vi+ 32 pp
1. Gender roles. 2. AIDS education. 3. Health education. 4. Asia and the Pacific.


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Chief Editor: Caroline Haddad
Design and Layout: Sirisak Chaiyasook

Published by
UNESCO Asia and Pacific Regional Bureau for Education
920 Sukhumvit Rd., Prakanong
Bangkok 10110, Thailand

Printed in Thailand

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ARSH/07/EP/030-electronic
Acknowledgements

This publication was developed from the UNESCO Bangkok-implemented, UNFPA-funded project, “Advocacy and Educational Support to Adolescent Reproductive Health (RASSR103).” Research, interviews and writing were undertaken by independent consultants Samra Akthar, Amy Horton and Chemba Raghavan, with support from project coordinators Francisco Roque and Philip Bergstrom. Special thanks are due to the many collaborating partners who contributed extensive feedback, knowledge and expertise during the development of this publication.

The collection of HIV prevention education practices presented in this work was made possible through the support of United Nations offices in Asia and the Pacific, namely those representing the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), the United Nations Economic and Social Commission for Asia and the Pacific, ESCAP and UNAIDS.
Preface

“… gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS…”

Article 14, Declaration of Commitment on HIV/AIDS,
United Nations General Assembly Special Session (UNGASS) of HIV/AIDS, June 2001

In the past six years, international agreements and, to a certain extent, national commitments have recognized the urgent need to reach young women and girls with HIV prevention messages in order to empower them to make decisions that reduce their risk. Momentum surged in 2004 as organizational leaders and staff, government officials, and other practitioners gathered for the “First Asia-Pacific Women, Girls and HIV/AIDS Best Practices Conference,” which was held in Pakistan. World AIDS Day that same year carried the theme, “Young Women, Girls and HIV/AIDS.” The campaign slogan, “Have you heard me today?” focused the world’s attention on how gender inequality is fueling the AIDS epidemic.

The United Nations General Assembly (UNGA) underscored this linkage between gender inequality and HIV/AIDS infection during its 87th Plenary Meeting in June, 2006. During that meeting, UNGA pledged its efforts to:

“…eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection… provision of full access to comprehensive information and education; ensure that women can exercise their right to have control over, and decide freely and responsibly on matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence.”

One year later, we find an increasing number of HIV education programme responses (but still too few) targeting women and girls – and young people, in general – within a culturally-appropriate, gender-sensitive framework. Gender inequalities that result in lack of access to information, education and economic opportunity, and which perpetuate gender-based violence, rape and stigma, are still pervasive in the Asia-Pacific region. For these reasons, women and girls’ vulnerability to HIV infection remains a serious concern.

Efforts to promote gender equality in access to formal schooling, as well as equality in the classroom, are paramount to increasing literacy, reaching young people with life skills education, female empowerment and other factors that reduce vulnerability to HIV. The non-formal education setting also provides a critical pathway for reaching young women with HIV prevention education strategies – especially those on the margins of society. In Asia and the Pacific, where fewer girls than boys are in school, and large numbers of women are illiterate, fighting the epidemic means both promoting access to formal education and implementing and strengthening out-of-school programmes that teach and empower. Gender-sensitive strategies should be applied to achieve equality in access to education, and should be integral to every stage of HIV education programme design, planning, implementation and monitoring/evaluation.

Thus, in recognition of the goals put forth during UNGASS and beyond, this publication highlights some experiences from Asia and the Pacific that have targeted young people – and young women, in particular – with HIV prevention education messages. Often these activities have been part of larger integrated strategies that are reflective of the fact that there is no one single AIDS epidemic. Indeed, the disease is spreading in different ways and in very different socio-cultural, political and economic contexts across the region. Therefore, it is hoped that some of these approaches and lessons learned can be adapted and applied in other local settings in order to reach greater numbers of young people, and ultimately, to save lives and strengthen communities.
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### Acronyms

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<tr>
<td>AIDCOM</td>
<td>Asian Institute for Development Communication</td>
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<td>AIDS</td>
<td>Auto-Immune Deficiency Syndrome</td>
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<td>ARV</td>
<td>anti-retroviral</td>
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<td>CDC</td>
<td>Cairo Demographic Centre</td>
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<td>EHDAG</td>
<td>Environment Health and Development Advisory Group</td>
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<tr>
<td>GBV</td>
<td>gender-based violence</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IDU(s)</td>
<td>injecting drug user(s)</td>
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<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
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<tr>
<td>MSM</td>
<td>men who have sex with men</td>
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<tr>
<td>NGO</td>
<td>non-governmental organization</td>
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<td>PLWHA</td>
<td>people living with HIV/AIDS</td>
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<td>RHIYA</td>
<td>Reproductive Health Initiative for Youth in Asia</td>
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<td>STI</td>
<td>sexually-transmitted infection</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNESCAP</td>
<td>United Nations Economic and Social Commission for Asia and the Pacific</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGA</td>
<td>United Nations General Assembly</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>UNICEF</td>
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<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
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<tr>
<td>VCT</td>
<td>voluntary counseling and testing</td>
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<td>VSO</td>
<td>Voluntary Services Overseas</td>
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Introduction

"Reducing infection rates in women and girls is essential if AIDS is to be brought under control. Current prevention programmes are not achieving this."
- UNAIDS, WHO. AIDS Epidemic Update, 2004

An estimated 38.6 million [33.4 million–46.0 million] people worldwide were living with HIV in 2005. An estimated 4.1 million [3.4 million–6.2 million] became newly infected with HIV, and an estimated 2.8 million [2.4 million–3.3 million] lost their lives to AIDS (UNAIDS, 2006). In many countries around the world, the majority of new infections are occurring among women, particularly young women and wives. Women between 15 and 24 are 1.6 times more likely than young men to be HIV-positive (UNAIDS, UNFPA, UNIFEM, 2004). Globally, nearly 12 million young people between the ages of 15 and 24 are living with HIV/AIDS, and more than half of those newly infected with HIV today are between 15 and 24 years old (UNAIDS, UNFPA, UNIFEM, 2004).

These numbers reflect a global trend also unfolding in parts of the Asia and Pacific region: HIV prevalence is increasing at alarming rates among young women and girls. In some countries, such as Cambodia, transmission is the highest among this group.

- In South Asia, young women now represent 62% of the HIV-infected population.
- Of the 740,000 young people living with HIV/AIDS in East Asia and the Pacific, 49% are female (UNAIDS, UNFPA, UNIFEM, 2004).
- Out of the 1.8 million young people living with HIV in South and South East Asia, 40% are female (UNAIDS, WHO, 2004).
- As of 2004, in East Asia, women comprised 22% of all adults living with HIV, and 28% of young people aged 15 to 24 were living with HIV.
- In South and South-East Asia, 30% of adults (up from 28% in 2002) and 40% of young people living with HIV are women and girls (UNAIDS, UNFPA, UNIFEM, 2004).

A 2004 joint UNAIDS/UNFPA/UNIFEM report emphasizes the urgent need for HIV prevention approaches to target young women using strategies that address their specific needs and realities. “Effective prevention is composed of many facets—including education, health services, media campaigns, behaviour change, life skills-building and job training. All of these components must address the critical role that gender plays in sexual and reproductive life, and how it affects HIV prevention” (UNAIDS, UNFPA, UNIFEM, 2004)

The ability to address the broad set of complex gender-based causes that make both men and women vulnerable to HIV, including those inequalities that both perpetuate a lack of access to information and education and influence behaviour, is critical to successful HIV prevention education. Notably, the empowerment of young women and girls and the involvement of young men as equal partners in decision-making are fundamental.

For whom is this publication?

This publication aims to provide HIV prevention education leaders and practitioners working outside of formal school settings with the information and tools to understand the complexities of gender specific to the region, and to support implementation of gender-sensitive approaches in HIV prevention education programmes and activities.

What will you find in this publication?

Designed as a compilation of information from a variety of sources, this publication compiles previously published materials as well as new insight that are relevant to the Asia-Pacific region. Regional and national data related to HIV/AIDS prevalence and transmission, where available, in addition to common tools, instruments and concepts in the field of gender studies, have been synthesized and repackaged throughout.
In addition, a collection of practices presents the experiences of country and regional out-of-school HIV prevention education projects and/or programmes, as well as provides background and local context in order to facilitate the adaptation and implementation of similar approaches in other settings throughout the region.

Many of these practices demonstrate promising responses to gender-based issues related to HIV/AIDS and young people, and in particular, young women. Some practices do not exhibit an explicit effort to integrate gender; rather, programming approaches and activities evolved when a clear need to address gender-based issues emerged. Projects that address gender-based norms among young men and that target boys specifically to promote gender equality are included. Examples of experiences in the region point to specific lessons learned in regard to addressing aspects of gender in programming, and specific recommendations based on these and other factors are also included.

While this publication does contain multiple facts, data and statistics synthesized from available research in order to provide an overview of the Asia-Pacific regional situation, it does not go into great detail about the gender-based factors that are fueling the epidemic. There already exists a vast amount of literature on the topic of HIV/AIDS and gender, including the unique vulnerabilities to the disease faced by women and girls, in particular. Increasingly, programme officials understand the ways in which gender shapes vulnerability to HIV infection. However, there remains limited practical knowledge about how to specifically address gender in their programmes, notably via education interventions in the non-classroom setting.

