

# AIDS CAPTIONS

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## *Women and AIDS: Empowerment and Prevention*



FAMILY HEALTH INTERNATIONAL  
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## Skill Training for Women

Economically disadvantaged women at high risk of contracting HIV were more likely to use condoms consistently after being exposed to an in-depth peer education program, researchers from the University of Alabama at Birmingham reported in the October 25 issue of the *Journal of the American Medical Association*.

Women also reported greater improvements in social skills associated with increased condom use, including sexual self-control, communication and assertiveness, than women who did not receive any HIV education until the end of the three-month study.

Sexually active, heterosexual African-American women, 18-29, were recruited for the study at stores, clinics and agencies in a San Francisco, California, neighborhood and randomly assigned to one of three groups. One group participated in five in-depth peer education sessions, another group attended one HIV risk-reduction session, and the third group received no HIV information until after follow-up interviews had been conducted.

The peer education sessions were designed to address the behavioral, social and cultural factors that can make it difficult for women to negotiate condom use with their partners and increase their risk of HIV infection. Peer educators discussed and demonstrated sexual communication and assertiveness skills and gave participants opportunities to practice those skills. Other sessions emphasized such issues as ethnic and gender pride, correct condom use, and rehearsing sexual negotiations with uncooperative partners.

## Treating STDs Reduces AIDS Risk

Findings from a Tanzanian study suggest that treating people for sexually transmitted diseases (STDs) can dramatically reduce their risk of HIV infection. The number of new HIV infections was reduced by 40 percent among people who received STD treatment through a trial conducted by Tanzanian and British researchers in Tanzania's Mwanza Region.

Researchers from the African Medical and Research Foundation, the London School of Hygiene and Tropical Medicine and other research organizations observed the effect of integrating improved STD diagnosis and treatment with the existing primary health care system in six Tanzanian villages. Standard health care, which usually did not include STD treatment, was continued in six control villages. The treatment group had access to an STD reference clinic and laboratory, a regular supply of drugs, and health centers staffed by closely supervised, trained health care staff.

Over the study period of two years, 11.6 of every 1,000 adults in the treated group of 6,000 adults became infected with the AIDS virus, as compared to 18.6 of every 1,000 adults in the control group of 6,000. At a cost per treatment of US\$7.50 to \$15, the intervention was considered very cost effective by researchers. A 1992 World Bank study estimated that the cost of treating an adult with HIV/AIDS in Tanzania was approximately US\$290.

Because epidemiologic studies suggest that the presence of other STDs enhances HIV transmission, the World Health Organization recommends that HIV programs include improved STD

case management. The Mwanza study is the first to demonstrate on this scale the effectiveness of providing STD treatment as a way to reduce the risk of HIV transmission.

## New Transmission Hypothesis

Differences in HIV strains could explain why the virus is primarily transmitted through heterosexual intercourse in developing countries but spread most often in industrial countries via homosexual sex and shared needles, a Harvard scientist reported at the Third International Conference on AIDS in Asia and the Pacific in September.

Retrovirologist Max Essex and other Harvard researchers, in collaboration with scientists from Mahidol and Chiang Mai universities in Thailand, tested various virus subtypes on cells gathered from the vagina, cervix, breast and penile foreskin. They found that HIV "subtype E," the strain with which most Thai heterosexuals are infected, grew best on the cells that line the female genital tract. "Sub type B," the strain that dominates in Europe and the United States, showed virtually no growth on these cells.

This finding suggests that there may be two separate HIV-1 epidemics: one in which subtype B predominates that is spread by blood and anal intercourse, and a second involving the other HIV-1 subtypes and primarily vaginal sex.

Although the hypothesis was received well by most, others had serious reservations. One researcher noted the overwhelming presence of subtype B in the Caribbean, Central America and Brazil, all regions with primarily heterosexual epidemics.

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This issue is dedicated to the memory of

**Phibeon T. Gerald Muchando,**

an AIDSCAP IEC/NGO officer in Zimbabwe,  
 who died November 5, 1995, at the age of 43.

Cover Photo:  
 A women's organization holds a meeting  
 in Ahmedabad, India. Sean Sprague/PANOS



**E. Maxine Ankrah**

# Let Their Voices Be Heard: Empowering Women in the Fight Against AIDS

by *E. Maxine Ankrah,*  
*AIDSCAP Women's Initiative*

At the recent U.N. Fourth World Conference on Women in Beijing, a new issue became a critical part of the delegates' packed agenda: the growing threat of the AIDS epidemic to women.

More than 30 events—workshops, panel sessions, press conferences, youth meetings—challenged participants at both the official conference and the concurrent NGO Forum in Huairou to learn how HIV/AIDS, from which most women were once thought to be “immune,” now endangers women and girls in every corner of the world.

On September 5, designated Women and AIDS Day by the United Nations, a panel of HIV-positive women spoke of the long and painful struggle against fear, shame, rejection and illness that had transformed each into an HIV/AIDS activist. A young South African, Prudence Mabela, told the overflowing room about the cruel treatment she had received from her university and her community when

her HIV status was revealed without her consent. Her proud voice, calm and clear despite the horror of the story she told, has become an invaluable tool in the movement to demand support and treatment for HIV-positive women around the world.

## **The Growing Threat to Women**

Ten years earlier, though, at the U.N. Decade for Women conference in Nairobi, the subject of HIV/AIDS never came up, even though Kenya and neighboring nations in east and central Africa were then at the global epicenter of the epidemic.

In retrospect, this is not surprising. By the year 2000, more than 13 million women will be infected, and 4 million will have died from AIDS. Global HIV transmission rates by then will be slightly higher for women than for men. But in 1985, those numbers were very different: for every infected

woman, ten or more males were HIV-positive, depending on the country. “High-risk groups”—gay men, commercial sex workers, intravenous drug users, hemophiliacs—were the prevailing prevention targets, and few studying the disease looked beyond these limited categories to understand vulnerability. Ten years ago, many epidemiologists, physicians and behavior specialists failed to grasp that HIV would not respect the artificial boundaries that mainstream science had drawn around it. Apart from individual women who were sex workers or who took drugs, women as a whole were not believed to be in serious danger of contracting the virus, particularly monogamous and married women and young girls.

That year—1985—was also the year that my own sociological research on AIDS in Uganda began. Like my colleagues, I, too, did not yet perceive the emerging threat to women. But one day

in Kampala I saw a newspaper photo that, in an instant, revealed the ultimate direction of the epidemic.

It showed a young village woman dying of AIDS, sitting in the dust in front of her hut. She was unspeakably thin, skin and bones. The disease had sapped the life from her. I know about village life; my in-laws are villagers, and I was well aware how far from the centers of power these people live their daily lives. I remember thinking, this is a woman who will never have a voice.

### The Gender Perspective

Since 1985, we've come to understand more about why the rates of infection for women and girls have skyrocketed. The reasons have less to do with biology or behavior—the focus of most HIV studies—than with fundamental issues of power and control.

Because of their low social status, women and girls throughout the world lack the ability to determine many things about the course of their own lives. Limited access to economic resources and fear of violence force many women to yield control over sexual relations to men.

Few would question that this dynamic controls the lives of impoverished female commercial sex workers in developing countries. But economic dependence also plagues monogamous and married women unable to maintain themselves and their children without help from better-paid male partners. In many developing countries, some women have several steady male partners who help support them and pay for their children's school fees.

Many cultures tolerate multiple sex partners for men, and often women have reason to believe that their male partners may be infected with a sexually transmitted disease caught from someone else. When women cannot control their sex lives, they cannot say no to men—including their husbands—who they fear may be infected. Afraid of a violent reaction or abandonment and economic ruin, they can-

not force, or sometimes even ask, their male partners to use condoms so that both can be protected. While many men, aware of the dangers of HIV and other STDs, voluntarily use condoms, other men find the request offensive or even evidence that the woman herself has not been faithful. Without a prevention method they can control, millions of women face the threat of HIV infection every day, both throughout the developing world and in nations like the United States, where AIDS is the single greatest killer of African American women in their most productive years.

The epidemic has created a demand for younger and younger female sex partners, who men believe are less likely to be infected. In different parts of Africa, "sugar daddies" court school-

girls, offering gifts and cash. In Asia, brothel brokers seek rural families that will sell their daughters, to be offered to HIV-wary male clients in the cities. Unprotected sex is especially risky for girls, who, like all women, have higher biological vulnerability to HIV infection than men. It's little wonder that, in many parts of the world, girls and young women 15 to 24 years old now have almost twice the infection rates of males the same age.

Too often, then, the needs and vulnerabilities of women and girls are overlooked by HIV prevention programs that do not take the question of power into consideration. Too often "universal" behavior change messages—"Use a condom every time you have sex"—bypass entirely the question of who controls the decision to use

D. Singh JB PICTURES



*In India, twelve-year-old Shanti was freed by police during a raid of the brothel to which she had been sold.*



*A Costa Rican woman and her baby.  
HIV/AIDS, from which most women were once thought to be "immune,"  
now endangers women and girls in every corner of the world.*

all the issues at the Beijing conference, from health and reproductive rights to economic development and education, from ending violence against women to legal reforms to strengthen their rights. For HIV prevention, empowerment takes the forms of economic opportunity to lessen women's dependence, social and political advancement to give women a voice, and HIV prevention methods that women can control.

Empowerment as an HIV/AIDS prevention strategy for women is a central focus throughout this special issue of *AIDScriptions*. Geeta Rao Gupta offers an opinion on how to close the gap between discourse on gender sensitivity in HIV prevention and the reality of daily program practice. Lawyer Jane Kiragu examines efforts in Kenya and elsewhere in Africa to reform long-standing discriminatory laws that inhibit the ability of women and girls to protect themselves from HIV and, once infected, from impoverishment. Nash Herndon updates readers on development of women-controlled HIV prevention methods such as the female condom and vaginal microbicides. From Thailand, Kari Hartwig reports on a special workshop for AIDS prevention professionals from Southeast Asia, one of the first to examine HIV transmission among women as a cross-border issue requiring regional cooperation.

Also critical for women is the issue of care. Women are and have always been the caregivers for their families and communities. The epidemic has put enormous pressure on women in many regions of the world, who must simultaneously care for ill husbands and other family members, look after children and earn income, even if they themselves are sick, writes Kathleen Henry.

a condom at all. Too often women—particularly those for whom “Be monogamous” is either already a fact of life or an economic impossibility—find little of value in what prevention programs promote. Because so many standard prevention approaches fail to reach them, women remain far more ignorant about the epidemic than they should be after more than ten years of HIV programming—with deadly consequences.

### **An Empowering Solution**

Meaningful prevention programming for women requires a different kind of strategy, one that has at its heart the concept of empowerment: creating programs that help women gain control over their economic, social and sexual lives.

Empowerment of women was a primary theme throughout discussion of

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Limited funding for gender-sensitive prevention and care programs is a serious problem in developing countries. Peggy Scott, Julie Becker and Rita Badiani examine the value of integrating HIV prevention into existing family planning programs. Haliana Shariff looks at the scarce resources available in developing countries for women-oriented counseling and treatment programs to slow perinatal transmission of HIV. And Telma Cavaleiro, an HIV prevention activist in Brazil, describes how nongovernmental organizations in her country have led the way in reaching women with HIV prevention education despite tight budgets.

### **Making the Connections**

Since I saw that stark photo in 1985, the epidemic has come closer and closer to home for me. In the last ten years, I have lost many women friends and col-

leagues, from Uganda and elsewhere, to AIDS. I have seen whole regions of Africa devastated by AIDS, and observed the epidemic's alarming spread into Latin America and Asia.

Yet I am also convinced that the international women's movement, recently reinforced by the Beijing conference, can help strengthen the effort to protect women from HIV. A disease fueled by ignorance, economic and political disenfranchisement, and sexual powerlessness, AIDS cuts across common issues facing all women: domestic violence, trafficking of girls and young women, better health, improved

educational and economic opportunities, equality under the law. Unfortunately, many fighting to have the voices of women heard on these issues have been slow to incorporate HIV/AIDS prevention into their agendas, which can only happen when women see HIV/AIDS in one woman as a potential global threat for all women.

The tactics and lessons of the women's movement—networking to educate and empower, promoting analysis from a woman's perspective, understanding the need to reach women "where they are," encouraging women to speak of their experiences—

are ones that HIV prevention programs must learn to adopt, with input from the women they serve. As approaches designed by women become more and more part of standard HIV programming, I believe we will achieve what may not have been possible ten years ago: giving women a voice against HIV/AIDS. ■

*Dr. E. Maxine Ankrab is senior advisor, AIDSCAP Women's Initiative, which is responsible for increasing gender-aware programming throughout the AIDSCAP project.*

Alexandra Avakian CONTACT



*A young Ugandan woman dying of AIDS receives care from her mother and a home care attendant.*



## Gender and HIV/AIDS: Transforming Prevention Programs

*by Geeta Rao Gupta,  
International Center for  
Research on Women*

Our understanding of the HIV/AIDS epidemic has evolved over the past decade, from the misguided belief that the virus is only a problem for sex workers and other "risk groups" to the recognition that all women are vulnerable to HIV. The epidemic is finally being cast within a much broader reproductive health framework, and the power imbalance in gender relations is seen to be at the root of all vulnerability. Yet despite the growing sophistication of the discourse, an appropriate programmatic response seems elusive.

The Women and AIDS Research Program—17 studies in 13 countries conducted by the International Center for Research on Women with funding from the U.S. Agency for International Development—identified many obstacles to preventing HIV infection among women. They include sexual

norms that limit women's access to information by dictating that they must be ignorant about sexual matters, women's economic dependence on men, violence against women and widespread acceptance of male promiscuity. Somehow, despite the fact that we also identified opportunities for intervention, what people heard were the barriers and constraints.

One response to these seemingly overwhelming barriers has been to conclude that women are powerless and to revert to a focus on men. But programs aimed at changing men's behavior do not attempt to challenge any of the contextual determinants of that behavior. Instead, the emphasis is still on condom use and education.

A second response has been the search for an alternative technology for prevention—a much-needed female-controlled technology to give women

an alternative to male condoms. Thus arose the movement to develop a microbicide, test the acceptability of the female condom, and examine more closely the possibility of offering the diaphragm with nonoxynol-9 as one alternative in a hierarchy of prevention options.

Although these responses are pragmatic, they implicitly convey a passive acceptance of the unchangeable nature of social roles in general and male sexuality in particular. The belief that "men will be men" and will seek multiple partners for sexual release and that women will remain powerless to modify sexual interactions acts as a strong deterrent to change. Recommendations to economically empower women or to improve their access to education are characterized as long-term measures outside the domain of AIDS prevention. So while the dis-

course accepts the wider context of women's vulnerability to HIV, the programmatic response remains restricted to the margins.

What can and should AIDS programs do to address gender concerns? To proceed, we first need to clarify certain basic assumptions. The first assumption is that all women are not alike. There is an undeniable commonality of experience because of gender, but many variables—class being one—intervene to create complex differences. Women are at different points on the empowerment continuum; therefore, there can be no single blueprint for action.

The second assumption is that social systems are not immutable; they can and often do change to meet different needs. There are many examples of the definition of the norms governing male and female roles changing due to critical events, such as World War II. Such changes also can be brought about through concerted effort—especially when the lack of change has the potential to destroy the entire social system or subsystem. One example is changes in the social norms that dictated the sexual behavior of gay men.

Bringing about such change requires multiple, mutually reinforcing interventions and a focus that goes beyond one behavioral act. But we have to believe that it can be done. We can push the envelope on social norms that discriminate and compromise the rights of individuals. Together, we can begin to question the definitions of masculinity and femininity—definitions that now threaten the well-being of communities.

