ARROWs For Change

Women's and Gender Perspectives in Health Policies and Programmes

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Women at Greater Risk of HIV Infection

One of the persistent beliefs about the HIV/AIDS pandemic is that it is mostly men who get infected. The reality, particularly in developing countries, is that women are not only getting infected at a faster rate than men but are also suffering more from the adverse impact of AIDS.

As of mid-1996, the Joint United Nations Programme on AIDS estimates that of the 25 million adults infected with HIV since the start of the epidemic, more than ten million are women. It is becoming evident, however, that the proportion of HIV-positive adults who are women is becoming greater with close to half of the 7,500 new infections daily occuring amongst women. Significantly, nine out of ten HIV-positive women live in a developing country. In Asia-Pacific, 1.4 million women have been infected with HIV out of an estimated total of 3.08 million adults from the late 1970s until late 1994 (KIT, SAfAIDS, WHO, 1995).[1]

Source: M. Berer; S. Ray. 1993. Women and HIV/AIDS: An International Resource Book. London: Pandora.

Women are at risk of HIV infection for many reasons. Biologically, women are more vulnerable because of the greater mucus area exposed to the virus during penile penetration. Younger women below 17 years old are at increased risk as they have not yet completed their biological development—having an underdeveloped cervix and low vaginal mucus production. Furthermore, women who have other sexually transmitted diseases, especially those that cause ulcerations, face a greater risk of HIV infection.

Gender Inequalities and the Greater Risk

Importantly, women's exposure to such biological risks are also related to their exposure to gender inequalities in society. In societies where the legal and social status of women is inferior to that of men; where educational opportunity is curtailed for women; and where women have no or little control over their sexuality, the sexual behaviour of their male partners and the use of condoms; women are much more vulnerable.

Further, women's lack of a strong negotiation base in sexual relations is indicated by surveys that show more than four-fifths of all HIV-positive women are infected by a male sexual partner, and studies in Africa and elsewhere have shown that many married women have been infected by their only sexual partner, their husband. The inability of women to refuse sex with their husband, even when they know that he is HIV-positive, has been a major cause of transmission to women, especially in societies where men with multiple partners are tacitly condoned. Combine these realities with the social and economic pressures of poverty, then the risk to women is substantial.

In Northern Thailand, for example, poor families have been known to release their daughters to agents offering jobs in Bangkok, often for a fee, only to find their daughters have been forced into sex work and thus exposed to extremely high risk of HIV infection. In other countries, such as India, very

young girls are given or even sold into marriage to much older, sexually experienced men with whom they have no powers of negotiation.

The trafficking of women across borders for sexual purposes, common in many parts of the world, and the vulnerability of women to rape during war are risk factors for HIV infection which are directly linked to women's social and economic status. Exacerbating the risk is the inadequacy of healthcare facilities and the lack of appropriate education strategies for poor and isolated women in rural areas.

Even when women are not infected, the impact of AIDS amongst family members is felt most by them because the burden of care inevitably falls on the women. If the husband is ill and the family income drops, not only does the woman have to care for him but she also has to find work outside the home in order to feed the family. When he dies, the family invariably suffers not only the trauma of the loss but also from the loss of income. The vicious circle of poverty futher exposes the women and children to risk of infection.

Direction for Prevention Programmes

HIV/AIDS prevention programmes have too often failed by assuming incorrectly that women are at low risk of HIV infection. Economic, social and cultural factors related to risk have not been sufficiently addressed when doing a gendered analysis of HIV/AIDS transmission. Too often such programmes urge prevention methods which women have little or no power to apply, such as condom use, abstinence and mutual fidelity. Even when women understand the risks involved, they are often unable to protect themselves because of pressures and expectations from traditions and cultures. For example, in Asia-Pacific, great emphasis is placed on having children and women's childbearing role, and the importance of these aspects makes it difficult for women to ask their partners to use condoms for protection against HIV infection as condoms also act as a contraceptive.

The particular vulnerability of women to HIV infection has been recognised in the Cairo Programme for Action and the Beijing Platform for Action (BFPA). Recommendations for gender-sensitive HIV/AIDS initiatives are one of the five strategic areas in the Women and Health section of the BFPA. This area emphasises the involvement of women infected with HIV/AIDS in all decision-making levels and processes of policies and programmes. It includes recommendations on:

- ❒ development of community strategies;
- ❒ sensitive legislation;
- ❒ policies and practices to protect women;
- ❒ promotion of equal gender relations;
- ❒ better access to appropriate and affordable preventive and treatment services;
- ❒ action-oriented social research on prevention;
- ❒ women-controlled methods of protection.

Ultimately, society can only protect itself from HIV by changing its own attitudes towards women. Any move toward the recognition of women's rights and enabling women to make their own choices in life will have the good effect of also protecting them from HIV/AIDS. In the end, gender equality would benefit all of society, not only women.

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■ **Reference:**

[1]**KIT; SAfAIDS; WHO.** 1995. *Facing the Challenges of HIV/AIDS/STDs: A Gender-based Response.* The Netherlands: KIT, SAfAIDS, WHO.

***ARROW*s For Change** is published three times a year and is a bulletin primarily for Asian-Pacific decision-makers in health, population, family planning, and women's organisations. It provides: ♦ Women's and gender perspectives on women and health, particularly reproductive health ♦ A spotlight on innovative policy development and field programmes ♦ Monitoring of country activities post-ICPD, Cairo and post-FWCW, Beijing ♦ A gender analysis of health data and concepts ♦ Resources for action.