The Annex contains bibliographic references for further information on the gender-based factors that make young women more vulnerable. See also Info Box 3 below: “Overview of Gender and Vulnerability to HIV/AIDS,” reprinted from Integrating Gender Into HIV/AIDS Programmes, Interagency Gender Working Group (IGWG) and USAID, 2004.

The focus of this publication is on HIV prevention education; however, it is recognized that gender norms and inequalities affect all aspects of HIV/AIDS programming, including care, treatment and support for people living with HIV/AIDS (PLWHA), as well as efforts to reduce stigma surrounding the disease. Sustained, intensive, comprehensive responses are critical to halting and reversing the spread of the epidemic. No single strategy is effective.

Lastly, HIV prevention efforts within the formal education sector cannot be overlooked as a critical avenue for reaching young people with HIV prevention information and life skills. Analysis by the
Global Campaign for Education suggests that if all children received a complete primary education, around 700,000 cases of HIV in young adults could be prevented each year – 7 million in a decade (UNICEF, 2004). Furthermore, based on recent analyses of national representative surveys in as many as 53 countries, a UNICEF report demonstrates that education, particularly education for girls, has the potential to equip young people with the knowledge, attitudes and skills needed to reduce their risk of contracting HIV. Data compared across countries and regions and disaggregated by education levels shows that young women and men with higher levels of education are more likely to have increased knowledge about HIV/AIDS, a better understanding of ways to avoid infection, and an increased likelihood of changing behaviour that puts them at risk of contracting the disease (UNESCO, 2004).

UNESCO participates with other UN agencies, NGOs and community-based organizations in efforts to advocate and ensure HIV prevention education is incorporated into government education policy as well as classroom curricula and materials. The organization recognizes that the creation of an enabling environment as well as proper training and support for practitioners and educators are critical. UNESCO also strongly supports efforts to make sure girls have equal access to formal education, and leads efforts to promote Education for All initiatives in the region. Indeed, facilitating ways to achieve gender equity in all aspects of classroom learning is a key goal of UNESCO Bangkok’s Gender in Education Network in Asia.

Terms and Definitions
What are gender-based approaches?

Practitioners in the field of gender studies commonly evaluate the application of gender-based approaches into programming along a continuum. The Interagency Gender Working Group (IGWG) Research/Evidence-Based Task Force has outlined three distinct gender integration approaches into which a programme tends to fall. (See Info Box 2.) This publication uses and recommends this continuum framework as well as other tools and concepts available in the field, such as the gender lens, to evaluate gender-based approaches to HIV/AIDS prevention education for young people.

A gender-based approach to HIV prevention education programming invokes the fundamental principles of ensuring gender equality, as well as:

INFO BOX #2: Gender Integration Approaches

These three approaches are as follows:

- **Those that exploit or exacerbate gender inequalities** in the pursuit of reproductive health and demographic goals. These strategies might emphasize male sexual dominance in marketing slogans aimed at men to use condoms, or inadvertently reinforce make dominant decision-making power by involving men in their female partner’s health care services without training to counteract providers’ tendency to direct information primarily to the man and not the woman.

- **Those that accommodate gender differences**. In some cases, accommodating inequitable gender norms may provide benefits more quickly than approaches that seek to change gender systems. An example of this type of strategy would be disseminating HIV prevention information door-to-door in communities where women’s movement outside the home is limited. This outreach may increase access to information but, in most cases, door-to-door distribution of information does little to challenge the belief that women who leave the home without a male relative’s permission are not respectable.

- **Those that seek to transform gender relations to promote equity**. In the case of accessing HIV-prevention information, a project might help a community examine its norms that inhibit prevention for women and men, and result in efforts to transform support for women’s mobility and related empowerment efforts as a key element of HIV prevention. For instance, this approach would work to change gender relations so that men and women would support women’s rights to be mobile outside of the home, and to attend a clinic without needing to secure her male relative’s permission.

Reprinted from Integrating Gender Into HIV/AIDS Programmes, published in 2004 by the Interagency Gender Working Group (IGWG) and USAID.
- Takes into account the gender-based inequalities that fuel the epidemic.
- Addresses these inequalities by:
  - Promoting equity in access to the information, education and services that all young people need in order to make informed decisions about their sexual health;
  - Reaching out to both young men and young women to ensure their equal partnership and participation;
  - Empowering young women to realize their full potential as active participants in society; and
  - Involving young women and men in equitable ways in some or all aspects of programming.

Definitions

Adolescents, youth and young people: Where possible, this publication has adopted the following definitions for adolescents, youth and young people used by UNFPA:
  - Adolescents: 10- to 19-year olds (early adolescence 10 to 14 and late adolescence 15 to 19)
  - Youth: 15- to 24-year olds
  - Young People: 10- to 24-year olds

Gender: Gender is not a major feature in many educational systems in the Asia and Pacific region, often because it is not well understood. "Gender" does not refer to the biological differences between males and females; the term "sex" covers this distinction. "Gender" does refer to the social roles, responsibilities, and behaviours that are believed to belong to men and women; for example, "men as income earners" and "women as child caregivers." Gender roles are created by a society and are learned from one generation to the next. Because gender roles are socially learned, they can be changed to achieve equity and equality for women and men. For instance, we can change the gender roles of "women as child caregivers" to "women as income earners," "men as income earners" to "men as child caregivers," or, better yet, "men and women as income earners and child caregivers."

What is a Gender Lens?

“A gender lens is a tool which enables one to view the participation, needs and realities of women alongside the participation, needs and realities of men. A gender lens can be a checklist, a survey, a problem-solving drama or can take on many other forms. The origin of the term “gender lens” is a comparison with our sight. Just like we need two healthy eyes to see clearly and fully, we need to see the distinctive realities of men and women, boys and girls, to get the full picture needed for sustainable development.”


Examples of the concept of “gender lens” can be found in the Toolkit for Promoting Gender Equality in Education), which was published by UNESCO in 2004.
INFO BOX #3: Overview of Gender and Vulnerability to HIV/AIDS

**Gender Norms and Unequal Power in Sexual Relations**

- **Norms of femininity inhibit knowledge and assertiveness, and decrease ability to negotiate safer sex.** Gender norms for femininity may place a high value on sexual innocence, passivity, virginity, and motherhood, and women are not supposed to be knowledgeable about sex and generally have limited access to relevant information and services. They often, therefore, remain poorly informed about sex, sexuality, and reproduction and are less able to discuss these issues with their sex partners. In addition, where virginity for girls is highly valued, some unmarried couples may engage in sex, which, when unprotected, increases risk of transmission of HIV/STIs. In most cultures, women's and men's social value is often derived from their ability to have and raise children, leaving women vulnerable to HIV/STI transmission because condom use is perceived to be in direct conflict with procreation (Gupta, et al., 2002; Gupta, 2000).

- **Norms of masculinity inhibit knowledge and support for shared decision-making and promote aggression and risk-taking.** Gender norms for masculinity often dictate that men and boys should be knowledgeable, experienced, and capable of taking the lead in sexual relationships. Multiple partners for men are condoned and even encouraged in many societies. Gender norms of aggression and dominance also sanction gender-base violence (GBV). The norms surrounding young men's sexual initiation and multiple partners are barriers to effective HIV/STI prevention for youth. Use of alcohol and drugs are also associated with traditional norms of masculinity, and both limit the ability to negotiate safer sex and increase the likelihood of violence (Barker, 2000; Cohen and Burger, 2000).

- **Gender and sexual identity.** Traditional gender norms of masculinity and femininity contribute to homophobia and related silence, denial, stigma, and discrimination against males who have sex with males (MSM), transgender, and third-sex persons. There norms affect access to accurate prevention information, power to negotiate consistent and correct condom use, and if living with HIV/AIDS, access to treatment, care, and support. In particular, limited access to accurate, non-stigmatizing prevention information increases vulnerability for HIV infection among MSM, transgender, and third-sex individuals and their male and female sex partners (Gupta, 2002; Parker and Aggleton, 1999; Mayorga, et al., 2003).

- **Unequal power in relationships.** Gender norms related to sexuality often place men in dominant roles and women in subordinate or passive roles. These unequal relations, in turn, are often further reinforced by larger social, economic, and legal inequalities (see below). The result is that inequalities in power between men and women limit women's ability to control whether, when, and how to engage in sexual relations (Gupta, et al., 2002; Population Council, 2001).

**Gender Roles in Households and Communities**

- **Inequalities in decision making mobility, and access to resources.** Within households, men often control decisions regarding use of household resources, which may make it difficult for women to get the resource needed to gain access to services. In addition, both women and men tend to put greater emphasis on men's health needs and devote household resources to meeting those needs. Women may also have limited mobility due to cultural norms that preclude women from leaving their household, or may have difficulty accessing health care services where they cannot go to a clinic with the permission or approval of their partner (Gupta, et al., 2002; Gupta, 2002).

