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Gender Based Violence, Sexual Abuse and Exploitation in South Asia Increases Risks and Vulnerability to HIV/AIDS

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Introduction

Gender inequality in the region is the driving force behind two distinct but interrelated epidemics – violence against women and girls and HIV/AIDS. Gender-based violence throughout the life cycle is extensive in the South Asia region, ranging from foeticide and infanticide to physical, sexual and emotional abuse in public and private spaces. There is growing evidence in the region that violence against women, especially domestic violence, is of epidemic proportions with 40 to 70 percent of women and girls in South Asia experiencing some form of physical, sexual and emotional abuse (Hayward 2000).

"There is also mounting evidence of a complex link between child sexual exploitation and the ongoing spread of HIV/AIDS in the developing world..... Children who are forced into the sex trade - which a new UNICEF Report, Profiting From Abuse, puts at a million a year worldwide - are exceptionally vulnerable to contracting the virus that causes AIDS."

–Carol Bellamy, Executive Director, UNICEF Keynote address to Second World Congress against the Commercial Sexual Exploitation of Children, Yokohama, Japan, 17 December 2001

An equally disturbing new epidemic in the region is HIV/AIDS, which is now lurking at the edges of mainstream society. Current statistics reveal that although national HIV prevalence rates for countries in the region are low (1 percent and lower), there are already localized epidemics within particular populations.

From over a decade of research we know that gender norms and gender inequality play a critical role in the spread of HIV infection, making South Asia, with high levels of gender inequality, fertile ground for the rapid spread of infection. The National AIDS Control Organization of India estimates that currently 20 to 25 percent of all HIV infections in India are among girls and women and that the gender gap in infection is decreasing over time.

Given that girls and women in South Asia face increased vulnerability due to the gender discrimination and abuse throughout their lives, discrimination circumscribes their power to exercise choice in many critical areas including education, marriage, reproduction and employment. Coupled with high rates of domestic violence and abuse, this discrimination translates into high levels of vulnerability to HIV infection among women and girls. Violence undermines the ability of women to access HIV/AIDS prevention,

care, support, and treatment programs and HIV/AIDS, in turn, contributes to an increased risk of violence because of the stigma and discrimination experienced by those who are infected or affected by the disease. There is, thus, a dynamic interplay between the spread of HIV/AIDS and gender-based violence in the region.

"For millions of girls and women worldwide it is clear that violence, AIDS and human rights abuses are experienced as three strands of the same traumatic reality"

–Dr. Peter Piot, Executive Director, UNAIDS
Commission on the Status of Women,
Forty-third Session,
Panel on Women and Health: HIV/AIDS
and Violence against Women

This paper explores the gender-based vulnerability of women and girls to HIV/AIDS in South Asia and the linkages between HIV/AIDS and violence against women and girls. The paper provides an overview of the main issues and challenges in more effectively containing the spread of HIV/AIDS and increasing the safety and protection of women and girls from violence in South Asia. The first section of the paper briefly outlines the extent of gender inequality in the region, with a special focus on the extent and forms of gender-based violence. The second section, presents the broad contours of the HIV/AIDS epidemic in the region and the ways in which gender fuels the spread of infection. The interrelation between women's and girls' vulnerability to HIV/AIDS and violence is presented in the third section. This is followed by a discussion of the key lessons learned and 'what works' to address violence and to protect girls and women in the HIV/AIDS epidemic. Finally, the paper concludes with a discussion of the way forward and the responsiveness required at all levels.

HIV/AIDS in South Asia

A rapidly evolving epidemic

Almost 1 million people in Asia and the Pacific acquired HIV in 2002, bringing to an estimated 7.2 million the number of people now living with HIV in this region – a 10% increase since 2001. Current UNAIDS/WHO projections suggest that more than 40% of the estimated new infections between 2002 and 2010 will occur in Asia and the Pacific.

Currently, within the region and in many South Asian countries, national HIV prevalence levels as yet remain comparatively low – majority of people in the region are not infected. This offers an important window of opportunity but is little cause for comfort. Twenty years global experience has shown that no country in the world is inherently protected by geography, culture, tradition and religion.

Moreover, in especially populous countries, low national prevalence rates can seriously distort understanding of the epidemic. India's national adult HIV prevalence rate of less than 1%, for example, offers little indication of the serious situation facing the country. In fact, an estimated 3.97 million people were living with HIV at the end of 2001. This is the second highest figure in the world, after South Africa.

Elsewhere in the region, in countries such as Bangladesh, Nepal and Sri Lanka, there are rapidly developing local epidemics among those groups most vulnerable to HIV. These include sex workers, injecting drug users, men who have sex with other men, migrant populations and others made vulnerable by economic and social instability. Among injecting drug users, in particular, exceedingly high levels of infection have been reported – upwards of 50% in parts of Myanmar and Nepal, and in Manipur in India.[1] High rates of needle-sharing have also been documented among drug users in Bangladesh.

If left unchecked, concentrated epidemics affecting only a few individuals can rapidly develop into more generalised ones. Globally, there is increasing infection rates among younger people and in particular among young girls. There are approximately six thousand new infections among young people everyday. Available data from Nepal and India suggest that new infections are occurring increasingly

in young people below the age of 29.[2] This has serious implications for some countries in the Asian region in which approximately 54% of its population is below the age of 25.

Evidence from a study in India also indicates that young women who are being infected are mainly, those within the context of a monogamous relationship.[3] NACO has estimated that of the roughly 27 million pregnancies that occur annually in India at least 100,000 occur in HIV positive women. This is likely to lead to approximately 30,000 infected babies and a further 70,000 children likely to be orphaned as a result of HIV/AIDS.[4] In some states in India, up to 85% of women attending antenatal clinics are below 20 years of age, indicating something of where the future burden of the epidemic will lie.

Data on impact of AIDS in the in the region is very limited. But discrimination and stigma have been widely reported. The NACO/UNICEF study in India on impact found that children are likely to be withdrawn from schools, are being forced to leave schools or prevented from playing with other children.[5] Similar acts of discrimination were the findings of a situation analysis of children affected in Nepal.

In areas hard hit by the epidemic, AIDS is likely to become the leading cause of death among young adults. HIV in India is already one of the two largest and growing causes of death.[6] Children may become the household's only breadwinners if working-age adults are sick. Exacerbated by gender stereotyping, girls are likely to be kept at home to care for sick relatives, or to do housework. This is serious enough in countries where the gender gap is slight, but in South Asia it compounds existing inequalities in the uptake of schooling by girls. Though the precise numbers of individuals as yet affected within the region is unknown, and more research is needed, there can be no room for complacency in this respect.

Gender Inequality and Violence Against Women and Girls in South Asia

Persistent gender inequality throughout the life cycle is pervasive in South Asia. From denial of life at birth to differential access to nutrition, health care and education in childhood and from restricted mobility and economic opportunity and early marriage in adolescence, to lack of voice or decision making in adulthood, women rarely realize the principle of equality that is enshrined in the constitution of every country. Socially and culturally determined gender norms that are embedded in the institutions of family, community and society perpetuate gender hierarchies and drive this unequal balance between men and women, boys and girls.

"The word "gender" differentiates the sociologically attributed aspects of an individual's identity from the physiological characteristics of men and women. Gender has to do with how we think, how we feel and what we believe we can and cannot do because of socially defined concepts of masculinity and femininity. Gender relates to the position of women and men in relation to each other. These relationships are based on power."

–Gender, HIV and Human Rights: A Training Manual UNIFEM, 2000

Typically, gender norms ascribe greater access to productive resources and decision-making authority to boys and men as compared to girls and women, which results in an unequal balance in power in gender relations that favours boys and men.

A summary of regional data on the standard indicators of women's and girls' status indicates the exceptionally difficult situation of women and girls in South Asia. Discrimination against South Asian women and girls begins at, or even before, birth. Female foeticide and infanticide, neglect of health of girls, and gender-biased feeding practices all are manifestations of the son preference and patriarchal structures which prevail across the region. As a consequence South Asia has one of **the most distorted sex ratios in the world.** There are only 940 females for every 1000 males compared to a global average of 1060 females per 1000 males. This suggests that there are nearly 79 million women and girls "missing" in the region who would have been alive if the sex ratio followed the global norm (Mahbub ul Haq 2001).