And the final assumption is that empowering women is not a zero-sum game. Power is not a finite commodity; more power to one ultimately means more power to all. Interventions within the women in development field have shown that poor men support women's empowerment when it en-

ables women to bring much-needed resources into the family or community or when it challenges power structures that have oppressed and exploited the poor of both sexes. Empowering women to protect themselves, to speak up and to access technologies also frees



In sum, we must do  
what is in our immediate  
control—modify existing  
programs to ensure that  
they are gender sensitive.



men from the stereotypical role of oppressor and exploiter. That message must be communicated without any caveats.

Given these assumptions, what can AIDS programs do to tackle the gender issues that stand in the way of effective prevention? First, we must ensure that traditional AIDS programs are gender sensitive. And being gender sensitive requires that we know what women need and that our programs respond to their needs.

So, for example, we found that without sex education and basic information about reproductive anatomy and physiology, women can do very little to protect themselves. Such information is easily provided, and there should be no excuse for not providing it. We also know that women need to have access to a technology they can control and use. Efforts to provide access to a female-controlled prevention method are all steps in the right direction that should have occurred long ago.

Second, the information we provide

must not reinforce gender stereotypes for short-term gains. Many past education efforts have perpetuated a predatory, violent, irresponsible image of male sexuality. This must stop. No amount of data on the increase in condom sales as a result of such campaigns is going to convince me that they are not damaging in the long term. Any gains achieved by such efforts are unlikely to be sustained because they erode the very foundation on which AIDS prevention is based: responsible and respectful sexual behavior. We know now that women suffer from the consequences of such an image of male sexuality and masculinity. And men rarely benefit. We have learned that the macho image of masculinity as the man who is always in control puts a lot of pressure on adolescent boys and limits their ability to speak up about their need for more information or about their doubts and fears.

Third, we must not presume that the availability of a service, commodity or information ensures its accessibility equally to women and men. Women's access to services is greatly constrained by a range of factors, including restrictions on their mobility, which make distance an insurmountable barrier, and competing demands on their time, which increase the cost of waiting for care or traveling long distances.

The way to tackle such barriers is to design services that are women-friendly as much as they are men-friendly. This means providing services at times that are convenient for women; integrating services to reduce the time spent waiting for or traveling to multiple services; making condoms and STD diagnosis and treatment available in places where women can access them without fear of social censure; and, whenever possible, providing community outreach services so that distance does not become a barrier to women's use of a service.

In sum, we must do what is in our immediate control—modify existing



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*A village women's meeting in the Ferkol region of Senegal. Women benefit from participating in social support networks where HIV prevention and other critical issues can be discussed.*

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programs to ensure they are gender sensitive. To encourage widespread analysis of programs from a gender perspective, there is an urgent need for practical training tools that can highlight different ways to increase the gender sensitivity of a program and its staff.

**T**hese modifications in existing programs are essential but not sufficient to bring about sustained social change because they do not, for the most part, deal with the larger contextual issues that lie at the root of women's vulnerability to HIV. I am referring to two very important components of power: economic resources and social support.

The standard recommendation for dealing with these barriers is to improve women's socioeconomic status. But what can AIDS programs do about women's economic and social status? First, they can and should explore the possibility of linking up with economic interventions that are already in place, such as credit programs, agricultural extension services for women farmers, women's cooperatives or savings schemes. Linking up means providing AIDS information and services through those channels rather than setting up parallel, vertical programs just for HIV/AIDS. Such linkages ensure the most efficient use of financial re-

sources and of skills. They require collaboration with other non-AIDS groups, including women's groups, and a strong conviction that economic empowerment is essential for sustained, effective prevention.

This is not an impossible dream. People are already experimenting with such expanded AIDS programming. The Zambian National AIDS Program (NAP), with support from the Global Programme on AIDS's Prevention Research Unit, is working in collaboration with a women's group called Women for Change, the YWCA and the Zambian Cooperative Federation to give women fish traders the opportunity to form a cooperative that will provide them with interest-free loans. These loans will ensure that the women have fish to trade without having to provide sexual favors to the fishermen who control their access to fish or the truck drivers who transport them from the urban areas to the fishing depots.

In the Zambian program, the women's group has the institutional expertise to identify gender issues for the design of the program, the cooperative federation has the technical know-how on setting up successful cooperatives, and the NAP has the expertise in AIDS programming. We desperately need more such alliances.

Although the results of this particular experiment are not yet available, we

know that forming cooperatives is also a way for women to gain access to a social support network. From the Women and AIDS program we learned that giving women the opportunity to meet regularly in groups, away from home, gave them much-needed social support from their peers. AIDS programs can enable women to meet regularly for group educational sessions or counseling and in that way offer them a legitimate social support group.

A second way for AIDS program practitioners to influence women's socioeconomic status is to advocate for improvements in women's access to education and productive resources. Because AIDS has fatal consequences for women and entire communities, it tragically provides an opportunity, like never before, to push for policy changes to improve women's social and economic status. And who better than AIDS service organizations and program experts to undertake such advocacy—because improvements in women's social and economic status are essential for the success of all HIV prevention. ■

*Dr. Geeta Rao Gupta is vice president of the International Center for Research on Women (ICRW) in Washington, D.C., where she works on reproductive health projects. This opinion piece is adapted from a speech she gave at the 3<sup>rd</sup> USAID HIV/AIDS Prevention Conference in Washington on August 7, 1995. Entitled "Gender and Sexuality: Implications for HIV Prevention," the speech will be published in full by ICRW.*

# Scientists Search for HIV Prevention Methods Women Can Control

by Nash Herndon

The message has been delivered millions of times, on thousands of posters and brochures, across the air waves and in classrooms and dusty village squares all over the world: Use a condom every time you have sex to avoid becoming infected with HIV. This barrier method remains the single most effective and affordable technology available to protect people from HIV/AIDS and other sexually transmitted diseases (STDs).

Yet for half the world's population, this message is a painfully mixed one. Women who are economically dependent on and socially subordinate to men often lack the power to negotiate condom use with their partners. Male resistance to condom use can be a formidable barrier to women's protection.

The need for prevention options that women can control is becoming more urgent as the epidemic continues to spread rapidly among women. Many experts believe that worldwide, more women than men will be HIV-positive by the end of the century. In some regions, such as sub-Saharan Africa, more women than men are already infected. As with several other STDs, women are more biologically susceptible to HIV infection than men—transmission from an infected man to a woman is easier than from an infected woman to a man.

Giving women new ways to protect themselves from other STDs is important, since STD infections make it easier for HIV to pass from person to person. Also, the medical consequences

of having an STD infection can be more serious for women, leading to pelvic inflammatory disease or infertility. STDs among women are more often asymptomatic than infections among men and are more difficult to diagnose, which could delay timely treatment.

Today the only female-controlled STD prevention strategy is the use of existing barrier contraceptives. The recently developed female condom is not widely available outside Europe and North America, and it is relatively expensive. Spermicides and other barrier methods that can be used without a man's knowledge offer a limited degree of protection. Research is under way to develop a new category of prophylactics called microbicides that would offer better protection against many STDs, including HIV.

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*The female condom consists of a soft, loose-fitting sheath and two flexible polyurethane rings at each end. One ring serves as an insertion mechanism and anchor inside the vagina. The other ring remains outside the vagina after insertion, providing protection to the labia and the base of the penis during intercourse.*

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## Female Condoms

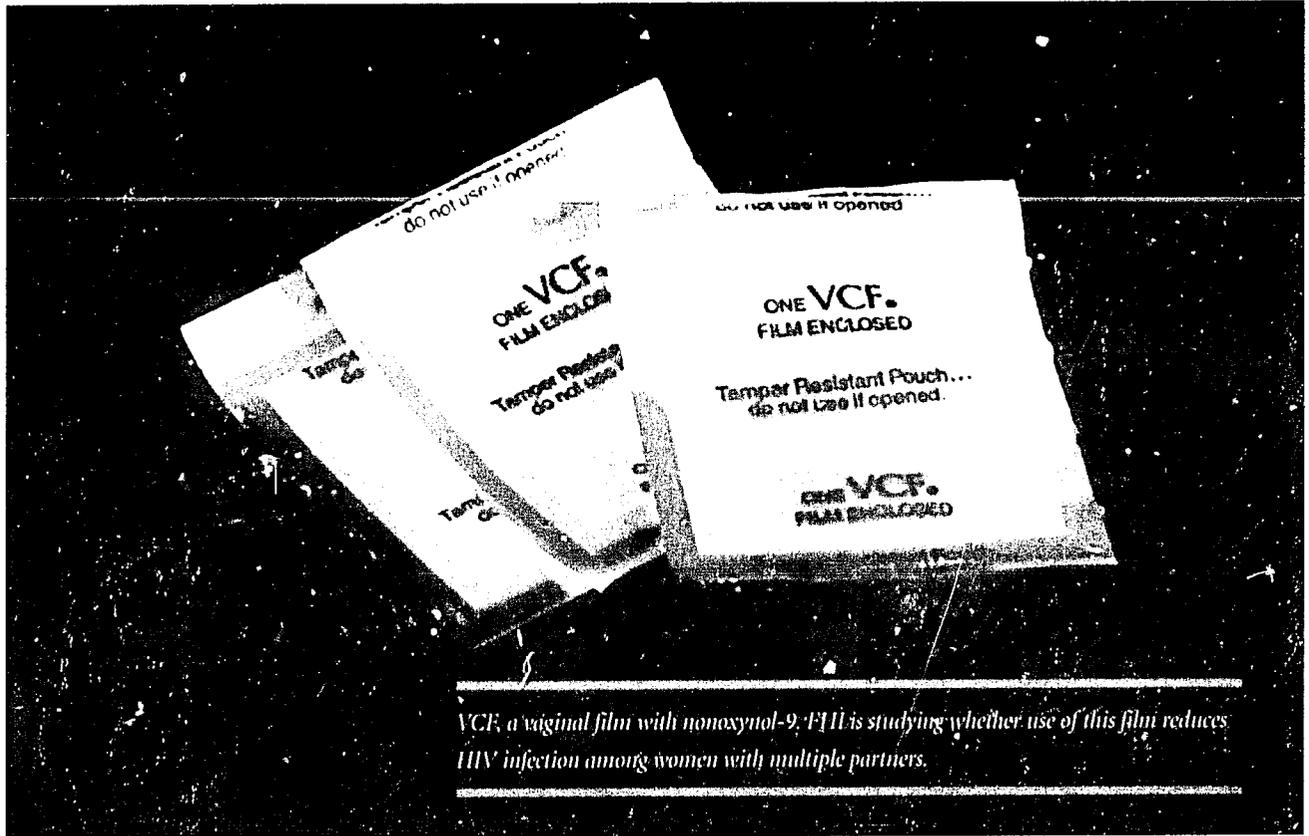
The female condom is one prevention method controlled by the woman who uses it, although some cooperation from a male partner is still necessary. Female condoms are made of a polyurethane plastic that is sturdier than the latex used in male condoms, potentially offering greater protection, less frequent breakage, improved comfort and longer shelf life, even under unfavorable storage conditions.

The device covers the cervix, the vagina, and a portion of the female perineum, as well as the base of the penis. Since it covers much of the external female genitalia, it provides a more extensive barrier and may offer somewhat greater protection than male condoms against genital ulcer diseases, such as herpes and chancroid.

Laboratory studies have found that the female condom is impermeable to

Wisconsin Pharmaceutical





*VCF, a vaginal film with nonoxonyl-9. FHI is studying whether use of this film reduces HIV infection among women with multiple partners.*

various STD organisms, including HIV. The one study involving human use was a clinical trial conducted by Family Health International (FHI) and the Contraceptive Research and Development Program (CONRAD).

In the trial, 104 women who had previously been diagnosed and treated for recurrent vaginal trichomoniasis were assigned to a group using the female condom or to a control group (volunteers who indicated they would not use the condom). After 45 days, reinfection with trichomonas occurred in seven of the 50 controls (14 percent) and five of the 34 non-perfect users (14.7 percent), but in none of the 20 participants who reported perfect use of the female condom.<sup>1</sup>

FHI and the World Health Organization (WHO) will conduct at least one study of female condom use and cervical infection. Until more research is completed, the female condom's ability to prevent STD infection remains speculative, but promising, says Dr.

Paul Feldblum of FHI, who specializes in barrier methods.

### Acceptability

Women in industrialized countries are beginning to use the female condom for protection against STDs. The United States Agency for International Development (USAID) recently provided a limited supply of female condoms to family planning and health programs in 22 developing countries. USAID will carefully evaluate whether to continue supplying them.

But widespread use will depend on users' attitudes. Dr. Feldblum noted that the device was new and unfamiliar to most people. "The female condom may become more appealing with time, as people become more accustomed to the concept," he said.

For six years, FHI has evaluated the acceptability of the female condom among diverse populations. In the clinical trial by FHI and CONRAD, the most frequent complaints were not lik-

ing the inner ring and movement of the device during use. There were few insertion-related complaints, although some women said that it took more than one attempt to get used to inserting the condom. Many women reported that they liked using the device and would recommend it to others.

In another study, 56 Thai couples reported that they found the device to be generally acceptable, but that the outer and inner rings caused an uncomfortable feeling during intercourse. Most of the couples reported decreased sexual satisfaction. Many of the men felt the device was too large. A group of 20 Thai prostitutes reported that the female condom was too long.<sup>2</sup> A second study was conducted with these women using a shorter device, but the overall acceptability improved only marginally.

A study sponsored by the AIDS Control and Prevention (AIDSCAP) Project's Women's Initiative in Kenya and Brazil is investigating women's per-

ceptions of the female condom as a protective method against HIV and other STDs. This research, which began in October 1995, will examine the influence of various social, cultural and economic factors on acceptability and the degree to which women feel use of a female-controlled method increases their power within a relationship.

Cost is another barrier to more widespread use of the female condom. The average price is \$2.50 each in the United States—about five times the price of a male condom. Studies are under way to determine whether female condoms can be cleaned and used more than once. If multiple use is feasible, using the device would be less expensive.

### **Spermicides**

Spermicides are sometimes recommended as a fall-back method when condom use is unacceptable and risky sexual contact is inevitable, since spermicides appear to offer some protection, especially against bacterial STDs.<sup>7</sup> In the United States, for example, the New York State Department of Health recommends the use of a diaphragm and spermicide when abstinence or condom use is not feasible. As a last resort, it suggests that women use a spermicide alone, although this method offers the least protection from infection.

In laboratory studies, the widely used spermicide nonoxynol-9 (N-9) inactivates many STD pathogens, including HIV, Gonococci, chlamydia, genital herpes, spirochetes, candida, trichomonas and organisms causing vaginosis are inactivated by N-9. Since spermicides are designed to kill sperm cells, they should also destroy HIV-infected cells found in the semen of HIV-positive men. How well spermicides work, however, depends on proper dispersal in the vagina and other factors. Also, N-9 is occasionally irritating to vaginal and cervical cells, especially with frequent use, which can increase the risk of HIV infection.

Not enough research has been done to evaluate how effective N-9 use can be in protecting a woman from viral infections like HIV. "How much N-9 coverage is needed is among many important questions that need to be answered," Dr. Feldblum cautioned. "For example, keeping N-9 use below the threshold of causing irritation may actually lower the risk of contracting HIV, while frequent use and tissue irritation may enhance HIV transmission."

With funding from the U.S. National Institutes of Health, FHI is studying whether N-9 vaginal film use reduces HIV infection among women with multiple partners. WHO recently completed safety trials of the film among healthy volunteers in Amsterdam, Antwerp and Bangkok and is planning further studies in two African countries and one Asian country. Benzalkonium chloride and menfegol, spermicides that are widely used in some countries, also have inactivated HIV in laboratory tests, but more research is needed to evaluate their ability to protect against viral infections.

