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International Expert Meeting on Gender and HIV/AIDS

THE INTERNATIONAL EXPERT MEETING[1]

Key recommendations

1. Advocate gender friendly policies

To break the vicious cycle of gender role induced HIV vulnerability and to transform the social construct of gender in the society, there is a need for gender sensitization and re-orientation of policy-makers, community leaders, family, and parents and particularly the younger generation. The sensitization process shall also aim at influencing modifications of laws to become gender friendly.

2. Promote enabling environment by strengthen gender sensitive programmes

Gender sensitive programmes should encompass not only those for HIV/AIDS but also reproductive health and development programmes. Build capacity for both individuals and organizations on evidence-based gender sensitive programme approaches to reduce the differential HIV vulnerabilities between women and men, especially for HIV positive women and men. Promote active participation of men together with women. Monitor and evaluate programmes to ensure evidence-based approaches.

3. Promote partnership and networks for effective responses to HIV/AIDS

Forge partnerships among governments, NGOs, private sectors and research institutions to devise balanced gender relations. Monitor and evaluate programmes to ensure gender sensitive approaches at household, community, national, regional and global level.

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1. Noted 25th July 2001

Key notes

1. HIV/AIDS requires multisectoral, holistic responses (para 37)

HIV/AIDS influences not only health but also socio-economic and cultural aspects of our life and links to the gender roles assigned to men and women by each society. These are development factors thus require development responses. Gender being a social construct is one of the key components to be addressed when responding to HIV/AIDS. To effectively prevent HIV/AIDS, holistic approaches for individuals, families and communities beyond targeting categories of people are essential.

2. Reducing gender related vulnerabilities will reduce HIV vulnerabilities (para 62)

Although the experts come from different countries, commonalities emerged on gender related HIV vulnerabilities. Research has confirmed women's higher biological susceptibility to HIV then men. Additional societal imposed gender roles further women's vulnerabilities. These vulnerabilities include the lack of access to education, information, health, counseling and other services, decision making power, including that on women's own sexual matters and health. Many national HIV/AIDS programmes focus on health aspect of HIV, few addresses the root causes of HIV vulnerabilities.

3. Alleviation of HIV related socio-economic impact on women vs. men (Para 68)

The socio-economic and cultural vulnerabilities faced by women are disproportional to that of men. During economic crisis, or in the process of economic reform and globalization, female workers instead of men are the first to lose their employment. Social discrimination against People with HIV/AIDS resulting in more economic and social hardships for HIV positive women than men.

4. People's mobility must be factored in HIV/AIDS programmes (para 50)

Population movements compounded with gender roles fuel HIV vulnerabilities. Voluntary and

involuntary search for economic opportunities heighten rural to rural, rural to urban and inter-country movements throughout South East Asia. Trafficking of people, some fueled by certain country's population policy that resulted in disproportionately increased male to female ratio, others stimulated by international sex tourism or crime syndicates, contribute to diverse foreign sex worker populations in many Asian countries. The reality that people move made it critical that HIV responses are not only dealt with domestically but also regionally. HIV epidemics have changed from being confined among high-risk groups through general population into families. Thus the responses must address the continuum of sending, transit and host communities, including HIV positive returnee's reintegration and protection of families.

5. Human rights (paras 59, 60,61)

How a woman is being treated in her society will influence the ability of the society to effectively respond to HIV/AIDS. To reduce HIV vulnerabilities of a society, it is necessary to empower women by protecting women's basic rights including that of sexual rights. Gender relations between men and women need re-orientation to eliminate violence, trafficking, abuse of women and girls by men.

6. Promote gender sensitive prevention, treatment, care and support (para47)

HIV prevention starts with individuals. It is important to distinguish between the individuals versus the risky behaviours. The fallacy of blaming sex workers for HIV transmission without dealing with client-imposed unsafe sexual behaviours must be redressed. Programmes targeting registered sex workers in known commercial sex work establishments fail to capture the larger number of those engage in sexual transactions outside of the formal establishments. Societal expectations of women's submission to men in sexual relations result in the challenge of how to protect women in marriage and in courtship from being infected by their spouse and sex partners. Punitive policies aiming at reducing HIV transmissions may inadvertently fuel the epidemic by creating barriers for people to seek help and preventive services.

Proceedings

The International Expert Meeting on "Gender and HIV/AIDS" was opened on 24th July with introductions of participants. Ms. M. Matsuda, Director of Asian Women's Fund and Meeting organizer, stated that the Meeting objective is by highlighting the challenges of gender and HIV/AIDS in South East Asian countries to raise public awareness and find ways forward. Following a regional overview by UNDP South East Asia HIV and Development Programme, country presentations covered Cambodia, China, India, Japan, Lao PDR, Philippines, Thailand and Viet Nam. The Meeting concluded with a public forum where the country experts shared their experiences with the Japanese public at the Tokyo Women's Plaza.

This Meeting is timely following the United Nations General Assembly Special Session on HIV/AIDS (UNGASS): global crisis-global solution, held on 25-27 June 2001, New York. UNGASS Declaration on HIV/AIDS provides a political commitment of Member States in response to HIV/AIDS. Among the targets, specific references were made on gender, women and girls. Each country is expected to report on their progress in reaching the time-bound targets each year, it is an instrument to facilitate networks of NGOs at local, national, regional and global levels working to reach the targets in partnership with multi-lateral, bilateral entities, governments and private sectors.

Gender and HIV/AIDS: The Tip of the Ice-Berg

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I. Introduction

HIV is a virus, which everyone is susceptible to. The HIV virus is dynamic thus poses a challenge to humanity's effort in tackling the threat of its infection.

People hope to find ways to prevent HIV infection and to treat AIDS through modern technology by inventing different vaccines or producing varied combinations of anti-retroviral medications.

Today, it has been two decades since the first case of AIDS was defined in the world. Yet, nowhere are scientists or the medical professionals near in finding a solution to preventing HIV infection and in treating AIDS.

At the beginning, most of the AIDS programme responses have been focused on the health dimension. The strategies devised through a health-focused approach have not stopped the epidemic from spreading as is shown in the most affected African countries. There are lessons to be learned from these unsuccessful attempts.

One clear lesson is that combating AIDS requires complex strategies that reach far beyond health. Dealing with HIV/AIDS from health-focused approach alone is like tackling an iceberg from its tip only. The enormity of the challenge is how to encompass the entire iceberg beyond just its tip.

Slowly, one begins to come to accept that tackling HIV/AIDS, one would need other means

[1] The opinion expressed in this paper is that of the author and may not represent the official position of UNDP

to complement the heroic efforts advanced so far in medical science. Just like the tip of the iceberg is only a fraction of the entire iceberg, it would not be effective attempting to remove an iceberg by pulling on its tip only.

Efforts from health sector alone addresses only a fraction of the totality of the challenge, at the United Nations Development Programme (UNDP), we learned that addressing the root causes for HIV vulnerabilities would require development interventions and thus open wider the options available to people in responding to HIV/AIDS. Gradually, the voice of the people and the communities starts to emerge and responses are being cultivated to broaden the tools in support of and to complement the health paradigm.

In fact, development as an approach against HIV/AIDS is just beginning to be recognized. Additional cosponsoring partners to provide a multi-sectoral framework also reflect it in the United Nations system through enhancing the United Nations responses to HIV/AIDS. Today, in addition to WHO, the United Nations' responses to HIV/AIDS include the cosponsor ship of UNDP, UNICEF, UNFPA, UNESCO, UNDCP, the World Bank and most recently, ILO.

II. HIV, Gender and Development Link

Development as a major approach against HIV/AIDS is recognized by the United Nations as reflected in its setting up of the United Nations joint programme on AIDS. However, the major challenge remains in mobilizing Member States in translating such recognition into fact. It is similar to the challenge of recognizing the entire iceberg and making efforts to remove it as a whole and not just chipping at its tip.

Gender and development have a natural link. Whereas sex is a biological phenomenon created by nature, gender is a social construct created by people. Development modifies social constructs. Development focuses on the socio-economic aspects of the social constructs that also include gender issues. For example, the UNDP's efforts in promoting the integration of gender considerations in development programmes is one of the many

efforts made by the United Nations' system to modify the inequities created in the social system.

Whereas sex is a pre-determined status not alterable by people despite of medical interventions, such as sex-change operations, development strategies by a society can be designed to modify the socio-economic and cultural root causes of the vulnerability to HIV. In this process, the gender relations could evolve.

For example, when an alternative income generation activities were created in a rural village of China, it created unprecedented opportunities and alternatives for many rural women. Many of the women from the project village, for the first time in life, were able to generate income themselves instead of totally reliant on working out of the land owned by their spouse or family.

The opportunity of financial independence gave these women the chance to consider how to utilize the newly gained income. The ability to decide on their own how to spend economic resources opened their eyes to the value of education. The knowledge and skills provided by education, in turn, enhanced their ability to make sound decisions on resource allocation such as on the types of income generating activities to undertake. Education further opened up other employment and income generation activities previously not an option to them. In this same process, the women metamorphosized and become their own persons instead of remaining a nameless attachment to a man or a family. Such transformation altered the relationship and interactions between them and the male members of their family, relatives and community.

Although we are in the twenty-first century, there are many women who are sold to bondage and forced into sexual services against their will. There are also those being trafficked into sex work in entertainment establishments. There are others who willingly made a conscious decision to sacrifice their own health and life by going into sex work for the future possibilities and survival of the rest of their families. These are all factors leading to HIV vulnerabilities.

When women have alternatives to their livelihood, they could then make rational choices whether to seek employment away from home and what type of employment they would engage in. When people are being provided with clear, understandable information on the consequences of risky sexual encounters, with the necessary access to the tools to protect themselves, with environments, which enables them to act on self-protection from HIV or other harms including violence, HIV epidemics could have a better chance to be under control.

The lessons we learned are that the alternatives and opportunities introduced to both men and women through socio-economic development, opened up the possibilities for people to choices and alternatives. The women, in such a case, were then empowered to make decisions that affect their lives instead of forced to carry out decisions made for them by others.

Development process, when implemented in a gender sensitive way, provides both men and women with choices. However, the final decisions as to which ways people choose to take should be up to the individuals. Part of the challenge of development process is how *not* to impose the external value systems and judgment onto those being empowered.

III. Mobility System Illustrates Gender & Development Link to HIV Vulnerabilities

The UNDP South East Asia HIV and Development Programme (UNDP-SEAHI), as requested by the participating ASEAN member countries, focus its efforts of technical assistance to these countries through tackling the challenge of reducing HIV vulnerabilities that are associated with the mobility system through development efforts.

Mobility system is a development construct. In the globalization of information, economics and society, there is an ever growing number of population on the move: both domestically: between cities, between rural and urban areas as well as internationally. Most of these movements of people are for economic, social and cultural exchanges. Particularly in South East Asia, the cultural and kinship linkages that cut across national boundaries influence much of the economic exchanges.

An example of international population movement in South East Asia is the large number of migrant workers from among the countries. For example, there are large numbers of overseas contract workers from Bangladesh, Cambodia, Indonesia, Thailand and Viet Nam in Malaysia. Equally, there are many people from Cambodia, southern China, Lao PDR, Myanmar, Viet Nam and some Eastern European countries to work in Thailand, many of which engage in sex work. Similar phenomenon is occurring in other South East Asian countries.

Based on the assessments conducted in 1999 and 2000 by the countries in collaboration with UNDP-SEAHIV, the proportion of female[2] among the migrant population is increasing during the past decade. Today, in some countries, there are more females than males moving out of the countries or rural communities to seek opportunities.

Mobile population per se is already vulnerable compared to sedentary population because they are away from home, social support network such as friends and families, familiar languages or dialects and are without a pre-existing nitch in the new environment. These factors perpetuate their being marginalized in the host environment.

In this context, the gender role further heightens people's HIV vulnerability: both for males and females. In the case of men, many men could not resist the loneliness or having to proof their macho image under peer pressure, resort to risky behaviours they may not otherwise engage in at their home environment. These behaviours could be risky casual sex with multiple partners or use of substances including illicit drugs that could alter their ability to make rational decisions or take responsible actions.

Cultural influence: Many of the vulnerabilities encountered by females differ from those for men. Based on certain cultural construct for gender, single women are not to travel away from home alone. Often arrangements were made for them to take a journey into other communities, cities or countries with other people, often with men. In the appearance of giving these young women protection in strange environments, the men actually exact sexual favours from the very women they were supposed to protect.

[2] The term female is used in this context because among people who move, many are children and young people not yet reaching legally defined adulthood.

***Lack of higher education*:**

The vulnerabilities increase when women come from rural communities and without high levels of education. Being less favoured when families decide, based on limited resources, on which child to send for schooling, girls are often left to work at home. Being less educated resulting in these women having less employment options. Whereas less educated male migrants could seek hard physical labours such as construction, transport or guard work, many such employment options are less open to females. Furthermore, there are more frequent incidences where employers, in addition to requiring female workers to perform pre-assigned tasks, expect to be able to gain sexual favours from their female employees. The phenomenon is particularly common among domestic workers, factory workers in industrial zones or entertainment workers.

However, education level alone is not an indicator for women to have more options for employment outside of sex work. Some of our country studies actually shown that women entering into sex work, either formally or informally, might have better education compared to those who from the same villages who did not enter into sex work.

***HIV vulnerability related to development projects*:**

When there are infrastructure constructions to improve socio-economic development, often the HIV impact was not part of the pre-development assessment, such as are commonly done for environmental impact assessments. Many infrastructure development projects engage workers from outside of the communities where the constructions occur. Many such workers may be foreign contract workers: the engineers, the installation technicians, the labours or truckers who bring in construction materials.

On the one hand, there is an influx of men from outside of the communities with cash on hand but away from their families and loved ones for a prolonged period of time, sometimes up to 3 or 5 years. On the other hand, the local community, many are located in rural areas and had no previous contact with the outside world; find an instant opportunity to provide services and entertainments to these workers. Without sufficient HIV preventive education and awareness and lacking access to condom supply or health services, the local communities and the incoming workers are both vulnerable to HIV.

Non-mobile women are equally vulnerable:

In the world of increasing communications and enhanced mobility, let us not forget that elderly women and housewives are increasingly vulnerable. In some rural villages of South East Asian countries, we are now observing a trend of more women getting HIV infected than men. Many of these women got infected not because of risky behaviours on their own but because their spouses have been traveling and engaging in unprotected sexual encounters while away. The HIV virus was brought back home and women got infected without having the options of negotiating the use of condom to protect themselves from HIV infections that are passed on by their spouses.

IV. Responses

Knowledge and protective tools such as condoms are public goods that should be made available to everyone. To facilitate the availability and accessibility of these commodities and services, one needs to promote an enabling environment.

Some examples of the UNDP-SEAHIV' efforts in collaboration with the countries are listed below as illustrations of creating enabling environment to reduce HIV vulnerabilities for people: both those who are mobile and those who remain in the communities, either the home communities, transit communities or host communities.

A. Policy: *Chiang Rai recommendation*

In view of the high HIV vulnerabilities for the communities and workers coming into contact with the communities where infrastructure construction projects take place, at the policy level, with the facilitation of UNDP-SEAHIV, the ASEAN countries, through its Taskforce on AIDS, adopted the following recommendation in 1999:

> "That construction contractors are required to include HIV prevention programme for its workers and the communities where the projects are located as a precondition of their bidding for the construction contract".

The gender implication is that now both men and women workers and the communities are being given an enabling policy environment where access to HIV prevention services is a right and not a luxury.

It is encouraging to report the Chiang Rai recommendation is also being promoted by the World Bank, Asia Development Bank, the Japanese International Construction Bank and bilateral donors involved in infrastructure construction.

B. Tools: *Model contractual clause*

To assist countries, donors and construction companies to fulfill the Chiang Rai recommendation, with the support from DFID, a draft model contractual clause has been developed so that countries or communities where infrastructure constructions are taking place have a readily available tool to promote the binding requirement.

A critical component of such a model clause is the clear delineation of resource allocation for HIV prevention programme that is separate from the overall construction costs. This is provided to ensure that construction companies do not sacrifice HIV prevention programmes in their overall resource allocations process.

This model clause is important for NGOs working in communities where construction work is occurring. Recognizing the importance of adequate quality of HIV prevention programmes to be provided, the clause specified that the construction companies are to engage qualified NGOs or other civil society organizations in providing the HIV prevention services. These is where gender sensitive NGOs working on HIV prevention programmes can contribute to ensure the proper implementation of the policies and tools being developed in the partnership of the United Nations, governments, NGOs and donors.

C. Gender sensitive development programmes: *Family camps*

For construction sites, instead of forbidding women on site, it is actually conducive to allow workers to bring their family along and set up family camps. The women could be employed by the construction sites to keep the camps, cook, and provide care and other

supportive services for the operation of a healthy camp environment for the workers. At the same time, the male workers would have families around to support them and to care for them thus reducing the loneliness and frequency of sex worker visits while spending prolonged contract work away from their hometown. The results could be improved health of workers, decreased absenteeism from work and increased employment opportunities for women.

V. UNGASS Targets relating to Gender

The landmark United Nations General Assembly Special Session on HIV/AIDS (UNGASS) took place from 25 to 27th June 2001 in New York produced a Declaration of commitment on HIV/AIDS.[3] This is a global political commitment by Member States to targets set for 2003, 2005 and 2010. This is a tool that could facilitate the work of NGOs in reducing HIV vulnerabilities of people and an opportunity to advance the improvement of gender construct of our society through sound development.

The UNGASS declaration has made strong references to gender issues. For example, in the preamble paragraph 4, it recognizes women being most affected by HIV/AIDS and girls are most vulnerable. Paragraph 14 stresses gender equality and empowerment of women is fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS.

Specific targets: in the operating paragraphs 37, calling on strengthened ***leadership*** at all levels of society, specified the development and implementation of multisectoral national strategies and financing plans to integrate a gender perspective by 2003.

For ***prevention*** targets in paragraph 47, efforts devised to achieve time-bound national targets would challenge gender stereotypes and attitudes, gender inequalities in relation to HIV/AIDS and encourage active involvement of men and boys by 2003. By 2005, there should be HIV/AIDS prevention programmes for migrants and mobile workers are specified in paragraph 50 and provisions for HIV-infected women.

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[3] United Nations Special Session on HIV/AIDS: global crisis-global action, 27th June 2001

The HIV/AIDS and ***human rights*** targets set for 2005 are particularly focused on women as reflected in paragraphs 59, 60 and 61.

Vulnerability reduction targets the empowerment of women as stressed in paragraph 62 by 2003.

Alleviating social and economic impact target by 2003 in paragraph 68 requires specific review of such impact on women and the elderly in all levels of society.

HIV/AIDS ***in conflict and disaster affected regions*** specify targets for 2003 by recognizing increased risk of exposure to HIV infection among women in paragraph 75 and the inclusion of gender component in HIV/AIDS awareness and training defense and peace keeping personnel.

If the targets listed in the Declaration can be achieved, it would require consorted efforts by all levels of society in transforming the current social construct of gender in our society. In other words, it would require dealing with root causes, which are development based: education, access to information, resources and services, providing socio-economic opportunities to both men and women. To achieve these targets, it would require political and resource commitment to strengthen socio-economic development from individual level to families, communities, countries, regionally and internationally in gender and culturally sensitive ways.

VI. How Can the Iceberg Be Melted?

The UNGASS Declaration calls on all countries to take the necessary steps to implement the Declaration, in strengthened partnership and cooperation with other multilateral and bilateral partners, governments, NGOs, private sectors and research institutions.[4]

Are these targets truly achievable? The important issue is the process towards achieving these targets. The questions are more fundamental. Is the world ready to deal with the root

[4] UNGASS last paragraph, 27th June 2001

causes of gender inequalities? To do so, it would require fundamental transformations in the socio-economic constructs, which are the basis of development.

The world is burning with HIV/AIDS. What one see today of HIV epidemics in Asia is only the tip of the iceberg. One needs to be prepared to tackle the iceberg in its entirety not just the tip in order to win the battle. We must find ways to deal with our differences and reach out for common grounds. Governments need NGOs just as NGOs need good governance to facilitate NGOs' ability to serve people.

HIV/AIDS cuts across national boundaries thus countries cannot resolve the HIV challenge without cooperation and respect for others at regional and global levels. Similarly, whereas special efforts are made for Africa, heightened efforts are due for Asia in order to prevent the potential of an even bigger iceberg from being built up.

China

Gender and HIV/AIDS in the Mekong River Regions with particular reference to Yunnan Province of P.R. China

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This paper has four parts. The first part introduces the framework and findings from my previous publications on international sex tourism in Asia and HIV/AIDS. The second part describes the particularity of the Yunnan Province of P.R. China which forms a part of the Mekong River Region followed by the background of the P.R. China which is the third part of this paper. The last part will introduce gender and HIV/AIDS issues in general, not only in the Mekong region as it was not introduced in any first three parts of this paper.

Theory: Economic disparity and HIV/AIDS epidemic

I would like to summarise here what I have written in my previous article (Otani, 1996 in Japanese and 1998 in English) which has lead me an opportunity to be invited to this expert meeting on Gender and HIV/AIDS.

The findings of the article were: 1) international sex tourism is a rapidly expanding industry in Southeast Asia; 2) the nature and length of relationships between sex workers and their clients should be considered in designing HIV/STD prevention programmes; 3) sex tourism is fueled by a twofold economic gap, that is the economic gap between countries where the sex trade takes place and the client's home country and the economic gap within a country where the sex trade takes place and the client's home country and the economic gap within a country there the sex trade occurs; 4) it is true that sex tourism is one of the factors affecting the spread of HIV infection resulting from sexual contact between sex workers and

[1] This report is a product of the staff of the World Health Organization (WHO) but the judgments made in the report do not necessarily reflect the views of WHO.

their local clients; and 5) while HIV infection through sex tourism accounts for only a small percentage of the total cases, the sexual networking of those involved in sex tourism has contributed both to the spread of HIV within the host country and to the global spread of HIV. (Otani, 1998, 1996. and Otani and Tarantola, 1995)

In this article, I focused on the sex trade between developed countries and developing countries. However, as the finding 5 explained it is not the major causes of the HIV pandemic in the region. Also as the finding 3 explains, the economic gaps exists within a country. The economic gap between people benefiting and those not benefiting from the ongoing economic growth in Southeast Asia serves as a stimulus for the development of sex industries, including sex tourism. In this paper, I will introduce the sex trade among developing countries in relation to the HIV epidemic in the region.

In the article, I did not discuss Globalization that now cannot be overlooked. I would like to incorporate the impact of globalization into my arguments.

Yunan Province of P.R. China

China's southern province of Yunnan forms a part of the Golden Triangle together with Laos, Myammer, Thailand as well as Vietnam. This area has to be looked at as a one region than drawing a line with country boarder lines. This can be shown by both epidemiological research (Beyrer et al., 2000. Piyasirisilp, 2000. Yu et al. 1999. and Weniger et al, 1994) as well as sociological research (Beyrer et al., 2000. Otani, 1998a 1998b and 1996, Otani and Tarantola, 1995). (See Appendix 2.) Yet the differences among the countries that forms the Region is important. (See Appendix 1.) Migration occurs between the places with economic disparities.

The commercial sex industry in Thailand includes women and girls trafficked not only from rural Thailand bur from neighbouring countries such as Myanmer, China (principally ethnic Dai from Yunnan), Laos and Cambodia (Asia Watch, 1993. Beyrer, 2001). Also the sex trade in Myanmer is rapidly expanding both in its cities and in the Shan border areas with China where 2,000 – 3,000 Chinese people cross the border bridge each day to gamble

and use the services of prostitutes in the Myanmar side (Beyrer, 2001) and Myanmer wants to establish economic links with China.