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Gender Relations in Urban Households in Bombay: Challenges for HIV/STD Prevention

In an attempt to gain a clearer understanding of the barriers that low-income women face in protecting themselves from sexually transmitted diseases (STDs) including HIV, a qualitative sample survey was carried out in Bombay, India, by the Tata Institute for Social Sciences. The survey was to identify women's sexual and reproductive health behaviours and examine the economic and sociocultural realities which influence those behaviours.

Local NGOs were approached by the research team to help identify 35 low-income women of childbearing age to participate in the focus group discussions. The women were divided into six groups; however, about three weeks after beginning the group discussions, the team found that many women felt uncomfortable discussing such sensitive topics as sexual experiences within the group format. Therefore, the team decided to conduct two-hour individual interviews with eight of the women, with an emphasis on their sexual experiences.

Findings on Gender-Power Relations

One common observation from the study was that in male-female relationships, whether social or sexual, men appeared to have power over women.The study indicated that the possession of several key resources—mobility, information and skills, money, social support—are necessary to having power over one's life and within relationships. Restrictions on women's mobility are imposed by their parents during childhood and by their husbands in marriage.

In the domain of reproduction and sexuality, the women were constrained by their ignorance of menstruation, sexual intercourse, pregnancy and childbirth until they actually experienced them. This lack of information and knowledge led to a literal powerlessness in being able to ascertain their own sexual and reproductive state of health and significantly affected their ability to seek appropriate care. As a result of a lack of information about reproduction processes, the women felt that they were not in control of their own bodies, whether it be during sexual relations or childbirth.

The interviews highlighted that having access to money enabled women to make significant life choices, such as in educational careers and in ending abusive and unfulfilling marriages. These women had a lifelong familiarity of understanding violence as a source of power used by one person to influence or control another. Husbands were reported to have resorted to physical violence as a mode of interacting with their wives and maintaining the dominant decision-making position within the relationship. In some instances husbands beat their wives to make them submit to sexual relations. A woman recounted, *"I was scared. I felt he will beat me if I refused. I did not like sleeping with him . . ."*.

The women found that the social support (i.e., information and sense of community) provided by their natal family and NGOs was invaluable in their efforts to gain a measure of control over their lives.

Implications for STD/HIV/AIDS Prevention

The research findings demonstrate that low-income urban women in Bombay live in an environment of unequal power relations between women and men. This reality appeared to be the overarching explanation for women's subordinate position within marriage and society and a major factor which increases their risk of STDs and HIV.

The women indicated that cultural silence and unequal power relations serve as barriers to communication between women and men about sex, reproductive health and STDs/HIV. Women mentioned that persuading a husband to use a condom would be impossible under circumstances where sex occured through the use of force or violence. Negotiating condom use also requires women to be assertive and dominant—behaviours that go against their socialisation to be deferent to male authority.

In such scenario, the prevention of HIV/AIDS is a great challenge. Women's vulnerability to the disease emanates from their weaker resource base and bargaining power as compared to men. Reducing their vulnerability necessarily means strengthening their fallback position (outside options should cooperation of the husband and family cease) by strengthening their control over financial, human, intellectual and material resources. Women's risk of HIV/AIDS is most effectively reduced through transformation of social structures which lie outside the health sector. The creation of societal conditions where women are paid on par with men, where they have equal access to credit and training and where they have the right to inherit, own and control productive assets, would increase women's resource base and increase their control over various arenas of their lives, perhaps including the sexual arena.

This article is a compilation of selected paragraphs from:

■ **George, Annie; Jaswal, Surinder.** 1994. "Understanding sexuality: an ethnographic study of poor women in Bombay, India". *Report-in-Brief: Women and AIDS Research Program.* Washington DC: International Center for Research on Women. [1717 Massachusetts Ave., NW, Suite 302, W. DC 20036, USA]

■ **George, Annie.** 1996. "Gender relations in urban households in Bombay: challenges for HIV/STD prevention" [paper presented at the conference on] *Reconceiving Sexuality: International Perspectives on Gender, Sexuality and Sexual Health, 14–17 April, 1996, Rio de Janeiro.*

Positive Women Victoria: Supporting Women with HIV/AIDS

By Philomena Horsley

Positive Women Victoria is a support group for women with HIV/AIDS that is run by women with HIV/AIDS. We are the only group of its kind in Australia that is directly funded by government, through the National/State AIDS Matched Funding Program. We are also the contact point for the National Network of Positive Women, many of whom met at the First and Second National Positive Women's Conferences. The Network keeps positive women across Australia informed and connected, for example, through its newsletter with a list of representatives in each state.

How did we begin? In 1984, a woman was diagnosed with HIV. She hoped to find other HIV-positive women so she left her name with doctors so that they could put women in touch with her. It was not until four years later that she was contacted by another woman. Within a few years, a small number of women were meeting regularly and they formed Positive Women Victoria. They met to support each other, and to lobby for greater attention to be paid to gender issues in HIV/AIDS, particularly in the areas of medical treatment, research and prevention education.