As a region, South Asia has **the largest gap between the rates of male and female literacy** (37.2 percent in 1997) and 44 percent of the world's illiterate women are South Asian. Girls face particular discrimination in education with selective enrolment, retention and dropout patterns. The gender gap in education is very wide in South Asia in primary and secondary education. According to UNICEF, the ratio of girls' to boys' enrolment was 82 percent for primary school and 71 percent for secondary school (UNICEF 2003). Yet millions of girls cannot fully avail of educational opportunities, as a significant proportion of them drop out before completing primary school. Nearly 50 percent of girls enrolled in primary

schools in India and Nepal drop out before the 5th standard (UNESCO). The withdrawal of young girls from schools is a reflection of the systematic discrimination faced by them in the family, which undermines the full development of their potential and significantly reduces their self-esteem. For those who manage to stay in schools, there is growing recognition that girls face differential treatment by teachers and the risk of violence in schools, including sexual violence.

Official statistics in South Asia show **women's economic participation is a small fraction of that of men.** The majority of South Asian women work in the informal sector and as unpaid family workers with their work unrecognized in national systems of accounting. **Girls are also forced to work in** factories, as domestic servants, and as unpaid labour in family enterprises. Most commonly girls are expected to share the burden of housework including taking care of younger children and domestic chores. South Asian women's real GDP per capita at US $874 is lower than any other region in the world, including sub-Saharan Africa (Mahbub ul Haq 2001). Furthermore, **women's political representation in South Asia is abysmal** - only 7 percent of South Asian parliamentarians are women.

The culture of patriarchy is deeply entrenched within the countries of the region and its ideology ensures that **women have limited access and control over resources.** To a large extent, legislation has codified male privileges and women remain unable to gain equal access to inheritance or property and face other restrictions (Mahbub ul Haq 2001). For example, personal laws, which can be highly discriminatory, govern inheritance rights in Pakistan and Bangladesh. The inheritance laws derived from Hindu laws in both India and Nepal contain discriminatory provisions on inheritance to joint family property which prevent women having access to land and movable property. Recently the Nepali Parliament, after six years of intensive lobbying, has passed a bill on inheritance rights recognizing the right of daughters to inherit equally with brothers in family property, though the girl must renounce her share at the time of marriage.

The culture of son preference arises out of a belief in the inherent superiority of men, the fact that sons are parents' security for the future and to perform family rituals. Daughters are generally seen as an economic liability, to be married away and sent to their "rightful house". In Nepal, Sri Lanka, India and Pakistan girls are referred to as another's property entrusted to the natal home till their marriage.

The Human Development Report (HDR) of South Asia for 2000 observes that "several factors that transcend class, religion, culture and locality… effect the lives of all South Asian women. These include: responsibility for housework and child care; vulnerability to domestic violence and the economic vulnerability that reflects women's unequal legal and social status." (Mahbub ul Haq 2001). The report further analyses that these commonalities are based upon a shared sub-continental history of colonialism, layers of religious, cultural, economic and political structures shaped by strong patriarchal values that disempower women.

The Role of Gender Relations in the Spread of HIV/AIDS

The inequality evident in gender relations that provides men with greater access to economic resources is often replicated in heterosexual interactions. Male pleasure supersedes female pleasure and men have greater control over their sexuality than women do. Sexuality is the social construction of a biological drive. It is a multidimensional and dynamic construct. Explicit and implicit rules imposed by society, as defined by one's gender[7], profoundly influence an individual's sexuality.

Power is fundamental to both sexuality and gender relations. The power underlying any sexual interaction, heterosexual or homosexual, determines when, how, and with whom sex takes place. The balance of power in any sexual interaction determines its outcome. An understanding of individual sexual behaviour or sexual risk thus necessitates an understanding of gender and sexuality as constructed by a complex interplay of socio-cultural and economic forces that determine the distribution of power.

Gender norms that create an unequal balance of power between women and men are deeply rooted in the socio-cultural context of each society. By defining the societal ideals for feminine and masculine behaviour and sexuality, socio-cultural factors greatly affect women's and men's access to information and services, their sexual behaviour and attitudes, and how they cope with illness once infected or affected.

Prescribed Gender Stereotypes: Throughout the region, women and girls are regarded as inferior and subservient, economically and socially dependent on their fathers, husbands, and sons over the life cycle. Culturally, the normative ideal of a good woman and wife is one who is subservient, self-sacrificing, and innocent about sex. A high premium is attached to the virtues of virginity and chastity in girls and a family's honour is dependent on the sexual purity and fidelity of its girls and women. Women are valued as mothers and motherhood is the ultimate expression of femininity.

Masculinity, on the other hand, is expressed in terms of positive images – strong, fearless, decision-maker, and active sexual being. There is wide acceptance of the norm that men may have multiple partners and initiate and control sexual interaction. Studies in South India among male STD clients revealed that 82% had sexual relations with multiple partners (UNDP, 1999). Among young men, 'manliness' is often equated to violent sex. Men often feel burdened by the need to sexually satisfy their women because they fear they may be publicly ridiculed by their wives.

Thus the ideals of femininity and masculinity in the region place a pressure on men to be more knowledgeable about sex, seek multiple partners, and physically dominate over women. For women, the ideals of femininity limit their knowledge of sex, their access to services for sexual health and their capacity to negotiate protection in sexual interactions. These gender ideals, thus, increase both women and men's vulnerability to HIV infection.

Low economic status: From qualitative research conducted in South Asia, as well as elsewhere, it has been established that women's economic vulnerability and dependency on men reduces their bargaining power. This makes it less likely that they will be able to leave a relationship that they know to be risky, less likely that they will be able to cope with illness once infected; less likely that they will be able to access information and treatment and care services; and less likely that they will be able to care for loved ones who are infected (UNIFEM 2002; Rao Gupta 2000). Economic vulnerability and poverty also makes it more likely that women will exchange sex for money, safety, or favours. The majority of sex workers in the region are either trafficked into the trade or voluntarily choose prostitution because of dire poverty and the need to provide for their families. 70 to 80 percent of women in the region are in insecure and invisible jobs in the informal sector and even those that are employed in the formal sector earn less than men. Occupational segregation also persists, with women employed in much larger numbers as teachers, office assistants, and domestic help than men (UNIFEM 2000). These inequalities and realities create fertile ground for the spread of HIV by increasing women's vulnerability to infection.

Violence against Women and Girls

Violence is experienced throughout the life cycle of women and girls in South Asia. Women and girls face harsh discipline in family and schools as children, denial of choices in marriage and reproduction, abused as adult women in the family and society as well as neglected and abused as widows in old age. The specific forms of violence experienced by women and girls in the region, range from physical, sexual and psychological abuse in the private and public spheres, to social customs . These include child marriage, devadasi or dueki (dedicating a woman to the temple), niyogi (the marriage of a widow to the deceased husband's younger brother), dowry deaths and honour killings. Other forms of violence are also common such as stove (or 'kerosene') deaths in India and Pakistan and acid burning in Bangladesh.

Violence against women and girls, a gross violation of human rights, is defined in the United Nations Declaration on the Elimination of Violence Against Women as "… any form of gender based violence, that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life.

Domestic violence: As the HDR for South Asia pointed out, vulnerability to domestic violence is common throughout the region, transcending class, caste, religion, culture and locality. It is globally recognized as a problem of epidemic proportions with serious economic and health consequences. According to WHO, population-based surveys from various parts of the world find that 16 to 50 percent of ever-partnered women report they have been physically assaulted by their intimate partners. In the South Asia region there are few large population surveys establishing rigorous prevalence rates. The available evidence indicates that the levels of domestic violence in South Asia are very high as shown in Table 1.