A brothel in Cambodia where Thai business come may offer women and girls trafficked from Cambodia, Thailand, Vietnam, China or the Philippines. Cambodian women have been trafficked to Singapore, Hong Kong, Malaysia and Thailand. A brothel in Thailand has women and girls trafficked from rural Thailand, Myanmer, China, and Cambodia. Thai women have been found in sexual slavery in Japan, Germany, USA, Australia, and Sweden.

The number HIV/AIDS cases in China vary by sources. Official statistics reports that China had 22,517 known HIV carriers in the country of more than 1.2 billion at the end of year 2000. State media have reported most of them are drug users. The Ministry of Health experts think the number could be more than 600,000 and the United Nations estimates that China will have 10 million or more HIV/AIDS victims by year 2010 unless it acts decisively soon.

The Yunnan province has several special features. Although Yunnan is poorer than the East coastal areas of China, it is richer than neighbouring provinces of China and neighbouring countries. Its geographical importance for trade in the region makes the province prosperous. Its annual per capita income in 1991 is US$178 (Yunnan Provincial Bureau of Statistics, 1992) (Li, 2001). It is home to many national minorities. More than a third of the province's population are ethnic minorities. In the beginning of the HIV epidemic in China, 80% of the reported HIV case of China concentrated in the Yunnan Province. The main transmission route was intravenous drug use (IVDU). In 1996, the HIV epidemic outbreak was reported along the migration routes of workers from the Yunnan Province to other provinces such as Xinjinan and Guangxi (Beyrer et al. 2000. Piyashirislip et al. 2000; Yu et al. 1999). Also some epidemiology study shows several HIV transmission routes from neighbouring countries such as Vietnam and Myanmmar to Yunnan and Guanxi Provinces of China (Beyrer et al. 2000. Piyashirislip et al. 2000. and Weniger et al, 1994)

The World Health Organization (WHO) is funding an intervention project targeting sex workers in Yunnan Province starting April 1999. The provincial officials call them 'entertainment workers'. The clinic is housed in a hospital that offers medical care as well

as counseling. All clinic staff are trained at the nearby Kunming City STD hospital, and outreach work includes visits to local entertainment establishments, the distribution of free education materials to sex workers (both written and audio-visual materials), and training peer educators among the women. mid-course evaluations indicated that the project had been quite successful in raising HIV awareness among female sex workers. Positive behaviour changes such as increased HIV awareness and somewhat higher condom use have been reported.

U.S. Embassy officer in Beijing who visited the site reported that one of the important factor what made the pilot project successful was that it had earned local financial and policy support. A local authority is often reluctant to announce its HIV/AIDS situation and tends to choose denial in fear of the damage to their image and the consequent loss of revenue from the tourism. Other factors to success may be difficult to replicate in other parts of Yunnan: 1) the project is located close to Kunming City, a major source of expertise, opportunities for training and skilled professionals; 2) the township involved is fairly prosperous; 3) the hospital is the only high-level hospital in the area, so many women would go there anyways, making the target population easier to access; and 4) most important, the project has good relations with the local Public Security office. Project staff explained the project to Public Security and persuaded the policy that public health and public security goals coincide. The attitude of local public security officials towards HIV work with prostitutes or IV drug uses can vary widely in different parts of Yunnan, as well as in different parts of China.

Background of China

Rapid economic growth as a nation is significant while the economic gap is widening between rural and urban areas as well as among provinces and within a province. The highest GDP growth of 10% had been reported over years. It has been slow downed a little to 7-8% but it is still highest in the world (See Appendix 1). With this rapid economic change and economic-driven social changes, globalization and China's entry to WTO and its implications to health as well as gender and HIV/AIDS will be important to follow.

Other characteristics of China includes its political system of China. It has the single ruling party of the Communist Party.

Urbanization is being observed in China. With rapid development, cities are expanding and a town is becoming a city. Also, rural to urban migration is a major feature of current China's social changes. Migration from rural to urban had not been looked favourably by the Chinese government but it is now changed. More rural people migrate to urban areas seeking job opportunities. This pattern has to be looked at by gender. Not only men but girls and women migrate in desperate to look for a job and income revenue. Some are voluntary. However, increasing number of women are kidnapped or tricked to bring to other places. In Beijing in 1997, about 34% of 2.3 million incoming migrant workers were women. 46% of them were unmariied. Of these women the overshelming majority was between 18-20 years old (China UN TGA). The trafficking is not only to be sold as a prostitute but as a wife of those farmers who cannot find their job. This is not only for a very young woman but middle age women who have a child or two children have been kidnapped to be sold as a wife.

Vulnerability is not only with those migrate to urban areas or other rural areas. As experienced in other countries, women who stay behind are also at risk of being infected by HIV from their migrating husbands when they return home from urban areas for certain periods of time.

China has achieved a relatively high gender sensitive employment policy and implementation. The World Bank reports that the gender indicators show higher achievement in East Asia compared to South Asia, North Africa and Middle East, Africa and Latin American Regions. It is because of China's achievement. However, it is also reported that with the current economic growth policy, women tend to be the first to be laid off at reforms and reorganizations. At the era of globalization, social and economic changes with rapid economic growth may blind the attention to its negative impacts. More women than men may be lead to poverty because markets discriminate against those with inadequate market power.

WTO is said to be an international agency that takes little account of the effects of the free market (a market that is rigged in favour of the economically powerful) on the poorest people. Countries that are forced to lower tariff barriers and end preferential trade agreements are liable to widespread loss of jobs or the collapse of farming as their markets disappear. Such policies dislocate family support systems. (Wilson, 2000) And poverty is a major factor of vulnerability to HIV. Poverty may lead girls and women to prostitution and engagement in sex without a condom against higher fees.

Now Beijing has won the bit to host the 2008 Olympics. This will boom the construction works in the city and is estimated to create day labour job opportunities. This will encourage rural farmers to migrate to work in Beijing. This is another example of migration pattern that needs to be looked at by gender analysis. It is a challenge to protect the health of migrant workers in China.

As a result of China's population policy, imbalanced sex ratio has been reported especially from rural areas: 120 males to 100 females in rural China. Some villages, even as high as 140 to 100. Demand for women becomes very high. This has several implications. More practice of men buying a prostitute. More women are tricked or kidnapped and sold to a farmer who cannot find their wife. This sex ratio also reflects the reality of the large number of rural girls who are not officially registered. When they are not registered, they have no access to basic education and health care. Public health programmes including HIV/AIDS prevention as well as empowerment of marginalized and vulnerable populations need to take the ways to reach out these unregistered rural girls.

Trafficking of women

The New York Times and other newspapers reported a 37 year old rural Chinese woman with two children who was able to return home in Guangdong Province after being kidnapped, drugged, places on a train and sold for about $1,500 or $12,000 as a bride to a brick maker in faraway Xinjiang Province, rescued by her family who borrowed $1,250 for the travel cost and when she was already three month pregnant and had an abortion (Rosenthal, 2001). This is just a case of hundreds of thousands of Chinese women who are sold on a black market each year. Since year 2000, the government has been waging a

harsh campaign against trafficking in women, featuring highly publicized arrests and death sentences. But it has been reported the number of kidnapping keeps increasing.

The trade reflects the extremely low social status of poor rural women. Rural girls get inferior schooling, training and medical attention when compared with boys. Most kidnappings occur when uneducated young women with little hope and confidence leave their hometowns looking for jobs. They are desperate for work but don't know what is suitable or how to find it. So they can be easily tricked, then forced to work as prostitutes or sold to poor men who can't find wives. A report says that as of 1999 the police were rescuing 10,000 women a year, and this is just a fraction of those kidnapped.

Once kidnapped and sold, when girls are penniless, illiterate and without friends in their new homes, have no means of escaping or contacting their families. And when they have a child, some start to see it as their fate and often reluctant to leave any longer. Some girls get repeatedly kidnapped and sold.

Prostitution in China

China is not an exception from a very long history of sale and trade in women. However in1949, one of the first social programms was to eradicate prostitution. Some four million women were rehabilitated (Beyrer, 1998). Yet with the rapid economic growth of China in the 1990s, this has been changing as everyone wants money. In late 1990s, it has been reported that prostitution are increasing rapidly.

> "In China, prostitution is widespread and take many different forms. The rapid growth of China's sex industry is not simply a matter of the moral fall of those women who sell themselves. The context of this problem includes rapid economic development, a growing gap between rich and the poor in both cities and the countryside, unemployment, poverty and relative poverty, and a solutions that could make the sex trade disappear in a short time. The only solution is for the health authorities and public security to work together to see that prostitutes use condoms... and get regular medical care. Only in this way can we ensure that the chances of HIV

being transmitted by prostitutes can be reduced." – Wang Yanguan, The Chinese Academy of Social Sciences Institute of Philosophy, "Strategy of Tolerance and HIV/AIDS Prevention in China", April 2000.

Many prostitutes in China have been kidnapped or impressed into prostitution and many are poor migrants from the countryside. Many prostitutes are migrants who work outside entertainment establishments or who work occasionally as prostitutes to supplement their income.

Blood Transfusion. Blood safety

Several villages started to report the HIV prevalence rate of 65-80% of the village population. It has been reported at everyday newspapers both in Chinese and English in May and June 2001. The HIV epidemic is due to malpractice of the blood collection and blood transfusion. In early 1990s, the virus continued to spread unfortunately because officials blocked research and education campaigns about HIV, considering as their embarrassment.

The major malpractice was the plasma collection methods. Blood from dozens of sellers was pooled and put into a "huge centrifuge," where it was spun to separate the desired plasma, at villages. The remaining fraction, mainly red cells, was divided up and transfused back into the sellers, who felt the process to be healthful because it limited the blood loss. So, even those who donated only a few times ran a high risk of becoming infected.

Blood has been sold for cash: $5 for donating each 400 cc's of blood. In rural villages under poverty, often girls are the first to be asked by their parents to drop out from school when the parents can no longer pay the school fee. Some parents make a child to sell their blood to pay the school fee. For this, girl may be at higher risk. It is not proved and this has to be looked at.

A group of villagers from the central province of Henan came to Beijing to look for someone to take responsibility to stop what is going on at the Wenlou village. In this village, 65% is HIV-positive of a population of 800 and 40 are dying each year (BBC, 2001). Blood selling was a very serious problem before 1995. In 1996 the health department issued new

regulations and lots of small blood collection centers were closed down. Although HIV prevalence is high, there are not many AIDS orphans AIDS orphans. But it will soon increase significantly.

With the request from the Chinese Ministry of Health, WHO started a blood safety project from in the early year 2001. China is making efforts to discourage paid-blood donation but encourage voluntary donation to decrease the risk of infected blood. Blood is scarce and it is difficult but the increasing voluntary donation is being reported. Blood safety is one of the top priorities from both the Chinese Ministry of Health and WHO.

Law

The HIV/AIDS policies are not taking consistent approaches cross sectors but seem to be still in the confusion. Some sectors are repeating the mistakes of other countries while some sectors such as the Ministry of Health is taking open and highly efficient approaches. The efforts of the Ministry of Health alone would not work. It needs the cooperation of other ministries and sectors. In order to do so, it requires the political commitment from the higher level of the government.

Chinese lawmakers are proposing make spreading the AIDS virus a crime punishable with life imprisonment for prostitutes (US Embassy Beijing, 2001). Ministry of Health is highly aware of the problem of this approach and wishes to take the approach to protect the human rights of people infected with HIV. In fact, the Ministry of Health has emphasized patients' rights and the voluntary nature of AIDS patients. This kind of law would worsen discrimination and discourage people from getting tested for AIDS when it identifies the people who "knowingly" spread the disease to be punished. We have learnt from the successful policy of Thailand and other countries, punishing the few would not be the effective prevention but only worsen the situation. Educating the many and increasing the awareness are the effective approaches.

Lawmakers are under pressure to do something since the recent lifting of a ban on AIDS-related reporting in the state-run media that may appear to have fed a public panic through with the news of serious HIV epidemic in the country. Making the law of punishing may be a traditional approach or easier way to appear to be doing something but this is a mistake.

This law would drive HIV-infected men and women underground and will make it more difficult to prevent the spread of the diseases or those who are already infected to seek care.

Beijing calls on employers and individuals to report any "suspected AIDS patients" to local health authorities, and calls for any mandatory testing of "prostitutes, their clients or possible spreaders of AIDS" who are apprehended by police or the courts. (Chang, 2001)

Increasingly honest media reporting on the HIV/AIDS epidemic in China has been leading to urge the development of legal and policy issues in China. It is still a changing period which needs proper guidance since there public reacts in the way of tracking down and marginalizing the men and women with HIV/AIDS.

Gender and HIV-related Biological and medical issues

Women, particularly the younger age groups, are at higher risk of contracting sexually transmitted diseases including HVI/AIDS because of biological factors, not only soio-cultural factors that include their low negotiating capacity in matters of marriage, sexuality and increased risk of physical or psychological violence.

The increased susceptibility of adolescent girls at these ages to HIV infection has been well describe, and has been biologically linked to the increased vascularity of the immature cervix, the putative site of most heterosexual transmission of HIV (Moss, Clementson, & D'Costa, 1991. Beyrer, 2001)

Many clinical studies proved that the risk of mother-to-child HIV transmission is vastly reduced with inexpensive and effective medicines at the time of delivery when the infection occurs from mother to baby.

I would like to show the economic analysis done by Dr. Mead Over of the World Bank (World Bank, 2001).

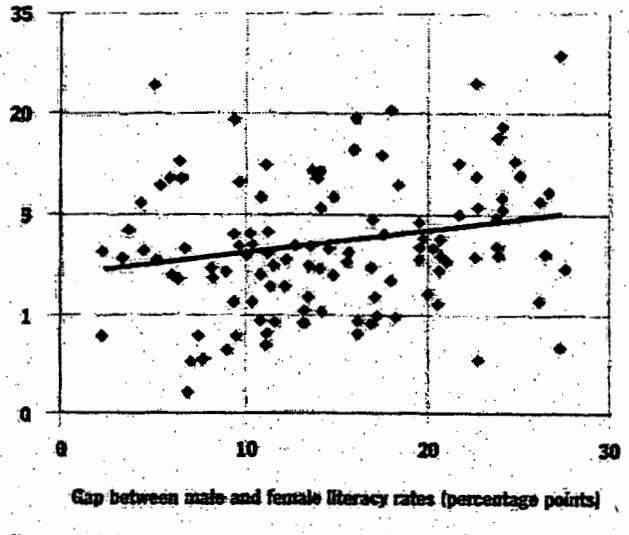
Gender inequalities in schooling and urban jobs accelerate the spread of HIV (Figure from his analysis in 1998). The AIDS epidemic will spread rapidly over the next decade – until up to one in four women and one in five men become HIV infected, already the case in several countries in Sub-Saharan Africa.

ENGENDERING DEVELOPMENT

Figure 5 HIV Infection Rates are Higher Where Gender Gaps in Literacy are Larger

Urban adult HIV prevalence rate

Percent (log scale)



Note: The plot includes 72 countries (32 in Sub-Saharan Africa, 20 in Latin America and the Caribbean, 15 in Asia, 4 in the Middle East, and 1 industrial country). The vertical axis measuring the percentage of urban population infected with HIV has been transformed into a logarithmic scale. Points on the plot represent data for individual countries after removing the effects of other societal variables used in the regression analysis (including GNP per capita, an income inequality index, religion, and proportion of population foreign born).

Source: Over (1998).

Conclusion

The HIV/AIDS epidemic and related issues are neither a problem of one country, not a problem which one country can solve by itself. The issue requires regional and global collaboration. NGOs, governments and international organizations must work together with multi-sector collaboration of medical and health expertise and education, employment, legal, community development, gender and other expertise. Especially gender-sensitive approaches are increasingly important in order to understand the epidemic and social background and to promote more efficient prevention of the disease and care programmes for those who have already been infected and their families.

Appendix1: Key indicators for countries in the Mekong Region

Economic

Countries	Population (millions) 1999	Surface area Thousands of sq.km 1999	Gross National Product (GNP)			GNP per capita		
			Billions ofdollars 1999	Rank 1999	Avg.annual growth rate (%) 1998-99	Dollars 1999	Rank 1999	Avg.annual growth rate (%) 1998-99
Cambodia	12	181	3.0	133	4.5	260	186	2.2
China	1,250	9,597[a]	980.2	7	7.2	780	140	6.3
Japan	127	378	4,078.9	2	1.0	32,230	6	0.8
Lao PDR	5	237	1.4	160	4.0	280	184	1.5
Myanmar	45	677	--	--	--	--	--	--
Thailand	62	513	121.0	31	4.9	1,960	102	4.1
The Philippines	77	300	78.0	40	3.6	1,020	131	1.4
Vietnam	78	332	28.2	60	4.2	370	167	2.9

a: include Taiwan

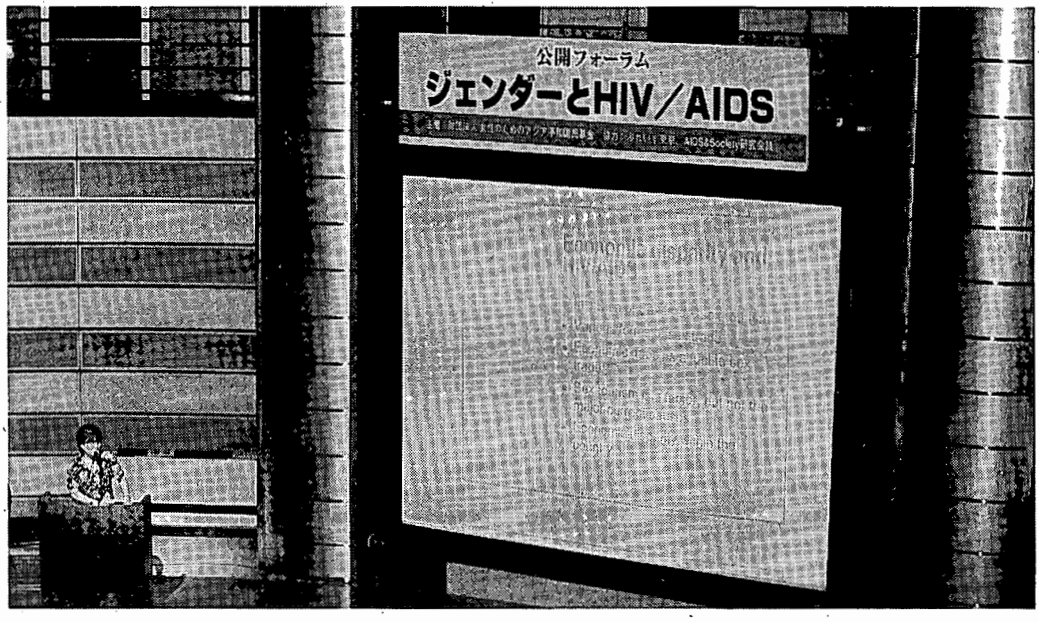
Quality of Life

Countries	IMR[a] Per 1,000 live births 1998	MMR[b] Per 100,000 live births 1990-98	Life expectancy at birth Years 1998		Adult illiteracy rate % of people 15 and above 1998		Urban population % of total	
			Males	Females	Males	Females	1980	1999
Cambodia	102	--	52	55	43	80	12	16
China	31	65	68	72	9	25	20	32
Japan	4	8	77	84	0.0	0.0	76	89
Laos	96	650	52	55	38	70	13	23
Myanmar	78	230	58	62	11	21	24	27
Thailand	29	44	70	75	3	7	17	21
The Philippines	32	170	69	77	5	5	38	58
Vietnam	34	160	66	71	5	9	19	20

a: IMR stands for Infant Mortality Rate (per 1000 live births)

b: MMR stands for Maternal Mortality Ratio (per 100 000 live births)

Source: World Development Report 2000/2001. World Bank. Oxford University Press.



Appendix2: Maps from Beyer, C. et al (2000)

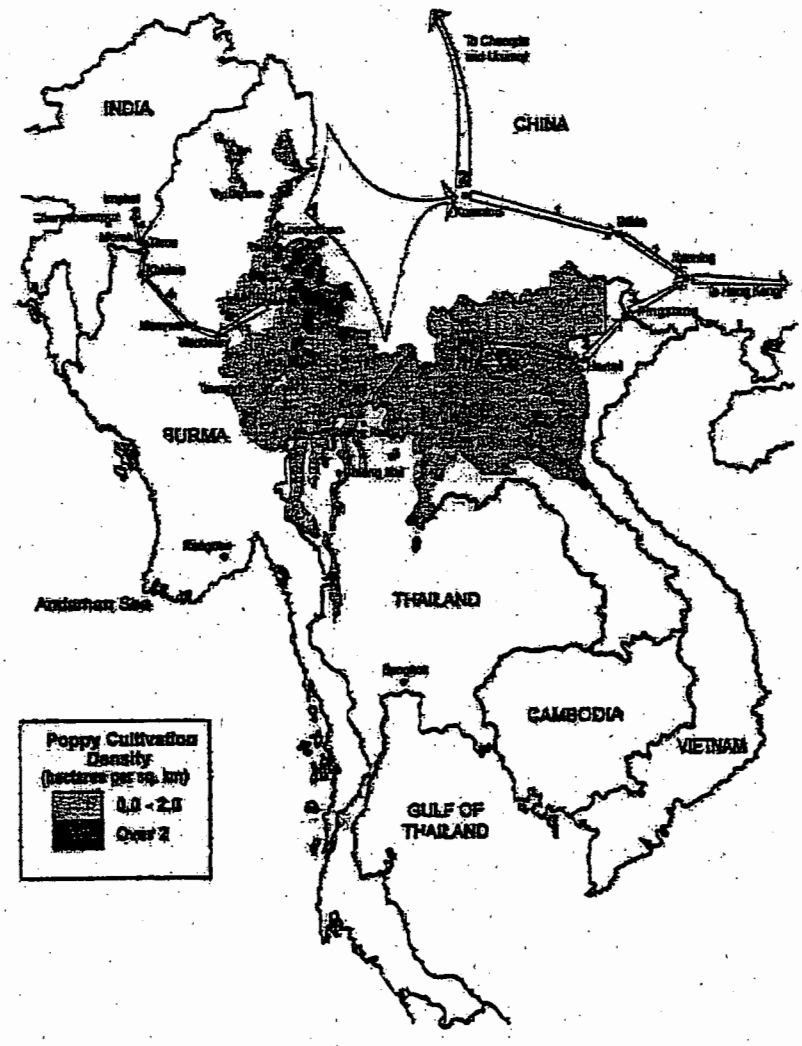


Fig. 1. Opium growing areas and cultivation density, and overland heroin trafficking routes in south and south-east Asia, 1999. Density measured in hectares/km² from 0.0 to over 2.0

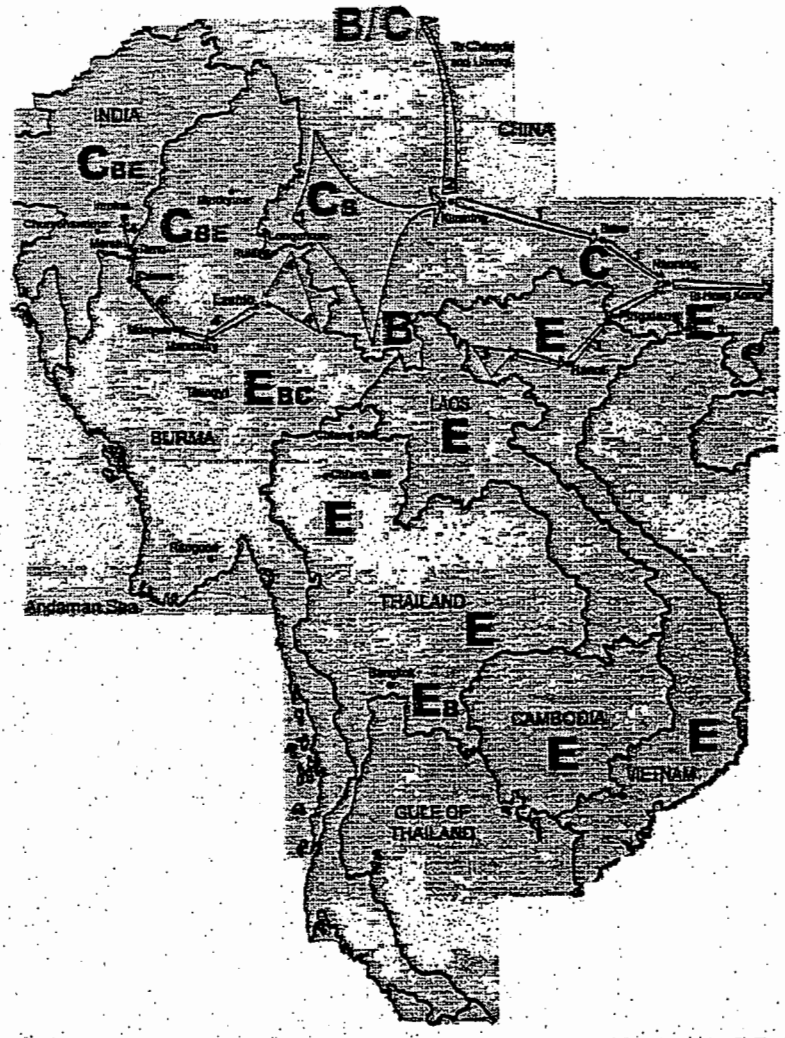


Fig. 2. Four principal heroin trafficking routes and known HIV-1 subtypes (B, C, E, B/C recombinant) in south and south-east Asia, 1999.