Gender Issues in HIV/AIDS

The need for special attention to gender issues continues, and current issues include:

- the need for women to be represented in drug trials and treatment research so that women can be better informed with regard to the effects on women's bodies;
- the need for more research with regard to HIV-positive women and pregnancy, and better access to treatments for children who are HIV-positive;
- greater representation of women in policy and programme development to ensure that gender issues are considered in all government and community strategies related to HIV/AIDS;
- the development of information and prevention education strategies that specifically and sensitively target women, involve consultation with women, and are realistic about the roles and responsibilities women have within families and society;
- greater attention to the legal rights relevant to positive women such as the threat of compulsory ante-natal testing.

Services for Positive Women

Since 1994, we have received funding for one paid worker and have office space donated by the main AIDS hospital in Melbourne. We provide a range of free and confidential support services for HIV-positive women:

- individual contact —women can talk to another positive woman in person or via the phone. Confidentiality is assured;
- group support meetings—we have day and evening meetings, several times a month, for women to meet and share their experiences;
- a drop-in centre—women drop in to have a chat or use our resources. For instance, we have information files on topics such as HIV/AIDS treatments, pregnancy and HIV, "how to tell others?" and relationship issues, as well as a small library of books and international newsletters and journals on HIV/AIDS;
- free massages offered by volunteers;
- information and referrals—we can refer women to specialist HIV/AIDS health practitioners and counsellors, as well as organisations that are sensitive to the needs of women with HIV, in areas such as emergency financial assistance, housing and home care;
- a monthly newsletter—members say that this is our most important service because it gives women all over the state (and interstate) access to up-to-date information and to other women's stories. The newsletter contains women's personal stories, information and news about our activities. It is sent exclusively to positive women to maintain contributor's confidentiality. A third of all positive women in Victoria are on our mailing list. We also have a public information newsletter that is distributed two to three times a year to health professionals and relevant organisations to keep them informed about our activities.

The use of our services continues to grow. On a monthly basis, we get an average of around 70 contacts from positive women: about 50 contacts with agencies wanting our assistance; and the rest are requests for speakers for public talks (an average of ten public talks in a month) and for information from students researching in the area. Because the organisation is run by women living

with the virus, we understand the special issues facing women. For instance, the need for confidentiality is extremely important so that women can both protect themselves and their families from discrimination. Women also need to know specific information about how HIV/AIDS affects their bodies and what treatment options exist for them. They are also particularly interested in reproduction issues—getting pregnant, or helping children who are infected.

Articulating Positive Women's Voices

Positive Women can act as an advocate on behalf of individuals and groups. For instance, recently a woman gave birth in a large public hospital and experienced serious discrimination because of her HIV status. We lodged a complaint on her behalf and are now working with this hospital (and others) to improve their policy and standards of care in relation to positive women. A number of our women find that their children are refused entrance to childcare centres or schools due to staff's ignorance and fear of AIDS. We approach these organisations to inform them that this exclusion is illegal and offer to educate staff and other parents. We also assist women to find free legal help in other cases of discrimination. There is a constant need for information on these rights and other issues. We work to ensure that AIDS-related publications incorporate information that is relevant to women's concerns.

In attempting to correct the general perception that AIDS is a "male" disease in Australia, we make sure that positive women are represented on various state and national committees so that women's voices are heard, and to fight for the funding of services and resources specifically for women. Positive Women is represented on the People Living with AIDS Lobby Group, the Victoria AIDS Council, the National Association of People Living with AIDS and the Australia Federation of AIDS Organisations, among others. We are also represented internationally on GNP+, the Global Network of People Living with HIV/AIDS.

We also run a Speakers Bureau, a group of openly HIV-positive women who go out to speak to school children, community groups and to doctors and other health workers. By doing this, we believe that we can change the stereotypes that people have about women with HIV. For instance, the community view is that positive women are "dirty and diseased" women who must have become infected through prostitution and drug use. The majority of women, in fact, have been infected by their husbands and boyfriends. However, we make it very clear that we are not concerned with how a woman is infected—we welcome all women to our group regardless of their background, mode of infection, sexual

Source: Women's Health Resource Collective. 1992. Positive Women: Women with HIV/AIDS Speak Out

orientation, age, nationality or religion. We also educate people about HIV/AIDS and how to prevent infection. It is very empowering to stand before a group of people as an openly positive woman and confront their ignorance with the reality.

In 1997, in Australia there are nearly 1,000 women living with HIV. Most of these women contracted the virus from heterosexual sex. They range in age from children to women over 60 years. We now make up nearly ten per cent of all new HIV diagnosis here.

New National Strategy

In December 1996, the Federal Government released its new national three-year HIV/AIDS strategy. It acknowledges that people living with HIV/AIDS must be totally involved in the development of policy and services, and that our human rights must be protected. It maps the process for the national coordination of Australia's response to HIV/AIDS and identifies action strategies in the priority areas of education and prevention, treatment and care, research, international assistance and cooperation and legal and ethical issues. Positive Women Victoria is working to ensure that these goals are met, and that awareness of gender is critical to Australia's response to HIV/AIDS.

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Nepal

■ A national-level Mini-Beijing Conference, attended by 800 participants from 71 (out of 75) districts, was held in Lalitpur, Nepal on the 15–18 February, 1997. This big event, quoted as, *"the most successful and biggest event ever done by women for women in Nepalese history",* by our national contributor, was organised by a coalition of Nepalese women NGOs called the Beyond Beijing Committee. Representatives from the indigenous, "untouchable", village and district development committees, NGOs, lawyers, academia, inter-governmental organisations, police and various ministries were among the participants. The theme of *Equality for Empowerment Towards 21st Century* with the slogan "Equality begins at home" were chosen to initiate a national debate on women's equality, justice, peace, development and empowerment in the light of the 21st century.

