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Women, Girls and HIV/AIDS

Vulnerabilities and Opportunities

The 2004 World AIDS Campaign carries the theme "Women, Girls and HIV/AIDS." With about 17 million between 15 and 49 years old afflicted by the virus, women are increasingly becoming the face of HIV/AIDS.

Women are vulnerable to HIV infection primarily because they lack adequate knowledge on HIV/AIDS. Moreover, they lack access to sexual health and educational services and are unable to negotiate for safer sex due to gender inequality. Poverty can also fuel the spread of HIV as women engage in unsafe sex in exchange for money, housing, food or education.

This issue of *Health Alert Asia Pacific* examines the factors that make women vulnerable to HIV. The first article looks at the human rights aspect of the disease, discussing the matter of AIDS-related discrimination and gender. It also looks into the programs that are needed to address HIV/AIDS—programs that would create an environment that empowers women and uphold their health and dignity.

The condition of migrant women is closely examined in two articles since migration could lead to greater vulnerability to HIV infection due to socio-economic conditions, cultural obstacles and gender inequity.

The life story of Faye on pages 6-7 narrates how a woman's desire to work in another country was shattered when she contracted HIV. It describes how she stood tall despite her illness, her life taking on a new meaning as she volunteered for various NGOs.

The issue of migration is significant in Cambodia in the context of HIV/AIDS. The article on pages 8-9 looks into the interweaving factors that lure young Cambodian women to work in other places, and increases their risk for HIV.

Looking towards solutions, this issue also features the developing research into microbicides and the advocacy of the Global Coalition of Women and AIDS. Microbicides, by providing women a safe sex tool they can control, can help abate the transmission of HIV and other STDs. Meanwhile, the Global Coalition of Women and AIDS furthers its advocacy by bringing to the fore the issue of AIDS as it particularly affects women.**HA**

IN THIS ISSUE

Illustration by Boy Dominguez

HIV & Human Rights: a Gender-Based Response

Susan Paxton*

HIV/AIDS disproportionately affects women. AIDS is now the world's fourth leading cause of death, and the epidemic is increasingly heterosexual. Women are more vulnerable to contracting HIV, are often blamed for spreading the virus, bear the burden of care, and face the greatest levels of AIDS-related discrimination. Public health policies rarely consider the gender dimensions of their response to HIV/AIDS. Likewise, HIV research frequently overlooks women's concerns; for example, female-controlled barrier methods such as female condoms or microbicides receive relatively little research support.

Women's Greater Vulnerability to HIV Infection

Women are physiologically more vulnerable to HIV infection. There is more virus in sperm than in vaginal secretions; the vagina has a large mucosal surface; young women are most vulnerable because the mucosal lining is thinner and easily ruptured. Coerced and violent sex increases the risk of lesions—entry points for the virus.

Coupled with these are socio-economic determinants. Women constitute two thirds of the world's poor and consequently have far less ability than men to ensure that their sexual encounters are safe. ABC messages of "abstain, be faithful, use condoms" fail to recognize the context of women's lives. In many societies, women are expected to be virgins before marriage to older men (who are more likely to be infected), and are not expected to make decisions about their sexuality; marital rape is rarely recognized as a crime. Although sex outside marriage is often culturally accepted for men, married women who try to negotiate abstinence or condom use may face violent outcomes. Many poor families, wittingly or unwittingly, sell their daughters into sex slavery.

Women are likely to be less educated than males, more overworked and underpaid, and financially dependent on men. This limits women's ability to access information on HIV/AIDS prevention, care or treatment.

AIDS-Related Discrimination

A young woman is often the first person in a family to be tested for HIV, often from increased routine screening during pregnancy (which in many instances happens without informed consent). She is then often accused of bringing HIV into the family. Once diagnosed with HIV, she has limited reproductive choices—decisions are often made by health care providers, husbands, or in-laws, resulting in unwanted pregnancies, or coerced abortions and sterilizations. Because abortion is still illegal in many countries, it has to be carried out in ways that severely endanger women's lives. Confidentiality (or lack thereof) from health service providers is another serious issue.

A documentation of AIDS-related discrimination in Asia conducted by APN+ found that HIV-positive women face significantly greater levels of discrimination at home and in the community than their male counterparts. The study interviewed over 760 HIV-positive people, half of whom were women. Women were more than twice as likely to be forced to change their place of residence and almost three times more likely to be physically abused because of their HIV status compared to men; 30 percent of women faced ridicule or insult because of their HIV status compared with 20 percent of men.

