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I. Introduction

About a quarter of a century has passed since the human immunodeficiency virus (HIV) was identified and acquired immunodeficiency syndrome (AIDS) was identified as a disease. Although HIV/AIDS was initially perceived as a health issue, today it is increasingly recognized as a cross-cutting issue of development and human rights that affects different segments of the population differently. Its close links with poverty and discrimination and the global trend of quickly increasing proportions of infections among women are forcing policy makers in a range of sectors to address the pandemic.

The gender dimensions of HIV/AIDS have been increasingly recognized by the international community in recent years, starting with the General Assembly Special Session on HIV/AIDS in June 2001, where 189 countries signed a Declaration of Commitment acknowledging that "gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS. A set of targets was established that had women as central, including "By 2005, National Strategies should empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection."

At the High Level Meeting (which served as the regional input to the Beijing +10 review) organized by UNESCAP, in September 2004 in Bangkok, its member states acknowledged gaps in full implementation of the Beijing Platform for Action and in the Bangkok Communiqué that was adopted at the meeting, noted "the lack of regional cooperation and partnership initiatives for combating the spread of HIV/AIDS, noting the high prevalence of HIV/AIDS in the region particularly among women, while recognizing the need to address the challenge of reducing the vulnerability of women and girls to HIV/AIDS".

In recent years epidemiological evidence has shown that infections are increasing fastest among women, especially young women. In addition, the interconnectedness of HIV infection and the vulnerability of women due to traditional cultural and sexual roles must be addressed. This paper focuses on the ways in which HIV/AIDS affects men and women differently, highlighting that risks of contracting the virus differ for men and women, addresses gender-specific reasons for faster rates of female HIV/AIDS prevalence, and highlights features and experiences of HIV/AIDS in a few sub-regions. It also reviews effective strategies and concludes with recommendations. Being aware of the multi-dimensional nature of the pandemic and who is affected and how will, hopefully, enable policy makers and decision makers at all levels to plan interventions in a way so as to address the major factors which fuel the transmission of the virus and deaths due to AIDS.

II. Trends and key issues in the Asia-Pacific Region

While the AIDS pandemic has taken many lives in the Asia-Pacific region, the past decade has seen some remarkable progress in the development and implementation of strong HIV-prevention and treatment strategies. Cambodia, the Indian state of Tamil Nadhu and Thailand are cases in point. But more and more countries in the region have been moving into higher adult prevalence categories and gaps between countries in HIV prevention responsiveness have also become wide, exacerbated by social and cultural constraints regarding sexual taboos, resulting in effective HIV-prevention interventions encountering inertia or overt resistance. Particularly troubling is the prospect of an HIV epidemic in parts of the region originally assessed as low-risk based on low HIV prevalence rates in the 1990s. As is the case with the more recent threat of avian flu, the failure of governments to give adequate attention to existing or potential epidemics or to institute a proactive prevention plan, combined with the proliferation of practices and behaviors which put people at risk of contracting such viruses threaten to make these countries the "new frontline" of an epidemic in this decade.

The prospects for the region are troubling. While worldwide HIV infection levels in Asia are low relative to other regions of the world - due to the size of the Asian population as 60 percent of the world's total - even with relatively modest infection rates, the numbers of people endangered are alarming. In 2005, the HIV prevalence rate for adults in the Asian region was 4 percent or an estimated 8.3 million people.[1] [2] In India which is currently facing an epidemic, an estimated 5.1 million people were living with HIV infection in 2003.[3] Indonesia, a country identified as being on the brink of an AIDS epidemic, is the world's fourth largest country in terms of population.

The progression and evolution of HIV/AIDS and campaigns to prevent its spread have also increasingly revealed the intensifying and widening consequences of the disease on women. Moving beyond the original high-risk population for HIV infection (drug injectors, homosexuals, prostitutes), changing HIV transmission patterns in the past few years have resulted in an increase in the numbers of women becoming infected. Data estimates show that the percent of women aged 15-49 living with AIDS increased from 2003 to 2005 in South and Southeast Asia (1%), East Asia (1%) and Oceania (11%).[4]

Ironically, one of the vulnerable groups emerging for high risk in the region for HIV infection are women in long-term stable relationships (married women, girlfriends) with men who engage in extramarital affairs or commercial sex. The prevention of HIV infection in women hinges largely on the attitude, behaviour and practice of the men in their lives.

Not only are women biologically more at risk of contracting HIV if exposed to it[5], but the social, cultural political and economic environment in which women live makes them vulnerable to HIV infection. Factors such as women's limited power to insist on condom use, the fear of violence deterring women from seeking HIV testing or treatment, lack of knowledge about HIV/AIDS, to name a few, contribute to women's increased susceptibility to HIV/AIDS and inability to protect themselves.

The influence of conservative religious nature of a number of societies in the region along with faith-based organizations is also proving to be a major factor determining whether governments can launch an effective HIV-prevention campaign. Religious authorities in a number of countries have opposed the promotion of HIV education on the use of condoms, for example, on the grounds that such an initiative would promote promiscuity. Their role in perpetuating women's ignorance as well as traditional religious gender stereotypes subjecting women to subordinate and disadvantaged positions relative to men, contribute to making women particularly vulnerable to HIV infection. Although much is still needed to be done, there are signs that this is changing. In a number of countries, religious leaders are increasingly cooperating with government health officials and organizations.

The sexual taboos prevalent in a number of Asian societies have also been a barrier to open discussion on safe sex, which is of critical important to an effective HIV-prevention campaign. Although in a number of countries, this is still a major challenge, some countries have been able to break down the walls and open up the public dialogue. Central to Thailand's success, for example, was the aggressive information and education campaign from which public discourse around sexuality and sexual health gradually emerged.

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[1] AIDS Epidemic Update, UNAIDS and WHO, December 2005, p.31.
[2] HIV prevalence refers to the total number of people living with HIV, irrespective of when they have been infected. (AIDS Epidemic Update, p.17)
[3] Ibid 33.
[4] Ibid 4. It should be noted that correct interpretation of HIV prevalence rates need take account of a number of considerations. For example, stabilization of HIV prevalence does not necessarily mean the epidemic is slowing. It could signal … where roughly equal numbers of people are being newly infected with HIV and dying of AIDS. p.17
[5] In women, the area exposed to semen containing HIV is larger and generally exposed for a longer period.

A. Greater Mekong sub-region

The Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that the rate of HIV infection among women in the greater Mekong sub-region (GMS), in particular in Vietnam, Laos and Cambodia, is rising at a faster pace than among men.[6] Cambodia has been a high prevalence country for over a decade and has experienced some sharp increases in prevalence in short periods. Rates of infection among CSWs have come down through campaigns to promote condom use; however; HIV is increasingly being transmitted by married men who visit prostitutes. HIV/AIDS is associated with injection drug use as well as CSWs in Myanmar, Southern China and Vietnam. The remainder of this section is focused on the case of Thailand, how it has addressed the problem, continuing challenges and changes overt time.

In 2004, an estimated 572,500 adults and children were living with HIV/AIDS in Thailand[7], and an estimated 58,000 had died of AIDS during 2003.[8] The overall HIV prevalence rate for adults is estimated to be 1.5 percent, the second highest among countries in Asia and the Pacific region but down from 2.4 percent more than 10 years ago and 1.8 percent in 2003.[9] More than 85 percent of reported cases in 2004 were transmitted through sexual intercourse, and 38 percent of the reported cases were female.[10] HIV prevalence among injection drug users (IDU) in Thailand remains high (40 percent in 2004).[11] The number of sexually transmitted infections (STIs) has also increased in recent years.