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High Risk Groups in Phnom Penh

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AIDS has been dramatically increased in Cambodia, which being threatened people's lives and the development process. It is reported that currently, Cambodia has the highest infection rate in the region. The first case of HIV positive in Cambodia was reported from the national blood bank in Phnom Penh in 1991, then in 1993 the first AIDS case was reported. Estimation in late 2000, there are about 170,000 between the age of 15-49, are HIV positive.

In 1992, Ministry of health with the support from WHO conducted the anonymous blood test in Phnom Penh among the high-risk groups. Then from 1994, the survey was done every year in order to gather and analyze the information on AIDS epidemic and to demonstrate the infection among the selected high-risk groups. The survey has shown that at the beginning, number of men infected are much more higher than women, but from year to year, the figures of the infected women keeps going up.

The low status of women, poverty particularly among women, the vulnerability, lack of access to information because of high illiteracy, social attitudes, sexual behavior and practice, lack of medical facilities, patriarchal structures and the commercialization of women contribute to the prevailing HIV/AIDS epidemic.

Women represent a remarkable economic force in Cambodian society but women are not equally benefiting in the fruits of economic development.

Women represent the majority of the population (54%) but this is not reflected in their representation in decision-making processes.

Women control 85% of small enterprise in urban Cambodia and constitute 60% of the agricultural workforce in rural Cambodia, but women are still:

- More illiterates than men
- Virtually not much included in the positions of power and decision making processors
- 145 times more likely to die from pregnancy related illnesses than women in developed countries

Yet, there are a significant proportion of children dying from health and nutritional problems.

In Cambodia the infant mortality rate under one year is as high as 115 per 1,000 live births, compared to other countries in the region, the infant mortality rate is 42 per 1,000 births.

Health and access to a health system is a priority and a right as is education. But in Cambodia, there are still lots of inaccessible and unaffordable. Girls are grossly under represented in the education system at all levels. Women are still victims of suppression and violence

Female labor is cheaper therefore women can easily fall prey to exploitation and harsh dangerous conditions. The following proverb that has become esteemed and proclaimed exhibits the prevailing gross inequalities and status of women in society: *The men look like gold. When it drops in mud, we can clean it, but the women look like white clothes, when it drops in mud we cannot clean it to be white again.* What does this say about the perception of women in the society? Among other connotations this saying reflects the different status that is imbedded in the society. Men are encouraged and almost praised for experiencing sex with sex workers both before marriage and after marriage. Often with no or little regard for safe sex practices and run a high risk of being infected with AIDS.

This unequal status imposed on women and which prevails in Cambodian society makes it difficult for women to negotiate safe sexual practice. Sex workers who are themselves victims of this trade in sex, sex workers who sell themselves sexually in the context of the struggle for survival are horribly mistreated and discriminated against. Often they are not able to protect themselves.

Women and children become the innocent victims of this entrenched behavior. More and more women including pregnant women (2.7%) are HIV positive, and there is still lack of substantial research that can accurately exhibit the problem.

Poor health and inadequate services continue to impact on many women's lives that struggle daily merely to survive.

These factors contribute to the overall problem of HIV/AIDS. For women and children who are severely disadvantaged and need to be empowered to prevent being abused, dominated and taken advantage of because of their status, gender or age.

HIV/AIDS can be combated even with scarce resources if the political will is there and everyone assumes responsibility.

To stop the AIDS epidemic, to survive our women and children, we must commence a process of individual and collective responsibility to address the issue. Women cannot do this alone men have to join the struggle. If having partners and valuing family traditions and values then men must take responsibility and commence a dialogue regarding this issue. It will not go away by ignoring it. We must not hide and behave shyly, but we must confront the issue.

The implications to the future of our society are tremendous, the consequences are frightening in our society that has little and inadequate services in place to deal with this potential traumatic crisis. The social and economic costs in the foreseeable future are frightening. We must act! Every one is responsible from the government down to the poor farmer. AIDS has not barriers no discrimination let's unite and fight together.

To end my talk I would like to encapsulate some main points in my message that we as women:

- We demand change
- We demand commitment from all
- We want safe good access to health
- We want access to information

- We want equal status
- We want equal participation in all areas

The AIDS STD Health Action (ASHA Project) Project of the Public Health Department

Seema Shroff
Bombay Municipal Corporation AIDS Cell

Preface

May 1986 marks a watershed in the history of Indian Public Health, even as the first case of AIDS was detected in Madras closely followed by an AIDS death recorded in Mumbai. Due to a lack of adequate information, NGOs immediately started focusing on CSWs. The logic behind the move was that as HIV/AIDS was an STD, the commercial sex worker was a natural vector to start prevention activity. By targeting CSWs, most NGOs knew they were taking the easy way out and would become high profile enough to get the attention they so eagerly sought.

The Public Health Department of Mumbai Municipal Corporation knew that a major part of the burden of HIV prevention would have to be undertaken by its own staff. Till date, the civic health department has never shirked as duty when major calamities struck the city ever since it became India's Prime City. However, we realized our inadequacy in fighting this new epidemic and sought technical support of the Government of India and WHO.

In December 1991 a medical anthropologist was sent to prepare a more reasoned project document. With the assistance of the Public Health Department Officer, the project document was prepared under the heading "Intervention among brothel based sex workers and their clients: a pilot project was to reduce the incidence of STDs, increase awareness of HIV/AIDS and condom promotion."

This multi pronged approach seemed too ambitious and did not achieve the expected outcome. The peers could not be motivated either because they did not feel the need to participate or did not have the time. However, priority was still on sex workers and their

need to negotiate condom use, which opened a Pandora's box of options. This part of the preventive strategy had to be strengthened by empowering women in prostitution and increasing both their negotiating powers and the availability of condoms.

The AIDS STD Health Action (ASHA) Project

AIDS Cell under Public Health Department of Mumbai Municipal Corporation started working on HIV/AIDS Prevention activities from April 1992. This intervention programmes in Kamathipura and Khetwadi areas of Mumbai were initiated because of the presence of largest number of CSW's, male clients and eunuchs in these areas. With the technical and financial assistance from W.H.O. Knowing the heterosexual route as the prime route for the spread up HIV/AIDS and STD, the services under the Cell were established in the organized brothel based red light area of Kamathipura and Khetwadi. The activities were carried out on the basis of the community needs and learnt many experiences in relation to implementation of HIV/AIDS Intervention Programmes particularly in the red-light districts.

Broad Objectives

Main objective of the project

1. To reduce the incidence of STD and HIV infection among women in prostitution and their clients in the target area of Kamathipura and Khetwadi.

2. To reduce incidence of STD and HIV infection among low risk population groups.

3. To function as an implementing, research and resource unit of MMC AIDS Cell for STD/HIV/AIDS intervention programme (with marginalised, unorganized and vulnerable sections of community) by generating and then offering/ sharing innovative approaches, strategies, methodologies, actual skills and experiences gained through this project with MMC AIDS Cell and other agencies working in this field.

4. To evolve a clear set of guidelines for STD/HIV/AIDS Intervention that will help to create a set of consistent approaches for addressing different high-risk behaviours.

Interventions

The intervention initially started in Mumbai metro's red-light areas of Kamathipura and Falkland Road. While implementing this intervention programme, various strategies, activities and sub components evolved. This enriched the experience of the staff and helped them effectively to undertake intervention programmes in the community. To reach out to the marginalised community of CSWs an agenda was developed around sensitive issues as it was essential to have the active involvement of the community. Accordingly, it was done by drawing human resources from within the community by recruiting animators. These animators were trained in delivering a holistic health package for the control and Prevention of HIV/AIDS. The animators function was to reach the women in prostitution and provide health services, guidance and necessary assistance promoting healthy safer practices.

Outreach

Project has female animators to work with women in prostitution. It is needless to state that woman in prostitution has been denied their basic rights like shelter, food, cloths, conducive environment etc. The exploitative environment where the living conditions are pathetic under which the client who pays for sex totally dominates the sexual interaction. In this situation it is unfair to expect women to control and prevent the STD/HIV infections. The friendly female animators have the general discussion with the women in the community. They try to address the problems of women starts from the differences of brothel keeper, health problems, problems related to children, ration cards, bank accounts etc. The group is also trying to advocate for the better civic services in the community.

Women and AIDS

As the pandemic spread in India, it was becoming increasingly clear that women had little or no negotiating power for condom use or even over their own sexuality. To involve and train women activists in increasing the bargaining power of women and to intervene wherever they could, ASHA decided on a multi-pronged strategy of involving women's groups. The initial step was to have a state level workshop for women on HIV awareness.

Seven women's organizations were selected to empower women in particular to take up HIV Prevention programmes and sexual hazard avoidance. On a pilot basis, in depth training was held for the numerous women's groups. The training sessions are still conducted on a sustained level. It is difficult to educate and empower all the women in the community. But we have no other go. Women are beset by inequalities on all sides – social, economic, cultural and familial. Although, several social struggles have resulted in the creation of some rights and space for women, the onset of HIV/AIDS is now triggering off a fresh wave of oppression against women. The spread of the HIV epidemic is inextricably linked to sexuality, in its many dimensions, i.e. sexuality and reproduction, sexuality and man-woman relations, sexuality and the oppression of women. Given that the sexual arena is one in which women have been traditionally disempowered, the epidemic threatens to sweep away several of their basic and hard own rights. There is no doubt that women are more susceptible to HIV infection and they are more likely to be infected by a single act of intercourse with a partner who is infected by a sexually transmitted infection. "Women's social vulnerability to HIV- the fact that women are likely to have male partners who do not protect themselves from the virus- is heightened by a range of physical factors which make it easier for man to transfer HIV to a woman than vice versa." In the Indian context, there is little doubt that unprotected sexual behaviour on the part of men results in women getting infected with HIV. This has in fact prompted many women's groups in India, to take a stand that marriage may be the greatest risk factor as far as HIV is concerned. In a situation where, the ailments of women- whether major or minor do not attract an adequate response in the male-centred family, the plight of women infected by HIV is added persecution. Among the other tribulations faced by such women are: denial of a share in the family property, vile treatment by colleagues in the workplace and, in some cases, even retrenchment from jobs.

In Conclusion

The government policy has failed to take into account that AIDS has a twofold impact on women. Their familial economy and social lives are shattered. Within this mileu, the lack of information of the real needs of women are some of the reasons why women are totally alienated from accessing government health services. The state government's focus on sex workers, truck drivers and street children as in high risk, ignores persons most vulnerable, i.e. the housewife and the general population. The government insists that HIV/ AIDS is a medical problem and that it has to be countered at the level- the government's planning, programme and implementation all betray this mindset.

The programme needs to recognize the linkages that need to be established to plan and execute programmes that are holistic rather than target oriented. Community owned interventions are sadly missing from the Govt. package. Persons infected and affected HIV does not figure in the new plan. 'High risk groups' are targeted top stop HIV transmission into the larger community. However, there is no mention of the people and the community that are part of this group. They remain just indicators in the formulas that project the 'rate of HIV transmission'.

AIDS seems to directly negate a woman's place in society as well as her rights. The illustrations of women lives reflect the increasing trend in rural areas of using HIV/AIDS as an excuse to deny women their right to property, to their children, to information, to work, to access medical treatment, to alimony. The list will continue to add if an immediate and prompt reassessment of the needs of women infected and affected by HIV/AIDS is not prioritized by both society and the state.

The factors that feed into gender mainstreaming would have to impact the organizational culture at 3 levels.

1. At the policy level to ensure that the issue of gender equality becomes a visible and central concern in conceptualization and planning.

2. At the programme level to ensure that opportunities are created for women's leadership and informed participation at all levels.

3. At the organizational level to ensure that space and opportunities for learning growth and contribution to organizational goals are created and equally by women and men at all levels.

POLICY APPROACHES TO WOMEN AND DEVELOPMENT

A brief understanding of WAD and GAD

Since the 1950s the issue of women in development have reflected different development paradigms and social policies. Their predominant approaches have been identified and critiqued, the understanding of which is crucial to the development alternatives facing us today. Although the three approaches actually overlap in terms of their applicability to different countries at different times, we could identify to a large extent their predominance and relevance with reference to the dominant development models of the time. The ' Women in Development' approach coincided with the seventies, the ' Women And Development' with the eighties and the ' Gender and Development' approach, although conceptualized long before, actually came into applicability in projects only in the nineties.

The WID approach started emerging at the time of restructuring economies in the Third World nations, when many of them were involved in the struggle for independence. There were changes in the development policies in many nations. Focus was on modernization, industrialization and rapid technologization of the agrarian sectors to the industrial sectors. The belief was that this would enable the growth of the third world economies. The trickle down theory assumed that the benefits of development would also equally benefit men and women both. By the late 60's this modernization theory was subject to criticism from many quarters. In the 70's three books written by women provided an alternative framework for analysing the issue of women and development:

- " Women's role in Economic Development" by Esther Bosrup (1970)

- " Adverse Impact of Development On Women" by Irene Tinker (1976)
- " Domestication of Women – Discrimination in Developing Countries" by Barbara Rogers.

Esther Boseup's work in Africa on Women's role in Economic Development (1970) was seen as a landmark feminist critique of development policies. Boserup looked at the agricultural sector, primarily female farming patterns in **Africa and Asia** to show that while women's reproductive roles were the same across countries and cultures, their productive roles differed. New technology actually lowered women's status by reducing their access to productive work. During the colonial period and afterwards women were increasingly relegated to the traditional sectors and to subsistence economy, as men were favored for employment in the modern sector for cash crops and wage jobs. She emphasised on the importance of drawing women into the modern sector by providing them with education and skills.

The critique of the dominant development model was that it was mainly misinformed and misguided planning based on data that was clearly biased against women. (In fact, in the Indian context, we know in the state of Rajasthan and Haryana, where girls are often not mentioned in the census.)

Irene Tinker focused upon the invisibility of women's work, saying that policies were not reflecting women as producers. They saw them only as beneficiaries and reinforced their traditional roles. She also stated that they implied the imposition of western models and western stereotypes of family structures, which did not reflect a society where relationships were differently structured.

Barbara Rogers critiqued the dominant perception of women as irrational and trapped in culture and tradition. Since male planners saw women as incapable, they left them out of the development process. She emphasised the need for integrating women into the development issues. This approach of integrating women into development was termed as WID.

Between the 50s and 70s there was a 'Basic Needs Fulfillment" approach, more in the Socialist Welfare mode. There was a belief in individuals' capacity to better their lives and

the creation of opportunities was considered an important support function. Women were looked as a homogenous category, chiefly as mothers and wives. Institutions like Mahila Mandals and Yuvak Mandals working on block or community development were set up. Projects for women revolved around mother and child progamme, e.g., ICDS.

The seventy was the UN decade of Women, a report on the Status of Women was brought out and a WID lobby was formed in the US. They actively ensured the passing of the Percy Amendment to the US Foreign Assistance Act, and ensured foreign aid to assist women in development. A lot of international, regional and national WID agencies came up in India. In the 1970s other policy approaches welfare, anti-poverty, equity and efficiency followed. These approaches emphasised that women should be seen as equal to men and should be supported through training and skill building in the public sphere. It challenged sexual division of labour, recognizing women's work within the household and outside and on recognizing women's needs and interests. They focused on income generation.

Some of the weaknesses of the WID approach highlighted were that

- It was rooted in liberal feminism and attempted to create a space for women with in the existing framework, and counteract its adverse impact without really questioning it.
- There was exclusive focus on women as a homogenous category, negating the reality of multilayered oppressions at the level of caste, race, class, marriage, singleness, religion etc.
- There was emphasis on equity strategies.
- There was focus on "poor women".
- Not enough looking structures of inequality and the subsequent load on women's work.
- Elasticity of women's time was taken as leisure time.
- No strategic alliances to dismantle subordination.

In the late 70's thorough examination of the roots of women's subordination was done, through an analysis of global capitalism combined with patriarchy. Concepts of reproductive labour, unpaid work, sexual division of labour, role of household and the gender relations within in, the links between household as an economic unit and the global economy emerged.

WAD

This is essentially based in the socialist feminist perspective, which recognized the existence of inequalities base on class and gender that mediated development planning. It came with the recognition that capitalist development while not excluding women used them in particular ways, exploiting their productive and reproductive capacities, and to combat it, it was seen that all structures of domination need to be challenged. The important aspects of women's development at this time were that a number of feminist groups came up that questioned and attempted to redefine developmental processes, there was an attempt to include women in the processes of development.

The third world perspective put forth by DAWN (Development Alternative for Women in the New Era), at the Nairobi Conference on women focused upon debt crisis, expenditure on miniaturization, equity in international political and economic systems, redistribution of global resources between and within societies, women's struggles against violence, the population debate and self-reliance/empowerment of women.

In the 1980s there was a critique of the neo-liberal policies – that the policies were top-down, that women were seen as homogenous category, differences between them were being ignored and they were being seen as passive agents of development. Also, most literature was seen as ethnocentric avoiding thorny issues such as power and how knowledge and hierarchies of knowledge are constructed within development discourse.

The critiques of the WAD approach highlighted that –

- Class contradiction was seen as primary, gender as secondary, and there was still a need to challenge hierarchies within this. This implied that it looked to challenge class hierarchies first then gender.
- Since it was not looking at the world economy as a whole, it did not examine and question the gap between the first and third world or attempt to bridge it.
- Feminist processes are complex, multi-layered transformative practices focusing on struggles within the development processes, and it is difficult to put a framework on it.

- The patchwork approach of adding women to an already defined development framework was no longer acceptable.

The shift to empowerment approach acknowledged differences between women and looked for long term structural changes, it look for a transformative politics which would integrate gender concerns from the very beginning and eliminate inequalities based on class, gender, race and focusing around strategic gender interests. Thus the conceptual shift from women to gender.

GAD

The concept of gender was to distinguish between biological differences and socially constructed inequality while the concept of gender relations sought to shift attention away from looking at women and men as isolated categories to looking at social relations through which they were mutually constituted as unequal social categories.

Gender relations are an aspect of broader social relations and like all others constituted through the rules, norms, procedures and practices through which resources are allocated, tasks and responsibilities are assigned, value is given and power is mobilized. It recognises the interlocking of gender relationships to class, caste, and gender within the context of multiple identities of women and men. It sees gender relationships in conjunction with other social, political, cultural and economic systems of domination. It looks at the totality of men and women's lives rather than the productive sphere. Women's own agency and capability for change should be recognised and they should be included as active subjects of development. The GAD approach identifies areas of resistance, rigidity, areas of flexibility and opportunity and alliances with individuals and organizations.

In 1989 Caroline Moser, provided a framework for planners, incorporating the idea of women's practical and strategic needs. Practical needs are basic, immediate or short term needs arising out of the condition of women. They are of the level of material changes. Strategic needs arise from the disadvantaged , subordinated position and status of women and require long term changes, not only in policies and programms, but in ideologies. GAD sees the household as the basic unit where changes need to be effected and brings the

personal into the public sphere. It also talks of strategic programmes to visiblise the subordination of women so that men and women are to understand the whole notion of justice and dignity for women.

In looking at long term structural and ideological change, we then looked at the question of technology. Technology has a material basis for development, which is the dominant thinking, coming from an ideological base that devalues women, it was not surprising that almost all technology goes against the interest of women and contributes to enhance the discrimination against them. Thus technology is in fact fraught with inequality and creates disadvantages for the already marginalized groups.

The critique of the GAD approach:

It is said to be an instrumentalist approach, which did not challenge market paradigms or State. It does not acknowledge new forms of patriarchy. Feminists have also critiqued the GAD approach, contending that terms like 'gender violence instead of 'sexual violence' dilutes and de-politicizes the struggle against patriarchal ideology e.g. religion is not challenged in this process. Gender training does not touch the personal and tends to be patronizing at times.

Sustainable development

Effects and experiences of current development

- Unemployment, Labour lost due to mechanisation.
- Marginalisation of women and unskilled workers due to lack of know how with modern technology, and incapability to compute with modernisation techniques, and modern markets.
- Homogenising markets and sinking identity.

- Displacement due to development projects – the displacement due to development is seen to be far more significant compared to the massive displacement at the time of India's partition.

- Increase in societal malpractice's where there were none earlier- for example dowry is now demanded in many communities where it was not, this was attributed to increasing consumerism.

- Increasing crime rate and violence against women.

- Increasing depletion of resources, decline in gathered items from the forests and village commons reduces income directly. There is also decline in access to fodder and fuel.

- Displacement takes its toll on the social and kinship relationships and supports poor households.

- There is devaluation and marginalization of women's knowledge, and secondly the degradation of natural resources and their appropriation by a minority results in the destruction of the material basis on which women's knowledge of natural resources and processes is founded and kept alive.

- Loss of fertility of land due to increased usage of chemical fertilizers – disruption of the ecological balance.

- Increasing dependence of the people on the government and on NGOs.

- Increased shift from subsistence farming to cash crops increasing dependence on the markets. Markets are no longer in our own hands due to globalization.

More than 50% villages have no access to safe drinking water but 90% villages have access to Coca-Cola. We have more illiterates now than we had at the time of independence. The incidence of anemia, night blindness is higher today than ever before.