TABLE 1: **Prevalence of Violence Against Women in South Asian Countries**

Country	Findings (% of women in sample size)
Bangladesh	
1999 (Naripokko 1999)	61.8% reported physical violence at some point in their lives
1996 (Schuler, Hashmi , Riley and Akhter 1996)	47% report having been ever beaten by their husbands, 19% in the past year
1999 (Koening, et. al. 1999)	42.1% reported recent physical violence
India	
1997 (Jejeebhoy and Cook 1997)	40 % were physically assaulted by their current male partner.
2000 (INCLEN 2000)	40% reported being physically assaulted by their husbands, 52% reported psychological violence and 50% of those reporting physical violence reported experiencing it in pregnancy.
Nepal	
1997 (Saathi 1997)	82% reported they knew of one incident in which woman had been beaten
Pakistan	
1998 (Ahmed 1998)	A human rights study indicated that 80% of women surveyed reported domestic violence.
1999 (Qureshi, et.al. 1999)	66.8% reported some form of physical abuse in marriage
Sri Lanka	
1990 (Sonali 1990 – cited in Hayward, 2000)	60% suffer domestic violence.

There is also evidence that physical abuse frequently coexists with sexual abuse. The central underlying factor is the belief that women's bodies are the property of men and boys. A Nepali woman lawyer states: "The root cause of violence against women and girls is their lack of property rights. A woman is born as another's property, not her own." Or, as stated by a Pakistani man, "We consider women as valuable property – to be protected from damage and presented to the husband in prime condition." (quoted in Hayward 2000:16)

Domestic violence has serious costs which are only now being explored in depth. New studies on the health and economic costs of domestic violence are yet to be undertaken in the region. Existing evidence points to significant health consequences such as fractures, chronic pelvic pain, headaches, gynaecological disorders, and suicide ideation.

The most important cost of domestic violence is, however, **the impact on children and the intergenerational transmission of violence**. A study in Nicaragua highlights some of the dimensions of the cost to children: "Children from families in which women are subject to domestic violence are three times more likely to require medical care and are also hospitalized more frequently. Some 63 per cent of these children repeat a grade at school and on average drop out at age of 9 …" (MacCulloch 1997:2) Apart from the impact on health and education, studies have established that witnessing violence as a child is a strong predicator for experiencing or perpetrating violence as an adult (INCLEN 2000).

In addition to violating the rights of women to bodily integrity and safety, domestic violence and abuse, as well as the threat or fear of violence, fuel the spread of HIV infection by restricting women's and girls' ability to question a partner's fidelity or ask for safe sex. The threat of violence also makes it difficult for women and girls to ask for information or to access services that they may need in order to protect themselves.

Forced Sex, Sexual Abuse and Sexual Coercion: Within the South Asia region, sexual violence comprising of forced sex, sexual abuse and sexual coercion has been an area of silence and shame for girls and women. Central to the gendered construction of sexuality in the region are the control of female sexuality and the common belief of impurity of women and girls. Men's virility, on the other hand, is dependent on frequent and varied sexual activity. Sexual violence is thus viewed as an acceptable method of validating manhood. Women, on the other hand, view sexual violence as a reflection of their basic "impurity" and thus a matter of shame.

For women and girls the **forms of sexual violence commonly experienced are rape, incest and sexual coercion and forced sex in marriage**. The issue of sexual abuse of children has emerged as an important area of research and advocacy and there is growing evidence that the sexual abuse of girls often occurs within the natal family. While there is little systematic information on the problem, newspapers regularly report, often in a sensationalized manner, the rape of young children. An examination of the police records in five leading cities in 1994 in India revealed that nearly half of the rape cases were of young girls below 16 years of age. Similarly in Nepal, one study found that nearly 50 percent of victims of rape were below 16, and most of them were raped by their relatives (Hayward 2000). In Bangladesh, of 5738 official rape cases between 1991 and 1996, 16.26 percent were cases of minors.

Apart from official recorded data, qualitative studies through the region confirm the **high level of sexual abuse experienced by young girls and boys.** A survey by Sakshi of 350 school girls in Delhi in 1997 found that 63 percent had experienced sexual abuse by a family member. Another survey by RAHI of 1000 middle and upper middle class women found that 70 percent of the respondents had been sexually abused as children and nearly 50 percent experienced the abuse when they were under 12 years of age (Poore 2000). In Sri Lanka a retrospective study among secondary and university college students found that 12 per cent of the girls and 20 per cent of the boys reported experiencing sexual abuse as children (de Silva 1996). A small qualitative study of rape survivors in Nepal found that 39 per cent survivors were below the age of 19 (Deuba and Rana 2001). Most of these studies confirm that sexual abuse results in long-standing health and psychological impacts such as chronic pain, low self-esteem, lack of trust, and inability to articulate feelings.

The female body is also more vulnerable biologically to infections. Rape and sexual abuse during childhood greatly increases a girl's risk to HIV infection because of the potential for damage to the tissue in an immature genital tract, thereby greatly increasing the efficiency of transmission of HIV. Survivors of sexual abuse are more likely to engage in risky behaviours in adulthood, such as compulsive and risky sex and the excessive use of drugs and alcohol, all of which are risk factors for the spread of HIV infection. Research in Sri Lanka of college youth indicated that **youth who experienced sexual abuse as children are likely to become perpetrators**, with 71 per cent of those admitting to sexually abusing children (de Silva 1996).

Equally scant are data on forced sex in marriage though several recent studies have highlighted that the problem is more extensive than previously thought. A study in Bangladesh on a sample of 500 women found that 26.8 percent reported forced sex in the past year (Hills and Hadi 2000). A survey of 9,938 women in India found that 15 percent of the women reported forced sex in the previous 12 months, and that it was a regular occurrence in marriage. (INCLEN 2000).[8] A detailed study on masculinity in three regions of India found that 50 per cent of the 963 men surveyed, reported perpetrating forced sex in the past year. Interestingly, men in very high numbers reported that they had sex even when the wife had openly expressed unwillingness, based on the reasoning that marriage sanctified the sexual availability of the wife at all times (Duvvury, Nayak and Allendorf 2002).

The preponderance of forced sex in marriage is disturbing when linked to the common practice of early marriage in much of the region. In Nepal there is evidence

that the average age of marriage for girls is 14-15. In Pakistan nearly 35 per cent were married by the age of 15 (UNFPA 1998). In many parts of India, girls are betrothed at birth itself and sent to marital home with the onset of puberty ranging from 12-15. The **early age of marriage is a risk factor for HIV infection** because it exposes girls to sex with sexually active older men who may have been exposed to the virus. A newly married girl has almost no ability to negotiate the use of a condom within a social context that defines a bride as the property of her husband. Although it is widely believed that the sexual initiation of young girls in marriage occurs only after puberty, often young girls are married and sexually raped by their husbands before the onset of menstruation. Many of these young girls are more likely to experience continued sexual violence in the marriage.

Other forms of sexual interactions, such as transactional sex, even though they are often not coercive or forced, expose young women and girls to serious health risks. Often young girls and even boys engage in sex for gifts and small amounts of money. While these relationships may not be forced, the unequal balance of power between sexual partners that typically characterizes such relationships circumscribes the rights and freedom of the young woman and makes it difficult for them to set the terms of the interaction or insist on protection from pregnancy or infection.

Trafficking for Sexual Purpose: Trafficking of women and girls for the growing sex industry is an increasing phenomenon in the region. Estimates of the sex industry in the region are few. India is a major receiving country and also acts as a point of rerouting. Available estimates indicate that nearly 7000 young girls between the ages of 12 and 20 are trafficked from Nepal to India every year. NGO activists estimate that 10,000 to 15,000 women are trafficked yearly from Bangladesh (UNICEF ROSA 2001).

Trafficking in the region is fuelled by poverty, the long standing conflict in certain pockets of the region, and particular social customs. Both India and Nepal have a tradition, known as the *devdasi* in India and *dueki* in Nepal, in which young girls are dedicated to the temple or goddess. In Nepal among the Badi community, girls and women are commonly forced into prostitution and 35 to 40 per cent of these girls are below the age of 15 (UNICEF ROSA 2001).

Trafficking of women into sex work greatly increases girls' and women's risk of HIV infection because of the multiple sexual interactions that define prostitution and because of the lack of

"Trafficked within and across borders, press-ganged into prostitution, pornography and other intolerable forms of child labour, they (children) are overwhelmingly drawn from the ranks of the most vulnerable - refugees, orphans, abandoned children, child labourers working as domestic servants, children in armed conflict - and those whose sexual abuse began at home or in other familiar surroundings."