Widows and single women are even more vulnerable to human rights violations (including physical assault), and disproportionately head poor households.

Practical Ways Forward

Programs to address HIV/AIDS need to challenge and transform cultural norms that are harmful, enhance women's participation in decision-making, and remove barriers to women's improved health and dignity. To overcome gender-based discrimination and promote women's health, we need to strengthen compliance with international treaties and conventions aimed at ensuring that all women's rights are upheld, including rights to employment, education, information, sexual and reproductive choice, and property ownership. However, legislation alone cannot change harmful traditional norms and create a culture of respect for women. Only in combination with actions at all levels of society can we ensure that policies are translated into practice.

Political Leadership

Governments should be pressured to provide leadership in treating women with dignity and respect, and to ensure legislation addresses the vulnerability

Photos by HAIN

of women and protects their interests. It is essential that boys are taught the importance of advancing and upholding women's rights. Rights and power should be seen as qualities that, if shared, create advantages for *everyone* in society.

Women also need physical security and sustainable livelihoods, independent of men. Action must start through increased educational and employment opportunities, including free education, micro-financing, and women's property ownership schemes.

School authorities have an important role to play in effective HIV education, by developing a curriculum that includes information on the impact of gender violence on families. Non-judgmental sex education, delivered before people make their sexual debut, results in later age of first intercourse, higher incidence of monogamy, and higher rates of condom use.

Faith-based organizations can provide significant leadership in supporting the rights and dignity of HIV-positive people, especially women. Their power to influence public opinion cannot be underestimated. Business communities can also take a strong leadership role by introducing gender-equitable workplace policies and HIV-awareness programs for all staff.

U.N. agencies, the World Bank and bilateral donors can also play key roles in promoting the mainstreaming of HIV across all sectors. They need to include the knowledge, experiences and views of networks of HIV-positive women in their policy work.

Health Service Policy

Health care staff must provide adequate, non-judgmental information to ensure people make informed reproductive health decisions. No woman should be tested without her voluntary, informed consent. Mandatory testing of pregnant women must stop and be replaced with voluntary testing and couple counseling. A high proportion of young HIV-positive women are passionate and highly motivated about arresting the spread of HIV—these women can be trained and employed as pre- and post-test counsellors.

There is also a need to address the problem of poverty, which denies most women access to health services. Because pregnancy may be the only time many women visit health care facilities, innovative approaches for the dissemination of good HIV-related information must be explored. Health staff also need to recognize the importance of confidentiality for all patients.

Contributions of HIV-Positive People

HIV-positive women play important roles as speakers and advocates, and should be encouraged, supported and employed in these roles. Exposure to people living with HIV, particularly women, has a profound and significant impact on people's attitudes to HIV.

Involvement of HIV-positive women's organizations in all aspects of decision-making that affects their lives should be promoted. Organizations often assume that an HIV-positive man or a few token women can represent the perspectives of all HIV-positive women and girls. This is unfair on both the individuals and the networks of HIV-positive women that have been formed. The contributions of these networks are often overlooked and rarely adequately financed. They need strong support through proper recognition, capacity building, and financial support.

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Creating an Enabling Environment

Traditional gender norms, where boys are trained to adopt dominant roles in society and girls to accept this, must change in order to protect both women and men from HIV. Women and men need access to education that questions and challenges these norms. They need appropriate information about sexuality and the dangers inherent in unequal gender relations, together with the space to learn and practice negotiation skills.

Community-based initiatives that recognize the growing heterosexual dimension of this pandemic and the need for better communication between men and women are crucial. Programs such as the "Stepping Stones" package on gender, HIV, communication and relationship skills need scaling up, adaptation and duplication. There are many committed HIV-positive people willing to be trained and employed as facilitators of such programs. NGOs would do well to collaborate with them in mutual sharing of their knowledge and skills.

Working alone, no sector of society can create the changes needed to end the disproportionate burden HIV places on women. The response has to be at multiple levels—from local to global—through multiple media, and must address multiple factors—legal, economic, social, physical, psychological and sexual.