If we look at some statistics at the global level, we find that 20% of the humankind residing in the North controls –

81.2% of world trade	82.7% of world GNP
80.5% domestic investment	80.6% of domestic savings
94% of all research & development	

Thus the current development paradigm breeds inequality is voiceless, ruthless, rootless. It is also futureless. Its characteristics are –

- It is GNP profit and material oriented not welfare oriented. In spite of the obsession for production, there is not enough to go around.
- Human beings are considered superior to nature and nature is used for their benefit resulting in ecological disasters.
- Nature is marginalized in the process. It is aptly called the 'rape and run' economy.
- 50% of the people are not consulted or considered central in this process. The marginalization of women is therefore evident.
- It leads to centralization of resources with the control shifting from the communities to a few people and hence it is an economically unjust development paradigm.
- It forces the homogenization of cultures, foods, lifestyle, and agriculture.
- If some people control resources and majority is without control violence becomes necessary, this cannot be achieved without coercion.

If this is not sustainable development then what is?

The model of sustainable development that we are looking for would be –

- Oriented towards human beings not profit.
- Emphasis on inner growth and inner satisfaction.
- Human beings and nature are in harmony with each other.
- There will be centrality of women in this paradigm of development.
- Decentralization of decisions and resource to the grass root level – the local people get to decide how to use their resource and how to distribute them.
- Partnership model rather than dominator model – based on love nurturing and caring.

A last word to women –

Here' s what you could do....

- Enjoy yourself, become human, sing, dance and laugh.
- Make another women happy.
- Practice democracy, decentralize decisions and do not allow dictatorship.
- Be ecological.
- Consume sparingly.
- Validate sustainable knowledge like ayruved, homeopathy, save seeds and use them.
- Link up with people movements.

The situation of sex workers in Japan

Nozomi Mizushima
SWASH (Sex Work and Sexual Health)

SWASH (Sex Work and Sexual Health) is an organization which strives for safer working environment for sex workers in Japan. In particular, SWASH is focusing on health issues related to sexual service such as STD (including HIV) and birth control. Sex workers here had been object of research but had difficulty having their own voice heard. In the current situation in which prostitution is a crime, sex work is kept underground. Therefore, it is difficult to grasp the working situation in which some workers become victims of violence and STD. Also, it is difficult to start action to change the situation. We try to understand the current situation from the workers' point of view and to make more realistic change, such as reduction of STD and violence against workers including sexual violence.

1) Constitution of sex industry and classification of the business contents

The works the female sex workers in Japan do can be divided into vaginal intercourse and non-vaginal intercourse. The great variation of non v-p intercourse is unparalleled in the world. As there is little social recognition of these variations works, it is difficult to get realistic picture of each working situation related to HIV/STD infection. These variations came about as a result of the legal definition of sexual intercourse in Japan, which defines sex as a penis penetrating a vagina. Business transaction of thus defined sexual intercourse is forbidden by law. In other words, sexual activities other than thus defined male-female intercourse are not considered legally as sexual intercourse and so those who conduct business transaction of these activities have no legal responsibility.

Because of this, TGSW and male sex workers as well as female sex workers who are engaged in the non v-p intercourse type work less socially recognizable and the preventive measures depend on themselves and their customers.

Here, we first try to give a summary of the contents and business practices of the whole sex industry and then clarify the problems of each particular types of works.

Fig. 1 Constitution of sex industry in Japan (female SW)
Fig. 2 Constitution of sex industry in Japan (Trans gender SW)
Fig. 3 Constitution of sex industry in Japan (male SW)

Object: sex industry in which female/TG/male SWs engage

Methods: We classified Japanese sex industry in two: Vagina-to-penis intercourse industry and non v-to-p industry in relation to the target practices of preventive medicine. "Designations" are in accordance to laws and police white paper. Some of the "Common names" differ in various areas. "Numbers of the shops" are ones registered to the area's public safety committees. The business practice which are designated as target practice by preventive medicine are:

(A) (non v-to-p intercourse) deep kiss, body licking, fellatio, mutual stimulation of sexual organs with hands, hand job, fake intercourse (stimulation to penis with thighs), cunnilingus, ejaculation in mouth or onto the face, stimulation of anus with hands, rimming (licking anus), penetration of penis into anus, mutual stimulation to sexual organs (or anus) with sex toys and other utensils,
(B) (vaginal intercourse) vaginal sexual intercourse
(C) (SM business practice) consumption of urine and excrement, play which induces blood, medical play using catheter, enema, etc.

Consideration: "Number of shops" are registered numbers. However, there are many more unregistered shops. The reasons for that can be of tax evasion or outside of business permission area etc. Also, SWs of each shop move irregularly. Because of these reasons, it is difficult to determine the exact number of shops and SWs. By conducting more in depth research of each particular type of work and area, we expect to get each area's particular problems and common problems throughout the industry.

In sex industry, there are certain number of male and TS/TG SWs (＊1). There are also quite a few foreign SWs. In this paper, the term SW includes all of above mentioned, but this particular research focused on those types of business in which female SWs are engaged.

Other types of SWs will be the subject in the future. Also, the sex industry consists of not just SWs but basically of SW plus management and customers. It is necessary to research and educate management and customers.

(＊1 : TS/trans sexual; those who had sex change or who want to have sex change. TG/trans gender; those who feel alienation to one's own gender)

2) HIV/STD-related knowledge and prevention among sex workers working in non vaginal-intercourse sector of sex industry in Japan

Objective: Sex industry, which does not involve vaginal intercourse, is quite common in Japan because of the law which prohibits women to prostitute by vaginal intercourse. Though sex work is basically legal unless it involves vaginal intercourse, little is known about the working condition of sex workers in this sector especially those that potentially put them at risk for HIV/STD infection. We conducted questionnaire survey for sex workers working at the "Fashion Health" establishments, a typical nonvaginal-intercourse sector in Japan to know their knowledge, attitude and behavior on STDs and their needs for HIV/STDs prevention.

Methodology: Self-administered questionnaire was distributed to ten "Fashion Health" establishments in Tokyo and ninety-five sex workers responded (response rate=38%). The questionnaire was developed by SWASH (Sex Work and Sexual Health). SWASH is a Community Based Organization consisted of sex workers and supporters in cooperation with epidemiologists.

Results: Compared to the recent results of the nationwide KAP survey in Japan, the rate of correct response to basic questioned on HIV/STDs was generally high among sex workers. Regarding condom use, many of them (68.4%) expressed the desire to use condom during fellatio which was the main service in their work, while the actual condom usage rate was quite law with 29.5% responded "occasionally" and 70.5% "never". The main reasons for non-condom use were; "policies of the enterprise they work for " (92.6%), "easy to perform the sexual service" (29.8%) and "demand from customers" (25.5%). The reason why they use condoms were; "demand from customers" (66.0% cut out of 50 respondents who answered occasionally use condoms), "possible STDs symptoms of customers" (46.0%) and

"for STDs prevention" (40.0%). Many respondents answered they need more information on STD prevention (73.6%), and treatment (54.9%) and reliable medical institutions where they can visit for advice (48.4%).

Conclusion: This research preliminary revealed that though the sex workers working in non vaginal-intercourse sector are well aware of the risk for STDs and want to prevent them, they were unable to do so because of the pressure from their employers and customers.

3) our struggle: Sex workers' workshop around HIV/STI alternative prevention

Objective: Identify the problems sex workers have and share the alternative prevention through experimental sharing.

We hold monthly workshop of HIV/STI prevention with sex workers. We have educated ourselves to be facilitators in a way to benefit other workers to become aware of prevention of HIV/STI and to empower them. We reach them by using the networks each staff has. A non-judgmental gynecologist attends it as an adviser. The topics are "the uneasiness and how to make changes", "information about HIV/STI prevention" and so on. As far as now, this is for only female sex workers. Here we introduce to you "how we achieve the abundance of knowledge".

Each participant writes the problems and encounters they have had with their clients and owners in index cards. And we put them on a wall and read them. Each of them talk about how she felt and what she did. Also other participants make suggestions about it when they have alternatives or different experience. We empower them to show the alternatives in a practical way to solve their problems.

- There are many conflicts about condom negotiation in blowjobs and intercourse with their customers. The suggestions are "ignore him with a nice smile", "convince him in a polite way", "indicate the possibility of pregnancy", "find a way to put a condom without him knowing" and "refuse him if he insists on not using a condom".
- There is a hard problem with the owners who make sex workers unable to use condoms in their services. And they feel that they can't change their attitude. The suggestions

are "change the working place?" (But the reality is that almost of the massage parlor owners don't let us use condoms. It's because they lose their customers.) It suggests us that it is necessary for HIV/STI prevention in the sex work industry to change the attitudes of the owners and customers.

Fig.1 Constitution of sex industry in Japan (female sexworker)

Classification	Designation	Numbers of registered shops (1998)	Common names	Business style		Related laws
				The contents of service*	Business area	
Nonvaginal-intercourse sector	Store type fashion health (massage parlor)	863	health, fashion massage, image club, sensual massage, soft SM	A	beds in individual rooms at shops	the Law on Control and Improvement of Amusement and Entertainment Business
	Dispatch type fashion health		delivery health, dispatch massage		hotel, private residence	
	Cabaret and others	4557	pink salon, OO salon, Nuki (ejaculation) cabaret		seats in shops	
Vaginal intercourse sector	Bathhouse with private rooms	1268	soapland	A + B	rooms in shops	
	Restaurant for entertainment		brothel, Chon-no-ma (short time)			Anti-Prostitution Law
	Street		Street worker		hotel, private residence	
	Managed type		(girls wait at restaurants, bars, snack bars and clubs)			
	Dispatching		Hote-toru, date club			
	Self-employed		individual prostitution			
Nonvaginal-intercourse sector	SM club		SM club	A + C	individual rooms in shops, hotel, private residence	the Law on Control and Improvement of Amusement and Entertainment Business
Sex entertainment industry	Strip tease show theater	494	Strip theater (dance, individual service)	A + B + C	theater	
	Adult video (porn video)		Adult video		studio, hotel	

*the contents of service

A: non-vaginal intercourse
fellatio, handjob, deep kiss, ejaculation into mouth or face, rimming, fake-intercource, cunnilingus

B: vaginal intercourse

C: SM industry only
urine and excrement consumption, SM play which induces blood, medical play (catheter, enema etc)

Fig.2 Constitution of sex industry in Japan (trans-gender sexworker excluding FTMTG*)

Classification	Designation		Common names	Business style		Related laws
				The contents of service	Business area	
Nonvaginal-intercourse sector**	Store type fashion health (massage parlor)		"New-Half" helth	A	beds in individual rooms at shops	the Law on Control and Improvement of Amusement and Entertainment Business
	Dispatch type fashion health		"New-Half" helth		hotel, private residence	
	Cabaret and others		"New-Half" salon, bar		seats in shops	
	Bathhouse with private rooms		"New-Half" soap		individual rooms in shops	
		Street	Street worker		hotel, private residence	
		Managed type	(workers wait at restaurants, bars, snack bars and clubs)			
		Dispatchin g	Hote-toru, date club			
		Self-employed	individual prostitution			
	SM club		SM club	A + C	individual rooms in shops, hotel, private residence	
Sex entertainment industry	Strip tease show theater		Strip theater (dance, individual service)		theater	
	Adult video (porn video)		Adult video		studio, hotel	

* FTMTG: Female to male trans-gender

** It is very difficult to distinguish between "non-vaginal" and "vaginal" sector

Fig.3 Constitution of sex industry in Japan (male sexworker)

Classification	Designation		Common names	Business style		Related laws
				The contents of service	Business area	
Sex industry for male customers			massage	a part of A	shop, hotel, private residence	the Law on Control and Improvement of Amusement and Entertainment Business
			"Osawari"-bar	a part of A	seats in shops	
		Street	Street worker, "Tachinbo"	A	hotel, private residence	
		Managed type	"Urisen"-bar		hotel, private residence	
		Dispatching	Dispatch-type host			
		Self-employed			hotel, private residence	
	SM club		SM club	A + C	beds in individual rooms at shops, hotel, private residence	
Sex industry for female customers	Dispatch type		Dispatch-type host	A + B (+ C)	hotel, private residence, and others	
Sex entertainment industry	Strip tease show theater		Strip theater (dance, individual service)	A + B + C	theater	
	Adult video (porn video)		Adult video		studio, hotel	

Laos

Report on HIV/AIDS in the Country of Lao PDR

Soulany Chansey
Lao Red Cross

Introduction

Lao PDR stands in a unique position among Asian countries confronting HIV. The country continues to experience low HIV prevalence even among populations deemed to be at high risk of acquiring the virus, while it shares its borders in with countries which are battling HIV in epidemic proportions, especially Thailand, Cambodia and Myanmar. Lao PDR is at the preliminary stage of a potential epidemic and the implications for the country could be enormous. As trade and new land routes open up into neighboring countries, the prospect of HIV being introduced through migrating and mobile populations in Lao PDR is increasing. Communities previously isolated to both the virus and HIV intervention efforts would be vulnerable to its spread. The National Committee for the Control of AIDS Bureau in Lao PDR (NCCA) and its partnering governmental, non-governmental, and international organizations, recognize this susceptibility and have taken steps to increase both surveillance and intervention programs in an attempt to avert an HIV/AIDS epidemic in the country.

As of the year 2000, in ten reporting provinces, 717 people have tested HIV positive out of 61,130 blood samples tested. There have been 190 reported AIDS cases and 72 people have died of AIDS. The provinces reporting the highest number of people testing positive for HIV are Savannakhet, Vientiane Municipality and Champasak. The number of HIV cases in these provinces in 1999 and 2000 was 125/ 78 and 34 respectively. The majority of people with HIV are males aged 20-29 and the primary mode of transmission is through heterosexual intercourse. Case reports from Savannakhet indicate, that most patients requesting HIV tests at their facilities are male seasonal migrant workers to Thailand, who are already displaying opportunistic infections associated with AIDS. The second most

populous group testing positive in Savannakhet have been women who exchange sex for money.

In 1997, the Ministry of Health attempted to institute an HIV sentinel surveillance program to develop a clearer picture of HIV and its prevalence in Lao PDR, instead of responding to case reports. After completion of two of the four target provinces, the surveillance was aborted. Other smaller studies of HIV prevalence in specific target populations have been conducted, but a large scale study of HIV prevalence and the behaviors leading to its spread, was still lacking in Lao PDR. At the recommendation of the NCCA, non-governmental and international organizations working in HIV/AIDS, it was decided that the rapid implementation of a second generation HIV surveillance system, studying HIV-related risk behavior and the prevalence of HIV and other sexually transmitted infections, was mandatory for understanding and combating HIV in Lao PDR.

The behavioral surveillance survey (BSS) was conducted in 2000-2001 by the NCCA in partnership with Family Health International (FHI), the Office of the Population Technical Assistance team (OPTA) and five Provincial Committees for the Control of AIDS (PCCA) including Luang Prabang, Vientiane Municipality, Khammuane, Savanakhet and Champasak. Using standardized and country specific indications, the BSS measured behavioral practices that could influence the transmission of HIV and enables researchers to track these behavioral trends over time. The second important step in this combined surveillance project in the HIV Sentinel Surveillance (HSS) and STD Periodic Prevalence Survey (SPPS) was conducted in Lao PDR and coordinated by the NCCA with FHI the Lao PDR HIV/AIDS Trust, WHO, CHASPPAR and the EU/STD Project. The biological markers of HIV prevalence studied in the HSS:SPPS in combination with the behavioral data collected in the BSS, will provide important information to help understand the relationship between behavior and infection and allow interventions to be targeted in the most productive and cost effective ways.

A national second generation surveillance program was conducted in June 2001 to survey the prevalence of HIV/AIDS, as well as STIs and risk behavior. First results are available now from the National Committee for the Control of Aids Bureau, Ministry of Health Lao PDR. Based on these results, planning for future intervention will be more accurate and

responsive to the current reality. This knowledge will also serve as a critical tool to inform local decision-markers, the general public and the international community, of the true extent and nature of the epidemic in Lao PDR.

Efforts of national and international partners over recent years have seen a major increase in awareness of HIV/AIDS/STIs among the general population and behavior is changing. This is evidenced by the significant increase in condom use, even among the most vulnerable groups. With heterosexual intercourse being the primary mode of transmission, sex workers and mobile populations such as migrant workers, drivers, businessmen and youth are the most vulnerable groups. These have direct links with the general population. Activities such as peer education, life skills training and other behavior changing activities are already targeting these groups.

A special feature of HIV/AIDS work in Lao PDR is its multi-sectoral approach. This is critical to the success of prevention work and all are committed to further strengthening the skills and co-operation required. This work includes advocacy in a variety of sectors and levels of leadership. Advocacy is the key to ensuring that Lao PDR remains a low prevalence country. Both nationally and internationally it must be emphasized, that low prevalence does not mean low threat. In reality, Lao PDR is currently perceived as having more urgent health problems. It is therefore important to convince people that a presently invisible virus that has the potential to kill many people in the future, requires the same attention and resources as other health issues including malaria and curable illnesses such as diarrhea, which are killing people today. More than this, there must be recognition that HIV/AIDS is not simply an individual health issue, as everyone must take responsibility. The timing is also critical before costs of the national response to HIV/AIDS rise as local capacity and activities are forced to be stepped up, and as more care and support is required. More resources need to be allocated to combat HIV/AIDS, but also more co-operation is needed with other health programs such as those for the prevention of malaria and tuberculosis, to increase efficiency and effectiveness and to recognize real linkages. The message of this year's profile is that now is the best time to respond to the HIV/AIDS epidemic in Lao PDR. Never again will there be the opportunity to potentially save many lives with a minimum of resources. Many dedicated individuals and organizations are already working to ensure that

Lao PDR can continue to develop without the crippling threat and reality of AIDS. Together we can stop AIDS in Laos.

Background Information

Geography

The Lao People's Democratic Republic (Lao PDR) is a landlocked country surrounded by five neighbors: Myanmar and Yunnan Province of the People's Republic of China in the north, Vietnam in the east, Cambodia in the south and Thailand to the west. The country covers 236,800 square kilometers. The landscape is mostly mountainous especially in the north and east. The Mekong River crosses the country and runs over 1,000 km along the border with Thailand, with the Mekong plains providing the most fertile land and supporting the majority of the population.

Population and mobility

There has been a significant increase in domestic and cross-border population movement to neighboring countries with high HIV prevalence. Mobile populations are found to be vulnerable to HIV infection due to the greater likelihood of being engaged in at risk behavior when outside their normal social environments and have therefore been targeted for prevention work in Lao PDR. A key focus group is young adults from rural areas seeking work in urban semi-urban centers and increasingly abroad, especially in Thailand. Foreign labors, especially from China and Vietnam have been increasing in recent years, due to many infrastructure projects where a large labour force is needed. Other mobile populations in Lao PDR include traveling business people and government officials, military, police, as well as truck drivers and construction workers. Increasing numbers of report are being received of sex workers who move between provinces in the hope of attracting more customers, or of avoiding authorities. The growing number of tourists visiting Lao PDR also has the potential to increase the demand for sex services, particularly if Laos is perceived to be a low prevalence country.

Literacy and education

The population's literacy and education are crucial factors in facilitating HIV/AIDS prevention work. A literate person with some degree of education, is more likely to learn

about HIV/AIDS through some source of media, than a non-educated person. Furthermore, education has an empowering influence on individuals, enabling one to have access to greater opportunities and make better choices in life.

In Lao PDR adult literacy has risen during the past five years. The 1995 the literacy rate of the population above 15 years, was 60% and in 2000, 70%. Literacy was higher for men at 82% compared to 59% for women. The primary school enrolment rate was 73% for boys and 68% for girls in 2000. In addition to gender disparities, there are remarkable regional, urban/rural and ethnic variations in literacy as well as in access to educational services. There is one national university in Lao PDR with under-graduate courses available.

Health situation in Laos

The health status of Lao PDR is characterized by high mortality rates, low life expectancy and a high population growth rate. Malaria is the leading cause of mortality in Lao PRD with an estimated 1.4 million cases per year resulting in 14,000 deaths. The leading causes of morbidity in children under five are common communicable diseases such as acute respiratory infection (ARI), diarrhea and malaria. The main causes of child deaths are malaria, ARI, diseases and epidemics such as dengue fever, measles and meningitis. Surveillance for most infectious diseases is currently inadequate for several reasons, including the lack of guidelines for case definitions, lack of trained staff and facilities and current health-seeking behavior, such as self-medication. Compared to other under-developed countries, Lao PDR is average on most measures, but considerably lower than the average of all developing countries.

HIV/AIDS still has a low prevalence in Lao PDR. There are signs that the rate is slowly increasing. To maintain low rates, Lao PDR has already taken prompt action to combat the disease. As mentioned in the introduction, HIV/AIDS has links with other diseases, such as tuberculosis and malaria. However at this point in time, the HIV-status of most people with such illnesses is rarely known and the two are rarely linked.

HIV/AIDS Situation

Background to HIV/AIDS in Lao PDR

The Lao PDR is bordered by countries that have a higher prevalence of HIV/AIDS. The Lao PDR may have less HIV/AIDS than its neighbors because of:

1. cultural values which emphasize monogamy and faithfulness
2. a history of relatively less internal and external travel and migration,
3. illegal injecting drug use is rare,
4. commercial sex establishments or brothels are rare or non-existent,
5. those with multiple sexual partners have relatively fewer partners than in some other countries, and
6. actions taken to prevent HIV transmission, such as condom promotion and health education, may have decreased unsafe sexual behavior.

Although HIV seroprevalence in the Lao PDR is currently low, it is at risk of an increase in HIV/AIDS transmission in the future. Risk factors include:

1. proximity to countries with higher prevalence of HIV/AIDS
2. increasing socio-economic development
3. increasing travel and migration, both internal and external
4. the existence of poverty and low living standards, which have been shown to be associated with an increase in risk behaviors
5. increase in the use of illicit drugs and the regular use of alcohol
6. increase in risky sexual behaviors including having more than one sexual partner
7. poor access to effective STD treatment
8. relatively low awareness about the existence, causes and prevention of HIV/AIDS in some segments of the Lao population
9. poor implementation of universal precautions against HIV/AIDS transmission in health facilities and
10. poor implementation of universal screening for HIV of blood transfusions or blood products before use.

Epidemiological Situation

In Lao PDR the first person with HIV was reported in 1990 and the first person with AIDS in 1992. As of 31 December 2000 the cumulative number of people reported with HIV was 717 of which 190 had progressed to AIDS with 72 AIDS-related deaths recorded. This includes 213 new cases in 2000 (155 men and 58 women) from 4,909 tests (3,571 men, 1,338 women). If we are to take these results as indicative of the national situation, Lao PDR would have a prevalence rate of 0.04%. Health information systems are incomplete and there is probably underreporting. Second generation sentinel surveillance studies done in 2001 have shown an HIV seroprevalence of 0.75% among female sex workers in the entertainment industry in Vientiane and two provincial capitals. Seroprevalence in a sample of long distance truck drivers and female factory workers was 0%.

Of the total number of recorded HIV cases 61% are male and 32% female with the remainder unknown. The most affected age group has been 20-29 year olds (54%) , followed by 30 to 39 year olds (36%), most of whom are reported to be male. The estimated geographic distribution of HIV/AIDS is 35% in Vientiane Municipality, 50% in Savannakhet Province and 15% in the other provincial centers. Of new cases reported in 2000 the largest number was recorded in Vientiane Municipality (54 cases), followed closely by Savannakhet (50 cases). It is worth noting, that these figures should be considered in terms of the current means of testing in Lao PDR. For example only ten of the country's eighteen provinces have testing facilities and in some cases the tests that are conducted are taken from low-risk groups. It is therefore generally assumed that current figures under-report the true extent of HIV in the country. Although it is also true to say that the increasing number of positive cases can be attributed to both the spread of HIV, as well as more tests being conducted.