Critical issues affecting women such as health, gender violence, women's full participation in decision-making process and in politics, poverty, education, media and environment, were discussed during the conference. Based on the conference's inputs, the Beijing Committee is finalising the conference Declaration and Plan of Action (POA). The draft Declaration, among others, recognised the need to translate the Beijing Platform for Action to respond to the situation in Nepal, as well as calling for the effective implementation of the UN Convention on the Elimination of All Kinds of Discrimination against Women (CEDAW). The draft POA addressed all the critical issues mentioned above. In the health section, it urged the government to prioritise women's health and development, based on women's lifecycle and their changing health needs, in the national Ninth Fifth-Year Plan. Government needs to work with NGOs to enhance gender-based health programmes with the strengthening of preventive programmes. For instance, by making treatment, services and information more accessible and economically viable to women. On gender violence, the POA called for the repealing of all discriminatory laws against women, beginning with the enactment of laws on equal property rights during the forthcoming Nepalese parliamentary session. Furthermore, the Nepalese government who has rectified CEDAW, was urged to immediately submit its initial report to the treaty body, as well as to formulate and effectively implement policies and laws consistent with the provisions of this Convention.

■ The Ministry for Women and Social Welfare has set up a committee and sub-committees on all the 12 critical issues identified in the Beijing Platform for Action (PFA). Each of the twelve groups, consisting of NGOs, government agencies and experts, has developed a final report to the ministry. These reports are to be forwarded to the National Planning Commission, for consolidation in the coming national Ninth Five-Year Plan. The report will not be distributed until its submission to the Commission.

Indonesia

■ The Indonesian government made a move to discuss the issue of women's reproductive rights during a national conference, *The Consolidation of Gender Equality: Implementing the Proposals from the Fourth World Conference on Women,* held on 28 March, 1996 in Jakarta. The high rate of maternal mortality in Indonesia was identified as a major issue of concern. The conference also examined strategies to reduce this rate. Concurrently, the Ministry of Women's Affairs has launched the national programme called *Gerakan Sayang Ibu* (literally translated as Love Mother Movement) in an attempt to reduce the extremely high maternal mortality rate (450 per 100,000 in 1990) in Indonesia. Meanwhile, on 12 December, 1996, a seminar was held in Jakarta to discuss girls' education in Indonesia and identify strategies and aspirations to improve the education of girls in the 21st century.

Sri Lanka

■ The Family Planning Association of Sri Lanka is undertaking the promotion of gender equity and women's empowerment under its second Three-Year Plan, from 1997–1999. To do this, the Association will strengthen community-level activities of the Association's District Level Committees, NGOs, and the community-based organisations. A National Women's Task Force, which was set up for this purpose, will be aided by district-level committees to monitor the progress of the project. The project is expected to cover at least 16 districts for the first year, a total of 40 cluster villages. Fifteen women leaders will be selected and trained to conduct gender equality and sensitisation programmes in each of these villages.

Vietnam

■ A national seminar on *Improvement of Women's Health,* organised by the Research Centre for Gender, Family and Environment in Development (CGFED) and funded by ARROW, was held in Hanoi on 28–29 April, 1997. Researchers, academicians, senior-level personnel of the Ministry of Health and media people were among the 40 participants present. The seminar began with the launching of the

health resource kit, *Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific*, published by ARROW for which CGFED was one of the contributors. The resource kit was designed as a practical tool to assist in the implemention of the Cairo Programme of Action and the Beijing Platform for Action. A resource person, Ms. Indu Capoor of CHETNA, India, who was a representative of ARROW, emphasised the need to make primary health care programmes more gender-sensitive. She further highlighted that women's health is neglected throughout their lifecycle, except when they are mothers. This bias is reflected in national provisions, for example, the Maternal and Child Health Programme. Therefore, there is a critical need to include the concerns of adolescent girls, older women and single women in the health programmes. In addition, there is a clear need for gender-sensitive policies which are well-reflected in the programmes at the field-level.

The seminar identified key issues relating to gender, such as the importance of having a policy and programme goal that clearly emphasises gender aspects—the specific needs of women and men; addressing men's roles and responsibilities; and listening to women's voices to ascertain social and cultural factors which are vital but missing in health programmes and services at the grassroots-level. Fifteen seminar papers on various critical issues on women's health in Vietnam were presented. These include issues on sexual health, cervical and breast cancers, infertility, abortion and the newly established hotline service on women's health.

The United Nations Joint Programme on HIV/AIDS

■ The International Centre for Research on Women (ICRW), an NGO based in Washington DC, USA, is conducting a "Taking Stock" Exercise on Gender and HIV/AIDS for the United Nations Joint Programme on HIV/AIDS (UNAIDS). The purpose of this exercise is to produce a comprehensive document that highlights both published and "grey" literature on women, gender and HIV/AIDS; with a special focus on the development of the discourse away from a focus only on "risk" toward a more comprehensive discussion of women's vulnerability to HIV/AIDS.

In addition, ICRW will also explore—through document collection and personal interviews—the body of knowledge and experience gained over the past 20 years in improving women's socioeconomic, political and legal status and how traditional development interventions have influenced the gender-power disparities that have been identified as contributing substantially to women's vulnerability to HIV infection.

This review will be used by UNAIDS staff in Geneva and in the field, as well as by those working in the UNAIDS co-sponsoring agencies (WHO, UNDP, UNICEF, UNFPA, UNESCO and the World Bank).