AIDS challenges us to face the greatest of human taboos—sex, death and gender. The task before us is extraordinary, and so are the many groups of people who are facing up to the task. **HA**

** This article is a condensed version by **Susan Paxton** of the Asia Pacific Network of People Living with HIV/AIDS (APN+) and the Australian Research Centre in Sex, Health and Society, La Trobe University, Australia. The original version of this article is entitled "Oh, This One is Infected – Women, HIV and Human Rights in Asia Pacific" written for the UN Office of the High Commission on Human Rights in 2004, which she co-authored with Alice Welbourn, Chair of the Board of Trustees of the International Community of Women living with HIV/AIDS (ICW).*

The Global Coalition on Women and AIDS

Launched on February 2, 2004, the Global Coalition on Women and AIDS is an informal grouping of partners and organizations working to mitigate the impact of AIDS on women and girls worldwide. It is a growing global, inclusive movement seeking to support, energize and drive AIDS-related programs and projects to improve the daily life of women and girls. The Coalition seeks to build global and national advocacy to highlight the effects of HIV and AIDS on women and girls and stimulate concrete, effective action. Efforts are focused on preventing new HIV infections, promoting equal access to treatment, addressing legal inequities, and mitigating the impact of AIDS for women and girls.

The Coalition recognizes that the vulnerability of women and girls to HIV infection and the impact of AIDS are linked to underlying gender inequalities and societal norms that need to be challenged. The Coalition is focused on effecting changes in areas that have a direct and significant impact on the lives of women and girls - through strengthening their capacity and resilience, as well as their position in their families and societies.

The Coalition's focus:

- preventing HIV infection among girls and young women
- reducing violence against women
- protecting the property and inheritance rights of women and girls
- ensuring equal access by women and girls to care and treatment
- supporting improved community-based care
- promoting access to new prevention options for women, including microbicides
- supporting on-going efforts towards universal education for girls.**HA**

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Self-Help Groups

Self-help groups are set up by or for people living with HIV and exist around the world. They can be a great source of support, help and advocacy for positive people both locally and nationally.

Self-help groups can provide:

- Emotional and social support at home or in group sessions
- Opportunities to meet and share ideas and practical information with other people living with HIV
- Training in education, public speaking and counselling skills
- Opportunities for earning an income through setting up income-generating projects such as sewing or raising chickens and sharing the profits
- Empowering each other to do things like negotiate condom use or stand up to abuse
- A basis for advocacy and campaigning.

Setting up a self-help group

It is essential that founder members be clear about the main purpose of the group. Will the group be a support group for newly diagnosed people? Or will it concentrate on education and campaign work? In general, income-generating projects should not be mixed with psycho-social support groups as they are not always compatible. Whatever the group's aims are, they should always be discussed with new members. Women and men with HIV and AIDS may have quite different needs and concerns, depending on how long they have known they are HIV positive, their state of health, their financial situation, and family responsibilities. Many women prefer a women's group. Others feel it is important to involve men.

To ensure that everyone attending the group is encouraged to participate and feels safe, it is useful to agree how group members will work together. This can be achieved by agreeing on some ground rules. Other groups have found the following guidelines useful:

- Respecting the need for confidentiality
- Striving for non-judgemental attitudes and behavior
- Being open to the varied experiences of group participants on the grounds of race, religion, sexuality, or drug use
- Offering each other constructive feedback, and using language which is accessible to all group members
- Respecting each other's feelings and views
- Ensuring that the group is welcoming to new members. Sometimes older members forget how scary it can be going to a first meeting
- Meeting a new person outside a formal support session to explain what happens in a meeting
- Thinking about where to hold support meetings in order to make women feel welcome and safe
- Considering whether women will be able to maintain their privacy if they attend a support group

Some positive women desperately need material support such as money or food. Make sure that it is made clear to new women if your group cannot provide these. Do you have information about other organizations which can respond to these needs?

Meeting in a group may not always be appropriate. Some positive women are afraid for their own and their families' safety if their HIV status becomes known. In this situation it may be necessary to visit someone in their own home so confidentiality is not breached. In other situations, support through phone calls works well.

Support groups and self-help groups can play an important role in advocacy. It is easier to be open and involved in prevention and care when we join together. Our strength is multiplied, and we give each other confidence. Self-help groups demonstrate to the world that people with HIV are living positively. Together, we are more able to demand changes and help each other at the same time. **HA**

Source: International Community of Women Living with HIV/AIDS (ICW). A Positive Women's Survival Kit Fact Sheet 4: Self-Help Groups

Faye's Life

There were days when Faye was happy and thankful that she was alive. But there were also days when she was inconsolably depressed. Faye had her moments of quiet acceptance and moments of stubborn denial. To Faye, life was a struggle – against her physical condition, and between complex, often conflicting, emotions.

The youngest of three, Faye was born in the summer of 1963 in a small village in the Philippines. Her father tended a small farm while her mother stayed at home. "We grew up in poverty," she remembered.