Women and HIV/AIDS

Women in Lao PDR are generally considered to be particularly vulnerable to HIV/AIDS, not least because of their low literacy, education and health status, often resulting in a general lack of knowledge about sex, STIs and HIV/AIDS. While official figures show women's HIV rates are currently lower than men's, it is also true that considerably fewer women than men are tested. In 2000 for example, only 1,338 women were tested, compared to 3,571 men (see table 3.2 on p.14).

Lao culture dictates that women will engage in neither pre nor extra-marital sex, however HIV/AIDS and particularly other STI rates are increasing among women, although they are still lower than men. For many women, negotiating condom use with a male partner, whether he is a husband or boyfriend, can be extremely difficult, and is often not broached. This further increases the vulnerability of women, particularly if their partners have other partners. One group of women in Lao PDR perceived to be vulnerable to HIV, are housewives, whose husbands visit sex workers, or who have a mia noi (little wife). This increases the risk of infections and transmitting them further. Due to the perception that Lao is a low-prevalence country, Lao girls and women are targeted by the sex industry, generally in neighboring countries.

Female Factory Workers **(Vientiane Municipality)**

The factory workers selected for this study were all women working in small to large garment factories in Vientiane Municipality and living in dormitories either on the factory grounds or nearby. These women were considered internal (domestic) migrants because a majority had left their homes and families to seek work in the city. A majority of the garment works in Vientiane were women below the age of 20. The factory-owned dormitories had strict regulations and curfews, usually 10:00 pm. If women were not back in the dormitories by the time of curfew, they were not allowed to enter and had to spend the night off grounds.

Service Women **(Women providing a service for men)**

(Vientiane Municipality and Luang Prabang, Khammuane, Savannakhet and Champasak Provinces).

Formal, brothel-based sex work is rare in Laos, and prostitution is illegal. Defining and identifying women who sell sex for money in Lao can be particularly difficult. Women working in small drink shops and nightclubs may engage in commercial sex transactions, but their employment in these venues does not automatically signify that they are selling sex, as opposed to just serving beer or having conversations with their customers. To develop a better understanding of the behavioral risks of service women, the study did not screen participants to find out whether they were commercial sex workers. Instead, all women who worked in these establishments and had direct contact with the patrons, whether by selling them drinks or sitting with them, were defined as service women. For this reason, the term commercial sex workers cannot be used to fit this population.

As previously described, service women are not necessarily selling sex for money, but because of the nature of their jobs, they are more likely to have greater opportunity to engage in commercial sex work, than women who do not work directly with customers in drinking establishments. 84.1% of the relatively young population said that they had sex, and three-quarters of the service women had sex in the past 12 months. Eighteen percent had a regular partner in the past 12 months. Five percent of the service women reported that they were currently married, so it is likely that a majority of the regular partners of the service women are not spouses. One-quarter of the service women said they had a non-regular partner in the past year, and almost two-thirds reported that they had sold sex for money in the past 12 months.

One aspect of increased risk of acquiring HIV for commercial sex workers is the frequency of clients over a specific time period. Of the service women who had commercial sex in the past year, almost all reported having only one client on the last day worked, 2.9% had two clients, and less than 2% had 3 or more clients.

Over 50% of the service women that had sex with a non-regular partner in the past 12 months had used a condom during their last sexual contact; while 43.7% reported using a condom every time with non-regular partners in the last year.

The vast majority of the service women who had a paying client in the past 12 months said they had used condoms. Ninety-one percent reported that they have a used a condom during their last sexual contact with a client and 72.7% used a condom consistently with all clients in the past month. The male population in the study reported a lower proportion of commercial sexual intercourse protected by condoms. A direct comparison cannot be drawn however, because information regarding where they engaged in commercial sex, the nationality and other characteristics of their commercial sex partners was not gathered.

Factory Workers

Ninety percent of the factory workers living in dormitories in Vientiane Municipality reported that they have never had sexual intercourse. Of all the factory workers, 3.8% had sex with a regular partner and 2.2 % had sex with a non-regular partner in the past year. Slightly more than half of the female seasonal migrant workers reported that they had never had sex.

Forty-one percent of them said they had sex with a regular partner and 2.8% with a non-regular partner.

Social, Political Behavioral and Education Aspects

Political

The Lao PRD constructs its HIV/AIDS/STD policy and control activities on the following universal principles:

- non-discrimination
- a multicultural, integrated approach
- voluntary approaches with informed consent
- confidentiality and privacy in counseling, testing and care.
- empowerment of individuals to take personal responsibility
- gender equity
- accessibility to affordable and acceptable services
- reduction of risk for vulnerable individuals and community groups, and involvement in decision making of those with and affected by HIV/AIDS.

The Lao PDR HIV/AIDS policy has three sections which are:

1. prevention of HIV infection
2. care and support for those infected and affected and
3. mitigation of the adverse impact of HIV/AIDS on the social and economic development of individuals and the nation.

The Lao PDR will concentrate its efforts on prevention. Planning and preparation must be done for care and mitigation, but with success in prevention, care and mitigation will remain of relatively smaller needs. As the main method of acquiring HIV is through unsafe sexual behavior, promotion of safer sexual behavior is the core strategy for HIV/AIDS/STD control. The promotion of safer sexual behavior includes:

1. Encouragement of sexual abstinence until marriage
2. Encouragement of fidelity within marriage
3. Encouragement of the use of condoms in situations where abstinence or faithfulness are not certain, including making condoms widely available.

Effective HIV/AIDS/STD prevention requires clear and frank messages about sexuality that take into account the cultural and societal values of the Lao PDR without compromising clarity. All forms of media are appropriate for the dissemination of HIV/AIDS/STD messages.

Social and behavioral aspects

The term gai long (literally lost chicken) is used to specifically refer to a woman who one does not plan to sleep with. For example in one conversation, a man said: "I can't restrain myself, a gai long comes along and I can't stop myself. If I am drunk and a pretty woman comes, I won't use a condom that would be a waste". Mirroring patterns in other Asian countries where women commonly depict sexuality using male standards, Lao women repeat the same explanation, 'sometimes our husbands don't always intend to sleep with other women. They just end up in this situation'.

Because sex is not always a foregone conclusion, the notion is cultivated that somehow it is out of the man's hands if by chance a young woman will sleep with him. The onus of the occasion implies one must make the most of the moment, forget any thought of the implications. This constructed narrative for sexual experience greatly denies forethought about the sexual implications and the need for precautionary practices. The denial of personal responsibility is abetted by a social system that on the one hand makes women's intimacy available in restaurants and bars and on the other, maintains a veil over such activities through active suppression. Moreover in so doing the motivation to use condoms is greatly lessened despite the increasing awareness of HIV as a personal threat.

Awareness and knowledge about HIV/AIDS/STIs

Planning effective prevention campaigns needs to research "what and how much" people know about HIV/AIDS. In Lao PDR, recent efforts have provided valuable information in this regard. It appears that awareness and knowledge about HIV/AIDS, especially among target groups has increased. However for many remote areas access to the means of gaining information is limited. Recent studies carried out in Lao PDR confirm that educated people and those in urban areas where there is higher literacy and greater access to information and mass media have greater knowledge of HIV/AIDS. Gender-based and regional patterns also appear, with males appearing to have more knowledge of HIV/AIDS than females and those in the central region of Lao PDR are more aware than in the north and south. This

implies, that still more effort is needed to reach out to rural and remote areas particularly those with different ethnic minorities, who need to be catered for.

According to the Reproductive Health Survey 2000, 31% of women had never heard of HIV/AIDS (urban 7% rural 36%) 48% had never heard of STIs/RTIs (urban 20%, rural 55%). Of those who had heard about HIV/AIDS, awareness of different modes of transmission was as follows: sexual intercourse 64%, blood transfusion 35%, injection 46%, and mother to child 15%. Urban and educated women had more knowledge of each aspect. Mother to child transmission is clearly the least known mode in every group. Similar results were obtained by the Vientiane Sexual Behavior and Condom Use Survey 1999, and the Adolescent Reproductive Health Survey 2000, with the most recognized mode of transmission being sexual intercourse, with the lowest awareness being of mother-to-child transmission.

In the ARH survey 2000 young people between 15 to 25 were interviewed nation-wide, revealing that 25% had never heard of HIV/AIDS. Young people with some education were twice as likely to have heard about HIV/AIDS. Similarly, urban youth had greater awareness than their rural counterparts (93%vs. 67%), and males were more aware than females (81% vs. 68%). Those in the central region seemed to have much higher knowledge of HIV/AIDS than those in northern and southern regions (86%vs. 65%). For people who had heard about HIV/AIDS the main sources of information were family, relatives and friends (24%), TV (23%), radio (23%), print media (19%) and health workers (7%) (ARHS 2000). In Vientiane Municipality, television was identified by 82% as the main source of information, followed by radio (64%) and newspapers (51%). The majority of respondents in the ARH survey 2000 recognized several ways of preventing HIV/AIDS, such as not being sexually promiscuous (62%), not visiting sex workers (60%), and not sharing needles and syringes (56%). However, the knowledge of condom use as a preventive measure was relatively low (55%). There were also many misconceptions regarding prevention such as taking medicine before sexual intercourse and washing genitals after sexual intercourse. The ARH survey 1999, also reported that several myths about the modes of transmission of STI/HIV and protection still prevail such as transmission through using the same toilet as an infected person and contraceptive pills providing protection against STIs. More research needs to be

conducted to find out how widespread misconceptions are and to ensure they are not being a source of information about HIV/AIDS for 24% of Lao people.

The ARH survey 1999, also reported that the role of education was a crucial factor affecting awareness and knowledge about HIV/AIDS with word of mouth likely to be an important source of information for many in rural areas where formal education is not accessible for everybody. Efforts must be made to harness this form of communication and ensure that it spreads correct information. Peer education and friend telling friend activities are currently being implemented in Lao PDR.

In the HIV Vulnerability and Population Mobility survey 2000, both service women and clients were interviewed in northern and central regions. It was reported that the professional clientele of service women were more aware of AIDS than other women. In the north, knowledge of AIDS was quite absent among service women and the use of condoms was entirely up to the customer. In Vientiane Province service girls were predominantly ethnic Lao with lower than average education. AIDS awareness was higher than in the north, but condom use was inconsistent.

Interestingly, it was found that in the north there appears to be a demand for educated minority girls in the service profession, as a large part of their work is courting and providing company for the clients, in addition to offering sexual services. The study points out that while this can be considered discouraging from the point of view of education, it should be taken as a positive sign for the future of HIV/AIDS education, if the majority of the service girls are literate with some education background.

Sexual behavior

There exists little in-depth formal research information on the sexual behavior and attitudes of people in Lao PDR, especially of the many minority groups. The scant anthropological information that does exist was written some decades ago and is limited. It is usually written as part of larger cultural descriptions. Especially now that rural and remote people are increasingly targeted, understanding their life, customs, beliefs and therefore their resulting behavior is important. Without knowledge of behavior and the attitudes of different

population groups, it is difficult to design programs to meet the needs and perceptions of different people.

Lately, some valuable work has been carried out to fill some of this gap. Recent studies concentrating on sexual attitudes and behavior deal with such issues as sexual activity before marriage, communication about sexual issues, current partnership status in relation to sexual activity with one or multiple sexual partners, sex with service women and pregnancy of unmarried women. Much of this data has been collected with respect to gender, age, education, profession, and rural/urban living environment of the respondent. This knowledge gap is also expected to narrow with the results of the Behavior Sentinel Surveillance work of the NCCAB and its partners.

According to the nation-wide Adolescent Reproductive Health Survey 2000 (ARHS), sexual intercourse before marriage and among unmarried adolescents and youth is still reportedly low, with only 8% reporting ever having sexual intercourse. Most of the first experiences of sexual intercourse were unprotected (79%), among close friends (80%), and took place at home (63%). Male respondents report much more frequent sexual encounters than female respondents (12%vs. 4%). The higher sexual activity of young men compared to young women is reported also in the Vientiane Sexual Behavior and Condom Use Survey 1999 (75%vs.25%). In both surveys it was found that the less educated the young respondent was, the more likely she/he was to engage in early sexual relations (<19 years). Sensitivity of sexual matters shows in communication of these issues, with 67% of adolescents never having discussed sexual matters before marriage with anybody. It appears that young adolescent men do not have sexual relationships with bar girls. In the ARHS survey 2000 only 5% of the male respondents admitted to ever having sex with a bar worker, and among this group were more urban than rural men and more government/private sector workers than students. Compared to these statements by youth, about 70% of the general population interviewed in the Vientiane Sexual Behavior and Condom Use Survey 1999 agreed with the statement that "married men often pay for sex with prostitutes". Also in a focus group discussion with married female Government workers, it was stated that both husband and wife are aware that after drinking it is likely that the husband will visit a sex worker. This issue was confirmed by focus group discussion with male Government workers.

Sexual Activity and Condom Use

Three types of sex partners are looked at in this study. The first, commercial partners, are women whom the respondent paid for sex. "Paying " a sex partner is defined as an exchange of cash for sex. Exchange of non-monetary gifts is not included because it creates a gray area around the division between commercial and non-regular sex partners. Regular partners are defined as either spouses or live-in sex partners. A non-regular partner is anyone who is not a regular or a commercial sex partner. A non-regular partner may be a long term girlfriend of many years or a one time sexual encounter. Such sexual relationships may not preclude multiple sexual partners in the same way that a cohabitating partner might, so all are considered high risk sexual contacts in this study.

Attitudes toward condom and condom use

The access to condoms and related research has made significant progress in recent years. The research on condom use has been dealing with knowledge about condoms both as a means of protection against STIs including HIV, as well as for contraception. The source or knowledge about STIs and HIV, as well as the purchasing place for condoms have been asked, and attitudes and beliefs towards condom use has been another crucial study aspect. The research observed gender, age, rural/urban, professional and educational disparities.

There appears to be a gap between knowledge and practice regarding condom use: what people know and how they apply this knowledge in their lives may diverge considerably. The Baseline Survey of 1999 on Kap regarding STIs in LuangPrabang and Oudomxay Provinces observed the same pattern in all study areas: the percentage of people who knew about condoms was much higher among those who said they had never used one.

In the ARH Survey 1999, it was found that although there is widespread recognition that condoms protect against STIs, there also seems to be an unwillingness to use them. One reason given for not using condoms, was the belief that a man will not have sexual satisfaction if he uses a condom. There seemed to be less awareness about condoms as a means of contraception, and rural men particularly had less knowledge of the dual benefits of condom use.

Reasons for not using condoms were given in the Vientiane Sexual Behavior and Condom Use Survey as trust in partner (40%), lack of availability (27%) and dislike of condoms (13%). More women complained about the lack of availability than men, and men were more likely to have used condoms than women. It appears also that some people, especially men, tend to play with AIDS. They claim to be unafraid of it because we all die someday. Some young people, both men and women, report that young men may not use condoms because it is a challenge to not use protection. Some commercial sex workers commented that young people are most at risk of not using condoms as this group feels the most powerful, healthy, young and untouchable by disease and virus. Alcohol may also be a factor of non-use among young people.

Much good work has been done in promoting condoms in Lao PDR. Since the promotion campaigns started, particularly of Number One condoms by PSI, condoms are increasingly available in many non-traditional outlets such as night clubs and guest houses. Research by PSI and Red Cross also shows that there is more open discussion about safe sex behavior amongst adolescents and between women and men. It may be that much discussion on condoms between men and women is in joke-form but it is already a good start in freeing and relaxing the discussion forum. Comments collected from the work of the Red Cross and PSI demonstrate some current views.

Attitudes to AIDS and condoms

Besides more open discussion, concerns towards condoms are also expressed both by administrators and some sections of the general population, who fear that the promotion of condoms could be interpreted as advocating sex work or sexual promiscuity. The current stigma attached to condom use can be seen in participant responses, where over half the women and men felt that a woman who carries a condom is loose/cheap. Condom use is very strongly associated with commercial sex; therefore many women also feel embarrassed to buy condoms from shops. Related to this, is the common idea that a woman can not ask her partner to use a condom because this implies that she does not trust her partner or that she herself has been unfaithful. This also works the other way round, as men do not dare to introduce using a condom with their wives . They feel embarrassed to buy condoms, as it makes them look like "bad men" who sleep around.

The difficulty of introducing condoms into regular relationships which should be based on mutual love and trust is obvious and recognized. The attitude that condoms are only needed with casual partners is common. The HIV Mobility study reported that professional clientele were more aware of AIDS than service women, and men reported using condoms, which the service women confirmed. However, most of the service women also said that they did not use condoms with their boyfriends. Similar finding are reported in PSI in the Barriers to Condom Use surveys.

Educational Programs

The global record demonstrates the value of the peer education approach to HIV/AIDS prevention. The Red Cross strategy was to develop a program taking into account lessons learned from effective HIV programs regionally and internationally. Initial steps included talking with young people about their knowledge, attitudes, behaviors and practices. The results of this research were analyzed before any activities commenced, and the findings were published to be shared by other groups.

Peer education processes began drawing on the results of the Lao research, use of materials to support behavior change communication (BCC) and the experience of the trained project team in the field. Materials produced to support these processes included a manual, pamphlets, video and flipchart.

Peer education workshops in Bokeo Province were originally held in collaboration with CARE, with project staff from Lao Red Cross and CARE co-facilitating, enabling both organizations to learn from each other. This same strategy was used in Savannakhet in collaboration with Norwegian Church Aid and the Provincial Committee for the Control of AIDS. Formal training in the processes of peer education has been conducted through the Lao Red Cross with spaces made available to other agencies.

Selection of volunteers to assist with training was conducted though local networks. The Lao Red Cross approached authorities and mass organizations from the target districts of each province to provide three or four delegates to attend a one-day, basic HIV/AIDS workshop. Lao Red Cross also provided selection criteria, which included age, gender and availability to conduct workshops. The Lao Red Cross program manager ran these selection

workshops whilst observing the participants in order to select the volunteers with the greatest potential to be good trainers. The peer education workshops take place over two days and try to limit numbers of participants to between 10-15 young people with a definite limit of 20 people. The program has criteria for the selection of participants such as gender-balance or single sex groups and age limits. Project officers who are present at all workshops review trainers' performance continually. A small team always conducts the workshop and to date this has been a method for ensuring some level of quality control.

An issue of major concern for the program has been the limitation of promoting condom use through the peer education program in contexts where affordable, quality condoms are not available. Through partnerships and networks, the program has therefore played a role in helping to establish a condom social marketing program-run by PSI- in Lao PDR. This included hosting a delegate from the National Committee for the Control of AIDS to join with the Lao Red Cross President in visiting the condom social marketing program of PSI in Cambodia. The peer education process is continually being adapted to suit conditions in Lao PDR. There is a standard format for peer education workshops, but this is modified where necessary. Each project team member decides in conjunction with the local authorities what the situation is in the village and the workshop is designed around the needs of the village.

Despite providing criteria for selection of trainers and discussing these with local authorities, there were many instances of people being put up for selection who were older than the specified age of 15-30 years old. This age limit was based on assumptions of what works well. Sometimes the gender criteria of 50% men and 50% women was also disregarded or not well understood.

The program managed to maintain a gender balance among trainers, despite several setbacks. But the age criteria were adjusted to allow for some slightly older trainers. This was discussed and considered within the project team. In a community that venerates age and is less confident or even skeptical of youth in positions of authority, it was considered acceptable to have a mix of ages among trainers. There was a belief that local authorities and young people themselves would find young trainers on their own a less credible source of information. With this in mind the upper age limit was set at 30.

The program eventually concluded that the real peer education was not what took place in the structured workshops, but what happened after these workshops when young people discussed the issues among themselves. The program assumes that young people will decide for themselves how best to conduct this 'real' peer education: in environments and with people that are most suitable to them.

Please note: At present Lao PDR has no research on HIV/AIDS in relation to Violence, Prostitution, Poverty and Labour.

Conclusion

There is a very high likelihood that Lao PDR will experience an HIV epidemic. The epidemic spreads silently because most transmission occurs before people have symptoms, and thus before they know they are infected and before others can tell they are infected. The HIV epidemic is already widespread in all surrounding countries.

Some forms of development will assist a national response to the HIV epidemic. Improved communication infrastructure will enable better provision of information to all people. Improved opportunities for paid work will reduce the need for people to work in the sex industry or to sell illegal drugs. Improved transport infrastructure will make it easier for people to travel to receive or to provide treatment and care. Increased tourism will make it easier for people to talk with foreigners about their experience of the HIV epidemic in other countries.

However, other forms of development may help spread the epidemic. Mass media can promote forms of culture and consumerism which undermine Lao culture, especially amongst young people. Movements of people from rural areas to cities can disrupt families, enhance experience of isolation, and provide sexual or drug using enticement that might otherwise not be available. Increased mobility, even within Lao, takes many workers away from environments with stable relationships and community support. Rushed development of tourism could lead to the forms of sex tourism which are unknown in Lao but widespread in surrounding countries.

Thus, the need for an expanded and more effective national response to the challenges of the HIV epidemic is urgent. This response must include careful consideration of a range of interacting factors which do not currently see HIV as relevant to their areas of expertise and interest.

The NCCA will promote and co-ordinate the national response. Members of The NCCA and other organizations in all sectors and in all provinces, will work as partners to ensure the development of an expanded multi-sectoral response to the HIV epidemic over the next five years. The objectives of the National Committee for Control of Aids will:

- mobilize and support effective multi-sectoral responses
- mobilize and support effective provincial responses
- develop the ability of others to respond to the challenges of the HIV epidemic
- co-ordinate the national response
- enhance the partnership between sectors
- mobilize external support

The NCCA aims to:

- conduct surveillance, social and other research in to HIV developments
- provide special resources for HIV related programs such as condoms, essential drugs, other resources for care and support.
- reduce the prevalence of other STDs.
- provide care and support for people living with HIV and AIDS.
- provide community counseling.
- prevent the spread of HIV though blood transfusion.
- develop innovative responses to the challenges of the HIV epidemic.