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1 MSM is a term that refers to the behavior of males (both adult and younger) who have sex with other males. It recognizes that some MSM also have sex with female partners and that MSM may not necessarily identify as being “gay,” “homosexual,” or “bisexual.” The term “transgender” is used to refer to attitudes, behaviors, and other characteristics that differ from the gender roles and norms the dominant society has assigned to a particular biological sex (e.g., this term may refer to males who dress and live as women while still being anatomically male). The term “third sex” refers to those individuals whose biological attributes (hermaphrodite) and/or gender identities are neither those of a “woman” nor a “man,” but rather another “third” sex. (Heardt, 1994)
“Women’s work” and unequal care-taking responsibilities. With families and communities, gender norms assign women and girls the primary role of care-taking and do not view this as “work”, but rather as a natural part of being female. In the context of HIV/AIDS, women’s burden of care has increased, with women and girls generally assuming the primary burden of care for PLWHA. The increased burden of care, in turn, further limits women's and girls' access to reproductive resources. For instance, care-taking decreases women's time available for income generation and food production; it also hinders girls' ability to attend school (Gupta, et al., 2002; Lewis, 2003; UNIFEM, 2001).

Larger Social, Economic, and Political Inequalities

• Lower socio-economic status of women and girls. The socio-economic status of women and girls places them at greater risk for acquiring HIV and can also lead to harsher consequences of the HIV/AIDS epidemic. Women's and girls' lack of access to productive resources reduces their ability to negotiate condom use or leave abusive relationships. In some instances, lack of educational and economic opportunities may cause women to exchange sex for material goods (often called “transactional sex”). This may include relationships with visiting partners or older men or more formal sex work as a means for earning income. Many respondents noted the growing gap in ages between HIV infection in young women and men, especially in the African context, were data show that young women ages 15-24 have a rate of HIV infection that is 5-6 times that of their male counterparts (UNIFEM, 2003). Gender differences in the impact of the epidemic—in terms of time spent caring for others, girls' removal from school, or denial of inheritance rights—further decrease women's and girls' socio-economic resources and increase their vulnerability to HIV.

• Lack of legal rights to inheritance and property. Under some legal systems and customary practices, women are denied the right to inherit land and property and, further, a woman herself may be inherited by her husband’s male family members following his death. HIV/AIDS has increased the number or women widowed and has led to more widows at younger ages. Loss of property and inheritance decreases the access of women and their families to productive resources—increasing their vulnerability to HIV and compromising the ability to meet their basic needs, such as nutrition and housing. Thus, with the HIV/AIDS epidemic, the scope and impact of property rights violations on women, children, and communities has increased dramatically (Human Rights Watch, 2003).

• Mobility and migration for work. While social and economic inequalities tend to increase women's vulnerability to HIV, gender patterns in employment also impact men's vulnerability. Due to limited access to employment and income, men sometimes leave their communities to seek economic opportunities. Men who migrate for work. (e.g., seasonal agricultural laborers) or have mobile jobs that take them away from their families (e.g., truck drivers) are in environments that increase their vulnerability to HIV through unprotected sex with female or male sex workers or injecting drug use with contaminated needles. In some cases, depending on the economic situation of the community and family, the family members left behind may have to engage in sex work to support themselves. Young women, too, are increasingly migrating for employment and face particular risks. As young migrating women may not have the skills needed in formal work sectors, they may be more likely to turn to sex work for income: other young women may face vulnerabilities related to being away from traditional support structures (Lewis, 2003; River and Aggleton, 2001).

Cross-Cutting Gender Issues

• Gender-based violence (GBV) affects both the risk of contracting HIV and the consequences of disclosing HIV status. GBV is a leading risk factor for HIV as well as a feared consequence of disclosure for women. Research indicates that fear of violence limits women's ability to negotiate condom use or fidelity with their partners (Gupta, 2002: IGWG, 2002a). GBV limits women's ability to decide whether, when, and how to engage in sexual relations, as well as their ability to leave unsafe relationships (Gupta and Weiss, 1993). Sex workers also experience very high levels of violence, with limited recourse to protection from or prosecution of perpetrators, placing them at increased risk for HIV infection (Church, et al., 2001: Alexander, 2001). In mobile populations (e.g., refugees or displaced groups), GBV—and particularly rape—puts women and girls at an added risk for HIV/
STIs. In addition, studies have shown that some women may face harsh consequences following disclosure of HIV-positive status, including the threat of violence (Maman et al., 2001). at the same time that a majority of women may experience positive outcomes (USAID/synergy, 2004).

For young women, sexual coercion is a key factor limiting their ability to prevent HIV/STI transmission. Research shows that many young women's first sexual encounter may be coerced. For example, a study in Western Kenya of an intervention to improve adolescent reproductive health found that two-thirds of the girls reported that they had not wanted to have sex at the time of their last sexual intercourse, whereas almost all boys reported that their last sexual intercourse was consensual (Warren, et al., 2001). Increased attention is also focusing on schools as a site of sexual coercion of girls and for boy (Mensch, et al., 1998).

In addition, GBV affects males who have sex with males (MSM). Within MSM relationships, gender norms often dictate that one partner is dominant and the other submissive. The submissive partner may have less power in the relationship and may face the threat of the use of violence that can be associated with such lack of power. In addition, violence against MSM by communities and police drive MSM underground, which makes reaching MSM with prevention information and supporting conditions for safer sexual practices extremely difficult (Niang, et al, 2002).

• Gender-based norms and stereotypes fuel stigma and discrimination. Gender norms blame and shame women for being “vectors” and responsible for spreading HIV, and for having engaged in assumed “promiscuous” behavior. Gender norms often assume that if a woman has acquired HIV, it is because she has behaved in a way that has transgressed the norm of what proper women should do. These norms fuel stigmatizing responses of blame and shame directed toward HIV-positive women. In addition, women historically have been stigmatized as reservoirs of infection, responsible for potentially polluting their partners and households. Because voluntary counseling and testing (VCT) programmes have often targeted women, especially in the context of prevention of mother-to-child transmission (PMTCT) of HIV, these programmes have often unintentionally exacerbated the stigmatizing view that women are responsible for HIV. Since women are often tested first, they are frequently the first ones in a relationship to be identified with HIV-positive status. Women thus may face blame for bringing into the household. In the context of decision-making related to reproductive choices, HIV-positive women may also face negative judgement by community members and health care providers related to being sexually active. The consequences of stigma and discrimination faced by HIV-positive women are often harsher than the consequences for men, including women being thrown out of their homes or experiencing GBV (Aggelton and Chase, 2001; Aggelton and Parker, 2002: Nyblade, et al., 2003; ICRW, 2002: ICW, 2002).

Gender norms also blame and shame MSM as responsible for HIV due to their perceived “immoral” sexual behaviors. MSM face the double stigma of being blamed for their sexual behaviors as well as for their serostatus within family, community, and health care settings and the broader social environment (Aggelton and Parker, 2002).

Reprinted from Integrating Gender Into HIV/AIDS Programmes, published in 2004 by the Interagency Gender Working Group (IGWG) and USAID.
Overview

In Asia and the Pacific, where more than 7 million people are living with HIV/AIDS, girls and young women represent a substantial and growing proportion of new infections. In South Asia, young women now represent 62% of the HIV population (UNAIDS, 2004). Of the 740,000 young people living with HIV/AIDS in East Asia and the Pacific, 49% are female (UNFPA, 2003).

The mode of transmission in Asia has been mainly through injecting drug use and sex work. Cambodia, Myanmar and Thailand are already dealing with serious epidemics, all three of which have made efforts to halt the spread of transmission by targeting high risk groups – with varying degrees of success. Countries such as China are facing high rates of infection among high risk groups, and the gap between the rates of HIV infection among men compared with those among women is narrowing. In some South-East Asian countries like Indonesia, Nepal and Viet Nam, the HIV epidemic is exploding among injecting drug users (IDU) and commercial sex workers, of which the majority are under 25 years of age (UNAIDS, WHO, 2004).

However, the epidemic has great potential to move from high risks groups to the general population, contributing to a rise in infection rates among young women. Emerging evidence is revealing that spouse-to-spouse transmission is becoming more common, primarily as a result of men engaged in high risk behaviours who are infecting their wives with HIV. Women now account for more than one quarter of new HIV infections in India, according to estimates, and 90% of those who test positive at antenatal clinics say they are in single, long-term relationships (UNAIDS, WHO, 2004). In 1992, approximately 90% of HIV transmission in Thailand was occurring between sex workers and their clients. Ten years later, by 2002, an estimated 50% of new infections were between spouses as a result of current or former male clients of sex workers transmitting the virus to their wives (UNAIDS, UNICEF, WHO, 2002).