After finishing primary school, Faye left their house for the city and stayed with her aunt who promised to send her to high school. She eventually became active in church work, teaching Christian education in her community.

Primarily motivated by economic reasons, Faye decided to work abroad and, after eight months of waiting, she finally left for Malaysia. When she arrived in Kuala Lumpur, she worked as a domestic helper. Life was difficult – she had to take care of children and was expected to finish her tasks within an imposed schedule.

Meeting James

On Sundays during her days off, Faye would hear the morning mass at the St. John's Cathedral together with her friends, selling brassieres for additional income after the mass. The rest of the afternoon would be spent with friends in malls and picnics.

Faye neither expected nor wanted to have a boyfriend in Malaysia. However, a phone call that turned out to be a "wrong number" resulted in a romantic relationship. The man on the other end continued to engage her in conversation, and they became phone pals for about four months until they decided to finally meet. His name was James, a Chinese-Malaysian widower working as a bank accountant.

Faye was convinced that James loved her. She spent her Sundays with him and his daughter. Faye recounted that they did not use protection when they made love. Instead, James only used the withdrawal method as a contraceptive measure. At some point, James proposed marriage to Faye, and told her they could settle in Malaysia. While Faye considered the proposal, the thought of her aging mother weighed heavily on her. Finding it difficult to leave her mother, Faye turned down James' proposal and returned to the Philippines.

Having stayed in the Philippines for almost five months, during which James stopped sending letters, Faye returned to Kuala Lumpur to work for a new employer. After about four months, she met James in a shopping center—they got together and relived old times. After getting physically intimate that afternoon, James took her to his apartment and confessed that he had married a Filipina entertainer.

Five years after her breakup with James, Faye applied for a visa to join her employer's family in Europe for vacation. For this, she had to go through a medical exam. A few days later, she learned that she had HIV.

Homeward Bound

Her first reaction to the seemingly incredible news was denial; anger, disbelief and fear consumed her. She felt she could never handle suffering and death. She broke down and kicked the chairs around, even accusing the nurse of manipulating and altering the results. Faye was inconsolable.

Faye was immediately sent home to the Philippines. Upon arriving in Manila, Faye was met by representatives of an NGO providing care and support to Filipinos living with HIV/AIDS. She was brought to their office in Manila where she stayed with other volunteers. Soon after her arrival, she went through more medical examinations to confirm the test results in Malaysia.

When the tests confirmed her HIV status, Faye decided to go home to her family in the province. However, she just couldn't tell them about her condition. Painful as it was, she distanced herself from her mother and other relatives whenever they had cough, fever or other ailments—both to hide her ailment and to prevent catching a disease.

Upon returning to Manila, Faye participated in HIV/AIDS education campaigns and study tours to the provinces. During one of their study tours, she noticed that one of her breasts was hard. When this did not disappear after her period, she decided to have a biopsy. Faye had malignant breast cancer.

At times, Faye felt hopeless about her situation. "I won't be able to work abroad, or even here. Even if I find a job, I will not earn much," she cried. "It is painful for me that I cannot help my mother."

Picking up the Pieces

However, Faye was still thankful for a lot of things. With her savings from working abroad, she was able to build a house for her mother—a fulfillment of her childhood dream. She was also grateful that she had a job in an NGO that allowed her to buy her daily meals and her monthly dose of vitamins. She was also able to receive some benefits from the Overseas Workers Welfare Administration.

Still, Faye wished the government would give more support to people like her. Her apprehensions were evident in her attitude towards the future. She worried that she would not have money to buy the medicines that she or her mother would need. She feared the possibility of experiencing extreme pain before she passed on.

Faye kept herself busy by joining educational tours. They went to local government units, schools and colleges to disseminate information on HIV/AIDS. "I share my story with them. This helps unburden my emotional load," she recalled. "I tell them how I contracted HIV and share my life now." Faye also went on radio programs to share her views on HIV/AIDS. Though meeting different kinds of people was a kind of diversion for her, she was, paradoxically, forced to relive her experiences. "The memories keep coming back and then I couldn't help crying. Even when I talk, I sometimes cry."

Living with HIV/AIDS changed Faye's life – she realized how much more education on HIV/AIDS is needed. Having gone through so much in her struggle against HIV/AIDS, she often said, "I hope people like us will not grow in number."

Eventually, Faye worked on the program staff of an NGO. Her tasks included educating prospective women migrants in the community about migration realities and health. She also became an active member of organizations of people living with HIV/AIDS.