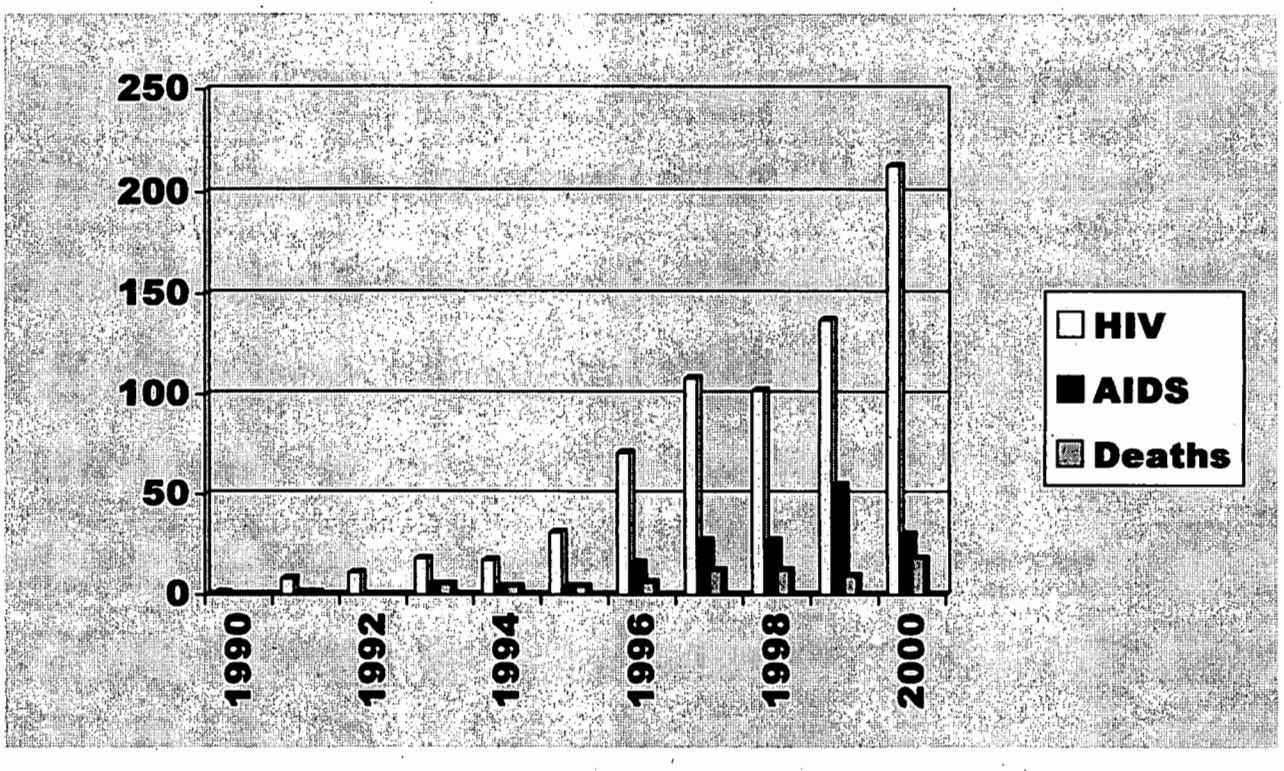
There will be a need for ongoing and flexible development of the National Plan, as the HIV epidemic is not static. Its cause and consequences continue to evolve, in Lao, in Asia and globally.

Unfortunately the national plan does not address all possible problems which are likely to arise within the HIV epidemic. One reason for this is, that resource is limited. Another reason is that new issues will arise as the epidemic unfolds. It is crucial for the NCCA and all internal and external agencies involved in addressing the HIV/AIDS epidemic, to be pro-active, in order to avoid widespread social and economic consequences. If the epidemic spreads widely, it will affect Lao national productivity and social development. Minimizing the cause and consequences of the HIV epidemic requires diverse action.

Reported number of people with HIV and AIDS

Reported number of people with HIV and AIDS			
Indicator	Value	Year	Source
Year HIV first report		1990	NCCAB
Year AIDS first reported		1992	NCCAB
Cumulative number of reported HIV	717	Dec.2000	NCCAB
Cumulative number of reported AIDS	190	Dec.2000	NCCAB
Cumulative number of reported AIDS-related deaths	72	Dec.2000	NCCAB
Estimated cumulative HIV infected persons	1,200	1999	UNAIDS/WHO
Estimated HIV prevalence (%) for persons 15-49 years	0.01	1999	CCA UNAIDS/WHO 1999
Estimated adult HIV prevalence (%)	0.04	2000	Estimate taken from NCCA Bureau data and recorded by both the Synergy Project Lao PDR Country Profile and UNDP 2000

Report HIV cases 1990-2000



Year (1990-2000)

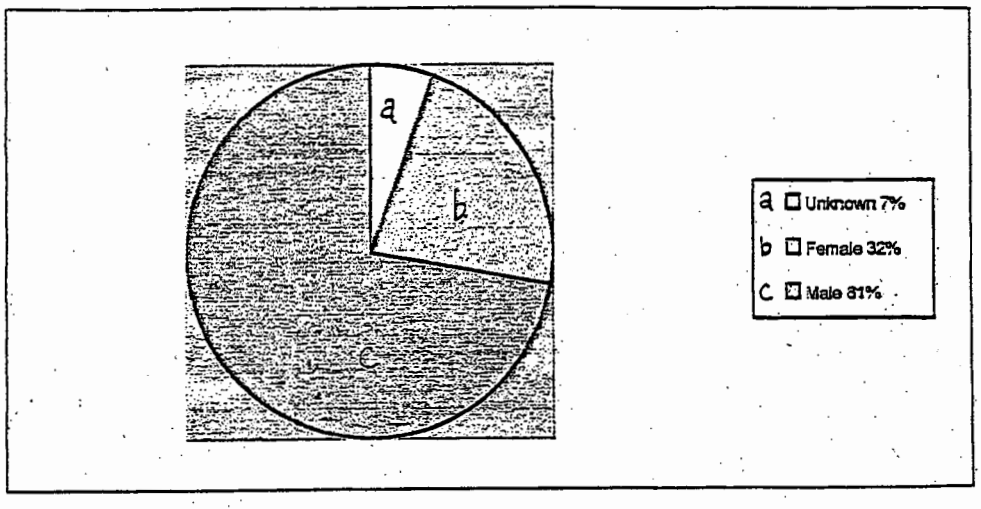
Cumulative HIV infected persons by selected group as of 12/1999

Cumulative HIV infected persons by selected groups as of 12/1999			
Group	Number of persons testing HIV positive	Number of persons tested	HIV positive results as % oft total tests
Patients	224	1890	12
Lao repatriates	71	983	7
Voluntary testers	59	4151	1
Blood donors	34	38573	0.09
Villagers	26	300	9
Bar workers	14	2015	0.7
Prisoners	12	598	2
Students	4	1223	0.3
Employees	4	438	0.9
Pregnant women	4	742	0.5
Total	452	50,913	0.9

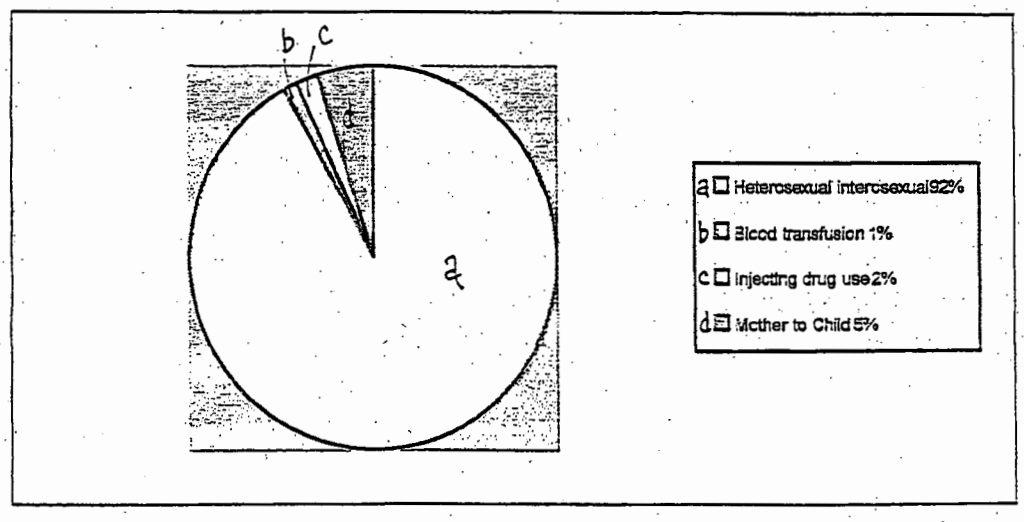
Modes of Transmission among cumulative cases (1990-2000)

Modes of Transmission of reported cumulative HIV cases 1990-2000		
Mode of Transmission	Number of reported HIV cases	% of Total
Heterosexual intercourse	664	92
Mother to child	37	5
Injecting drug use	12	2
Blood transfusion/blood products	4	1
Homo/bisexual intercourse	0	0
Other/Unknown	0	0
Cumulative Total	717 cases	100 %

Cumulative (1990-2000) reported HIV cases by gender



Cumulative HIV cases out of 717 persons reported with HIV by mode of transmission (1990-2000)



Lao Project in making contact with sex workers/bar girls.

Collaboration

Lao Red Cross HIV/AIDS/STD Project has 7 Provinces and we have extra province that project finned from other organization Save the Children Australia in that Province. We work along the road. The road leads to Thailand. Project name is HIV/AIDS in Paklay-Kenthou. Coordinate with PCCA, DCCA Of cause if have Road Construction people also come to visit bar worker. And we do workshop for bar girls. We contacted authority and the owner of the night club. The workshop we done in night club.

Workshop

The workshop similar peer education workshop. But for bar worker we should be careful do not say stronger, blame, friendly. Let them believe us before we discuss.

Selection Volunteer + follow up

After we finished the workshop we selected one volunteer. She is active and she can talk with her friends and she also has talented. She is 20 year old. Finish secondarily school. She still lives there. She comes from city. Some time she goes to Thailand.
About follow up I received report from Volunteer district.

After 3 moths we went to visit them. We Interviewed owner shop. We did small group discussion among participants and participant's friend. We ask them how are they going, they go to talk with their friend and how they need to help.

Gender & HIV/AIDS: A Philippine NGO Response[1]

Gladys R. Malayang
Women's Health Care Foundation, Inc.

Background/Introduction

First allow me to greet all of the participants to this meeting of experts in gender and HIV/AIDS. I am honored to be able to join this meeting and to learn from all of you as we face enormous problems now and even more so in the coming years with respect to the HIV/AIDS virus.

HIV/AIDS is one of the elements of reproductive health and as such comes under the overall definition and concepts embodied within reproductive health. As in all the other elements, gender and gender relations is vital to the understanding of and is part of the solution to the reproductive health problems existing today.

The paper that I will present to you today will discuss the gender aspect of HIV/AIDS from the perspective of the providers of quality health services and information. I submit that as we seek to assist and advocate for persons at risk and those with HIV, gender sensitive and appropriate information and services being provided is of vital importance towards the prevention and control of HIV. This paper is one NGO's experience with how it transformed its organization towards a gender responsive provider of reproductive health services and information.

This paper shall first look at the Philippine situation with regards to reproductive health, HIV/AIDS and gender. Then it will share and provide insights on the experiences of Women's Health Care Foundation as it developed gender-responsive reproductive health

[1] A paper presented at the Experts Meeting on Gender and HIV/AIDS, sponsored by the Asian Women's Fund, Tokyo Japan, July 24-26, 2001.

services and information to respond to the needs of women and men in high risk situations for STDs and HIV.

The Philippine Situation

The Demographic/reproductive health profile

The Philippines is an archipelagic country with 7,000 islands and more than 120 language groups being spoken. As of 2000, the population stands at 76 million with an annual growth rate of 2.36%. The fertility rate is 3.6 with about 56% of the population less than 24 years old.[2] Maternal mortality (172/100,000 l.b.)[3] and infant mortality (37/1,000 l.b.)[4] continues to be at an undesirable level even if 95% of its population is educated. Contraceptive use is at 49 percent (32% modern methods with condom use only at 1.7% and traditional methods 17%)[5] and an unmet need for contraception is about 20%.

HIV/AIDS situation

A the end of July 2000, 1,402 recorded cases of HIV. Of the total number infected, 442 had developed AIDS and 203 deaths have been recorded[6]. Two areas of concern are: (1) most of the documented new cases of HIV are from the youth age group and are overseas Filipino workers who go back to their provinces causing a rise in HIV in the rural areas. and (2) even with a low prevalence HIV rate, there is a high incidence of sexually transmitted diseases and it has been shown that the pattern of growth for HIV/AIDS follows the increase of STDs.

Most of those who acquire the HIV are from the vulnerable groups (women, youth and transgender males). This situation is compounded by unequal gender relations and a strong stigma that exists against the disease. There is also growing evidence that HIV/AIDS is spreading not only in areas where high risk groups are present (tourist areas and where there is a high concentration of women in prostitution) but also in the countryside. Poverty in the rural areas also force women to offer sex in exchange for food or rice which opens up the vulnerability of women in these circumstances.

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[2] World Resources 2000-2001: People and Ecosystems, World Resources Institute, 2000.
[3] 1998 NDHS, NSO
[4] WRI, 2000.
[5] 1999 Family Planning Survey, NSO
[6] Philippines Surveillance data, July 2000

Other Developments and Future trends

Although the Philippine is one of the countries in Southeast Asia that has a slow rate of HIV/AIDS growth, the government and partner NGOs in the country try to avoid the sense of complacency that overtakes situations like this. The Philippines, through its Congress enacted Republic Act 8504 known as the "Philippines AIDS Prevention and Control Act of 1998" that prescribes policies and measures to prevent and control the spread of HIV in the country. Other than a provision for a nationwide program for information and education, this legislation also includes the rights of individuals including rejection of mandatory testing for HIV, confidentiality, non-discrimination of PLWHA in the workplace, schools, travel, health institutions and access to insurance services.

A strong NGO community that is mainly the force behind an effective information dissemination has been instrumental in the awareness raising against HIV. Hand-in-hand the government and civil society are moving forward to keep the prevalence rate of HIV in the country low. The presence of a multi-sectoral body made up of GO and NGOS, known as the Philippine National AIDS Council, is presently implementing a five year medium term plan of action that looks at all aspects of the spread, prevention and information necessary to have an effective national HIV/AIDS program.

Gender Issues re reproductive health in the Philippines

HIV/AIDS is one of the elements of reproductive health as described in the ICPD Cairo document. Since gender is at the core of the reproductive health concept, HIV/AIDS necessarily has to be seen within the context of gender. Even when indicators for women empowerment have improved in the Philippines for the past ten years, much remains to be done in the area of equity and equality. Even more so in the realm of reproductive health, the most difficult circumstances arise when negotiations, decision-making and power structures are at a personal and intimate level such as in a reproductive health situation.

Some statistics to indicate gender inequities in reproductive health are:

- One out of ten women have been physically harmed by someone close to them, one third being harmed during pregnancy
- 10 women die every 24 hours from pregnancy related causes
- One out of every four women had induced abortions

- Among married women, 20% have expressed wishes to limit and space births but have no means to do so

Gender issues are seen in the number of women who die because of pregnancy; in the number of prostituted women both within the country and working in other lands; in the number of violence cases being filed in the lower courts and treatment of battered women in hospitals; in the number of women below the poverty line; in the number of women being raped; in the number of growing women who have acquired HIV. These numbers all show the real face of gender disparity existing in the country. These numbers show that women seldom have the choices or the means to make these choices. Circumstances, cultural constraints, and personal capabilities are all hindrances to a woman's right to protect her body and her health.

All of these gender-related concerns also impact the HIV/AIDS situation in the country. If seen in a more pragmatic manner, HIV/AIDS and its control or spread is ultimately dependent on individual persons. As a woman interacting within the family and within her community, the manner in which she is treated and the experiences she has in dealing with health services and providers will ultimately be one of the determinants on how HIV and its deadly partner AIDS will be controlled within the country.

What will determine quality information and health services that responds to gender needs and issues? How will this be accessed by women and their partners who have been exposed to the HIV virus?

A Philippine NGO Experience

Background on WHCF

The Women's Health Care Foundation is a non-government organization that believes in empowering women and their families towards better health and better lives. Dedicated to quality reproductive health services and information, WHCF has been reaching women, men and youth in Metro Manila and outlying provinces for the past 21 years with this mission: "To seek to ensure that all women have access to quality health services and

information for them to achieve and maintain good health and protect their reproductive rights throughout their life cycle—in what ever circumstances and situation."

WHCF was created to provide a holistic approach to health services for women who only had family planning and maternal and child care available exclusively for her. WHCF initially provided services that included infertility, treatment of STDs, counseling for women and couples (including those women victims of violence), a referrals to hospitals and other professionals like psychologists and lawyers. Today, WHCF has widened its services to include information and education activities on HIV/AIDS, safe sex and sexuality. The concept of gender however had to gradually be built into the organization itself. Processes and systems had to be reexamined to ensure that the gender perspectives are part of the organization.

Gender responsiveness was a niche that the organization has identified as a response to the need for services that take into account the differences between men and women and the imbalance that exists because of these differences. In so doing, WHCF hopes to contribute to the interventions that address the inequalities that promote vulnerabilities to reproductive health diseases, including HIV.

Engendering the organization

Like stone thrown into a pond, gender awareness, sensitivity and responsiveness must start at the center and ripple outward to touch not only the people within the organization but all those who come in contact with it: the clients, the communities, the co-workers in the field. The center is the very heart of any organization: its vision, mission and goals. The review of the VMG reflects an effort to assess the very foundation of the organization. Any organization that sets out to be gender sensitive and responsive specially necessary for those working in HIV/AIDS should start with mission and vision statements that are gender sensitive. Today, phrases like the following are part of WHCF's VMG:

"...women are respected and treated with dignity"

"...women are co-decision and policy-makers"

"...women are able to exercise their reproductive rights including the decision on the number and spacing of their children"

"...women are equipped with adequate and proper information"

"... women freely and responsibly manage their fertility without coercion, discrimination and violence."

Some Questions To Ask On Engendering An Organization

- Are the organization's vision, mission and goals reflective of gender concerns?
- Does the organization uphold gender principles in its set-up?
- Does its board and management promote gender equality and equity in its composition and the policies that it sets?
- Is gender mainstreamed within the organization? Are there specific indicators reflecting this? for e.q. board composition, policies on sexual harassment, etc.
- Is decision-making within the organization participative?
- Have the staff gone through a gender-training, awareness raising program?
- Is there a continuous upgrading of staff skills and knowledge on gender practices and gender tools?
- Is the staff promoting gender sensitivity in their interpersonal relationships with each other, with other organizations, as well as their clients?

Engendering Clinic Procedures

Clinic/Office protocols and procedures are the guidelines of behavior for the staff. Incorporating gender concerns into the protocols and guidelines will help ensure that the staff will implement gender-responsive practices in their operations. Imbedding gender into clinic protocols assures the organization that even with sometimes lapses of the staff, the protocols to be followed will continue to embody and impart gender-responsive services. Part of clinic procedures will take into consideration concerns about the client like: who has control over the client's time and resources, who makes decisions on reproductive matters, comfort level of clients in examination of their bodies, multiple roles of women, acceptance and handling of authority. Engendered clinic procedures will also highlight and recognize the power structures existing within a clinic setting and make these power structures enabling rather than crippling.

For clients in the high risk groups or who, after taking the clinical history would reveal that they have been exposed to the HIV virus need special consideration in terms of counseling and education. Counseling and education methods should incorporate a gender perspective, upholding informed choice and self-made decisions.

Some Questions To Ask On Engendering Clinic Procedures

- Do all clinic procedures uphold the rights of clients?
- Do clinic procedures take into consideration the right of the client to make her/his decisions?
- Do the clinic procedures include considerations to promote access and lessen barriers to quality reproductive health and HIV/AIDS services?
- Do fees and charges for services reflect the realities of the clients in terms of capacity to pay?
- Are procedures and protocols reviewed on a regular basis in the light of gender appropriate interventions? e.q. Are the medical records for clients confidential, complete, unsegregated for PLWHAs etc.
- For persons in HIV/AIDS high risk groups and those living with AIDS, is the clinic perceived to be 'friendly' to them? For e.q. Are the clinic hours accessible to women in prostitution?

Engendering the IEC materials

With the enormous amount of resources and time being spent on developing IEC materials for HIV and AIDS, the question of sending the right message to women and men in terms of gender issues need to be examined. Many organizations may be good in developing IEC materials but have little or no experience with gender. Thus, a number of the materials we see being distributed not only do not uphold the gender principles but may even promote the inequalities existing within society. For example, a brochure promoting safe sex through condom use shows a picture of a woman in prostitution luring males in the street. What other 'hidden' messages could also be communicated here? Those women in prostitution are the carriers of the disease. In reality, statistics and research have shown us

that women more often are the recipients of the disease rather than the carriers. That more women are infected by men rather than men being infected by women should have been the message instead.

Some Questions To Ask On Engendering IEC Materials

- Is the language used gender sensitive and appropriate?
- Are the materials developed particularly for men or women? Are the materials then suitable for each group, recognizing unequal power relations and access to resources and providing ways and means to overcome these inequalities and inequities?
- Do the pictures being used reflect sensitivity to the situations of women and men?
- Are the topics fitting to the audience of the IEC materials? Are examples used not demeaning to the position of women in society?

Engendering the communities

Lastly, when all systems are in place within the organization, the mandate of raising the awareness on gender among the clients themselves are of paramount importance. How could this be done?

WHCF has done several types of interventions to promote gender awareness among clients. One of them is to make sure that there is easy access to information that is comprehensive, appropriate, accurate and confidential. In a community setting, this could be done through the structures already existing for information dissemination. Counseling and services could be done through a working referral system.

Another intervention is to involve the male segment of the community in reproductive health and HIV/AIDS interventions and activities. Men in communities, once involved, and gender awareness have increased, can be movers in promoting HIV/AIDS prevention and control. Community interventions have worked best when the various sectors of the community are involved. Gender awareness raising is most easily done among the youth. This is one

opportunity to reach both young men and women for a realistic and positive view towards men/women differences.

Some Questions To Ask On Promoting Gender Awareness Among Clients

- Are clients provided with privacy in clinic procedures?
- Do clients feel that they are treated as individuals rather than just a health condition?
- Are clients given the opportunity to inquire, to consider and make their own decisions regarding the care of their conditions?
- Are there programs for male participation/involvement in communities?
- Are systems in place to promote decision-making that recognizes the diverse needs of women and men?
- Do women and men equally have open access to information and services?

Conclusions/Recommendations

This paper has been presented to share with you one organization's experiences with creating a gender responsive environment for communities and vulnerable groups whose reproductive lives are threatened by diseases like HIV and AIDS. These experiences are did not happen overnight and neither will any implementation of a program that deals with changes in behavior and belief systems. As we seek to make a better world for women and men, who because of the nature of our cultures and social structures are exposed reproductive health risks, the following recommendations are made:

1. That organizations dealing with reproductive health care services and information strive to embody gender equality and equity within their own structures and systems.

2. That in dealing with persons vulnerable to or those who have already been diagnosed with HIV, all aspects of the organization: structures, processes and systems, procedures and even staff behavior should be gender sensitive and responsive

3. That gender processes need to practiced on a day-to-day basis—it is not an instant event; having all of the staff go through gender sensitivity training and revising policies and procedures will not ensure application of gender principles. What ultimately matters is how gender equity and equality is translated into action.

As a health facility that promotes reproductive health, WHCF has applied in various aspects of its operation and organizational structure gender principles and processes that is inherent in the definition of reproductive health. The task is not done. There is more work ahead of us—monitoring, evaluating the effects, and ultimately assessing what all of these has meant to the woman who comes inside our doors. For those of you whose clinics and service facilities are providing reproductive health services, I am sure that in your struggles to provide what is empowering to your clients you have met similar situations as we have. We have much to learn from one another and through this sharing of thoughts and ideas, we continue to hope that in the days to come we shall meet our goal of providing health services that is equitable and allows women to make informed decisions about their reproductive lives.

Philippines –2

Living with AIDS and Saving the Endangered

Ma. Isabel E. Melgar, Ph.D.
AIDS Society of the Philippines

In this important gathering and forum, I would like this audience to remember the Philippines for three things: 1. Its beautiful beaches 2. Its women 3. A low and slow HIV/AIDS prevalence. These things as you know are all high risk areas.

The Philippines, being an archipelago of 7100 islands woos the world with scenic landscapes, white beaches and coves, and red-orange sunset. 'Philippines' naturally endowed environment has also to some extent shaped the national personality that characterizes its people: warm, resilient, artistic, and relaxed. The second asset of our country are its women who had excelled not only in politics, but in industry, health, community services, sports, and the arts as well. Two of them, as you know, have their own claims to fame: Cory Aquino, the charismatic wife of our modern-day hero; and who eventually headed the country following the EDSA Revolution. And our current president, a former professor in economics, President Gloria Macapagal-Arroyo who took over the presidency following the impeachment initiatives against Mr. Estrada on grounds of graft and corruption. The third piece of this national image is our low HIV/AIDS prevalence. It is at the state which, compared to its Asian neighbors, keeps our policy makers from the hysterics of fighting the gaping flames of a deadly pathogen.

