

Women, Hiv/Aids and Development: Towards Gender Appropriate Prevention Strategies in South-East Asia And the South Pacific

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I INTRODUCTION

1 Background to the report

This report provides an overview of the gender implications of the HIV/AIDS epidemic in South East Asia and the South Pacific, and a review of HIV/AIDS prevention and control strategies in these regions, with particular reference to gender issues in their design and implementation. The issues involved are complex and there is considerable diversity of situations among countries. It is only possible to draw out broad themes about the experience so far, with illustrative examples from particular countries.

HIV/AIDS involves complex issues of gender and sexuality. Here, the primary focus is with the implications of HIV/AIDS for women, particularly heterosexual women. This is because of the growing incidence of heterosexual transmission, and the relative lack of power of women in most societies. This is not, however, to deny the importance of involving men in AIDS prevention - in fact this is crucial to preventing AIDS among women, as emphasised below. There is relatively little activity among, or information about, gay men and male sex workers (many of whom do not identify as homosexual and have female as well as male sexual partners), although one or two examples are given. Homosexual women are not explicitly mentioned in any of the literature reviewed, and the organisations focusing on gay people seem to be mainly geared towards men. Thus the issues for lesbian women are not discussed.

The availability of information on the extent of the epidemic and its socio-cultural context, on evolving patterns of transmission and on current prevention and control activities is highly variable. This in itself reflects differing stages of the epidemic in different countries, and varying political commitment to addressing the HIV/AIDS issue, as well as varied levels of official and NGO activity, and of international donor/agency involvement. In particular, almost no information seems to be available on the situation in Cambodia, Laos, Myanmar and Brunei. In addition, most of the literature on gender issues in HIV/AIDS prevention is specific to Africa and thus must be interpreted with caution in relation to South East Asia and the Pacific.

2 Structure of the report

The report is structured as follows. The next section summarises current knowledge about the epidemiology of HIV/AIDS in the region, including recent statistics. The third section is an overview of the implications of HIV/AIDS for women, drawing on the general literature, and, where possible, relating general issues to region specific factors. The fourth section looks at the current thinking about prevention and control strategies, in a global sense, particularly in relation to women. The fifth section focuses on prevention and control activities in the region. The sixth and final section draws some conclusions about gender appropriate strategies for prevention and control, which might be of value in policy formulation. A bibliography is appended to the report, as well as a list of selected current activities/organisations involved in HIV/AIDS related work in the region. Inclusion in this list does not imply that the any particular organisation is promoting 'gender appropriate' strategies. However, the notes in the list and comments in the text should give some indication as to which activities are of particular value in this connection.

II EPIDEMIOLOGY OF HIV/AIDS IN SOUTH EAST ASIA AND THE SOUTH PACIFIC

1 Current prevalence of HIV/AIDS in South East Asia and the Pacific

South East Asia and the South Pacific in the global context

Asia and the most of the Pacific (excluding Australia and New Zealand) have been classified as a 'pattern III' region by the WHO in relation to the HIV/AIDS pandemic: 'HIV was introduced into these areas in the early to mid-eighties. Although there is indigenous spread of the virus in most of these countries, the prevalence of both AIDS and HIV infection was low at the end of the 1980s, with no clearly dominant pattern of HIV transmission. However, the situation is changing rapidly in a few countries. During the late 1980s, the prevalence of HIV infections has greatly increased among intravenous drug users in South East Asia, especially Thailand, where the prevalence is now nearly 50 percent; focal increases (up to 50 percent) have been recorded among female prostitutes in several cities in Thailand and India,' (Chin, 1990: 221.)

Whilst the number of officially reported cases of HIV/AIDS across most of South East Asia and the Pacific is low relative to other regions of the world, the epidemic has probably reached 'take off point' in Thailand (ODI/IDS, 1992: 4) and is already well established in many other countries (particularly the Philippines, Malaysia, Myanmar, Papua New Guinea, and French Polynesia). But the inadequacies of the data available on HIV/AIDS in many countries in the region means that it is difficult to know with any certainty what the level of infection really is.

The HIV/AIDS epidemic in South East Asia and the Pacific has not yet reached the dramatic proportions of some other regions (notably Sub-Saharan Africa and the Caribbean) but this merely points to the importance of making early interventions which might limit further spread of the disease.

According to conservative WHO estimates, by the end to the 1990s, 250,000 annual adult AIDS cases and deaths can be expected in Asia. (AIDSED Newsletter, 1/1992: 19.) The implication is that without timely interventions, the situation could be dramatically worse.

Given the rapid spread of the disease in Asia and the need to continually reassess transmission mechanisms, it has been suggested that the broad regional typologies used by WHO are of declining utility:

'[T]he biological and behavioural factors responsible for the heterogeneity observed **within**, rather than between regions, now provide the most important clues for understanding the spread of HIV infection and its prevention.' (Elias, 1991: 24; emphasis added)

Added to this, the implications for women (and children) of the global AIDS pandemic are increasingly being recognised as extremely serious. 'During its first decade, the HIV infection/AIDS pandemic has caused an estimated 500,000 cases of AIDS in women and children, most of which have been unrecognised. During the 1990s, WHO estimates that the pandemic will kill an additional three million or more women and children throughout the world.' (Chin, 1990: 24.)

Table 1

RECENT OFFICIALLY REPORTED HIV/AIDS CASES
IN SOUTH EAST ASIAN COUNTRIES

SOUTH EAST ASIA ¹								
	AIDS CASES			HIV CASES			Rate	Date
	Male	Female	Total	Male	Female	Total		
Brunei			2			6	0.8	1/91 ²
Cambodia			0			2		11/91 ²
Indonesia			21	(31)	(2)	(33) 40		12/91 ³
Laos			1			1		4/92 ²
Malaysia	(43)	(5)	(48) 52	(992)	(22)	(1014) 3317		6/92 ²
Myanmar			14			2743		3/92 ⁴
Philippines	51	21	72	105	147	252		4/92 ⁵
Singapore			67	116	8	124		2/92 ⁶
Thailand	327	37	384	22039	6677	28716		4/91 ⁷
Vietnam						57		12/91 ⁸
TOTAL	(421)	(63)	533	23283	(6856)	35258		

¹ Data on AIDS cases from WHO, **Weekly Epidemiological Record (WER)**, 1992, 67 (14) (April) and 67(27) (July). Rate figures are for AIDS cases per 100,000 population, taken from April 1992 edition of **WER** for indicative purposes only; they may not correspond exactly to absolute numbers given where there is variance in date of reporting. Data on HIV cases from various sources cited below. In the TOTAL row, figures are given in brackets where the series is incomplete. Where two figures appear in a column, the higher figure is used for totals

² Data on HIV cases from **WorldAIDS**, March 1992: 11

³ Data on HIV from **WorldAIDS**, March 1992; 40 seropositive of 164,812 people tested.

² Data from **Straits Times**, 26/6/92, reported in **AIDS Newsletter**, 1992, 7(10/11): 17.

⁴ Data on HIV cases from **WorldAIDS**, March 1992: 12; 2743 seropositive of 103,051 tested.

⁵ Data from Health Action Information Network, 1992, **HIV/AIDS Information Kit for Medical and Nursing Students**, HAIN, Manila.

⁶ Data for AIDS cases from **Straits Times**, 23/5/92, cited in **AIDS Newsletter**, 1992, 7(8): 14; data for HIV cases from **Straits Times**, 4/7/92, quoted in **AIDS Newsletter**, 7(10/11): 17.

⁷ Data from **AIDS Feedback**, 1991 (5), reproduced in **AIDS Newsletter**, 1991, 6(11): 24. AIDS cases includes AIDS (106) and AIDS related complex (ARC) (278). Other sources give 179 for total AIDS cases (**WER**, July 1992, data to 10/91); 271 AIDS/ARC cases and 23845 HIV infections (**AIDS Newsletter** 1992, 7(3): 11, quoting data from WHO Collaborating Centre at Mahidol University, Bangkok).

⁸ Data on HIV cases from **Guardian**, 16/4/92/ **WER**, 67(14): 98 both quoted in **AIDS Newsletter**, 1992, 7(6): 13.

Table 2

RECENT OFFICIALLY REPORTED HIV/AIDS CASES
IN SOUTH PACIFIC COUNTRIES

SOUTH PACIFIC ⁹								
	AIDS CASES			HIV CASES			RATE	DATE
	Male	Female	Total	Male	Female	Total		
Federated States								
of Micronesia			2			1	2.1	11/91 ¹⁰
Fiji			4			10	0.5	2/92
French Polynesia			27			102	13.5	11/91 ¹¹
Guam			10			34	6.7	11/91
Kiribati			-			3	-	1/92 ¹²
Marshall Islands			2			5	4.6	1/92 ¹³
New Caledonia			19			78	9.0	10/91 ¹⁴
Papua New Guinea			68			103	-	3/92
Tonga			2			3	2.1	11/91
Western Samoa			1			1	0.5	11/91
TOTAL								

⁹ Data from South Pacific Commission, 1992, **Pacific AIDS Alert**, No 3, unless otherwise stated. In a few cases, there is some discrepancy between SPC figures and WHO (**WER**, 1992, 67(27)) figures. Remaining Pacific Islands not listed here had no reported AIDS cases as at end '91/beginning '92, i.e: American Samoa, Cook Islands, Mariana Islands, Nauru, Niue, Palau, Solomon Islands, Tokelau, Tuvalu, Vanuatu, Wallis and Futuna Islands (see **WER**, 1992, 67(27)).

¹⁰ SPC data show only 1 AIDS case as at 11/91 whereas WHO data show 2; rate is based on WHO figure.

¹¹ **WorldAIDS**, March 1992: 12, gives 97 HIV cases as at Jan 1992.

¹² Data from **WorldAIDS**, March 1992: 12; SPC data gives 2 cases HIV as at 11/91.

¹³ Data from **WorldAIDS**, March 1992: 12.

¹⁴ Rate is from **WorldAIDS** March 1992: 12, where AIDS cases given as 18.

Current statistics and estimates for South East Asia and the Pacific

Tables 1 and 2 provide recent breakdowns by country - and gender where available - of officially reported cases of HIV/AIDS for countries in South East Asia and the South Pacific respectively. There is some inconsistency in the figures between different sources and this is indicated in footnotes to the tables. A gender breakdown was not available for all countries, which in itself is indicative of a lack of gender focus in the monitoring of HIV/AIDS.

The statistics presented in the tables only include officially reported cases of HIV/AIDS. There are no authoritative estimates of the prevalence of infection in the total population. Due to under-recognition and under-reporting, the official statistics are thought to represent only a fraction of actual cases, probably less than one third.

Moreover, the relationship between reported and unreported cases is not a linear one; rather the ratio of unreported to reported cases tends to rise as the number of reported cases increases (*AIDSED Newsletter*, 1/1990: 23). Thus these statistics give a very understated picture indeed.

Gender and age breakdown of HIV/AIDS cases

Available male:female ratios of seroprevalence and AIDS cases, based on officially reported statistics, tend to show that men are infected in greater numbers than women. Table 3 demonstrates this for AIDS cases in selected countries in South East Asia and the Pacific. However, the reported levels of HIV infection are not universally higher for women than for men - in the Philippines the reverse is true.

Table 3: Cumulative number of AIDS cases with percent male and female, in selected South East Asian and South Pacific Countries (as at 3/9/91)

COUNTRY	TOTAL AIDS	% MALE	%FEMALE
French Polynesia	27	81.5	18.5
Guam	8	87.5	12.5
Malaysia	28	89.3	10.7
New Caledonia	16	93.8	6.3
Papua New Guinea	37	62.2	37.8
Philippines	53	77.4	22.6

Source: Castle, 1991:69

The rate of HIV infection is rapidly becoming more equal by gender in developing countries generally, including in South East Asia and the Pacific (de Bruyn, 1992: 250; *AIDSED Newsletter*, 1/1992: 19). Heterosexual transmission is becoming the dominant mode in developing countries - with some country variation - particularly where the disease is already well established:

'[D]uring the second half of the 1980s, HIV infections among homosexual/bisexual men have shown a decreasing trend in most areas of the world. By contrast, there has been a slow but steady increase in HIV infections among heterosexual populations.' (Chin, 1990: 224.)

Whilst in all countries in South East Asia and the Pacific region women constitute less than half of the overall reported AIDS cases, in certain countries there is already a high level of female infection, indicating a possible rapid rise in the male:female ratio of prospective AIDS cases in the near future. Comparing the male:female ratios of AIDS cases to those for HIV infections, where data is available, (i.e. for Malaysia, the

Philippines and Thailand - see Table 1) only Malaysia appears to show a falling proportion of women becoming infected, perhaps due to the apparently increasing infection rate among predominantly male intravenous drug users there. In the Philippines the officially reported number of HIV positive women exceeds that of men by almost fifty percent.

However, these figures have to be interpreted with extreme caution, since the patterns of testing may lead to strong biases. For example, in the Philippines, the numbers of women tested compared to men is very high, which may explain the apparently high proportion of female infection. (Marge Berer, personal communication.)

In other cases, it is possible that the official figures underestimate the levels of infection and AIDS among women, because women are less likely to come forward for testing or treatment at clinics (where data is often collected) due to the social stigma attached to the disease and to their relative lack of access to health facilities. The fact that women are known to be less likely than men to present themselves at STD clinics would seem to bear out this latter point. (Elias, 1991: 5.)

Where statistics are broken down by both age and gender, the pattern tends to be that women have proportionally higher rates of infection at younger ages - in some cases exceeding male rates for particular cohorts. For example, according to 1990 official data from the Philippines, in age groups 20-29 years, the frequency of infection of women exceeded that of men by three to four times. In Thailand, June 1991 data shows that the number of HIV positive women exceeds that of men by more than three times in the 15-19 age group. (Philippines, Department of Health, 1990: 14 and **AIDS Newsletter**, 1991, 6(11): 24.)

The peak levels of AIDS and HIV infection emerge at correspondingly younger ages for women than for men - in the case of Thailand late teens/early twenties versus late twenties early thirties (AIDS) and late teens versus late twenties early thirties (HIV). These factors in the age/gender pattern of HIV infection/AIDS obviously need to be addressed in devising gender appropriate prevention strategies. (**AIDS Newsletter**, 1991, 6(11): 24.)

Projections from the reported data

As emphasised above, the statistics presented in Tables 1-3 are only of officially reported cases of HIV/AIDS and are not representative of overall levels of infection. It is very difficult to project from the reported cases to estimates for the whole population, because the disease is not randomly distributed, and because of selection or participation bias in the reported statistics. What is certain, however, is that levels of infection are much higher than those reported in official statistics, for both men and women. For instance, it is now estimated that there are as many as 400,000 HIV infected people in Thailand alone (**AIDS Newsletter**, 1992, 7(4): 9).