Individuals and organisations that have evaluation documents or other unpublished literature that describe interventions aimed at improving women's status, particularly if the interventions were able to measure improvements in the realm of gender-power relations within households and communities, are asked to contact: Daniel Whelan, Project Director, International Centre for Research on Women, 1717 Massachusetts Ave., NW, Suite 302, Washington DC 20036, USA.
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Calling for Country Updates!!

We are urging national NGOs or individuals in countries of Asia-Pacific to write to us and share your country's efforts to implement the Cairo and Beijing Platforms, particularly relating to women and health. Our bulletin readers would like to know:

- **Are there any new policy statements?**
- **Are there any efforts to develop a National Plan of Action post-Beijing?**
- **Are there any law reviews or reforms?**
- **What are the critical issues addressed in any of these effors?**
- **Is the process participatory (public, NGOs, other groups consulted)?**
- **Is there any NGO-GO collaboration?**
- **Is your organisation involved in Cairo or Beijing follow-up activities?**
- **Are there any groups doing monitoring work in your country/area?**

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From the Documentation Centre

_____. 1996. *The Status and Trends of the Global HIV/AIDS Pandemic: Asia-related Sections from the Report of a Two-day Symposium held in Vancouver by AIDSCAP/FHI, The Francois-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health and UNAIDS, 2 August 1996.*
[lists.inet.co.th:///pub/sea-aids/esgen/esgen3.txt]

One of the key issues discussed in this symposium is the impact of HIV/AIDS prevention and care programmes in Asia. Thailand's well-documented programmes have some positive influence, particularly in the sex industry. In India, the Philippines, Singapore, Myanmar and Malaysia, there are various prevention and education efforts, but not enough data to evaluate any change in risk behaviour. Countries in the early stages of the HIV epidemic and efforts to reduce the rate of infection include Bangladesh, Bhutan, Brunei, Indonesia, Nepal, the Maldives and Sri Lanka. The symposium states that epidemiological surveillance and the evaluation of data is an essential first step in any HIV/AIDS programme. Recommendations include: (1) improve data collection and strengthen researches on HIV/AIDS; (2) disseminate the results; (3) focus prevention efforts on women, youths and marginalised communities; (4) give special attention to explosive epidemics in India, Cambodia, Myanmar and South Africa and potentially explosive epidemics in Indonesia, Eastern Europe and a few countries in West Africa; and (5) all related individuals and organisations at all levels must link to improve prevention and care efforts, monitor trends and evaluate programme impacts.

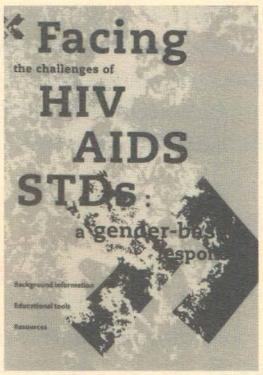
■ ***Source:*** *<ftpmail@inet.co.th> [SEA-AIDS Mailing List Archives of UNAIDS]*

_____. 1996. *Consensus Statement on Research Gaps/Issues Developed at the Women and HIV/AIDS Workshop, May 26–31 1996, Nairobi, Kenya.*
[lists.inet.co.th:///pub/sea-aids/stdis/stdis14.txt]

This consensus statement on research gaps and issues was developed at a workshop in Nairobi, organised by the Network of AIDS Researchers of Eastern and Southern Africa (NARESA) and the Society for Women and AIDS in Kenya (SWAK). It has five parts, namely: (1) capacity-building issues; (2) end-user participatory involvement in research process; (3) dissemination of research findings; (4) advocacy for basic interventions in women's health; and (5) distribution of the recommendations on the identified research gaps. The document states that in order to implement recommendations on capacity-building and end-user participation, it is necessary to change the: (1) attitudes and perceptions of donors and researchers; (2) attitudes of university administrators, communities and governments, respectively, towards research outputs of academic staff; the capacity to collaborate actively; and acceptance of original research and the willingness to include research findings in their policies and programmes. Several strategies to disseminate research findings from grassroots organisations to the highest levels of government and the media were developed. Helpful suggestions were then made on interventions for women's health needs, whereby, the interventions have to be prioritised, the recommendations have to be formulated and addressed to relevant bodies, and the implementations have to be monitored. The list of suggestions is preliminary, thus providing a useful and practical tool to any organisation interested in research on Women and AIDS.

■ ***Source:*** *<ftpmail@inet.co.th> [SEA-AIDS Mailing List Archives of UNAIDS]*

KIT; SAfAIDS; WHO. 1995. *Facing the Challenges of HIV/AIDS/STDs: A Gender-based Response.* Amsterdam: Royal Tropical Institute; Harare: Southern Africa AIDS Information Dissemination Service; Geneva: WHO. 52 p. [1 monograph + 8 cards + 2 posters]



This resource pack provides background information and ideas on how to incorporate a gender-based approach into policies and programmes for policy-makers, planners and programme implementors. After outlining the global epidemiology of HIV infection, AIDS and STDs, the booklet explores the concepts of gender and a gender-based response. The next section focusses on the impact of the epidemic, elaborating on how gender-related factors affect HIV infection risks and obstacles to prevention and care. The gender-based responses and strategies are suggested and described. Personal testimonies and brief description of programmes and interventions personalise the text, show the impact of gender inequality on female and male risk and coping, and provide examples of effective responses. To conclude, a checklist on "how gender-sensitive is your work?" is provided for assessing existing or planned programmes and interventions. Cards and posters are designed as guides for practical activities. They provide suggestions for working with women, men and youth to make them aware of the relation between gender and HIV/AIDS/STDs. The

group work helps people to explore their feelings, knowledge, ideas, values and beliefs, and can be adapted to meet different needs and settings.