Monogamy and Early Marriage

Early marriage has been found to be a risk factor for HIV/AIDS in several studies (Clark, 2004; Bruce & Clark, 2004), likely because many early marriages are imposed and may involve unwilling partners. As a result of this, in some cases one or both partners may not be monogamous, which often invalidates the claim of protection from HIV/AIDS infection within marriage. Indeed, the perception – particularly among girls and women – that early marriage offers them safety from HIV infection may be a large risk factor for many women in the region. For these women, misplaced trust in spousal fidelity may cause them to be less cautious in their approach to sexual relations. For instance, Newmann et al (2000) contend that, “Single partner heterosexual sex with their husband was the only HIV risk factor for the majority of women. HIV prevention and intervention strategies need to focus on married, monogamous Indian women whose self-perception of HIV risk may be low, but whose risk is inextricably linked to the behaviour of their husbands” (p. 250).

Early marriage of girls and young women exists in many countries in the Asia and Pacific region, and is common practice in South Asia. Thus, many young women and girls’ first sexual debut takes place during adolescence, and within the context of marriage. In India, 50% of girls are married by the age of 18. In Nepal, 19% of girls are married before the age of 15, and 60% by the time they are 18 years old (UNICEF, 2005).
Analysis of household survey data conducted by UNICEF in 2005 showed that 48% of South Asian females aged 15 to 24 had married by the time they were 18 (UNICEF, 2006). Most of these young girls are married to older and often more sexually experienced men, and lack the power to negotiate safe sex or to refuse it. In countries like India, where early marriage is prevalent, it is the primary HIV risk factor for young women.

Regardless of age, marriage and fidelity do not shield women from contracting HIV or other STIs. A study of 400 women attending an STI clinic in Pune, India, found 25% of the women were infected with STIs and 14% were positive for HIV; 93% of the women were married, and 91% had never had sex with anyone other than their husbands (UNAIDS, UNICEF, WHO, 2002).

Condom use is often rare within marriage. Both sexes in a relationship often fear being suspected of infidelity at the suggestion to use a condom. Also, women of all ages who wish to have children, but have no other way of protecting themselves from HIV, put themselves at risk.

Young women may also face unequal power within the relationship and find it difficult to refuse sex. They may fear violence, rejection and abandonment or even believe that they are required to be sexually available in marriage.

**Sex Work**

Gender-based norms and inequalities that increase vulnerability to HIV and other STIs are both reinforced and magnified within the sex industry. Young men and women make up an alarming percentage of the sex trade in the region, and are often coerced or lured into the industry under false promises for economic opportunity. The Social Welfare Board of India has reported that roughly two out of five sex workers are children under 18. As many as 48% of adolescent sex workers are HIV-positive in Pune, India. In Cambodia, where the majority of sex workers are young, over a quarter between ages 15 to 19 are infected with HIV (Terre des homes, 2007).

In parts of Asia, young women are trafficked within and across borders and forced into sex work. Poor economic conditions, especially in rural areas, and gender-based discrimination against girl children have contributed to an increase in trafficking of young women for sex work in recent years. A study conducted by Terre des Homes Foundation recently found that the sex work of Nepalese girls aged between 12 to 18 years remains prevalent in brothels in the Indian cities of Mumbai and Kolkata, where young girls are trafficked from Nepal at an average age of twelve. A life of prostitution, extreme economic hardship and slavery renders many of these women powerless and hopeless by their mid-twenties, and social reintegration is not common. Many are infected with HIV/AIDS. In addition, the report found that these women were often rejected by their families in Nepal, and very few could go back to their homeland due to the stigma of being a sex-worker (UNICEF, UNAIDS, WHO, 2002).

**MSM**

Recent research has found that men who have sex with men (MSM) represent another vulnerable population that is a potential agent of HIV transmission to women in the region (At Risk Key and Neglected Populations, UNAIDS, 2006). For example, a recent study of non-brothel-based female sex workers in India conducted in Andhra Pradesh found that 42% of the men in their sample were married, and 50% had also engaged in unprotected sexual intercourse with women within a period of three months preceding the study (Dandona, et al, 2005, reported in AIDS Epidemic Update, UNAIDS, Dec 2006). Similarly, in a study from Beijing, 28% of MSM reported having had sexual intercourse with both sexes, and 11% reported having unprotected sexual intercourse (Gibson et al, 2004 reported in UNAIDS, 2006). The vulnerability of such groups is sometimes compounded by rigorous governmental or social sanctions against homosexuality. In these cases, MSM may shield themselves from such sanctions by not disclosing their sexual behaviors and practices. Risks to their female partners may also increase because of lack of access to and availability of resources.
Injecting Drug Use

Injecting drug use, a major risk factor for HIV, often begins in adolescence. Half of the estimated 50,000 people injecting drugs in Nepal are between the ages of 16 and 25 years (UNICEF, UNAIDS, WHO, 2002).

Most injecting drug users in the region are men, but the impact of drug abuse on women and girls is widespread. The partners of drug users are often very poor or low-paid sex workers who have little access to information about HIV prevention methods. Likewise, the interplay of drug use, sex work and other risky behaviours is sustaining serious epidemics in the region, and young people are not excluded.

Migrant, Refugee and Minority Populations

In 1995, there were an estimated five to seven million non-national migrants living in South, South-East and East Asia (UNAIDS, 2001). Migrant groups and refugees are particularly at risk to HIV transmission as they are often the victims of poverty, discrimination, and exploitation. They also have limited access to education, social and health services (UNDP, 2004).

Within the Greater Mekong sub-region, approximately 75 million people belong to ethnic minority groups (Asian Development Bank, 2005). A majority of these culturally diverse and linguistically complex groups are located in remote mountainous agricultural areas. Whilst this physical isolation has in the past offered some protection from HIV, it has also hindered access to preventive programmes and campaigns. In comparison to the general population, the rate of HIV among ethnic minority groups is increasing more rapidly with numerous structural issues adding to their vulnerability to HIV transmission, including: “remoteness, poverty, lack of access to health, education and culturally appropriate information (Asian Development Bank, 2005).” Ethnic minority women, in particular, are more physically susceptible to HIV, and this is compounded by existing gender disparities.

Knowledge, Attitude and Behaviour about HIV/AIDS among Young Women in Asia and the Pacific

A recent survey conducted by UNAIDS (the Demographic Health Survey/AIDS Indicator Survey, 2005) reported that, in general, HIV-related knowledge was higher in young men than in young women. Recent research in the region points to increasing disparities in knowledge, attitudes and behaviour related to HIV/AIDS among young women in Asia and the Pacific, as well (Quinn & Overbaugh, 2005; Choi, Gibson, Han & Guo, 2004). This lack of knowledge and discriminatory attitudes and behavior may stem from denial in the form of lamenting the collapse of a traditional moral order (Nepal, 2007), or an unwillingness to accept that HIV/AIDS may be a part of the landscape in their own countries (Ruxrungtham, Brown & Phanuphak, 2004). The need for better national reporting (despite significant advances in monitoring and evaluation) is also underscored by most of these studies.

Despite the trend toward increased infection rates among young women and girls, they know less than men about how HIV/AIDS is transmitted and how to prevent it. Even though young women throughout Asia and the Pacific might have heard of HIV/AIDS, many harbor misconceptions related to the disease, and understand little about their rights and responsibilities for protecting themselves.

A UNICEF study (2003) conducted from 1991 to 2001 to measure HIV/AIDS knowledge of girls between the ages of 15 to 19 revealed common misconceptions, such as “a healthy looking person cannot have the AIDS virus.” The following are percentages of girls from Asia and Pacific countries that had at least one major misconception about HIV/AIDS:

- 58% in Cambodia
- 64% in Mongolia
- 65% in Viet Nam
- 84% in Indonesia
- 95% in the Philippines

A more recent UNICEF study revealed that in 2003, approximately 61% of women aged 15 to 19 in Indonesia knew about AIDS, but did not know how to protect themselves from HIV infection (UNICEF, 2003). Only 27%
of women aged 15 to 19 in Viet Nam could correctly identify three primary ways of avoiding HIV infection (UNAIDS, 2006) Of girls between the ages of 15 and 19, 48% in Mongolia, 53% in the Philippines and only 11% in Nepal knew where to get an HIV test (Engender Health, ICRW, 2004). While a relatively high number of urban and rural Nepalese youth have heard of HIV/AIDS, only 28% could correctly identify two correct modes of transmission (UNAIDS, UNICEF, WHO, 2002).

In addition to the knowledge dearth, a lack of skills and confidence to resist unsafe or unwanted sex and peer-pressure to use alcohol and drugs also puts young people at risk. Delaying the age at which young people first have sex can protect them from infection, as young people engaging in sexual behaviour at an early age are more likely to have high-risk or multiple partners and are less likely to use condoms (UNAIDS, UNICEF, WHO, 2002). Yet studies reveal that adolescent sexual activity is on the rise throughout the region, especially in urban areas. A study in Bangladesh reveals that 88% of unmarried urban boys and 35% of unmarried urban girls had engaged in sexual activity by the time they were 18, while in rural Bangladesh those figures were 38% for boys and 6% for girls (UNFPA, 2005).

Similar research in Thailand shows a trend towards the first sexual encounter occurring at a younger age (approximately 14 to 18 years), and that this, coupled with other factors, has lead to increases in unplanned pregnancies and HIV infection among young people. Young women are especially affected: In 2003, the Ministry of Public Health estimated that women aged 15 to 29 accounted for 61% of new infections (UNFPA, 2005).