Men who have sex with men (MSM), many of whom do not consider themselves to be homosexual, constitute a high risk population. In many countries, a large percentage of male commercial sex workers (CSWs) have sex with men as well as women; however, while large initiatives have been launched to promote 100 percent condom use in sexual exchanges with female CSWs, far less efforts have been made to reach male CSWs. Whether it is well hidden or out in the open as in the case of Thailand, urban areas in particular, often host a sub culture of trans-genders who are generally male (in Thailand termed *kathoey*). One particular challenge that Thailand faces now is regulating condom use in "indirect" sex service establishments such as massage parlors and bath houses. Much sexual exchange has moved to these settings. There is also a sub-culture of trans-gender and transvestites in many countries. This is one group which has not been well reached in prevention and treatment efforts.

In a study on the male commercial sex business in Bangkok as a new channel for HIV transmission, it was found that many men who work as entertainers and in karaoke bars or in bath houses have sex with men and often (to a lesser extent) women.[12] There was a lot of variation among these men in terms of consistent use of condoms and concern about HIV. One group of HIV positive men 18 to 22 years of age who were CSWs did not consistently use condoms while having sex with customers while others did. However, some tended not to use condoms with female partners and older female customers, putting these women at risk. Unlike female CSWs, many male CSWs did not have medical check ups or advice due to the stigma attached to their work. The need for getting more information out on HIV and STIs was emphasized.

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[6] UNAIDS: web.amfar.org/treatment/specialreport/overview.asp
[7] http://www.amfar.org/cgi-bin/iowa/programs/globali/record.html?record=23
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Koetsawang, Suporn and Topthai, Kuntee "Pilot Study of the Male Commercial Sex Business in Bangkok, Thailand The New Possibility of HIV Transmissions", April 2003,, Foundation for Quality of Life Development.

In 2003 Thailand had more male AIDS patients than female at every age group except 5-24, (almost 50/50 in the 25-29 age group) where women slightly outnumber men.[13] Surveys show that increasingly, young Thai women tend to more frequently be engaging in premarital sex where condom use is frequently low. The Thai Association for the Promotion of the Status of Women, in its 2003 report, stated that the average age for first sexual intercourse is 16 for girls and boys; it is more common now to have more than one partner and 66 percent of female teens living in Bangkok reported not using condoms and not negotiating for safe sex with their partners. Already more female teens than male are infected with HIV.

As UNAIDS said "Thailand has demonstrated the success possible in addressing HIV and AIDS when a well-resourced and politically-supported response to the AIDS epidemic is coupled with a broad partnership of public, private and civil society actors using innovative, practical interventions to address HIV risks and vulnerabilities. Thailand in particular, caught in an escalating AIDS epidemic in the 1990s, has reduced the number of new HIV infections by an estimated 88 percent from 1991 to 2004 and successfully averted what appeared to be an impending crisis.[14]

UNAIDS reported that HIV in Thailand today is spreading to more diverse populations than were infected ten years ago and that current prevention efforts and interventions have not kept pace with this evolution of the epidemic in Thailand. Public information and education campaigns, once ubiquitous, are now barely perceptible and public concern about individual and personal risks of HIV infection— once a cornerstone of the Thai success—have ebbed to worrisome levels, particularly amongst Thai youth. Transactional sex, conducted outside brothels, connected to "entertainment" establishments continues to grow without the serious commitment to prevention which the "100 percent condom" programme brought to brothel-based transactional sex at the outset of the epidemic in Thailand.

Critical populations which most need to be reached today with prevention, care and treatment interventions and services—particularly injecting drug users, migrant and mobile populations, and men who have sex with men—continue to be marginalized onto the fringes of Thai society and social services. Despite some successes, stigma and discrimination against persons living with HIV and AIDS is still prevalent in many communities.

Thailand's unique mix of adequate national resources combined with an extensive and effective public health infrastructure has enabled it to rapidly scale-up treatment access for antiretrovirals in the country to roughly half the number of people living with HIV and AIDS requiring treatment, which is a great success of the past year. Additional investments in support of expanded access for the coming year will be necessary to reach the remaining people living with HIV and AIDS requiring treatment.

Looking at the entire population, HIV transmission is primarily through infected male and female sex workers and through injecting drug users. While infections among commercial sex workers have decreased, HIV infection among IDUs has increased. Much more prevention efforts are needed in general and for this group specifically.

With the Asia Highway and Asia Development Bank (ADB) project to help GMS countries develop tourism, concerns are also growing about the social impact and potential for sparking a dramatic increase in HIV infections. Commercial sexual exploitation of children is already a problem in some parts of GMS countries as is trafficking in women and young girls – internal and cross-border – for prostitution in response to demand from truck drivers and road construction workers. Migrants and refugees lack access to health information and services and it is hard collect meaningful data on them

[13] Ministry of Public Health, Epidemiology Division, Office of the Permanent Secretary, Thailand.
[14] External Review of the Health Sector Response to HIV/AIDS in Thailand, WHO and Ministry of Public Health Thailand, 2005, p.9

since they move across borders. Upland ethnic communities living in exploited environments and border areas are particularly vulnerable to disease because of poverty, lack of access to education and health information and services as well as their marginalized status in society.[15] In addition, drug abuse is prevalent among some highland minorities, which in itself increases the risk of HIV infection.

B. Pacific Islands

The adult HIV/AIDS prevalence rate in Oceania is 0.2 percent, according to UNAIDS, with an estimated 35,000 adults and children living with HIV/AIDS, including 7100 women.[16] Papua New Guinea (PNG), the worst-affected country in the Pacific, has an HIV/AIDS prevalence rate of 0.6 percent - which has reached epidemic proportions. More than 90 percent of the 11,200 HIV infections reported across the 21 Pacific Islands countries and territories by the end of 2004 were recorded in Papua New Guinea.[17] According to UNAIDS and the World Health Organization (WHO) in 2005, HIV/AIDS prevalence in Oceania, among young people ages 15-24, 1.2 percent of women and 0.4 percent of men were living with HIV/AIDS.

In Papua New Guinea, there were 12,000 official reported cases, an estimate which could range from 80,000- 120,000.[18] Other figures of officially reported cases in the Pacific Islands range from 246 in New Caledonia, 173 in Guam, 220 in French Polynesia, 171 in Fiji, and 12 in Samoa between 1999 and 2001.[19] The only two Pacific Islands countries that have not reported HIV infections are Niue and Tokelau. A lack of testing facilities, stigma attached to getting tested for HIV/AIDS, and low levels of surveillance lead to a lack of statistics and reliable data on HIV/AIDS prevalence.

