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ARROWs For Change

Women's, Gender and Rights Perspective in Health Policies and Programmes

HIV/AIDS and Sexual and Reproductive Health and Rights:

How has Funding Fuelled the Divide?

For a pandemic that thrives in poverty and enhances poverty, nothing could be more awash in money than HIV/AIDS. Even though the Global Fund for AIDS, Tuberculosis and Malaria has not yet met its goal of raising US$10 billion, there is still US$7 billion more than there was in 2001 when the Fund was just formed. In addition, Bush's President's Emergency Plan for AIDS Relief (PEPFAR) promises US$15 billion for HIV/AIDS programmes around the world.

But, as the saying goes, be careful what you wish for, in case you get it. For the first two decades of the global AIDS pandemic, activists, scientists and doctors lamented the lack of funds for effective HIV/AIDS prevention, treatment and care programmes. Millions died who could have been saved through better funded treatment and support. Millions more could have avoided infection if governments and community organisations had the finances to organise better and more effective prevention programmes. But now that money is available by the bucketful, people are still becoming infected or dying from a lack of knowledge and care. According to UNAIDS estimates, at the end of 2005, 38.6 million people worldwide were living with HIV and an estimated 2.8 million lost their lives to AIDS.[1]

The reduction of women's vulnerability to HIV depends on empowering women to make sexual and reproductive choices of their own, but these are exactly the sort of programmes that are not receiving funding.

Much of this has to do with money becoming available with strings attached. In particular, US funding comes with conditions that are completely at odds with empirically proven prevention programmes. PEPFAR money may not go to any programme that prefers condom promotion over abstinence. Abstinence-only programmes can be assured of receiving American funding, a fact that makes even successful condom-based programmes make 180 degree about-turns, as has happened in Uganda. Once, Uganda was a country best known for its successful HIV prevention efforts, but recently, as the US ramped up financing for abstinence-only approaches, condoms remained impounded in government warehouses.[2] In addition, programmes promoting harm reduction strategies, including needle exchange programmes, which are sorely needed in Asia and Eastern Europe, have no chance of receiving US funds.

Ideology seems to be the main obstacle to obtaining funding these days. As with the US global 'gag rule' against organisations working on sexual and reproductive health and rights, US funding now seems to be driven by right-wing religious dictates rather than scientific data. NGOs around the world have found themselves suddenly bankrupt because of the reversal of funding criteria, with those working on women's health suffering the most. At the 2004 ICPD Countdown to 2015 Roundtable in London, delegates contended that US policies concerning international sex education and reproductive health are contributing to childbirth- and abortion-related deaths as well as the spread of HIV among women around the world. Similarly, policies against harm reduction programmes for drug users also indirectly harm the women who are the partners of drug users left vulnerable to HIV infection.

Compared to PEPFAR, the Global Fund is less subject to US policy, but the Fund has been criticised for its unwieldy bureaucracy, despite good intentions. Applications for funding have to go through a country coordinating mechanism (CCM). In theory, the CCM includes representatives from governments, multilateral or bilateral agencies, NGOs, CBOs, academic institutions, and people living with HIV and AIDS, who are supposed to work together to develop and submit grant proposals.[3] In reality, this does not happen evenly across the board, or even at all, in some countries. While the Fund has tried to circumvent this to some extent by funding NGOs, such as the Thai Drug Users Coalition, directly, in most cases

applications have had to go through the complicated CCM process, with varying degrees of success. Even when the Fund has disbursed money, more country-level bureaucracy has prevented funds from reaching those who need it most. For example, the Fund approved US$ 122 million to provide antiretroviral (ARV) treatment to 700,000 Indians with HIV/AIDS, yet no more 47,000 people are actually receiving ARVs.[4] Bureaucratic snags have held up the money for a year, during which time thousands of poor HIV-positive Indians have died. It is an unspeakably tragic irony.

Also problematic is the fact that major bilateral and multilateral donors exacerbate the divide between HIV/AIDS and SRHR, as they maintain distinct departments for HIV/AIDS and SRHR, and typically fund projects and services in these areas separately. In addition, the verticality of AIDS funding has been intensified by the narrow remit of the Global Fund, which in its initial conception failed to make linkages with SRHR.[5]

Where in all this do women fit in? The short answer is nowhere. Not only is women's health threatened by ideologically-based funding policies, but the whole question of sexual and reproductive rights is slowly becoming marginalised.[6] Not because money is being diverted towards HIV/AIDS rather than SRHR programmes, but precisely because the HIV/AIDS programmes being funded are those which do not consider sexual and reproductive rights as necessary issues at all.

The reduction of women's vulnerability to HIV depends upon empowering women to make sexual and reproductive choices of their own, but these are exactly the sort of programmes that are not receiving funding. Instead, funding is being made available for abstinence-only programmes, a concept that is irrelevant particularly for married women and those who are victims of sexual violence. Indeed, most women who have become infected are married to one partner. Nor are other so-called prevention programmes meant to empower women to take control of their sexual and reproductive lives. While antenatal testing programmes meant to save babies from infection have been effective, their effects on the babies' mothers in terms of maintaining their quality of life are still unknown. With stigma prevalent in many countries, HIV-positive women are reluctant to seek treatment for themselves, especially for gynaecological and sexual health concerns.

In addition, prevention for women has largely taken the form of mandatory testing, especially for couples intending to marry. Although touted as a means to protect women, in reality this disempowers women by taking away any element of choice or decision-making. Testing without counselling does nothing to prevent women from becoming infected later in life, precisely because it does not deal with the existing power differentials between the sexes, between husband and wife.