In late 2003, Faye started feeling pains on her back and under her arm. She also started having coughs. At first she attributed the pains to the changing weather, and her cough to allergies. In January 2004, after spending the Christmas holidays in pain, Faye decided to undergo a general medical check-up, including a visit to her oncologist. The bad news shocked her: the cancer had metastasized, spreading to her lungs, bones and liver. After three painful months, Faye succumbed to cancer and was laid to rest in her hometown in April 2004. **HA**

Source: An abridged version of an article that appeared in For Good: Life Stories of Filipino Migrant Workers Living with HIV/AIDS published in 2004 by the Action for Health Initiatives, Inc. (Achieve) and the Coordination of Action Research on AIDS and Mobility (Caram)-Philippines. (Email: achieve_caram@yahoo.com)

Migrant Women, Vulnerability and HIV/AIDS

Migrant workers are among the most marginalized and vulnerable populations at risk of HIV. Factors enhancing migrant workers' vulnerability to HIV include:

- Separation from spouse, family and socio-cultural norms
- Lack of access to information
- Difficulty in interpreting and accepting the new environment
- Isolation, loneliness and a sense of anonymity due to stigma and discrimination
- Marginalization and discrimination due to lower socio-economic status and poor living conditions
- Difficulties in accessing services, information or trade unions / other support organizations, due to working in disorganized sectors
- Difficulties in obtaining legal and policy support in the host country **HA**

*Source: **The Forgotten Spaces: Mobility and HIV Vulnerability in the Asia Pacific**.2004 by Caram Asia Berhad.*
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Khmer Silk: Examining the Tight That Tie Cambodia

Michael P. De Guzman*

HIV was first detected in Cambodia in 1991, while the country was reeling from decades of strife and civil unrest. The first cases of AIDS were diagnosed between late 1993 to early 1994. In the ten years that followed, reported cases of HIV infection quickly rose at an alarming rate, particularly among female sex workers and their male clients. This was partly fueled by the growth of the Cambodian sex industry and the continued displacement of people.

Today, Cambodia has the highest prevalence rate of HIV infection in Southeast Asia, at 2.6 percent of the sexually active population. Meanwhile, the epidemic is spreading to other sectors of the population—from female sex workers to male clients, from husbands to their wives, from mothers to their children. This spread of HIV/AIDS places a heavy burden on Cambodia's already fragile economy because a majority of those infected belong to the economically productive age group. Many of them have dependents and are likely to be economic migrants.

The issue of migration is very significant in Cambodia in the context of HIV/AIDS. Its geographic location in the sub-Mekong region has contributed to the spread of the virus. The movement (some say trafficking) of Vietnamese women into the country to work as sex workers, the transit of fishermen with high risk behavior from Thailand, and the general flow of migrant laborers between these countries aggravate the epidemic in Cambodia.

Internal migration further complicates the situation. The return of seasonal agricultural workers to rural areas during the wet season, the doubling of Phnom Penh's population during the Water Festival, and the reintegration of demobilized soldiers are just some examples of internal migration that may make the situation conducive for the spread of HIV/AIDS.

"Women Are Cloth"

Strict hierarchies govern social relations in Cambodia, with gender roles having deep cultural roots. For example, the *Chhbap Srei* (or, Rules of the Lady, a widely known Cambodian verse) teaches that a woman must remain virgin until she is married. On the other hand, according to the *Chhbap Pros* (Rules of the Man), male sexual activity, including buying sex, is considered normal. The Cambodian adage, "Men are gold, women are cloth," embodies this imbalance in gender relations, manifested in the acceptance of men's sexual excesses and the double standards imposed on women, ranging from sexuality to education and employment.

The vulnerability of Cambodian women is often an outcome of their inferior social status and rigid roles in the family. Women are often denied formal education and are simply taught to be caregivers and nurturers, leaving them powerless in society. However, in times of economic hardships, daughters may have to leave home to share in the income burden, having to work as servants or laborers outside their communities, doing jobs they would rather not do.

A complex and interlocking social, cultural and economic factors increase Cambodian women's vulnerabilities to HIV infection.

A Tight Weave

Cambodia has a young, rural population, with the youth composing 52 percent of the population in 1998. Of the 9.462 million people who are in rural areas, nearly two-thirds are below 20 years old and nearly a fifth is between 15 to 24 years old. Despite high infant mortality rates and maternal deaths, the population is still growing at an average of 2.5 percent, with the current average family size being 5.3. In Cambodian society, a larger family means a bigger family labor force. The lack of livelihood opportunities in the rural areas, the abundance of cheap labor—compounded by the fact that Cambodia has no other major industries except for tourism and garment manufacturing—forces young people, mostly women, to leave their homes in search of employment.