Contributing factors to the spreading epidemic in certain Pacific Island countries include stigma attached to being tested as well as to being HIV positive and high rates of rape and violence against women, especially domestic violence. Additional factors include high prevalence of STIs, low condom use, frequency of multiple sex partners, high rates of commercial sex work or transactional sex, and weak health systems lacking the ability to provide safe blood supplies, treat STIs and prevent mother to child transmission of the virus. In many Pacific Islands countries, public health services remain under-funded and inadequate to meet the health needs of the population. Many countries in the Pacific lack vitally important medicines to treat AIDS related health problems. Fiji for example, reported 142 HIV cases by the end of 2003, but only had adequate funding for ARV (anti-retroviral) drugs for 40 people.[20]

Pacific Islands communities also face unique obstacles in preventing HIV/AIDS because of issues specific to labour migration and the seafaring business, resulting in high levels of interregional and intraregional mobility. In Kiribati, for example, a phenomenon called “te korekorea” has been acknowledged. This term refers to the increasing incidences of young female sex workers in Kiribati associated with foreign fishing vessels, many of whom originate in the Republic of Korea. Korea’s National Youth Commission has interviewed residents in Kiribati, Korean fishermen, and others in collaboration with End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes**' (**ECPAT)-Korea, and found several underage sex workers in the bars solicited by the fishermen. In countries such as Tuvalu and Kiribati, earnings of seafarers, which is considered a

[15] Rockefeller Foundation, Learning across boundaries in the Greater Mekong sub-region programme.
[16] www.unaids.org/en/geographical+area/by+region/oceania.asp
[17] UNAIDS Fact Sheet Oceania, 21/11/2005.
[18] Singapore Straits Times, 7 November 2005.
[19] UNAIDS/WHO Epidemic Update, Oceania, page 74-75, December 2005.
[20] Scoop Independent News “Time runs out on South Pacific HIV/AIDS Crisis”. http://www.scoop.co.nz/stories/HL0506/S0001.htm

high-risk population, account for 25 percent of GDP.[21] According to UNICEF-East Asia and the Pacific Regional Office, recent studies found up to 22 percent of the young men in seafarer industry in the Mekong Sub-region to be HIV positive. Although a very a different region, it indicates that this mobile population is at high risk. [22]

An additional important aspect to take note of is that very high rates of violence against women, rape and sexual assault are thought to have caused significant increases in the incidence of HIV/AIDS, as well as other STI infections in PNG. According to the Papua New Guinea Common Country Assessment, 17 percent of the sex workers in PNG capital Port Moresby were found to be HIV positive[23]. When these findings are supplemented with information from a study in Port Moresby, indicating that 60 percent of married men engaged in commercial sexual activities[24], the possible reasons behind the spreading epidemic become more evident.

Women and girls have become the focus in the battle against HIV/AIDS in the Pacific, as Bessie Maruia of the PNG National Aids Council acknowledged, "The situation in PNG suggests a gender equalized epidemic fuelled by the difficult social and economic conditions. Of the total number of cases reported in 2004, 46 percent were female and 48 percent were males- a large number of HIV positive women are aged between 15 and 29 years old and men are over 30 years old".[25] The National AIDS Council of PNG stated that in addition to migration and extreme poverty, inequality between the sexes and high levels sexual violence against women need to be addressed. [26]

Violence against women is not the only reason for the increase in HIV/AIDS prevalence in the Pacific Islands, but this report will highlight the role of violence in contributing to the spread of the deadly virus. All actions to address HIV/AIDS must take gender inequality into consideration, and the virus cannot be contained if issues such as persistent and high rates of violence against women are not addressed effectively.

Papua New Guinea: "An epidemic in full swing"

As previously mentioned, PNG has been hardest hit by HIV/AIDS of the Pacific Island countries. Of the 11,200 new HIV infections reported in 21 Pacific Island countries by the end of 2004, 90 percent were recorded in PNG. Official statistics reports suggest as many as 7,320 cases, but the World Bank estimates there are at least 50,000 people in PNG living with the virus, and it seems the disease is spreading rapidly.[27] The number of new infections is growing by nearly 33 percent per year.[28] According to Franciscan Father Jude, who has worked in the jungles of PNG for 30 years and runs an HIV/AIDS clinic in Port Moresby, 50 percent of PNG's population will be affected by HIV/AIDS in 10 to 20 years' time.[29] Transmission of the virus is considered to be heterosexually driven. In the

[21] ADB Report and Recommendation of the President to the Board of Directors on a proposed ADB Grant to the Secretariat of the Pacific Community for the HIV/AIDS Prevention and Capacity Development in the Pacific Project.
[22] UNICEF HIV/AIDS factsheet "Young People and HIV/AIDS" June 2002.
[23] UNDP Common Country Assessment for PNG, December 2001 by the United Nations Country Team
[24] Cited in UNIFEM Fact Sheet on Gender and HIV/AIDS in PNG, original source from WHO Executive Summary of Mission Report, 2000.
[25] Secretariat for the Pacific Community Press release, 25, 28 October, quoted in UNESCAP Population Headliner Sept.- Oct. 2005.
[26] Cited in AIDS Epidemic Update December 2005 page 75, original source from National AIDS Council PNG, 2004.
[27] PACIFIC PANEL: Post-Yokohama Mid-Term Review of the East Asia and the Pacific Regional Commitment and Action Plan against Commercial Sexual Exploitation of Children (CSEC), 8-10 November 2004, Bangkok.
[28] UNAIDS/WHO Epidemic Update, Oceania, page 74, December 2005.
[29] Singapore Straits Times, 7 November 2005.

aforementioned Port Moresby study, 60 percent of married men engaged in commercial sexual activities,[30] while one study showed a HIV prevalence rate of 16 percent among Port Moresby female sex workers.[31] Yet another recent survey of sex workers in Port Moresby estimated that there are between 9000 and 10,000 sex workers operating in PNG, and that up to 30% of the largely female population did not have any formal education with few using condoms. [32]

PNG rates of all forms of violence against women are very high. In a study on Physical Assault on Women by an Intimate Male Partner-Population-based Studies 1982-1999, 67 percent of women in Papua New Guinea rural villages and 56 percent of women in Port Moresby, Papua New Guinea reported having been physically assaulted by an intimate partner. [33]
Reverend Yimbak of the National Aids Council noted that the incidence of gang rape and rape of even children was high in PNG, recalling that 480 cases were reported for every 100,000 women in 1997.[34] In 2005 so far, 151 rapes have been reported in Port Moresby.[35] It is known that chances for HIV transmission are higher during the physical trauma of rape. Some men refuse to wear condoms because they believe it lessens their manhood. In other reports, it was found that some used condoms in duplicate or triplicate in order to prevent infection, which indicates the low level of awareness and education about HIV/AIDS prevention in some regions.

Samoa

The WHO Multi-country Study on Women's Health and Domestic Violence against Women collected data on violence from interviews and questionnaires from women in 11 countries, including Samoa. In Samoa, data revealed that 41 percent of ever-partnered women had experienced physical violence at the hands of an intimate partner, and 20 percent had experienced sexual violence in their lifetime. In addition, 65 percent of all respondents reported violence by someone other than a partner since age 15, including 62 percent reporting physical abuse and 11 percent reporting sexual abuse. The main perpetrators of sexual violence were reported to be boyfriends (46 percent) and strangers (24%).[36] In addition, the percentage of ever-married or cohabiting women reporting that their current or most recent partner had been unfaithful according to their experiences of physical or sexual violence, or both, by that intimate partner, is approximately 26 percent by "current or most recent partner violent" in Samoa, according to the interviews conducted for the study. [37]

Regarding STIs, which can be useful information due to its link to HIV/AIDS, UNAIDS found that 43 percent of women in antenatal services in Apia had at least one STI.[38] In view of these figures, and the fact that the number of HIV infections in Samoa are on the increase, it is crucial that the Government, NGOs and community-based organizations take concerted action to address and combat violence against women and the spread of HIV/AIDS, and also acknowledge the connection between these problems.