### **Searching for Options**

Scientists are developing vaginal products that may eventually improve upon some of the shortcomings of currently available spermicides. Ideally these chemical barriers would protect a woman against a wide range of infectious agents and viruses, including HIV. Like spermicides, they could be applied vaginally in a gel, film or insert.

Investigators in India are testing the safety and effectiveness of a vaginal cream made from the neem tree that has contraceptive and microbicidal properties. The Population Council is conducting clinical trials to assess the safety of another microbicidal compound. The U.S. National Institute of Allergy and Infectious Diseases (NIAID) recently began three research projects to find topical microbicides that can control the spread of HIV and other STDs. And CONRAD is screen-

ing many compounds for antiviral activity and local tissue safety.

USAID provides much of the funding for microbicide research conducted by CONRAD, NIAID, WHO, the Population Council, FHI and the U.S. Centers for Disease Control and Prevention. These organizations and the Medical Research Council in the United Kingdom are part of an inter-agency working group organized by WHO to coordinate their activities and advocate for greater support for microbicide development. The group has developed models for preclinical research on microbicidal compounds and guidelines for clinical trials.

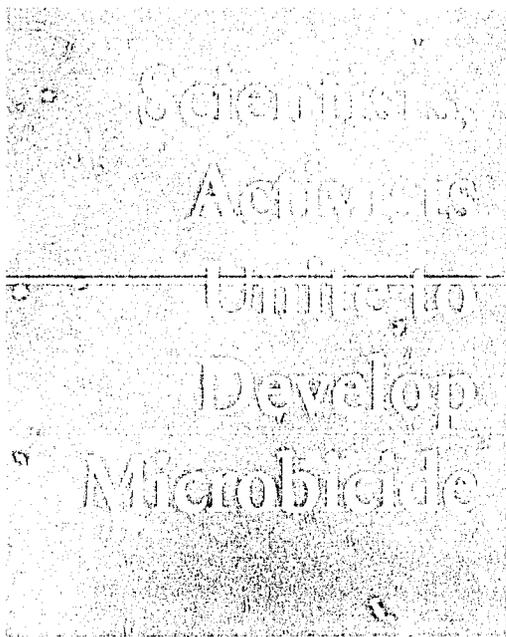
An ideal microbicide would not necessarily kill sperm, making the product attractive to women who want to become pregnant. It could be combined with a spermicide for women who do need contraception.

Many problems need to be resolved, suggesting that it will be years before a microbicide is available for general use. For example, the mechanism for how HIV is transmitted within the female reproductive tract is not clearly understood. Knowing more about the precise ways HIV transmission occurs will help scientists develop such a prophylactic microbicide. ■

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*Nash Herndon is managing editor of FHI's quarterly bulletin, Network.*



For years, women's health advocates and the scientists who develop contraceptives have had what women's health advocate Lori Heise calls a "mutually suspicious relationship."

Advocates charged that scientists were too focused on fertility control, rather than women's reproductive health, and that women were left out of the technology development process. Many scientists, on the other hand, argued that the advocates oversimplified the scientific and ethical issues involved in contraceptive research.

"For a long time, users of reproductive technologies and designers and testers of reproductive technology have been in two separate camps," said Heise, who is co-director of the Health and Development Policy Project and a member of the Women's Health Advocates on Microbicides (WHAM).

WHAM and the Population Council are trying to change that by bringing the two groups together to plan and monitor the development of a microbicide to prevent transmission of HIV and other STDs.

First convened by the Population Council, the International Women's Health Coalition and the Pacific Institute for Women's Health in 1994, WHAM consists of 11 to 12 organizations and individuals. The organizers chose members to represent women's

health networks and grassroots health and women's groups throughout the world, as well as because of their range of technical backgrounds.

WHAM members work directly with the Population Council, reviewing and commenting on plans and study protocols for testing the different microbicidal compounds now under development. But the group aims to have an even wider impact on the reproductive technology development process.

"We're trying to facilitate or catalyze discussion within the broader reproductive technology development field on ways to integrate women's needs and concerns into the technology development process," explained Heise.

WHAM members in different regions keep grassroots organizations informed about the status of microbicide research and solicit their recommendations on how such research should be conducted. They also represent women's concerns by serving on a number of advisory and review committees, including the World Health Organization's Interagency Working Group on Microbicide Development.

WHAM's first meeting in May 1994 gave members an opportunity to orient themselves to the science and politics of microbicide development by talking to scientists and legislators. The group met later in 1994 to develop a three-year work plan and hold a consultation on acceptability studies of microbicidal products.

The consultation and subsequent discussions affected the design and timing of the formulation preference study the Population Council is conducting in five countries, Heise said. WHAM members supported early acceptability research on various vaginal formulations (gel, film and inserts) to learn as much as possible about women's preferences. They also advocated the use of nonoxynol-9—which may offer some protection against HIV—instead of a placebo formulation.

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"For a long time, users of reproductive technologies and designers and testers of reproductive technology have been in two separate camps."

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WHAM and the Population Council are organizing a symposium in 1996 to help incorporate users' perspectives into the design of microbicide efficacy trials. Attention to the ethics of clinical trial design is particularly important because women who are most vulnerable to HIV infection are also extremely vulnerable to exploitation.

Grappling with the challenges involved in designing a scientifically rigorous, ethically sound clinical trial has fostered a new understanding between clinical researchers and women's health advocates, according to Heise. "When you really try to engage in struggling through an intellectual challenge together, that builds respect," she said. "I've seen real growth in mutual respect on both sides."

Heise believes both sides are learning from the process. Women's health advocates are challenging themselves to go "beyond critique" and become more sophisticated about the complexities of science, while the scientists are becoming more "in tune with the equally complex and totally different reality of women's lives in different parts of the world."

This dialogue between WHAM and the Population Council could serve as a model for greater collaboration among scientists, industry groups, and consumers and their advocates. "The larger potential of the process is a whole new way of going about technology development," Heise said. ■

—Kathleen Henry

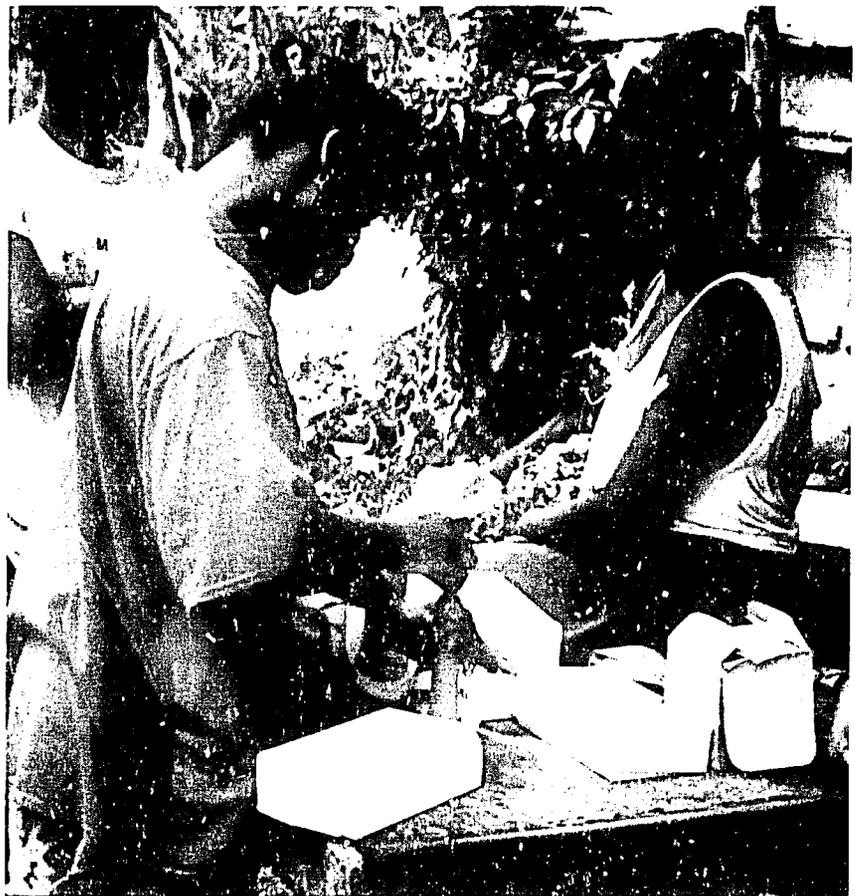
# HIV Prevention and Family Planning Integration Improves Client Services in Jamaica

by Peggy Scott, FAMPLAN  
and Julie Becker, IPPF/WHR

*A FAMPLAN rural outreach worker demonstrates correct condom use to a client and her neighbor. FAMPLAN staff members found that demonstrating condom use with models encouraged clients' participation in educational sessions.*

Throughout the world, many women have no contact with an organized health system except an annual visit to a family planning clinic. Family planning programs offer ideal opportunities to reach an important population at risk of HIV infection — sexually active women of reproductive age — with assistance in preventing HIV/AIDS and other sexually transmitted diseases. But can family planning programs offer comprehensive reproductive health services? Some affiliates of the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR), have accepted that challenge. Peggy Scott of the Jamaica Family Planning Association (FAMPLAN), Julie Becker of IPPF/WHR and Rita Badiani of the Family Planning Association in Brazil describe their organizations' experiences with integration.

Julie Becker/IPPF-WHR



Two years ago, few clients of the Jamaica Family Planning Association (FAMPLAN) used condoms. Counselors rarely mentioned condoms to their clients, except as a back-up contraceptive method.

Today, FAMPLAN staff distribute hundreds of condoms every day, and many clients are using two family planning methods: pills or another method for contraception and condoms to prevent HIV and other sexually transmitted diseases (STDs).

This new interest in condoms—and preventing HIV—is the result of a FAMPLAN program that integrates HIV and STD prevention into all clinical and community services. With technical and financial assistance from the International Planned Parenthood Federation/Western Hemisphere Region through financial support from the U.S. Agency for International Development (USAID), the program is designed to promote sexual behavior change, increase condom use, and improve STD diagnosis and treatment.

### **A New Model**

In Jamaica, as in other parts of the world, HIV and other STDs are a grow-

ing threat to family planning clients. Many married women and women in other kinds of long-term relationships are becoming infected, often by their husbands. During the past five years, the male-to-female ratio of AIDS cases reported to the Pan American Health Organization dropped from 2.5 to 1 to 1.3 to 1.

Recognizing the increasing vulnerability of Jamaican women to the epidemic, FAMPLAN launched an integrated program in October 1993. The goal was to create a permanent change in the way family planning services were provided, rather than a short-term, isolated project. But since integration of STD prevention into family planning was something new, we faced many unanswered questions. Would the staff be willing to learn new skills? How receptive would our clients be? Would they be willing to even discuss HIV and STDs? Would integration compromise the quality of our family planning services?

Before the program began, staff members from the IPPF/WHR HIV/STD Prevention Program conducted a training needs assessment that included formal and informal discus-

sions with FAMPLAN management, clinic staff and outreach workers and on-site observations of staff-client interactions. This assessment revealed that safe sex practices were not promoted in FAMPLAN services and counselors did not address sexual behavior change. Counselors seldom presented condoms as a family planning option or as a method to be combined with others. None of the staff members showed clients how to use condoms.

We also learned that FAMPLAN nurses had minimal knowledge of STD signs and symptoms and had difficulty distinguishing STDs from other infections. No referral system was in place for STD testing or treatment.

The findings of this baseline assessment provided the information needed to develop staff training curricula. All staff, including drivers, support staff and others who usually do not provide direct client services, were trained in HIV/STD education and counseling skills. Initial two-day training sessions focused on HIV/STD prevention information and basic counseling skills. More in-depth training in sexuality, sexual health, and education and counseling skills was provided at a later date.

Julie Decker, IPPF/WHR



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*A rural outreach worker and supervisor talk to a young man about HIV/STD prevention as they provide door-to-door outreach. Integration of family planning and HIV/STD prevention has enabled FAMPLAN to reach more men.*

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## Integration in Action

FAMPLAN has integrated HIV prevention and safe sex counseling into all its services, which include family planning clinics, rural outreach, and programs for factory workers, migrant workers and youth. FAMPLAN's HIV/STD project coordinator facilitated the process through continuous staff training and appraisal. She also conducted focus groups with current and potential male and female clients to learn about their knowledge of contraception and HIV/AIDS prevention and their attitudes and sexual practices.

Under the integrated program, individual and group counseling is offered to inform clients and build skills. Nurses and counselors help clients explore their sexual lives and relationships with partners, determine their own risk and develop safe sex negotiation skills. When they present a family planning method, counselors explain whether it offers any protection from STDs and emphasize the importance of using condoms with each method.

All clients learn how to use a condom and are asked to demonstrate how to put one on a penis model. FAMPLAN staff members found that demonstrating condom use with models encouraged clients' participation in educational sessions. Rural outreach workers report that now that they use models, word spreads quickly and people gather round to hear what they have to say. "I'm so happy since I got this penis model," one counselor said. "I just love to walk with it!"

Clients also receive a free sample of two condoms and learn where to purchase additional supplies. A promotional condom package developed by FAMPLAN promotes the dual benefits of condoms—protection against pregnancy and STDs—as well as dual method use, or the use of condoms with other family planning methods. Condom distribution has been expanded in rural areas by training shopkeepers and other well-known community members to complement

the educational services provided by outreach workers.

To improve diagnosis and treatment of STDs that can increase the risk of HIV transmission, FAMPLAN clinic staff have been trained to recognize signs and symptoms of STDs, and treatment and referral procedures are being developed. Clinic staff members treat STDs using the syndromic management approach recommended by the World Health Organization, which involves treatment without a laboratory diagnosis based on a physical examination and a patient's reported symptoms. Laboratory diagnosis is used to complement the syndromic approach when needed.



The goal was to create a  
permanent change  
in the way  
family planning services  
were provided.



FAMPLAN is also developing procedures to help staff identify women with potential asymptomatic infections through risk assessment. Since insertion of an intrauterine device (IUD) puts women with untreated STDs at increased risk of pelvic inflammatory disease, the risk assessment procedures will be particularly important for determining which clients should be screened for STDs or treated prophylactically prior to IUD insertion.

## Meeting Challenges

Initially, convincing some staff members of the importance of integration was difficult. We emphasized that rather than asking them to take on ad-

ditional duties, the program was meant to change the way services were provided. Instead of simply dispensing family planning methods and explaining how to use them, FAMPLAN staff would provide a more comprehensive reproductive health approach to client services. Participatory exercises, such as role plays, helped staff members feel more comfortable discussing sexuality and recognize their personal and professional biases against condoms.

Some rural outreach workers found that when they integrated HIV/STD prevention into their work, they were unable to reach as many clients because of the additional time needed to do counseling. We assured them, however, that the increased quality of services compensated for the small drop in client numbers.

We also emphasized that if counseling begins with an understanding of the sexual lifestyle and circumstances of a client, it can help a counselor determine what information is most relevant to that client. It might not be necessary, for example, to spend a great deal of time explaining the details of all methods. Therefore, changing the focus of a counseling session from an explanation of family planning methods to an exploration of the sexual health needs of a client can actually save time as well as improve the quality of the counseling.

The greatest barriers we face are the cultural barriers to sexual behavior change. Most women are unable to convince their partners to use condoms for fear of having their fidelity questioned—a moral double standard in a country where it is widely acknowledged and even accepted that men often have more than one sexual partner.

These barriers can only be overcome through continual face-to-face interventions. A family planning counselor can help a client strategize about responses to arguments against condom use, help her think about the best time and place to bring up the subject, and help empower her to refuse unsafe sex.



Julie Becker, IPPF-WHR

*FAMPLAN staff members concentrate on a participatory exercise during a training session on sexuality and counseling skills.*

Safe sex is defined as sex that is not only safe from HIV/STD transmission, but also from unwanted pregnancy and the abuse of power.