These young, rural women who are lured to work in other places often fit into a certain profile—15 to 24 years old; from a large, low-income family where at least one parent is either sick or cannot work; and have little educational attainment and limited skills. This lack of education and marketable skills increases the likelihood of them ending up as domestic helpers, garment factory workers, beer promoters, and sex workers.

While working in these sectors does not necessarily mean that they will be infected with HIV, a complex and interlocking social, cultural and economic factors

Weave of Vulnerabilities an Women to HIV/AIDS

A garment factory worker in Phnom Penh. Photo by jbj-Crossroads to Development

combine to increase their vulnerabilities to the disease. The culture of gender inequality makes girls inferior relative to men, making it difficult for them to stand on their own. This same culture limits their chances of developing themselves through education, making them prone not just to exploitation and abuse but also to trafficking.

An instilled sense of responsibility for her family, often translated into a pressing desire to earn money, forces many young women to tolerate exploitative working conditions. Many of these young women, specifically the sex workers and beer promoters, are gainfully employed in jobs that do not respect their rights, having a negative impact on their health and general well-being. The loneliness of separation from their families is accompanied by the disappearance of the protection that they usually obtain from their families. When homesickness brought on by this separation is added, they become more open to seeking emotional support from relationships that may lead to risky behaviors, rape and other forms of violence.

In 1999, a qualitative survey among young garment factory workers revealed cases of rape by boyfriends, colleagues, or strangers; incest; sexual coercion; drugging and trafficking. A 1995 survey of sex workers found that nine percent of them entered the sex industry after being raped, half of them by their stepfathers. Other studies corroborate findings of rape, incest, or being sold.

Sometimes, society's perception of a certain population group increases vulnerability. In a profiling survey of beer promoters, only 4.7 percent of the sample admitted that they had sexual relations with clients. However, all beer promoters are affected by their prevailing image as sex workers. This is boosted by the fact that beer promoters are classified in Cambodia's HIV sentinel surveillance system as indirect sex workers. This image can be dangerous because it may make them more susceptible to exploitation or abuse, either from their employers or from their clients.

Threading the Solutions

Like Thailand, Cambodia has been successful in stemming the rise of HIV infection among female sex workers and their male clients. The challenge now lies in replicating this success in other segments of the population to which the virus has spread. The link of migrants to the AIDS epidemic has been recognized by the government, and programs to respond to this issue have been implemented, largely in collaboration with local and international NGOs.

While many policies and programs are in place, the overall weakness of the social sector and the limited skills of social workers bog down the implementation of these initiatives. This is compounded by the inevitable link between migration and trafficking—another area where government laws and policies are inadequately enforced—and the endemic corruption that afflicts the civil service sector in all levels of government.

Last September, Cambodian Foreign Minister Hor Namhong signed four international agreements while at U.N. Headquarters in New York. One of these is the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which seeks to end clandestine trafficking of undocumented workers and guarantee the rights of both documented and undocumented migrants.

If the conventions are ratified by parliament, Cambodia is required to submit a report to the U.N. on steps taken toward implementation within one year of entry. But for the conventions to be meaningful, "the government must write a regular, credible report", says Kok Galabru, founder of local rights group LICADHO (Cambodian League for the Promotion and Defense of Human Rights). She cites the government's first report on women's rights for the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), which was finally sent this year, 12 years after the convention was ratified in 1992. She adds that NGOs should prepare shadow reports to patch government's omissions.

Cambodia's tardiness in the submission of the CEDAW report is not an exception, but rather the rule. The initial report on racial discrimination was a year late; children's rights, three years late; civil and political rights, four years late; torture and cruel punishment, nine years late; economic, social, and cultural rights, now a decade overdue and still pending. "To sign is just a show," says Koul Panha, director of the independent election-monitoring group ComFrel. "There are a lot of good written documents, but the implementation is inconsistent." **HA**

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Microbicides: An Added Ray of Hope

Bobby Ramakant*

Global HIV data, tragically, confirm what women's health, rights, and social justice advocates have been saying for a decade—social, economic, and sexual vulnerabilities among women, particularly young women and girls, harm their health and increase their risk of HIV and other sexually transmitted diseases (STDs). Existing prevention strategies have largely failed to address these vulnerabilities, focusing instead on abstinence, mutual monogamy and male condom use—none of which are easily controlled by women. The faces of HIV and AIDS in the world today are increasingly those of young women, many of whom are married, many of whom contracted the virus during adolescence.