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[30] Cited in UNIFEM Fact Sheet on Gender and HIV/AIDS in PNG, original source from WHO Executive Summary of Mission Report, 2000.
[31] Cited in UNIFEM Fact Sheet on Gender and HIV/AIDS in PNG, original source from WHO Executive Summary of Mission Report, 2000.
[32] PACIFIC PANEL: Post-Yokohama Mid-Term Review of the East Asia and the Pacific Regional Commitment and Action Plan against Commercial Sexual Exploitation of Children (CSEC), 8-10 November 2004, Bangkok
[33] Intercountry Workshop for Parliamentary Advocacy/AFPPD/UNFPA).
[34] http://www.fijiwomen.com/index.php?id=1226
[35] Singapore Straits Times, 7 November 2005.
[36] World Health Organization Multi-country Study on Women's Health and Domestic Violence against Women: http://www.who.int/gender/violence/multicountry/en/
[37] World Health Organization Multi-country Study on Women's Health and Domestic Violence against Women Chapter 8, page 66: http://www.who.int/gender/violence/who_multicountry_study/en/index.html
[38] UNAIDS/WHO Epidemic Update, Oceania, page 75, December 2005.

Fiji:

Officially reported and confirmed HIV cases in Fiji stood at 156 in May 2004, but the Fiji Ministry of Health estimates that this figure represents only about one-third of the actual cases.[39] Other reports, such as the 2004 Human Development Report and the UNAIDS Global report of the same year, estimate the number of adult and child HIV cases to be 600.[40] More women are being infected at a younger age now than before. In 1989, within the age group of 19-29 years, females accounted for 25% of cases, however, in recent years (1998-2003) females accounted for more than 40% of HIV positive cases. [41]

Research completed by the Fiji Women's Crisis Center on domestic violence and sexual assault found that 80 percent of survey respondents had witnessed violence in their home, 66 percent of women surveyed reported that they had been abused by their partners, and 30 percent of these suffered repeated physical abuse, with 44 percent reporting having been hit while pregnant. [42] As in PNG, these figures on violence against women are extremely high.

The Ministry of Health in Fiji advocates abstinence and faithfulness to prevent HIV/AIDS, but many people feel this is inadequate and insufficient, as well as an unrealistic approach. Many faith-based organizations, no matter how well-meaning and important their work is, do not support condom use because they allegedly cause promiscuity and family break-ups, according to Dr. Lawrence Hammar of the Papua New Guinea Institute of Medical Research.[43]

According to media reports and press releases by the Fiji Women Crisis Center, people with HIV/AIDS have been brutalized, rejected and stigmatized across the region. There are instances of killings, beatings, as well as witch-hunt like practices, and severe alienation are mentioned frequently.

III. Factors fueling the HIV/AIDS pandemic

> *"People's capacity to deal with the threat of disease is fundamentally shaped by the social and economic conditions in which they live"*[44]

From many years of experience dealing with HIV/AIDS in various parts of the world, it is clear that a set of factors associated with (or even determinants), of HIV/AIDS has emerged. Poverty (and the associated lack of employment, education and poor health), low status of women, conflict, to name a few, are conditions in which HIV is easily transmitted. Exposure to violence also is strongly associated with an increased risk of HIV infection. Recent and forthcoming studies from the United Nations and its Specialized Agencies draw attention to how pervasive violence is throughout the world, especially against children and women and the huge impact it has socially, economically and in terms of health. Discrimination and stigma fuel the pandemic by denying people access to services, treatment, employment, inheritance and discouraging people from being testing and disclosing to others that they are HIV positive. Denial of human rights is a common thread for most of these issues.

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[39] UNAIDS fact sheet: http://www.unaids.org/EN/Geographical+Area/by+country/fiji.asp
[40] http://www.youandaids.org/asia%20pacific%20at%20a%20glance/fiji/index.asp
[41] PACIFIC PANEL: Post-Yokohama Mid-Term Review of the East Asia and the Pacific Regional Commitment and Action Plan against Commercial Sexual Exploitation of Children (CSEC), 8-10 November 2004, Bangkok
[42] http://www.fijiwomen.com/index.php?id=1621
[43] The Double Whammy: STDs and sexually transmitted dis-ease in PNG. Dr. Lawrence Hammar of the Papua New Guinea Institute of Medical Research.
[44] UNRISD "AIDS in the Context of Development" Paper No 4, December, 2002, Joseph Collins and Bill Rau.

There is also a growing trend towards younger people exchanging sex for pocket money and gifts (e.g. Pacific Islands and Japan). Commercial sex work, while not new is gaining attention as a means of STI (including HIV) transmission, with transgender people and transvestites, sexual abuse of children and other traditionally taboo issues being given attention in some countries. Some of these groups tend to be vulnerable already and commercial sex work enhances that vulnerability to becoming infected and having to face stigma and discrimination, or in the case of children inability to access health care if they are abandoned or out of poverty, living on the streets and in train stations. The fast growth in use of mobile phones, internet access and information technologies in general has meant new risks for especially children being targeted for sexual exchanges and pornography production. This certainly presents new risks of HIV transmission.

A. Poverty

Although between 1990 and 2001, much progress has been made in income poverty reduction in 23 Asia-Pacific region countries for which sufficient data is available, much of it is due to progress in China and India. Gaps between rich and poor and by specific part of the country have widened significantly. Many countries are doing poorly in reducing maternal and child mortality, which is a symptom of poverty, lack of access to health services, gender discrimination, which are also associated with HIV/AIDS. [45]

Poverty also goes hand-in-hand with poor health and nutrition and lack of education and opportunities. For example, where son preference is strong, it is common for mothers and girl children to eat last and for girls to have fewest opportunities for receiving an education. Girls are seen as a burden to their families and are often married off at an early age, leading to early child bearing and a continuation of the cycle of poverty.

As the Special Rapporteur of the Commission of Human Rights on Violence against Women had pointed out in her 2004 report, “women and girls are particularly vulnerable to HIV/AIDS owing not only to their biological conditions, but also to economic and social inequalities and culturally accepted gender roles which place them in a subordinate position vis-à-vis men regarding decisions related to sexual relations. Relations of dominations are multiple and they intersect, creating for women layers of inequalities and subjection to different forms of violence” (E/CN.4/2004/66, paras. 47 and 53). Owing to gender inequality, HIV-positive women are stigmatized, which trigger further discrimination and violence. Therefore, understanding of the interplay between gender inequality, violence and HIV can offer plausible areas of intervention to fight the pandemic effectively

Throughout the world, the poor are at greater risk of contracting HIV and a greater percentage of the poor are women as compared to men. Being poor means having little or no voice, power, access or say in decision-making processes. In addition, it means being vulnerable to abuse, violence and being dependent on risky means of survival. For many women, sex work is one of the few means of survival. Male commercial sex workers in Bangkok also reported that most of them had found that this type of work offered them a much better income than what they could get from any other job.

Another is men, women and children resorting to more risky behaviour such as prostitution and dangerous work as a survival strategy. With the introduction of measures such as Structural Adjustment Programmes (SAPs), of the 1980s required by the World Bank and International Monetary Fund (IMF) in order to enable countries to receive further assistance, meant that most governments cut funding of social services such as education and health care. Such programmes also hit the poor hardest, women in particular as within families they were the main care givers and parent looking after the health care and education within of their families.

[45] ADB/ESCAP/UNDP, A Future within Reach, 2005.

B. Gender discrimination

"*A lack of respect for women's rights both fuels the epidemic and exacerbates its impact.*[46]

Gender-based discrimination affects risks, access to and quality of care and treatment by families and communities of women in girls in many ways. Some specific areas are described in greater detail below; however, measures are urgently needed to address many other forms of discrimination and abuse which hinder progress in reducing the HIV infection and the impact of AIDS.