### **Two Methods?**

FAMPLAN staff were not alone in their reservations about integration. Other family planning professionals have questioned our integration efforts, fearing that a shift from long-term methods to condom use might threaten the reductions in fertility rates Jamaica had achieved. To ensure that these gains are not reversed, FAMPLAN stresses correct condom use. We have found that most clients, both male and female, do not know how to use condoms correctly, which we believe contributes greatly to their reported low levels of effectiveness.

FAMPLAN also actively promotes dual method use. Although many family planning experts doubted that clients would use two methods at once, nurses at both FAMPLAN clinics report that an increasing number of women are asking for condoms along

with their regular family planning method.

### **Integration Works**

By mid-1995, FAMPLAN's integrated program had reached approximately 20,000 people. Condom distribution skyrocketed after the program began. In 1994, we distributed 213,000 condoms—up from only 60,000 in 1992.

Outreach workers report that there is more awareness of the need for safe sex. As one client puts it: "I never used anything before, but now I can't take a chance." Another client said that if her husband did not use a condom, then "no sex."

Integration has also enabled FAMPLAN to reach more men. Most of our clients are women who often say that we should talk to men directly. More and more men are now finding their way to our clinics to purchase condoms for protection against AIDS and other STDs. "This thing is spreading too rapidly," one man said. "I have to protect myself."

Despite their initial fears, FAMPLAN staff found that integration actually improved the quality of family planning services. Staff capacity to counsel clients has been greatly enhanced, particularly in their ability to discuss the relationship between family planning methods and HIV/STD transmission and to help people develop safe sex negotiating skills.

FAMPLAN staff once believed that it would be difficult or even impossible to discuss sexuality openly with their clients. In fact, when asked sensitively, clients are often relieved to have an opportunity to express their concerns and fears about their partners' behavior. Many clients welcome the opportunity to get information about HIV and other STDs and to explore their personal risk.

*Peggy Scott is chief executive officer of the Jamaica Family Planning Association. Julie Becker coordinates the International Planned Parenthood Federation, Western Hemisphere Region's HIV/STD Prevention Program.*

## Group Dialogue Empowers Brazilian Women

***"After fighting many times, I got my husband to use a condom.***

***I screamed and wailed. I told him that his penis was  
thicker and more pleasurable [with a condom].***

***He has been using condoms now for three  
months. Now I feel more secure  
and indeed feel pleasure."***

As this Brazilian woman's experience demonstrates, it is difficult for many women to talk to their partners about condoms—but not impossible. Discussing their concerns with other women and practicing ways of communicating with their partners can help women gain the confidence and skills they need to negotiate safer sex.

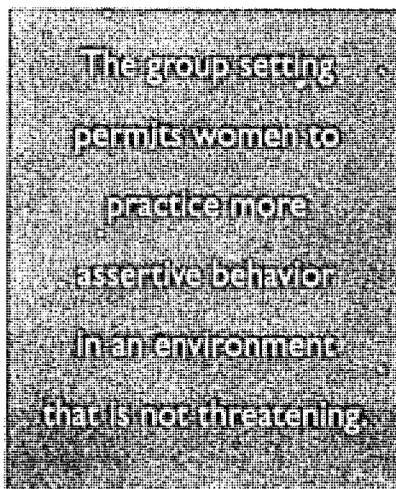
This woman's successful negotiation with her husband came after she had participated in three group discussions at one of the clinics of the Sociedade Civil Bem-Estar Familiar no Brasil (BEMFAM). The major nonprofit family planning and reproductive health provider in Brazil, BEMFAM offers these group sessions as part of a larger project that includes integration of HIV/STD prevention with clinical services, school-based and community-based prevention projects, and STD diagnosis and treatment.

BEMFAM developed its integrated project in response to the rapid expansion of the AIDS epidemic among Brazilian women during the early 1990s. The male-to-female ratio of reported AIDS cases in Brazil was 9 to 1 in 1987, but by 1994 it was 4 to 1.

The project began in 1991 with formative research and a pilot intervention. Funded by the U.S. Agency for International Development's

AIDSTECH and AIDSCOM projects, this research and pilot phase included interviews with BEMFAM clients and tests of a group intervention approach with women attending a BEMFAM clinic and a community health post in Rio de Janeiro.

Two issues emerged from the research that would be central to the development of interventions. First, although women know how HIV is transmitted, those who are married or in consensual unions do not perceive themselves to be at risk. Women believe that if they stay with one partner, they will be protected. Second, women do not talk to partners about sexuality and condoms because they are afraid of raising questions about fidelity. Con-



dom use within a relationship is only considered appropriate for pregnancy prevention.

During the pilot intervention, participants expressed a need to continue sharing experiences. They felt that the group discussions had positive repercussions on their lives, helping them become more conscious of the importance of preventive health practices.

BEMFAM responded to these needs by developing a women's group intervention project to facilitate dialogue about sexual health. With support from IPPF/AVIIR, the Women's Project began in 1993 in the states of Rio de Janeiro and Pernambuco. It was later expanded to the state of Rio Grande de Norte and, through the support of the Ministry of Health, to the state of Maranhão.

All women who attend each clinic on a given day are invited to participate in a one-hour group discussion with eight to 15 participants before receiving medical services. Almost all clients who are invited agree to participate. Groups are facilitated by a BEMFAM staff member who has received special training.

Two novela-style booklets developed during the research phase—*Acorda Adelaide* (Wake Up, Adelaide!) and *Conversando é que a Gente se*



*Acorda Adelaide*

*(Wake Up, Adelaide!)*

*a novela-style booklet with characters and stories women can relate to their own lives, helps stimulate discussion about sexuality, relationships and HIV/STD prevention.*

STDs they contracted from their husbands. They often address their fears about raising the subject of condom use with their partners. Participants also express indignation at their own and other women's submissive attitudes toward sexual relations. While some women's comments confirm this submission to male dominance, others are able to assert their independence.

These group discussions have a different effect from individual counseling. The group setting permits women to gain confidence and practice more assertive behavior in an environment that is not threatening. It also gives them an opportunity to share their life stories, which helps them recognize that they are not alone in their feelings. This identification with others' experiences empowers women to take control of their health and sexual lives.

Behavior change is a difficult process, but we are already beginning to see positive results. Some women report that they intend to talk with their partners, that they believe they have the skills to do so, and that they intend to use condoms correctly.

From October 1994 to July 1995, 3,464 clients participated in group discussions and 40,688 condoms were distributed. Almost three out of four participants accepted condoms offered after the group session. Approximately 18 percent returned to the clinic for additional condoms. ■

—Rita Badiani and Julie Becker

*Rita Badiani is coordinator of BEMFAM's Planning Department and its Women's AIDS Prevention Project.*

*Entende* (Communicating for Better Understanding)—help stimulate discussion. The booklets use stories and characters that clients can relate to their own lives. In one, a condom breaks because the couple doesn't know how to use it properly. In another, a woman convinces her partner to put on a condom by offering to try erotic ways of using it.

All participants learn how to use condoms correctly by putting them on

realistic penis models. They anticipate situations in which they would be able to discuss and negotiate condom use with their partners. Facilitators stress the importance of condom use for HIV/AIDS, but also help women recognize the importance of taking care of their broader reproductive and sexual health needs.

In the group discussions, women talk about faithfulness and unfaithfulness, lack of sexual pleasure, and the

# Women and AIDS Care: Coping with “Triple Jeopardy”

by Kathleen Henry

A woman dies alone in a crowded rural hospital, abandoned by her husband and family because she is infected with HIV.

A mother waits to hear the results of a test that will tell her whether she has passed the AIDS virus to her newborn child.

A grandmother struggles to feed her five grandchildren, who have already lost their mother to AIDS, while caring for their bedridden father.



Karen Kasmauski

*This Ugandan villager, attended by a home care worker, does not have long to live.*

These women illustrate what the Society of Women Against AIDS in Africa calls the “triple jeopardy” of HIV/AIDS for women. As individuals, they are at risk of infection because of a host of biological, social and economic factors that make women particularly vulnerable to HIV. As mothers, they can infect their children with the virus. And as society’s traditional caregivers, they are expected to care for husbands, sons and other family members with AIDS while somehow finding a way to support their families.

Women’s needs for care and support as people living with HIV/AIDS and as the main providers of care for those with HIV/AIDS already exceed the resources available from families, communities, nongovernmental orga-

nizations (NGOs) and governments. During the next five years, this gap could widen as more and more of the 15.5 million living people infected with HIV—including at least 6.5 million women—develop AIDS.

## **What Is Care?**

Too often AIDS care is narrowly defined as expensive antiviral therapy with AZT and other drugs that are not available to most people in the developing world. The World Health Organization (WHO) proposes a much broader definition of care that includes clinical management of illnesses resulting from HIV infection, nursing care, counseling and social support. These services should be offered across a “continuum of care,” from home and

community to hospital, linked by strong referral networks.

Even in industrialized countries, some of the most effective interventions for prolonging and improving the quality of life for people with HIV are “low tech.” In the United States, for example, AIDS program personnel say the most important services they provide for people living with HIV/AIDS are education, counseling, advocacy and social support, which can include everything from being a sympathetic listener to practical assistance with housing problems.

Support from relatives, friends or volunteer “buddies” can reduce stress, which may prolong life. Nutrition guidelines, assistance in quitting smoking, and guidance on how to avoid in-

*This young AIDS patient receives home care from TASO, The AIDS Support Organization of Uganda*



J. Stettin/our SABA

fections that will assault an already weakened immune system also can help people with HIV/AIDS live longer, healthier, more productive lives.

Following such guidance is difficult when a person is too sick to work and cannot afford the appropriate food or when safe water is not available. But even in the poorest settings, families and communities can help people with HIV maintain nutrition and hygiene. Prompt and appropriate treatment of the common illnesses that affect people with HIV/AIDS, such as diarrhea, tuberculosis and bacterial pneumonia, also may be feasible in such settings.

Given the limited funding available for HIV/AIDS, most donors concentrate on prevention rather than care. But many working in the field believe that the most effective prevention programs are integrated with care and support services. Such integration enables programs to reach people living with HIV/AIDS and help them avoid passing the infection on to others. It also involves HIV-positive people—who are often the best educators—in prevention and makes prevention efforts more credible.

“Care is a value in itself and also a vehicle for prevention both before and after infection,” said Dr. E. Maxine Ankrah, senior advisor to AIDSCAP’s Women’s Initiative.

### **Giving and Receiving**

In many developing countries, women are more likely to have some contact with the health care system than men because they visit clinics for antenatal, family planning and well-baby services, according to Dr. Sandra Anderson, a nurse-scientist in WHO’s Health Care and Support Unit. But access to all kinds of health services—particularly HIV/AIDS care—is limited for women and men for many reasons, including a lack of trained staff and shortages of essential drugs at health centers.

The stigma associated with HIV/AIDS also limits access to care and affects the quality of the care available. People are reluctant to go to their nearest health post because they do not want their neighbors to know about their HIV status, and many health workers are afraid to tell people who do seek treatment that they are infected with HIV.

“You need staff who understand something about the diagnosis and treatment of HIV-related illnesses, but they also have to have openness, confidence and a positive attitude to talk about this disease,” said Dr. Anderson.

The stigma against people with HIV/AIDS is “relentless,” she added. “Even in countries that have been coping with this epidemic for nearly a decade, the stigma remains discouragingly high.”

That stigma may make it particularly difficult for women to seek care, Anderson said, citing the example of a woman who brings her baby to a clinic and finds out they are both HIV-positive.

“That’s when terrible difficulties in her life begin that make her wish she had never gone for health care,” Dr. Anderson said. “The chances that she is going to be blamed for bringing this illness into the family are very high.”

Even in their homes and communities, women with HIV/AIDS may have no one to care for them. Some women are sent back to their relatives to die or are abandoned by their families. Ugandan women with AIDS told research-



*Meheranissa, a former child prostitute dying of AIDS in an Indian hospital, receives care from her HIV positive mother.*

ers that when their husbands became sick, it was their duty to ignore their own suffering and care for the men.

Many studies have shown that women bear most of the responsibility for AIDS care. For example, in a recent pilot program at Kenya's Kenyatta National Hospital that identified a caregiver as part of an AIDS patient's discharge plan, only three of the 42 caregivers were men. Some men do provide care for women with HIV/AIDS, but it is usually considered "women's work."

Dr. Elizabeth Ngugi of the University of Nairobi attributes the inequity of the AIDS care burden to patients' preferences as well as to society's expectations. Women contribute to the problem because many automatically assume the role of caregiver in addition to their other responsibilities as mothers, wives and wage earners. Many have become the sole economic support for their families.

"Because of the woman's readiness to take on that role, then the tendency is to give her more and more, overburdening her with the activities," Dr. Ngugi said.

### Caregivers' Needs

"First of all, women who are going to be caregivers need information," said Dr. Anderson. This information includes how to care for a person with HIV/AIDS, where to go for medical assistance and how to take simple precautions to protect themselves from becoming infected. It also involves reassurance to counteract their fear of what they think is a very contagious disease.

Caregivers also need to know that they can take care of someone with HIV/AIDS openly, without condemnation from neighbors and friends. "They need a climate of acceptance and even one of reward," Dr. Anderson said. "Exactly what they don't need is to be stigmatized because they are willing to be the caregivers."

Counseling and emotional support are important for AIDS caregivers, whose pain at the prospect of losing loved ones to AIDS may be mixed with fear, shame and anger. Many are HIV-positive themselves and worry about what will happen to their children when they die.

Some of these concerns can be ad-

ressed through social support, such as assistance in drawing up wills or help with school fees. Many NGOs offer training, support groups and respite care. Some also provide financial subsidies or help families start income-generating activities, such as raising chickens or growing flowers to sell in the market.

### Cost and Responsibility

Home care has been touted as the most effective as well as the most economical way of caring for people with HIV/AIDS. It can improve the quality of care by giving people an opportunity to continue living in their communities and allowing them to die with dignity. However, many fear that home care is simply a way for governments to assign the cost of AIDS care to communities—particularly women.

"There's a very popular notion out there that you shift the responsibility from the public sector into the household," said Quarraisha Abdool Karim, South Africa's national AIDS program coordinator, who believes that this idea is misguided.

Many families want to care for their

sick relatives at home, but find themselves overwhelmed by the physical, financial and emotional demands it entails, Dr. Ngugi said. "They are really willing to share what they have, but there is a limit," she said.

One solution is to send mobile teams of health workers and counselors to people's homes to support caregivers. In Uganda, for example, Kitovu Hospital's mobile clinic program provides training, counseling, and sometimes food and medicine to people caring for AIDS patients in their homes.

Such programs have had to change because the growing number of people with HIV/AIDS makes it impossible for hospital staff to visit the homes of all who need support, according to Dr. Anderson. A more realistic model is now used by Kitovu, which sends a team of specialists to a local club or other central place in a town twice a month to give caregivers advice and assistance. In Zambia, Monze Hospital's outreach staff trains and monitors health workers and groups of volunteers who support AIDS caregivers in their homes.

"Countries and programs are looking at more sustainable programs that still can give some kind of support to those caregivers who are on the front line," Dr. Anderson added. "They are mobilizing the people who are right there at the grassroots—the neighbors, members of religious organizations, the youth group."

Government health services and nongovernmental organizations are beginning to train village health workers in the skills they need to help people cope with AIDS. The AIDS Service Organization (TASO) in Uganda, for example, has extended its services for people living with HIV/AIDS and their families through the TASO Community Initiative. Under this program, TASO trainers help community leaders form a village AIDS committee and identify community needs and objectives. Community AIDS workers cho-

sen by local leaders and trained by TASO conduct formal and informal educational sessions with groups and individuals, visit homes to provide counseling and assistance with care, distribute condoms and refer people for HIV testing and medical treatment.