2 Transmission of HIV/AIDS in South East Asia and the Pacific

Global transmission patterns

On a global level, the main transmission mechanisms for HIV at 1990 were: sexual intercourse (75 percent - of which 60 percent from vaginal intercourse); intravenous drug use (10 percent); perinatal transmission (10 percent) and blood transfusion (five percent). The transmission likelihood varies with each mechanism, so that the likelihood of infection from infected blood or blood products is over 90 percent, and through perinatal transmission, 20-40 percent¹. Other transmission mechanisms are between 0.1 and 1 percent 'efficient'. (AIDSED Newsletter, 4/1991: 10.) These patterns are not static, however, and overall trends suggest that heterosexual and perinatal transmission are increasing.

Trends in HIV transmission in South East Asia and the Pacific

Various factors are thought to pre-dispose South East Asian populations to the rapid spread of HIV/AIDS. These include: intravenous drug use with a high degree of needle sharing, particularly in Thailand, Malaysia and Myanmar; the existence of large scale sex industries, especially in Thailand and the Philippines, such that small sections of the population - i.e. sex workers and their clients - have a large number of partners; high levels of STDs (an important cofactor in the spread of HIV infection)²; and low levels of condom use. (See e.g. IDS/ODI, 1992: 4; **AIDSED Newsletter**, 1/1990: 24.)

Muecke (1992) also cites (in the case of Thailand) 'high population mobility, sexual mores that endorse male sexual freedom and restrict it for women who are not prostitutes, ...an uncircumscised male population, and age mixing of sexual partners (older men choosing younger women rather than age peers).' (Muecke, 1992: 897.)

Other factors mediating the spread of HIV infection and incidence of AIDS may be the lack of comprehensive blood screening facilities (particularly in the Philippines - see below); and a low levels of hygiene in formal and informal health care, particularly in poorer countries or where health services are underfunded or poorly integrated.

In countries with a high incidence of TB (e.g. the Philippines; Cambodia), HIV infection among TB sufferers can lead to a rapid spread of TB through the general population. (Castle, 1991: 25; AIDS Newsletter, 1992, 7(5): 10.)

Not all these factors exist in all countries, however. For example, in the Philippines, the transmission of HIV through needle sharing is thought to be virtually non-existent, apparently because of a cultural aversion to needle use, and because of the high cost of injectible drugs. (Castle, 1991: 25-6).

¹ The wide range for perinatal transmission is explained by differences in likelihood of transmission depending on the stage of advancement of the disease in the mother, and on the route of transmission to the mother.

² It is not entirely clear whether STDs are indeed cofactors in the sense of facilitating the spread of HIV infection or whether they are 'risk markers' which are associated with sexual behaviour likely to promote HIV infection. (Elias, 1991: 25-6.)

As well as epidemiological and behavioural and other factors which increase the likelihood of a rapid spread of HIV infection, socio-cultural and socio-economic factors may also hamper HIV/AIDS prevention work. Many instances of such factors are highlighted in this report, which lead to gender biases in responses to HIV/AIDS.

In the Pacific, specific risk factors include:

'cultural and religious taboos which make people reluctant/unable to talk about sexual matters; existing high rate of STDs; generally low status of women (anecdotal evidence suggests that many of the women infected so far in the Pacific are faithful wives of unfaithful husbands); lack of funds/strong health infrastructure in some countries; multitude of languages/scattered populations (either over many islands, or huge geographical area as in the case of PNG).' (Patricia Sheehan, SPC, personal communication.)

Fertility rates and maternal mortality rates tend to be high in many Pacific countries, suggesting that conditions at childbirth are inadequate, with implications for the risk of HIV infection during childbirth. The vulnerability of small island communities, with high levels of tourism and migration, is a major issue, with the current situation of some Caribbean islands - where HIV prevalence rates surpass those even in the worst affected countries in sub-Saharan Africa - demonstrating just how devastating the effects of HIV/AIDS can be.

Blood and blood products

Comprehensive blood screening facilities are still fairly recent, or are still being established in many developing countries. For example, in Thailand, '[b]lood was not routinely screened for most of the 1980s and still fresh blood for emergencies cannot be screened in most peripheral centres (*AIDS Newsletter*, 1992, 7(3): 11.) In the Philippines, it is estimated that only 10-11 percent of blood was screened in 1991, due to the prominence of the commercial blood sector and the inability of health authorities to regulate this sector (Lucas, 1992). In Indonesia, screening of blood only began in March 1992 (*AIDS Newsletter*, 1992, 7(6): 11). In Papua New Guinea, the 1988 **National Policy Document on AIDS Control** stated that 'it must be accepted that universal screening of all blood donations in PNG remains economically unjustifiable.' ((Papua New Guinea, Department of Health, 1988: 8.)

The lack of comprehensive screening facilities has particular implications for women. 'Women ... receive proportionately more transfusions than do men, reflecting the impact of ... maternal anaemia related to high parity, malaria, complications of childbirth and blood lost as a consequence of incomplete and septic abortion.' (Elias, 1991: 23.)

Intravenous drug use³

Intravenous drug users (IDUs) were one of the first groups in the South East Asia region to show very high levels of infection. Heroin injection is well known in Myanmar, Thailand, Malaysia and Singapore, and may be spreading to other countries. It is a social activity, although the forms vary across cultures, which encourages group participation and the sharing of syringes.

'Data from Thailand - with an estimated 400,000 drug injectors - shows that 63 percent of the 23,845 cases of HIV infection are among IDUs. Unofficial estimates ...

3 Most of this section is based on Joergen Gammelgaard and Panos, 'Shifts in drug taking threaten Asia,' in **WorldAIDS**, May 1992.

suggest that Myanmar has 160,000 IDUs of whom half are already infected with HIV. One government official has admitted off the record that his department had tested 85,000 IDUs and found that 85 percent were infected. ... In Malaysia, there are nearly 4000 cases of HIV infection, approximately 80 percent of which are IDUs.'

(**WorldAIDS**, May 1992)

The existence of a large indigenous opiate production industry among hill peoples of Thailand, Myanmar and Laos (the 'Golden Triangle') and associated patterns of drug use and trafficking within the region and internationally, are a growing cause for concern. 'There is evidence of an epidemic of HIV along the smuggling routes from the Golden Triangle.' (**AIDS Newsletter**, 1992, 7(1): 14.)

The local availability of refining technology has shifted the manufacture of heroin from raw opium further back up the chain of distribution, thus increasing local availability - and consumption - of high grade injectible heroin, at relatively low prices.

In some countries, injection of drugs is not widespread but there are fears that a shift towards injection is underway in many countries, as previously occurred in Thailand, Malaysia and Singapore. Heroin injection in Asia is often introduced by middle class youth, who may relinquish the habit relatively easily, but create an environment in which lower income groups emulate their injection behaviour.

Harsh legislative measures introduced in many South East Asian countries are thought to have impeded efforts at HIV/AIDS prevention work with IDUs in the region. Authorities tend to stress the need to eradicate the problem, rather than to provide safer alternatives to injection, or improve hygiene and limit needle sharing. There may also be a tendency to see IDUs as a distinct subculture which does not impact on wider society (Ford, 1991: 411).

Youth

In most countries in the region, there is growing concern about the impact of HIV/AIDS on young people, as evidence is amassed of high levels of sexual activity among adolescents - even in relatively conservative societies - and of rising levels of STDs among young people. The phenomena of child prostitution and street children (who are often 'freelance' sex workers) in many countries in South East Asia (especially Thailand and the Philippines) further underlines the potential impact of the HIV/AIDS epidemic on very young age groups.

Evidence suggests that there is greater potential to alter the behaviour and attitudes of younger people with regard to sexuality and HIV/AIDS, because their opinions and behaviour patterns are less well established, so that preventive activities aimed at young people are not only highly necessary but may also be particularly effective.

The HIV/AIDS problem is particularly pertinent to young women, because AIDS rates among women peak in their late twenties, suggesting that many infections occur in their late teens. Most AIDS education in schools is focused on secondary age groups. Women tend to have lower participation rates in education, more so at higher levels. There is clearly a need to address younger age groups (from primary school level) particularly women, and to do outreach work with those not in schools (particularly girls).

Increasing heterosexual transmission

The pattern of HIV transmission in South East Asia and the Pacific is an area of ongoing research and debate. The picture varies greatly from country to country and is continually shifting. However, a common trend is the increasing dominance of heterosexual transmission.

According to one researcher, Thailand has experienced four epidemic waves: 'Starting in infection in intravenous drug users in 1988, HIV spread to female prostitutes (about 15 percent of whom were infected in 1991) and thence to their male clients in 1989. The fourth wave appeared in pregnant women in 1991. There are indications that this pattern is being repeated in neighbouring countries.' (*AIDS Newsletter*, 1992, 7(12): 10.) According to the Population and Community Development Association in Thailand, the 'peak rate of infection for full-time prostitutes will be in 1993; among their customers in 1995-6; and in the latter's wives in 1997 and for a new generation of children in the year 2000.' (*AIDS Newsletter*, 1991, 6(15): 13.)

Women in general, as well as sex workers, are at increasingly high risk of infection, largely due to the high risk behaviour of their partners, rather than their own. A survey of sexual behaviour among a stratified sample of 2801 male and female Thai Buddhists found that:

'Thai men ...[have] large numbers of sexual partners ... Thai women show much more restricted patterns of sexuality with most sex occurring in relationships, however the low use of condoms puts many of these women at risk through their relationships with higher risk male partners.' (Sittitrai et al, 1991, quotation from abstract.)

Reports from Singapore also suggest an increasing trend of heterosexual transmission, particularly among young people. A survey in 1989 found that '[a]t least 6000 men put their wives at risk by having unprotected sex with them and prostitutes in the same period.' Heterosexuals made up 57 percent of cases in 1991 compared to 28 percent in 1990. (*AIDS Newsletter* 1992, 7(8): 14.) In the Pacific generally, heterosexual transmission is the main mode of spread of HIV. (Sheehan, personal communication.)

3 The social context of HIV transmission

Studies of HIV/AIDS in South East Asia and the Pacific have tended to focus on epidemiology, particularly of 'high risk groups,' and more recently, on 'high risk behaviour,' and attempts to modify it. Broader issues of sexuality and gender, and poverty and underdevelopment (which themselves underly high risk behaviour) are less prominent in the literature on South East Asian and the Pacific.

Sexual behaviour and sexual bargaining

The need for behavioural research on sexuality is now widely acknowledged, in order to design and monitor prevention and control activities. Standard KABP (Knowledge, Attitudes, Beliefs and Practices) surveys have been conducted, or are planned, in many of the relevant countries, focused on specific groups, or on samples from the population as a whole. There is a small but growing literature in this area, which should facilitate the improved design of prevention programmes.

In the Philippines, Health Action Information Network (HAIN) have conducted a KABP survey of nursing and medical students in Manila (see below); the Council for Health and Development have carried out a sociocultural survey on sexuality and AIDS in the Philippines, with some gender analysis (see list); and various studies have been done focused on sex workers both prior to and in conjunction with interventions (e.g. Bagasao et al, 1990).

KABP studies have also been done in Singapore (1989) and Vietnam (1990). (*AIDS Newsletter*, 1992, 7(8): 14; Bailey, 1991.)

In the Pacific KABP surveys are said to have been conducted in Fiji (thought to be unreliable), American Samoa (not yet fully analysed); and French Polynesia (see below) (Sheehan, personal communication). A further such study in Vanuatu is planned. A research project based at the Institute of Medical Research in PNG is focusing specifically on the AIDS risks for women in urban and rural areas, across 15 different cultures (Pacific Women's Resource Bureau, 1992: 11).

In Thailand, the majority of the studies done have been on the behaviour of sex workers, often in conjunction with interventions, e.g. Swaddiwudhipong et al (1990a). Some surveys in Thailand have also been conducted with broader groups, however. For example: the Shah et al (1987) study on married women in Bangkok - see below; and the Swaddiwudhipong et al (1990b) survey of men's behaviour and knowledge about AIDS in Mae Sot, Tak. This is a rare example of a study focusing on men, around a quarter of whom were regular clients of sex workers (i.e. had visited a sex worker in the last month) but of whom only one third to one half had ever used a condom with a prostitute. (Swaddiwudhipong, 1990: 447.) The Sittitjai et al (1991) survey quoted above looks at partner relations and risk of HIV infection and addresses the consequences of male behaviour for women.

However, there is still a tendency in such studies to see sexual behaviour and decision making about sexuality as a matter of individual choice, whereby the provision of information about risks could lead to 'rational' changes in behaviour. This approach ignores factors of power and status which are involved in sexual decision making, which generally prevent women from imposing new modes of behaviour, due to their lack of sexual bargaining power (Worth, 1989: 304). KABP and similar surveys need to take up issues of gender in relation to sexuality more explicitly. At the very least, they should focus on both men and women, and include analysis of differences in knowledge, perceptions, behaviour etc by gender. They should also attempt to investigate the dynamics of sexual bargaining, as well as the standard 'knowledge, attitudes, beliefs and practices' questions.

The advent of the HIV/AIDS epidemic is itself modifying patterns of sexual behaviour as the sex industry responds to changing demands, brought about by the fear of AIDS. Rather than adopt safe sex practices, as men become more aware of the risk of infection, they may demand younger and younger women - particularly virgins - for commercial sex, as well as for casual sex and marriage. Thus there is a need for ongoing longitudinal research into patterns of sexual behaviour and its social context.

Socio-economic and socio-cultural issues

Poverty - particularly rural poverty and landlessness - coupled with the rapid commodification and monetisation of Thai society, is undoubtedly the major underlying factor in promoting the large scale entry of young women from particular regions into commercial sex work (Ford, 1991: 408). In the Philippines also, the majority of sex workers come from the poorest provinces (Tan et al, 1989: 186).

In rapidly urbanising societies such as the NICs (Newly Industrialising Countries) of South East Asia, rural urban income differentials may be growing, fuelling migration to urban areas, and the growth of an affluent urban class, which leads to increasing demand for urban based sexual services. Whilst the sex industry is often portrayed as being mainly patronised by foreign visitors, in Thailand at least, the majority of men frequent sex workers and this is widely perceived as normal. (Muecke, 1992.)

Young women are frequently 'sold' into prostitution by their families - often at a very young age - in order to purchase land, but modern inputs and consumer goods, or to build houses in rural areas. The lack of alternative opportunities, and high rewards from sex work compared to other work (as much as 25 times higher than the median rewards from other work (Ford, 1991: 408)) mean that it is often the most

attractive of highly restricted options, from the point of view of parents and, sometimes their daughters. (Gordon and Kanstrup, 1992: 30; Muecke, 1992; Ford, 1991.)

Muecke (1992) goes beyond a purely socio-economic analysis of the rise of prostitution in Thailand, to provide a cultural explanation. She argues that traditional, particularly Buddhist, values have allowed the rapid growth of commercial sex work to be accepted and even encouraged, as a way of shoring up growing rural-urban income differentials arising from urban based modernisation in the country. The flow of income from urban based women to their rural families through remittances is legitimised by prevailing norms according to which women support the family, village and other institutions of Thai society, and daughters have a duty to repay their parents. In some Northern areas of Thailand, there seems to be relatively mild stigma attached to 'temporary' involvement in the sex industry, particularly where it enables women to improve the situation of their families. (Muecke, 1992; Ford, 1991.)