Donors, governments, policymakers, programme managers, health services providers, and other stakeholders must recognise that to protect women against HIV infection, we need holistic approaches that address gender issues and sexual and reproductive rights issues. The reduction of women's vulnerability to HIV is contingent upon issues of education, empowerment, access, and equality. While seismic shifts in societal attitudes are needed, small steps must be encouraged. Indeed, there are small programmes in countries like Mozambique and Mali where social clubs for young girls are set up to empower them through activities and discussions on sexual health. Positively, there have even been high-level discussions calling for the advancement of the relationship between SRHR and HIV/AIDS, namely the 2004 Glion Consultation on Strengthening Linkages between Reproductive Health and HIV/AIDS convened by the World Health Organization (WHO) and the United Nations Population Fund (UNFPA).[7] Funding, however, remains the tail that wags the dog – when so many countries depend on a few ideologically-driven donors, the dog seems certain to lie down and die.

Governments would do well to remember their commitments to the ICPD Programme of Action, which clearly articulates in Chapter 7 (7.32) that "Information, education and counselling for responsible sexual behaviour and effective prevention of STIs, including HIV, should become integral components of all reproductive and sexual health services." HIV/AIDS programmes must move beyond a model focused on individual behaviour change to consider issues of violence, discrimination and power that play into women's risk of infection and inability to access treatment and support, and simultaneously work towards erasing such vulnerabilities and barriers.

Endnotes

1 *UNAIDS. 2006. 2006 Report on the Global AIDS Epidemic. http://www.unaids.org/en/HIV_data 2006GlobalReport/default.asp*

2 *Health GAP August 26 2005. Media Advisory: "10 months and C and Counting: The Condom Crisis in Uganda." http://www.healthgap.org/press_releases/05/082605_HGAP_PA_Uganda_teleconference.html*

3 *The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2006. Country Coordinating Mechanisms. http://80.80.227.97/en/apply/mechanisms/*

4 *Nair, Rupam Jain. 28 November 2006. "Lacking free AIDS drugs, 18 die in Indian town." Reuters. http://today.reuters.com/news/articlenews.aspx?type=healthNews&storyid=2006-11-28T124704Z_01_B87804_RTRUKOC_0_US-AIDS-INDIA-DEATHS.xml*

5 *Berer, Marge. 2003. "HIV/AIDS, Sexual and Reproductive Health: Intimately Related." Reproductive Health Matters.11(22):6–11.*

6 *Kaufman, Joan; Messersmith, Lisa. 2005. "Integrating the Fields of Sexual and Reproductive Health and HIV/AIDS." [unpublished] http://paa2006.princeton.edu/download.aspx?submissionId=60226*

7 *WHO; UNFPA. 2006. Glion Consultation on Strengthening the Linkages between Reproductive Health and HIV/AIDS: Family Planning and HIV/AIDS in Women and Children. WHO HIV/2006.02*

By Marina Mahathir, Member, International Steering Committee, Asia Pacific Leadership Forum on HIV and Development

Reducing Filipino Migrant Domestic Workers' HIV and SRH Vulnerability: The ACHIEVE Experience

The private nature of the work done by Filipino migrant domestic workers renders them vulnerable to physical, sexual and psychological abuses. With minimal access to sexual and reproductive health and rights (SRHR) information and services as well as gender-based differences in power, female domestic workers encounter difficulties in halting sexual advances and negotiating for use of condoms to protect themselves from STIs and HIV.

The impact of these circumstances on their health is tremendous. The National HIV/AIDS Registry of the Philippine Department of Health currently states that among the overseas Filipino workers infected with HIV, migrant domestic workers comprise 18%.[1] This is significant, given that only 8.6% of those working overseas were employed in the domestic sector. Regrettably, it is difficult to implement and monitor standards of protection and education for migrant domestic workers, as their work is not legally recognised as work in many destination countries.

In response to this growing concern, Action for Health Initiatives (ACHIEVE), Inc., a Philippines-based NGO implementing programmes on migration and health, with a specific focus on the SRHR and HIV vulnerability of Filipino migrant workers, is currently implementing a project that brings together various stakeholders in health and migration: domestic worker communities, migrant support organisations, health institutions, and local and national government institutions. Because the vulnerability of domestic workers is both behavioural and structural, ACHIEVE believes it is imperative to implement a holistic programme that responds to the issues comprehensively at different levels. ACHIEVE also focuses on continuous advocacy directed at the Philippine government.

At the start of the project, ACHIEVE conducted a survey to assess the SRHR health status and needs of migrant domestic workers, specifically looking at the knowledge, attitudes and practices of migrant domestic workers in relation to SRHR; SRHR-related problems encountered; and the level of access to SRHR information and services in the three phases of migration.[2] The study ran for 18 months and covered four major cities in the Philippines. Interviews were conducted with 302 potential migrant domestic workers.

Findings showed that 24% of the participants were not aware of reproductive tract infections (RTIs) and although 75% had some familiarity with AIDS, only 33% knew that safer sex practices could prevent HIV transmission. It was alarming to find that 77% perceived that they had no chance of becoming infected with HIV. To address these knowledge gaps, community-based trainings were conducted to raise the awareness of migrant domestic workers on SRHR issues, including HIV/AIDS. To sustain these educational discussions at the community level, a core group of migrant domestic workers were trained to become peer educators. The peer educators have also developed their own training modules for their specific community. A typical module includes a day-long session that covers HIV/AIDS, STIs, family planning, maternal health, child care, and abortion. These discussions are contextualised within the participants' lives as women and as migrant workers.

This work also encompasses building the capacity of government and NGOs to enable them to provide better services to Filipino migrant workers, particularly with regard to HIV/AIDS. A training session generally takes two days and covers a number of issues: basic HIV/AIDS information, gender and sexuality in the context of HIV/AIDS, the relationship between migration and HIV vulnerability, and counselling and managing the HIV-related concerns of migrant workers. With the support of local officials, ACHIEVE was also able to work with the local government units in two provinces. A memorandum of agreement was signed between ACHIEVE and two Provincial Health Offices and one Municipal Health Office to set up a reproductive health desk to cater to the specific needs of migrant domestic workers before they go abroad and upon their return. ACHIEVE's commitment is to train health personnel in handling SRHR and HIV/AIDS issues, including counselling.

