Management, Research.International Center for Research on Women (ICRW), 2002. Available online from: www.icrw. org

interpretations of what it means to be a man in many societies – be strong, successful, sexually active, heterosexual and privileged over women - are in direct opposition to those behaviours, ideas and beliefs that are more gender equitable, safe and low risk in terms of HIV transmission.

CONSEQUENCES OF DOMINANT GENDER NORMS ON HIV TRANSMISSION AND CARE

The manner in which boys and men grapple with and subscribe to dominant models of masculinity contribute to HIV vulnerability in a number of ways. Compared with women, men have more sexual partners. Clients who buy sex are primarily men. Men's attitudes concerning condom use and negotiating sex are greatly shaped by gender norms that grant men perceived entitlements to pleasure from women and control over women's bodies. Men are overwhelmingly the perpetrators of violence against women and other men. Gender-based violence is, in one brief definition, violence used to keep in place restrictive gender norms.

Dominant models of masculinity are often equated to heterosexuality, sexual experience, skill and multiple sexual partners. Some young men may feel pressured to acquire sexual experience early and to have many sexual partners. These masculine norms lead some into experimenting with sex at a young age and in unsafe ways, or to buy sex (UNAIDS, 1999). Men who hold attitudes and beliefs that prioritize men's pleasure over women's or assume men have rights to women's bodies increase women's vulnerability to HIV and AIDS. There are specific sexual practices, sometimes preferred by men, which also increase women's vulnerability to HIV (UNDAW, 2003).

The stigmatization of men who have sex with men often forces individuals to keep their sexual behaviour secret and deny their sexual risk, thereby increasing their own risk as well as the risk of their partners, female or male (UNAIDS, 1999). A study with nearly 970 men from three states in India exploring the notion of masculinity and its links with violence found that men endorse initiating and controlling sex as an important marker that constitutes sexual satisfaction. This was especially true for young

educated men and men from higher economic groups. Most disturbingly, nearly 60 percent of the men who agreed that the ability to sexually satisfy was an important marker of masculinity felt that force during sex was a characteristic of sexually satisfying a wife/partner. Young men and men of middle social status were most likely to endorse the use of force during sex (ICRW, 2002).

Condom use has a direct relation to perceived notions of masculine sexuality and pleasure. Noar and Morokoff (2001) documented the effects of "masculinity ideology" on condom usage and sexual and reproductive health in general. Their findings indicate that traditional male gender norms lead to "more negative condom attitudes and less consistent condom use" and promote "beliefs that sexual relationships are adversarial." Community assessments undertaken by the International HIV/AIDS Alliance found that the most frequently cited reasons given by men for not using condoms and for having multiple partners were about sexual pleasure. In the Cambodian assessments, men were frank in stating their unwillingness or inability to deny themselves their sexual desire.

Notions of gender and sexuality underlying men's behaviour not only influence the transmission of HIV, they also influence disclosure, treatment, care and support. Dominant gender norms can taint men's attitudes about what it means "to be strong" and "in control", and consequently their sexual behaviours, risk taking and use of healthcare. Men are less likely to seek preventative care and an HIV testing, to disclose a positive test result, or seek care and support outside the home. It is well established that fear of violence at the hands of their partners acts as a significant barrier for women to disclose their status.

A UNAIDS study conducted with men in Tanzania shed light on men's lack of involvement in care and support and revealed that on occasion "male heads of households would wish to do more when their partners fall ill but were curtailed by cultural definitions of maleness and the roles defined which determine masculinity" (Aggleton & Warwick, 1998). Typically, men are not involved in antenatal care or routine

health care during pregnancy, a site where HIV testing often takes place. In Papua New Guinea, where efforts are being made to involve men through couples counselling in social work services, some difficulties are being experienced including poor male response to health worker counselling, domestic violence upon disclosure of HIV status, the lack of responsible attitude towards the care of HIV-exposed children, and irresponsible sexual behaviour of known HIV-positive men (UNICEF, 2005).

INVOLVING BOYS AND MEN FROM THE PROJECT TO THE POLICY LEVELS

Identifying negative consequences of masculine norms and transforming them to the positive is a basic practice shared by much work with boys and men overall. This approach is based on the premise that gender norms do change and that change can be influenced in differing ways. Despite dominant masculine norms there are boys and men who want to challenge and change these norms but feel unsupported. Qualitative observations from around the region suggest that some young men want to change and challenge the unequal power relations between women and men and accompanying harmful masculine norms. Yet, many men do not know how to go about this change, or if others feel the same way within their families and peer groups. There is therefore need to view men and boys as potential partners, not as merely obstacles, and provide spaces for sharing those voices of change and create supportive system within the communities and families of young men and boys.