The International Community of Women Living with HIV/AIDS (ICW) describes the experiences reported by women. Women who have been infected by HIV are typically blamed for bringing it into the household, despite the strong evidence available that shows married women not engaging in extra-marital sex are being infected by their husbands who are engaging in extra-marital sex. Because of fear of being thrown out of her home and being denied access to her children, many women do not seek treatment.[47] Because of a high social value on virginity in unmarried young girls and "innocence", parents, schools and communities provide little, if any, information on reproductive health and sexuality. HIV positive women are frequently tested without their consent and may be pressured to terminate a pregnancy without being provided with information regarding mother-to-child-transmission risks or offered medicines which could prevent it. Many women have to obtain permission from their husband or male relative to access care or reproductive health services. When households have few resources for treatment, males are often given priority. In cultures where women and children eat after men, women living with AIDS may not be able to meet their requirements for adequate nutrition.

Women are often diagnosed as HIV positive when they attend a prenatal care clinic. Testing at that time is often done without consent of the patient. Test results are often given to her husband or male family member, putting her in danger of being discriminated against and even forced out of her home.

Shivananda Khan, Executive Director of Naz Foundation International, describes the situation of widespread discrimination, social exclusion, disempowerment and abuse which is common for men who are considered too feminine and not living up to accepted notions of masculinity. In one survey, 64 percent of respondents reported harassment by police and are often sexually assaulted if they do not pay extortion demanded by police and "hoodlums", and 87 percent said they had been sexually assaulted or raped simply because they were effeminate.[48] Many societies in the region have specific terms for such men (generally defined as a man who is sexually penetrated by another man and gendered roles rather than "sexual orientation). The male penetrator is not stigmatized or deviant but as a normal part of the general population. The men who are subjected to sexual abuse are at high risk of contracting HIV while the men who have sex with them, if infected put their wives and other partners at risk. Good examples of laws which protect men who have sex with men and transgenders can be found in Australia and New Zealand. In Fiji, sexual orientation is protected under the constitution.

Women, in fulfilling their role as care-giver in their families generally have a heavy burden when family members are living with AIDS. Fetching water and sources of fuel for cooking and the additional time

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[46] Human Right Watch, *Policy paralysis: A call for action on HIV/AIDS-related human rights abuses against women and girls in Africa* (December 2003).

[47] International Community of Women living with HIV/AIDS (ICW) vision papers.

[48] "MSM, HIV/AIDS and Human Rights in South Asia", a paper by Mr. Shivananda Khan, Executive Director of Naz Foundation International presented at an Expert group meeting on HIV/AIDS and Human Rights in Asia-Pacific in Bangkok March 2004.

needed for washing due to vomiting, fever and diarrhea may make it impossible for women to give time to income generating activities.

1. Schooling

> *Providing good-quality basic education and skills-based prevention education is fundamental to reversing the spread of HIV/AIDS, particularly for girls. Girls are at greater risk of contracting the disease, bear a disproportionate share of its burden and comprise the majority of new infections globally. Yet, because of persistent gender disparity, they are often denied an education and thus protection against infection. (UNICEF, Girls, HIV/AIDS and Education, 2004).*

Lack of education results in lack of access to decent employment and generally relegates people to work in the informal sector which offers no social security in case of sickness and old age. People with little education generally participate little in the political process. There have been improvements in primary school completion rates globally since 1990; however, opportunities for continuing with secondary education are still lacking in many countries. Evidence suggests that among all levels of education, secondary and higher levels have the greatest payoff for women's empowerment. Such as increased income earning potential, decision-making authority, ability to bargain for resources within the household, control over one's own fertility and participation in public life.[49] Education is beneficial for both girls and boys because it serves as a vehicle for transforming attitudes and beliefs and entrenched social norms that perpetuate discrimination and inequality.

A joint project of UNICEF and the Global Coalition on Women and AIDS, demonstrated the linkage between sexual knowledge and behaviour and educational level among young people. It described three priorities areas that would support schools in protecting girls and mitigating the impact of HIV/AIDS: getting and keeping girls in school; proving life skills-based education; and protecting girls from gender-based school violence. States parties to the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) also are legal obligated to ensure, on a basis of equality of men and women, Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning. (Article 10 (h)).

Unfortunately, in many of the poorer countries with a large population of young people, the right to education is absent. Even in cases where there is no tuition officially charge, the costs of sending children to school can be prohibitive for parents due to a range of school fees (for grading tests, homework, contributing for the infrastructure, heating etc. of schools as well as costs of transportation, school supplies and uniforms), that parents must pay. Throughout the region, women are often married off at a young age, and once girls reach adolescence, parents often prefer to keep their daughters safe at home. Unfortunately, many of these young brides also end up as young widows later. With minimal education and no property rights, poor widows have few means of support.

Despite some progress, there are few countries which provide free primary education even when it is compulsory. Even when officially tuition is not charged, there are often countless other fees which must be paid by families for supplies, uniforms, transportation, to have exams marked and so on. Privatization of education has also become a global trend, meaning that those who can pay can receive good quality education while those who are poor must accept often lower quality State-provided education. This is unfortunate since good quality education is vitally important for one's life opportunities and as a means of preventing HIV infection on an individual level but also important for

[49] UN Millennium Project Task Force on Education and Gender Equality, "Taking Action: Achieving gender Equality and Empowering Women', Earthscan, 2005.

the human resources development and ultimately economic and social development of a country. Impoverishment can be caused by HIV/AIDS which can cause mothers to resort to sex work in order to afford the costs of education for her children or withdraw them from school. Children who have HIV/AIDS also face discrimination in schooling.

2. Property, land and inheritance rights

Women in general and widows in particular, often are denied their rights to inheritance, land and property. This placed them in a situation of economic dependency and increases their likelihood of having to resort to migration or selling sex for survival. Articles 13 - 16 of CEDAW address land, property and inheritance rights of women. States parties must ensure the right […] to equal treatment in land and agrarian reform… The International Covenant on Civil and Political Rights, in its General Comment 28 (Sixty-eighth session, 2000) on Article 3: Equality of Rights between Men and Women, [para 19]. "The right of everyone under article 16 to be recognized everywhere as a person before the law is particularly pertinent for women, who often see it curtailed by reason of sex or marital status. This right implies that the capacity of women to own property, to enter into a contract or to exercise other civil rights may not be restricted on the basis of marital status or any other discriminatory ground. It also implies that women may not be treated as objects to be given, together with the property of the deceased husband, to his family. States must provide information on laws or practices that prevent women from being treated or from functioning as full legal persons and the measures taken to eradicate laws or practices that allow such treatment. A more in-depth review of this issue can be found in below, where it is discussed in the context of violence against women.

C. Violence against Women

Violence against women is one of the four major causes of death in the world today. One of every three women in the world will be a victim of violence in their lifetime. Domestic violence accounts for the largest amount of gender-based violence, it is a violation of human rights and the largest threat to women's security and freedom, and is also seen as a pervasive public health problem globally.

Violence against women is a gender issue, and an issue with regard to the spread of HIV/AIDS. Not only are women more vulnerable to infection due to their lack of power in negotiating sexual relations and especially condom usage, but violence against women, including rape, domestic violence, rape in marriage, and sexual violence, renders them extremely susceptible to infection. It is also physiologically easier to be infected with the HIV virus during an act of rape or sexual violence than during non-harmful sexual intercourse when one person is HIV-positive. In addition, women are vulnerable to violence by intimate partners once it is known that they had undergone HIV-testing, and even more so when their HIV-positive status is made public or known to the intimate partner.