In carrying out these related activities, ACHIEVE ensures the involvement of domestic workers living with HIV. They educate others through sharing their knowledge and experiences and they themselves are empowered through this process. Their critique and analysis informs the direction of ACHIEVE's research; and they also set up advocacy networking meetings that plan for or evaluate and monitor responses to migration, SRHR and HIV/AIDS.

Endnotes

1 *The Philippine Department of Health's HIV and AIDS surveillance is posted on their website (www.doh.gov.ph/NEC/HIV.htm) monthly.*

2 *The three phases of migration cover pre-departure, on-site and reintegration.*

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SPOTLIGHT

Indonesia: Challenges of Synergising HIV/AIDS & Sexual and Reproductive Health and Rights

Asian Development Bank 2006

This article by Esthi Susanti Hudiono was chosen because it clearly delineates how practitioners on the ground experience the HIV/AIDS and SRHR divide and discusses some practical synergistic solutions to bridge this divide. Esthi Susanti Hudiono is the co-founder of Hotline Surabaya, which has successfully worked with officials and legislators in East Java, Indonesia to increase the budget for HIV prevention and services and enact legislation to prevent discrimination based on HIV status. Esthi is also involved in the Indonesian Reproductive Health & Rights Monitoring and Advocacy (IRRMA) Project.

In Indonesia, HIV/AIDS prevention and treatment programmes have been largely aimed at the high risk groups. According to the Indonesian Ministry of Health, in 2002, the population vulnerable to HIV transmission, consists of: IDUs (38%); sex workers' clientele (30%); regular sex partners of high risk people (14%); gay (9%); sex workers (8%); and transvestites (1%).[1] Since 1997, HIV testing has been done at a drug rehabilitation centre in Jakarta and statistics from 2001 indicate that transmission of HIV among IDUs has drastically increased by 45-48%.[2] Simultaneously, as the incidence of HIV has increased among IDUs, there has also been an increase in HIV infection in prisons and detention centres through the sharing needles and unsafe sexual behaviour.[3]

HIV is also spread through the commercial sex industry. In Indonesia, it is estimated that there are between 190,000 – 270,000 female sex workers and between 7 – 10 million men who are clients of sex workers. At least 50% of male clients are married or have regular partners and less than 10% of them use condoms consistently.[4] The transmission of HIV is extremely complex because modes of transmission overlap: men who have sex with men (who may also be IDUs), may also have sex with their wives or female partners. IDUs may not only be exposed through injecting drugs, but also through buying sexual services without using condoms. IDUs also may have regular girlfriends and partners who would then be vulnerable to infection. Clients of sex workers also may have girlfriends and partners who are at risk.

A national HIV/AIDS strategy concentrated on high risk groups leaves most women who are considered low risk, extremely vulnerable, and sets the stage for the feminisation of HIV/AIDS.

Marrying both the HIV/AIDS and SRHR fields will contribute greatly to increasing the effectiveness of prevention programmes. For example, in West Papua, Indonesia, 51% of those infected with HIV are women, just as many as men. If SRHR advocates do not take up the issue of HIV, or if HIV advocates do not bring in the perspectives of gender and sexuality, this will be a great loss of the possible contribution to effective prevention strategies. There are areas of common ground, especially on the issues of mother-to-child transmission, STIs, contraception, and prevention strategies and services for youth. Regrettably, in Indonesia, women are presented with few contraceptive options and limited services exist for youth. Generally, women and youth are considered low risk groups and have little access to HIV information under prevention strategies which focus on high risk categories. It would be ideal, if the two fields were operating indivisibly and at all points women would receive information about HIV – whether when they are receiving contraceptives or having a pap smear test. Women who come into family planning clinics (which would work well

in Indonesia due to a strong contraceptive prevalence rate) should be considered ready targets for HIV prevention strategies. Women should be offered free and voluntary testing at these sites. There is a definite need to widen the understanding of HIV issues and to see how they intersect with mother and child health care (MCH) and contraception issues. Positive moves in this direction have been made by a few health service providers in Indonesia. For example, the PKRE (Essential Reproductive Health Services) integrates HIV and SRH into a one-stop service. It has a support group for HIV positive individuals and also supplies antiretro virals (ARVs). But so far the government has not comprehensively combined both HIV and SRH strategies in health programmes or policies.

A comprehensive, over-arching strategy is essential because currently most women fall into low risk categories. Also, HIV/AIDS prevention strategies and programmes for the different categories of women currently fall under different departments. Programmes for sex workers fall under the infectious diseases division of the Health Department. These programmes focus on sex workers through surveillance and do not take into account the needs and empowerment of sex workers, as the perspective is oriented at protecting public interest, namely, the clients. Information programmes also do not effectively focus and target clients of sex workers as modes of transmission. An SRHR approach which includes male involvement may be able to target the clients of sex workers more effectively.

HIV programmes for women are assigned to the public health division of the Health Department under the PKRE (Essential Reproductive Health Services) for mothers. However, two blind spots occur in this approach:
1) women in monogamous relationships are rarely targeted for HIV prevention strategies which include testing; and
2) the psychological, social and cultural aspects hamper the open implementation of the programme.

Strategies and programmes which combine HIV/AIDS and SRHR approaches would consider women with high risk partners as actually being a high risk group and target them as such. This population of women is in fact larger than the population of sex workers, yet are sidelined by most strategies and programmes.

A combination of HIV/AIDS and SRHR approaches would be particularly effective and useful in targeting female adolescents who may be IDUs or who have high risk partners. This group currently falls under the department of education via the SRHR education programme. However, the jury is still out on whether or not SRHR education will be implemented in schools. In the meantime, this group of young women, which is particularly vulnerable, is not addressed. Hotline Surabaya's research indicates that this group can be considered high risk, as intravenous drug use occurs mainly in urban areas among young people, the majority of whom live with their parents and have a high school education. Intravenous drug use is not limited to lower socioeconomic groups. This group is also particularly difficult to target because premarital sex is stigmatised and IDU (considered criminal) is also stigmatised.[5] Simultaneously, as incidence of HIV has increased among IDUs, there has also been an increase in HIV infection in prisons and detention centres through the sharing needles and unsafe sexual behaviour.[6]

... if the two fields were operating indivisibly... at all points women would receive information about HIV...