While previously young males in Thailand were ushered into manhood through sex with casual sex workers (CSW), there is now a shift to girlfriends, lovers, casual acquaintances and classmates. However, prejudices against young women engaging in casual sex still exist, and virginity is the expectation. Yet, there is evidence that “indirect” sex work is common; anecdotal evidence suggests that young school and university girls are exchanging casual sex for monetary favors in order to purchase mobile telephones and other brand-name goods. Yet patronizing sex workers is still common and acceptable for young Thai men. Condoms, while widely available, are not used frequently enough in contact with CSWs, and are used very infrequently within relationships (UNICEF, 2003).
Gender-based Barriers to Information, Education and Services

“The first, most fundamental source of power for individuals in society is access to information, education and skills. We must give women and men basic information about their bodies, sexuality, disease and reproduction. Access to information is vital for individuals to protect themselves from the HIV/AIDS pandemic, and more importantly, it is a basic human right.”

- UNAID, WHO. Integrating Gender into HIV/AIDS Programmes, 2004

Numerous studies in the region still reveal that young people, especially young women, do not have access to the most basic information, education and services they need to make appropriate decisions about sexual behaviour, drug use and related risks that make them vulnerable to the disease. This problem is exacerbated for the most vulnerable populations, who typically lack access to traditional education and health services.

Young people often lack a safe, supportive environment where they can interact with adult role models and trusted mentors, such as youth-friendly health service centres. Youth-friendly health services provide comfortable, age-appropriate settings for delivery of general reproductive health information—including HIV/AIDS prevention information—voluntary counselling and treatment (VCT), early diagnosis and treatment of STIs and/or drug dependence, and anti-retroviral therapy. However, in many rural areas such services do not exist. Where such services are available, young women may be prevented or discouraged by peers, partners, spouses or parents from visiting.

Access to information, education and services are often limited for young women with HIV or AIDS in the region. While there have been forays into using schools as contexts for education in Thailand and other areas, more needs to be done to reach women who have dropped out of school or are in the workplace. Young women in informal employment sectors (eg. domestic laborers) appear to possess very limited knowledge or access to resources concerning HIV/AIDS (Toyota, 2006). The “invisibility” of Burmese maids in Thailand, for example, is a huge risk factor: These young women frequently work in “off-the-record” arrangements and do not have a visible presence, like Filipino maids, that will command governmental attention. Furthermore, women in the region also face stringent restrictions, stigma and discrimination. Sometimes, participation in local community events is restricted (leading to loss of existing and new social networks), and at other times, such stigma may be enacted in refusal to allow infected children in

% of Women (aged 15-24) with Comprehensive and Correct Knowledge of HIV*

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Cambodia</td>
<td>30%</td>
</tr>
<tr>
<td>Mongolia</td>
<td>20%</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>20%</td>
</tr>
<tr>
<td>India</td>
<td>10%</td>
</tr>
<tr>
<td>Indonesia</td>
<td>5%</td>
</tr>
</tbody>
</table>

*Comprehensive and correct knowledge implies that they can identify two methods of avoiding HIV transmission (limiting sexual partners and using condoms) and know three common misconceptions about HIV transmission.


local schools, violations of confidentiality, denial of rights to participate in marriage or death rites or even dismissal from employment (Busza, 1999). It seems critical, therefore, to have an in-depth understanding of the specific issues that surround women (Lyttleton, 1999) working in informal sectors, as well as those women who attend to domestic work in their own homes.

Improved access to gender-sensitive information, education and services can be a catalyst for transforming gender-based norms that often take root during adolescence. Girls and boys in most parts of the world begin sexual activity during adolescence. HIV prevention education programmes can support healthy decision-making related to sexual activity, and encourage both young men and women to examine and challenge gender norms and expectations that often lead to behaviours which foster the risk of HIV infection.

- Young people must understand the risks involved in unsafe sex and drug use, both of which are on the rise among adolescents in many Asian countries.
- Young people must not only be educated, but empowered to make decisions that affect their health, sexual or otherwise.

**From Education to Empowerment**

HIV prevention education strategies must not only teach women how to protect themselves from the virus, but also address the root social, economic and political factors that influence behaviour, and seek to change that behaviour. For example, socio-economic factors may disempower women from making decisions that limit their risk. In Mumbai, India, many women felt that the economic consequences of leaving a long-term relationship they saw as risky far outweighed the health hazard of staying in the relationship.

**Participatory approaches** have been employed more widely after the onset of the HIV epidemic and proven effective in empowering communities to more openly discuss difficult and taboo topics such as gender and sex. Participatory learning approaches (PLAs) have been recognized by many practitioners as especially appropriate for young people, in part because they are often based on visual and storytelling tools, and enable young people to become involved in all parts of planning and implementation – thereby increasing relevancy.

**Peer education methods** have proven especially effective in challenging harmful traditional beliefs and behaviour through personal dialogue. Young women can be empowered through personal interactions and their ability to share experiences. Peer group discussions can also provide a forum for reflecting on gender roles/relationships and for building communication skills among young men and women. Peer-to-peer approaches are often found to be more engaging for young people than traditional, didactic methods.

In addition, the behaviour and actions of young men are vital in determining the risk to females; hence, the involvement of men and boys in prevention education strategies is critical.

Engaging young men in HIV prevention education strategies that seek to transform gender-based norms and inequalities fuelling the epidemic is not an easy task. Rigid socio-cultural constructs present in most Asia-Pacific countries perpetuate gender stereotypes of how “real” men are supposed to behave. Often social and peer pressure for boys and young men, in particular, make it difficult for them to stay safe and keep their partners safe. Certain stereotypes, such as “real men take risks,” encourage young men to engage in behaviour like sex with multiple partners and drug use, which increases their own vulnerability as well as that of their sexual partners. For this reason, both young men and women must be educated and empowered to make sexually-appropriate decisions.

Prevention programmes focusing on young men can:

- Raise awareness of the relationship between men's behaviour and HIV/AIDS;
- Educate boys and young men to respect girls and young women, to engage in responsible sexual behaviour, to share in the responsibilities of protecting themselves, their partners, and their children and to care for those infected; and
- Counteract gender stereotypes by reviewing and changing male roles and masculine identities, as well as by discussing gender roles, rights, responsibilities and power relations (*Engender Health*, ICRW, 2004).
Practices

“Adolescence is a time when girls and boys are choosing their identities, laying the foundation for the women and men they will become. To establish enduring patterns of healthy behavior, values such as tolerance, respect for the opposite sex and equality must be instilled early on. Young women and girls, young men and boys, are key to defeating the epidemic.”

- UNFPA, UNAIDS, UNIFEM. Women: Meeting the Challenges of HIV/AIDS, 2003

This section presents six practices from the region that demonstrate promising achievement toward integrating aspects of gender into HIV prevention education activities. The majority do not target only young women or focus on HIV prevention exclusively, but rather have addressed gender inequality as part of larger, integrated youth reproductive health programmes.

The term “practice” as used here describes a process that is carried out by an organization/institution/community to address one or more specific problems. It can serve as an example and/or inspiration for others that are confronted with a similar problem. The practice describes in a practical way the whole process of implementation as it has taken place and gives an analysis of critical issues and lessons learned. The source of information is included to ensure that more details of the process can be obtained, if necessary. A practice usually has a longer time frame, and it must be sustainable in the context in which it is applied.

Methodology and Criteria of Selection

Practices were identified based on outreach and interviews with programme staff of UN agencies and other organizations implementing youth reproductive health programmes throughout the Asia-Pacific region.

Out of the practices reviewed, six were selected on the basis of the following key criteria. Selected practices met some or all of these benchmarks:

• Utilized gender-based approaches
• Designed innovatively and creatively
• Integrated with other reproductive health and/or family planning services
• Applied in other local settings
• Demonstrated impact
• Used youth participation in programming
• Research-based
• Community-based
1. Street Drama in Nepal

A culturally-appropriate “edutainment” approach to HIV prevention education proves more effective in reaching Nepal’s young women, and engaging the greater local community, too.