In a recent report on gender-based violence in Cambodia by GTZ and ICRW, research revealed that nearly half of new HIV/AIDS infections are being transmitted in an unexpected way; namely in married couples through sexual and gender-based violence. Gender-based violence can both increase the risk of HIV/AIDS and be an outcome of HIV/AIDS infection or status[50]. UN agencies have recently also put more of a focus on the connections between violence against women and HIV/AIDS transmission. According to the World Health Organization, one important impact of violence against women in terms of physical and mental health status is the transmission of STIs, including HIV/AIDS, while one of the consequences of HIV/AIDS may also act as risk factors for further aggression, forming a cycle of abuse. It is important to note that violence against women often increases during

[50] ICRW /GTZ report.

times of ethnic or civil conflict, and is often more accepted, with women in many cases subject to being subject to violence used as weapons of war.

The Special Rapporteur on Violence against Women, appointed by the United Nations Commission on Human Rights, Ms. Yakin Erturk writes in her 2004 report to the Commission which focused on violence against women and HIV/AIDS, "use of violence in all spheres of life has become widespread and legitimate." And goes on to state "discrimination against women, due to gender inequality, is multiple, and compounded at the intersection of patriarchy and other sites of oppression, which subjugate women to a continuum of violence, making them susceptible to HIV/AIDS. HIV/AIDS has fueled VAW and VAW has fueled HIV/AIDS. The two issues must be addressed together" (E/CN.4/2004/66).

The relationship between HIV/AIDS and violence against women has been given increased attention over the years and 2004 marked the launching of the Global Coalition on Women and HIV/AIDS. Prior to that, at its forty-fifth session (2001), the Commission on the Status of Women the issue "Women, the girl child and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)" was addressed. In its agreed conclusions (chk), the Commission urged Governments and all relevant actors to include a gender perspective in the development of HIV/AIDS programmes and policies (E/CN.6/2001/14). The General Assembly convened the twenty-sixth special session in 2001 focused on HIV/AIDS, and through resolution S-26/2 Governments committed themselves to implement, by 2005, national action programmes to empower women to freely decide on matters related to their sexuality and protect themselves from HIV infection. At its sixtieth session (2004), the Commission on Human Rights in its resolution 2004/27 stressed that the advancement of women and girls as the key to reversing the HIV/AIDS pandemic and in its resolution 2004/46, emphasized that violence against women and girls increases their vulnerability to HIV/AIDS, that HIV infection further increases women's vulnerability to violence, and that violence against women contributes to the conditions fostering the spread of HIV/AIDS.

Violence against women and health

One of the clearest links is between HIV and Violence against women. According to the World Health Organization Multi-country Study on Health and Domestic Violence against Women released in November 2005, intimate partner violence is the most common form of violence in women's lives. Women who suffer physical abuse from intimate partners experience serious health consequences and it is troubling because most of this occurs in spaces considered "private".

Violence against women and housing, land and property rights

Violence, commonly experienced by women in situations where their right to adequate housing is also violated is frequent and widespread. Women experience different forms of violence which are often a result of living in inadequate housing and the violation of their right to adequate housing contributes to their vulnerability to gender violence. Violence that relates to women's right to adequate housing occurs at all levels, in the family, the community, by the State and globally.

Within the home this can take the form of domestic violence, or rape and harassment before during and after forced evictions, or in situations of armed or ethnic conflict. Domestic workers, for example, may be forced to live in closed spaces or sleep on kitchen floors, sometimes at risk of being raped by their employers. Degrading housing and living conditions such as lack of access to water, sanitation, electricity, health care and lack of space and privacy can make women more vulnerable to gender violence, abuses and related exposure to HIV/AIDS.

Marginalized women who have less secure rights to adequate housing are particularly vulnerable to gender-based violence, including single women, women-headed households, widows, women from indigenous, minority or descent-based communities, women living under occupation, women who have been forcibly evicted, women who have faced domestic violence, women who have faced ethnic, armed conflict, women migrant workers and domestic workers, girl children, elderly women, women living in extreme poverty, women with disabilities and women with HIV/AIDS. [51]

D. Substance abuse

One of the main ways that HIV is transmitted in throughout much of the Asia-Pacific region is through injected drugs with shared needles and syringes. Men tend to be much more represented among injection drug users (IDUs); however, in some countries (e.g. Vietnam) women commercial sex workers are often injected drug users too. In Central Asia, there is a very close connection between opium and heroin trafficking and use of injection drugs.

E. Movement of People

More than ever before people are on the move. More and more, people are not able to find decent work without leaving their families. The recent phase of globalization is encouraging this trend as is exposure to images in the media and advertising attracting people to the possibility of a better life elsewhere and encouraging consumption. In addition, transportation routes not only mean an increase in movement of good but also of people, whether as workers in the transportation sector of providers of sexual and other services along transportation routes.

Globalization means that no country is unaffected and it has and will continue to also fuel the spread of the virus; therefore, it behooves all countries to consider the many entry points for action to fight the disease. Globalization, has its positive and negative sides. On the positive side, information flows have improved bringing the possibility of e-medicine, distance-learning and conducting business more efficiently. However, on the negative side, those individuals and countries that cannot compete will face job losses and fierce competition in the global market. The affect of this is a large number of people now moving within and between countries. Access to information and basic services is important for mobile populations.

The movement of people across national borders requires a response based on cooperation across borders. Although HIV is clearly a transnational problem, most HIV prevention is focused on the national-level. Johan Lindquist describes how "HIV prevention leads to the formation of a series of boundaries that aims to divide various populations from each other in an attempt to control contagion." Separation of "risk groups" from the "general population". Groups such as prostitutes, men who have sex with men (MSM) and migrant workers are labeled as "at risk" or as transmitting the virus, increasing the chances that they will be discriminated against and stigmatized. Issues of control and exclusion compete with issues of rights and empowerment. The focus on "risk groups" positions HIV outside the "general population" locating it in marginalized groups and thereby reinforcing moral boundaries" (J. Lindquist p. 55). Some strategies include attempting to push prostitutes into brothels where they are controlled by pimps, procurers and police.

1. Migration

The link between internal and cross border migration and HIV is strong: "It is estimated that 7.2 million people are living with HIV/AIDS in the Asia Pacific region and that more than 5 million are in

[51] Miloon Kothari, International Women's Day Statement.

South Asian countries, all of whom are labour sending countries."[52] According to the United Nations estimates, there are between 185-192 million migrants globally - up from 175 million in 2000. Asia has the largest number of migrant workers (with an increase in the number of migrants from 28.1 million in 1970 to 43.8 million in 2000). The significance of mobility as a co-factor of HIV infection in the Asia Pacific catapulted from being a non-issue in the mid 1990s to almost a centre stage position currently. In some of the low HIV prevalence sending countries like the Philippines and Sri Lanka, the major proportion of their HIV infection has been attributed to out-migration. In the Philippines, according to the National Registry of the Department of Health (April 2005), Overseas Filipino Workers (OFWs) comprised 33 percent of the total HIV infected cases. In Sri Lanka, 50 percent of reported HIV persons are returned domestic workers from the Middle East.