–Carol Bellamy, Executive Director, UNICEF
Keynote address to Second World Congress against the Commercial Sexual Exploitation of Children, Yokohama, Japan, 17 December 2001

power and control that typically characterizes the lives of young girls who are trafficked into prostitution.

Rape: Kidnappings, abductions and rape by non-family members are long standing traditional practices in parts of South Asia. From ancient times, an accepted form of marriage has been the kidnapping of the desired partner and this practice continues today not only among tribal communities but also among high caste groups. Rape has been a traditional instrument of caste and class oppression. In India, Dalit women have been routinely raped by landowners to drive home the complete powerlessness of Dalit men in the caste hierarchy. Rape has also been an instrument to assert ethnic and religious identity. Today in many of the conflict zones in the region, rape of women and girls is a frequent feature of the conflict. Impact of conflict on children is receiving growing attention but there is indication that the risk of rape and trafficking of young girls and boys is a potential problem (UNICEF ROSA 2001).

Violence against women and girls of such epidemic proportions as found in the region is likely to limit the mobility, voice and agency of women. In other contexts, violence and the fear of violence limit women's participation in development programmes and greatly increase their vulnerability to infection and unwanted pregnancy. Rao Gupta and Weiss (1998) have highlighted the fact that violence often hinders women's ability to use contraception, negotiate safe sex, answer personal interview questions directly or honestly, or to leave the house long enough to participate in community projects. In essence, violence against women and girls impacts their everyday freedoms. This denial of fundamental rights to women makes them more susceptible to HIV and fuels the spread of the HIV/AIDS epidemic in the South Asia region.

Prominent risk factors making South Asia an ideal breeding ground for HIV/AIDS epidemic among women and girls are:

- widespread poverty
- low status of women and girls
- illiteracy
- limited public awareness and knowledge of HIV/AIDS
- the shroud of silence
- trafficking of women and children into sex work
- low condom use among men and sex workers
- sharing of needles by injecting drug users
- lack of blood safety
- high mobility

The Relationship between Violence Against Women and Girls and HIV/AIDS

The pervasiveness of violence has significant implications for the spread of HIV and for HIV prevention. The most direct impact is through sexual violence and rape which directly puts women and girls at risk of infection, particularly in high prevalence settings. Women's greater biological vulnerability to infection is further compounded when forced or violent sex creates lacerations and abrasions in the genital tract. The vulnerability of young girls is even greater because the immaturity of their genital tract and reduced vaginal secretions makes them even more prone to infection.

Research conducted in diverse countries found that violence and the fear of violence acts as a significant barrier to women negotiating condom use or fidelity with their partners. The threat of violence also constrains women's ability to leave relationships that they perceive to be risky. Fear of violence has also been noted to limit women's use of HIV/AIDS counselling and testing services and inhibit women's disclosure of their serostatus. Women who seek HIV testing and counselling services, often do not disclose their status to their partner due to fear of a violent reaction. Therefore, domestic violence should be considered when formulating partner notification policies and HIV counselling protocols.

In studies in Africa, the stigma associated with HIV/AIDS and the fear of violence that this causes, proved to be barriers to the successful implementation of efforts that seek to reduce the perinatal transmission of HIV. Fear of stigma and domestic violence are important reasons that pregnant women refuse HIV testing or do not return for test results. Similar concerns have been voiced by HIV-positive women who have been advised to bottle-feed their babies to avoid the risk of HIV transmission. Because breast-feeding is the norm in many societies, women feared that using a bottle would brand them as being HIV-infected and expose them to the stigma and violence that often results. Fear of violence and stigma were the foremost reasons for women to decline to participate in voluntary counselling and testing or programmes to prevent mother-to-child transmission. Such factors may also constrain women's use of VCT in South Asia.

The nexus between violence, risky behaviour, and reproductive health has been documented by a number of researchers. Traditional notions of male and female

roles appear to foster violence against women. This relationship is also apparent from the results of a study conducted in India in which men who had experienced extramarital sex were 6.2 times more likely to report wife abuse and admit to being violent, than those who had not. In addition, men who reported symptoms of sexually transmitted diseases were 2.4 times more likely to abuse their wives than those who did not (Martin et al. 1999).

The experience of gender-based violence has also been found to be a strong predictor of HIV. Research in Africa has shown that younger HIV-positive women were almost 10 times more likely to report partner violence than similarly aged HIV-negative women.

What Works: Lessons Learned from Current Initiatives

A critical lesson that has been learned globally, is that accountability for reducing gender based discrimination and violence cannot rest with any one actor. Gender mainstreaming calls for every sector and all actors at all levels to integrate responsiveness to gender inequality in all that they do. Governments, I/NGO's, faith-based organisations, the private sector and the media, civil society and children and young people, each have specific roles in addressing the root causes and providing gender sensitive mechanisms to reduce such inequality.

Efforts to address violence against women and girls and prevent the spread of HIV/AIDS implemented by both governmental and non-governmental agencies in South Asia and elsewhere suggest some important lessons for future initiatives. Most programme responses have focused on four critical areas of **protection, prevention, recovery and reintegration.**

Existing approaches to address gender in HIV/AIDS programming fall along a continuum from "do no harm" (i.e. avoid making discriminatory distinctions between men and women that actually negate any real or potential programme successes) to "transformative" (i.e. changing gender roles and enabling more equitable gender relations). Each of these approaches, and their effectiveness in addressing the gender-related constraints and needs of women and girls is described below.

1. Do No Harm

The most basic and fundamental aspect of a gendered set of policies and programmes requires the elimination of those assumptions, suppositions and stereotypes that are damaging to women's and men's ability to benefit from interventions and policy responses to HIV/AIDS.

- **Do Not Perpetuate Gender Stereotypes:**
  National policies and communication strategies and the media need to ensure that they do not foster images of male sexuality that are violent, predatory and irresponsible. At the same time women need to be portrayed as empowered human beings, not as passive "victims" of male power and domination. In addition, women are often seen as "repositories" of infection and disease,

responsible for bringing illness and death into their households and communities.

Implementers need to revisit assumptions and strategies and recognise that although such efforts may result in short-term gains, for example, an increase in condom sales, in the long-term they encourage violence against women and erode the very foundations upon which HIV prevention activities are based, namely responsible, respectful, consensual, and mutually satisfying sexual partnerships (see Box 1).

Design interventions based on data on women's and men's lives in a particular community or setting, rather than based on stereotypical notions of gender roles will bring far better results.

BOX 1: **Is Schooling A Risk?**

A recent study carried out in a government-run, co-educational secondary boarding school in Kampala, Uganda demonstrated that even a well-designed and implemented HIV/AIDS education programme can be thwarted by the overall gender-discriminatory environment within which the programme is conducted. This evidence was corroborated by data collected from 21 other schools around the county.

The main finding of the study showed the school to be a site of an extensive set of gendered practices, which constituted a risk in themselves in terms of sexual health. In particular, four patterns or forms of "control" emerged from the study: hegemonic masculinity; gendered discipline patterns, sexual harassment, and 'compulsory' heterosexuality.

In the first instance, the AIDS education curriculum addresses the power disparities between male and female but the mechanisms used to gain power within the school—defining "leadership" as a male preserve, for example—compromises that part of the curriculum that seeks to change gender norms.

In terms of gendered discipline patterns, school officials defined differential levels of discipline for boys and girls, for example, by reinforcing the idea of girls as "victims" – where rules and regulations for them were designed "for their safety." Thus girls were more "policed" than boys, including treating girls as if they might "tempt" boys sexually. Girls were urged thus to be "obedient" in a manner not required of boys. These practices negated parts of the curriculum designed to encourage boys and girls to "question" gender role stereotypes as a means of empowerment.

Sexual harassment in this environment meant that boys controlled the language space and physical space of the girls, forcing them into silence. Harassment of the girls ranged from having to put up with verbal slights and insults to actual physical abuse—even adult female teachers experienced verbal abuse from boys in their classes.