A combination of HIV/AIDS and SRHR approaches would also be able to better serve women who are HIV positive. These women often have candida and need to seek SRH services, but they are usually too ashamed to do so or are uncertain as to how to access such services. Health professionals tend to question them on their marital status and their sexual life, which can be an awkward experience. For female sex workers, the stigma is greater because they cannot continue to work and are isolated. These women are afraid they will be discriminated against by health service providers and are generally ill-prepared to manage their condition.

For all the above reasons, effective policies, programmes and strategies must combine HIV/AIDS and SRHR approaches in order to effectively prevent the feminisation of HIV/AIDS in Indonesia and to help and empower women who are HIV positive.

Endnotes

1 *Piper, N; Yeoh, B.S.A. 2005. "Introduction: Meeting the Challenges of HIV/AIDS in Southeast and East Asia."Asia Pacific Viewpoint. 46(1):1-5.*
2 *Ibid.*
3 *Ibid.*
4 *Riono, R.; Jazant, S. 2004. "The Current Situation of HIV/AIDS Epidemic in Indonesia". AIDS Education and Prevention, Vol. 16, Supplement A: 78 – 90.*
5 *Piper, N; Yeoh, B.S.A. 2005. "Introduction: Meeting the Challenges of HIV/AIDS in Southeast and East Asia."Asia Pacific Viewpoint. 46(1):1-5.*
6 *Ibid.*

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International

Between 15 –18 May 2006, a dialogue on "Strategies for the South: Building Synergies in HIV/AIDS and Sexual and Reproductive Health and Rights" was organised by Fundacion para Estudio e Investigacion de la Mujer (FEIM) in Buenos Aires, Argentina. The dialogue involved participants from regional networks from Africa, Asia, Eastern Europe, Latin America, and the Caribbean. The event aimed to nurture dialogue on the intersection between HIV/AIDS, sexuality and sexual and reproductive health rights (SRHR) among those coming from various fields, including those working on SRHR issues; gay, lesbian, bisexual, and transgender activists; and human rights, youth and HIV/AIDS activists. It was an opportunity to fortify the participation and collaboration between regional networks in the South and improve the impact of international advocacy on women and HIV/AIDS. In turn, it was also a chance to identify factors that limit collective work and brainstorm on overcoming such barriers.

An important aspect of the meeting was the development of a sexual rights framework emphasising a person's right to sexual pleasure, to enjoy sex with whomever a person chooses and with however many partners a person decides. This framework was predicated upon the understanding that vulnerability does not lie with belonging to a particular 'high risk' group engaged in certain behaviours, rather it is existing social conditions and inequalities that create vulnerability to infection. Participants also identified common international goals between HIV/AIDS and SRHR. These included the need to improve the quality of life for PLWHA, along with their access to comprehensive SRH services; the necessity for a broad, rights-based approach to HIV/AIDS, complete with frameworks and strategies for advocacy, programmes and research; and the need to advance the work being done on the link between violence, HIV and SRHR. Participants determined that capacity building, campaigns, partnership establishment, community work, fundraising, and conferences were mechanisms for effective collaboration between different stakeholders.

Source: *Rodelyn Marte, an ARROW programme advisory committee (PAC) member, attended the dialogue on behalf of ARROW. Asian-Pacific Resource and Research Centre for Women (ARROW) No. 80 & 82, 3rd Floor, Jalan Tun Sambanthan, Brickfields, 50470 Kuala Lumpur, Malaysia. E-mail: arrow@arrow.po.my Website: www.arrow.org.my Tel: 603-2273-9913 Fax: 603-2273-9916*

The XVI International AIDS Conference was held in Toronto, Canada between 13 – 18 August 2006. The theme of the 2006 Conference was "Time to Deliver," focusing on the promises and progress made to scale-up treatment, care and prevention. Over 25,000 participants attended the Toronto conference, representing more than 170 countries around the world. A number of activities at the conference stressed the importance SRHR in the context of preventing the spread of HIV and mitigating the impact of the epidemic. Satellite sessions were held focusing on SRHR related issues, where topics included sexual identities and practices, contraception and fear-based preventative messages in the context of advocating for healthy, pleasurable sex. Skill building events were also held: one session focused on comprehensive training for health workers on the SRHR of HIV-positive women and another looked at gender and sexuality in Islam and the implications of this for HIV/AIDS prevention and support.

In an important move, the International Community of Women Living with HIV/AIDS (ICW) gave out a challenge on each day of the conference. They focused on 'Sexual and Reproductive Health', 'Access to Care, Treatment and Support', 'The Meaningful Involvement of People Living with HIV', 'Challenging Taboos', and 'Action for Change'. The ICW's '5 Key Challenges' were launched to breakdown stereotypes and vacuous rhetoric. As ICW states in their newsletter on the conference, "We're here, alive and kicking, and we want to stimulate passionate, intelligent discussions. Ask us what 'sexual and reproductive health rights and realities' mean in our lives."

Sources: Conference website for the XVI International AIDS Conference, Toronto, Canada, 13-18 2006. Website: www.aids2006.org, International Community of Women Living with HIV/AIDS (ICW), International Support Office, Unit 6, Canonbury Yard, 190a New North Road, London, UK, N1 7BJ. E-mail: info@icw.org Website: www.icw.org Tel: 44-20-7704-0606 Fax: 44-20-7704-8070

The meeting "Getting Closer – A Framework for Integrating HIV/AIDS and SRH" was held 23 – 25 October 2006 in Bangkok, Thailand. Together the WHO, UNFPA, IPPF, and UNAIDS worked to conceptualise and host the meeting as a way to facilitate the development of a catalytic framework for action between the HIV/AIDS and SRH fields. Guiding the meeting was the idea that integration in not about one area subsuming another; rather it is the open exchange of knowledge and identifying ways of amplifying the expertise in both the HIV/AIDS and SRH fields. The 50 meeting participants were drawn from the six IPPF Regional Offices; six representative Member Associations; and corresponding national, regional and global agencies of coalitions with HIV/AIDS mandates. The large number of HIV organisations

represented was seen as an important attempt to represent the needs of key populations, service providers and of people living with HIV in the process of developing the framework. The initial two days of the meeting focused on providing input and developing consensus on the areas of action in which the HIV community can play an expanded role in addressing relevant sexual and reproductive health issues. The final day built upon ideas and discussion from the previous two days to develop outline project plans from six selected countries, which included Nepal and Indonesia.