In India's Manipur State, 25 NGOs, the Health Department and the Regional Institute of Medical Sciences are collaborating on a project designed to provide comprehensive care to people living with HIV/AIDS. Funded by WHO and OXFAM, the Continuum of Care Project is training hospital, health center and NGO staff in AIDS care and support and is creating referral net-



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The stigma against  
people with HIV/AIDS  
is relentless.

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works among participating institutions to ensure medical and counseling support for home- and community-based caregivers.

As with home care, community-based programs should be seen as a way to extend and improve care, not as a substitute for public health and social services. "We must be careful that the endeavors of voluntary support systems do not allow the inadequacy of public services to go unnoticed," Dr. Ankrah said.

Government's role, according to Abdool Karim, is "to make resources available to support and facilitate community responses." These resources include a strong primary health care system for referrals, training and supervision of community health workers, and funding for community groups and other NGOs.

## Partnerships

As the number of AIDS cases and deaths rises, the challenge is finding a balance between quality of care and coverage. Dr. Anderson notes that governments can provide services to more people but the quality of care is often poor, while NGOs tend to offer high-quality care but low coverage.

"What you really want to try to do is to find a minimum level of quality with the most coverage possible," she said. "We need to know how to provide the best to the most with the least resources."

Many programs have had to scale down their programs in order to sustain assistance. For example, instead of trying to pay the school fees for a limited number of orphans to go all the way through school, Nsambya Hospital in Kampala, Uganda, now serves more orphans by ensuring that they get basic literacy and mathematical skills and some vocational training.

Another way to keep pace with the growing demand for AIDS care and support is to adopt a more multisectoral approach to providing the mix of services required, with each sector responding to the needs it is best equipped to meet. Governments can strengthen primary health care systems and create referral links with other public programs such as social services, agricultural extension and education. Businesses can give employees time off to care for the sick, and NGOs can provide social support and income-generating opportunities. All of these groups should work closely with people living with HIV/AIDS to fight the stigma associated with the virus.

This approach takes careful coordination and a willingness to work together. "AIDS forces us to be good partners with many people," Dr. Anderson said. "It requires all the different areas and sectors to come together and contribute." ■

# Mother-Child HIV Transmission: Prevention Options for Women in Developing Countries

by Halima Shariff, AIDSCAP/Tanzania

*I am getting married next month, and I am so eager because I know I will have children. That is what I have always wanted. But I am also afraid of AIDS. What if one of us has HIV? (Anastasia, 19)*

*My partner is unconcerned about my serostatus. I have told him over and over again I have the virus. But he never believed me and insisted on having a baby. Now my child is dying of AIDS. (Christine, 34)*

Anastasia and Christine,\* both from Tanzania, are at two very different stages of their lives, yet share a concern that is nearly universal for African women: motherhood.

Throughout the continent, most women want to have children, who are considered essential to self-fulfillment and family happiness. A childless woman can become an object of pity—vulnerable to abuse or abandonment by her male partner—for whom only the most tenuous social role exists.

But now the desire for children competes with a new concern: fear that a newborn may be infected with HIV. The virus that causes AIDS can be passed from mother to child, either *in utero*, in the birth canal, or postpartum

through breast milk. It's estimated that by the year 2000, as many as 10 million children worldwide could be infected with HIV—most through mother-child transmission—and more than 90 percent of them will live in developing countries.

In Africa, perinatal transmission occurs in an estimated 30 percent of births to HIV-infected women. With seropositivity rates among women of reproductive age as high as 30 percent in some regions of Tanzania, the next decade may see

growing levels of mother-child transmission that could overwhelm health resources and threaten recent national improvements in child survival rates.

Strategies to prevent perinatal transmission of HIV continue to be developed, yet the cost of implementing them can be a serious roadblock for developing countries. Throughout the 1980s, in fact, many believed that maternal prevention was the only affordable response for poorer countries. Now, public health experts and physicians are seeking ways to make new developments in perinatal transmission prevention available to women in the developing world.

## Education, Testing and Counseling

Perhaps the most fundamental barrier to stemming mother-child transmis-

\*Both names have been changed to ensure confidentiality.

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*A Zambian woman and her child, both infected with HIV, lie together in a hospital bed.*

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Ron Gillog/PANOS

sion in countries like Tanzania is the difficulty in getting accurate basic information about HIV to women, particularly those outside of urban areas. Unless they're specifically designed to address women's needs, even widely circulated HIV prevention messages often bypass women.

"Many women are still ignorant about the disease, even though AIDS awareness nationally is high," said Dr. Xavier Karlenza of WAMATA, a nongovernmental organization based in Dar es Salaam, Tanzania's capital.

Testing and counseling women who are HIV-positive would give them the knowledge to make decisions about whether and how to give birth, helping them understand how to lower the odds that their babies might also become positive. Unfortunately, testing is very expensive, and medical personnel generally test only women who exhibit symptoms of HIV infection, when and if they seek treatment at clinics. Counseling programs are rare in Tanzania and much of sub-Saharan Africa, particularly in rural areas. Some nongovernmental organizations and medical facilities offer maternal counseling, but it is not widespread enough to serve all the women who need it.

Structural problems also limit action that HIV-positive women can take, once they know their status and are aware of the risks of maternal transmission. Abortion is illegal in Tanzania and many other African countries. Women who choose to terminate their pregnancies must either have enough money to go discreetly to private doctors or be able to convince a doctor to rule the procedure medically necessary



J. Gubb WRIO

*A woman and her baby in the waiting room of an antenatal clinic in Tanzania.*

in order to get a free or inexpensive abortion at a public clinic. Contraception to avoid further pregnancies can be difficult to get and sometimes prohibitively expensive for poor women.

### **Dealing with Denial**

But even for women who have access to testing and counseling, knowledge is not always power. Financial dependence on men and traditional gender roles may deprive HIV-positive women of the ability to make decisions about childbearing and health.

Christine is a mother of three who lives on the outskirts of Dar es Salaam. Unemployed, she is involved in her second relationship since her husband died of AIDS in 1988.

"I was diagnosed HIV-positive three years ago, but because I still look healthy I've found it so difficult to con-

vince my lover that I have the virus," she said while breastfeeding her 18-month-old daughter, who also tests positive. "I regret that I became pregnant, but what could I have done, when this man insisted on having a child with me to cement our relationship?"

Christine's concerns about transmission of HIV were not enough to override her boyfriend's insistence that she become pregnant. His denial of the risks involved for Christine and their child—and of the need to use condoms both as protection for himself and as contraception—displays a widespread problem for counselors in Tanzania.

"Denial compels people not to acknowledge their vulnerability," said Dr. Karlenza. "Even after counseling, accepting change in life-style and sexual behavior must come from within a person."

Women determined to give birth may also avoid the truth about perinatal transmission. Asha Mruma, a counselor from the city of Arusha, encounters a great deal of denial from some of the HIV-positive women she tries to help. One woman she counseled several times was adamant that no harm could come to a child she conceived.

"All she wanted was to have a baby," said Mruma. "She did not want to see the danger of possible infection of her child after delivery simply because she was feeling well and strong."

Because women's status and role in African societies are so closely linked to the powerful cultural imperative of motherhood, denial will continue to be a barrier to preventing mother-child

transmission. Improving and increasing basic HIV education to the public—particularly the message that just because you look healthy doesn't mean that you're not infected—is one solution to the popular misconceptions that feed denial about HIV infection.

### **Breastfeeding**

A critical and much contested issue that has preoccupied counselors and public health professionals is whether to advise women in developing countries against breastfeeding because of the risk of HIV transmission through breast milk.

Estimates of likelihood of HIV transmission from breast milk range widely, from as low as 16 percent to as high as 60 percent. It's difficult to assess risk from breast milk because testing does not clearly reveal whether the virus was transmitted prenatally, during the birth itself, or later through breastfeeding. Recent research has shown that the chance of transmission through breast milk rises if the mother contracts the virus after rather than before she becomes pregnant, possibly because the rate of virus replication is higher in the early stages of infection. Other studies have examined the possibility that prolonged breastfeeding lasting more than a year may be riskier than shorter-term breastfeeding.

Breastfeeding has long been promoted in the developing world because it dramatically reduces infant morbidity and mortality. Breast milk contains important nutrients and immune factors not found in baby formula. And in parts of the world where clean, safe water is not available for mixing formula, breast milk saves children from many infectious diseases and malnutrition. Breastfeeding also benefits poor families.

"In many developing countries, where annual incomes are so low, the cost of infant formula is prohibitive,"

said Dr. Andrea Ruff of the Johns Hopkins School of Public Health. "The overall health and well-being of families would be compromised if they had to buy formula, and the infants themselves might be fed less in order to make the formula go further."

The World Health Organization advises pregnant women in regions of the world where infectious diseases and malnutrition are primary causes of death for infants to continue to breastfeed, regardless of their status. In regions where this is not the case, infected women are advised against breastfeeding. Counselors in Tanzania encourage their clients to breastfeed, no matter what their status is.

### **Zidovudine (AZT)**

This antiretroviral drug has been shown by the AIDS Clinical Trials Group to reduce perinatal transmission by two-thirds if given to women before, during and after delivery. Because of these dramatic findings, the U.S. Public Health Service created new guidelines for health workers recommending AZT for HIV-positive pregnant women in the United States.

Unfortunately, AZT is far too expensive for widespread use in Tanzania and other developing countries. But researchers are planning clinical trials in Thailand, Côte d'Ivoire and Haiti to test the efficacy of less costly short-term regimens during different stages of pregnancy and delivery.

"We're interested in finding out whether a shorter course of AZT during labor itself will lower the risk of transmission," said Dr. Ruff of Johns Hopkins, which will conduct the Haiti study in early 1996. "We'll also investigate whether a shorter course during the first couple of weeks of breastfeeding, when the infant ingests the colostrum loaded with the mother's antibodies, might also be effective."

Another antiretroviral drug, nevirapine, rapidly lowers the viral load and is also being investigated for use by pregnant women. It could be produced and administered at less cost than AZT, although its manufacturer does not appear to be interested in producing the drug for developing country use.

### **Cost-conscious Interventions**

The most affordable interventions are those that can be delivered to all pregnant women without the need for expensive testing. A 1994 study from Malawi shows greater risk of perinatal transmission in women with Vitamin A deficiency, although it is not yet known whether Vitamin A actually prevents transmission. Vitamin supplementation against disease is already part of the health promotion strategy in many developing countries.

Vaginal lavage—cleaning the birth canal—is a simple method of lowering HIV transmission risks during birth. Some concerns include the possibility that certain chemical cleansing agents may damage the fetus and irritate the mother's genital mucosa and should be avoided.

Mother-child HIV transmission is a serious threat to the future of developing countries where the epidemic is severe. As HIV/AIDS researchers continue to study perinatal transmission and discover new ways to prevent it, public health specialists and policy makers must also find ways to make new knowledge and treatments available and affordable for women and health care systems in developing countries. ■

*Halima Shariff is an AIDSCAP program officer based in Tanzania.*



Photo: Stuart Black Star

*A young couple in Cambodia. Workshop participants agreed that HIV prevention programs for Southeast Asian women work best in a family context.*

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The multinational character of the workshop reflected the kind of cross-border response now needed to stem the virus in Asia.

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# Bridging Borders in Southeast Asia: The Politics of HIV Prevention for Women

by Kari Hartwig, AIDSCAP/Thailand

*The personal is political.* This feminist rallying cry, born in the 1960s, has for decades expressed a core idea for women: that personal struggles—within the family, within relationships, within society and the workplace—are universal experiences for women that can become a catalyst for political action.

Exploring the political aspects of an issue as personal as protecting oneself from AIDS was the focus of a unique gathering, the first-ever interregional workshop on HIV prevention for women and their families to examine the need for cross-border solutions. Held in Chiang Mai, Thailand, from July 3 to 7, the “Women, Family and AIDS Prevention” workshop included representatives from bordering nations in Southeast Asia: Laos, Thailand, Cambodia, Vietnam and China.<sup>1</sup>

Hosted by the Women’s Studies Center of Chiang Mai University and funded by the AIDS Control and Prevention (AIDSCAP) Project, the Ford Foundation and the United Nations Fund for Population (UNFPA), the workshop examined gender-power relations, regional economic interdependence, national policies, community responses, family responsibilities and social and cultural expectations, placing the daily lives and struggles of

Southeast Asian women and their families within a political context. The goal: to develop ways to help women—and men—actively fight the epidemic both at home and across borders.

“Where does political will come from?” asked one participant, Nimalka Fernando, coordinator of the human rights desk of the Asia Pacific Forum on Women, Law and Development. “How do you motivate it at the community level in a way that includes women?”

Each of the invited countries sent a three-person delegation spanning the professional world of HIV/AIDS prevention: an academic researcher, a representative from a nongovernmental organization (NGO), and a public health specialist. In most cases, representatives from the same countries had not worked together before. Despite language barriers, participants from different countries involved in similar disciplines often found common ground in their work.

## **The Growing Crisis**

The multinational character of the workshop reflected the kind of cross-border response that is now needed to stem the virus as it spreads across Asia. Many international health experts fear that, with its huge population, high

rates of sexually transmitted diseases and flourishing commercial sex industry, Asia could become the epicenter of the epidemic in the next century. The workshop enabled participants to examine how HIV is crossing borders, cultures, languages and nationalities to affect communities and families throughout the continent, including an ever-growing number of women.

Thailand, Laos, Cambodia, Vietnam and China's Yunnan Province are neighbors. Regional economic growth, new trade initiatives and the growing openness between countries—as well as ongoing internal and international strife—have led to increased movement of people across their borders. The new Friendship Bridge across the Mekong River between Thailand and Laos is a striking symbol of the expansion of trade and collaboration. But as goods move across this bridge, so do people, and so does the virus that causes AIDS.

A researcher investigating this dynamic reported his findings to workshop participants. Through an AIDSCAP research initiative, Dr. Anthony Pramualrat of Thailand's Mahidol University had conducted a rapid assessment of activity along the Thai-Cambodian border at three different cross points. At each site, brothels on the Cambodian side served an increasing demand from both the local community and Thai men crossing the border.

Unfortunately, knowledge of how to prevent HIV does not appear to be so mobile. On the Thai side of the border were health outposts with posters and pamphlets about HIV prevention. If you asked people there about AIDS, they could explain how to prevent it.

But at the health outposts just a few kilometers within Cambodia, there was no information on HIV prevention, and few people knew about the virus. Young women in the brothels—most of them Vietnamese—knew nothing about HIV, nor would they have been able to read prevention posters in

Khmer and Thai had they been available.

### Women's Vulnerability

Changing socioeconomic conditions in the region that directly affect women are largely driving this epidemic. Increasing poverty in rural areas due to a shrinking agricultural land base forces many to migrate to the cities in search of income. Some village families sell their daughters to brokers for urban commercial sex establishments; other young women leave the countryside voluntarily to join the sex industry in order to send money back to their partners and families. Financially, successful sex workers in northern Thailand have often been regarded as role models in their villages: young women who have provided well for their parents and extended families and come back to marry and begin their own homes. It is only now, as these young women return with AIDS, that these practices are being questioned.

Monogamous and married women

are also increasingly at risk of HIV infection because of the extramarital sexual activities of their male partners. This population of women is seldom perceived as vulnerable to HIV and is thus rarely targeted by AIDS prevention campaigns. Even when monogamous women become aware of the risk to themselves, they have little power to demand condom use or other safer sex practices by their partners.