Migration and movement

The spread of HIV/AIDS in Africa is known to be related to migration patterns. The evidence there suggests that areas which are the destination of migrants are the most susceptible to high levels of infection with areas which are sources of migration being second most vulnerable and areas which neither send nor receive migrants being less vulnerable. (Elias, 1991: 32.)

Under such circumstances, women left behind by migrant partners may be forced to engage in sexual exchange for survival, if they are no longer being supported, and/or where family farms and businesses are no longer viable. Moreover, they may be exposed to risk of infection when the husband returns home after a long period in an urban area, or overseas, where he has probably been involved in other sexual relationships.

In South East Asia and the Pacific, the patterns of migration and associated spread of HIV may differ to that in Africa, however. In Thailand,

'[t]he high level of inter-regional mobility and migration has ensured that HIV has been transmitted by both CSWs (commercial sex workers) and their clients to all regions of the country. In particular the circulatory nature of rural-urban migration, where migrants keep close links to their home villages, has probably accelerated the pace of diffusion of HIV.' (Ford, 1991: 410.)

Ford suggests that research should be done on particular occupational groups, such as fishermen and lorry drivers, who are known to frequent low class brothels, and may be significant groups in the geographical diffusion (**ibid**).

Migration of women from poorer to richer countries in the region and their associated involvement in commercial sex work is also widespread - for example the presence of and up to 10,000 Thai commercial sex workers in Japan (Muecke, 1992: 892). Since the late 1980s, there has been an increasing number of Burmese girls brought into Thailand as sex workers, as well as women from non-Thai Northern hill tribes, Laos and southern China. These women are often highly vulnerable to exploitation, harassment and stigmatisation. (Muecke, 1992: 895.) Many Burmese women in Thailand work in low class brothels. Their lack of knowledge and power is reinforced by language difficulties. It is not known to what extent AIDS prevention efforts targeted at sex workers have addressed the problems of women from other countries, or who do not speak national languages. (AIDS Newsletter, 1992, 7(5): 10; Muecke, 1992: 895.)

It has been reported in the press recently that Burmese women are being deported from Thailand because of HIV positive status, and that these women may face

summary execution on their return to Myanmar. A Thai officer is quoted as saying that 25 HIV positive Burmese girls were killed by cyanide injections by Burmese authorities after they had been returned from Thailand. (*AIDS Newsletter*, 1992, 7(5): 10.)

Sex tourism

Men tend to move from richer to poorer countries in search of commercial sex, both intra-regionally and internationally. This 'tourist trade' has been explicitly promoted by authorities in receiving countries largely because of its economic benefits. Governments have an ambivalent attitude towards the sex industry which prevent them from enforcing their own laws against it. The HIV/AIDS epidemic has heightened this dilemma, because it potentially threatens tourist revenues. At the same time, in official statements sex tourism is often associated with the spread of HIV/AIDS, perhaps partly to deflect from the problems of rising indigenous infection. (Muecke, 1992: 894-898.)

In Thailand and the Philippines, vocal opposition has been expressed to sex tourism (and the sex industry geared to military bases) but relatively little action has been taken, other than to attempt to reassure visitors that commercial sex workers are 'AIDS-free', through regulating the sex industry. In Thailand the arrest of an American tour organiser recently, and public statements by tourism officials that sex tourists are not welcome, may be indicative of a shift of policy, but are more likely to be token gestures. The termination of leases on US bases in the Philippines may lead to shifts in patterns of demands in the sex industry, but tourism is still being heavily promoted. (*AIDS Newsletter*, 1992, 7(8): 14; Muecke, 1992: 896; Tan et al, 1989.)

Recently, the diversion of sex tourism to countries such as Vietnam and Laos has begun, where 'clean' girls are offered for commercial sex, and Cambodia is proposed as a future sex-tour destination. (*AIDS Newsletter*, 1992, 7(1): 14; Muecke, 1992: 895.)

III WOMEN AND HIV/AIDS

1 Gender implications of HIV/AIDS

There is a growing awareness that HIV/AIDS have qualitatively different and greater implications for women than men, particularly in developing countries. De Bruyn cites four major reasons for this:

- stereotypes related to HIV/AIDS have meant that women are either blamed for their spread or not recognised as potential patients with the disease;
- various factors, related indirectly and directly to gender, place women at increased risk of exposure to HIV infection;
- the psychological and social burdens are greater for women than for men;
- women's social position makes it difficult for them to undertake prevention measures.' (de Bruyn, 1992: 249.)

Gordon and Kanstrup (1992: 29) talk about 'women's lack of sexual self determination' which has both socio-cultural and economic causes, as the key issue underlying all health risks associated with sexuality, particularly HIV and AIDS. Some of the issues raised by these points are elaborated below.

2 Stereotypes and HIV/AIDS

Whilst recently there has been a shift away from a focus on 'high risk groups' towards high risk behaviour, earlier epidemiological and behavioural surveys with this emphasis have contributed to negative stereotypes about certain categories of people. Traditional ideas about STDs may also lead to a predisposition to identify AIDS with particular groups.

In Thailand, for example, STDs are commonly known as 'women's diseases,' and AIDS is literally called a 'prostitutes disease'. Whilst there do appear to be very high rates of HIV/AIDS among female sex workers in Thailand, there is a distinction between focusing prevention and control activities on particular groups, and identifying them as principal vectors of the disease. (de Bruyn, 1992: 250.)

These negative stereotypes are now well established and may be further reinforced by media reporting and by messages conveyed in AIDS control and information and education campaigns. In Thailand the government has consistently blamed the sex industry (particularly sex tourism) for the spread of HIV infection (Muecke, 1992). Policies to enforce testing for sex workers (such as the 'green card' policy in Thailand, introduced in 1991, and the long established 'pink slip' system in the Philippines) reinforce the perception of sex workers as vectors of transmission. The 'green card' system in Thailand brought forth strong criticism from NGO workers, such as the Director of EMPOWER (**WorldAIDS**, March 1992). In Vietnam, a play produced to raise AIDS awareness features a foreigner returning to Vietnam and is entitled MISS AIDS, which seems to suggest a possibly damaging identification of women with the disease (O'Sullivan, 1991).

There are numerous potentially negative consequences of this perceived association between commercial sex workers and HIV/AIDS. Commercial sex workers may suffer increasing prejudice, harassment and loss of income. The demand for 'clean' commercial sex workers leads to new and increasingly vulnerable groups of women becoming involved in commercial sex work (see above). Where compulsory testing is imposed, men will be encouraged not to use condoms, since they have an apparent

guarantee that the woman is 'clean' (Panos, 1990: 83). Women in general may avoid using condoms, being tested, or seeking early treatment, for fear of being branded as a prostitute, thus putting themselves and others at risk, or increasing their risk of early mortality (de Bruyn, 1992: 251).

The association of HIV with commercial sex workers (as well as male homosexuality, intravenous drug users and foreigners) tends to lead to both complacency and under-recognition of the virus in other women, conforming to prevailing dichotomous views of women as 'good girls' and 'bad girls'. Women who are not sex workers may not recognise the risks to them. (Caravano, 1991: 135.)

Even innovative approaches to AIDS awareness often seem to feature men as the 'victims' of AIDS (albeit through their own ignorance or recklessness) and women as loyal carers, for example: the Wan Smolbag Theatre Company, Vanuatu, in their play 'Warm Night'; the 'Charlotte's Story' video about a Samoan woman whose son died of AIDS; 'Maw Lum' traditional entertainment for AIDS education in Thailand. (**AIDS Health Promotion Exchange**, 2/1991: 10-13; Pacific Women's Resource Bureau, 1992.)

3 Risks of exposure and gender

Knowledge and perceptions of HIV/AIDS

Women may be at greater risk of infection than men because of their lesser awareness of the possible risks. Whilst knowledge of the risks is not sufficient to prevent high risk behaviour, it is a prerequisite for behavioural change.

Women in many - though not all - developing countries tend to have lower educational and literacy levels, lower attendance rates at schools (often progressively lower at higher levels) and lower access to the mass media through which AIDS awareness campaigns are promoted (e.g. radio, TV). These biases tend to particularly affect low income women in rural areas. (de Bruyn, 1992: 251.)

One study of knowledge of AIDS among married women in Bangkok in 1987 revealed that although awareness of the disease was widespread across all women, misconceptions prevailed. Misconceptions were particularly marked among women with lower educational levels, and in low income and younger age groups (these groups were not mutually exclusive). These groups of women were more likely to have gained their knowledge of AIDS through friends and relatives than through the mass media, and this knowledge was more likely to be inaccurate, particularly with regard to the curability of AIDS. (Shah et al, 1991.)

Another study of levels of knowledge and perceptions of AIDS, as well as sexual attitudes and practices, among nursing and medical students in Manila in 1991, revealed some small but significant differences in knowledge and perception of HIV/AIDS by gender. Even among these highly educated groups, women, compared to men, relied more on family and friends for information, tended to have slightly greater erroneous knowledge of HIV/AIDS and somewhat more pronounced tendencies to blame the spread of the disease on specific groups, notably female prostitutes. The research also suggested that women were slightly less likely than men to use 'hotlines'. (HAIN, **Health Alert**, Jan 1992, 125.)

In the Pacific also, there is evidence of differential levels of knowledge by gender. A recent KABP survey of transvestites and bar girls in French Polynesia found that '[t]he bar girls had significantly lower level of knowledge than the transvestites. Most wished to know more about AIDS.' (Sheehan, personal communication.)

On this evidence, then, it appears that women generally have less accurate knowledge of HIV/AIDS, and that lower income, younger and less educated women are particularly prone to misconceptions. The fact that women rely more on family and friends for information is also significant. This suggests that micro-level rather than macro information campaigns will reach women more effectively. Where mass media campaigns are used to raise public awareness, it is important to establish which channels are most appropriate to reach women.

Biological and health related factors

Biological and health related factors also potentially increase the likelihood of increased risk of exposure to HIV for women. Most sources claim that women are physiologically more susceptible to HIV infection through heterosexual intercourse than men. (Gordon and Kanstrup, 1992: 29; Foster and Lucas, 1991: 10.)

Correlations between STD and HIV infection are well documented. The symptoms of STDs are often less readily detectable in women, who often do not seek early treatment (for this and other social reasons). The importance of untreated STDs in women as a cofactor in HIV infection is thus probably more important for women. A concerted effort to combat STDs in general is clearly one major strategy for addressing the AIDS epidemic, which could be of particular benefit to women, although the delivery of STD services clearly needs to be redesigned to reach women. (de Bruyn, 1992: 251; Elias, 1991.)

As mentioned above, women may be at greater risk than men of infection through blood transfusion because they are the main class of recipients of large transfusions at childbirth. In many South East Asian and Pacific countries blood is not fully screened.

The use of intra-uterine devices (IUDs) is also often cited as a factor leading to increased risk of infection of women, because of their association with pelvic inflammatory disease. Some research suggests that other contraceptives, such as the pill, may also increase the risk of HIV infection for women. The spermicide Nonoxynol-9 has been associated with vaginal irritation which may facilitate the passage of infection. (Hunter and Mati, in **Women's Global Network for Reproductive Rights Newsletter**, 37: 19-22.)

The risks and benefits associated with different methods of contraception need to be clearly established through further research,⁴ in terms of STDs and particularly HIV, as well as more general and reproductive health, and women should be made fully aware of the risks and benefits of different methods.

Women's role as health workers

Women may be at greater risk of infection because of their formal and informal roles in health provision, particularly as traditional birth attendants (TBAs), midwives and also as nurses where thorough protection conditions are not enforced. Childbirth creates particular risks because of the large quantities of blood and other body fluids released. (de Bruyn, 1992.)

⁴ There is some difficulty with this in terms of recreating real life situations for testing - there has been considerable controversy over trials of nonoxynol-9 (de Bruyn, 1992: 254).

In the HAIN Manila survey cited above, nursing students (male and female) had strong reservations about working with infected patients, with the reservations being more pronounced among women. Whilst some of these reservations may be due to misconceptions, there is clearly a need to improve conditions and/or create confidence in medical environments, particularly in community based health provision where women predominate.

Women's vulnerability in war affected areas

The literature on women and HIV/AIDS in Africa refers to the risks of infection through voluntary or forced sexual relations with military and police personnel, especially in war affected areas, given the often high rates of seroprevalence of such personnel. Patterns of spread of the virus have been related to the movements of military personnel in central and east Africa. (de Bruyn, 1992: 253)

Whilst the political-military situation in South East Asia and the Pacific is very different from that in Africa, there is certainly cause for concern in this respect. The pursuit of armed opponents of the regime and persecution of minorities in border areas of Myanmar has recently intensified. Military occupation and repression by the Indonesian Army continues in East Timor. Fighting associated with the Cambodian civil war has subsided, but there are ongoing military activities and incursions by Khmer Rouge and other military groups. The implications of this for the spread of HIV/AIDS would depend on the epidemiological status of the military groups in question, among other factors. However, women in the remaining refugee camps along the Thai-Cambodian border - particularly those controlled or regularly visited by the military - must be potentially very vulnerable.

In Thailand, rates of seroprevalence among army recruits increased from 0.5 percent in November 1989 to 3 percent (preliminary data) in November 1991, a six fold increase, with rates for several northern provinces exceeding 10 percent in May 1991. HIV seropositivity in this population is strongly correlated with contact with commercial sex workers, incidence of STDs and low condom use. (AIDS Newsletter, 1992, 7(12): 10.)

Finally, the presence of US and other foreign military personnel permanently stationed on bases, or temporarily located there for 'R and R', is an important issue in the context of HIV/AIDS transmission. The historic links of the US and other foreign military presences in South East Asia and the Pacific with the sex industry are well known. In the Philippines, in particular, the spread of HIV/AIDS is blamed to a large extent on US military personnel. This is a major factor contributing to the high level of political opposition to the US military bases. Earlier protests, when 'hospitality women' working around base areas were found to be HIV positive, led to demands for US army personnel to be screened by military authorities. (**WorldAIDS**, November 1991.)

Whilst the popularly perceived role of US military personnel in HIV transmission may be exaggerated, it creates problems in tackling the spread of virus, since people perceive HIV/AIDS as a foreign problem. In the Philippines, particularly, health activists are now at pains to stress that the dismantling of the US bases will not result in the end of the AIDS epidemic (HAIN, 1992).

4 Psychological and social burdens of AIDS⁵

Women, especially sex workers, are often stereotyped as transmitters of HIV and other STDs (see above). This means that the stigma attached to seropositivity is particularly severe for women. Married women who are seropositive may be blamed or ostracised by their husbands, even if the virus was transmitted to the women by her husband. Seropositive women may be abandoned or divorced. Given the limited property rights of women in most societies, and their economic dependence on men, this could result in destitution.

For sex workers, especially where there is compulsory testing, seropositivity may lead to loss of livelihood, or result in a shift into less regulated establishments (and therefore probably more insecure and less remunerative work). Foreign sex workers may be deported, as noted above, with severe consequences.