At the project level, there is evidence that efforts to transform individual behaviours and beliefs can and do work. However, more work is needed with communities, institutions and at the policy level to create a broader conducive environment for change. A recent WHO/Promundo metaevaluation reviewed 58 programmes involving boys and men - including in the areas of HIV/AIDS prevention, gender-based violence, fatherhood, and maternal and child health. Of these projects 29%, or about a third showed solid evidence of having led to behaviour changes among men, 38% showed reasonable evidence of having led to attitude change, and the rest were

unclear or showed only knowledge change. Those programmes that specifically sought to question or change norms about manhood as part of their intervention – what are often called "gender transformative" programmes – showed even more evidence of attitude and behaviour change on the part of men and boys who participated.

The WHO-Promundo evaluation review also confirmed that a combination of individual interaction (general in group discussion sessions) together with community or mass media messages were general the most effective in achieving attitude and behaviour change with men. Additional research conducted by Promundo (forthcoming) in Brazil suggests that studying adolescent boys who do not conform to traditional expectations of masculinity can help us identify a number of factors associated with gender equitable attitudes among young adolescent males. These factors include: acknowledgement of the costs of traditional masculinities, access to adults who do not conform to traditional gender roles, family intervention or rejection of domestic violence, and a gender equitable male peer group. The creation of long-lasting change will involve identifying these positive norms, engaging communities in discussion about them, and building upon them to create the outcomes sought (UNDAW, 2003).

Because unequal gender norms and the HIV vulnerabilities they create are entrenched in communities and institutions, it is also necessary to look to communities and institutions for the resources and opportunities to support individual change and reflect positive gender transformation. Efforts to end gender-based violence have found that violence prevention efforts that come from and engage members of the community have a greater effect (see Pronyk et al., 2006). This is true for HIV prevention with men and boys as well.

As many of the current initiatives involving boys and men take place at the local project level, and their impact and potential have yet to be scaled-up to the public policy domain. One way to support this scaling up process is to identify what kinds of policies and laws can build a

more conducive environment for men's active engagement in HIV prevention and achieving more gender equality, how men can play greater roles in the implementing existing laws, and advocating for the rights of women and girls.

SUGGESTED DIRECTIONS FOR PROGRAMMES

The following are some of the lessons learned from the project level

- Move towards multi-sectoral and integrated programmes for men and boys; encourage programmes working on violence, health, asset creation and HIV to incorporate specific strategies to reach out and involve boys and men.
- Integrate HIV services within the larger family planning and health services, and specifically involve men in prevention efforts of transmission of HIV to their children and/or in the care of HIV-positive children.
- Engage men and women and boys and girls. Research shows the importance of sometimes engaging men and women separately, addressing and discussing their gender-specific needs, and then in other instances bringing them together.
- Use creative strategies to recruit or attract men and boys. Creating comfortable environments to engage men and boys is important. Reaching men and boys where they gather, work and hang out is a good practice, along with outreach messages to which boys and men can identify.
- Engage credible men. Prevention efforts should pay attention not only to gender transformative messages for men and boys but also who conveys the message. Whenever possible, men should talk to other men from the same communities, having some shared experiences. It may also be beneficial to engage role models who have an influence on men and boys such as peers, mothers, fathers, grandparents, community members and celebrities in programmes for change

- Provide safe spaces for boys and men where they can talk about their personal lives, sexuality and sexual health, experiences and use of violence, their frustrations, desires and challenges. Contrary to common beliefs about them, many boys and men are interested in talking about such issues.
- ♀ Engage boys from the earliest ages and use a lifecycle approach. The social reproduction of gender norms starts from the earliest ages when developing children construct their view of the world, their expectations, imitate the behaviour of men (if they are boys) and women (if they are girls), but can also and do transgress. The lifecycle approach refers to the idea of engaging individuals according to the changing needs and realities over the lifecycle, and a focus on key moments, opportunities, social institutions, socializing forces that can and should be drawn into questioning masculinities and gender privilege.
- Fatherhood, paternity leave, educating boys in how to care for others (informally and formally) is perhaps the "low lying fruit" in terms of engaging men in HIV prevention it may be the easiest place to start. Many men and boys can see immediate benefits and satisfaction to themselves by caring for others, including those living with HIV.

SUGGESTED POLICY RECOMMENDATIONS

- Invest in scaling up, sustainability and replication of successful programme interventions through a conducive environment
- Reduce the imbalance in power between women and men by ensuring policies that empower women such as decrease the gender gap in education, improve women's access to economic resources, increase women's political participation, and protect women from violence.



Establish coalitions between the HIV/ AIDS community and the international women's community to work together and hold governments accountable for the development, ratification and implementation of international relevant agreements.

RESEARCH SUGGESTIONS

- Identify structural changes and policies that could lead to large-scale change in men's notions of masculinity and their involvement in families – for example, policies around parental leave for fathers.
- ♀ Evolve methodologies to reach out and seek the involvement of brothers and fathers in ensuring awareness and realization of gender-equal practices and rights of women and girls, and seek their involvement in programmes to end violence and promote property rights of women.
- Undertakecreativeresearchonmasculinity and its determinants to identify the best approaches to promote gender-equitable male attitudes and behaviours.