In Uganda, social and sexual interaction within a co-educational setting is the norm—students do not self-segregate. In some cases, there were reports by girls of "forced relationships," that they conformed to in order to "be safe" despite their dislike of the situation. The boys were pressured by their peers to take on girlfriends, lest they be teased. Boys were also expected to "prove" themselves and often dared to "do something" with a girl. Failure to conform can lead to disciplinary measures by peers.

All these findings suggest that even well designed, "Best Practice" school-based prevention programs for youth may fail if the gendered environmental context is not taken into account.

Source: (Mirembe and Davies 2001)

- **Build partnerships with men and boys:**
  Blaming men for perpetuating injustices against girls and women has proved to be an ineffective strategy to reduce the unequal balance of power in gender relations. Such an approach runs the risk of shutting men out of the process of finding feasible solutions and significantly constrains the ability of programmes to work with women and men and young girls and boys as equal partners in promoting reproductive and sexual health. NGOs and community leaders need to recognise that men are not the sole problem to deal with in HIV/AIDS programmes.

Gender orientation and sensitisation efforts are required for a broad range of partners, both men and women to create more awareness that gender, class, caste, ethnicity, location, sexuality and age (among other factors) oppress women and girls as well as men and boys in different ways and with different consequences.

2. Gender-Sensitive Programmes

Programme design and implementation needs to take into account that the protection, prevention, recovery and reintegration needs of men and women are different. Distinct differences in physiology and gender roles and relations substantially influences *how* women and men will respond to initiatives designed to reduce risk, vulnerability or alleviate the impact of AIDS.

- **Address the Gender-Specific Needs of Men and boys:**
  Programmes that recognize the unique vulnerabilities that men and boys face represent an important and often overlooked aspect of gender-sensitive programming. Educational messages and media advocacy about prevention need to recognize the unequal power balance between men and women that is prevalent in all contexts and settings (see Box 2).

BOX 2: **Addressing Male Vulnerability in India**

The Healthy Highways Project was planned and implemented by DfID and the Government of India's National AIDS Control Programme (NACO). The project aims to reduce the number of new HIV infections among inter-city truck drivers, their crew and paid sexual partners. Two regional units manage the work, which has been mainly implemented through more than 30 NGOs, 18 transport companies and a number of transport-related associations.

In 1999, estimates suggested that almost 3.5 million people in India had become infected with HIV. Although there have been no studies to determine seroprevalence

Box 2 continued...

Box 2 continued...

among truck drivers, there have been alarming increases in HIV infection among ante-natal women in the areas where high concentrations of truck drivers live. There are up to five million truck drivers in India, and behavioral surveys show that 75 percent of truck drivers report extra-marital sex, mostly with sex workers (among whom HIV infection is up to 60 percent in the worst affected areas). Truck driving involves long periods of separation from spouses and families, dangerous and exhausting work, and relatively high earnings. Commercial sex partners are usually extremely poor and are mobile rather than brothel-based, making them difficult to reach with HIV prevention messages and technologies. Since condoms are usually associated with family planning, this type of "recreational sex' is usually unprotected.

The Healthy Highways Project offers STI care and counselling, condom promotion and distribution, dissemination of educational materials and face-to-face behavior change communication. While the mobility of drivers made conventional peer education impractical, training has been given to some who come into close contact with truckers, including petrol attendants, tobacco retailers and tea-shop owners. Beyond the 3.5 million men who have been reached through the project's activities, work has taken place with more than 33,000 sex workers, more than 2,000 of whom have been treated for STIs. In addition, the project had an indirect impact in protecting the spouses of the truck drivers from HIV and other sexually transmitted infections.

Men have reacted positively, welcoming services and expressing eagerness to obtain more information. The NGOs working with the men have established excellent networks and links with gatekeepers, but have not always had prior experience working specifically with men. This should be kept in mind in any attempts to replicate this kind of intervention elsewhere.

Source: (UNAIDS 2001)

- **Address the Gender-Specific Needs of Women:** women and girls need holistic services for protection, prevention, recovery and reintegration. Examples of effective programming include:
  - **a)** the integration of STI diagnosis and treatment interventions into anti-natal clinics to help women access such services without fear of social censure.
  - **b)** Providing women with a female condom or advocating for the development of microbicides are other examples of gender-sensitive programmes. Such efforts recognize that the male condom is a male controlled technology and take account of the imbalance in power in sexual interactions that makes it difficult for women to negotiate condom use, by providing them with a viable alternative.
  - **c)** An adaptation of the traditional model of prevention of MTCT is another example of a gender sensitive approach. The traditional MTCT prevention package consists of voluntary counselling and testing of pregnant women, the provision of antiretrovirals to protect the unborn child from infection, as well as the provision of breast milk substitutes to reduce the risk of infection to the baby once it is born.

Programmes now including provision of care and support for the mother a well as primary prevention of HIV in all women. Such an adaptation responds to women's needs and treats them as equally important as those of the child.

BOX 3: **MTCT Interventions**

The four-pronged strategy recommended for Prevention of Mother to Child Transmission:

- *Prevention of HIV infection in all women* - this is probably the most effective way of preventing mother-to-child transmission and involves providing appropriate information, including counselling to couples, promoting safe sex practices, promoting the delaying of sexual initiation, empowering women with the personal skills to act on their knowledge and ensuring that they have adequate access to condoms.
- *Prevention of unintended pregnancy among HIV infected women* - through the strengthening of reproductive and family planning services so that women and their partners can be provided with information to facilitate their decision of childbearing in the context of HIV.
- *Prevention of mother-to-child transmission of HIV* - this consists of a core package of interventions which includes among other things voluntary counselling and testing, anti-retroviral prophylaxis, safe delivery practices, counselling for appropriate infant feeding practices and care and support for HIV-positive mothers and their families.
- *Care and support to mother and children*

Source: UN Interagency Task Team

HIV/AIDS programmes that have successfully addressed gender discrimination have done so by acknowledging gender differences and designing services to meet the needs of women and men, girls and boys.

A long-term set of goals for the creation of successful and sustainable HIV/AIDS programmes, must make sure that gender-sensitive interventions are not at "end of the line."

3. Transformative Programmes

Programmes that seek to transform gender roles and create more gender-equitable relationships are more advanced than gender-sensitive approaches because they seek to change the underlying conditions that cause gender inequities within the context of HIV/AIDS programmes. They also transform HIV/AIDS initiatives by reaching both women and men and recognizing both genders as critical players in ensuring the effectiveness of HIV/AIDS programming.

- **Community-Based Transformative Programmes**:
  Transformative interventions use a variety of methods to work with men and women to facilitate an examination of gender and sexuality and its impact on male and female sexual health and relationships, as well as to reduce gender-related violence against women.

  One example is *Stepping Stones*, a well-known life skills training programme that uses transformative methods to address HIV/AIDS as well as broader community issues (see Box 4). Through a curriculum that includes group participation, ways to change, and examination of why people behave the way they do, participants are encouraged to take responsibility for themselves and others to promote safer, more productive, behaviour in the future. What is novel about projects like *Stepping Stones* in particular is that they actively target men for something other than promoting condom use or generic "safer sex" and "anti-violence" messages. These projects foster an environment that works with both men and women to redefine gender norms and encourage healthy sexual relationships.

  Examples of other programmes that seek to foster constructive roles for men in gender relations are the Men as Partners (MAP) programme in South Africa, the interventions that target young men, men in prisons, and a wide range of professional and working class men, designed and implemented by Salud y Genero, a small nongovernmental organization based in Mexico, and Project Papai in Recife, Brazil that targets young men on themes related to fatherhood.

- **Couple Counselling as a Method to Transform Gender Relations:**
  Other programmes that seek to transform gender relations include efforts to work with couples as the unit of intervention, rather than with individual men and women. Couple counselling in HIV testing clinics to help couples deal with the results of their tests and in family planning programmes to promote dual-protection against both unwanted pregnancy and infection are recent examples of efforts that seek to reduce the negative impacts of the gender power imbalance by including both partners in the intervention. Further research and efforts are needed to promote couple counselling and to test the effectiveness of this method in creating more gender-equitable relationships between women and men.