### Learning from Each Other

The workshop's opening days offered participants sessions exploring gender dynamics and HIV prevention, the changing context of the family in Asian societies, international strategies to incorporate women's rights within the human rights movement, women's networks in Asia, and the experiences of the host country, Thailand, in HIV prevention and care. Participants also exchanged information on the HIV epidemic and prevention activities within their own countries. Finally,

*A poor family in a village in northern Thailand.*



G. Diez, WHO



K. Hartwig, AIDS-CAP

*Workshop participants watch as other participants present work plans developed with the help of Chalutorn Burian (center), communication officer for the AIDSCAP Asia Regional office.*

members of each profession (researchers, NGO representatives and public health officials) met together to devise action plans for regional collaboration.

But the workshop didn't just stay indoors. Thailand has the most advanced HIV epidemic in Southeast Asia. More than 16,000 people in Thailand have been diagnosed with AIDS, and an estimated 700,000 are thought to be HIV-positive. Northern Thailand, where Chiang Mai is located, struggles with particularly high rates of seroprevalence.

With the surrounding communities as a vast learning laboratory, participants visited hospitals, health departments and various Thai NGOs working in AIDS care and prevention. On these field trips, participants met many people living with HIV or AIDS (PWAs). They spoke to commercial sex workers. They held AIDS orphans. For

many of these physicians, public health workers and academics, it was their first experience meeting an HIV-positive person.

Participants were surprised by what they saw and heard. "She was so young. And she's chubby, too." "I'm impressed by how the community and their families have accepted them. I'm impressed by how much PWAs are doing things for themselves."

When participants later shared information on the epidemic in their countries, evidence of the virus' border-crossing abilities appeared again and again. Of the 59 people reported with AIDS in the Lao People's Democratic Republic, most had been in Thailand for trade or business, or were border guards or men who had visited neighboring Thai brothels. In Cambodia, a high percentage of infected people are female sex workers—most

of them Vietnamese—who work in brothels along the Thai border. A 1994 study by the Cambodian AIDS Programme found 38 percent of sex workers in Sihanoukville to be HIV-positive. Nine out of ten infections reported in China are in Yunnan Province, primarily in the three districts sharing border with Thailand and Burma. Many infections are attributed to drug use in the "Golden Triangle" of Thailand, Vietnam, Burma and Yunnan Province.

### **The Family Context**

The workshop's focus on women within their families reflected the cultural, social and gender realities of Southeast Asia. Western health systems target individuals for behavior change messages to prevent HIV infection, but the lives of Asian women and their ability to remain free from infection cannot be removed from the context of family and community.

For some who attended the workshop, trying to change traditional gender relations in the family to give women greater negotiating power with their male partners was not realistic. Income generation projects for village women in Thailand, designed to offer alternatives to prostitution or to economic dependence on male partners, were regarded with skepticism by participants from Laos, Vietnam and Cambodia, who were pessimistic that such efforts could change fundamental attitudes about gender in their countries.

"Even if a woman earned more money than her husband, it would not change the power relationship," insisted one participant from Laos.

Despite differing views on economic empowerment, workshop participants did agree that HIV care and prevention projects for Southeast Asian women worked best within family and community settings. Thai intervention projects, such as the group Women Against AIDS, that use drama in the communities and schools and make

AIDS care and prevention a family and community concern were seen as powerful models.

### **The Politics of Implementation**

The strength of NGOs in Thailand and their close collaboration with the Thai government was both a surprise and an inspiration to participants from neighboring countries. Several representatives spoke of the marginality of nongovernmental efforts in socialist countries, where governments are often suspicious of NGOs and limit their activities.

"In my country, we only have foreign NGOs, and my friends from Laos tell me the same is true there," said a participant from Vietnam. "There are no local NGOs."

The concept of an indigenous women's group with no links to the government was also nearly inconceivable to the Chinese, Cambodian, Laotian and Vietnamese representatives. In their countries, all "women's activities" are handled by the women's union or a related youth union or labor union.

Even as some participants were astonished by the autonomy of Thai NGOs, they were also impressed by the Thai government's own activities in AIDS prevention and care. The coordination of programs from the national to the provincial and community levels seemed particularly remarkable.

Dr. Hehe Chang of the Yunnan Provincial Health and Anti-Epidemic Center suggested sending a Chinese delegation to Thailand to learn about HIV prevention and care strategies.

"Here, people look similar, the villages look similar, and the culture and family structure are similar," she said. "I think we should be learning from one another in the region."

Other programs in Thailand that impressed workshop participants are the HIV surveillance system and the government's "100 percent condom-only" brothel policy, which imposes legal sanctions on brothel owners who

do not require their employees to use condoms with all clients. But the possibility of replicating similar programs in neighboring countries seems remote. Chinese participants remarked that the programs created for and initiated by sex workers in Thailand could not exist in China, where laws not only outlaw prostitution but also punish any person or group providing support or information to sex workers.

The independence and collective strength of people with AIDS who have implemented their own support projects was also a surprise. "HIV-positive people in my country do not come together like this—they go back quietly to their homes," said one participant from Laos. "We don't know how to work with people with HIV," a Chinese participant observed. "We think of managing them and putting them away from us so as not to infect others."

### **Advocacy Across Borders**

As participants examined common issues, they agreed that the essential next step was policy advocacy. Building intergovernmental relationships that foster collaboration, as well as strengthening national programs, was considered critical to slowing the epidemic in the region.

"We need networks for local public health care people along the borders," said Dr. Tawesak Nopakesorn, a Thai military physician involved with the National Economics and Social Board of Thailand.

International lobbying efforts were discussed as an outcome of this workshop, including plans for a policy statement on women, family and AIDS prevention in bordering nations to be drafted at the Fourth United Nations World Congress on Women at Beijing. Nimalka Fernando of the Asia Pacific Forum on Women, Law and Development hopes to incorporate AIDS prevention as a women's issue on the Forum's agenda and facilitate networking on this topic through its interna-

tional network. A follow-up workshop, "Creating an Asian Network on Women and AIDS," hosted by AIDSCAP at the Third International Conference on AIDS in Asia and the Pacific last September, continued to build the network beyond this five-country region.

Participants discussed the possibilities of creating a health care workers' network within and between countries, publishing a newsletter, creating linkages with national and regional women's organizations, contacting journalists to share the insights of the workshop, and forming both cross-border committees and intersectoral committees that will build relationships between researchers and public health implementers.

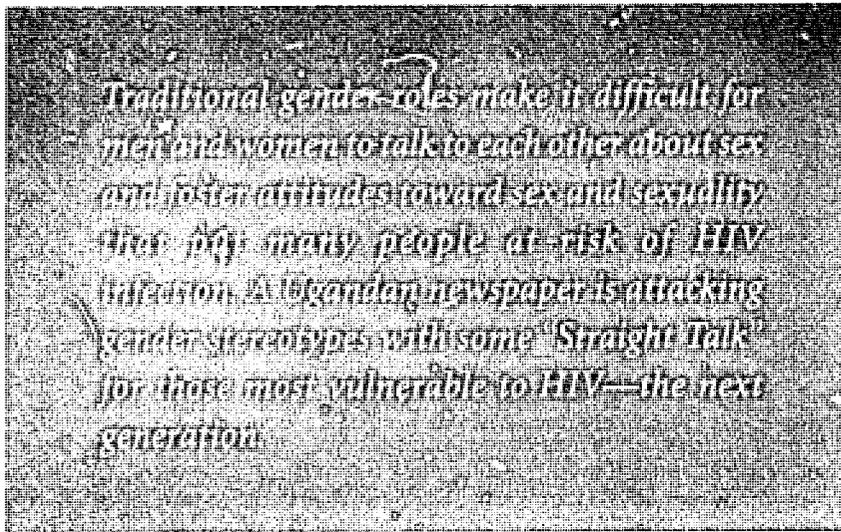
In the months since the workshop met, several of these proposals have taken shape. One newsletter has been published. The initiation of cross-border health posts was discussed in late July by Thailand's National Economic and Social Planning Board during its Five Year Plan (1997–2001) proposal development. And in Cambodia, meetings have been held with the Secretariat of States for Women's Affairs and the HIV/AIDS Coordinating Committee to debrief them on the workshop and to further initiate national networking on women and AIDS issues.

This workshop was a first: a first chance for health practitioners and researchers to share experiences across borders, to see how neighboring countries are working to stem HIV, and to discuss how to overcome national and regional barriers to create a comprehensive, regional strategy to protect women from AIDS. If the determination of the participants is any indication, the momentum generated in Chiang Mai can become a model for similar regional efforts on behalf of women in other parts of the world. ■

*Kari Hartwig is a program officer in AIDSCAP's Asia Regional Office in Bangkok.*

# Straight Talk for Youth: Ugandan Girls and Boys Learning to Escape Gender Stereotypes

by Kathleen Henry



*I didn't want him to think I was cheap by saying "yes" right away. And I was a little afraid of being dumped.*

*If she said "no," I would not take her seriously. After all, that is what is expected. It's like a game.*

Boys say girls are vain and materialistic. Girls say boys just want to con them into sex. But many boys believe they must "play sex"—even when they don't want to—to prove their manliness, while girls admit that they sometimes send mixed signals about their willingness to have sex.

This kind of dialogue occurs every month in the pages of *Straight Talk*, a newspaper produced by Uganda's Ministry of Information with support from UNICEF.

A monthly tabloid, *Straight Talk* is distributed as an insert in the daily

government newspaper, *New Vision*, which has a circulation of 40,000. An additional 30,000 copies of *Straight Talk* are sent to nongovernmental organizations (NGOs) and secondary schools.

The newspaper provides information and advice about sex, sexuality, HIV/AIDS and other sexually transmitted diseases (STDs), and relationships. According to Crispus Mundua of the Ministry of Information, one of its main purposes is to encourage boys and girls and parents and children to talk about these issues.

*Straight Talk* began in October 1993 as part of the media campaign of Safe-guard Youth from AIDS (SYFA), a collaboration between UNICEF and the Government of Uganda through the Uganda AIDS Commission and the Ministry of Health. SYFA works with government agencies and nongovern-

mental organizations to reduce HIV and other STDs among sexually active youth and to encourage young people to postpone sex.

Regular *Straight Talk* contributors include a sociologist and a physician. But much of the content comes from readers. The paper publishes dozens of letters in each issue, as well as articles by and interviews with young people.

Mundua says the newspaper receives five to 10 letters from readers every day. Some write to say how much they appreciate the publication and others ask for advice. In a column called "Dear SYFA," a physician and other specialists answer questions about a wide range of medical, social and emotional issues, from "How many tests should I have to make really sure I don't have HIV?" to "Is sex sweet?" Sometimes "Dear SYFA" asks readers to send their own responses to readers' questions.

*Straight Talk* also uses contests, surveys and quizzes to encourage reader participation. A "Do you mind if we ask?" survey asked readers about their first sexual experiences. The winner of a contest for the best story about sexual pressure and sexual boasting told of how he "began calculating imaginative sexual testimonies to furnish the proof of my manliness," after a friend teased him about being a virgin in front of a group of girls.

By providing a forum for young people's opinions and concerns about sex and relationships, *Straight Talk*

hopes to demystify sex, challenge gender stereotypes, and encourage real friendships between boys and girls. One article noted that boys and girls learn separate rules of sexual behavior that are like scripts in a play. Girls' sexual scripts link sexual intercourse with love, while male scripts emphasize satisfying their sexual desires. Another article dissected passages from romance novels, showing girls how some of their favorite books reinforce these scripts, depicting men who are strong and forceful and women who are helpless and submissive.

The newspaper also provides peer support for postponing sex. Letters from readers about why they decided to abstain from sex and interviews with rap singers and other influential young people who are virgins shows readers that "everyone" is not "doing it."

"It is true that many teenagers pretend they are having sex when they are not," wrote a 17-year old boy. Another wrote that one of his friends had told him sex would improve his manhood and his sexual performance. "I told that fellow that sex isn't a game you play in public like football."

*Straight Talk* avoids preaching. It offers tips on assertiveness and sexual negotiation with a light touch, using comics, caricatures and catchy headlines such as "Know Your Body Fluids" and "Funk Dat Pressure." Advice is dispensed with humor and a no-nonsense approach: "Girls, are you like a computer when it comes to sex? Programmed to go when someone presses the rigat button? ... So the next time a boy tells you, 'If you loved me you wouldn't make me suffer,' give him a friendly smile. Let him know **you know** that he's just trying to push your button."

Letters to *Straight Talk* suggest that the publication is helping boys and girls understand each other better. The publication also encourages dialogue between parents and children about sex and relationships.

"The biggest problem we have now,

especially among the youth, is lack of communication between the adults and the youth," Mundua said. "Therefore the youth end up getting information from their peers—information which in many cases is not correct."

The dialogue generated by *Straight Talk* occurs outside the newspaper's pages as well. Mundua reports that many schools have SYFA clubs that meet and discuss issues raised in the newspaper. World Vision, Inc., and other NGOs working with youth and their parents also use *Straight Talk* in their AIDS prevention activities.

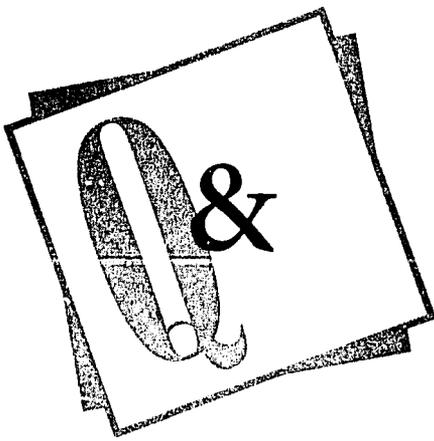


Young readers get accurate information on sexuality and STDs, dispensed with humor and a no-nonsense approach.

Michael Buja/AIDSCAP

Some parents, teachers and politicians have criticized the newspaper for tackling tough issues such as condom use, masturbation, premarital sex and sexual abuse, but most readers' reactions have been positive. A mother from Kampala wrote to urge all parents to let their children read *Straight Talk*.

Young readers say that *Straight Talk* fills a void in their lives. "Thank you for saying everything our parents fear to tell us," wrote one girl. Another said, "You have granted us the freedom to express our innermost feelings without shame."



## HIV Prevention for Women in Brazil: An Outspoken Activist Working at the Grassroots

**B**efore many government health agencies and mainstream research institutions recognized the growing threat of HIV/AIDS to women, grassroots nongovernmental organizations (NGOs) began to create women-oriented prevention, education and care projects, and to lobby for new national health and treatment policies supporting women.

In Brazil, GAPA (*Grupo de Apoio à Prevenção à AIDS*, or Support Group for the Prevention of AIDS), has long been at the forefront of grassroots HIV prevention and care efforts for women. A volunteer-based organization, GAPA works in both rural and urban settings, reaching across the social, political and racial spectrum.



Michael Buja, AIDS CAP

*Telma Regina Cavalheiro, who has worked with GAPA in São Paulo since 1991, has unusually broad skills and experience, but defines herself first and foremost as an activist. She received a degree in social medicine and public health from the School of Medical Sciences of Santa Catarina in southern Brazil, and has taught at the Catholic University of Campinas in São Paulo.*

*Before she came to GAPA, Cavalheiro worked as a health educator in England at the London Lighthouse and as a safe sex coordinator for the Brazilian NGO, Pela Vidda (For Life).*

*Cavalheiro now serves as coordinator for GAPA's SOS Women and AIDS Project.*

### **What is GAPA's mission?**

GAPA was the first nongovernmental organization (NGO) in Brazil to address HIV and AIDS. The organization was founded ten years ago by a group of citizens who saw the growing need to promote HIV prevention measures and lobby for adequate health services for those living with HIV. There are now 18 affiliate offices throughout Brazil.

### **How is GAPA accomplishing these goals?**

Today GAPA is primarily a political organization lobbying and networking for effective public health policies related to HIV/AIDS in Brazil and improved medical, psychological and social services for people with AIDS, as well as combatting discrimination against people living with HIV and AIDS. GAPA also provides HIV counseling, peer and outreach education about HIV/AIDS, and social, material and legal support to people living with HIV/AIDS and their families. It has one of the most complete libraries in the country, with books, magazines, educational materials and videos, and it disseminates information on the epidemic to the general public.