The Philippines has a population of 70 million and an annual growth rate of 2.3%. Literacy is quite high showing a rate of 93.9 percent. Literacy rates for males and females do not vary significantly. The overall poverty incidence is 37 percent. Of the total national government expenditure, only about 2.4 percent went to the health. Health care has been decentralized and devolved to the local government units.

What I have just said, are in a sense, public knowledge. The flip side to these images—the real images, is probably all you are waiting to hear. Like most Asian countries, we have pains and struggles but some little successes to report too.

HIV/AIDS in the Philippines

The epidemiological characteristics of AIDS in the Philippines are slightly different from other parts of this side of the globe. It occurred most prominently in men and women and not necessarily in homosexual men. As of the latest HIV/AIDS registry (DOH, May 2001), there are now 1,503 HIV-infected Filipinos. In 1987, the registered number of HIV/AIDS cases was only 38. At the turn of the century, this figure rose to about 1400 cases, quite a low prevalence compared to its Asian neighbors. The major mode of transmission is through heterosexual (60%) and homosexual transmission (16%). Unlike its counterparts in South Asia, HIV due to injecting drug use is minimal, some 13 cases out of the overall total cases. Initially, the major "risk groups" identified were sex workers and overseas contract workers. This caused the public to legitimize their denial that AIDS is in the Philippines. However, the Department of Health, the NGOs, notable AIDS advocates and the AIDS Society of the Philippines were never discouraged and I think it is through their relentless efforts that we have achieved a level of awareness and relative vigilance.

From the gender perspective, close to 600 or 37 percent of HIV-infected Filipinos are women; or one out of three PWAs is a woman. These women get infected at the young age between 19-29 years. Among men, most infections occurred in the 30-35 age group.

Looking at the patients seen at the Research Institute for Tropical Medicine (RITM) where HIV patients have been followed since 1986, the infected patients came from economic positions in life with professions ranging from medical and paramedical work, sex work, seamen, entertainment services, housewives, engineering/architecture, students and children. In the late eighties, AIDS was found among Filipinos returning from overseas work. These were mainly seamen, entertainers, professionals coming from all parts of the world. In the 1990s, AIDS was mainly acquired in the Philippines.

A Second Look at Low and Slow Prevalence

The low HIV prevalence in the country remains to be a curious phenomenon that sparks more questions and tentative answers. In the recent national convention on HIV/AIDS

(October, 2001), questions were raised like: "Are we safe?" "Are the figures for real?" "If it is, what do these numbers mean?" "Are we doing something right?" "Where do we go from here?" "Do we expect these figures to accelerate at some future time?" More talk and questions. And some tentative answers.

AIDS advocate and social scientist Dr. Michael Tan believed that the government and non-government responses were early enough to fend off and counter the invasion of AIDS in the country. Our country did amazing things and built up a strong defence through the cumulative efforts of both the government and the NGOs.

The country was able to launch AIDS awareness programs in the eighties and mount intensive training of medical and paramedical personnel on diagnosis and management. Although very limited comprehensive evaluation has been done, it is posited that prevention campaigns had some isolated impact. There are over 60 NGOs variably involved in AIDS-related activities, mostly in the area of prevention. Many of these NGOs are located in Metro Manila while the rest are geographically distributed in major urban centers around the country.

The creation of a multisectoral policy-making body, the Philippine National AIDS Council in 1992 also reinforced a national effort towards an integrated AIDS program. The AIDS Society of the Philippines was formally organized in 1996 which also served as a national forum for exchange of information and sharing of skills among AIDS organizations. In 1998, the National AIDS Law was signed which among others reinforced the AIDS care and control program in the country.

Dr. Ofelia Monzon, President of the AIDS Society of the Philippines, cautioned the public, however, on viewing the low statistics at its face value. She cited that there were real local conditions which should not escape scrutiny because these will change public impressions on the overall picture of this epidemic in the country.

First is the narrow basis of the registry where it is primarily based on reporting of physicians and laboratories. Reporting is influenced by diverse factors as the ability to diagnose

HIV/AIDS, the desire to withhold and keep confidential such information, the lack of laboratory facilities in remote areas and other relevant deterring factors.

Secondly, available information reveal the prevailing behavioral and sexual practices which are conducive to HIV/STD infection like multiple sexual partners in certain population groups, absence or minimal condom use, and high prevalence of STDs in some groups. The effect of many forms of drugs usage on HIV/AIDS in the Philippines is still unknown.

Thirdly, the exodus of some six million Filipino men and women to other countries together with the breakdown of the stable family life, adaptation to physical absence of significant member/s, changes in lifestyle and family income have its repercussions. Transmission of infection from infected workers to spouses and from mothers to children is being seen, although at a low number at the present time.

Women and AIDS

What do we need to know about women as far as their vulnerability to AIDS is concerned? What do we need to know about the status and role of women in our country that is relevant to our discussion of AIDS? Should we consider them now as our endangered species?

Women Power

The data and statistics about Filipino women speak of contradictions. Our women are more educated and are more literate than men (UNFPA, 1999). They were perceived as conscientious with academic work and responsible student leaders. In the 2000 National Secondary Aptitude Test, two girls' schools made it to the top five outranking the two leading boys' schools in Metro Manila. The female sector is a potential asset of the country waiting to be utilized.

We have winners and losers amongst women in our country. We have a small share of outstanding women dominating the service and community sectors. However we have also

reported cases of victims of domestic violence, sexual harassment and abuse as well as psychological trauma which were shared to you in last year's Expert Meeting (Rivera,200). Mind you, not all women are victims. Men get violated too. A recent study by Zelda Zablan of the University of the Philippines who did a survey among Ifugaos found that about 50% of the men were beaten up by their wives. The reason is that the women till the rice terraces and field; and when they come home, the husbands were still lazing away and had not cooked.

Unfortunately, the realities do not take off from the facts. Women's educational attainment and greater political participation have not translated into greater equity with men in matters of livelihood and control of material resources (UNFPA, 1999). This is particularly true within lower and middle strata of the society. A Labor Force Survey in 1998 showed that only 38 percent of the total work force and 37 percent of the total employment were comprised of women. About 53 percent of working-age women were economically inactive. However, this figure must be qualified since quite a sizeable were engaged in informal-sector activities and underground economy. Moreover, there is a growing number of women who have taken jobs abroad and have reversed their roles in their respective households.

This brings us to the unfortunate fact that since there are more jobs abroad, we continually lose many of our women labor and technical force to neighboring countries like Japan, Hong Kong, Singapore, Malaysia, Indonesia; the United States, Canada, Europe and the Middle East. The trend twenty years ago was that 88 percent overseas contract workers were men while 12 percent were women (Kanlungan, 1997). In 1995, over 50 per cent of these overseas workers were women matching the outflow of male contract workers. In 1999, over 60% were women migrants outpacing their male counterparts. These figures do not register any meaning to us AIDS workers until we humanize these cold numbers.

The Contemporary "Comfort Women"

Most of our women are surrogate parents and caregivers in foreign households. They are also hired or traded to fill the role left by the previous generation of comfort women during

the War. They entertain, they dance, sing along, mix drinks and sell sex. Meanwhile their children and partners miss them. While the years drag on, the families left behind, cope with the package of new money, material comfort and physical separation. Our women became the sacrificial lamb of the family.

The social and psychological consequences of this exodus created serious concern among government, church and community leaders. Drug addiction among children, early marriages, unwanted pregnancies, incest, leave from school, philandering of spouses are just among the horrible stories we hear.

Women work like carabaos and suffer beyond the imagination of her loved ones. We will not belabor on the statistics of deaths, derangement, rape, deception, exploitation maltreatment etc., reported day in and day out.

In line with the agenda of this forum, among the common problems reported by domestic workers and entertainers in Asia and the Middle East which threatens their well-being and increase their vulnerability to HIV/AIDS were:

*Sexual violence like rape
*Sexual and physical harassment by male employers
*Lack of access to health services
*Gender and discrimination issues inherent in the host country
*Limited counseling services about AIDS, STD and other reproductive health problems.
*Propensity to have multiple partners due to loneliness, cross-cultural influence, etc.

It is important to note that while majority of the contract workers are domestic workers and the tail end of the curve are entertainers, dancers, bar girls, prostitutes and nurses and caregivers, they share common problems. Regardless of the nature of their work, all of these women are susceptible to abuses and physical trauma precisely because of their inferior and weak status in the foreign land.

Many of these women have left their families. Being alone and the need to love and be loved is another area of vulnerability. This psychological condition is pervasive and often times ineffectively addressed. Intimate and extramarital relationships overseas appear to

be the norm rather than an exception. I have counseled some positive patients at the RITM who held decent jobs abroad but have acquired the virus through this one time tryst with an acquaintance whom they casually met. They did it because they were bored and very lonely.

What is more alarming is that those who have entered sex work through illegal means have no or limited access at all to an appropriate health facility. In addition, their severe working condition does not allow time and access (Ybanez, 2000). We expect to find sexually transmitted diseases and reproductive tract infections at the very least and HIV/AIDS at the very worst. And we know for a fact that untreated STDs facilitate HIV infection. And vertical transmission to their new-born children is not far away.

Wives of Contract Workers

In the recent past, we at RITM have received a number of wives who were tested positive and who have acquired the virus through their husbands who in turn have acquired the virus abroad. This is another area of concern for reasons that there is a need to reach thousands of uninfected innocent wives apart from their spouses. Among the infected wives, feelings like blaming, anger, guilt and depression affect their personal lives and their relationship with their spouses. This special group of clients therefore poses a challenge to AIDS counselors and attending medical staff in providing appropriate support to the negatively affected couples.

The Challenge of Condom Rejection

It was mentioned earlier that HIV/AIDS in the Philippines is transmitted primarily through sexual contact. Men have an aversion for condoms. Condom use among women is very low pegged at 1.7 percent (Women's Feature Service, 2000) Although cost is cited as one of the demotivators, the motivation to use (or not to use) condom presents an interesting psychological challenge for social scientists who are strategizing a model for behavioral change.

In a study of urban poor women in Las Pinas which I and colleagues at RITM studied (1997), almost half of the respondents perceived the condom as a birth control devise rather than as a protective measure against HIV. It is ironic that of those couples who are practicing family planning, only one used condom while the majority either used withdrawal, pills or ligation. Condoms were consistently avoided because it reduced the pleasure of sex. Moreover, this study found that a few women felt that a condom was not hygienic e.g. they were afraid that the rubber might get stuck inside their bodies. There were also some respondents who wanted to have children. And most important of all, the decision to use condom virtually lies on the man. In sex, it is always the man who initiates according to 90 percent of the respondents.

In 1994, when I did a study of bar girls, waitresses of beerhouses and women in massage parlors in one of the big cities in Manila, fifty percent of 336 respondents admitted that they did not know where they could get condoms while some 12 percent were completely ignorant about condoms i.e. what it was used for and how it was used. These women were registered and were supposed to be medically monitored by the social hygiene clinics every six months. Around 40 percent never sought medical check-up for the past six months. Less than 90 percent claimed having no history of STD. When tested, 54 percent had single STD while 62 percent had mixed STD. Ignorance, absence of information and no sense of urgency and health care are some of the factors which make their condition more pathetic.

What about the Catholic Church? Have they been significantly affecting the negative attitudes toward condoms. Respondents in both studies mentioned above did not ever mention the Church's prohibition of condoms as a reason for non-usage. I suspect the Church's message has more bearing on middle and upper middle class specially those who were educated in catholic private schools.

Where do we go from here?

We have to check our paradigms too. Is condom the solution to our problem? Or is it the attitude and core beliefs that we hold? Can the economic and social environment do

something to change people's lost sense of control and morality? How far can we go in protecting our overseas contract workers specially our exploited women? Can our leaders influence the fate of our contract workers, sex workers, male clients, youth and the equally vulnerable public men and women? How will people stop having multiple sexual relationships? How could the teachings and messages of the Catholic Church wield its influence to help control the further spread of this deadly virus? How could we create restraint and more reasoned vision of our own sexuality? How could we have healthy self-concepts so that mutual respect for one another could be internalized? How could we inculcate a sense of responsible choice in intimate relationships?

I hope that by the end of this experts' meeting, we will have concrete handles and creative paradigms to bring home with, as deep in our consciousness, we know that AIDS is creeping beneath us. One morning, Filipinos will get a wake-up call from a dream; that AIDS is no longer low and slow. If that happens, our beaches will never look the same.

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Gender and HIV/AIDS in Thailand : A Move Forward or a Step Backward?

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1. HIV/AIDS in Thailand

Thailand has is first HIV/AIDS reported case since 1984. HIV/AIDS in Thailand had started within a very specific group, bisexual and gay men and moved toward the general population. While the reported number is around 600,000, it has been estimated that the total infected population so far is no less than one million. This means that there are more than 5 percent of the total population have been affected by the disease. Though HIV/AIDS does not discriminate among men and women in its effects in general, the proportion of HIV infected persons between men and women is 3:1.

Gender had been hidden issue when discussing about HIV/AIDS in Thailand until recently. Attempts by myself and other women activists to bring up the issue of women empowerment in relation to HIV/AIDS was perceived rather in a negative attitude in the country's national seminar ten years ago. The attitude was that there is no linkage what so ever between gender (power relations) and HIV/AIDS.

However, much attention has been geared toward gender and sexuality in the recent National Seminar on HIV/AIDS held in Bangkok between July 11-13, 2001. The issues of Gender and Sexuality were discussed boardly. It is the first time a youth forum was organized. What has been found and learnt is the fact that, despite all activities and movements for gender right for a decade, Thailand is still struggling for a chance to change. A very obvious example was the following excerpt from 20 years old university male student responding to the question of "what would you do if you have made a girl pregnant? What would be your responsibility?"

"According to my experience, girls nowsaday are very easy-going. I will not take any responsibility until I have known for sure that the baby is mine. I will get a thorough check for DNA compatability. If the girl can sleep with me, she can sleep with others as well. I have to make sure that she is a good person before becoming my wife and the mother to my children. If a man sleep with a women, they have come to agreement and it does not mean that they agree to marry one another, especially on the man's side. How can she complaint when being pregnanted, but she never complaint at all while having sex. It is unfair for a man when he has to be responsible for a baby which is not his real baby. That women is taking this for granted.

This is what I am questioning that we are really taking a step forward or backward? What has been realized so far is that HIV/AIDS has its deep root in social and cultural context for the Thai community.

2. Gender and Sexuality in Thailand

Gender refers to the social roles that are ascribed by men and women. "Sex" refers to sexual characteristics. Distinction between the concept of gender and sex is useful, because anything associated with gender is a social construction or a social perception that can be modified or reversed in the interests of fair outcomes for both men and women. Sexuality (sexual behavior, attitudes and preferences) is a social construction of a biological drive. It has elements of biology, gender and power relations (imbalance of power) Sexuality as a social construction can be altered (Gray, et al., 1999).

Women in Thailand have been observed as having high social and economic status by various authors (Jones, 1977; Gray, et al., 1999) Thai women manages household budgets by tradition. This gives Thai Women the power to manage for the family routine expenditure. Decisions about major expenditure must be made between household members, particular between husband and wife.

One factor that contributes to high social status of the Thai Women is that marriage does not break them away from their parental families (Yoddumnern atting, et al., 1992). They can remain strong relationship and financial obligations toward their parents, with married and unmarried brothers and sisters and cousins who constitute the extended parental family. With regard to these relationship, Thai women maintain their strong supporting system particularly when they comeback to their parents, after divorcing or even being HIV infected.

However, although Thai women have high status in education, economic activity and management of household income, they are facing difficulties in their personal relationship, i.e., unequal power relations to their male partners. It is shown in expectations about acceptable behavior of each sex. Women are expected to display submissive or passive characteristics. They are described as "Weak, credulous and indecisive" (Gray, et al., 1999, Chayovan, et al., 1996) whereas their male counterparts are "strong, aggressive and capable of making decision". Married men who have extramarital relationship or visit sex workers are accepted as common. Having mistress or minor wife is regarded as personal wealth and even signify the men's level of sexual competency. Visiting sex workers is perceived as common form of entertainment among men and some wives tolerate this kind of activity with the reason that "it is only temporary, once in a while. It is still, better than having a mistress which is more permanent and creating long term suffering".

In brief, Thailand, with no exception, a picture of a society which gender roles exert a strong influence. People act out roles that have been established within a heavy gender-based construction of sexuality. Facing an AIDS epidemic, there is no excuse what so ever that women remain in their passive and subordinate roles which can make it very difficult for them to assert rights or inspiration. In some areas such as, reproductive health, women still remain having limited voices and choices for their rights.

3. HIV/AIDS in its gender context

3.1 Gender role as contributing factor to HIV/AIDS

What impacts that gender has upon HIV/AIDS epidemic?. As previously mentioned, Thai

men are allowed to have sex before marriage. Boys are accepted for their sexual behaviors. Being a man in Thai society, they are expected to be experienced with sex. Young men entering school or university will be escorted to visit sex workers as "having the first lesson with sex teacher". It becomes a very common practice. It is the matter of "loosing face" among young men if one remains a "virgin" man. Those will be look down as "sexually inexperienced" "young chicken" and "not knowing how to please women".

Though the condom campaign programme has been successfully implemented resulting in the dramatically-decreased rate of sexually-transmitted disease and maintained zero prevalence rate for HIV/AIDS for general population, several problems start to emerge. Since condom use is perceived as for "when having sex with prostitute", it is unlikely to be used among adolescent groups. Thus, HIV infection, unwanted pregnancy and abortion become major problems for the younger age group.

Thai Girls, being in a passive and submissive role, can hardly be capable of negotiating sex from their boyfriends. Also, with socioeconomic problems arising in the free market economy, people become more materialism and depend entirely on cash economy, more and more young women become in traps in casual sex industry, as means for their survival. It is estimated that a significant number of high school and university students engaged themselves as casual sex workers. Such "products" become popular among men at all level and all ages who are capable to "buy sex", in the AIDS epidemic era. Thai men keep their beliefs that the younger the girl, the lower chance of them getting STD/HIV. There was a recent report of three junior high school girls, who became HIV infected from their sex trading, appealed their case in the newspaper for apologizing and forgiveness from all men they had slept with in the past three months.

Gender roles and its power relations are still significant factors in HIV/AID epidemic despite all our efforts and attempts to combat AIDS. It has been well-stated and accepted by various AIDS experts that without reconstructing gender concepts and problems as well as empowering women of all communities, HIV/AIDS epidemic can hardly be prevented and controlled.

3.2 Marital and family relationships can be severely disrupted by HIV infections

When HIV/AIDS occurs in the family, disruption to marital relationships and family life can be expected. According to our study, one-third of women, whose husbands are HIV positive and found themselves HIV infected after, remain living with their husbands. However, these women will have to engage in the role of major income earners. They have to work while caring for the ailing husbands. They suffer for having dual responsibility for the family as a whole and for their marital relationships.

There are phases of adaptation and adjustment a positive women has to go through; first, the stage of "Toke jai" (Shock and disbelief) when finding that she is getting the disease. In this initial phase, women may experience anger toward their husbands. However, they will soon entering the second phase of "Sia jai" (depression and sorrow). Thai women think of themselves less than their children and family. Gender attitude play a significant role on this. An excerpt from young women who found that her husband had AIDS after only three months of marriage may be well explained for such attitude:

> *"The only good thing I can think of is that we do not have any children. For myself, I already become his wife. I love him so much. Sooner or later death will come to take me. So, it does not matter whether I die now or later on. I already have my commitment to be with him. We can die together.*

Keeping such attitude, HIV infected husband passed away with the good care of his wife whose health may be deteriorating, but remain husbands care givers till the last minutes. Separation may occur in some couples. In these cases, HIV infected Thai men will return to their parents and being cared for by mothers, older and younger sisters. According to gender roles, women play a significant part in caring for family members in any situation. Such gender belief may help women to overcome the crisis quickly, even too soon. The last stage is "Tham jai" when the women can finally cope with the situation. They will struggle with their responsibilities, caring for the family (often extended to the husbands' family) and bringing up their children, trying to get any possible money for their growing-up children

There are group of HIV positive women with higher socioeconomic class who can not "reveal" themselves for supports. The reason is that if they revealed themselves even to their own parents, their husband HIV status will also be revealed. These women live in difficult situation. There is no one to turn to and they have to keep up "good face", at the sometime tolerating to their husbands' psychosocial problem. Women place themselves to support their husbands and the family without seeking supports for themselves. For this group of women, we provide them psychological support and at the same time, keep their confidentiality in our project. However, there are a large number of women in this situation that we can not reach.

3.3 Gender and Reproductive Health of the positive women

Two out of three positive women in our study have had history of inducing abortion after HIV infection. As the majority of them found that they are HIV positive from Ante natal clinics. Most of them, at that time, were advised by health personnel to have abortion. Not until recently with the effectiveness of drug therapy, the women are advised to make their own decision whether to terminate their pregnancies or not. Some of the women managed to carry on with their pregnancy and having healthy babies. However, for a new HIV infected mother, only a few women take their chance and become successful of having healthy babies.

The majority of positive women experience STD's and RTI's (Reproductive Tract Infection) particularly with herpes simplex. Women suffer on and off with this opportunistic infection. It disrupts their life particularly stopping them from work. For those with day-to-day temporary job, it means less money for surviving

Although AIDS is found in only a few number of menopause and elderly women, it creates so much problems for women at this age. Social stigmatization and family problems arise. There is a case of 54 years old women whose husband died of AIDS. She has to carry on supporting her son to establish his business while trying to save the money for her ailing health.

3.4 Gender and sexuality among HIV men and women

Findings from our focus group discussions with positive women have shown that gender (power relations) still play significant role at personal relationship level.

HIV men still keep the same attitude toward sexuality. Their sexual attitude and behavior remain much the same. A 28-year-old positive man stated:

"I will never tell any women of my HIV status. My present girlfriend never believes this not even when I tell her. The matter is not AIDS, but love and understanding among the couple is more important. If she happened to know and rejected me for that, I will look for another woman. I do not care. There are hundreds, thousands and millions of them waiting outside for you providing you have "good words" for them, put brains into your mouth. They came after you.

Most positive Thai women think their sexual life has passed. Those who decided to maintain their sexual relationships will keep "mix-up" among positive people. Some healthy positive women were approached by non-positive men, but they will keep their distance. Most of them status before any decision taken in order to be faithful and honest to themselves and to the men. Only a few men in the study group show the same attitude.

The men's attitude toward their remaining life is different with those of positive women. Men tend to do anything for their health and their life, but women tends to devote themselves toward the children and their family without thinking of themselves.

3.5 Power Relations in Established Positive Persons' Club

The Thai government has supported the establishment of positive persons' club in different regions of Thailand. Strong positive women movement is very much apparent in the Northern region. Many AIDS widow clubs are organized in the aim to provide supports, social, economic and psychological, to their peers. This can be due to the high incidence rate of HIV in the region. In the Northeast region, the chairperson of the club is usually a man. According to our findings from the FGD with positive women, some of the group

activities are not appropriate for women. However, the women have to be passive, because they feel "men are very good in writing proposal, good in communicating and negotiating with the government workers for help, we are not good in this." This reflects women limitation of various skills, writing, communicating and technical skills.