Women are biologically more vulnerable to STDs and HIV/AIDS. Women are twice as likely as men to contract HIV from unprotected intercourse. Vaginal membranes are exposed to infectious fluids for hours after sex. Younger women are at greater risk because the immature cervix is more vulnerable to damage and infection. STDs often go undetected, and therefore untreated, in women. STDs increase women's vulnerability to HIV. Moreover, many women who get infected have only one mode of exposure to HIV—sex with their male partners.

Gender inequalities prevent many women from being able to protect themselves. Millions of women lack the social and economic power to insist on HIV prevention measures such as condoms, abstinence or mutual monogamy. Male and female condom use requires the tacit cooperation, if not outright participation, of the woman's male partner. HIV risk escalates among adolescent girls because of their physical vulnerability and susceptibility to rape, forced marriage, trafficking, economic dependence and coercion. Violence, coercion, and economic dependence render millions of women of all ages unable to "negotiate" condom use or to abandon partners who put them at risk. Millions live in societies that permit them no role in sexual decision making, condone male infidelity, and assign to women the burden of shame and stigma associated with infectious disease.

Developing Microbicides

Some dedicated advocates, scientists and donors are working to develop *microbicides*—gels, tablets, or other intra-vaginal products a woman could use to reduce her risk of getting HIV through sex.

Photo by JPV

Microbicides are still being researched, and will require significant political will, public investment and popular demand before they become available.

Microbicides are substances that can substantially reduce the transmission of HIV and other sexually transmitted infections (STI) when applied vaginally or rectally. Epidemiological models suggest that a microbicide with 60percent efficacy could avert 2.54 million HIV infections world-wide over three years.

Microbicides are not yet available, but are at different stages of research in a number of countries. They could be produced in a variety of forms: gel, cream, film, suppository, sponge or vaginal ring. Some could even be contraceptives, offering women dual protection.

Many studies report that women who do perceive themselves at risk for HIV have little success in asking their husbands to use condoms. While condom promotion has encouraged men to use condoms with sex workers and casual partners, most men still refuse to use condoms with their wife or regular partner. Predictably, HIV cases are rapidly increasing among married, monogamous women in countries like India. Microbicides will certainly help these women to protect themselves from STIs and HIV.

Many women want to get pregnant, for personal reasons, or to achieve the status and security that, in many societies, they can only attain through motherhood. Since condoms are contraceptive, women are forced to choose between childbearing and HIV prevention. Microbicides offer a ray of hope here too, being developed into two variants: contraceptive and non-contraceptive, which will make it possible for women to conceive without exposing themselves to the risk of HIV transmission.

Microbicides must be safe for all potential users—sexually active women and men, pregnant women, HIV-positive women, adolescents. They must also be compatible with condoms and other barrier methods. Potential mechanisms of microbicide action include:

- Killing or inactivating the virus by disrupting the surface membrane (surfactants) or boosting the vagina's natural defences (acidifying agents).
- Preventing the virus from binding to its target cells (adsorption inhibitors)
- Blocking replication of the virus once it has entered cells.

There are about 60 possible microbicides in the pipeline. Six potential products are soon likely to enter Phase III (large-scale multi-centric clinical trials) to assess effectiveness. These products include a surfactant (Savvy), an acidifying agent (buffer gel), and an adsorption inhibitors (PRO 2000, dextrin sulphate, carageenan and cellulose sulphate).

However, there are forces opposing the development of microbicides. Morally conservative and patriarchal social norms make it difficult to confront the reality of a sexually transmitted epidemic. A culture of silence around women's sexuality aggravates the stigma associated with seeking information or interventions about self-protection.

Much progress has been made on microbicides, but many challenges remain. Badly needed is a significant increase in investment from both the public and private sectors. Another challenge is to involve men, and to address the unequal power equation between men and women. Men and women alike should recognize that:

- HIV prevention must address women's needs and vulnerabilities.
- Women need education, economic opportunity and social support.
- Women need equality in order to protect their health and rights.
- Women need HIV and STI prevention tools they can control.
- Women need microbicides. **HA**

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The Global Action for Microbicides

The Global Action for Microbicides is a broad-based, international effort to build support for user-controlled prevention methods. Through advocacy, policy analysis, and social science research, the Campaign works to accelerate product development, facilitate widespread access and use, and protect the needs and interests of users, especially women.