■ ***Source:*** *Royal Tropical Institute, Mauritskade 63, 1092 AD Amsterdam, The Netherlands.*

Mane, Purnima. 1996. "Cross-national perspectives on gender and power", [paper presented at the conference on] *Reconceiving Sexuality: International Perspectives on Gender, Sexuality and Sexual Health, Rio de Janeiro, 14–17 April 1996.* 10 p.

This paper contains some of the findings of a study conducted by the WHO/Global Programme on AIDS Social and Behavioural Studies and Support Unit in 1994 on sexual negotiation, the empowerment of women and the female condom. The study, carried out in Indonesia, Costa Rica, Senegal and Mexico, was divided into two phases: the first involved an ethnographic study of gender relations and sexual negotiation in the different sociocultural settings; the second part was a qualitative enquiry on the female condom, including an intervention component with information on sex, reproductive physiology and anatomy, STD/HIV/AIDS and women's vulnerability to them. It was found that an important factor that prevented women from negotiating over sex was their economic and social dependence on men. However, through the intervention programme, the experience of women with the female condom was positive. Women felt with new knowledge gained, they were in a better position for sexual negotiation. Based on the experiences with the female condom in Senegal, the author concludes with the most important lessons learned: (1) the importance of introducing the female condom together with information, skills and collective experiences that contribute to the sense of empowerment; and (2) the introduction of technology for HIV/AIDS needs to be embedded in social and behavioural understanding.

■ ***Source:*** *ARROW*

Mboi, Nafsiah. 1996. "Women and AIDS in South Asia: some key issues of policy", [paper presented at the] *Regional Workshop on AIDS Policy in South Asia, Kathmandu, Nepal, February 5–9, 1996, Organized by The Economic Development Institute of the World Bank in Collaboration with the UNDP Regional Project on HIV/AIDS.* 19 p.

After a brief introduction, the author focusses on women's position in the AIDS epidemic, stating that poverty, lack of information and lack of autonomy in sexual matters contribute to the growing rate of HIV infected women, especially in South Asia, thus making it important to have policies which directly address the special issues concerning women and AIDS. She then identifies key policy issues and stresses the need for national policies which include efforts to educate as well as address prevention. Four policy issues of special interest to women are: (1) access to information about STDs/HIV/AIDS and supportive services for those needing treatment; (2) policy related to the sex industry, for example, the legal status of sex workers, their rights, regulations controlling those benefitting from the sex industry and the sexual exploitation of children; (3) human, intellectual and financial resources, including access to resources by people living with HIV/AIDS; and (4) re-orientation of healthcare providers and health systems to improve their effectiveness in providing gender-sensitive HIV/AIDS-related services. The first step in formulating and adopting a good policy is through a participatory development of the policy itself. The paper concludes with some tables with figures on women in South Asia and HIV/AIDS, and a list of references.

■ ***Source:*** *ARROW*

(i) Singh, Nalini (producer; director). 1993. *Positively Women: Focus: AIDS:* [Video on Women and AIDS in India]. New Delhi: UNDP HIV/AIDS Regional Project. 30 mins.

(ii) United Nations Development Programme, Regional Programme Division, Regional Bureau for Asia and the Pacific. 1993. *Film Discussion Guide for Positively Women:* [Focus: AIDS]. New Delhi: UNDP HIV/AIDS Regional Project. 48 p.

This resource pack includes a video produced by a well known Indian woman film maker and a film discussion guide. The video, which focusses on Indian women and HIV/AIDS, depicts the myth and misconceptions in Indian society which have contributed to the population's false sense of security that they are protected from infection. By talking with women and men of all social classes, the video reveals that the people of India, in fact, face many of the conditions which encourage rapid transmission of HIV. In particular, the film shows the special vulnerability of women, which is due to their poor genital health, poverty, lack of education, general powerlessness over their partners' sexual behaviour and their lack of skills in negotiating condom use. Unable to control these risk factors means that women will continue to be infected at the same alarming rate. The film is intended for group work and the film discussion guide booklet will help stimulate discussion and clarify the basic facts of HIV/AIDS, which should be discussed before viewing the film. This resource pack is an excellent tool for government agencies and NGOs to start an

HIV/AIDS prevention programme component.

■ ***Source:*** *United Nations Development Programme, Regional Programme Division, Regional Bureau for Asia and the Pacific, HIV/AIDS Regional Project, New Delhi, India.*

Zoysa, Isabelle de; Sweat, Michael D.; Denison, Julie A. 1996. "Faithful but fearful: reducing HIV transmission in stable relationships". *AIDS* Vol. 10 Suppl. A. pp. 197–203.