Source: International Planned Parenthood Federation, East & Southeast Asia and Oceania Region (IPPF ESEAOR), Kuala Lumpur Regional Office, 246 Jalan Ampang, 50450 Kuala Lumpur, Malaysia. E-mail: ippfklro@ippfseaor.org Website: www.ippfseaor.org Tel: 603-4256-6122 Fax: 603-4256-6386

Malaysia

The Asian-Pacific Research and Resource Centre for Women (ARROW) in collaboration with the FIGO committee on Women's Sexual and Reproductive Health and Rights held the ARROW-FIGO Parallel Forums on Sexual and Reproductive Health and Rights between 6 – 9 November 2006 in Kuala Lumpur, Malaysia. This event ran parallel to the FIGO XVIII World Congress of Gynaecology and Obstetrics (5 – 10 November 2006), which was also held in Kuala Lumpur. The forums, which were open to the public, were an opportunity for activists, researchers, students, academics, and other interested parties to listen to eminent FIGO health researchers and Malaysian activists speak on important SRHR issues. Each night presented the opportunity for both attendees and speakers to pose questions and share their experiences, which sparked an enlightening, dynamic exchange.

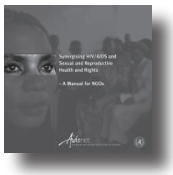
The first night's forum raised the issue of the unmet need for contraception as well as unsafe abortion in Malaysia, looking specifically at access issues and knowledge, attitudes and behaviours among Malaysian youth. The second night was devoted to discussing violence against women and its impact on women's reproductive health in Malaysia. The third night focused on health sector reform in Malaysia and the need to move towards a more citizen-driven proposal for health care reform; and the final night addressed the feminisation of HIV/AIDS in Malaysia and the importance of linking SRHR and HIV/AIDS services. Leading up to the forums, ARROW held a half day media sensitisation workshop on the key issues – contraception, violence against women, health sector reform, and HIV/AIDS – covered during the forums for nine journalists from local Malaysian newspapers. As a result, a series of articles on sexual and reproductive health and rights were published in the local media. Please contact ARROW, if you would like a copy of the proceedings of the forums.

Source: Asian-Pacific Resource and Research Centre for Women (ARROW) No. 80 & 82, 3rd Floor, Jalan Tun Sambanthan, Brickfields, 50470 Kuala Lumpur, Malaysia. E-mail: arrow@arrow.po.my Website: www.arrow.org.my Tel: 603-2273-9913 Fax: 603-2273-9916

India

A campaign on Women's Access to Complete and Continued Care during Pregnancy, Childbirth and After Childbirth was held to observe National Safe Motherhood Day (11 April) and World Heritage Day (18 April). Campaign activities took place between 11 – 18 April 2006 and were coordinated by the CHETNA-SUMA Secretariat of the Rajasthan State White Ribbon Alliance. The campaign took place in 21 districts (blocks) in Rajasthan, the largest state of India, where one maternal death occurs every hour. CHETNA was able to build the capacities of 19 representatives of CBOs on social mobilisation to assist in the campaign. Throughout this process, the objectives, activities and messages were collectively developed. The campaign reached 155 villages in the deserts, hills and rural plains. During the campaign week, district and zone level stakeholder meetings were organised, where policymakers, government officials, elected representatives, and civil society members deliberated on ways to make birth safer. Media workshops were held and it was felt the media's partnership was obtained. Nine leading newspapers covered the campaign throughout the week. There were also safe motherhood walks; door-to-door contacts and community meetings, to reach out to pregnant women and their families; and health camps, which were organised to ensure services during pregnancy. In total, 160 CBOs, 150 elected representatives, 2000 community members, and 550 women who were pregnant and breast feeding participated in the campaign. Dialogues also took place in which 118 public health officials and service providers participated. The campaign was supported by the White Ribbon Alliance India and UNICEF and has successfully led to a movement on maternal health. Local communities, civil society organisations, elected representatives, service providers, media, and district administration have all come together on a common issue – saving mother's and new born's lives.

Source: SUMA Secretariat, CHETNA, Samvaad Heritage Center, 3010, Desai Ni, Pole, Khadia, Ahmedabad-380001 E-mail: chetna@icenet.net Website: www.chetnaindia.org Tel: 91-079-2211-1405 Fax: 91-079-2211-0056

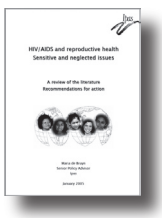


***Aidsnet. 2005. Synergising HIV/AIDS and Sexual and Reproductive Health and Rights** – A Manual for NGOs. Denmark: Aidsnet. 118p. Available online at: http://www.aidsnet.dk/Default.aspx?ID=1493*

The manual, *Synergising HIV/AIDS and Sexual and Reproductive Health and Rights*, is geared towards NGO practitioners who wish to enrich their HIV and AIDS work by drawing on the wealth of knowledge accumulated in the sexual and reproductive health and rights (SRHR) field. The book is arranged into 28 chapters and is practically structured using explanatory boxes, concrete examples and cases of good practice and common approaches. Topics addressed in the book include "Mainstreaming HIV/AIDS, SRHR and gender," "The rights-based approach," "Sexual Minorities and same-sex sexual activities," and "District Health Planning." The book answers the question as to what NGOs can do to merge these fields in their work, whether thorough working collaboratively or developing and implementing projects, campaigns, capacity building, and monitoring and evaluation activities that link the two areas. The final section in the book outlines overlapping interests between the fields: for example, the promotion of condoms as a dual method of protection against pregnancy and HIV and STIs. This publication in the outcome of a North-South effort between a writing team supported by a 'South Panel' of NGO partners and 24 peer reviewers based in various UN organisations, Danida and Nordic universities.