Developed by: BP Memorial Health Foundation with continuing support from RHIYA Nepal

<table>
<thead>
<tr>
<th>Category</th>
<th>Practice Details</th>
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<tbody>
<tr>
<td>Summary of practice</td>
<td>Dramas about various adolescent reproductive and sexual health issues are performed by a group of young people, both male and female, in open places or streets. The main objective of the performances is to enhance awareness about STIs/HIV/AIDS and to reduce adolescents’ risky sexual behaviours and practices.</td>
</tr>
<tr>
<td>Prospective users of the practice</td>
<td>This practice can be applied either by individuals or groups. Performers are needed for the various roles demanded by the issues or messages to be delivered to the viewers.</td>
</tr>
<tr>
<td>Problem addressed</td>
<td>Young Nepali women often face severe poverty, limited access to education and health services, and restrictive cultural and sexual norms. For these reasons, their health status and general well-being are at a disadvantage compared with boys. Nepal has the highest illiteracy rates in South Asia, and with wide gender discrepancies.</td>
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<td></td>
<td>Girls marry at an average age of 16. Thus, sexual debut and childbearing often begins early. But topics of sex and relationships are rarely discussed within the family or in schools, and young Nepali women are even more vulnerable because they have less access to formal schooling and health services. Many health service providers do not feel they need to inform married women and girls about reproductive health issues because they perceive that the women already know about such topics. Thus, young women and girls must rely on informal networks and opportunities for receiving reproductive health information.</td>
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<td>Gender-based inequalities also include lack of control over property and livelihood opportunities. The number of girls being trafficked to neighboring countries as part of the sex trade and as domestic workers has also increased. Due to poverty and lack of employment opportunities in Nepal, a large number of men migrate to India for work. In the course of living there, often without their spouses or families for long periods of time, many of these men engage in commercial sex (or sex with other women) and contract STIs and/or HIV/AIDS. Upon their return, the infection is often unknowingly passed on to wives or partners. While a relatively high number of urban and rural Nepalese youth have heard of HIV/AIDS, only 28% could correctly identify two correct modes of transmission.</td>
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<td></td>
<td>These realities pose a real danger for Nepalese women and girls, summoning the urgent need for awareness on issues related to trafficking and STI/HIV/AIDS prevention (especially condom use).</td>
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<td></td>
<td>Due to a lack of female participation in addressing these issues through other educational approaches (orientations, quiz contests, rallies, etc.), especially in rural areas, the concept of street dramas was developed to enable greater access for women and girls. Baseline research by the same organization pointed to the need for informal, rather than formal, modes of communication (Regmi, Subedi &amp; Lamsal, 2004).</td>
</tr>
<tr>
<td>Methodology</td>
<td>The project team decided to take a participatory, culturally appropriate “edutainment” approach to encourage higher numbers of female participants and to ensure the support of the larger community. Street dramas are typically enjoyed by all levels and groups of society. It is culturally accepted for women and girls to participate and watch them along with their families. In this way, street drama messages engage whole communities.</td>
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</table>
## Practice Details

Twenty-two youth members, ten male and twelve female, of Nawalparasi district of Nepal were trained during October 2002 by the Participatory Adolescent Reproductive Health Project (PRAHP) project of BP Memorial Health Foundation for the performances. After successful completion of the project, the actors performed a series of dramas focusing on adolescent sexual and reproductive health and HIV/AIDS issues in the communities. The drama shows proved effective and popular among participants and viewers, and follow-up surveys indicated increased knowledge on HIV/AIDS, especially among women and girls.

The Reproductive Health Initiative for Youth in Asia (RHIYA) continued to support the trained group by providing refresher courses on street drama techniques. Further trainings and performances have taken place in different districts of Nepal. The trained group is responsible for 40 street dramas in the RHIYA project areas.

## Impact

Follow-up surveys and qualitative interviews with participants and viewers indicated that the edutainment strategy utilized by the street drama project has led to:

- Increased awareness among girls and women about STIs/HIV/AIDS;
- Increased openness on the part of young women to discuss ARSH issues, including HIV/AIDS, with their peers (e.g. HIV/AIDS became a topic for discussion among all group members); and
- Increased awareness among girls and women about issues related to trafficking.

## Lessons learned

Street drama in Nepal is an effective means of disseminating information and education about ARSH and HIV/AIDS to whole communities, while simultaneously enabling young women and girls to be engaged and targeted in a culturally acceptable way.

Using culturally-approved methods of educating the community about sensitive topics like HIV/AIDS is the best tool.

Training and involvement of local youth in the project ensures its sustainability. Trained performers trained other peers.

Young actors help bring together young crowds.

## Contact Information

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## 2. Sewing for a Healthy Future in Cambodia

A unique reproductive rights approach reaches young women in the workplace, empowers them to protect themselves and helps them to recognize power relations that make them more vulnerable to HIV/AIDS.

**Developed by:** CARE Cambodia

<table>
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<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Summary of practice</td>
<td>Young female workers employed in Phnom Penh’s garment factories learn sexual empowerment and safer sex negotiation skills.</td>
</tr>
<tr>
<td>Prospective users of the practice</td>
<td>Young female migrant workers in Cambodia’s garment factories</td>
</tr>
<tr>
<td>Problem addressed</td>
<td>A major challenge for HIV prevention in Cambodia is controlling the disease’s spread among young people, especially young women. Young men’s sexual debut with a sex worker is still common throughout the country, and this has a direct impact on men and boys’ attitudes toward women and relationships. Sewing for a Healthy Future has been implemented in 25 of Phnom Penh’s approximately 250 garment factories, where 90% of the thousands of workers in each factory are female. Most of the young women are just above the legal age limit of 18, and are away from their families (often in rural areas) for the first time, living with few rules in close proximity to young male workers. Thus, they are vulnerable to unsafe sexual encounters that can lead to unintended pregnancy, the acquisition of STIs like HIV/AIDS, and rape. Despite this, few women carry condoms out of fear of being stigmatized as a “bad girl.” Girls who live away from their families, in contradiction to cultural norms and beliefs, face additional gender-based discrimination. Young men often seek out these women as sexual partners with no intention to marry, and further shun them after unsafe sexual encounters.</td>
</tr>
<tr>
<td>Methodology</td>
<td>The programme uses numerous methods to educate women about their rights to negotiate safe sex or refuse it, de-stigmatize the use of condoms for dual protection against STIs and pregnancy, and improve access to clinical services. CARE Cambodia initiated Sewing for a Healthy Future by working with general managers and human resource directors of the factories, demonstrating how productivity would be effected if workers were infected with HIV. CARE works to promote the advantages of corporate social responsibility in the factories, and with the Garment Manufacturers Association in Cambodia to highlight potential international business partners for companies that are investing in the well-being of their workers. All of the participating factory human resource directors are part of an advocacy group called “Strengthening Activities for Factory Education” (SAFE), and work with CARE to implement the International Labor Organization’s HIV/AIDS workplace policies. Sewing for a Healthy Future also promotes educational and behavioral communications change programmes with the garment workers, training about 15 workers every three months to become peer educators. They learn about gender violence, condom negotiation skills and how to delay the onset of sex. They are then required to speak to 10 other garment workers about the skills that they’ve learned. In an effort to make learning about sexual and reproductive health fun, the project has set up youth libraries in the garment factories and factory workers are encouraged to participate three times a month in structured games about reproductive health and HIV/AIDS, which offer prizes such as soap, toothbrushes and condoms. The project also makes use of radio broadcast systems in the factories to air programmes that include questions and answers about sexual health, and songs about preventing sexually-transmitted infections. In conjunction with Population Services International, CARE’s Sewing for a Healthy Future programme also offers socially-marketed condoms and birth control pills.</td>
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</tbody>
</table>
### Impact

The programme is currently implemented in 35 factories, reaching around 60,000 workers, targets up to 100,000 workers, and has been extended through 2005.

### Lessons learned

The SHF programme has been evaluated several times during the six years of its life. A qualitative evaluation was carried out in 1999, followed by a quantitative evaluation 2000. The evaluation from 2002 used both qualitative and quantitative methods. In general, the evaluations show that there has been an increase in knowledge among the garment factory workers about HIV/AIDS and about HIV transmission routes. One of the SHF programme's challenges is to keep working on breaking down the cultural barriers towards condom use - the issue of trust in relationships just being one of many. In this connection, it is also important for the programme to continue improving the factory workers negotiation skills when it comes to introducing condom use in a relationship.

### Contact information

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### 3. Playing Safe: Mobile Outreach to Young Males in Cambodia

Through a rights-based approach, the Playing Safe project seeks to empower young males to make safe and healthy choices that also demonstrate respect for the rights of women.

**Developed by**: CARE Cambodia

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<tr>
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<th>Practice Details</th>
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<tbody>
<tr>
<td>Summary of practice</td>
<td>A youth centre is supported by a mobile outreach van that provides young urban males with access to health information, including HIV/AIDS prevention information, and promotes gender equality in sexual decision-making. Peer educators disseminate information verbally and by providing IEC materials. The outreach van operates as an evening drop-in facility for young people who are not able (due to distance or other restrictions) to visit the centre.</td>
</tr>
<tr>
<td>Prospective users of the practice</td>
<td>This practice can be applied by any individual, organization or agency. Peer educators as well as an attractive outreach van that will draw attention and crowds of young people are needed. (The total budget to refurbish a van and equip it with a TV for a karaoke system and a generator is approximately US $14,000.)</td>
</tr>
</tbody>
</table>
| Problem addressed         | In Cambodia, the main form of HIV transmission is heterosexual sex, and men often have more sexual partners than women. Yet no services have existed to address the sexual and reproductive health needs of young urban men in Phnom Penh. Cultural stereotypes of masculinity and sexual dominance encourage gender-based violence and rape, which often lead to unwanted pregnancies and contracting of STIs, including HIV. A culture of silence surrounding topics of sex, including sexual violence, is pervasive.  
This project stemmed from the need for a safe and supportive space for young men to learn about and adopt safer sexual health practices and behaviours. Playing Safe has been developed in recognition of the need for a greater focus on young males as key agents in HIV/AIDS prevention and reproductive health promotion. |
Methodology

Playing Safe project activities are conducted through a peer education methodology based on building constructive social networks and harnessing the power of positive peer pressure to bring about behavioural change. Youth volunteers from the community are trained to become peer trainers/educators.