BOX 4: **The Challenges and Opportunities of Changing Gender Norms: The Stepping Stones Curriculum**

Stepping Stones is a life skills training package that encourages participants to find their lives, and those of others, worthwhile enough to look after themselves and each other. The original *Stepping Stones* package covers sessions grouped around four main themes: 1) group cooperation; 2) why we behave in the ways we do; 3) HIV and safer sex; and 4) ways in which we can change.

During workshop sessions, participants explore the range of factors that determine the quality of their lives and discuss their hopes and fears. Through this process, participants are encouraged to take control and responsibility for their own lives and form a strong bond by recognizing the equal value and contribution of each part of the community. It is on this basis that behavior change—not only for HIV prevention, but a wide range of other community development issues—can begin to take place.

Experience has shown that *Stepping Stones* requires time, good training, skilled facilitation, care, negotiation, prolonged follow-up and more time. A wide range of factors can prevent the successful transfer of *Stepping Stones* from one context to another. Strategies to promote its success include:

- Ensuring high quality implementation
- Promoting regular attendance
- Reducing barriers to attendance of poor men
- Bringing peer groups together
- Meeting special requests
- Challenging gender and age norms
- Working with issues of difference within the community
- Including on-going participatory monitoring

Source: (Gordon and Welbourn 2001)

4. Interventions to Address Violence Against Women

There are a range of approaches and interventions that are being implemented to address violence against women and girls in South Asia.

- **Legislative actions:**
  At the country level, most initiatives to address violence have been legislative. Issues such as dowry, cruelty to married women, trafficking, polygamy, rape of minors etc. have been addressed through various legislations in different parts of the region. The penal code of Bangladesh prescribes stringent punishment for kidnapping, abduction and rape extending to life imprisonment and capital punishment.. In Nepal and Pakistan, legislation on domestic violence is under discussion and a civil law on domestic violence has recently been introduced for discussion in the parliament of India. Although the legislation varies, most legal measures include a combination of protective or restraining orders and penalties for offenders.

- **Improved enforcement:**
  Enforcement of existing laws presents a formidable challenge. Procedural barriers and traditional attitudes of law enforcement and judicial officials undermine the effectiveness of existing anti-violence laws. National Ministries and NGO's need to invest more in capacity building programmes for judicial and law enforcement personnel to change behaviour and attitudes.

- **Psycho-social services for recovery and reintegration:**
  For the girls, boys and women who have experienced violence, a range of medical, psychological, legal, educational, and other support services are necessary. Both state and voluntary organisations have put on the ground a range of services at the community level aimed at mitigating the impact of violence on women and girls including counselling cells, shelters, legal aid services and referral networks. However, more comprehensive responses are required especially by the health sector. An examination of responses by the health sector in India to violence against women found that service providers within the health system were stymied by their own notions of appropriate gender roles, as well as by their conceptualization of domestic violence. These were key factors in limiting both the reach and quality of the health services for women who are victims of violence (Jaswal 2000).

Ultimately, for legislation to be effective, change in fundamental norms on gender and violence need to be transformed

- **Public advocacy:**
  The threshold of social acceptability of violence against women and children needs to be shifted upwards and outwards. Massive media and public education campaigns at all levels using every means for entry into every household and reaching every person, much like was done to reduce the acceptability of smoking.

There are five critical lessons learned from existing interventions on violence against women and children.

First: legislative resolution is necessary to establish the societal norm of the non-acceptability of violence. Promote policy advocacy for early ratification of international and regional instruments and resources for legal reform and enforcement.

Second: increased knowledge and information for effective implementation of laws and services. Knowledge and information are key to enabling women and girls to be active agents of change in their own situations.

Third: strategies need to address the root cause of women's and girls' vulnerability. Reduce economic dependency to confront violence, and not just mitigating the consequences.

Fourth: Zero tolerance of all forms of gender-based violence Community acceptability of violence and gender inequality have to be challenged.

Fifth: Transform the socialisation process of young boys and girls to identify and promote more equitable gender relations. Invest in schools through curriculum and textbooks revisions and life skills based education programmes to promote new gender norms that could sustain gender equality.

"What is needed now are increased efforts to promote youth participation and commitment; more services aimed at youth; more parental involvement; more education and information, using schools and other sites; more protection of girls, orphaned children, and young women; and more partnership with people with HIV and AIDS."

–Carol Bellamy, Executive Director, UNICEF
Statement on the launch of the latest statistics from UNAIDS
Berlin, 28 November 2000

The way forward

To enable women and girls to protect themselves in the HIV/AIDS epidemic and to eliminate gender-based violence in all its forms requires:

- quality, sex-disaggregated data on violence against women and children and HIV/AIDS;
- policies and interventions that empower girls and women and reduce gender inequalities;
- normative changes in the definition of gender relations and the acceptability of violence against women and children; and
- political commitment and leadership.

National surveillance systems for HIV prevalence need to be strengthened in all countries in the region and must be complemented by behavioral surveillance that monitors changes in sexual and preventive behaviors, knowledge and attitudes, and access to services.

1. Quality, Sex-Disaggregated Data: The paucity of data on gender-based violence and on the prevalence of HIV among women and girls in the region directly impacts the development and implementation of policies. It difficult to establish accountability or carry out assessments of the impact of policies and programmes without reliable data.

Community-based initiatives to assess the levels and types of violence against children and women, particularly the prevalence of child sexual abuse and sexual trafficking, must be supported by national and international resources. Such data can help to monitor the extent of the problem and guide resource allocation.

2. Policies and Interventions to Empower Girls and Women: Reducing vulnerability to violence and HIV requires the empowerment of girls and women. Basic education, information about their legal rights, available services, their bodies, sexuality, disease, and reproduction is essential if women and girls are to protect themselves from violence and HIV/AIDS.

To improve girls' and women's economic status to protect them from abuse, exploitation, and HIV/AIDS we must ensure access to economic resources and assets and:

- Invest in Girls Education;
- Ensure implementation and protection of women's property and inheritance rights;
- ensure access to formal sources of credit;
- ensure equal pay for equal work;
- ensure the provision of business, financial and marketing skills necessary for the success of their enterprises;
- ensure provision of access to agricultural extension services;
- ensure access to formal sector employment.

Social capital: Increase social support to women and girls who are struggling to change existing gender norms. Support expansion of social networks by providing them opportunities for sharing experiences and join efforts for raising awareness in communities (see Box 5).

BOX 5: **Adolescent Peer Organised Network in Bangladesh**

A unique programme that is making a difference in the lives of young girls is the Adolescent Peer Organised Network (APON) in Bangladesh. The network is a project designed and implemented by one of Bangladesh's leading NGOs, the Bangladesh Rural Advancement Committee (BRAC). The APON project aims to address the particular problems and needs of adolescent girls, whose health and wellbeing are at risk due to the conservative nature of traditional Bangladeshi society, which keeps them in ignorance about matters relating to sexuality and reproductive health by providing peer education and support, non-traditional vocational training and employment.

The network developed as a conscious response to the need articulated by young women and girls to have a forum to discuss issues of reproductive health, contraception, sex education and sexually transmitted diseases, which are not usually addressed in development programmes. They also wanted to learn about sensitive social issues such as inheritance law, oral divorce, dowry, women's legal rights, nutrition, children's health, physical harassment, acid attacks, and how to deal diplomatically with mothers-in-law.

In response to this need, BRAC developed a set of 20 booklets on 40 different social, economic and environmental issues in which adolescent girls had expressed an interest. The booklets not only convey information but also impart social skills to help girls to cope with gender-related issues that constrain their lives in a conservative society. They also provide information about whom to contact and what actions to take in the event of sexual abuse, symptoms of particular diseases, and how to obtain legal aid.

The most innovative feature of this network is the involvement of adolescent girls in the design and implementation of this programme. Peer educators, mostly those in 8th standard, work with groups of girls and young women to study the booklets, develop relevant take home messages and plan actions within their communities. The programme is supervised and monitored by adolescent leaders, supervisors and monitors. There are currently 5100 Peer Educators and nearly 150000 adolescent girls have participated in studying the booklets between 2000 and 2002. A critical impact of the programme is that young girls are questioning early marriage, affirming their desire for higher education and rejecting violence as inevitable. Moreover, adolescent girls themselves become the main change agents in the process of empowerment, which can also help to protect them from the threat of HIV/AIDS and other STIs.