### **When did GAPA begin its work with women?**

When I joined GAPA in 1991, it was to help develop a project to address the increasing incidence of HIV/AIDS in women in São Paulo. At that time few NGOs working with AIDS programming were aware of the specific needs of women, so this project was one of the first to target women. With a multidisciplinary team of women working as volunteers, the SOS Women and AIDS Project (SOS) promotes STD/AIDS education for women of reproductive age and offers support in the areas of legal and social assistance, counseling and medical referrals for HIV-positive women.

### **What issues does the AIDS epidemic raise for women globally?**

AIDS has not really raised any new issues for women but instead aggravated old ones. We continue to address women's dependence on men, their lack of access to power and resources, and their vulnerability to poverty and discrimination. Globally, there is a lack of research on women and HIV/AIDS, and women tend to be excluded from vaccine and antiretroviral protocols, so medical interventions for women have yet to catch up with treatment for men.

### **What do you see as particularly pressing HIV/AIDS issues for women in Brazil?**

The needs of HIV-positive women in Brazil vary enormously, depending on social, economic, religious and cultural factors. Urban poverty and other conditions of urban life help determine the course of the epidemic in Brazil's cities. In São Paulo, the ratio of male to female HIV infection has risen from 42:1 in 1985 to 2:1 in 1995, and AIDS is now the main cause of death among women in the child-bearing years from ages 15 to 45. For our women clients, HIV prevention is the issue our project deals with most frequently, and pregnancy and parenting decisions for HIV-positive women are also at the center of attention. Other issues are access to health care and protection from domestic violence. Unfortunately, national health care policies are not responsive to the complexities of women's lives; they still tend to characterize HIV-positive women primarily as vectors of pediatric transmission, sex workers or drug users.

### **Is integration of AIDS prevention into family planning and maternal and child health programs a priority?**

Some maternal and child health programs deliver HIV/AIDS education

and counseling and perform prenatal HIV tests, and some offer educational activities targeting HIV-positive women. But most family planning agencies in Brazil don't seem to have HIV prevention on their agendas, although women complain about having to go to different places for services and about the endless wait at each facility. Health professionals are aware that these services should be integrated, but before family and HIV prevention are integrated, a lot must be changed.

### **How do contraceptive methods in Brazil affect condom promotion and the epidemic?**

Sterilization and the IUD are the methods that doctors and family planning services tend to offer. Poor women are sometimes sterilized without their consent. The problem for a sterilized woman is how to justify or negotiate condom use with her partner without jeopardizing her relationship, because it forces discussion of the sensitive issues of trust and fidelity. Condoms are neither affordable for nor acceptable to most Brazilian men. A woman who insists on condom use is considered "unclean" or promiscuous. Sexism in Brazil makes negotiation of condom use and HIV prevention more difficult.

### **What's being done about STD infection?**

The incidence of STDs—syphilis, genital warts and vaginosis—seems to be increasing for Brazilian women. Given the links between STDs and HIV transmission, it's likely that this trend contributes to the increase in the levels of HIV infection. Unfortunately, STD/AIDS services reflect the same shortages of resources confronting all other health services in Brazil. They are not fully staffed, fully equipped or easily accessible. GAPA can only offer counseling on how to avoid becoming infected and referral to public sector STD services.



G. Magnoni/UNICEF

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*Mother and daughter in a poor neighborhood in São Paulo. Urban poverty can aggravate the risk of HIV for women.*

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### **What behavior change messages are Brazilian health agencies promoting for HIV prevention?**

Until 1992, few of the government's educational initiatives reached their intended audience effectively, and those that did used a "terrorist" approach to HIV prevention education. For example, the message, "If you are not careful, AIDS will catch you!" created panic rather than providing meaningful information. Fortunately, these messages have improved since the Ministry of Health and other agencies began to work closely with NGOs and other community organizations.

### **How do you compare the national response to the epidemic in Brazil to the response in other countries?**

Historically, the response in Brazil progressed pretty much the same way as in England or the United States. At first the epidemic predominantly affected gay men, commercial sex workers and drug users, and their specialized support groups were the first to respond. As HIV infection spread into the general population, government and health professionals were forced to formulate broader health policies. However, in Brazil both government and civil responses were slower and less effective than in the U.K. or U.S. Now, NGOs and government are cooperating to provide comprehensive HIV/AIDS prevention information to the public and services to those living with HIV/AIDS.

### **What other services does SOS offer?**

SOS started a call-in help line in September 1993. The help line was developed to provide women with a means of access to all kinds of information about HIV/AIDS.

### **Who calls the help line and what are the most frequently asked questions?**

Sixty-five percent of our callers are women. More than half the questions are about modes of transmission and symptoms of HIV/AIDS. Thirty-four percent of callers are looking for infor-

mation about HIV and STD prevention services available in the community. But many callers who ask simple, straightforward questions also have more complex and frightening issues to talk about. Our phones are staffed by five advanced psychology students, who are supervised by a professor and a psychologist equipped to deal with the deeper psychological needs of our callers.

### **What are some of these deeper needs?**

How to disclose one's HIV status and how to introduce safer sex into an existing relationship without putting that relationship at risk are very sensitive topics. Some callers express real panic when they discuss their fears about the possibility that they're infected.

### **What educational services does SOS offer?**

We sponsor two courses. The HIV/AIDS awareness-raising course called "AIDS in the Community" gives general information about HIV and AIDS and sensitizes participants to AIDS issues. The other gives women detailed information about HIV/AIDS and trains them to be multipliers or peer educators in prevention. We also publish educational materials to support these courses. The MacArthur Foundation funds our basic operations, the training courses and the help line, but most of our educational materials development is supported by the Ministry of Health and, more recently, by the Samuel and Levi Strauss Foundation.



# Women's Forum

## Young and Positive: One Woman's Campaign to Educate Youth

by *Jecenia de Jesus,*  
*International Community of Women Living With AIDS*

I'm a 22-year-old woman living with HIV. In 1991, I lost my mother to AIDS. I did not know that she'd died of AIDS until several months after her death. Because she was a drug abuser, I wasn't really surprised when I was finally told what had killed her. My mother's death was the hardest thing I thought I'd ever have to deal with.

Only ten months later, at a routine doctor's visit, when I was asked if I wanted to be tested for HIV, I remember being shocked and slightly offended. The doctor himself said I was not in any of the risk categories. To my surprise, two weeks later I received a positive diagnosis. I was 19 years old, HIV-positive and all alone.

I felt as many people do who test HIV-positive: isolated, with a heavy feeling of shame. I didn't exactly know why, I don't remember anyone ever telling me, but I felt as if I had done something wrong. I had a big secret, and I couldn't tell anyone.

I spent many months feeling very much alone and I didn't share my secret with anyone. I was only 19, and I hadn't even begun living, and I was waiting to die. Although I found the courage ten months after my diagnosis to see another doctor who explained to me that I didn't have AIDS as I'd originally been told, that I was carrying HIV, I still could not tell anyone.

In 1994, almost two years later, I finally met other people who are living with HIV. I couldn't believe that other people could live with this dreadful disease and still be happy and live positive lives. Finding the support of other people with AIDS (PWAs) helped me accept that I was HIV-positive and could live a long, positive life.

This has not been easy. I'm sometimes so very scared of this virus and what it can bring. I try on a daily basis to live my life to the fullest. Today, I take care of my 13-year-old sister, and try to teach her what she needs to make

*This essay is adapted from a presentation Ms. de Jesus gave to the 3rd USAID HIV/AIDS Prevention Conference in Washington, D.C., on August 8, 1995.*

it in this world, especially how to respect herself and her body. I want her to grow up with enough self-esteem and self-confidence to make the right choices in life, and that includes protecting herself from AIDS.

This does not mean that I or anyone else living with HIV made the wrong choices. I only used the misinformation that was given to me, and that was that I could not get HIV, that I was not in any risk category. Someone was wrong.

Today I dedicate my life to educating others, especially young women, about HIV and AIDS. Many young women I speak to are as misinformed as I was about risk, and even the ones who do know more about AIDS still don't believe it can affect them—until it hits home.

I recently spoke to a group of young women peer educators in Springfield, Massachusetts. I asked them toward the end of our session, do you know now how to keep yourself from becoming infected with HIV? I told them they needed to have enough self-confidence to tell their partners they had to wear condoms.

But working with young women and girls must mean more than telling them to develop self-esteem. Yes, we must instill these values in young women—but how can they achieve a sense of their own worth when all around them are families and communities that don't treat them with respect? AIDS education for young women means little if we don't also address these issues in the broader community, to create a context in which they can become stronger and smarter about how to protect themselves.

I also speak to people who are already infected, and try to teach them how to live positively with this disease. There is still hope, and we have to keep that hope alive.

The greatest support that I have has been received from other people with HIV, both at home and internationally.



People living with HIV and those significantly affected know firsthand what a tremendous load this disease is. This is why my involvement in organizations like the AIDS and Adolescents Network of New York and the AIDS Policy Center and the National Women's AIDS Project in Washington is so important to me.

Most important, I represent the International Community of Women Living with AIDS (ICW), which is an international organization based in London. Three years ago at the 8th International Conference on AIDS in Amsterdam, many women with HIV realized they were still being discriminated against and were very much alone and isolated. Because of the lack of support and information available to HIV-positive women, they got together to create an international organization to educate, support and, most of all, empower other women living with HIV. Today ICW has members in 70 different countries throughout the world.

Unfortunately, people with AIDS around the world are still fighting discrimination, as if living with a termi-

nal illness is not enough. I hope to see service providers, policy makers and, most importantly, people living with HIV working together on prevention and care services for all affected by this disease.

I hope I've helped to put a face on this disease, if one is still needed. I am only one of millions. I ask that participants at this conference take whatever information is gained here and share it with your communities. If we're going to work to stop the spread of HIV and AIDS, especially among young people, we must stop working in isolated efforts and start working together, developing solutions that make sense for communities as a whole. If nothing else, let AIDS bring us together to look beyond all our differences. ■

*Jecenia de Jesus is a full-time program assistant with the AIDS and Adolescents Network of New York. She is also a key North American contact for the International Community of Women Living with AIDS (ICW). For more information about ICW, write to its international headquarters at Livingstone House, 11 Carteret St., London, SW1H 9QL, United Kingdom.*



# Policy Profile

## HIV Prevention and Women's Rights: Working for One Means Working for Both

by Jane Kiragu, International Federation of Women Lawyers, Kenya (FIDA-K)

*Confidentiality, privacy, nondiscrimination, the right to know—these are some of the pressing legal and policy issues that HIV/AIDS has put at center stage in recent years. But for women in developing countries, more fundamental legal reform is also necessary to fight the epidemic. Women who lack basic rights—the right to control their own bodies, the right to choose their own partners, the right to own and inherit property—are deeply vulnerable to infection. A Kenyan lawyer and feminist examines how growing social pressures from the HIV/AIDS epidemic in her country and throughout Africa are forcing policy makers to reconsider long-sought reform of laws that discriminate against women.*

Africa, and African women in particular, have been hard hit by the AIDS epidemic. More than 7 million women in sub-Saharan Africa have become infected with HIV, and the virus continues to spread.

Many Kenyans are HIV-positive. According to World Health Organization statistics, one in 18 adults in Kenya is infected—a rate that soars as high as one in nine in urban areas. Surveys of pregnant women in some regions of the country show a seroprevalence rate as high as 30 percent.

In Kenya, throughout Africa and around the world, the threat to women—including married women and young girls who do not fit into traditional “high-risk” groups—is rising dramatically. By the end of this century, researchers estimate that the global ratio of male infections to female infections will rise to 1:1 or even higher, a sharp contrast to only a few years ago, when that ratio stood at more than

10:1. In many parts of Africa, the transmission rate for women is already higher than for men.

This shift has come about not because women are taking greater risks in their sexual lives, but because of social and cultural inequality, economic marginality, restricted access to power in public and private life, and legal systems that discriminate against women and deprive them of basic rights. Women also suffer from greater biological vulnerability to HIV infection.

Gender inequity of all kinds increases women's vulnerability to HIV infection in three closely linked ways. First, lack of economic opportunity for women, enshrined in social-cultural practices and reinforced by the legal system, leads to dependence on men, whose interests do not always coincide with women's need to protect themselves. Second, depriving women of the right to autonomy and control over their own bodies also deprives them of their right to refuse sex and to demand safer sex practices by men. Third, some cultural practices, many either protected by or ignored by the law, are directly and immediately dangerous and can lead to HIV infection. The solution is to empower women through legal reform to take advantage of economic opportunity, to determine when and with whom they will have sex, and to refuse cultural practices that endanger them.

These are basic rights that most men enjoy without question, and the International Federation of Women Lawyers (FIDA-K) and other women's organizations in Kenya have been fighting to

gain them since long before the AIDS epidemic hit the country. While the threat of HIV builds, there is a renewed drive for legal reform that benefits women in many African nations, as communities and governments feel increasing pressure to assist infected women and orphans who have been abandoned with no means of support.

In 1993, the Kenyan government created a special task force to examine the impact of standing laws on women. This body, headed by Judge Effie Owuor, has sought input from all women's organizations in the country in its review of the legal system. FIDA-K and other groups have submitted recommendations, but a final report from the task force has not yet been issued.

### Domestic Violence

Violence against women by their male partners is widely condoned by many African societies, including Kenya, where the belief that a husband may chastise his wife by beating her is deeply embedded. Among the Luhya community in western Kenya, wife beating is even considered a sign of love, which women have been socialized to accept and some-

times encourage. Kenyan law interprets wife beating as a domestic and, therefore, private matter, and law enforcement agencies avoid "interfering" in a family conflict.

Women who are repeatedly beaten or threatened with beating live in fear in their own homes. They are not in a position to negotiate for safer sex or to tell their partners they do not wish to engage in sexual intercourse, and are thus vulnerable to sexual abuse and possible infection with HIV or other sexually transmitted diseases (STDs).

FIDA-K has identified domestic violence as one of the major obstacles to tackle in ending the subordination of women in Kenya. In 1994, FIDA-K conducted gender sensitization workshops for law enforcement officers

L. Gubb/WHO



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*A Tanzanian girl who lost her parents to AIDS. In many parts of Africa a family's property traditionally returns to the husband's father or brothers when he dies, but some HIV-positive women are learning how to write wills so they can leave as much as possible to their orphaned children.*

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J. Mohr, WHO

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*A woman sits outside her home in a Nigerian village. Because of discriminatory inheritance practices, women who care for husbands with AIDS often lose their dwellings and possessions when the men die.*

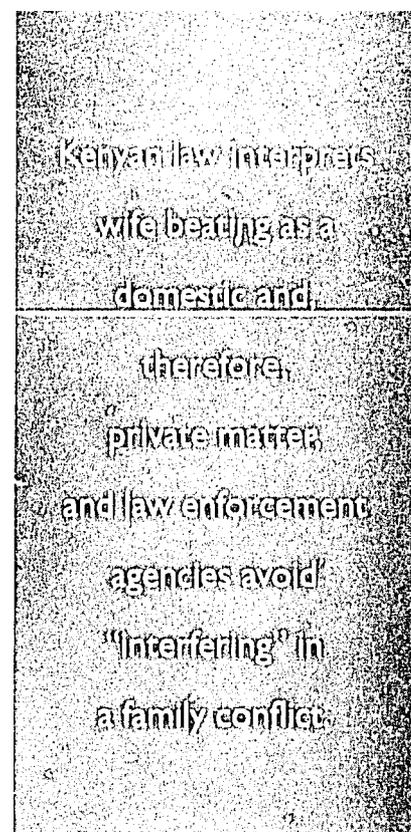
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around the country, with a focus on domestic violence. Linking the spread of HIV/AIDS with violence in the home was a true eye-opener for workshop participants, many of whom, as a result, committed themselves to protecting women who report domestic violence. FIDA-K and law enforcement agencies later co-sponsored a design competition for posters to educate the public about domestic violence. The three winning entries now hang in police stations around the country, and the success of this effort has built a spirit of cooperation between our organization and the police that we hope will continue.