The outreach van operates from 4 p.m. to 8:30 p.m. at different popular spots frequented by youth at night, but can also be carried out in the provinces. It is designed and equipped to appeal to young people as well as facilitate outreach activities. Youth workers and volunteers regularly commute to around 20 pre-identified key social/recreational sites within Phnom Penh. The staff and volunteer peer trainers on the van provide informal safe and responsible sexual health counselling, referrals to clinics for sexual health services, as well as promotion of youth-relevant social and sporting events, including the project’s youth centre activities.

The van is further used as a basis from which the staff and youth peer trainers can collect monitoring and evaluation data (both quantitative as well as qualitative) in order to determine the effectiveness of the project’s behavioural change strategies and rights-based programming amongst young males.

The project works from the basis of offering education or opportunities for discussion within the context of youth-owned and youth-facilitated social, recreational and sporting activities. Using the concepts of ‘good gangs’ and ‘positive peer pressure’, the project seeks to train intakes of peer trainers (every second training works with two different football teams) and those who graduate the course choose to commit to the team-identified code of conduct (revolving around safe and responsible sex and gender equality), and are socially encouraged amongst the group to adhere to these principles. After graduation, the intake of peer trainers are orientated to the youth centre and associated sporting and social activities, where they have free access to positive leisure activities. In return for this membership, they are obligated to be involved in peer outreach activities. For example, groups of peer trainers infiltrate existing social settings, such as football games, pool halls and nightclubs as well as facilitate events in order to promote safe and responsible sexual practice amongst their peers and advocate for the right of women to say ‘yes’ or ‘no’ to sex.

Impact

Playing Safe has trained over 300 peer educators and shared reproductive health messages with over 20,000 youth within Phnom Penh. The project has:

• Improved reproductive and sexual health of young people at risk in Cambodia;
• Enabled safer sexual and reproductive health behaviour, including increased utilisation of quality youth-friendly services among target young people in programme intervention areas;
• Worked to deconstruct gender-based norms and inequalities that negatively impact young women.

Lessons learned

• Educating young men on sexual issues has a positive effect on young women’s health status and vulnerability.
• It is easier to reach young people through popular culture.
• Peer education makes the process of learning comfortable and fun.

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### 4. Life Skills for HIV Prevention

This regional project focuses on capacity-building for groups working in multiple countries to develop and implement life skills-based education for young women to reduce their HIV vulnerability. Activities in Cambodia and Bangladesh, specifically, are models for addressing gender inequalities through life skills teaching and learning.

**Developed by:** Health and Development Section, Emerging Social Issues Division, UNESCAP

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<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Summary of practice</td>
<td>The project was part of UNESCAP’s overall effort to assist countries in the Asia-Pacific region in achieving Millennium Development Goal 6. At the United Nations General Assembly Special Session on HIV/AIDS in 2001, governments committed to ensure that, by 2010, at least 95% of their young men and women aged 15 to 24 have access to the information, education (including peer education and youth-specific HIV education), and services necessary to develop life skills required to reduce their vulnerability to HIV infection.</td>
</tr>
<tr>
<td>Prospective users of the practice</td>
<td>Government departments/agencies, international organizations/agencies and NGOs</td>
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<tr>
<td>Problem addressed</td>
<td>Young people throughout the region are vulnerable to HIV/AIDS due to a number of external factors, such as poverty and migration. This project also seeks to address those additional psychological “push” factors that make young people more vulnerable (including emotional pain, conflict, frustration, anxiety about the future, peer pressure and curiosity) and to address young women, in particular. With the prevalence of gender bias and gender discrimination, many girls throughout the region suffer from low self-esteem and are unable to negotiate when they find themselves in high-risk situations.</td>
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| Methodology               | Launched in 2001, the UNESCAP project, with the support of the Government of Japan, aimed to build the capacity of non-formal education service providers, as well as government agencies and NGOs concerned with youth, in designing and implementing effective life skills programmes for HIV/AIDS prevention. Participating countries included: Bangladesh, Cambodia, China, India, Lao People’s Democratic Republic, and Nepal. The first two phases of the project (2001-2003) focused on:  
  • Identifying effective approaches to integrating youth health concerns into non-formal education; and  
  • Building country-level capabilities in developing and designing life skills training programmes for youth.  
  The third phase of the project (2004) aimed to:  
  • Empower young women and men in vulnerable situations with knowledge and life skills through peer education for HIV/AIDS prevention.  
  The key steps in project implementation at the country level included the following:  
  1. Identifying youth target groups for intervention.  
  2. Training of trainers in life skills and peer-to-peer approaches.  
  3. Developing a pool of peer educators for HIV prevention.  
  4. Undertaking peer outreach for HIV prevention among vulnerable youth. |
The project partners in Bangladesh and Cambodia were most effective in addressing girls’ and young women’s vulnerability to HIV/AIDS, and in engaging this group in project implementation. Gender dimensions were especially highlighted in training and peer education activities, particularly with regard to sexual and reproductive health, violence and social values.

In Bangladesh, the Dhaka Ahsania Mission (DAM), a highly-reputed non-formal education service provider, trained 120 peer educators on the life skills approach to HIV/AIDS prevention. Those peer educators reached another 600 youth who attended community learning centres (Ganokendras). Young women accounted for 73% of those who participated in project management; 70% of trainers were young women; 50% of trained peer educators were girls and young women.

In Cambodia, the General Department of Youth and Sports trained 150 peer educators among garment factory workers. Those 150 garment factory peer educators, in turn, reached more than 600 of their co-workers.

Impact

Initial assessment of the target groups’ knowledge concerning HIV/AIDS and life skills yielded positive results. The majority of the peer educators and young people reached had better understanding of HIV transmission modes, prevention methods (such as safer sex), and life skills, including how to apply critical thinking and dealing with peer pressure on high-risk behaviour.

Young women who participated in peer education demonstrated greater self-confidence and ability to confront gender discrimination. With enhanced self-awareness and communication skills, they became better able to influence other young women in their communities in understanding how to cope with high-risk situations.

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5. Minority Language Radio Dramas against HIV/AIDS, Trafficking and Drug Use Target Young Women in the Mekong Region

Culturally appropriate, reality-based radio programmes produced in local minority languages empower and educate young women, and sustain the capacity of local communities to respond to threats like HIV/AIDS and drug use.

**Developed by:** Office of the Regional Advisor for Culture in Asia and the Pacific, UNESCO Bangkok

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<tr>
<td>Summary of practice</td>
<td>UNESCO is developing, testing, broadcasting and disseminating soap opera radio programmes and audio tapes researched and produced in minority languages. The goal is the prevention of HIV/AIDS, which is seen as part of a linked triad of problems: HIV/AIDS risk behaviours, trafficking of girls and women, and non-traditional drug abuse among highland minorities. The scope of this programme includes:</td>
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<td>Strengthening community-based groups (e.g. youth or women’s groups, community learning centres) in ethnic minority villages that can provide complementary and follow-up peer education support to the radio programmes;</td>
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<td>Building the capacity of local, ethnic minority script writers, multi-media producers, and community mobilizers;</td>
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<td>Developing supplementary materials, in the minority languages, which reinforce the messages contained in the soap operas.</td>
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<td>Capacity building of radio stations and research organizations.</td>
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<td>Prospective users of the practice</td>
<td>Any organization that has the resources to develop radio programming</td>
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<tr>
<td>Problem addressed</td>
<td>Many different ethnic groups live in the Mekong region. These minority people are at risk because of lack of access to education; poverty; cultural and social breakdown within some communities; non-traditional drug use; involvement in the sex trade; and very important, lack of culturally-appropriate information in their own languages. The past decade has witnessed an exponential increase in the trafficking of girls and women from the Greater Mekong Region countries into the sex industry. Moreover, with the opening of borders and improved transportation routes, the problem will only worsen. The greatest collective impact is on the upland minority groups of the Thai-Myanmar-China (Yunnan) periphery. One of the main barriers to prevention education is the vast number of distinct languages from different language families. Many of these are unwritten languages with no indigenous scripts.</td>
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<td>Methodology</td>
<td>UNESCO partners with broadcasting stations who broadcast in ethnic minority languages as well as with relevant research institutions and ethnic minority groups to develop programmes in minority languages that will attract girls and young women in highland areas – those most vulnerable to both sexual trafficking, exploitation and HIV/AIDS. These efforts are currently being undertaken with Radio Thailand, Chiangmai; Yunnan Provincial People’s Broadcasting Station, Kunming; and Lao National Radio, Vientiane. When appropriate, the activities will be expanded to include relevant institutions in Cambodia and Vietnam.</td>
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<td>UNESCO has developed a unique methodology to produce culturally-appropriate programmes in minority languages:</td>
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<td>1. The programme takes the shape of a dramatic soap opera, with a local heroine facing a wide range of experiences. Soap operas are generally well-known and liked by the audience. This form of communication tends to be better accepted by teenagers and youth, who would reject traditional pedagogic methods.</td>
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2. The content of the programme is based on actual experience. Real-life stories from various people are collected through participatory group discussion (focus groups) at the village level and integrated into the script so that the listeners can identify with the soap opera characters.