The authors make a case for intensifying efforts to reduce HIV transmission in stable relationships, as a significant proportion of all HIV infections is being transmitted through this means. They also describe the limitations of existing approaches to HIV prevention in addressing this reality. Apart from reflecting a greater awareness of the dynamic nature of population groups who are affected and the need to work towards a change in risk-taking behaviour, the HIV/AIDS programmes should also take into account that many married persons may be at risk of HIV because of the behaviour of their partners. However, the related gender imbalance and structural factors would have to be confronted first. Women are the more vulnerable partners because of gender-based power relationships, their social and economic dependency on men, as well as the pressure on them to bear children. The authors state clearly that the HIV pandemic cannot be contained in the long run without a commitment to social change. A research agenda has to be developed, starting with descriptive research to better understand sexual behaviour. Followed by intervention-related research to develop and evaluate promising approaches to behaviour change in stable relationships. Finally, biomedical research is required for developing improved technologies to reduce the risk of HIV transmission, particularly female-controlled methods.

■ ***Source:*** *Julie A. Denison, AIDSCAP, Suite 700, 2101 Wilson Boulevard, Arlington, VA 22201, USA*

OTHER RESOURCES

■ **Dallabetta, Gina; Hassig, Susan (eds.).** 1995. *Indicators for Reproductive Health Program Evaluation: Final Report of the Subcommittee on STD/HIV.* Chapel Hill, NC: University of North Carolina at Chapel Hill, Carolina Population Center. 74 p.

■ **The Pacific Basin Medical Officers Training Program (University of Hawaii); The Fiji School of Medicine.** 1995. "AIDS, STD and sexuality in the Pacific". *Pacific Health Dialog: Journal of Community Health and Clinical Medicine for the Pacific* September Vol. 2 No. 2. 188 p.

■ (i) **Victorian AIDS Council; Nash, Margo (director; producer); AS IF Productions (producer).** 1992. *Positive Women.* Victoria: Victorian AIDS Council. 22 minutes.
(ii) **Women's Health Resource Collective.** 1992. *Positive Women: Women with HIV/AIDS Speak Out.* Victoria: Women's Health Resource Collective. 75 p.

■ **GENDER-AIDS** by UNIFEM Regional Office for Asia-Pacific, Thailand. To subscribe, write to <gender-aids@lists.inet.co.th> and type message <subscribe gender-aids>.

■ **SEA-AIDS** by UNAIDS Asia-Pacific Inter-country Team, Thailand. To subscribe, write to <majordomo@lists.inet.co.th> and type message <subscribe sea-aids>.

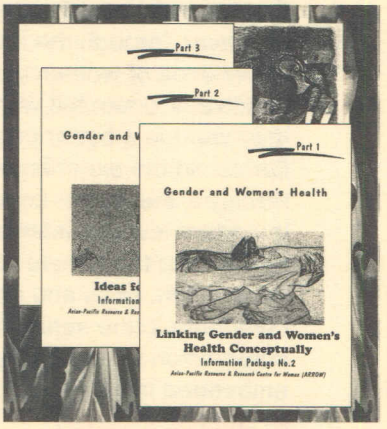
■ **HealthTouch Online**
<http://www.healthtouch.com/level1/leaflets/101810/101811.htm>

■ **HIV/AIDS in Southeast Asia**
<http://florey.biosci.uq.edu.au/hiv/AIDS-SEA/AIDS-SEA.htm>.

ARROW'S PUBLICATIONS

ARROW. 1997. *Gender and Women's Health: Information Package No. 2.* Kuala Lumpur: ARROW. v.p.

■ *Price: US$10.00 plus US$3.00 postal charges. Payment accepted in bank draft.*



ARROW. 1996. *Health Resource Kit. Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific.* Kuala Lumpur: ARROW. v.p.

■ *Differential pricing. For more information, please contact ARROW.*

ARROW. 1994. *Towards Women-Centred Reproductive Health: Information Package No. 1.* Kuala Lumpur: ARROW. v.p.

■ *Price: US$10.00 plus US$3.00 postal charges. Payment accepted in bank draft.*

ARROW. 1994. *Reappraising Population Policies and Family Planning Programmes: An Annotated Bibliography.* Kuala Lumpur: ARROW. 101 p.

■ *Price: US$5.00 plus US$3.00 postal charges. Payment accepted in bank draft.*

Gender and AIDS

Reducing women and men's risk of infection demands gender-based responses that focus on how different social expectations, roles, status and economic power of men and women affect and are affected by the epidemic. This involves analysis of gender stereotypes, redefinition of male and female relationships and roles, promotion of cultural beliefs and values supporting mutually responsible behaviour and exploration of ways to reduce inequalities between women and men. A supportive environment can be created thereby, enabling women and men to undertake prevention and cope better with the epidemic

KIT; SAfAIDS; WHO. *1995. Facing the Challenges of HIV/AIDS/STDs: A Gender-based Response. Amsterdam: KIT; Harare: SAfAIDS; Geneva: WHO.*

Gender-Power in Relationships

In many societies, men are expected to control women in all aspects of relationships. This involves decision-making on when and whom a girl/woman will marry, when and how she will have sexual relations, when and how many children she will have, household expenditures, etc. This type of male power is supported by tradition and social norms . . . Coupled with economic dependence on men, ideas and expectations concerning so-called "proper" male and female roles make it difficult or impossible for women to demand that men share responsibility for preventing sexual and peri-natal transmissions of HIV/STDs.