***CHANGE; ICW; Ipas; and PIWH. 2004. Fulfilling Reproductive Rights for Women Affected by HIV: A Tool for Monitoring Achievement of Millennium Development Goals.** 14p. Available online at: http://www.genderhealth.org/pubs/MDGNov2004.pdf*

On 8 March 2004, over 25 national and international organisations presented a statement to the secretariat of the UN Commission on the Status of Women that highlighted neglected areas in HIV-positive women's health. The statement has since been used to develop this practical tool that aims to critically tackle important areas of SRH, including the involvement of HIV-positive women in policymaking and programme implementation, fertility control that meets HIV-positive women needs and research on antiretroviral therapy in relation to fertility. The catalyst for creating this tool was the fact that many NGOs and CBOs have no formal or extensive research capacity, being unable to conduct large-scale baseline and follow-up surveys and therefore are not in as position to measure percentage increases and decreases. Nonetheless, many organisations can collect information that is useful for assessing whether progress has been made in fulfilling complete SRHR for HIV-positive women. A simple set of benchmarks and accompanying questions are proposed that can be used for undertaking such an exercise. Data to answer the questions can be gathered through both qualitative and quantitative means. This document is organised into sections: Section 1 introduces the relevant MDGs and neglected areas of reproductive health; Section 2 contains brief background information on the issues; Section 3 provides the data collection questions linked to MDGs 5 and 6; Section 4 gives some ideas on how the collected data can be used; and Section 5 lists the organisations that support the use of this tool. By connecting the questions to the MDGs, the organisations who participated in this publication hope that comparable data across countries and regions can be collected annually for presentation at national and international venues where HIV/AIDS policies and programmes are being formulated and reviewed.



***de Bruyn, Maria. 2005. HIV/AIDS and Reproductive Health: Sensitive and Neglected Issues** – A Review of the Literature, Recommendations for Action. USA: Ipas. 95p. Available online at: http://www.ipas.org/publications/en/HIVLITREV_E05_en.pdf*

This document seeks to provide those interested in staying abreast of the critical discussion occurring around the intersection of HIV/AIDS and SRH with a review of the current literature in this area. It seeks to provide policymakers, as well as those who design, implement and monitor and evaluate programmes HIV/AIDS and SRHR-related programmes with an overview of the issues regarding the SRH of women living with HIV/AIDS. In 2002, Ipas worked with three HIV-positive women, to carry out exploratory interviews with 36 key informants in Australia, India, Kenya, South Africa, and Thailand to elicit their views about the difficulties that HIV-positive women confront in dealing with both planned and unwanted pregnancies. An accompanying literature review covered factors including HIV-positive women's decisions about childbearing, HIV and pregnancy outcomes, measures to prevent perinatal transmission of HIV, and pregnancy termination by women living with HIV. This publication updates that previous literature review. This update addresses the provision of contraceptive information tailored to the needs of HIV-positive people, sensitive elements of HIV counselling and testing during antenatal care and labour before childbirth and abortion-related care. Stressed in this publication is the need for there to be more critical care and attention placed on the fertility concerns and needs of HIV-positive individuals. One of

the strengths of this publication is the author's provision of clear recommendations for action in the areas of "Gynecological, obstetric and maternal health care", "HIV counselling and testing," "HIV/AIDS and reproductive choice," and "research."

Kaufman, Joan; Messersmith, Lisa. 2005. "Integrating the Fields of Sexual and Reproductive Health and HIV/AIDS." *52p. [unpublished]. Available online at: http://paa2006.princeton.edu/download.aspx?submissionId=60226*

In this 52-page paper, Kaufman and Messersmith thoroughly review the major activities undertaken to link the HIV/AIDS and SRH fields and highlight the values each field brings to the collaboration. They also explore in detail the shortcomings and gaps in each field with regards to the other. After the introduction, the paper offers an analysis of the current initiatives between the fields, which is followed by two sections that lay out the strengths of each field. The fourth section focuses on the gaps, opportunities and major constraints to a linked SRH and HIV/AIDS response, which includes a discussion of the mutual distrust between fields and the political marginalisation of the SRH field, which has hampered collective work. The fifth section is a useful articulation of the strategies for moving forward between the HIV/AIDS and SRH fields, which is clearly presented as a series of recommendations. Overall, the authors argue that there is a deep need for collaboration between the fields given the expanding population of young, sexually active people in certain areas of the world, particularly in Asia, and the disproportionate toll the disease is having on young women. Also mentioned is the fact that with more people entering into lifelong ARV therapy, it is important to address their ongoing needs for sexual and reproductive health information and health services related to healthy sexuality and family planning.

UNESCAP. 2005. "Gender and HIV/AIDS in the Asia and Pacific Region." Manuscript issued by the Emerging Social Issues Division of UNESCAP, *Gender and Development Discussion paper Series No. 18. 22p. Available online at: http://www.unescap.org/esid/Gad/Publication/DiscussionPapers/18/DiscussionPaper18.pdf*

This paper is part of a series of publications previously known as the Women in Development Discussion Papers Series. Looking specifically the Asia-Pacific region, this 22-page paper takes as its point of departure the fact that epidemiological evidence demonstrates that infections are increasing fastest among women, especially young women. It argues that the interconnectedness between HIV and traditional cultural and sexual roles must be addressed in the region. It also argues that while there have been many lives lost and devastated by the disease, there have been some positive developments in strong HIV prevention and treatment strategies, with Thailand being referenced as a case in point. After the introduction, the paper outlines HIV/AIDS trends in different parts: first, the greater Mekong sub-region and, second, the Pacific Islands. It then goes on to discuss the factors fuelling the HIV/AIDS pandemic, including poverty, gender discrimination, violence against women, substance abuse, and the movement of people. The next section discusses effective approaches and lessons-learned, which are divided sections titled into "Good practices (examples from the Pacific Islands)", "Treating HIV/AIDS as a development issue" and "Commercial sex workers." The paper concludes with recommendations at the level of policy, law and societal beliefs and attitudes.