Source: (UNICEF 2002)

Leadership: Provide women and girls with leadership opportunities. **Women are empowered if they have the political agency to make decisions that shape their own destinies** (see Box 6).

BOX 6: **Sonagachi: Empowering Sex Workers to Prevent HIV/AIDS in India**

In 1992, the All India Institute of Hygiene and Public Health (AIIH&PH) in consultation with the National AIDS Control Organization (NACO) of India, the Ministry of Health and Family Welfare of West Bengal, and WHO initiated an HIV intervention targeting sex workers in Sonagachi, a red light district in Calcutta. In the beginning, the project was largely directed towards reducing the level of STDs and increasing condom use among sex workers. However, the programme has expanded to empower sex workers by enabling them to control their own lives and solve their own problems, as both a goal in and of itself and as a way to prevent the spread of HIV.

As of 2000, the programme had reached over 8,000 street-based sex workers, out of an estimated 12,000 living in Calcutta, in a wide variety of activities. Several health care clinics have been built and staffed to provide ongoing health care, distribution of condoms, HIV testing and counseling, and the like. Many women also participate in peer education during 6 week training sessions where they learn about health issues and where and when to go for health care. Through the peer education groups, a performance group developed that performs plays about STD and HIV prevention, as well as additional sex work issues. The group has performed at many venues, including the Twelfth World AIDS Conference in Geneva. In 1998, the sex workers initiated a Positive Hotline for counselling and support for HIV positive individuals, including both sex workers and the larger community. Perhaps most significantly, in 1995, the sex workers began a registered cooperative where they save money, provide loans and small investment schemes for members, and market condoms. With the profits, members have started a crèche for sex workers' children and purchased land for a training center outside of Calcutta where older sex workers produce handicrafts. Other activities have included legal aid and training and literacy classes for the sex workers and sensitization training for police. Despite challenges, including police raids and internal adjustments with the close integration of project staff and sex workers, the project has become a well-known success. Evaluations have consistently found significant improvements in knowledge of AIDS, condom use, and even STD and HIV incidence. For example, in 1992, 1.1 percent of sex workers surveyed reported always using condoms. By 1995, this rose to over 50 percent. Similarly, while HIV prevalence rose dramatically among sex workers in most parts of India, only 5.5 percent of randomly sampled women at Sonagachi were HIV positive in 1998.

While Sonagachi continues to expand and grow, complete with ongoing challenges, they attribute their continuing success to placing the control of the intervention with the community, building capacity among both staff and sex workers, treating sex workers as whole persons, and meeting the sex workers' felt needs.

Source: (UNAIDS 2000)

State and national-level policies to increase women's and girls' access to key resources. Key Policies to empower women and girls:

- decrease the gender gap in education,
- improve women's access to economic resources,
- increase women's civic and political participation,
- and protect women from violence are key to empowering women.

The CRC and CEDAW provide useful policy instruments to hold countries accountable for empowering children and women through the fulfillment of all rights. All the countries in the South Asia region are signatories of CRC and CEDAW and therefore can be held accountable for meeting their obligations.

3. Changes in Norms: Challenge the acceptability of cultural practices and norms that disadvantage women and promote a culture of silence around HIV/AIDS and violence is critical for prevention Community advocates and peer educators can serve to foster such dialogue. Schools and the media have a particularly important role to play in challenging existing norms and actively promoting new roles and responsibilities for women and men, girls and boys. Education and media policies can support such efforts by creating an enabling cultural environment for healthy sexuality and gender equitable relationships.

There are pockets within the region where more gender equitable practices are prevalent. Equal inheritance or matrilineal inheritance is found in Bhutan, among the tribal communities of the Northeast in India, and among Nairs in Kerala (Agarwal 1996). Remarriage for women is permitted among communities in Nepal, as well as among Muslim and Christian communities in the region. In Kerala and Tamil Nadu in South India and in Sri Lanka female life expectancy is higher than that for men and the sex ratio favours women. Access to education has improved considerably in these regions, with equal enrolment of girls and boys in primary schools and an increasing enrolment of girls in secondary and tertiary education. Fertility rates are also dropping, with Kerala and Sri Lanka reaching replacement level fertility. Experts have argued that the improved situation in these regions is due to social norms and practices that value women and girls, thus ensuring that they have access to entitlements such as education and health care (Sen 1999). Key factors that contribute to the greater value placed on women in these areas are the higher work rate of participation of women in agriculture, the less patriarchal kinship structure, and more equitable marriage customs.

4. Political Commitment and Leadership: Political will and determination is needed at the national and regional levels. Dedication and credible champions at the national level are required to call for zero-tolerance for violence against women and the necessary resources to address the gender-related vulnerabilities that fuel the HIV/AIDS epidemic. Leaders of political parties, faith-based organisations and communities, need to advocate for the empowerment of women and the transformation of gender norms and practices as pivotal to a new strategy for addressing HIV/AIDS and violence against women and children.

Regional cooperation to address the problem of sexual trafficking of women and children must continue and be expanded to address the economic and cultural forces that fuel this phenomenon. The collaboration of such national leaders across the region can form the basis for a regional network that is essential for addressing problems such as HIV/AIDS that do not respect political borders.

Global assessments of the HIV/AIDS epidemic repeatedly warn that South Asia is likely to be the next epicenter of the global epidemic. Although the current social and economic conditions of countries in the region underscore their vulnerability to such an occurrence, it is certainly not inevitable. The opportunity for an appropriate response to contain the spread of infection still exists. South Asia's ability to contain the epidemic rests on its vision and resolve to address the root of the problem – gender inequality and violence against women and girls.

"At UNAIDS, we firmly believe that respect and concern for human rights, including the rights of the child as well as equality between men and women, must be at core of a collective response to this disease...to end violence against women, we must help make the voices of millions of vulnerable women heard. If we are to empower women and enhance their protection, we must especially make those heard who are living in the shadow of violence and AIDS."

–Dr. Peter Piot, Executive Director, UNAIDS
Commission on the Status of Women, Forty-third Session,
Panel on Women and Health: HIV/AIDS and Violence against Women

Select Bibliography

Ahmed, Eman M. 1998. "Violence Against Women: The Legal System and Institutional Responses". Lahore: AGHS Legal Aid Cell.

De Silva, D.G. Harendra 1996. *Child Abuse: The Gravity of the Problem and Dilemmas in Management in Sri Lanka*. Colombo, Sri Lanka: Department of Paediatrics Faculty of Medicine Karapititiya, Galle, Sri Lanka and UNICEF Sri Lanka.

Deuba, Arzu R. and Pinky S. Rana. 2001. *A Study on the Psycho-Social Impacts of Violence Against Women and Girls with Special Focus on Rape, Incest and Polygamy*. Kathmandu, Nepal: Saathi and SNV Nepal

Duvvury, Nata, Madhabika Nayak and Keera Allendorf. 2002. "Link Between Masculinity and Violence: Aggregate Analysis" in International Center for Research on Women, *Men, Masculinity and Domestic Violence in India: Summary Report of Four Studies.* Washington, D.C.: International Center for Research on Women.

The EVAULATION Project. 1997. *Uttar Pradesh Male Reproductive Health Survey 1995-96.* Chapel Hill, North Caroline: University of North Carolina.

Gordon, Gill and Alice Welbourn. 2001. "Stepping Stones and Men: A desk-based review of the effects of Stepping Stones."

Hayward, Ruth Finney. 2000. *Breaking the Earthenware Jar: Lessons from South Asia to End Violence Against Women and Girls* Kathmandu: UNICEF, ROSA

Heise, Lori, Kirsten Moore, and Nahid Toubia. 1995. *Sexual Coercion and Reproductive Health: A Focus on Research.* New York: Population Council.

Hills, Beverly and Abdullahel Hadi. 2000. "Prevalence and correlates of the risk of marital sexual violence in Bangladesh", *Journal of Interpersonal Violence 15(8:*, 787-805.