Vulnerabilities of migrants can be seen in their lack of HIV awareness, absence of support services and facilities, violation of human rights and access to appropriate antiretroviral treatments and nutritious food during the entire process of migration. Both migration and HIV are transnational issues. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity as listed in the International Covenant on Economic, Social and Cultural Rights (Art 12.1, ICESCR). CARAM Asia and its working partners call for sending countries, the receiving "and transit" countries and concerned authorities to develop effective policies and protection for migrants against HIV/AIDS. Coordinated policies should include creating a friendly environment for the meaningful participation of mobile persons with HIV/AIDS by abolishing mandatory HIV testing and deportation, recognition of the right to work of HIV positive migrants, facilitating access to treatment, and policy backing for workplace initiatives to raise HIV/AIDS awareness and address discrimination. Above all, it must also facilitate the involvement of HIV positive migrants in all strategies and stages of decision-making.

Reducing migration or mobility through mandatory HIV testing and deportation in the hope of controlling the spread of HIV violates the rights of migrants and leaves destination countries with a false sense of security. In order to reduce HIV vulnerability of migrants, the following measures should be taken:

- Provide holistic health and HIV education
- Facilitate voluntary counselling and testing services
- Allow the migrant to continue working
- Provide access to treatment
- Abolish mandatory HIV testing and deportation of migrants

2. Conflicts

While a cause and effect relationship may be hard to prove, evidence suggests that war can lead to an increased risk of HIV/AIDS and that HIV/AIDS can make conflicts worse. Violent conflict creates conditions favourable to the spread of HIV. The military tends to experience high HIV infection rates. A military presence also creates demand for prostitutes. In Cambodia, for example, many years of conflict and poverty, followed by high demand for prostitutes from United Nations peace-keeping forces fueled the spread of HIV/AIDS. In Nepal, many women are trafficked out of the country to work

[52] *CARAM Asia and its partners call for immediate action to address HIV/AIDS amongst the mobile population on World AIDS Day* (December 1, 2005): http://caramasia.gn.apc.org/

in brothels in part due to the on-going conflict and lack of a means of earning a living at home. Many Asia-Pacific countries have experienced internal conflict in recent years. (e.g. Myanmar, Sri Lanka, Timor-Lest, Fiji and the Solomon Islands, Tajikistan, Georgia, Azerbaijan, Indonesia, Philippines etc.). Some of them still have fairly low HIV prevalence rates; however, displaced people, break down in the social fabric and social networks (resulting in behaviour change) and economic vulnerability are risk factors.

3. Trafficking in persons

Because a large number of trafficked women and children are engaged in work that is forced and risky in terms of vulnerability to sexual abuse and exploitation (e.g. prostitution and domestic work), they are at risk. If trafficked access national borders, they will have little, if any, access to information and health services. Ethnic minorities and tribal people often bear a heavy burden of AIDS and human trafficking.

IV. Effective approaches and lessons-learned

It is clear from over twenty-five years of AIDS research and initiatives that a purely biomedical approach is insufficient to have a significant impact on the spread of the disease. There is still a strong need to focus on the social determinants of disease and health. For example, it is important to examine the correlation between epidemiological trends and structural inequities in order to expose the fundamental social causes of public health events, including discrimination, stigma, and poverty. From this perspective health behavior is conceptualized, as an interactive product of the social environment and developing effective public health strategies requires interventions that extend beyond the level of the individual to target interpersonal, organizational, community, economic, political, and cultural factors. Consequently, individually-based prevention theories and practices are moderated by social, cultural, and environmental interpretations that attend to the situational and historical factors that construct health crises and public health interventions.[53] "More work needs to be done on local conditions and realities, including the issue of social controls and learning." [54]

A. Good practices -- examples from the Pacific Islands

- The Transex project, a well-targeted intervention to prevent HIV/AIDS for transport and sex workers, began in 1996 in Papua New Guinea. Sex workers were at the center of the creation of this project, in which police and transport workers received peer educators training, resulting in an increase in condom and voluntary HIV counselling and testing in high-risk groups. [55]

- The AIDS Task Force of Fiji was formed in 1994 as a network of concerned individuals engaged in peer education trainings for sex workers, and evolved into a community organization that trained peer educators in six other Pacific Island countries. Later it set up a sexual health clinic in Suva, and it has maintained a strong focus on peer education and outreach work among youth.

[53] A Sociomedical Sciences Approach to Public Health, Mailman School of Public Health http://www.mailman.hs.columbia.edu/sms
[54] UNRISD, AIDS in the Context of Development, P.13.
[55] Female sex worker HIV prevention projects, November 2000: UNIFEM Gender and HIV/AIDS information pack: http://www.unifem-eseasia.org/resources/others/genaids/genaid15.htm

- The New Zealand Police Domestic Violence programme coordinated under the banner of the Pacific Regional Policing Initiative raises awareness to improve people's ability to seek assistance in situations of domestic violence.

- Ms. Maire Bopp Dupont, the director of the Pacific Islands AIDS Foundation, has long been an advocate to educate students, youth and members of the Pacific Islands community on preventing HIV/AIDS, and eliminating the negative stigma attached to being HIV-positive. Herself HIV positive, she started the Pacific Islands AIDS Foundation, based in the Cook Islands, in 2001. She travels and lectures widely, advocates for changing attitudes towards condoms and the taboo subject of sex, and calls for increased national commitment at a high governmental level to tackle the epidemic in the Pacific Islands countries.

- The Secretariat for the Pacific Community and UNAIDS are focal points for HIV/AIDS prevention-related activities in the Pacific Islands, and have coordinated many actions to fight the epidemic. The UNAIDS Pacific office services two UN Theme Groups in Suva, Fiji, and Apia, Samoa. Most recently, in Fiji in September 2005, 21 police chiefs from the Pacific joined UNAIDS to combat HIV and AIDS among police forces by signing a Declaration of Partnership in an effort to scale up HIV prevention measures in Pacific communities.

- The Second Pan Pacific Regional HIV/AIDS Conference was held in Auckland, New Zealand from 25-28 October 2005. This important conference had the aimed to get political leaders of the Pacific countries to attend, show the human face of HIV/AIDS, examine the role of the media, and expose the lack of drugs for slowing the onset of AIDS. A wide variety of topics such as mobility, culture, gender and vulnerability were discussed within the conference's framework.

B. Treating HIV/AIDS as a development issue

One of the key message that have come from the twenty-five years of experience with fighting HIV/AIDS worldwide is that it must be put into the context of development and treated as a development issue. Also, by focusing on development (including job creation, improving access to and availability of basic services, and rural development in particular), a reduction in HIV/AIDS will follow. To start, demographic changes as a result of HIV/AIDS can have a significant impact on the demand for care givers with possible changes in the gendered division of labour as a result, loss of workers in their most productive years, and a big loss of the adolescent and youth population.

Poverty coupled with gender inequality and weak public services is a good breeding ground for HIV infection. HIV/AIDS prevention and care must be integrated into sectoral programmes as well as planning, budgeting and evaluation. Development is also associated with movement of people and often widening gaps between rich and poor which then impacts vulnerability to HIV infection.

At the 2001 Special Session of the United Nations General Assembly, Member States committed themselves to by 2003:

- evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to: address the impact at the individual, family, community and national levels;
- develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods, and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic;

- review the social and economic impact of HIV/AIDS at all levels of society especially on women and the elderly, particularly in their role as caregivers and in families affected by HIV/AIDS and address their special needs;
- adjust and adapt economic and social development policies, including social protection policies, to address the impact of HIV/AIDS on economic growth, provision of essential economic services, labour productivity, government revenues, and deficit-creating pressures on public resources

Much of this commitment has been left unfulfilled in most Member States, but they are crucial as they address the ways women are affected differently from men and have different needs for social protection, access to basic services, livelihoods and so forth. In addition, ensuring the right of all people to sexual and reproductive health services and information is essential in slowing and managing the HIV/AIDS pandemic. However, access and comfort with services available often vary for men to women. For example in Thailand, it has been found that HIV positive women often find social support through programmes for persons living with AIDS whereas men may not feel comfortable with such services due to shame or not being accustomed to seeking social support from such groups to the extent that women are.