Verma, Ravi K.; Pelto, Pertti J.; Schensul, Stephen J.; and Joshi, Archana. 2004. ***Sexuality in the Time of AIDS: Contemporary Perspectives from Communities in India****. New Delhi: Sage Publications India Pvt Ltd. 431p.*

Sexuality in the Time of AIDS: Contemporary Perspectives from Communities in India wrestles with the reality that India is in the middle of an AIDS epidemic primarily transmitted through sexual contact, but there is scant awareness of sexual mores in the country. The editors argue that this significantly hampers the development and implementation of effective interventions to halt the spread of the virus. This book presents a series of essays that build the reader's understanding of contemporary sexual behaviours and sexual attitudes in both rural and urban India and in difference strata of society. A blend of qualitative and quantitative information is presented in such a way as to be useful to a wide audience, particularly health professionals, activists, NGOs, researchers, policymakers, and educators involved with HIV/AIDS work and sex education. The book covers the sexual practices, attitudes and beliefs of adolescent girls, female and male sex workers, college students, and slum dwellers. Three broad topic areas are covered in the book: 1) An overview of the HIV/AIDS epidemic in India and the response of both the government and the public; 2) Perspectives from diverse communities concerning premarital, marital and extramarital sexuality; and 3) Lessons learned at the national level in terms of research methodologies and the development of new approaches to HIV/AIDS. Underscored is the need to view sexuality and HIV risk in a broad social context and to listen to the experiences of those from the community in order to move forward with innovative programmes to prevent HIV and treat and support those who are living with HIV.

Other Resources

Doupe, Andrew. 2006. *Integration of Sexual and Reproductive Health into HIV/AIDS Programming: Guide for Submitting HIV/AIDS Component Proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria, Round 6 and Beyond.* Washington D.C., United States: Global AIDS Alliance. 70p. PDF available at: http://www.globalaidsalliance.org/docs/GFATM_Round_6_HIV_and_SRH_Guide_May_2006.pdf

Family Planning and HIV/AIDS – A website designed to assist in users efforts to integrate the provision of family planning and reproductive health service with activities for preventing and treating HIV/AIDS. Website: http://www.fpandhiv.org/

IPPF; ICW. 2002. *Dreams and Desires: Sexual and Reproductive Health Experiences of HIV Positive Women.* London, England: WHO. 32p. PDF available at: http://content.ippf.org/output/ORG/files/5332.pdf

Murthy, Ranjani K. "The Implications of Integration for Sexual and Reproductive Health Services in Asia." [unpublished article] 36p. PDF available at: http://www.wits.ac.za/whp/rightsandreforms/docs/integrationasia.pdf

UNAIDS. 2006. *HIV and Sexually Transmitted Infection Prevention among Sex Workers in Eastern Europe and Central Asia.* 68p.

UNIFEM: Gender and HIV/AIDS – UNIFEM, in collaboration with UNAIDS, has developed this comprehensive gender and HIV/AIDS web portal to provide up-to-date information on the gender dimensions of the HIV/AIDS epidemic. Website: http://www.genderandaids.org/

Wang, Bo; Hertog, Sara; Meier, Ann; Lou, Chaohua; and Gao, Ersheng. 2005. "The Potential of Comprehensive Sex Education in China: Findings from Suburban Shanghai." *International Family Planning Perspectives.* 31(2):63-72. PDF available at: http://www.guttmacher.org/pubs/journals/3106305.pdf

WHO. 2006. *Sexual and Reproductive Health of Women Living with HIV/AIDS: Guidelines on Care, Treatment and Support for Women Living with HIV/AIDS and their Children in Resource-constrained Settings.* 83p. PDF available at: http://www.unfpa.org/upload/lib_pub_file/616_filename_srh_hiv-aids.pdf

ARROW's Publications

ARROW. 2005. *Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015, Asian Country Reports.* Kuala Lumpur: ARROW. 384p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW; CRR. 2005. *Women of the World: Laws and Policies Affecting Their Reproductive Lives, East and Southeast Asia.* New York: Center for Reproductive Rights. 235p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 2003. *Access to Quality Gender-Sensitive Health Services: Women-Centred Action Research.* Kuala Lumpur: ARROW. 147p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 2001. *Women's Health Needs and Rights in Southeast Asia: A Beijing Monitoring Report.* Kuala Lumpur: ARROW. 39p.
Price: US$ 10.00 plus US$ 3.00 postal charge

Abdullah, Rashidah. 2000. *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing.* Kuala Lumpur: ARROW. 30p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 2000. *In Dialogue for Women's Health Rights: Report of the Southeast Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the Beijing Platform for Action, 1-4 June 1998, Kuala Lumpur, Malaysia.* Kuala Lumpur: ARROW. 65p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 1999. *Taking up the Cairo Challenge: Country Studies in Asia-Pacific.* Kuala Lumpur: ARROW. 288p.
Price: US$ 10.00 plus US$ 3.00 postal charge

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 charge

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

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 charge

Definitions

Comprehensive Sexual and Reproductive Health Services

The ICPD Programme of Action (1994) outlines that comprehensive SRH services include:

- Family planning counselling, IEC and services;
- IEC and services for prenatal care, safe delivery and postnatal care;
- Prevention and appropriate treatment of infertility;
- Abortion, including prevention of abortion, management of complications arising from unsafe abortions and provision of abortions where legal;
- Treatment of reproductive tract infections; sexually transmitted infections, including HIV/AIDS; and other reproductive health conditions;
- IEC and counselling on human sexuality, reproductive health and responsible parenthood; and
- Referrals for further diagnosis and treatment as required for family planning services, complication of pregnancy, delivery, abortion, infertility, RTIs, cancer, STIs, and HIVAIDS