Single women who are known to be HIV positive are unlikely to find a partner. Widows whose husbands have died of AIDS are similarly likely to remain single. Such women are thus particularly vulnerable where employment opportunities are rare and inheritance rights weak.

HIV positive women who are or become pregnant face further psychological and social pressures. They may have to live with the possibility that their child may be HIV positive, which may not become apparent for many months after birth. They also have to contend with worry about who will look after their child if the child seems likely to outlive them. In some cases, women feel pressurised into having an abortion. In other cases, women may wish to have an abortion. In some cases abortion is illegal and therefore very risky - although some shifts in the law in this regard are noted below.

In most societies, women are the primary carers at household and community levels, so that the burden of caring for sick relatives often falls to them. This is doubly difficult when women themselves have AIDS.

5 Most of this section is based on de Bruyn, 1992.

IV HIV/AIDS PREVENTION AND CONTROL ACTIVITIES

1 Lessons so far

At the 1992 AIDS/STD Conference in Amsterdam, '[r]ealism about the interdependence of economics, prevention, treatment, control and evaluation was thrown into high relief. The diversity emphasised the need to adapt what we know to local conditions. The range of experience from across the world warned us of the pitfalls of thinking that all we have to do is tell people about the risks and persuade them to behave more safely (use condoms, clean needles etc). The evidence was clear than we do not know how to translate knowledge about prevention into practice, we do not know how to supply condoms and to maintain that supply at affordable levels, and that health promotion messages such as "stick to one partner" are not the whole answer.' (**AIDS Newsletter**, 1992, 7(12): 1.)

The WHO has recently completed a review of prevention programmes⁶, which also formed the topic for a session at the Conference. It was argued that prevention programmes **can** lead to behavioural change, especially increased condom use, which lowers the incidence of HIV/STDs. Four types of intervention were shown to have produced results, but each needed to be audience sensitive:

- person to person, especially peer led, interventions;
- mass media, e.g. for social marketing of condoms;
- service based interventions - e.g. provision of improved genitourinary services for sex workers;
- structural and contextual changes, for example, enabling legislation.

Some success was also reported in interventions involving intravenous drug users.

The basic message of the WHO evaluation was that existing interventions were showing results, but are not fully understood, and need to be extended further and managed better. Prevention requires careful analysis of the problem, clearly defined targets and evaluation. 'The greatest challenge is to increase their scale and to focus on creating enabling environments.' (**AIDS Newsletter**, 1992, 7(12): 28)

The need for prevention and control strategies to be complementary and linked is also increasingly emphasised, e.g. for interventions relating to drug users to also tackle issues of 'safe sex'. There is also a recognised need for greater integration of AIDS prevention activities with programmes addressing tuberculosis, and STDs and reproductive health generally. (**AIDS Newsletter**, 1992, 7(12): 10; Elias, 1991: 42.)

NGO assessment of the 1980s experience is that top down approaches involving legislative measures, fear arousing and moralising campaigns, a medical approach focusing on surveillance and screening of 'high risk groups' and educational campaigns targeted mainly at these groups, are often inappropriate, do not reach the wider population and may be counterproductive. Community based approaches emphasising participation in the design of education programmes, and in looking for safer sex practices have been found to be far more effective. (Gordon and Kanstrup, 1992: 32; Lucas, 1991.)

WHO and many other organisations and individuals working in the AIDS field are attempting to discourage the application of legislative measures in response to HIV/AIDS on the grounds that it is both counter-productive (compulsory testing will

6 It is not known whether this has been published.

lead to people who are at risk avoiding diagnosis and treatment, especially where linked to regulation of the sex industry, for example) and also raises issues of discrimination and human rights.

The human rights dimensions of the AIDS crisis and related legislative measures are only starting to be addressed now. Positive as well as negative legislation is needed to protect individuals from discrimination. A key issue here for women is that of reproductive rights. The fact that legislation has been introduced in some countries to allow abortion for HIV infected women has potentially negative (as well as positive) dimensions, particularly if HIV positive women are being coerced into abortions.

Prevention and care

The distinction between prevention and care often made by donors in allocating resources is being challenged, particularly by NGOs working in Africa, where some feel the battle for prevention has been lost, and priorities are shifting.

Whilst the issue of care may not yet be so pressing in South East Asia and the Pacific, the ethical basis for screening and testing is clearly dubious where no provision for care is being made. Persons who have tested HIV positive may be lost to follow up after their test result, as in Indonesia. Where there are no benefits to participation in screening activities, it may become increasingly difficult to involve people, further hampering efforts to monitor and control the spread of the virus. (Castle, 1991: 2-3.)

The above points imply that donors may need to be more flexible about the promotion and funding of HIV/AIDS prevention and control activities, in terms of the distinction between prevention and care, and also in terms of seeing HIV/AIDS related work as one of a range of integrated, mutually reinforcing activities.

2 HIV/AIDS prevention and control and women: recent challenges

Until the late 1980s, the particular implications of HIV/AIDS for women were not being addressed at an international level, in spite of the growing numbers of HIV infected women, particularly but not exclusively in Africa. In 1989, the WHO sponsored 'Paris Declaration on women, children and AIDS,' formally put the issues on the international agenda. (WHO, **World Health**: 16-17.)

However, whilst there is undoubtedly now greater recognition of the implications of HIV/AIDS for women (and children), there is clearly still a long way to go in designing and implementing gender appropriate HIV/AIDS prevention strategies which also address issues of poverty, power and bargaining in sexual relationships.

Gender bias in prevention messages

In late 1990, Elizabeth Reid, UNDP WID specialist and Policy Advisor on AIDS and Development, challenged the prevailing three messages of mainstream approaches to AIDS prevention and control, i.e: reduction in the number of sexual partners; condom usage; faithfulness in relationships and celibacy and abstinence outside relationships. In her view, all three preventive options are beyond the control of women and offer them little protection. Studies illustrate that 60-80 percent of infected women in Africa have only one sexual partner; condoms are designed for men, although most refuse to wear them, and few women have the power to change this; and at 1991 infection rates, an estimated 1500 faithful women were being infected each day. (Synergy, 1992, Vol 4 (2))

Better preventive measures should include the provision of improved hygiene and treatment in accessible places (women do not routinely visit STD clinics); more research into barrier methods other than condoms; and in broad terms strategies focusing on women and women's development, integrating them into the AIDS programming process (**Synergy**, 1992, Vol 4 (2)).

Gordon and Kanstrup (1992) have also highlighted the deficiencies of typical 'safe sex' messages, which they argue go against the perceived norms of heterosexual sex which exist in many cultures and reflect male sexual desire for penetration, orgasm and a variety of sexual partners. They point out that 'safe sex' not only requires a fundamental challenge to these norms, but also almost always requires more time, resources, privacy, intimacy, skill and trust than unprotected intercourse. For people engaged in commercial sex, the added time may lead to loss of income or even violence against them; for young inexperienced people, or people living in crowded accommodation, the environment may not exist for relaxed sex; for women engaged in sex as a duty or a paid service, the greater intimacy often implied by safe sex may be unacceptable. (Gordon and Kanstrup, 1992: 32.)

In many cultures, there are double standards about sexuality which tolerate and even promote male promiscuity whilst condemning female promiscuity. In these circumstances, women are not expected to challenge or even raise the issue of their partner's sexual behaviour. In these circumstances, for a woman to suggest using a condom is very difficult. It implies either that she does not trust her partner and fears he might be infected, or that she herself has slept with others and might be infected. Moreover, condoms must be used at each encounter, so these dilemmas for women are continually raised.

'Mothers and whores'

Caravano (1991) has also attacked mainstream prevention activities relating to women as 'mothers and whores' approaches, i.e. they only focus on women who are perceived as vectors of transmission of the virus to others (heterosexual men and children). This creates false divisions and complacency as well as downplaying the risks for women themselves. For instance, she points out that sex workers relate to stable partners in much the same way as other women (i.e. often without condoms) and that they often have children. She also highlights the need to direct much more preventive activity towards adolescent girls, who are involved in sexual activity at increasingly young ages, through both school and out of school activities.

Caravano also stresses the importance of finding HIV prevention methods which are not also seen as contraceptives. She argues that as long as childbearing is a major source of status for women, providing women with HIV prevention methods which are also contraceptives does not provide them with real choice.

'Woman friendly' protection?

Other arguments are advanced by Stein (1990) in favour of the development of effective virucides. Her view is that condoms are efficacious (i.e. they work if used) but not very effective (i.e. they are not consistently used) and that other methods which are less visible and more under women's control may be more effective, even if less efficacious. These views suggest that whilst condom use should certainly continue to be encouraged, much more work should be done in developing alternatives which are controlled by women.

The femidom (female condom), is now available in some western countries and was also recently trialled in Thailand (Sakhondavat et al, 1991). Whilst theoretically controlled by women, this may also have limitations in acceptability because of its

visibility, not to mention its cost (8-10 times cost of male condom). Its acceptability to both men and women must be ascertained, as it cannot be used without men knowing. The Thai study reported that:

'At each site a pocket of very satisfied users developed who rapidly learned how to use and insert the device and endeavoured to use it in all episodes of commercial sex. The highest initial use was seen among the brothel based prostitutes at approximately 15 percent of episodes while the bar based girls showed usage levels of less than 10 percent. There is evidence that the experience of the initial innovators does spread through an establishment and that given this "peer pressure", the usage levels with time increase.'(Sakhondavat et al, 1991, quote from abstract.)

These findings are encouraging, although they are based on a two week trial period only, and further follow up is clearly needed. Moreover, the biggest obstacle to wider use of the femidom is undoubtedly the cost factor which is currently prohibitive for developing countries.

In spite of controversy about agents such as Nonoxynol-9, the development of more efficacious virucides would seem to be an important step forward, if only to provide an option which is invisible to men. However, the promotion of condom use must remain a central part of HIV/AIDS prevention, alongside other methods as they become available and affordable.

V HIV/AIDS PREVENTION AND CONTROL ACTIVITIES IN SOUTH EAST ASIA AND THE SOUTH PACIFIC

1 Initiation and implementation of HIV/AIDS prevention and control activities

Official responses

With backing and encouragement from WHO, governments set up National AIDS Committees (NACs) to coordinate the response to AIDS nationally. NACs now exist in all countries of the world, including the South East Asia and the Pacific region, and most have developed or are developing short and medium term plans (MTPs) to address the AIDS epidemic.

At official level, most AIDS campaigns primarily involve the Ministries of Health and Education. There is usually limited - if any - representation of NGOs in general, and women's organisations in particular, on national committees, and representatives tend to be male. Official responses have tended to focus on control aspects of the HIV/AIDS problem - for example serosurveillance, legislation, and regulation of the sex industry - which may be counterproductive - see above. WHO has recently urged the NACs to 'demedicalise' their approach. (Gordon and Kanstrup, 1992.)

In South East Asia particularly, the often authoritarian and military dominated nature of government, coupled with prevailing socio-cultural norms, may predispose states to this type of approach. Entry restrictions and/or compulsory testing for immigrants and returning overseas workers have been introduced in many countries (for example Thailand, Philippines, and Indonesia), as well as legislation permitting HIV infected women to have legal abortions where abortion is otherwise illegal (French Polynesia; Thailand (proposed)).

Moreover, there may be limited resources for HIV/AIDS work, which are vulnerable to political shifts. For example, immediately after the military coup in Thailand the AIDS budget was cut in half, although it was subsequently restored. In some countries, social sector budgets are very limited, and central government may be giving responsibilities for AIDS related work to lower level authorities who do not have sufficient resources to carry it out, as in Malaysia, for example. (Osteria and Sullivan, 1991; Castle, 1991.)

Testing is too biased towards monitoring and surveillance. Counselling and follow up work is weak or non-existent, and drop out rates after testing are high. Testing still tends to be very biased towards certain 'high risk groups', which not only distorts the data, but also increases the likelihood of stigmatisation. Many community based organisations feel that there is an imbalance of resources with too much being spent on expensive serosurveillance activities at the expense of prevention and information campaigns. (Castle, 1991.)

Education activities in schools and other educational establishments are widespread in some places (e.g. Thailand - see Ramasoota, 1991) and have barely begun in others (e.g. Malaysia - see Osteria and Sullivan). Where population education, sex education or related subjects are already in the curriculum, introducing AIDS education is thought to be easier. Secondary school and university students are the main recipients of formal AIDS education, where it exists. However, particularly for women, there is a need to begin AIDS awareness education in younger age groups.

At a multilateral level, UNDP is increasingly taking up AIDS work in non-medical sectors, focusing on socio-economic factors in the spread of HIV/AIDS, as well as on

its socio-economic consequences. UNDP has recently established a regional initiative on HIV/AIDS for Asia and the Pacific, based at the regional office in New Dehli. (See list for details.) This is encouraging in the light of the views expressed by Elizabeth Reid of UNDP (quoted above) and the stated intention of the new initiative to look at women's issues (see notes in list).

NGO response

The local NGO response to HIV/AIDS has in many instances been distinct from the official response. Many NGOs now doing AIDS-related work have been involved in community based activities centred on other issues (sex industry; violence against women; drug users; community health; reproductive health; gay and lesbian issues etc) for some time, and only in recent years have begun to develop small scale projects and initiatives in response to the impact of HIV/AIDS on communities they serve.

Many of these projects have taken innovative and creative approaches to the problems raised by AIDS, tackled issues in a non-judgemental way, and developed activities appropriate to the particular social context. NGOs may also act as a lobby to change government policy or legislation, and may be able to convey messages or information which the government is not willing to provide, and work with marginalised groups beyond the reach of official services and institutions. However, NGO activities are frequently constrained by limited coverage, and non-replicability.

Countries vary considerably with regard to the dynamism and freedom of operation of the NGO sector, however. Thailand seems to have a particularly large and dynamic NGO sector, with considerable involvement in HIV/AIDS related activities. In Malaysia, by contrast, NGOs have difficulty in being recognised and are not so used to confronting government policy (Castle, 1991). The formation of NGO coalitions may be a helpful step in this regard, although not without its problems (see notes on Malaysia NGO AIDS Council in list.)

Many NGO projects are designed to involve peer leaders in outreach activities, counselling and care, but there is little information about how to operationise this. There is a need for successful models from elsewhere to be disseminated among NGOs, and for evaluation and dissemination of useful models from within the region, as they are developed. (Castle, 1991: 4.) The prospective launch of a South East Asia edition of AHRTAG's **AIDS Action** newsletter is a positive development in this respect. In general, there is a need for greater NGO coordination, and information sharing and dissemination to develop appropriate models of best practice.

International NGOs have also become increasingly involved in AIDS related work in the developing world, including South East Asia and the Pacific, although much of the focus up until recently has been on sub-Saharan Africa. NGOs of all kinds, but particularly those with a prior involvement in family planning and health issues, are prominent in this work.