Socioeconomic Change and HIV Prevention

Modifications in existing AIDS prevention programmes [to be more gender-sensitive] are essential but not sufficient to bring about sustained social change because they do not, for the most part, deal with the larger contextual issues that lie at the root of women's vulnerability to HIV . . . [which are] two very important components of power: economic resources and social support. . . . What can AIDS programmes do about women's economic and social status? First, they can and should explore the possibility of linking up with economic interventions that are already in place, such as credit programmes, agricultural extension services for women farmers, women's cooperatives or saving schemes. Linking up means providing AIDS information services through those channels rather than setting up parallel, vertical programmes just for HIV/AIDS. Such linkages ensure the most efficient use of financial resources and of skills. . . . A second way for AIDS programme practitioners to influence women's socioeconomic status is to advocate for improvements in women's access to education and productive resources.

Rao Gupta, Geeta.*1995. Gender and HIV/AIDS: Transforming Prevention Programmes. AIDScaptions Family Health International Vol. 11 No. 3.*

Men's Responsibilities

Because of their dominant position in many cultures, particularly with regard to sexual matters, men have heightened responsibilities to practice safe sex and to ensure that they do not put their sexual partners at risk of infection. Since their compliance is necessary, men should ensure that condoms are used, where condoms are required to practice safe sex. Men should always agree to use condoms when asked.

United Nations [Fiji]. *1996. Time to Act: the Pacific Response to HIV and AIDS. Suva: United Nations.*

Definitions

Under-estimation of Women's Risk

Women in Asia-Pacific and globally are particularly vulnerable to HIV infection due to their sexual and socioeconomic subordination, as well as the inherent biological vulnerability they face as females. It is estimated that 18 per cent of the people infected with HIV globally are in South and Southeast Asia alone in which the estimated HIV/AIDS female-to-male infection ratio is one female to 2.5 males.[1] It is more than likely that this ratio will increase since in Asia, women are considered to have a risk of contracting HIV that is five times greater than the men due to their greater vulnerability (World Bank, 1993).

The table provides statistics on the number of reported HIV/AIDS cases in selected countries of Asia-Pacific. It is essential to note, however, that these figures are under-estimated as there is a great deal of under-reporting of cases by governments to the WHO. WHO Western Pacific Region states that HIV/AIDS case reporting rates of countries can vary from 80 per cent to less than ten per cent of the estimated number of cases. Thus, prevalence estimates and reported HIV/AIDS cases often show great variability. For example, there are well over 7,000 reported cases of HIV/AIDS in Cambodia (see table) but WHO HIV prevalence estimate is at least 60,000.[2]

Reported HIV/AIDS Cases by Gender in Selected Countries of Asia-Pacific

Country	*HIV/AIDS cases (F)*[2]	*HIV/AIDS cases (M)*[2]	*HIV/AIDS cases (Unknown gender)*[2]
Australia	968	16,566	2,109
Cambodia	1,991	2,022	2,816
China	484	2,854	3
Fiji	2	12	21
Japan	475	1,165	2,118
Malaysia	683	16,210	70
Papua New Guinea (PNG)	147	165	141
Philippine	345	458	7
Republic of Korea	46	291	245
Viet Nam	631	3,442	80

Countries in Asia-Pacific are at different stages in their development of HIV spread. Initially, the rapid growth of HIV was more visible among commercial sex workers (CSWs) and their clients, injection drug-users (IDUs) (mainly males in Asia), and men having sex with men. Overall in the region, this probably accounts for the ratio of infected men outnumbering infected women. However, as the HIV epidemics in Asia mature, there is proliferation of the virus into the general population mainly through heterosexual contact since partners/spouses of IDUs and clients of CSWs become infected. It is reported that the infection of these generally monogamous wives and girlfriends becomes the most important route of female infection.[1] This trend has already been seen in Thailand and India, the two countries in the region with the most widespread HIV epidemics—reported figures for HIV/AIDS cases were unavailable, but prevalence estimates of HIV infection are 750,000 in Thailand and between two to five million in India.[1]

In Viet Nam, China and Malaysia, the majority of HIV/AIDS cases initially reported were among male IDUs.[2] This pattern appears to be changing, at least in Viet Nam and Malaysia, where there is increasing HIV prevalence among pregnant women and CSWs. In Malaysia, WHO reports that 69.7 per cent of the HIV/AIDS cases are attributed to injecting drug-use; and it should be recognised that the Malaysian government actively does HIV testing on IDUs which may account for the large number of confirmed HIV cases in this primarily male population.[3] The table also shows that there are many HIV/AIDS cases that are "unknown" where the numbers are especially high in Papua New Guinea, the Republic of Korea, Japan and Cambodia. This lack of gender aggregated data is skewed and does not accurately reflect the HIV prevalence among males and females in these countries.

Countries in Asia-Pacific need to realise that in order to control the impending HIV/AIDS catastrophe, the time to act is now. Along these goals, it is essential to develop appropriate prevention strategies and programmes based on HIV/AIDS data that is disaggregated by gender. Without such information, policy-makers and researchers will continue to neglect those groups who are at increased vulnerability, particularly, monogamous women who do not know they are at risk.

References:

1 ___. 1996. *The Status and Trends of the Global HIV/AIDS Pandemic, Official Satellite Symposium, XI International Conference on AIDS, Final Report, Vancouver, 1996, AIDSCAP, Harvard School of Public Health, UNAIDS.*

2 **WHO [Western Pacific Region].** 1996. *STD/HIV/AIDS Surveillance Report* No. 8 November 1996.

3 ___. 1995. *Women HIV and AIDS: Facing the Realities: Kuala Lumpur 17–22 July 1995: Final Report, The International Federation of Red Cross and Red Crescent Societies and the Malaysian Red Crescent Society.*

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