INCLEN. 2000. *Domestic Violence in India 3: Summary Report of Multi-site Household Study*. Washington. D.C.: International Center for Research on Women and The Center for Development and Population Activities.

Jahan Roushan and Mahmuda Islam. 1997. *Violence Against Women in Bangladesh: Analysis and Action.* Dhaka: Women for Women and South Asia Association for Women's Studies.

Jejeebhoy, Shireen and Rebecca Cook. 1997. "State Accountability for Wife-beating: The Indian Challenge", *Lancet Vol. 349 March*: S10-12.

Khan, M.E., John Townsend, Ranjana Sinha and Seema Lakhanpal. 1996. "Sexual violence within marriage", *Special Issue on Reproductive Health, Seminar 447(November):* 32-36.

Koening, Michae,l Mian Bozle Hussain, Saifuddin Ahmed, and Zoha Haoga. 1999. "Individual and Community-Level Determinants of Domestic Violence in Rural Bangladesh", Paper Presented at Population Association Of America Annual Meeting, New York, 25-28 March.

Krishna, K.P. 1995. "Girl Child and Sexual Victimization", *Social Change 25(2-3):* 124-32.

MacCulloch, Christina. 1997. "Domestic Violence: Private Pain, Public Issue", *The IDB Special Report (November):* 1-4, Inter-American Development Bank.

Mahbub ul Haq 2001. *Human Development Report for South Asia 2000, A Gendered Question*. Karachi: UNDP and Human Development Centre.

Martin, S.L., B. Kilgallen, A.O. Tsui, K. Maitra, K. Kumar Singh and L.L. Kupper. 1999. "Sexual behaviors and reproductive health outcomes." *Journal of the American Medical Association* 287(20):1967-72

Mirembe, Robina and Lynn Davies. 2001. "Is schooling a Risk?" Gender, power relations and school culture in Uganda. *Gender and Education* 13(4): 40-466.

Naripokkho. 1991. "Tanbazar alert" (updated 8 August) Dhaka: Naripokkho, Mimeo.

Paiva, V. 1993. "Sexuality , condom use and gender norms among Brazilian teenagers", *Reproductive health matters 2:* 98-108.

Peterson, J.L., O.A. Grinstead, E. Golden, J.A. Catania, S. Kegeles and T.J. Coates. 1992. "Correlates of HIV risk behaviors in black and white San Francisco heterosexuals: The population-based AIDS in multiethnic neighborhoods (AMEN) study." *Ethnicity and Disease* 2:361-70

Poore, Grace (ed.). 2000. *The Children We Sacrifice: A Resource Book*. Silver Spring MD:Shakti Productions.

Qureshi, Asma Fazia, Narjis Rizvi, Fauziah Rabbani and Fatima Sajan. 1999. "Domestic Violence: Determinants and Consequences" Report Prepared for WHO Centre, KOBE, Japan, October.

Rao Gupta, G. 2000. *Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How*. Plenary Address, XIIIth International AIDS Conference, Durban, South Africa, July 12, 2000

Rao Gupta, Geeta and Ellen Weiss. 1998. *Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention.* Washington, D.C.: International Center for Research on Women.

Saathi. 1997. *A National Survey on Violence against Women and Girls in Nepa*l. Kathmandu: Action Aid.

Schuler, Sidney Ruth, Syed M. Hashemi, Ann P. Riley and Shireen Akhter. 1996. "Credit Programmes, Patriarchy and Men's Violence Against Women in Rural Bangladesh", *Social Science and Medicine*.

Sen, Purna. 1998. "Development practice and violence against women", *Gender and Development 6(3):* 7-16.

Sen, Amartya. 1999. *Development as Freedom*. New York: Alfred A. Knopf.

Sharma, Vinit, Rachna Sujay and Anuragini Sharma. 1998. “Can married women say no to sex?: Reprercussions of the denial of the sexual act”, *The Journal of Family Welfare 44(1):* 1-8.

Sheikh, Misbah M. 1997. “Unveiling Violence in South Asia: A Priority for Action”, Kathmandu: UNICEF Regional Office for South Asia (mimeo), June, cited in Hayward 2000.

TARSHI. 2002. “Women Sexulaity and AIDs”, Paper presented at the South Asia Regional Conference on Women and AIDS, TISS, Mumbai, India.

UNAIDS. 2000. Epidemiological Fact Sheet: Bangladesh – 2000 Update. Website: http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Bangladesh_en.pdf

UNAIDS. 2000. Epidemiological Fact Sheet: India – 2000 Update (Revised). Website: http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/India_en.pdf

UNAIDS. 2000. Epidemiological Fact Sheet: Nepal – 2000 Update. Website: http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Nepal_en.pdf

UNAIDS. 2000. Epidemiological Fact Sheet: Pakistan – 2000 Update. Website: http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Pakistan_en.pdf

UNAIDS. 2000. “Female sex worker prevention projects: Lessons Learnt from Papua New Guinea, India and Bangladesh”. Geneva, UNAIDS.

UNAIDS. 2001. *Working with Men for HIV Prevention and Care*. UNAIDS/01.64E. Geneva, Switzerland: UNAIDS.

UNAIDS. 2002. *AIDS epidemic update - December 2002.* UNAIDS/02.46E. Geneva, Switzerland: UNAIDS.

UNFPA. 1998. “Socioeconomic, Demographic and Reproductive Health Profiles of Adolescent Girls in SAARC Countries”, South Asia Conference on the Adolescent, New Delhi, July 21-23.

UNICEF. 2003. *The State of the World’s Children*. New York: UNICEF

UNICEF ROSA. 2002. Girl Power in Bangladesh: BRAC’s Adolescent Peer Organized Network, BRAC Report to UNICEF ROSA. Dhaka, Bangladesh: UNICEF Regional Office for South Asia.

UNICEF ROSA. 2001. *Sexual exploitation and sexual abuse of children in South Asia*. 2nd World Congress Against Commercial Exploitation of Children. Kathmandu, Nepal: UNICEF Regional Office for South Asia.

UNICEF/UNAIDS. 2001. *Survey of Teenagers in Nepal for life skills development and HIV/AIDS interventions*

UNIFEM. 2000. *Progress of the World’s Women 2000:UNIFEM Biennial Report.* New York: UNIFEM.

UNIFEM. 2002. *Women, Gender and HIV/AIDS in East and Southeast Asia.* New York: UNIFEM.

UNDP. 1999. *AIDS in South and Southwest Asia, A Development Challenge.* New Delhi: UNDP.

USAID. 2002. Asia and the Near East: Education and Training: Sector Overview. Website: http://www.usaid.gov/regions/ane/newpages/sectors/overview-ed.htm

WHO. 2002. “Integrating gender into HIV/AIDS Programmes.” Review paper for expert consultation. June 3-5, Geneva, Switzerland.

World Bank. 2002. *South Asia Regional HIV/AIDS Overview & Strategy.*

Endnotes

1. http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/India_en.pdf
2. NACO (2001) Estimation of HIV/AIDS in India. http://www.naco.nic.in/indianscene/esthiv.htm and NACO (2000) Combating HIV/AIDS in India. http://www.naco.nic.in/indianscene/country.htm See also http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/India_en.pdf and http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Nepal_en.pdf
3. UNAIDS and Sociometric Corporation (2001) *Gender Almanac*. http://www.unaids.org/gender/docs/Gender%20Package/GenderandAIDSalmanac.pdf
4. *Feasibility study of administering short AZT interventions among HIV infected mothers to prevent MTCT:MOHFW, NACO, UNICEF, Dec.2001*
5. Ravi K Verma, et al. The impact of HIV/AIDS related deaths on households and their coping strategies: A study with special reference to children: A case of India. A UNICEF-NACO supported study,2000
6. National AIDS Control Organisation , 2001
7. Other factors, such as age, economic status, and ethnicity influence sexuality. However, this paper focuses on the interrelationships between gender and sexuality.
8. Forced sex in this survey included sex even when the wife expressed disinterest, sex with physical force, sex with threats or submission to sex because of overall fear.