The International Planned Parenthood Federation (IPPF) in conjunction with its sister organisations in other countries and Family Health International, a US based NGO, are both playing a major part in supporting HIV/AIDS related work worldwide. (See list at end of report.) Family Health International has recently been given a large amount of money by USAID to extend its AIDS related activities. (**AIDS Newsletter**, 1992.) In this and other instances, bilateral donors are promoting AIDS related work through NGOs.

Multilateral organisations are increasingly encouraging the role of NGOs in AIDS related work, both directly and indirectly - for example through the UNDP and WHO

partnership programmes; through facilitating the setting up NGO fora and by encouraging governments to support their work. (Castle, 1991)

Women's organisations and HIV/AIDS

The involvement of women's organisations in HIV/AIDS related work in South East Asia and the Pacific is very variable. In much of the Pacific, and also in Thailand and the Philippines, women and women's groups appear to be very active (see below). In other countries, women's organisations seem less prominent, perhaps because they are less well established, or do not have strong 'grassroots' connections.

It might be useful for potential donors to attempt to assess the views of different women's organisations on HIV/AIDS related work, the extent of their current or planned involvement, capacity for future involvement and areas of comparative advantage, and constraints to their involvement in promoting HIV/AIDS prevention. However, there are obvious dangers in promoting HIV/AIDS as a 'women's' issue to be addressed by women's groups - i.e. that it may become a lower political priority and command less resources.

2 Overview of activities in South East Asia

Thailand

In South East Asia, Thailand has the most pressing problem of HIV/AIDS in terms of numbers of infected people, and the likely rapidity of further spread of the disease. Not surprisingly therefore, it is in Thailand that HIV/AIDS related work is most developed. Pressure from NGOs as well as multilateral agencies has led to a shift in official policy away from legislative and top down approaches to more education based approaches in the last couple of years. (**AIDS Newsletter**, 1991.)

A recent evaluation of the official HIV/AIDS prevention programme (1987-90) in Thailand (Ramasoota, 1991) concludes that there is evidence that the HIV/AIDS education programme has been effective. The evidence presented is largely in the form of a reduction in the numbers of people presenting themselves at STD clinics for treatment, and, of these, a reduction in the numbers found to be infected. There are some questionable assumptions here.

'The reduction in STD attendants is encouraging **if, as suggested, it reflects a true reduction in STD incidence during the four year period...** The question, too, is **whether the observed reduction in attendants really resulted from the education campaign on AIDS and other STDs.**' (Kidson, 1991: emphasis added.)

The reduction in STD attendants/incidence was noted for all regions except the south, and for many occupational groups, including sex workers. Incidence is rising among young people under 15 however, by 22 percent over the evaluation period, again highlighting the need to focus attention on young people. Groups with higher educational levels tended to have greater reductions in attendance/incidence, perhaps confirming that official campaigns are more effective among highly educated populations.

Dramatic reductions in particular STDs are noted (chancroid, syphilis and gonorrhoea) and are attributed to increased condom use. Other evidence is given of increased condom use among sex workers, but levels of condom use among male clients remain low, as do general levels of use in the north, east and central regions. The need for intensified work among male clients of sex workers, and in these regions, is stressed. (Ramasoota, 1991: 496.)

One rather disturbing argument presented in the evaluation is that wives (including female sex workers) transmitting STD to their husbands or regular partners, is an

important 'risk behaviour' which has not been affected by the education campaign. 'House wives involved in hidden promiscuous sexual behaviour are very risky since they usually deny condom use due to theoretical respect and faithfulness to each other.' (Ramasoota, 1991: 496.) If this is a genuine phenomenon it suggests that many women are involved in sexual exchange. The implication that women 'deny condom use' seems rather one-sided, given other evidence of men refusing condom use. It may be that 'housewives' are not being used as scapegoats for increasing levels of heterosexual transmission.

The evaluation concludes that activities should be extended on an integrated, community-wide and countrywide basis, involving both health and non-health agencies. Another positive element in the review is its strong emphasis on the need to protect confidentiality and human rights. (Ramasoota, 1991: 497.)

Much of the focus in Thailand has been on sex workers, and innovative approaches have been developed to reach this group, particularly by NGOs, for example EMPOWER. EMPOWER has developed safe sex cabarets for sex workers and their clients, which emphasise condom use, and the assertiveness of sex workers in relation to uncooperative clients. In this activity, it is felt to be important to give the safe sex message to sex workers and their clients when they are together. EMPOWER also provides various forms of training for sex workers, including English lessons, which improve the women's ability to negotiate and bargain with their clients.

An evaluation of the EMPOWER activities, and those of FACT (a gay men's group) concluded that:

'[t]ightly defined communities, especially those with solidarity born of marginalisation, prove effective in organising both around AIDS prevention and broader community development. Grassroots community development can grow to encompass AIDS prevention and, conversely, AIDS prevention can grow to encompass community development. Determinants of this include groups' perception of the subculture in the larger social formation, and degree of prior organisation in the community.' (Apisuk et al, 1990.)

Elsewhere, there have been attempts to introduce 'condom only' policies in brothels. These have been relatively successful where brothel owners/managers ('mamasans') have been involved in the implementation of such policies and where there is a sense of group solidarity among sex workers. (**AIDS Health Promotion Exchange**, 1/1992: 12.)

Another evaluation of attempts to promote condoms and health education among low socio-economic prostitutes in Mae Sot concluded that 'the effect of health education and condom promotion among our study prostitutes was modest.' (Swaddiwudhipong et al, 1990,). The Khon Khaen condom only brothel project mentioned above also found that whilst they had relative success in promoting condom use among sex workers, condoms were not used in relations with stable sexual partners (**AIDS Health Promotion Exchange**, 1/1992: 12). This concurs with evidence from numerous other studies in Africa and elsewhere (e.g. Worth, 1989).

Whilst much commendable work has been done in Thailand, there are many areas which have yet to be fully addressed. HIV/AIDS among female sex workers has received a great deal of attention whilst other groups, such as male clients of sex workers, male sex workers, and IDUs, have received much less, particularly in official policy.

IDUs (mainly male) and male sex workers are perhaps not seen as priorities because they are perceived to be less likely to spread the infection to (heterosexual) men. Also, they may be viewed as sub-cultures isolated from mainstream society. IDUs and male sex workers probably have at least some female partners however, and the

risks of infection to them must be addressed, as well as the risks from heterosexual transmission for women more generally.

Philippines

The overall policy on HIV/AIDS in the Philippines seems fairly liberal and the environment possibly more tolerant than some neighbouring countries. (Osteria and Sullivan, 1991.) However, there is widespread concern about HIV/AIDs in the Philippines, and also frustration at the inadequacy of official efforts to tackle the problem, which seems to be fairly low on the list of political priorities. (Castle, 1991: 25.)

A public health education has been launched through the mass media, but its effectiveness is limited by lack of funds and other factors (Osteria and Sullivan, 1991). The Catholic Church establishment is opposed to family planning, including condoms, and has been able to prevent their distribution in some areas (**WorldAIDS**, November 1991). The information given in official literature on HIV/AIDS is sometimes ambiguous, incomplete, or too technical. For example there is a lack of information on how to use condoms properly, on how to sterilise needles and on the risks of transmission to children, for pregnant mothers. Some information in public brochures uses the male pronoun - which implies that only men are at risk, and refers rather non-specifically to 'certain sexual acts'. (Osteria and Sullivan, 1991.)

The inadequate screening of blood (see above) due to the dominance of the commercial blood sector, is an extremely serious issue, particularly for women, as noted above. The official advice is to refuse transfusions from non-accredited blood banks, but this hardly seems adequate or feasible, particularly in emergency situations. (Osteria and Sullivan, 1991.)

There is a huge sex industry in the Philippines, with strong links to the officially promoted tourist industry, as well as the presence of US military bases in the country. As elsewhere, the sex industry operates at a number of different levels and includes many 'freelancers'. There are a large number of street children, particularly in Manila, some of whom are also forced into sex work to survive.

The relatively early awareness of HIV/AIDS in the country arose in connection with this industry. 'Hospitality girls' working around the bases have been required since the fifties to undergo compulsory testing for STDs (the 'pink slip' system), at Social Hygiene Centres operated with support from US military authorities. Pre-existing opposition to the presence of US military bases was further spurred by the HIV/AIDS problem and the perception that US military personnel were spreading the infection among these women. (**WorldAIDS**, November 1991.) However, the impending closure of Clark air base and other installations means that the focus on the US military presence as a factor in HIV transmission is becoming increasingly irrelevant, and may even have contributed towards unhelpful misconceptions.

In the late 1980s, NGOs associated with GABRIELA's⁷ 'Commission on Violence Against Women' were running drop-in centres providing counselling and support services for 'hospitality women' in four major locations - Olopango, Manila, Davao, and Angeles (Tan et al, 1989). GABRIELA and HAIN (Health Action Information Network) provided technical support for these activities. Other groups were involved

7 GABRIELA is a national coalition of women's groups in the Philippines

in advocacy work and attempting to challenge regressive legislation, such as the quarantining of AIDS sufferers. (Tan et al, 1989.)

These activities have been, or are being, reviewed in the light of recent changes in the situation (Marge Berer, personal communication). However, it is still worth some brief comments on these activities.

The drop-in centres attempted to challenge prevailing 'rehabilitation' approaches towards sex workers. AIDS was not the primary issue addressed in most cases, because the women using the centres presented a whole range of other more pressing problems (at least in the short term), such as low pay, unwanted pregnancy, and physical and emotional abuse. The approach was to provide a broader educational programme including reproductive rights, sexuality and women's rights. A group rather than individual approach was taken, attempting to raise the consciousness of the women, through self-awareness sessions, and other campaigns. For example, a controversial campaign to claim compensation from US authorities for HIV/AIDS infected women and insist on 'blue slips' for US military personnel, succeeding in gaining considerable support from hospitality women. (This was seen as a symbolic political campaign, with the purpose of raising consciousness, rather than as one which would actually achieve its goals.)

Each centre had to adapt its activities to very specific local conditions, and in some cases success was limited by such factors as opposition from bar owners, the lack of confidence and consciousness among the sex workers and their short-term time horizons, in face of the long-term implications of HIV/AIDS. (Tan et al, 1989.)

In Davao, on Mindanao - a very deprived region which has been the base of communist uprising and government counter-insurgency - there is a much smaller but growing sex industry and the HIV/AIDS problem is less evident. Here the TALIKALA group ran an effective AIDS education campaign, reaching up to 500 women. They produced AIDS education materials in local languages and took them out to sex workers on an AIDS Roadshow, which included humour and explicit visual aids, and attempted to challenge misconceptions. (Tan et al, 1989.)

Whilst male sex workers are less stigmatised than female sex workers and are more able to re-integrate into 'respectable society,' they often have a range of sexual partners, including both women and men, and few identify themselves as homosexual. Many have girlfriends and eventually marry. There is little HIV/AIDS activity aimed specifically at this group. The Reachout AIDS Foundation (see list) is one group aiming to reach such workers with AIDS prevention. (**AIDS Action**, September 1991: 5.) HAIN is also working with male sex workers (**Health Alert**, 1992, 125).

The Philippines National Red Cross has been supporting work with street children, who have very restricted access to health services. They have trained social workers, psychologists and street educators from NGOs in primary health care, first aid, STD treatment and family planning, and education and counselling on drug use, sexuality and AIDS. These fieldworkers are then expected to do outreach work with street children and refer 'high risk' children to doctors. Eventually some street children are themselves to be trained as peer educators. (**AIDSwatch**, 1991, No 13.)

HAIN has also undertaken a KABP survey of nursing and medical students in Metro Manila, and in conjunction with this, has developed an Information Kit on **HIV/AIDS for Medical and Nursing Students** (see bibliography). This provides clear and concise information about political and social and sexual as well as technical issues, including gender. For example:

'[t]here are many things that society can do to help control HIV. But to be able to do this, there must be openness to discuss the many issues surrounding HIV, especially sexuality. **This does not just mean frank discussions about sex, but must also**

extend into such issues as gender equality. As long as women are denied a voice in sexual matters, they will remain trapped in high risk situations. ' (HAIN, 1992, Module 9; emphasis added.)

Malaysia and Singapore

In Malaysia, government public health institutions have been dominant in the response to AIDS, partly due to an absence of NGOs serving particular communities where AIDS may be a problem (Pink Triangle which works with gay men; and Malaysia Care, which works with drug users, are exceptions to this - see list). This may be related to draconian laws against homosexuality and drug taking and stigmatisation of these groups.

Initially at least, education seemed to feature low in the priorities set out by the Ministry of Health Division of Health Services, which coordinates official activities on AIDS prevention and control. Strong censorship and religious conservatism are problems in this respect. Early action was taken on blood screening however, and health facilities are generally quite good. (Osteria and Sullivan, 1991: 133-8.)

General public education as well as education of health workers and 'high risk groups' forms part of the official agenda in Malaysia. However, there appears to be a reluctance or inability to reach out to 'high risk groups'. 'AIDS prevention efforts aimed at sex workers do not appear to be a priority of the government, nor of any of the community groups.' Plans (presumably by NGOs) to reach out to female sex workers are being considered but nothing is close to implementation. Client education is not being considered. (Castle, 1991: 17-18.)

The messages purveyed in official AIDS awareness literature for the general public seem to advise against any forms of homosexual activity and exhort drug takers to stop taking drugs. Osteria and Sullivan have commented that in Malaysia (and elsewhere in Asia), 'the AIDS pandemic is being used to shore up traditional values and promote behaviour consistent with these values'. (Osteria and Sullivan, 1991: 138.)

More recently, the government is becoming increasingly vocal about AIDS, and there is growing official acceptance of the need to encourage discussion about condoms and HIV prevention, in spite of the conservative climate. Moreover, recently there has been a shift towards encouraging NGOs to become more active in providing information, particularly to 'high risk groups'. However, there are continuing fears at government suggestions that compulsory testing may be implemented. (Castle, 1991: 18.)

Only a little information was available about activities in Singapore, which seem to have been fairly limited to date. A media education campaign was launched in early 1992. Around the same time, the Infectious Diseases (Amendment) Bill was introduced in the Singapore parliament, which contains provisions requiring people who are HIV positive to inform their partners and to refrain from donating blood. Singapore already has other AIDS related legislation requiring infected people to undergo counselling or comply with safety measures and also to prohibit the disclosure of identity of any person infected with HIV. (*AIDS Newsletter*, 1992, 7(2): 11.)

Indonesia

'Indonesia is at a crossroads in defining its response to AIDS which has only recently become an issue of interest in the country, capturing media attention. Awareness campaigns have hardly begun and research is still in its infancy. ... with its large Muslim population the country will be a case study of how to balance practical

safeguards against moral and religious attitudes. Preventive campaigns will need to discuss sex openly, often against religious sensibilities. But health authorities recognise the need to involve religious groups who could hinder prevention if they were not supportive. The country's pragmatic approach towards family planning in recent decades ... encourages hopes of a similar response to AIDS... Both prostitutes and brothel owners contribute money every month to a government-run rehabilitation programme for prostitutes which gives them alternative work skills and money to start new lives.' (**AIDS Newsletter**, 1992, 7(4): 11.)