Specifically, the goals of the Campaign are to:

- Raise awareness and mobilize political support for increased funding for microbicide research, female condom and cervical barrier methods;
- Create a supportive policy environment for the timely development, introduction and use of new prevention technologies; and
- Ensure that as science proceeds, the public interest is protected and the rights and interests of trial participants, users, and communities are fully represented and respected.

For information contact: info@global-campaign.org
www.global-campaign.org

Resource List

Reducing Girls' Vulnerability to HIV/AIDS: The Thai Approach (UNAIDS Case Study) by C. Kanchanachitra, 1999. In Thailand, too many girls find themselves at an early age in the sex industry because they are thought to be "safe" and uninfected with HIV, but the risk of infection to them and hence to their clients is very high. This case study describes some responses to the problem, focusing on changing the attitudes of girls and their parents with regard to sex work, and on providing means for girls to avoid becoming sex workers.

Women and HIV/AIDS : Confronting the Crisis, 2004 A joint report by UNAIDS/UNFPA/UNIFEM. This report concludes that women are bearing the brunt of the HIV/AIDS epidemic and that strategies to reverse it cannot succeed unless women and girls are empowered to reclaim their rights. Noting that half of all people infected with HIV are women, the report documents the devastating and often invisible impact of AIDS on women and girls and highlights the ways discrimination, poverty and gender-based violence help fuel the epidemic.

The Implications of Early Marriage for HIV/AIDS Policy, 2004 by J Bruce, S Clark, 2004. New York: Population Council. [Brief based on the background paper for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents]. Discusses married adolescent girls' reproductive health, vulnerability to HIV infection, social and economic disadvantage, and rights. Write to HAIN for a copy.

Photofile: http://www.unaids.org relating to Women, Girls, HIV & AIDS. The images on this page are thumbnail views of photographs used in the World AIDS Campaign 2004. Calendar produced by UNAIDS.

Women, Children and HIV: Resources for Prevention and Treatment, 3rd ed., 2004 [CD-ROM] Contains key resources on HIV infection in women and children, covering topics on parent-to-child-transmission of HIV, voluntary counseling and testing, infant feeding and nutrition, clinical care of women and children living with HIV infection, care and support of orphans and vulnerable children. Request from gshiv@chi.ucsf.edu, 4150 Clement St., #111V, San Francisco, CA 94121, USA.

Useful contacts and their websites

The following organizations and their corresponding websites contain many resources related to women, girls and HIV/AIDS and other issues around it. It is best to contact these organizations directly or search their site to see more of their resources.

Global Campaign for Microbicides **http://www.global-campaign.org/index.htm**
The Global Campaign for Microbicides is a broad-based, international effort to build support among policymakers, opinion leaders, and the general public for increased investment into microbicides and other user-controlled prevention methods. To write - c/o PATH | 1800 K Street NW, Suite 800, Washington, DC 20006, USA. Phone: (202) 822-0033; Fax: (202) 457-1466, info@global-campaign.org

International Center for Research on Women **http://www.icrw.org/index.htm**
ICRW's mission is to improve the lives of women in poverty,advance women's equality and human rights, and contribute to the broader economic and social well-being. To write1717 Massachusetts Avenue, NW, Suite 302, Washington, DC 20036, Phone: (202) 797-0007, Fax: (202) 797-0020; Email: info@icrw.org

International Partnership for Microbicides **http://www.ipm-microbicides.org**
IPM has been established to accelerate the discovery, development and accessibility of microbicides to prevent transmission of HIV.

International Community of Women Living with HIV/AIDS (ICW) **www.icw.org**
ICW is the only international network which strives to share with the global community the experiences, views and contributions of 19 million incredible women worldwide, who are also HIV positive.

World Association of Girl Guides and Girl Scouts **http://www.wagggsworld.org**
World Association of Girl Guides and Girl Scouts is working on projects on AIDS prevention and awareness in over 70 countries across the world, and is currently running an AIDS Badge curriculum in conjunction with UNAIDS. To write World Bureau, Olave Centre, 12c Lyndhurst Road, London, NW3 5PQ, England. Tel: +44 (0)20 7794 1181; Fax: +44 (0)20 7431 3764; email: wagggs@wagggsworld.org

United Nations Children's Fund (UNICEF) **http://www.unicef.org**

United Nations Population Fund (UNFPA) **http://www.unfpa.org**

United Nations Development Fund for Women (UNIFEM) **http://www.unifem.org**

World Health Organization (WHO) **http://www.who.int**

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