- Undertake research to identify ways to overcome the barriers to couple counselling and to test the effectiveness of this method in creating more genderequitable relationships and in reducing vulnerability and stigma.
- Invest in rigorous evaluation to test the impact and effectiveness of programmes reaching out to men and boys.

PROMISING PRACTICES

The need to intervene early to influence the socialization of young boys in order to foster gender equitable attitudes and behaviours forms the basis of most of the interventions with men and boys. Two excellent examples are the Stepping Stones programme and the Men as Partners (or MAP project) of EngenderHealth. Both foster constructive roles for men in sexual and reproductive health. The curricula for these programmes use a wide range of activitiesgames, role plays, and group discussions-to facilitate an examination of gender and sexuality and its impact on male and female sexual health and relationships, as well as to reduce violence against women. MAP has been successfully

adapted in other countries with diverse cultural setting by Engender Health.

Another widely respected programme is Program H, which engages men and boys in the discussion of masculinities. Its operating strategy is based on the natural variation in young men's views about gender inequalities and gender violence. This intervention, adapted in India and Tanzania, and now being adapted in Viet Nam, builds directly on insights gained from listening to the voices of those young men who openly question gender injustice.

Another example of an organization engaging boys and men in critical reflections about masculinity, both in group educational sessions and via community and mass media campaigns, is the work conducted by an Indian NGO Sahayog that has started a multi-state effort to engage men at the community level to start local efforts to reach men with messages to end violence against women and girls.

A literature review identified 57 interventions with men and boys in the areas of sexual and reproductive health, maternal, newborn and child health (MNCH), gender-based violence, fatherhood and HIV prevention that had some impact evaluation and in some way applied a gender analysis – a recognition of salient versions of manhood as being part of the problem – in the intervention. Of the 57 studies, 24.5 percent were assessed as effective in leading to attitude or behaviour change; 38.5 percent were assessed as promising in leading to attitude or behaviour change; 36.8 percent were assessed as unclear (see Barker, Ricardo & Nascimento, 2007).

YAARI DOSTI (MUMBAI AND GORAKHPUR)

The Horizons Program/Population Council, Instituto Promundo, CORO for Literacy, Mumbai, Daud Memorial, Gorakhpur and MAMTA, New Delhi conducted operations research in urban slums in Mumbai (in the western state of Maharashtra), and in rural villages in Gorakhpur (in the northern state of Uttar Pradesh) to examine the effectiveness of various interventions, group education activities and life style social marketing campaign, designed to improve young men's attitudes toward gender roles and sexual relationships and to reduce HIV risk behaviors and partner violence. The sample included married and unmarried young men aged 16-29 years old in urban settings and, aged 15-24 years in rural settings. The results suggest that young men became less supportive of inequitable gender norms after participating in the interventions, whereas in the comparison groups, there tended to be little or no positive change, or the changes were in the wrong direction. Similarly, there were significant improvements among intervention participants in key outcome indicators, including condom use, partner communication, partner violence, and attitudes toward PLHIV. The domain of domestic life and child care seemed to fare best whereas the violence domain seemed to fare particularly poorly in the urban site Nevertheless, the study documented a significant reduction in reported partner violence among the intervention groups, whereas there was a significant increase among respondents in the comparison. It was evident that attitudes toward violence are very deeply rooted and thus may be more difficult to change. Study findings indicate that men perceive violence as a tool to control women and justify it through various reasons

For detail see: R. Verma, J Pulerwitz, S. Khandekar, V. Mahendra, AK Singh, SS Das, A. Nura, S. Mehra, G. Barker 2007. "Promoting Gender Equity as a Strategy to Reduce HIV Risk and Gender-based Violence among Young Men in India," *Horizons Final Report*. Washington, DC: Population Council.

MEN AS RESPONSIBLE PARTNERS (GUJARAT AND UTTAR PRADESH, INDIA)

Partnering with local organizations, and adapting the global Men As Partners (MAP) program, EngenderHealth developed community-based, peer-driven interventions with young men and boys. The results were dramatic: men thoughtfully engaged in discussions, role-playing and games about gender issues. The MAP workshops created real change in participants' attitudes toward women. Furthermore, it is the first gender-related HIV awareness and support program of its kind in Asia. EngenderHealth India has produced several videos that document the goals, approaches and successes of its MAP work. In these digital stories, Indian men share how their HIV-positive status has affected their attitudes and the lives of their families and friends. Each one highlights a variety of interrelated topics such as sexuality, disclosure, masculinity, positive living and prevention. The videos were produced as part of EngenderHealth's Men As Partners' in Positive Prevention program, which works in Gujarat and Uttar Pradesh to engage HIV-positive men as responsible partners in prevention. The men have all become MAP advocates, working to help other HIV-positive people in their communities.

For details see http://www.engenderhealth.org/ia/wwm/wwm-india.html

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