3. The script is composed directly in the selected minority language by local minority writers to ensure that it is culturally as well as linguistically acceptable to the audience.

4. The script is translated into English and into the national language to check its scientific accuracy.

5. Local musicians compose traditional local music and songs in the minority language, which underscore the health-related themes.

6. The programme is tested in order to verify that an appropriate and efficient message is conveyed.

7. The programme is broadcast.

8. Selected follow-up audience research is conducted in villages to evaluate how appropriate the broadcasting timing is, as well as the understanding of the programme and the impact of the message.

9. The script, tapes and related output of the programmes are packaged and distributed for further pedagogical and educational uses and for future re-broadcasting.

10. The programme is proposed to radio stations in other countries of the region where the minority is present. The script and format may be adapted to suit the needs of the radio station or local community.

**Impact**

Evidence of the high demand for and usefulness of the radio dramas as educational tools became quickly apparent as local health practitioners made (and continue to make) frequent requests for the recorded broadcast materials in all local settings. Additional countries have expressed interest in applying this strategy, and radio stations are getting very positive feedback from listeners.

**Lessons learned**

It is crucial to provide training, even if the staff involved have been trained earlier.

It is important to understand not only the language, but the culture and socio-economic realities of the community that is being targeted in order to effectively write and direct dramas. Employing local researchers and engaging the local community in production is an effective strategy to support this concept.

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### 6. Efforts in the Sichuan Province, China

By involving commercial sex workers in the planning and development of culturally-appropriate Information, Education and Communication (IEC) materials for STI/HIV/AIDS prevention, this experience empowered young women to be their own agents of change.

**Developed by:** Mianyang Municipal, Cairo Demographic Centre, Sichuan Province

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<tr>
<td>Summary of practice</td>
<td>As part of the China-UK HIV/AIDS Prevention and Care Project, local project staff from the Mianyang HIV/AIDS Prevention and Control Office engaged commercial sex workers (CSWs) in the design, development and dissemination of IEC activities (picture books, games, dramas) that integrated knowledge about safe sex and STI/HIV/AIDS.</td>
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<tr>
<td>Prospective users of the practice</td>
<td>Any organization working with CSWs</td>
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<tr>
<td>Problem addressed</td>
<td>Mianyang City is nestled in the northwest area of Sichuan province and is an important transportation hub in this region, with a developed economy and a large number of migrants. Since the first HIV case was detected in Mianyang City in 1995, by the end of 2003, a cumulative total of 138 HIV infected persons were identified. At the same period, STD morbidity is on the increase with an annual rate of 20 to 30% (data from Mianyang CDC). Surveys showed that there were around 2,500 CSWs at public entertainment establishments in urban areas of Mianyang City by the end of 2001, concentrated in hair and beauty salons, saunas, karaoke bars, entertainment centres and hotels. Service women at these settings mainly came from rural areas. CSWs at “high-grade” entertainment establishments provided a variety of sexual services, attracting many clients of different backgrounds. The number of CSWs was larger in “medium-grade” entertainment establishments than in high-grade and low-grade settings. CSWs at “low-grade” settings were less educated (often illiterate) and lacked the awareness of self-protection. The rate of consistent (condom use) was found to be very low; only 10 to 15% used condoms in every sexual encounter. The factors for inconsistent condom use were mainly lack of health-related knowledge, low level of awareness of STI/HIV/AIDS and shortage of IEC materials tailored specifically to CSWs. These CSWs are usually in the age range of 15-45 years, approximately 60% of these workers are between the ages of 15-25.</td>
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<td>Methodology</td>
<td>Initially, programme managers had developed IEC materials on their own, or adapted them from other locations, but CSWs were not receptive to these materials and found them confusing and uninteresting. Project staff proposed that cartoons invoking the image of a popular local news cartoonist/caricaturist (Mr. Gong Xu, Executive Editor of the Mianyang Evening News) would be an interesting format for imparting HIV prevention information. Gong Xu willingly agreed to act as an “image envoy” for Mianyang’s HIV/AIDS prevention and control efforts, as well as to produce the art at a reduced cost. Four picture books and six picture posters were developed. In order to better engage young women, capture the realities of commercial sex work in the local context and thus improve effectiveness of the messaging, it was decided to involve the CSWs directly in reviewing and editing the content. The materials were further edited by the Women’s Federation, project experts and leaders.</td>
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Overwhelming receptiveness and enthusiasm on the part of CSWs to this effort led project staff to seek further involvement of CSWs in developing additional IEC materials, including games and comedy skits. The young women succeeded in developing both the content and simple stage materials for multiple “mini-dramas”, reflecting real local scenarios to educate about various aspects of HIV/AIDS and STI prevention. Project staff on-hand at performances answer questions, provide facts and give condom demonstrations.

Based on qualitative feedback from project peer educators, the need for additional cartoons was identified due to the high level of illiterate CSWs at medium- and low-grade establishments. The Mianyang Project Office has since developed a set of 6 IEC cartoon booklets dedicated to these local CSW peer educators.

Impact

Qualitative interviews and follow-up surveys indicated a high increase in STI/HIV/AIDS-related knowledge following training sessions for peer educator CSWs where IEC activities were conducted.

CSWs working in all settings sought condoms for purchase from the project office in higher numbers than previously.

Lessons learned

Participation of CSWs in developing the IEC material made it more useful, appealing and effective for those involved as well as other CSWs.

Invoking a popular local figure as part of the development and dissemination strategy made the material more attractive and influential.

Close collaboration with other local stakeholders, such as media organizations and NGOs, was necessary.

Consistently prioritizing the needs of the CSWs in all aspects of programme management helped to keep clear focus among staff and direct project activities.

7. Efforts in India: Stepping Stones

Through a rights-based approach, the Stepping Stones project which is a training package on HIV/AIDS, communication and relationship skills.

Developed by: Action Aid, India
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<th>Practice Details</th>
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<tr>
<td>Methodology</td>
<td>The approach is to uphold three interlinking rights — the right to dignity, the right to self-determination and the right to comprehensive care — with a special focus on women and children.</td>
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<td>In some places (eg Guwahati), the focus is on home-based care, counseling for positive living, formation of mutual support groups, with thrust on medical needs as well as social issues such as life skill development. In Andhra Pradesh, ActionAid supports WINS, a local organisation to form collectives of sex workers and positive people. It has led to the formation of Chittoor Network of Positive people to provide support in times of distress to the families of PLWHAs. Alternate livelihood options and legal aid is provided to fight stigma and discrimination faced by women. Support has been mobilised from government hospitals for medical assistance. In Tamil Nadu, ActionAid has started working with a positive network (SIPN) with about 1700 positive people from the Hijra community in Tamil Nadu. The focus is on understanding their needs, advocating for free ARVs, treatment and care for PLWHAs.</td>
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<td>Impact</td>
<td>Stepping Stones is being promoted as a participatory module for behavioural change in communities. Lucknow, Kolkata and Chennai regions will be implementing the project in addition to Karnataka and Maharashtra. As part of research for this activity, five articles have been produced: 1. Drug Patents and Its Impact on PLWHAs in India 2. MDG 6 An Ambitious Goal for Asian Countries 3. Access to Medicine for PLWHAs in India 4. Shattered Dreams - A situational Needs Assessment of Positive Children in Bangalore, Karnataka 5. Guidelines on Integrating HIV and AIDS into Development Projects</td>
</tr>
<tr>
<td>Lessons Learned</td>
<td>Several factors are fuelling the epidemic, including denial, poverty, gender inequalities and violence against women. Interventions are hindered by a high degree of stigma and discrimination and an entrenched unwillingness to discuss issues of sex and sexuality. At a macro level, legally the odds are stacked against people living with HIV and AIDS, with numerous human rights violations and an unfortunate lack of governance on health and education issues.</td>
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<tr>
<td>Contact</td>
<td><a href="http://www.actionaidindia.org/camp_hiv.htm">http://www.actionaidindia.org/camp_hiv.htm</a></td>
</tr>
</tbody>
</table>
Bibliography


UNAIDS. 2005. The Demographic Health Survey/AIDS Indicator Survey


UNAIDS. 2006. At Risk Key and Neglected Populations.


UNDP. 2004. No Safety Signs Here: Research Study on Migration from Seven South and North East Asian Countries.


Resources

Advocacy Tools


Educational Tools (teaching/learning and training materials)


Programming Assessment Tools (for measuring gender sensitivity/responsiveness)


Gender and HIV/AIDS


Young Men and HIV/AIDS Prevention


Grant, L. (2005) *FROM COTTON TO PRECIOUS GEMS: The Use and Abuse of Commercial Sex-Workers in the Context of the Police, Law and Society in Cambodia.*