In Indonesia, there are still problems with blood screening due to lack of resources, and widespread implementation (in urban areas) only began in March 1992. However, work is being done by the Red Cross to modify medical practices with regard to blood transfusions. Scarce resources for health also mean that the 'one person, one needle' policy is not feasible, and other approaches are being researched. (Castle, 1991: 7; **AIDS Newsletter**, 1992, 7(4): 11.)

Youth are considered a high risk group - an overall shift of STDs to younger people has been observed - there is (at 1991) no formal sex education in school curricula, although a model has been developed which is now being trialled. (Castle, 1991: 7.)

Although STD monitoring is not compulsory, most cases are believed to be clients of sex workers, and the incidence is generally thought to be higher among men than women. (NB this suggests that the level of STD infection among sex workers must be high too.) (Castle, 1991: 6-7.)

Little is known about sexual beliefs and behaviour, although there is a theoretical commitment to behavioural research. The level of condom use is thought to be around three percent for population at large and for sex workers - although Indonesia is a net exporter of condoms.

One major problem in Indonesia has been the nearly 100 percent drop out rate of seropositive individuals referred to follow up programmes, reflecting the weakness of counselling and the lack of incentives to participation (in terms of treatment, support etc). (Castle, 1991: 2-3.)

The NGO sector in community health/family planning activities appears quite strong. UPLEK (see list) has developed educational materials for use with high risk groups, including female sex workers. The Indonesian Public Health Association has conducted research, training and outreach work, the latter mainly with tranvestites (the rationale for this is not clear). Several groups are planning involvement in HIV/AIDS related activities - including at least one women's group - Kalyanamitra (see list).

Vietnam⁸

According to a Save the Children Fund report from 1991, 'As far as HIV/AIDS is concerned, the country is wide open to infection because of the prevalence of STDs, the poverty, and a pragmatic attitude about sex but not about discussing it. The initial threat is to those in the main cities, those with contacts with foreigners. The South East Asian businessmen and tourists will bring HIV infection along with their demand for sexual services. The Vietnamese in Ho Chi Minh City have lost their pride and look to foreigners for all that is attractive. They have mislaid

⁸ This section is based on Bailey, 1991, and O'Sullivan, 1991.

their culture of poetry, song, dance or theatre which denies many of the usual avenues for community health education.' (Bailey, 1991.)

The report also notes the increasing numbers of commercial sex workers in Ho Chi Minh City, in 1991 numbering around 10,000 in Ho Chi Minh City, with a range of levels of activity, from middle class women servicing foreigners, to rural migrants selling sex from bars or home. STD levels among arrested commercial sex workers are reported to be 50 percent, and levels of condom use around two percent. Although intravenous drug users (6-7000 in Ho Chi Minh City) had not yet become infected, they inject opium with shared needles, so that once infection does occur it will spread quickly.

Prevention and control activities are in the process of being implemented. With support from WHO, a National AIDS Committee has been set up and a Medium Term Plan devised (1991-3). This plan stresses the need to create positive attitudes and remove the stigma attached to HIV/AIDS as well as the need to reduce the risk of HIV infection for women of childbearing age.

A KAP survey was conducted in 1990 in urban areas and will be repeated in 1992. The survey included both 'high risk' and non 'high risk' groups, and revealed that most people thought they were not at risk. Sentinel serosurveillance activities are underway, and projects to reach commercial sex workers and drug users have been launched in the nine sentinel cities, which will combine voluntary and confidential testing with health education, although difficulties have been reported in contacting 'high risk groups'. Mass media campaigns have begun using billboards, television etc and projecting the messages of monogamy through marriage, the risk of drug taking and the need to use condoms. Formal and non-formal education activities are also planned with the support of UNFPA, including the introduction of AIDS education into the secondary school curriculum. UNFPA is also beginning to integrate AIDS prevention into MCH/FP activities, and shift the targeting of condoms from women to men.

The Youth Union and Women's Union, amongst other groups, have been given responsibility for IEC activities among their respective constituencies. There may be some difficulties with this sectional division of responsibilities: for example the Women's Union is reluctant to work in conjunction with other groups, and resists attempts of other organisations to work with their constituency, which is hampering an integrated education programme (at least in Ho Chi Minh City). The Woman's Union has responsibility for work with women, including the rehabilitation of prostitutes. 'The Woman's Union's attitude towards prostitution is one of benevolent condemnation where the women are criminals to be cured and saved.' (Bailey, 1991.)

Elsewhere, [t]he Asian Housing Corporation is working with the City Housing and Planning Department in some of the slum districts [of Ho Chi Minh City] to improve conditions by means of income generation and low interest credit schemes. This type of approach may hold more promise for the women working as prostitutes than the best health education.' (Bailey, 1991.)

Cambodia, Laos and Myanmar

Almost no information is available on the HIV/AIDS situation, or on prevention and control activities, in these countries. HIV infection is known to be high in Myanmar, mainly because of high levels of drug use (see above). Although there appears to be very low levels of infection in the other countries, on official reports, there are clearly a number of serious risk factors, as outlined above.

3 Overview of activities in the South Pacific⁹

In the Pacific, the South Pacific Commission is the key regional centre which collects information and resources related to AIDS work, provides small grants - several to women's groups - for AIDS/STD work, and publishes the quarterly newsletter **Pacific AIDS Alert**, as well as a monthly bulletin. Their publications regularly feature information on women and AIDS. SPC, in conjunction with the Pacific Women's Resource Bureau, have also developed a video 'Charlotte's Story,' about a Samoan woman whose son died of AIDS.

Private family planning clinics which are IPPF affiliates are involved in training and the development of resource materials relating to HIV/AIDS all over the region. The Red Cross are also involved in HIV/AIDS related training across the region. The Pacific regional office of the YWCA and the Commonwealth Youth Programme (South Pacific Region) have also conducted some training of workers.

Outside organisations such as the New Zealand Family Planning Association, have been involved in trying to develop sexuality education. The Australian Family Planning Association has also developed some videos on reproductive health issues, including STDs/AIDS and sexuality, for use in the region. WHO has also supported the development of resources for schools based sexuality and AIDS education (WHO/UNESCO, 1989), and several women in prominent positions in the health and education sectors (see below) are pursuing the implementation of such activities.

Women's organisations (mainly NGOs) seem to be heavily involved in AIDS awareness work.

'In PNG, a national workshop on women and AIDS was organised through the Department of Health and Women's Division of the Department of Home Affairs and Youth, and several women's groups have taken advantage of SPC's small grants scheme for AIDS and STD prevention to run workshops on AIDS for women.' (Sheehan, personal communication.)

Some of the work being done in the Pacific is through local women's committees (which may be branches of national organisations) and some by senior women in the health and education services. Keeping up the momentum of good work has often relied on particularly charismatic or committed individuals, however. (Marge Berer, personal communication.)

For example, in Kiribati, women's committees are addressing the issue of AIDS prevention at local gatherings and training sessions. Similarly, in Western Samoa, women's committees are responsible for identifying health problems, including AIDS, and some representatives have attended AIDS awareness workshops. The Minister of Education, Youth Sports and Culture in Western Samoa, is a strong supporter of AIDS education and is attempting to integrate it into the family life curriculum in schools.

In Tonga, nursing and health education workers (primarily women) are involved in AIDS education and the development of materials. They have also assessed infection control procedures (implement sterilisation; blood spillages etc) among health workers. In French Polynesia, a support network has been set up by community

⁹ Most of the following paragraphs on women's activities in the Pacific are based on Heckert, K, forthcoming, 'Some activities in the Pacific Islands,' in Berer, M., with Ray, S., forthcoming (1993).

workers for men and women who have casual sex, and for sex workers, based at an STD clinic. Courses are being run at the nursing school on STD/AIDS prevention.

In the Cook Islands also, nurses are also involved in AIDS education. The head of the Health Education Unit is also working in conjunction with churches and NGOs on AIDS awareness. The woman Director of Curriculum at the Ministry of Education is also a strong supporter of AIDS education in the school curriculum. In the Marshall Islands, the woman Director of Family Planning Services has set up a youth theatre project which includes AIDS prevention messages in its village presentations.

In Fiji, a prominent STD physician, Dr Mridula Sanaith, provides care for AIDS patients and speaks publicly about AIDS. She meets regularly with groups of gay and bisexual men and women in casual relationships. She has also been spreading information on HIV/AIDS through a weekly radio show on women's health issues, which includes a phone in session (personal communication, Marge Berer). The Fiji Women's Crisis Centre (which deals with issues of violence against women) has incorporated STD/AIDS awareness and HIV counselling in its training programmes, as has the Fiji Women's Rights Movement. The National Indian women's group in Fiji undertakes community education - including AIDS education - for Indian women.

At the Fifth Regional Conference of Pacific Women in Guam in the topic of AIDS and STDs was a significant part of the health presentation, which formed a central theme of the conference. Regional sub-caucuses preceded this meeting, which began the work of problem identification in relation to STD/AIDS prevention issues. (SPC, 1992; Pacific Women's Resource Bureau, 1992; Marge Berer, personal communication.)

VI TOWARDS GENDER APPROPRIATE HIV/AIDS PREVENTION AND CONTROL STRATEGIES IN SOUTH EAST ASIA AND THE SOUTH PACIFIC

1 The need for gender appropriate strategies

It is clear that heterosexual transmission is already, or is rapidly becoming, the dominant mode of transmission of HIV/AIDS in South East Asia and the South Pacific. Female sex workers have already been badly affected by the epidemic, and women generally - and through them children - are increasingly at risk of infection.

The above review shows that, whilst there are pockets of good work going on - mainly by NGOs - which do address issues of gender, for the most part, HIV/AIDS prevention and control activities are not dealing effectively or adequately with the gender implications of the epidemic.

Since HIV/AIDS has come late to the region, and several governments are still in the process of developing their their response, there is the opportunity to draw on what has been learned from elsewhere in the world, and in the region - particularly with regard to gender issues and HIV/AIDS - in order to ensure that interventions are as effective as possible. Indeed, given the potential for further spread of HIV infection in these regions, and the limited resources available, it is vital that the response is both timely and effective, in order to minimise the social and economic consequences of the epidemic.

Drawing on the above review, as well as experiences from elsewhere, some key issues are highlighted below, which need to be addressed in formulating gender appropriate strategies for HIV/AIDS prevention and control.

2 Addressing gender in HIV/AIDS prevention

Alternative technologies

At a global level, further rapid development of alternative and affordable technologies, for preventing HIV infection, which can be controlled by women must be a high priority.

This includes refinement of the female condom, and the development of an effective, non-irritant virucide, if possible. These should not be seen as alternatives to male condoms, but rather as providing women with options under their control. Further acceptability trials need to be done in the South East Asia and Pacific region with female **and male** respondents. The cost issue needs to be addressed in order to make these options accessible to women.

Socio-economic issues

The issues underlying 'risky behaviour' and poor health (e.g. due to untreated STDs) are socio-economic and socio-cultural, and often relate to gender inequalities in access to resources, status and bargaining power in sexual relationships.

Schemes which offer income earning or low interest credit opportunities to young women (and their dependents) are needed to provide alternatives to sex work, particularly in areas where migration of young women to enter sex work has become an established pattern, and in areas where sex workers operate. These should not be conceived as rehabilitation programmes for female sex workers, but as broader

development initiatives designed to increase the range of options available to low income women.

Extending HIV/AIDS education to all women

There is an urgent need to stress and convey the message that ALL WOMEN are at risk of HIV infection.

Public information and education campaigns must contain messages which make clear the specific risks to women - and their children - of casual sex, of unprotected sex with their immediate partners, as well as the particular risks of blood transfusion to women. Real life stories of women with HIV/AIDS would be of particular value although obviously full consent would have to be obtained. However, this must be done in a sensitive, non-moralistic way to avoid stigmatisation. (The Charlotte's Story video is a good example, although it presents women in a caring role.)

Formal and non-formal education on HIV/AIDS needs to begin at earlier ages than is generally being done. This is particularly true for girls, who seem to be at risk at younger ages, and tend to be less well represented at more advanced levels of the education system.

HIV/AIDS education should be set in the context of broader discussions on gender and sexuality, if possible integrated into existing aspects of the curriculum. Outreach and non-formal activities are also needed for children - particularly girls - who are not attending school. In the longer term, efforts are needed to increase female literacy and enrollment rates in education at all levels, so that women have more direct access to all forms of information about HIV/AIDS. Young people, especially women, also need to be given training in assertiveness, in order to increase their self confidence in refusing sexual advances, and in general.

Women in war affected areas, or refugee women, may be particularly vulnerable and services need to be developed to reach these groups. Programmes which address IDUs and male sex workers also need to address the risks of sexual transmission to their partners, who may often be women. Rural as well as urban women must be addressed, particularly but not exclusively, in areas with high levels of outmigration, or other risk factors.

Involving men

Men as well as women need to be involved in education on HIV/AIDS, particularly on the need to use condoms, as well as the proper way of doing so.

It is important that both men and women are presented with the same information about safer sex. Men and women may need to be addressed separately and then together, for the message to be taken seriously by men. It may also be important that men are addressed by men (their peers), in order to take the issue seriously. Outreach to workplaces is one way to reach men. Visual presentations using models are helpful in illustrating condom use.

Getting the message to women

Women are more likely to be receptive to information and advice gained through personal contact, i.e. through family and friends.

Micro campaigns involving discussion groups, and peer-led communication, and drawing on existing networks, of friends, family, youth groups etc, may have a more significant and lasting impact on women than mass media campaigns. Group activities enable sharing and learning, and provide the opportunity for challenging misconceptions. Such activity could also provide an opportunity to impart skills, and create materials which could be used in further HIV/AIDS education work (e.g. through drama or video workshops, or poster design).

The form in which messages are conveyed - as well as their content - are important in mass media campaigns. Media channels to which women have access and which they regularly use should be used for HIV/AIDS awareness campaigns. The women's health radio programme/phone in, in Fiji is a good example of a valuable and gender sensitive mass media initiative.

Sex workers

An exclusive or excessive focus on sex workers - or other 'high risk groups' - often serves to stigmatise them, and creates complacency among other groups, including women who are not - or do not see themselves as - sex workers.

Existing interventions to assist sex workers should be built on and extended but they need to be operated in conjunction with broader campaigns. Restricting the focus of activities to 'high risk groups' may seem to be a cost effective way of channelling resources, but this is illusory, since it has limited effectiveness on its own and may lead to complacency among the wider population. The 'high risk group' approach also tends to compartmentalise and homogenise the 'groups' in question, whereas in reality they may be very heterogeneous and well integrated with 'respectable' society. Stigmas and stereotypes attached to so-called 'high risk groups' need to be challenged in HIV/AIDS information and education campaigns.

Criminalising, stigmatising, attempting to reform, or imposing compulsory testing on sex workers is counterproductive.