Source: United Nations. Programme of Action of the International Conference on Population and Development, Report of the International Conference on Population and Development, 5-13 September 1994, UN Doc. A CONF.171/13. Website: www.unfpa.org/icpd/icpd_poa.htm

Sexuality

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

Source: WHO draft working definition, October 2002. This definition was the result of a WHO-convened international technical consultation, but does not represent an official WHO position, and should not be used or quoted as a WHO definition. Website: www.who.int/reproductive-health/gender/glossary.html

The Right to Enjoy Sex

In sexual relationships, you have the right to:

- Enjoy sex just for the pleasure of it
- Enjoy sex right up into old age
- Be treated as an equal sexual partner
- Be treated with dignity and respect
- Express your desires, needs and concerns - and be listened to
- Be the one to initiate sex
- Choose your sexual partner, whether they are the same or the opposite sex.

You too have the responsibility to respect the rights of your sexual partner.

Source: South Africa's Sexual Rights Charter, Women's Health Project, P.O. Box 1038 Johannesburg, 2000, South Africa. Email: womenhp@sn.apc.org Charter online available at: http://www.wits.ac.za/whp/sex-rights-charter.doc

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Written contributions related to the post-ICPD and Beijing activities are welcome. Please send them via e-mail to: arrow@arrow.po.my or by mail to:
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Young People's Knowledge in Asia on Consistent Condom Use and the Prevention of HIV

More than half of the world's young people – almost 850 million between the ages of 10 and 24 – live in the Asia-Pacific region. This demographic surge of people entering their productive and reproductive years offers great potential for development, but it also signals an urgent SRH challenge, as research demonstrates that new adult HIV infections are increasingly occurring among 15-24 year olds, with a disproportionate number of young women being infected and affected.[1]

Thus far in Asia and the Pacific, HIV prevalence in most countries has been restricted to vulnerable groups, particularly injecting drug users and sex workers; but without appropriate and effective interventions, the virus could spread rapidly, becoming more mainstream. The large number of sexually active young people has the potential to fuel the epidemic, especially when the SRH needs and concerns of young people have historically been overlooked.[2] The situation demands a scaling up of HIV and AIDS advocacy, prevention and treatment efforts directed at youth, but reaching youth is not easy. The same factors that increase young people's vulnerability to infection (e.g. increased mobility, trafficking, sex work, poverty, level of education, limited access to health services, and illiteracy) are also significant barriers to the impact of prevention activities. Young women are particularly difficult to reach, given gender beliefs and roles that can limit their exposure to prevention efforts.

The United Nations Population Fund and Reference Bureau in their effort to track the extent to which national information and education programmes on HIV and SRH have succeeded, have recently begun tracking the percentage of young people aged 15-24 who know whether a person can protect her- or himself from HIV by consistent condom use.[3] Data are currently available for Cambodia, India, Indonesia, Mongolia, Nepal, the Philippines, and Vietnam. Taking the average between these countries, only 54.1% of young women know that a condom can offer effective protection against infection, suggesting national HIV and SRH efforts are generally weak and ineffective. This is concerning given that the median age for first sexual intercourse for women is quite young: 19.9 (Cambodia); 18.6 (Indonesia); 16.9 (Nepal); and 21.9 (Philippines). For three countries – India, Indonesia and Nepal – there are data on whether young men know that a condom can offer protection against infection. The average between the countries is 74%, which suggests that while not good, young men have greater access to comprehensive HIV prevention information.

Indonesia and Nepal demonstrate pronounced differences between young women and men in their knowledge. Indonesia presents the most extreme example, with a percentage point difference of 55 between women and men. This suggests that those designing and implementing prevention programmes and campaigns need to specifically target young women and take into careful consideration influences, whether cultural, religious, political, or economic, which result in gender-based differences in access to comprehensive information.

A comprehensive, gender-sensitive and rights-based approach to the delivery of HIV and SRH information is crucial for young women – an approach that stresses women's empowerment in this process and identifies and challenges personal and structural barriers to women's ability to negotiate for the use of condoms.[4] Although reaching young women with the knowledge that condoms can protect them from infection is an important, and oftentimes difficult, first step, it is simply not enough. It is critical that education must include increasing young women's self esteem, confidence to take action, decision-making skills, and ability to communicate concerns and needs.[5] At the same time, male responsibility must be focused on, which includes improving young men's potential to listen to and respect their partner.

	Women 15-24 who know that a person can protect herself from HIV by consistent condom use, %	Men 15-24 who know that a person can protect himself from HIV by consistent condom use, %
Cambodia	64	N/A
India	62	63
Indonesia	23	78
Mongolia	77	N/A
Nepal	39	81
Philippines	54	N/A
Vietnam	60	N/A

Endnotes

1 *United Nations Population Fund and Population Reference Bureau. 2005. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators 2005. http://www.unfpa.org/upload/lib_pub_file/524_filename_country_profiles_2005.pdf*

2 *Ooi, Chye Pei; Kabir, Sandra; and Satia, Jay. 2006. Innovative Approaches to Population Programme Management: Linked Response to Reproductive Health and HIV/AIDS. Volume Ten. Kuala Lumpur, Malaysia: International Council on Management of Population Programmes (ICOMP).*

3 *All percentages on this indicator are taken from United Nations Population Fund and Population Reference Bureau. 2005. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators 2005.*

4 *UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS. HIV/AIDS and Gender: Fact Sheet. http://www.genderandaids.org/downloads/events/Fact%20Sheets.pdf*

5 *UNAIDS; UNFPA; UNIFEM. 2004. Women and HIV/AIDS: Confronting the Crisis. http://www.unfpa.org/hiv/women/docs/women_aids.pdf*

By Michelle Rogers, Programme Officer, ARROW