An important outcome of this joint campaign has been the creation of formal recommendations to amend Kenya's penal code to include domestic violence as a separate offense and to promote privacy and confidentiality at police stations for women who take violence complaints to the authorities. Legislative action is needed to turn these recommendations into law.

### **Marital Rape**

In 1994, the office of the Attorney General in Kenya, prompted by FIDA-K, initiated debate among national policymakers on whether marital rape should be recognized as an offense punishable by law. But many male politicians and religious leaders continue to reject the concept that intercourse between husband and wife can be coercive and that women should be able to say "no" to their husbands. Thus, little



legislative progress has been made.

This failure to recognize the right of a married woman to refuse intercourse heightens her vulnerability to HIV infection if her partner is involved in extramarital affairs. Women's organizations in Kenya continue to lobby for legislative recognition of this crime against women.

The battle around this issue illustrates one of the handicaps that women's organizations face in Kenya and elsewhere in Africa. Although women make up about 55 percent of Kenya's population of 25 million, they are woefully underrepresented in government, commerce and other positions of power. There are six female legislators in Kenya's 200-seat parliament and only one woman minister, the first ever appointed to the cabinet. Lobbying for support for women's issues can be an uphill battle when many legislators remain unconvinced of the need to empower and not paternalistically "protect" women.

### **Wife Inheritance**

Some tribes in Kenya practice wife inheritance, whereby widows

If a woman defies custom she may be shunned or even expelled, and many African women prefer to risk infection than to be rejected by family and community.

remarry within the deceased husband's family or ethnic community, often to a man who already has wives or other sexual partners. This has been justified as economic security for women who lose their husbands' income or property, but it deprives women of the right to choose their own lives after widowhood and can coerce women into sexual relations that may be dangerous for them.

This deeply rooted tradition takes different forms in different regions, sometimes allowing for some level of consent by the woman. Among the Luo in western Kenya, widows must submit to wife inheritance, but may choose their male "inheritor" from their husbands' ethnic group. Within certain communities in Zambia and elsewhere, some widows are forced to have unprotected sex with a brother-in-law—not necessarily leading to remarriage—in the belief that the act will cleanse them of their dead husbands' spirit.

This cultural barrier to the basic human right to choose one's partners raises vulnerability to HIV. If a woman defies the custom, she may be shunned

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*A young Ethiopian woman collecting wood. A woman's backbreaking work rarely leads to financial security and independence in regions where women cannot take advantage of economic opportunities.*

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or even expelled, and many African women prefer to risk infection than to be rejected by family and community.

Pressure to end wife inheritance is growing in regions of Kenya where HIV transmission rates are especially high. FIDA-K's proposal to the national task force reviewing laws relating to women calls for eradication of the practice altogether. Others propose allowing it to provide security for widows and their children, but to prohibit the requirement that widows be forced into sexual relations with their new partners.

### **Property Issues**

Patriarchal traditions keep many Kenyan women from owning or inheriting property and thus attaining some level of economic independence from men. While national law does not expressly forbid property ownership by women, cultural practice largely eliminates for women the main method by which Kenyans come to own property: inheritance. Parents rarely bequeath property to daughters, and those who do are looked upon with scorn. Women who attempt to buy land, businesses or other major assets find that banks will not lend them money unless a husband or other male family member co-signs the loan. This is a prime example of how gender discrimination within the culture works its way into the financial structure, perpetuating women's economic dependence on men and ultimately limiting their ability to control their personal and sexual lives.



F. Hille, WHO/IL0

A horrifying  
violation of  
human rights,  
female genital  
mutilation  
promotes the belief  
that the bodies  
of women  
and girls are  
ultimately the  
property of men.

In many Kenyan communities and throughout much of sub-Saharan Africa, a man's property traditionally returns to his own family when he dies. Too often in recent years, a tragic and ironic story has been repeated. A woman caring for a husband ill with AIDS finds herself impoverished when he dies because neither has been able to earn an income. His family takes her house, garden acreage or other property and possessions—sometimes down to the cooking pots—leaving her homeless and destitute, just as she herself becomes ill from the infection passed on to her by her husband. The husband's relatives may also decide to take her children from her—the woman can usually do little legally to stop them—but often the children also become victims of poverty and homelessness. Once again, cultural practices that impoverish women can also lead them to infection, because widows with few means to support themselves may turn to commercial sex work to keep themselves and their children alive.

The issue of inheritance is a difficult one. Even though they or their female relatives could be left impoverished by traditional inheritance practices, many poor women in Kenya support the status quo because they do not want to "lose" the wealth of deceased sons. Yet, like FIDA-K, most organizations in Kenya that support legal reform for women call for an end to the complex web of tradition and law that keeps most women from owning and inheriting property.

Elsewhere in Africa, the Zambian organization Women in the Law and Development in Africa (WILDAF) is addressing this issue by translating inheritance laws into native languages and training paralegals to teach Zambian women about their rights. In South Africa, organizations that help HIV-positive women write wills are empowering them to pass on as much of the family's belongings and wealth as possible to their orphaned children. And in Tanzania, some measure of true legal reform was won in recent years: legislation entitling widows to 50 percent of their husbands' property.

### **Female Genital Mutilation (FGM)**

Kenyan women are taught that sexual pleasure is for men alone, and that showing signs of pleasure in lovemaking brands one as having "low" morals. Among the Maasai, Kikuyu, Meru and Kiisi tribes, the practice of female genital mutilation—excision of the clitoris and/or labia, usually done to infants or young girls—has long been justified on the grounds that it reduces the libido and sexual pleasure. A horrifying violation of human rights, this tradition promotes the belief that the bodies of women and girls are ultimately the property of men, and that women's right to their own sexuality can be "excised" from them, just as parts of their anatomy are cut away.

The operation is usually performed without anesthesia, with unsterile in-

struments that can harbor bacteria and the HIV virus. Certain genital mutilation procedures can lead to a lifetime of pain from irritation, tearing during intercourse and birth, infection and scar tissue growth. Women who have undergone such mutilation frequently suffer from bleeding vaginal abrasions, which may make them more vulnerable to HIV transmission during intercourse with an infected man. This cruel practice can also cripple women emotionally, sexually and psychologically throughout their lives.

Throughout Africa, many women's organizations have initiated efforts to educate and lobby against FGM. Because this ancient practice is so deep-rooted, progress can be slow. But in Ghana last year, the Ghanaian Association on Women's Welfare (GAWW) succeeded in its campaign to amend the nation's 1960 Criminal Code to include FGM as an offense punishable by up to three years in prison. GAWW, recognizing that making FGM illegal is not enough to end the practice, is also continuing a national campaign to educate Ghanaians about the practice.

FIDA-K and many other women's rights organizations in Kenya support efforts to enact and enforce laws that prohibit female genital mutilation. Kenya's penal code includes the crime of "grievous bodily harm," which we believe should include FGM, but few cases have been tried to test this interpretation because the police are reluctant to prosecute. FIDA-K's community rights education project is working hard to educate and encourage law enforcement agencies to understand FGM as a prosecutable offense. For the moment, educational campaigns aggressively promoted by such grassroots organizations as Maendeleo Ya Wanawake (Advancement of Women) remain the focus of the campaign to end FGM, so that when the laws do change, Kenyans will be ready to give up this cruel tradition rather than practice it underground.



Barry S. Brown/PANOS

*Kenyan women enjoy their adult literacy class in Meru. Literacy and education are tools of empowerment for women in developing countries.*

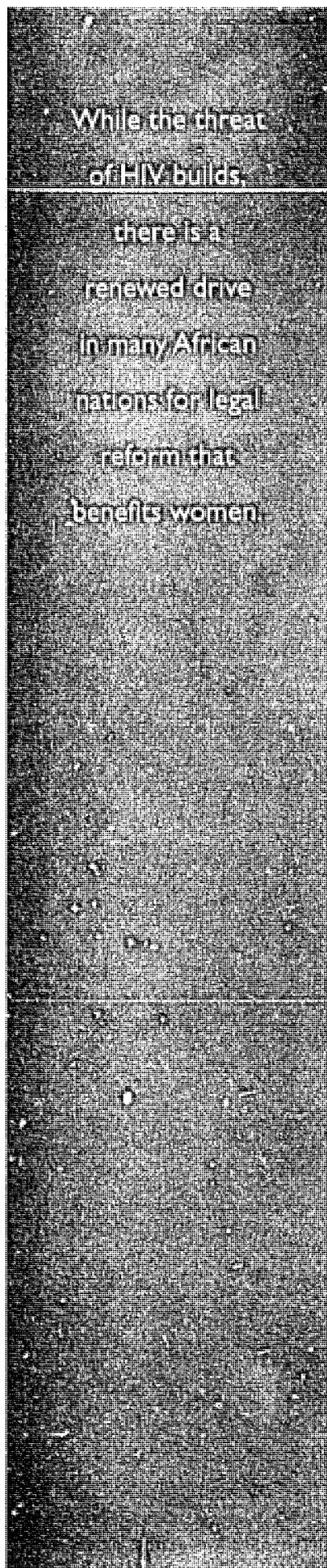
### **Protecting Young Women and Girls**

In Kenya, underage girls are frequently married off against their will to older men seeking sex partners uninfected by HIV. The poor families from which many of these girls come sometime benefit financially, while the girl children lose opportunities to continue their education and their right to choose when and whom to marry.

There is a risk that some of these men may be HIV-positive and could pass the infection on to the next generation. Practices like these contribute to the high rates of infection in Kenya among girls and young women 15 to 24 years old, an age group with more than twice the number of females infected as males.

Underage marriage is one of the reasons why girls are taken out of school

in Kenya and elsewhere in Africa at higher rates than boys. Family poverty is another reason: parents or guardians may withdraw girls before they graduate to save money for their brothers' school fees. The low level of literacy among Kenyan women is a tragic result. Only 51 percent of Kenyans are literate, and only 15 percent of this population is female. Education and literacy are critical tools for self-esteem,



While the threat  
of HIV builds,  
there is a  
renewed drive  
in many African  
nations for legal  
reform that  
benefits women.

economic empowerment and, ultimately, effective HIV prevention. Poorly educated women and girls are too often victimized by misinformation or lack of information about the epidemic, safer sex options and legal rights.

In neighboring Uganda, the government is taking a proactive approach to protecting girls. Village committees are empowered to enforce regulations forbidding premarital sex, sexual abuse of minors and underage drinking, and the Ugandan Army has created a new code of conduct for its soldiers, forbidding sexual relations with unmarried girls.

### **Defending Sex Workers**

Women who must resort to commercial sex work for economic survival are especially vulnerable to HIV infection. The criminalization of prostitution in Kenya means that female sex workers cannot report abuse by their clients. Few female sex workers feel they can afford to insist on condom use and other safer sex practices for fear of losing customers, their only source of income.

Women's rights organizations in Kenya insist that the basic human rights of female sex workers—including the right to remain uninfected by HIV—be protected by law enforcement agencies, which often treat such women as if they had no rights at all. Some groups have called for decriminalization of commercial sex work, arguing that this will put sex workers in a better position to negotiate for safer sex and to demand an end to abuse. Again, economic opportunities are critical, to give sex workers the ability to leave their dangerous line of work and support themselves and their children in more productive ways.

### **Empowerment and Legal Reform**

National HIV prevention programs and politicians who condemn abuse are not enough to protect the women of Kenya from a fatal epidemic that

shows few signs of abating. Legislative and policy reform that drives deep into the heart of women's economic and social inequality must be enacted, and Kenya's leaders must have the political will to confront entrenched social-cultural norms that oppress women and leave them profoundly vulnerable to HIV/AIDS.

Despite what at times seems like an uphill struggle for change in many parts of the continent, women in Africa and around the world now have a new policy model for female empowerment and legislative action against the epidemic. The Platform for Action adopted at the U.N. Fourth World Conference on Women in Beijing this past September calls for all governments to review and amend laws and enact legislation against social-cultural practices that may contribute to women's susceptibility to HIV infection.

As a member of the United Nations and a signatory to all of the U.N.'s international policy documents, Kenya can be a leader in Africa by aggressively pursuing legal reforms that enable women to protect themselves. Women in Kenya and throughout Africa must unite politically to demand that such action be taken, to save our own lives and the lives of the next generation. ■

*Jane Kiragu is a lawyer and a council member of the Kenyan branch of the International Federation of Women Lawyers (FIDA), which has 75 branches throughout the world. She is the convenor of FIDA-K's Women's Health and Reproductive Rights Subcommittee and is currently conducting research on female genital mutilation in Kenya.*

# Resources

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## Programming Through the Lens of Gender.

Gender in Development Programme/UNDP. This information package contains eight booklets that define the gender approach to development. It explains the steps taken by the UNDP in developing a strategy for mainstreaming women's issues into programming. The booklets include information on services to the field, the U.N. Fourth World Conference on Women, special initiatives, programming guidelines, key concerns for UNDP staff, a survey of approaches, an overview and additional reading suggestions. Several of the approaches have been or are being tested in country programs. The booklets are available free from UNDP, 1 U.N. Plaza, New York, NY 10017, USA.

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## Putting Gender on the Agenda: A Guide to Participating in United Nations World Conferences.

This 51-page handbook provides specific and practical information about how these conferences work and how to enhance nongovernmental organization (NGO) participation. It describes how U.N. world conferences are planned and organized and contains suggestions for NGO activities based on NGO experiences. Available free from the U.N. Development Fund for Women (UNIFEM), 304 East 45th Street, New York, NY 10017, USA.

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## Women and the World Development Series.

United Nations Nongovernmental Liaison Service. This series of reports is the outcome of more than a decade of research on world development and its impact on women. It suggests ways to bring women's concerns more directly into the development process and to bring about an improvement in women's status worldwide. Each volume is fully illustrated and contains a resource guide and description of how to use the book in workshops and seminars. It is available free to people working in developing countries from the U.N. Nongovernmental Liaison Service (UN-NGLS), Room 6015, 866 U.N. Plaza, New York, NY 10017, USA.

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## Getting the Message Out: Designing an Information Campaign on Women's Health.

Family Care International (FCI). This step-by-step guide is designed to help local organizations in Africa develop, produce and evaluate education materials and messages on women's health for local communities. The guide includes sample messages, checklists, questionnaires and a resource list. Available free from FCI, 588 Broadway, Suite 503, New York, NY 10012, USA, if fewer than five copies are ordered.

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## Healthy Women, Healthy Mothers: An Information Guide.

Family Care International. This 200-page book on women's health issues in Africa is designed to help health workers provide accurate, up-to-date information for the women they are serving. Written by a Ghanaian obstetrician, the book includes chapters on all stages of pregnancy and postpartum care, family planning, infertility, adolescent health and sexuality, prevention of STD transmission and the role of men in women's health. Available free from FCI, 588 Broadway, Suite 503, New York, NY 10012, USA, if fewer than five copies are ordered.

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## The Grafton Compact: Integrating Women into the Decision-Making Processes of PVOs.

InterAction, American Council for Voluntary International Action. The second edition of the Grafton compact reports on the 1988 and 1990 conferences on Women, Leadership and Development, which examined the role of women in U.S. private voluntary agencies and recommended ways to achieve equal participation of women in every phase of development. It is available for \$7 from PACT Publications, 777 U.N. Plaza, New York, NY 10017, USA.