Prevention efforts need to target a range of groups such as uniformed armed forces; youth; men who have sex with men; mobile populations and injection drug users in various settings including the workplace and must include control of sexually transmitted infection (STIs) and mother to child transmission. How services are delivered is also important. Testing and counseling should be voluntary and the clients should be treated with respect. Discriminatory attitudes on the part of service providers often serve to discourage people from seeking out information, treatment or continuing with programmes.

Some prevention efforts rely on approaches such as behaviour change communication (BCC), which makes use of a range of communication channels and can tailor messages to various groups and the larger community to promote and sustain positive behaviour change to reduce risk. However, women as well as people to whom messages are directed must be an integral part of the process of developing them. The HIV/AIDS epidemic forces societies to confront cultural ideals — and the practices that clash with them. BCC is vital to this process and can set the tone for compassionate, responsible interventions. It can also produce insights into the broader socio-economic impacts of the epidemic. People must reach a point of reflecting on the balance of power within the social systems and understanding how that feeds the pandemic as well as its the broader socio-economic impact. It is not enough to only understand the urgency of the problem. Also, one message does not fit all. Tailored health messages disseminated through in a variety of communication channels are more effective for promoting and sustaining risk-reducing behavior change.

A big factor in motivating people to reduce their risk and vulnerability to HIV their understanding of the urgency of the epidemic. Individuals and communities must be given basic facts about HIV/AIDS, taught a set of protective skills and offered access to appropriate services and products. They must also perceive their environment to be supportive of challenging the status quo. Attitude and behaviour change is required in order to make progress in the removal of stigma and discrimination.

As HIV is primarily an STI, this requires national and community discussions on sex and sexuality, risk, risk settings and risk behaviors. It also means dealing at the national and community levels with stigma, fear and discrimination. Treating STIs is important in itself. Infection with an STI increases the risk of HIV transmission risk and other health problems such as ectopic pregnancy and severe congenital infections and can cause stillbirths and infertility. In pregnant women, syphilis results in fetal loss in a third of cases, and half the surviving infants suffer congenital disability.[56]

[56] Family Health International.

C. Commercial Sex Workers

Major risk behaviour for HIV/AIDS in Asia are: buying and selling of sex, injecting drug use and male-male sex.[57] Throughout the region there are male and female commercial sex workers (CSWs) and people who exchange sex for drugs and even basic needs such as food. Sex workers are not; however, a homogeneous group and there is a wide range of situations in which they work ranging from forced prostitution in horrible conditions often involving very young girls and boys, to women and men who report choosing sex work often as the only means of earning a living or with the best potential for higher earnings. Some people work on their own and others through a brothel owner or pimp. Their knowledge of STIs and ability and interest in negotiating safe sex varies considerably. All of these factors imply different risks of HIV infection.

Female CSWs have been traditionally labeled as high risk; however, in Thailand for example, a policy of 100 percent condom use has helped decrease the rate of infection in this group, while the rate of infection among male CSWs or other groups traditionally seen as low risk is climbing. What is more often the case is that prostitution is illegal so it is forced underground. Commercial sex workers are often hard to reach because they may have to frequently move and often face harassment.

Recommendations

Following is a list of key recommendations or areas which need strengthening. Some are policy-oriented, some involve changes in the law; while others have to do with deeply-rooted attitudes, behaviours and beliefs which must be tackled through a range of approaches over time. Implementing these recommendations would be a step towards social justice and promotion of human rights, even if not in the context of HIV/AIDS. The HIV/AIDS pandemic has in many respects simply shone light on existing inequality, discrimination and injustice. This list is far from exhaustive, but is meant to briefly highlight key issues.

1. Access to voluntary and confidential testing is still needed in many places. Counseling and information on matters such as prevention of mother-to-child transmission and breastfeeding must be made available.
2. Places where women can access information or reproductive health services should not be limited to prenatal clinics where unmarried women or women who have no children cannot easily access services. Measures must be taken to end discrimination and rudeness of health care service providers to women and socially marginalized people. Women and girls also need prevention options they can control themselves, such as the female condom and microbicides - sponges, gels, creams, and suppositories that block HIV transmission.
3. Information and treatment must be accessible to those who are illiterate, women and socially marginalized people so that they can protect themselves.
4. Measures must be taken to stop sexual abuse of prostitutes, street children and effeminate males by the police.
5. Financial barriers that prevent girls from going to school must be removed.
6. Violence against women must be prevented, perpetrators punished and awareness of the seriousness of the problem raised within society at large as well as among health care workers and those working in the administration of justice.
7. Implement laws to safeguard women's property and inheritance rights.
8. Care givers (many of whom are very young, very old and women) must be valued and supported

[57] AIDS in Asia: Face the Facts, p.7; 2004, Monitoring the AIDS Pandemic Network (MAP).

9. Decriminalize behaviours which are associated with the reducing the threat of transmission of HIV such as possessing a clean needle and syringe for injecting drugs or a condom. Laws which make it a criminal act to publish sex education materials if they are deemed to be obscene, anti-sodomy laws which can allow for as much as life in prison (e.g. Section 377 of the Penal Code of Bangladesh, India and Pakistan), must be reviewed along with religious and customary law. "All scientific evidence suggests that large-scale programmes that provide substitutes for injected drugs and that increase access to clean needles will reduce new HIV infections among injectors."[58]
10. Give adequate attention to orphans and street children who are at high risk for sexual abuse and exploitation and therefore HIV infection.
11. Incorporate into development planning possible AIDS-related demographic and labour changes as well as increased demand for basic services, potential food security problems etc.
12. Ensure a human rights approach is followed in all HIV/AIDS activities (prevention, treatment etc.) based on legal instruments such as: the International Covenant on Economic, Social and Cultural Rights and its General Comment 14 on right to health, Convention of the Rights of the Child and its General Comment 4 on Adolescent Health and Development; Convention on the Elimination of All Forms of Discrimination against Women and its General Recommendation No. 24 on Women and Health along with Guidelines on HIV/AIDS and Human Rights
13. Work-related issues must be given attention. These include dismissal from employment due to being HIV positive, stigma which makes it hard for micro and small enterprises to attract and keep regular customers and care burdens which limit time available for earning income.
14. Behaviour of men which increases the risk of HIV transmission must be addressed.
15. Unequal power relations must be addressed.
16. Women's organizations and organizations which work on HIV/AIDS could both benefit from closer collaboration.

VI. Concluding remarks

A number of good recommendations have been put forward by a number of NGOs and institutes working on HIV/AIDS, the Global Coalition of Women and HIV/AIDS, and many others. At the United Nations General Assembly Special Session on HIV/AIDS (2001), a list of commitments was adopted by governments. In addition, legal instruments to which the vast majority of countries are States parties, impose specific legal obligations on States parties. The Committee on the Elimination of Discrimination against Women recommended that States ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS. HIV/AIDS has so clearly exposed the imbalances of power, discrimination and marginalization of people within each socitey. Addressing violence against women and all forms of discrimination will also significantly help States in achieving the commitments they made, their legal obligations as well as Millennium Development Goals.

[58] Monitoring the AIDS Pandemic Network (MAP), AIDS in Asia: Face the Facts, p.6, 2004