Such measures will simply make living conditions worse and make sex workers less accessible and amenable to HIV/AIDS prevention interventions. In the absence of social support systems, being seropositive is no guarantee that a woman will withdraw from the sex industry; indeed it may increase the pressure on her to work knowing that her she must have resources to support and care for herself.

Interventions aimed at the sex industry need to address others working in it apart from commercial sex workers.

Those in relatively powerful positions, such as brothel owners and managers; pimps; hotel and bar owners/managers etc., can be instrumental in introducing or maintaining risk-reducing policies.

The continued reluctance of male clients to use condoms, and the fact that sex workers often do not use condoms with steady partners, are two major factors limiting the success of interventions with sex workers.

This highlights the need to focus AIDS awareness on the clients of sex workers and their regular partners, and to improve the negotiation skills of sex workers. Incentives for clients to use condoms could perhaps be developed, in conjunction with brothel and bar owners, who may themselves need incentives and to introduce such policies. Focus on particular occupational groups (e.g. military and police personnel, lorry drivers, fishermen), or locations (ports, transport routes, hotels, bars, workplaces) in order to reach potential clients may be a useful strategy.

Female sex workers are a very heterogeneous group and a variety of strategies are needed to reach women operating at different levels of the sex industry.

Different strategies are needed to work with brothel based sex workers, with bar based sex workers and with 'freelancers'. Foreign or minority women sex workers should also be targeted in prevention and supportive activities.

Service delivery

HIV/AIDS prevention activities for women work best when provided as one of a range of services, for example, general reproductive health services.

They may also need to be supported by legal education, services and advocacy, childcare, skills training (e.g. in assertiveness and negotiation skills), as well as

HIV/AIDS education and confidential (voluntary) testing facilities, backed up with proper counselling and referral/support services. Services need to be delivered in such a way that they are accessible to women, particularly low income women. The nature of the range of services provided should be flexible, depending on the needs presented by women in the locality.

There is a need to integrate HIV/AIDS related activities with broader issues of reproductive health, particularly STD prevention and treatment and MCH/FP services.

Integration with MCH/FP services may be a positive step forward given that many women have access to these services at community level. However, it is not just a case of adding a new element to existing activities, but rather of reshaping the whole package. The almost exclusive focus of MCH/FP activities on women has led to a situation in the face of the HIV/AIDS epidemic, where women are being targeted with condoms that men will not use. In several countries in South East Asia - e.g. Thailand - there have been widespread campaigns to promote family planning, which have met with some success. Positive aspects of this experience need to be drawn upon in developing HIV/AIDS education strategies in conjunction with other reproductive health services.

Pre- and post-counselling services, and appropriate referral and care, which deal with the specific risks to women, and the particular implications of HIV/AIDS for women need to be developed.

Proper referral and care needs to be developed such that, for example, women - including pregnant women - have access to clinical trials or other forms treatment on an equal footing with men. Care for women is needed, particularly for those who have been abandoned or divorced, which also provides facilities for children.

HIV positive women need to be provided with economic opportunities, social and psychological support.

HIV positive women could be provided with opportunities - with appropriate training - to work in AIDS education or counselling. The formation of self-help groups and networks of HIV positive women and their families should be facilitated to provide support.

Health sector interventions

Blood screening needs to be urgently improved in some countries. Meanwhile, attempts to limit large scale blood transfusions, particularly to women in childbirth, should be continued.

Infection control activities should be extended, particularly in less well resourced health environments, and further efforts made to increase AIDS awareness and confidence of formal and informal health workers.

Research

More research is needed on socio-economic, and socio-cultural factors in HIV transmission, particularly with regard to gender. Further surveys on sexual behaviour are needed, especially among young people, and should include investigations of the dynamics of sexual relationships. Gender issues should be addressed in research design, data collection and analysis. Careful monitoring and evaluation of activities, including their gender impact, is also needed.

Organisational Implications

National AIDS Committees should include better representation of women's organisations, both official and NGO, and specific sets of measures to involve women in HIV/AIDS prevention strategies should be developed, in the national policy framework.

Women's organisations should be encouraged and supported in taking initiatives in HIV/AIDS related work, particularly where they have experience of work in relevant areas (e.g. women's health, reproductive rights, youth work, counselling, legal advocacy, health education). They should also be encouraged to co-operate and work in conjunction with other organisations, so as to provide integrated campaigns and interventions.

Networking, information sharing, and exchange of experiences of women and women's organisations involved in HIV/AIDS work, should be supported, particularly within the region, and for women from countries with less developed systems.

Resource implications

More resources are needed for micro-level, gender appropriate HIV/AIDS prevention activities. Given limited resources there may need to be a shift in resources away from surveillance/compulsory testing and costly mass media campaigns.

Donors may need to be more flexible in the funding and promotion of HIV/AIDS prevention activities.

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LIST OF ORGANISATIONS AND ACTIVITIES¹

ORGANISATION

ACTIVITY

Regional

AIDSED Centre
UNESCO PROAP
920 Sukhumvit Road
PO Box 967
Prakanong Post Office
Bangkok 10110
THAILAND
Tel: (66-2) 391 0577
(66-2) 391 0880
Fax: (66-2) 391 0866

Established July 1990. Regional exchange centre for AIDS education and health promotion materials; clearing house for materials; regional resource dissemination and publication. Publishes quarterly **AIDSED Newsletter**. (See **AIDSED Newsletter**, 1990: 2-3.)

WHO Regional Office for Western Pacific
P O Box 2932
United Nations Avenue
Manila 1099
PHILIPPINES
Tel: (63-2) 521 8421
Fax: (63-2) 521 1036
Contact: Georg Peterson

Coordination office for WHO activities throughout Western Pacific Region, including HIV/AIDS related activity; evaluation and monitoring of country level programmes. This office actively promotes condoms and will directly ship them to NGOs etc on request. Uses consultants to look at condom distribution issues. Willing to directly fund NGOs through contractual services agreement (CSA) scheme (subject to government approval). (Castle, 1991:29)

WHO Regional Office for South East Asia
World Health House
Indraprastha Estate
Mahatma Ghandi Road
New Delhi 110002
INDIA
Tel: (91 11) 331 7804
Fax: (91 11) 331 8607
Contact: Dr U Ko Ko (Director)

Coordinating office for WHO activities throughout South East Asia, including HIV/AIDS related activity. See above.

WHO/South Pacific Commission Information Centre for Prevention of AIDS
BP D5
Noumea Cedex
New Caledonia
Tel: (687) 262 000
Fax: (687) 263 818
Contact: Patricia Sheehan, Health Documentalist

WHO/GPA promotion centre for South Pacific. Publishes **Pacific AIDS Alert** every quarter. Collects regional data and supports country level activities, in particular through small grants for AIDS/STD prevention, some of which have been given to women's groups to run AIDS workshops for women. (Information from P Sheehan, SPC.)

UNDP Asia/Pacific Regional Initiative
UNDP Regional Office
P O Box 3059
New Dehli 110003
India
Tel: (91 11) 69 04 10
Fax: (91 11) 462 7612
Contact: Dr Joyce Lyons
(Project Manager)

New initiative aiming to: raise awareness of HIV/AIDS in non-health sectors, including contribution of NGOs; engage other donors in addressing socio-economic impact of AIDS; create a framework for UNDP which will guide its AIDS programme for next five years. These objectives will be met through the organisation of country level, subregional and regional workshops and meetings. Priority areas include the contribution of NGOs and economic issues (transport sector; tourism; cost effectiveness of compulsory testing). Women's issues and private sector responses also to be explored. (Castle, 1991: 15-16.)

Asia Pacific Development Centre
Women's Health Resource Section
Persiaran Duta
P O Box 1224
50770 Kuala Lumpur
MALAYSIA
Tel: (60-3) 254 8088
Fax: (60-3) 255 0316
Contact: Rashida Abdullah,
Rita Rajhashim

In process of setting up a women's health network for South East Asia. (Personal communication, Marge Berer.)

International Organisations
(NGO)

Appropriate Health Resources and Technology Action Group (AHRTAG) Ltd
1 London Bridge Street
London SE1 9SG
United Kingdom
Tel: (44) 071 378 1403
Contact: Chris Castle

NGO promoting and supporting primary health care activities in developing countries, including HIV/AIDS related activities. Publishes monthly newsletter AIDS Action in English, French and Spanish. **AIDS Action** is distributed in developing countries by project partners in Africa and Latin America. AHRTAG intends to launch an English language edition for South East Asia in conjunction with HAIN in the Philippines in the near future. At present they distribute 40 000 copies of their English language edition which is mainly geared towards Africa in Asia, demonstrating the need for a regional based publication which gives information of value to community based groups. (**AIDS Action**; Chris Castle, personal communication.)

The Save the Children Fund (SCF)
Mary Datchelor House
17 Grove Lane
London SE5 8RD
Tel: (44) 071 703 5400
Contact: Dr Peter Poore
Charlotte Kanstrup

NGO working in developing countries, on a broad range of issues including emergency relief, and health, particularly in relation to children. Supports projects in a large number of countries, including Cambodia, Vietnam and Laos. Assisting with the setting up of national AIDS prevention and control activities in Vietnam. (Bailey, 1991; O'Sullivan, 1991.)

Family Health International
P O Box 13950
Research Triangle Park
NC 27709
Tel: (1-919) 544-7040
Fax: (1-919) 544 7261
Contact: Judith Fortney (Dir of
Reproductive Epidemiology and
STDs Division)

US-based NGO engaged in research and technical assistance for contraceptive development, reproductive health, family planning and AIDS prevention in developing countries. Considerable experience of AIDS prevention work worldwide (45 countries), working through National AIDS programmes, MOHs and NGOs. Key interventions included: persuading policy-makers to support interventions among commercial sex workers; building on existing community programmes; collaborating with IPPF (see below) to strengthen NGOs and support interventions with marginalised communities; ensuring safe blood supplies; supporting research especially on spermicides and oral contraceptives and HIV. Also work on costs of prevention and treatment and on integration of family planning/primary health care and AIDS prevention. Recently given \$167 million for AIDS related work over five year period by USAID. (Family Health International **Report** 1988-90; **AIDS Newsletter**, 1992, 48.)

International Planned
Parenthood Federation (IPPF)
P O Box 759
Inner Circle
Regent's Park
London NW1 4LQ
United Kingdom
Tel: (44) 071 486 0741
Contact: Gill Gordon

UK headquarters of international network of planned parenthood associations throughout the world. Work on reproductive health issues including AIDS, through AIDS Unit. Publishes **AIDSwatch** newsletter and various other publications. Has substantial AIDS database. Funds activities, and provides training, runs workshops, assists in development of resources etc.

Indonesia

Indonesian Public Health Association (IPHA)
Jl. Pegangsaan Timur 16
Jakarta
INDONESIA
Contact: Dr Myrnawati, Dr Imran Lubis

NGO with strong ties to MOH and branches in all 27 provinces. AIDS activities to date include: publications for health professionals including midwives; transvestite outreach project 'Myrna Fantastic Dolls' running workshops providing information about HIV/AIDS, safer sex strategies, empowerment, monitoring HIV infections and provision of counselling; research into condom use among transvestites; research into condom use and distribution, especially how to promote better quality condoms, including supplying these to transvestites for sale as income generating activity as well as for personal use. Future activities envisaged (as at 9/91) are: training of trainers among IPHA branch staff; research into behavioural and social issues among male and female sex workers in Jakarta; education and information dissemination for male and female sex workers; development of an information centre in Yogyakarta which would provide hotline, counselling, condom distribution, clinical care, models of training and education and possibly a newsletter; travelling fellowships. (Castle, 1991: 13.)

Indonesia Planned Parenthood Association (IPPA)
Tel: (62-21) 334 721
Fax: (62-21) 750 6002
(62-21) 739 3193
Contact: Ninuk Widyantoro

Working in reproductive health; IPPF affiliate. (Marge Berer, personal communication.)

Kalyanamitra (Women's Communication and Information Centre)
Jl. Kaya Bogor No 30 (km. 20)
Kp Makassar Karawat Jati
Jakarta 13510
INDONESIA

'Established six years ago by five women...the centre publishes a bulletin twice a year and a newsletter three times a year, with the aim of supporting NGOs and government agencies with information about women's issues in Indonesia. Issues explored include health, religion, employment, the legal system, violence, environment, and trafficking ...' In 1991 ran a project on women and rape. As at 9/1991, considering its involvement in AIDS issues and contacting other women from NGOs in relation to this. (Castle, 1991: 13.)

Sahabat Remaja 'Friends of Youth'

Originally a project of IPPA (see above). Since 1990 an independent NGO, with 15 percent of activities HIV/AIDS related and designed to reach youth, tour guides, occasional sex workers; mass media and other NGOs. Projects are carried out by volunteers and include a hotline, face to face counselling, and information about health and personal development. AIDS education and training is viewed within the context of family planning and sexual health. Depends on funds from public, UNFPA and IPPF. (Castle, 1991: 14)

UPLEK - University of Udayana Denpasar Bali INDONESIA

Founded in 1987 to develop community based studies on health. Involved in development of AIDS education materials targeted to male and female sex workers (including controllers); homosexual groups; workers in bars, hotels and tourist industry; and decision makers. Hosted national AIDS seminar in July 1991 with aim of developing a national AIDS network for coordination and disseminating information, sharing and developing resources. Proposes (1991) to establish centre for AIDS information as focal point for national network, which will collect and catalogue information; serve as referral centre; act as resource centre and provide technical assistance; publish a bi-monthly newsletter (this has already begun). (Castle, 1991: 12-13.)

Malaysia

**All Women's Action Society (AWAM)
43 C Jalan SS6/12
47301 Petaling Jaya
MALAYSIA
Tel: (60-3) 703 7334**

Women's rights charity founded in 1985 operating a resource centre and organising seminars and workshops designed to address issues of rape, violence against women and women's legal rights. There are various splinter groups. Advocacy is important part of their work and has included the development of a domestic violence bill, a review of rape laws and a public campaign against domestic violence. Produces bimonthly newsletter **Waves**. Concerned about Islamic revivalism and rising incidence of polygamy as issue affecting women with implications also for HIV infection. As at 1991, plans to develop pamphlets and materials on women and AIDS and industrial health issues affecting women. They also hope to establish a women's health clinic and drop in centre. (Castle, 1991: 21)

**Health Action International
IOCU Regional Office for Asia
and the Pacific
P O Box 1045
Penang
Malaysia
Tel: (60-4) 371 396
Fax: (60-4) 366 506
Contact:**

Regional office for Asia and the Pacific of International Organisation of Consumers Unions (IOCU) Produces newsletter **HAI News**. HAI is an informal network of consumer, development action and other public interest groups worldwide. It works to further the safe, economic and rational use of pharmaceuticals worldwide, to work towards implementation of WHO programme for essential drugs and to look for non-drug solutions to public health problems. Not known to be working on AIDS issues but probably has affiliate organisations which are. (**HAI News**, October 1992; Marge Berer, personal communication.)

Malaysia Care

Christian organisation formed in 1979 focusing on disabled, child care, mental health and outreach to drug users and prisoners. AIDS related work mainly in relation to latter two groups. Operates a drop in centre and visiting service for prisoners. Facilitates anonymous testing, pre-test counselling and follow up referral. (Castle, 1991: 21)

**Malaysia Family Planning
Association
Contact: Mr Maniam**

As at 1991 not yet actively involved in AIDS work but interested in establishing hospice care and in outreach to sex workers. Plans to focus on women from a family planning perspective, but reports problems in initiating these activities. (Castle, 1991: 22)

NGO AIDS Council

Coordinates growing number of NGOs involved in AIDS work in Malaysia. Membership includes Pink Triangle, women's rights organisation and family planning association. Set up to initiate projects and to convey messages which are not being put across from official sources. Difficulties in obtaining NGO status and thus in accessing funds. Divisions between different organisations (at different levels of activity) about what function of council should be. (Castle, 1991: 20-1)

Pink Triangle

Initially formed to address gay issues, 90 percent of activities now AIDS related. Because of difficulties obtaining charitable status has incorporated as business. Full time co-ordinator recently added thanks to funds from AIDAB. Current AIDS activities include: AIDS awareness variety show; AIDS pantomime; AIDS hotline; video showings; public talks at civic groups and public and private schools; promotion of free and anonymous testing, including pre-test counselling and follow up services. Future activities may include: new premises to include drop-in centre; production of educational videos and materials (particularly aimed at gay men); setting up of internal support group. (Castle, 1991: 18-20)

Philippines

**Council for Health and
Development
P O Box SM-463
Sta Mosa,
Manila
PHILIPPINES**

National consortium of non-government community based health programs and institutions serving the poor and marginalised, formed in 1989. Commitment to right to life, empowerment and holistic approach to health and development. Aims to enhance health care system through support to NGOs; develop the capacity of people to respond to their increasing health needs; strengthen the capacity of NGOs through networking, sharing resources and providing a support system; promote community based approach to health care among government and private sector institutions. AIDS is one of four priority areas (others being medical missions, relief services and video project on community based care). Provides training for NGOs in programme management etc. AIDS work has included a socio-cultural survey and a project looking at ways to support sexually prostituted women. The survey is expected to explore gender issues and provide suggestions about the future direction of AIDS programmes in the Philippines. (Preliminary data only available as at 9/91.) Future plans (as at 9/91) include facilitating NGO coordination and project with migrant workers. (Castle, 1991: 27-8)

**Health Action Information
Network
9 Cabanatuan Road
Philam Homes
Quezon City
PHILIPPINES
(Mailing address: P O Box
10340 Broadway Quezon City)
Tel: (63-2) 97 88 05
Fax: (63-2) 721 82 90
contact: Dr Michael Lim Tan**

Formed in 1985 in response to need among alternative medical and health groups for research and documentation activities. Provides link between health education and medical services. Diverse activities including research and documentation, education; networking; and specific projects, including a Human Sexuality project (this encompasses reproductive health, prevention and control of STDs including AIDS, protection of rights of vulnerable groups such as sex workers). HAIN works with male sex workers on AIDS/HIV issues. Recently they conducted KABP survey among nursing and medical students in Manila on HIV/AIDS/sexuality in 1991 (see **Health Alert** 125 - Jan 1992 for results). Following this they produced an **Information Kit on HIV/AIDS for Medical and Nursing students** (see bibliography). HAIN produces a monthly newsletter **Health Alert**; It is one of a consortium of groups in Philippines working with women (esp sex workers) on AIDS and other issues (other groups include Women Health and Buklod Centre). (**Health Alert**, 125; Castle, 1991; Marge Berer.)

**Isis International
Asia regional office
85-A East Maya Street
Philamalife Homes
Quezon City
PHILIPPINES**

International networking organisation on women's issues, with offices in Geneva (and a resource centre) and in Latin America. Focus on women's health issues and related networking. Have produced an edition of their newsletter **Women's World** on AIDS (see bibliography for details). (Marge Berer, personal communication).

Kabalikat

Founded in 1988 as NGO partner to engage in research oriented pilot intervention project for sex workers. Runs a drop in centre in the Ermita red-light district, which provides meals and will eventually provide clinical care for the treatment of STDs. Focus on sex workers connected to establishments such as bars and massage parlours. Current activities include seminars on STDs for workers in 'entertainment' industry; peer education in negotiation skills, especially among women from rural/uneducated backgrounds; outreach work with street youth, especially 'freelancers' providing information and encouraging condom use. As at 1991, planning to work with youth in schools and with school 'gatekeepers' (joint work with Reachout AIDS Foundation - see below). (Castle, 1991: 27.)

**Reachout AIDS Education
Foundation
1066 Remedios Street
Malate Manila
PHILIPPINES 1004
Contact: Jomar Fleras**

Group of artists working to promote AIDS awareness. Have produced a play and a video around AIDS issues. More videos planned for the future as well as a project with Kabalikat to perform drama in schools conveying safe sex messages. (Castle, 1991: 29.)

**Remedios Counselling Centre
The Remedios AIDS
Information Centre
1066 Remedios Street
Malate Manila
PHILIPPINES 1004
Tel: (63-2) 597 450**

Supported by AIDSCOM, the counselling centre is located in Ermita 'red light' district and operates a hotline and provides a space for NGOs to meet. Expected to facilitate coordination among NGOs by providing regular meetings and a newsletter. Supported by the National AIDS programme. Members include HAIN (see above), STOP (Stop Trafficking in the Philippines) and the Institute for Social Studies and Action (ISSA). (Castle, 1991.)

The Library Foundation (TLF)
Mezzanine Floor
The Library Pub
1779 Adriatico St
Malate Manila
PHILIPPINES
Tel: (63-2) 522 24 84
(63-2) 50 92 95

Founded in 1989 by a group of gay men, and primarily targeting young gay urban professionals, although with a concern for lower socio-economic classes, students and transvestites. Activities include a 'values and attitudes clarification workshop' aiming to make people accept and feel positive about their sexuality, general AIDS information activities and peer counselling. As at 1991 planning to undertake research into effective interventions for gay community, to publish a monthly newsletter (to broaden its community), the production of videos and the establishment of a drop in centre. (Castle, 1991: 28)

Thailand

Adventist Development and Relief Association (ADRA)
Box 11-234
Phrakanong
Bangkok 10110
THAILAND
Tel: (66-2) 390 0001
Fax: (66-2) 381 1424
Contact: Jeffrey Wright

Promoting safe sex and discouraging women from entering sex industry through 'maw lum' traditional entertainment combining music, drama, dance and mime, in poor Eastern province of SiSaket. Professional performers devise script from set plot on AIDS theme. Followed up with schools programmes, counselling and condom distribution. (**AIDS Health Promotion Exchange**, 3/1991)

AIDS Outreach Intervention Project
Epidemiology - Biostatistics Program
University of Illinois
Room 555
School of Public Health West
2121 West Taylor Street
Chicago IL 60612
Tel: (1 321) 996 5523
Fax: (1 312) 996 0064
Contact: Dr Wayne Wiebel

'Indigenous leader' programme model for HIV/AIDS prevention among intravenous drug users. Using social networks and ethnographic methods. Projects in USA and Thailand (Bangkok). (**AIDS Health Promotion Exchange**, 2/1991: 7)

AIDS Crusade
c/o Women Lawyers Association
Tel: (66-2) 512 2123
Fax: (66-2) 513 7094
(66-2) 253 5784
Contact: Sumatra Troy

Working with poor rural prostitutes. (Personal communication, Marge Berer.)

**Association for the Promotion
of the Status of Women**
501/1 Mu 3, Dechatunga Road
Sikan
Donmuang
Bangkok
THAILAND
Tel: (66-2) 566 1774
(66-2) 566 2288
Fax: (66-2) 566 3481
Contact: Khunying Kanitha
Wichienchareon

Began activities 1981-2 for destitute women and children; provides information to women; holds meetings in Northern Thailand; has outreach activities on railway and bus routes; counselling; emergency home care; referrals; vocational training courses; women's shelters including provision for children; targeting sexual practices and drug use; in 1990 established Gender and Development Research Institute. (Information from project leaflets and from Marge Berer.)

Duang Prateep Foundation
Lock 6
Art Narang Road
Klong Toey
Bangkok 10110
THAILAND
Tel: (66-2) 249 3553
Fax: (66-2) 249 5254
Contact: Prateep Ungsongtham-
Hata

Active in child education and community development for 13 years in slum areas of Bangkok, including anti-narcotics programmes; HIV/AIDS community education through anti-narcotics networks; use of motorcycle boys in prevention campaigns; AIDS education for men as clients of sex workers. (**AIDS Health Promotion Exchange**, 4/1990: 10; personal communication Marge Berer.)

EMPOWER
P O Box 1065
Silan Post Office
Bangkok 10504
THAILAND
Tel: (66-2) 234 3078
(66-2) 234 0398
Contact: Chantawipa Apisuk
(Director)

Since 1985, working with female sex workers in Bangkok, providing English lessons and other forms of training; running a drop in centre; producing newspaper (**Patpong Newspaper**); drama activities; safe sex cabarets; telephone advice; counselling; working for reorientation of health provision; health promotion and fund raising activities, focusing on human rights of persons with AIDS; expanding work into provincial areas. (**AIDS Health Promotion Exchange**, 4/1990: 14-15.)

Friends of Women
Tel: (66-2) 270 0982
(66-2) 270 0929
Fax: (66-2) 271 2433
Contact: Niramol Phrvethatorn

Working on issues to do with violence against women; forced prostitution etc. (Personal communication Marge Berer, Nicholas Ford; Ford, 1991: 408.)

Hotline Centre Foundation
90/269 Moo Ban Yoo Charoen
Soi Sang Sa-ard
Wipawadee Rangsit Road
Bangkok 10900
Tel: (66-2) 277 8811
(66-2) 277 7699
Fax: (66-2) 275 8354

Involved in counselling, befriending and advice work, face to face, by mail and by telephone advice line; self defense training for women; running informatin centres. Focus on women's rights, sexual and family problems, protection of women from victimisation in prostitution. Particular focus on youth, rape victims, migrant workers etc. (Thai Volunteer Service, 1987, **Directory of NGOs in Thailand**; Marge Berer, personal communication.)

Khon Khaen University
Department of Obstetrics and
Gynaecology
Faculty of Medicine
Khon Khaen 40002
THAILAND
Tel: (66-43) 242 331
Fax: (66-43) 243 064
Contact: Dr Chaumchom
Sakondhawat

Study of 13 brothels to identify AIDS prevention strategies; found that some brothels have 'condom only' policy, implemented by managers (mamasans); design of strategy to replicate this policy in 22 other brothels through information exchange among managers and solidarity among sex workers; evaluation of impact of intervention using questionnaire and participant observation and monitoring of STD data highlighted problem of non-use of condoms with stable partner. Need for more intensive training and follow up to promote condom only policy. (**AIDS Health Promotion Exchange**, 1/1992: 12.)

Mahidol University
Institute of Population and
Social Research
25/25 Salaya
Nahorn Pathom 73170
THAILAND

Producing **Newsletter of Social Science Research on AIDS**; research project on patterns of sexual activity and AIDS/STD related knowledge in low income areas in central and North-east Thailand, also focusing on travel and migration as a factor in HIV transmission (in collaboration with Centre for Population and Family Health Institute of Columbia University). (**AIDSED Newsletter**, 4/1991: 24.)

Population and Community
Development Association
8 Sukhumvitg 12
Bangkok 10110
THAILAND
Tel: (66-2) 510 402/3
(66-2) 523 960/4
(66-2) 527 349
contact: Tavatchai Traitongyoo,
(Deputy Executive Director)

Has developed epidemiological model of HIV in Thailand; counselling service; distribution of condoms and 'AIDSernalia' (key rings, lighters etc with AIDS awareness messages); training agents of change; AIDS exhibitions for low income employees and rural areas; mobilisation of taxi drivers to disseminate information about HIV/AIDS in Bangkok and Thonburi areas. (**AIDSED Newsletter**, 1/1990: 10; **AIDS Health Promotion Exchange**, 4/1991:8-9.)

Thai Volunteer Service
Visid Prachuabmoh Building
4th Floor
Chulalongkorn University
Bangkok 10500
THAILAND
Mailing Address
(P O Box 2848
Bangkok
THAILAND)
Tel: (66-2) 251 4481
Contact: Jon Ungphakorn
(Director)

Trains volunteers and NGO staff for work in community and social development programmes across the country. Also follow up and evaluation. Produces various publications including directory on NGOs. (Thai Volunteer Service, 1987, Directory of NGOs in Thailand.) AIDS related work: education; counselling; home visits; legal advice; training courses on HIV; self help group; clinic; focus on women with children and teenagers. (Personal communication, Marge Berer.)

Other Information Sources

BERER, Marge
16 Sach Road
London E9
Tel: (44-81) 806 9182

Writer on women and AIDS; author of forthcoming book **Women and AIDS: an International Handbook**, including a chapter on the Pacific (see bibliography for full reference).

Bureau of Hygiene and Tropical Diseases
London School of Hygiene and Tropical Medicine
Keppel Street
London WC1E 7HT
Tel: (44-71) 636 8636
Fax: (44-71) 590 6756
Contact: Caroline Akerhurst

Has comprehensive database on HIV/AIDS issues. Produces regular bulletin, **AIDS Newsletter**, which abstracts from a wide range of journals and newspapers worldwide, as well as giving editorial comment and covering annual International AIDS Conferences.

FORD, Dr Nicholas
Institute of Population Studies
Hoopern House
101 Pennsylvania Road
Exeter
EX4 6DT
Tel: (44-392) 57936
Fax: (44-392) 263801

Researcher on AIDS issues in South East Asia, especially Thailand. Has done comparative research on behaviour and safe sex in different levels of sex industry establishment in Thailand (see bibliography for publications). Has been involved in research/intervention projects involving sex workers (promotion of condom only policy) and most recently, female factory workers. (Ford, personal communication: IDS/ODI, 1992: 4.)

HIV/AIDS and Development Program
c/o ACFAO
14 Napier Close
Deakin 2600
Australia
Tel: (61-06) 285 1816
Fax: (61-06) 285 1720
Contact: Tim Mackay

Joint project of Australian Council for Overseas Aid and Australian Federation of AIDS Organisations.

Panos Institute
9 White Lion Street
London N1 9PD
Tel: (44-71) 278 1111
Contact: Neil McKenna (editor
WorldAIDS)
Lawrence Zavreiw

Information and policy studies institute dedicated to working in partnership with others towards greater public understanding of sustainable development. Publishes irregular dossier on AIDS issues, including **Triple Jeopardy: Women and AIDS** (see bibliography), as well as bi-monthly magazine, **WorldAIDS** which includes many articles written by regional correspondents, particularly on South East Asia. **WorldAIDS** also features a DATAFILE section which gives updates on statistics on HIV/AIDS from different regions at regular intervals. (See Tables 1 and 2.) (**WorldAIDS**; Neil McKenna, personal communication.)