4. Conclusion and Recommendations

Gender play a significant role in the AIDS era. Major problems we are encountering has their deep roots in gender. Women are struggling through gender bias and misconceptions. There are still so much work to be done in accordance to the gender rights reproductive right and sexual right for the women in all communities, not just in Thailand. Women should have their voices and yet choices for their own sake in society. It is undoubtedly, time for all women and their male counterparts to work together for further steps forward for the advancement of mankind.

4.1 Gender education and reorientation for general population

It is necessary to reeducate the present generation as much as educate the new generation on gender roles and power relations. The task my be difficult and take time. By exertion of human right perspective, cultural norms, beliefs and tradition should change gradually. Thai women in history used to be regarded as men's properties. Husband could sell his wife and fathers could sell daughters when they ran out of money. It was their right at that time. Thai women nowadays are free from being "slaved wife". However, there should be some measures taken to be sure that "slavery" is not taken in different forms. Use both male and female as gender educators.

4.2 Establishing supporting system for HIV positive women

It is more than "a must" to create good supporting system for women with HIV infection. In AIDS epidemic, women suffer more than men with their role expectation. Establishment of peer supporting groups are essential for those who are out in the open and for those who are hiding in the shade of stignatization and in the fear of "not being a good wife".

Supports should be geared for both men and women, so that responsibilities are not placed heavily on the women's side. Appropriate counselling should be done for all families with HIV infected person. Economic supports should be provided for families in need. Women should be encouraged for protecting reproductive health right, i.e., maintaining their needs for children and family.

4.3 Local, National and International Networking for Gender Watch Activities

Allied activities and movement must be encouraged at all levels. All forms of discrimination against women should be diminished. Women should gain access to health care and information as much as men. HIV mothers must be supported by communities and governments to carry on their functions as well as being cared by others for their health. Promoting gender issues and power relations between men and women as complementary to one another rather than opposite power.

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The New Face of AIDS in Thailand : Younger and Women
A Reflection on Gender and HIV/AIDS

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1. HIV/AIDS in Thailand

HIV/AIDS has now become a major public health challenge to Thailand which experienced the earliest HIV/AIDS epidemic in Asia. The latest statistics shows that Thailand ranks third (128,606 cases) for top ten countries reporting the highest number of AIDS cases among 210 countries reporting to WHO as of November 2000.

Responses to AIDS

Thailand has been seriously committed in solving problems of AIDS. The interventions have been effective although it was a slow start, taking into consideration that the first national policy on AIDS started only in 1991. Now, it is toward the end of the 1997 – 2001 Prevention and Control Plan. The World Bank in its study on *Thailand Responses to AIDS : Building on Success Confronting the Future* attributed the success on several factors including good surveillance system and good pilot projects which resulted in effective policy options. The NGOs have also played an effective monitoring role well.

Past achievements as cited by the World Bank included a reduction of the infection rate among sex workers from 86 percent in 1990 to 19 percent in 2000. The Promotion of 100 % Condom Use Project which enabled sex workers and STD patients receive accessible and efficient / effective services, thereby reducing the risks involved. The project also demonstrated a good multi-sector cooperation among concerned parties in 100 % condom use e.g. brothel owners, PH officers, NGOs and police. Good cooperation led to a decentralized planning system and budget allocation.

Even though success has been achieved to a certain extent in the reduction of the overall infection rate, a big concern is related to the increase in women, younger ones being affected.

A decade ago, women seemed to be on the periphery of the epidemic. Today they are at the center of concern with an alarming increase of HIV/AIDS infection. For the past two years, 1999 and 2000, the number of young girls and adolescents in the age range of 10 – 24 years affected by AIDS exceeded that of males. Statistics of 2000 appear below.

Percentage of AIDS patients classified by age groups and sex in 2000

Age Group	*Percentage of Male Patients*	*Percentage of Female Patients*
0 – 4	50.96	49.04
5 – 9	53.59	46.41
10 – 14	27.27	72.73
15 – 19	39.44	60.56
20 – 24	44.87	55.13
25 – 29	62.95	37.05
30 – 34	74.57	25.43
35 – 39	76.26	23.84
40 – 44	77.01	22.99
45 – 49	76.76	23.24
50 – 54	72.28	27.72
55 – 59	74.80	25.20
60 >	80.52	19.48

Source : Ministry of Public Health

A study in 2000 also found that among factory workers, the rate of infection has changed in the past 10 years. At the beginning, the ratio between men and women was 9: 1, it came to 3:1 and now it is close to 1:1.

Rate of infection among pregnant women has been increasing in all regions from 1.74 in 1997 to 2.2 in 1999. Area specific, for pregnant women in Bangkok, the rate has increased

from 1.3 to 2.3. Undoubtedly, as infections in women rise, so do infections in the infants born to them.

Another tragic point is that HIV infection in women is no longer restricted to the high-risk behavior groups. It has spread through heterosexual transmission to monogamous wives or partners of HIV-infected men. More than 90 percent of HIV cases of women sheltered at the Emergency Homes of the Association for the Promotion of the Status of Women, a charitable non-governmental organization in Thailand, are infected by their partners.

As the incidence of AIDS among Thai women continues to grow, it has been slowly recognized that social factors have much to do with the infection. Unequal gender relations place women at a more vulnerable position towards HIV/AIDS and expose men's risk-taking behavior. However, more attention has to be dedicated to strike at gender issue and HIV/AIDS on the public agenda as there is still in tackling HIV/AIDS problem the lack of understanding of the operating influence of gender roles and relations in the transmission and prevention of the epidemic. A much greater effort has to be made to awaken the society that while *the disease itself is a health issue, the way the disease is transmitted or the epidemic is a gender issue.*

2. Examining The Gender Construction in Thailand

Situation of Thai women

Since the 1970's, considerable efforts have been made by the government and non government organizations and women's movements to strengthen the roles and advance the status of women in Thailand to reduce gender inequalities. As a result in present day Thailand, there is a greater participation of women in all spheres of life and women play an integral in social and economic, a little less in political development of the country.

Thai women participate actively in labour force, constituting nearly half of the economically employed population. Job opportunities are now much more accessible to women whose potential and capabilities have been recognized. Sustained economic growth in the decade

prior to the economic crisis in 1997 has improved many aspects of social development in Thailand. Women's health has improved with life expectancy at birth now being five years longer than that of men. In education, the literacy rate has increased significantly to 91 percent.

In politics and administration, representation of women is still rather low both at the national and local level. The general trend is that women have a greater interest in politics as supporters and campaigners but not necessarily the election candidates. At the national level, women senators and members of parliament form less than 10 percent of the total whereas at the lowest level of local administration level, they form about 10 percent. Representation of women as government executives is 12 percent.

While these scenarios are a source of encouragement, a closer scrutiny shows that while women's conditions have improved in some areas, inequality still persists in others. The intrinsic nature of inequality based on gender relations between men and women as determined by deep-rooted cultural beliefs and traditions relating to their respective roles, remains largely unchanged. The gains have not been accompanied by much greater control over women's own lives. Particularly concerning health, there is not much awareness about women's rights to health and their vulnerability to HIV.

Socialization of Men and Women in the Thai context

In Thailand, gender differences between women and men are generally rigidly defined. In the family, daughters are socialized to stay home, to do household chores, to take care of brothers and sisters and to participate much less in society than boys.

Girls are expected to start their domestic responsibilities in their early childhood while the boys are excused from household chores. Boys are given more freedom to roam and to play outside.

Emphasis on boys' physical strength and leadership reflects Thai social values which characterize masculinity as a biologically determined tendency to act as provider and

protector, leading to girls to internalize the belief that they are weaker than boys and need to be protected.

Through the process of socialization, the stereotypes of femininity and masculinity have been formed, formed, reinforced and passed on from generation to generation. In gender training courses carried out by the Gender Development Research Institute, when participants are asked to list what comes to their mind upon hearing the words "men" and "women". It is found that women are characterised by gentleness, politeness, service-mindedness, weakness, shyness, dependence, emotionality and responsibility for taking care of the house and children while men are characterised by accomplishment, leadership, responsibility to be head and financial provider of the household, physical strength, and decisiveness.

It is thus not surprising to find that in the study, by Warunee Fongkaew (1995), interviews with young girls revealed that girls aged 11 – 14 in the focus group agreed that women should be polite, gentle and well-mannered. They also felt that women need protection from men whom they said should be strong, confident and leader of the family while the most important value of being a mother is as the person who gives birth to human beings and takes care of the family well-being. Women were described as physically and emotionally weak.

Such internalized values and beliefs have consequently led to a significant power differential between men and women, with women being accorded subordinate status in society in general and in sexual relations in particular.

Subordination of women and HIV vulnerability

The followings are some of examples of how women can be more vulnerable and how protection does not look easy as it seems.

In sexual relations, males are expected to initiate relationships while sexual assertiveness in women is often stigmatized. Thus, many women believe that men should decide when and

how to have sexual relations. Women's fear of abandonment limits their role in sex to satisfying men's desires

Women are expected to have one lifetime sex partner and assume responsibility for keeping men monogamous, upholding the role of protecting the integrity of the couple which is culturally assigned to their gender roles. Men's polygamy is generally experienced as women's failure. As a result, women are more likely to be monogamous than men and to have fewer lifetime partners. The issue is that when reliance on monogamy or mutual fidelity is advocated as a principal solution for AIDS protection, it can be misleading for women as fidelity protects against AIDS only if it is completely mutual and lifelong. It creates an illusion of safety for individuals who are monogamous but who cannot be certain about their partners.

Love is used to explain not using protection against HIV. Stable sexual relations generate levels of trust that lead women to be less insistent about prevention. Love and trust create a false sense of security that replaces the feeling of a need for protection and this puts women at risk. Findings in one study confirmed this behavior. Male factory workers use condoms with sex workers but do not use it with girlfriends (, 2000).

Within marriage or other long tern relationship, the very suggestion of condom use carries with it an indication of infidelity or other behaviors that could threaten the security of relationship, making it difficult for both men and women to introduce condoms into an existing relationship. It is generally more difficult for women to negotiate safer sex practices. To do so may have serious repercussions ranging from stigma to fear of violence or abandonment. The sexual vulnerability of women is compounded by their economic subordination. If the women are economically dependent on the male partners, the situation is much more difficult for them to negotiate safer sex practices to protect themselves from infection. Male resistance to condom use and women's inability to negotiate safer sex puts women as well as men at greater risk of HIV infection.

Schools and other institutions that work with adolescents are rather conservative in providing sex education or otherwise discussing issues related to sexuality due to social and cultural concerns about protecting young women from sexual experience. As a result,

young women lack adequate information and skills to protect themselves if they are sexually active. A study found that girls acquired information about sex from the media (Fongkaew, 1995).

Women are also vulnerable to coerced sex, including rape and other sexual abuse in and outside of the family and forced prostitution.. Any non-consensual penetrative sex can carry an increased risk of transmission of HIV and other STDs particularly as men who rape are not likely to use condoms. Violence against women, the clearest sign of male domination, thus makes women directly or indirectly vulnerable to HIV. It should be noted that in Thailand, although violence against women has been underreported, the number of sexual violence that has been officially reported has more than doubled in the past 10 years. In 1990, there were 2,817 court cases on sexual violence where women were victims. The number increased to 5,840 cases in 1999. In 1999, statistics showed that one girl aged 15 and below was raped each hour (Bhongsvej, M. and Vichitranonda, S ; 1999)

The AIDS /HIV reality challenges us to continue towards a true revolution that promotes cultural changes and this means changing from the inside out.

3. Case Study: HIV/AIDS and the Association for the Promotion of the Status of Thailand

The Association for the Promotion of the Status of Women (APSW), a non-partisan, non-profit, charitable organization located in Bangkok, Thailand. Its main mission is to provide assistance to destitute women and empower women by promoting women's rights and eliminating discrimination against women.

One important activity of the APSW is the Emergency Homes which provide help for destitute women and children who are victims of forced prostitution, rape, HIV/AIDS, abandonment, domestic abuse and unemployment. On any given day, there are some 130 women and children staying at these Emergency Homes. Up to the present day, more than 40,000 women and children from all over the country have been helped by these services. All the services and assistance provided to the women include food and shelter, physical

and mental rehabilitation, education and vocational skill training to enable them to become self-reliant after they leave the Emergency Homes.

Assistance to HIV/AIDS Cases

As sexually transmitted diseases, HIV/AIDS pose an increasing threat to women in Thailand, the past three to four years have seen a major increase in the number of HIV/AIDS cases seeking assistance . Actually, the assistance to HIV/AIDS cases started about 10 years ago and up to now, there have been over 500 women and a small number of children who have sought the APSW's help. At present, there are 17 women and children sheltered at the Emergency Homes. APSW's HIV/AIDS quarters in full capacity can shelter 30 patients.

Assistance that is offered to HIV/AIDS cases include shelter, rehabilitation and counseling services, home visits, vocational skill training according to interests. There is no medical doctor attached to the Emergency Homes, however, the APSW is working in close cooperation with state hospitals to provide health care to HIV/AIDS patients. The caring system at the Emergency Homes is carried out by the cases themselves. The HIV positive but healthy cases tend to the less healthy ones. There is a timetable for activities on each day. These include visits to the hospital if required, group or individual counselling, physical exercise, meditation sessions, vocational skills activities.

Some of the cases are also actively engaged in AIDS network activities and serve as invited speakers in sessions organized by the network in AIDS prevention campaigns. For about two years, the APSW got support from the Ministry of Public Health for a project which enabled home visits of other HIV/AIDS cases in Bangkok. The project was successfully led by several HIV positive activists.

Gender Issues

Over 90 percent of the HIV/AIDS cases of the APSW got infected by their partner and generally did not realize that they were infected after the death of their partner. They were reported to have lacked information about HIV/AIDS. Many have found that people generally assume that if they have HIV infection, they have had multiple partners or

engaged in prostitution, labeling them as bad women. As a result of this stigma associated with HIV infection, some have been evicted from their homes, abandoned by the family members.

Working with the New Generation

The work of the Emergency Homes in offering the assistance to women and children is very much on the welfare end. Facing with the problems faced by women which are mostly gender-based, the APSW has considered that proactive approach should be attempted, despite the small scale it could afford to carry out. In recent years, the APSW, in recent years, has carried out activities with youth in attitude – forming programs. The themes center around issues that are of great concern to the APSW. The past several years have seen activities launched to create youth leaders who could serve as change agents through conducting activities with children in schools in Don Muang area where the APSW is located. Thus in 1999, the APSW initiated and launched a project entitled "Learning from Friends" where the focus was to train youth catalysts who could assist in disseminating knowledge and understanding on HIV/AIDS prevention using a gender-based approach.

"Learning from Friends" Project

In recognition of the gender dimension of the HIV/AIDS epidemic and the risk and vulnerability of youth and the fact that it is more effective to use youth leaders in changing the attitudes among their peers, the APSW set the goal with an aim to instill in youth of selected schools and educational institutions in Don Muang area, appropriate social attitudes, values and behaviours in relation to gender-based HIV/AIDS prevention and the sense of family and community responsibilities.

Major project activities included the followings:

1. Meetings were held with the teachers of 7 schools so that presentation on project concepts was made and activities to be carried out were explained and at the same time raising awareness on gender and HIV/AIDS.

2. A Family Camp was organized to raise an awareness of the parents of students selected to participate in the youth leaders training with the main objective of highlighting the importance of gender roles of family members in the prevention of social problems particularly HIV/AIDS that affect youth and the important roles the family relationship play in this regard.

3. The youth leaders training aimed at facilitating skills including life skills and at raising an awareness of gender based approach to HIV/AIDS prevention. Topics included gender awareness, life skills, leadership skills, group dynamics, HIV/AIDS prevention. Interviews with HIV infected women at the Emergency Homes were also made.

4. Youth leaders upon the completion of their training then conducted "Learning from Friends" activity programs in their own schools but the design may be different according to the leaders participating. Sessions conducted in these schools shared similar features. Each session lasted 3 hours. Topics included leadership, gender, family relations – roles /conflicts, violence, drug addiction and HIV/AIDS.

The sessions employed participatory methods - brainstorming, VDO, games and songs. Presentations were also made to reinforce important points.

The project resulted in the followings:

1. There was an increase in the awareness of the teachers, parents and Don Muang community on ways that youth can assist in the prevention of HIV/AIDS.

2. There are now an additional 33 youth leaders (20 females and 13 males) from 7 schools who have been trained as youth leaders who have acquired leadership and facilitating skills, more profound knowledge and better attitudes on the gender-based approach to the prevention of HIV/AIDS.

3. A total of 281 M1-M3 students (135 girls, 146 boys) from 3 schools participated in sessions that new youth leaders took part in conducting the sessions which helped raising an awareness on gender and prevention of HIV/AIDS.

On the whole, the project results were very positive and the objectives set were fully achieved (APSW,2001). Through the trust the youths had on project staff, it was discovered that many students have personal and family problems which in many cases could easily lead to deviant behaviors. It is quite convincing that very close family ties are the most important and need to be strengthened to avoid social problems that Thai youth are encountering. A pilot family camp which was a success helped the parents to have heightened awareness on gender roles and how gender had implications on the way they have brought up their children. It was suggested that family camps be organized as one preventive measure for HIV/AIDS problem among youth.

4. Revisiting the Gender-Based Approach to HIV/AIDS

Points to Reconsider

When linkages have been formed between gender and HIV/AIDS epidemic, in many cases it may be assumed that intervening with women is enough to improve their status. Focusing on reproductive health programs, one expects that it means paying attention to women's reproductive and sexual needs and rights which will be asserted when women are empowered.

The questions are :

Is it feasible to empower women by focusing only on women?

In circumstances where women's status is subordinate and women are powerless both in domestic realm as well as in society, how can they assert their reproductive and sexual rights?

How can women negotiate with their partners from a dependent position?

Many reproductive health programs targeting at women thus may be considered successful. For example, at the end of the programs, women have become more knowledgeable of their rights and better aware of the sexual risks, even the programs aiming at empowering sex workers to negotiate condom use.

Then it may be clear that there is a need to shift to men to play a part in the search for solution. Thus in programs where men are the target, for example, the 100 percent condom use project which was successfully launched in Thailand, still one might have doubts.

Are we reinforcing the male dominant relationship?

Whether to use or not use condom, to have sex or not have sex, thus seem to be totally dependent on the good will of the male partners; i.e.; it is within the discretion of the male partners.

Are we once again entrusting the decision-making to men?

Another point to consider is related to the alternative often proposed to be the solution of many problems to today. Many times, when issues of gender inequality are discussed and attributed to be roots of many problems or when empowerment of women is mentioned, very often the family as an intervention to work on is proposed as an appealing alternative or approach. Family, as an institution seems attractive and much more acceptable as it includes men, women and children, all encompassed. However, within the reproductive health system, if family is taken as an intervention unit, cautious consideration has to be made as power relationships among family members may be omitted from being resolved.

After all, it is gender relations that are issues of concern which need to be tackled, not only men or women. We cannot afford to consider women without involving men or to work with men without including women in HIV/AIDS programs.

Thus, if vulnerability of women to HIV infection is to be reduced,

- both men and women must join hands to eliminate gender discrimination and the subordination of women.

- all those in positions of power - policy makers, administrators, community leaders must recognize the linkages between women's economic and social status and their vulnerability to HIV infection.

- men and women must reexamine the ways they perceive themselves as men and as women and the ways they relate to each other as husband and wife, partners, lovers, brothers and sisters, parent and child, colleagues and friends.

Unless the interlinkages between HIV infection and the gender relations are recognized, the fundamental change required to stop this HIV/AID epidemic is unattainable.

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Vietnam-1

Women and AIDS in Ho Chi Minh City

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Introduction

In Vietnam, since the first case detected in 1990, eight years later HIV has spotted all over the country. As of May, 2001, HIV infected cases reported reach 36,445 nationwide, in which, there are 2989 death cases and 5490 AIDS patients. Drug users infected are the leading cases at 60,94%. The infection profile by age has a precipitous peak in the age group 20-29 at 49,37%.

The proportion of 8:1 between men and woman in HIV infection in 1996 is narrowed as 3:1 in 2000.

General situation of women and AIDS in HCMC

Ho Chi Minh city is largest city in Vietnam with 5,169,449 in population as of 2000.

People in the city is open, dynamic and sensitive to the change that makes the city a well-known center of economic, trade, scientific, cultural growth in the open-door policy.

In 1990, the first case of HIV infected is detected in HCMC which agitated the public and made HIV infection a big issue. Since then, HCMC consecutively ranks first in the number of infected cases nationwide.

In 2000, with 7,444 seropositive cases, Ho Chi Minh city suffers more than ¼ of the cases in Vietnam. In which, women cases reached 1,490 and the proportion of women and men was 1:3.

Year	90	91	92	93	94	95	96	97	98	99	00	Total
Male	0	0	1	586	443	465	582	624	849	975	1429	5954
Female	1	0	2	45	40	86	120	158	256	189	593	1490
M/F %	100		66.7	7.1	8.2	15.6	17.4	20.2	23.2	16.2	29.3	20

Source: National AIDS Committee of HCMC, 2001.

The report of National AIDS Committee of HCMC realized that the infected women cases have been increased more and more in the recent years. Concretely, 15,6% cases of the infected women in 1995 increased to 29,3% in 2000. The children consequently infected through mother-to-child mode of transmission grew up remarkably from 0,4% in 1995 to 3,1% in 2000.

The social, economic, gender inequality, and structure issues that have placed women at an ever-growing risk of acquiring HIV.

Women in family are at risk of HIV infection without any resistance. Center for Tropical Diseases of the city, one of three centers responsible for HIV/AIDS cases in the country, noted that women did not know they got infection until they came to the Center, 97% of them were acquired HIV from their husbands.

Women in prostitution ranked second after drug users have moved from 2 to 3% for several years, but their infection rate began grow up considerably in 1998.

Year	93		94		95		96		97		98		99		00	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
CSWs	7	1,1	11	2,3	19	3,4	17	2,4	24	3,1	25	2,3	89	7,7	321	15,8

Source: National AIDS Committee of HCMC, 2001.

The situation becomes worse. The age of infected CSWs tends to lower than before. The number of CSWs aged from 13 to 15 increased 6.7% in 2000 if compared to 3.5% in 1998, according to the figure of Women Rehabilitation Center in HCMC. And, young CSWs

involving in IV drug use reach 50%. In addition, the growth of infected cases has been found out among CSWs who come back from the brothels in Cambodia. Their infection rate is as much as four times higher than domestic CSWs.

HIV/AIDS in Gender Context

In term of the infection of HIV, women are more vulnerable to the infection than men physically and socially. Risk of infection in women is higher from 2 to 4 times than in men through unsafe sex (Phan Thi Le Mai, 1996)

- ***Stereotype related to HIV/AIDS and its transmission mode have had a deleterious effect on women***

Unlike other places in the world, the first cases usually feel upon at–risk behavior groups, the first seropositive case in Vietnam was an ordinary young woman, who was in love and just wanted holding love by giving love, that led her to engage in premarital sexual activities with her fiance, an oversea Vietnamese. At that time, people were startled by the new fatal disease in the scandal reportage on the dailies that told the story of a woman with the notoriously fast loves. HIV/AIDS was introduced to the public for the first time under the name of the disease spreading from prostitutes or from the women who practice immoral sexual habits.

- ***Submissive to men which creates condition for the HIV infection to women***

Traditionally, the husband is the most powerful one because he is the head of the family. Wife should obey husband. This tradition sanctions wife not to refuse sexual activities to husband even she knows that he has extramarital or becomes the person who can pass on HIV to her. There was a woman who came for counselling disclosed that she got HIV test every 3 months since she knew her husband was not faithful. This was the only way she could do for "HIV/AIDS prevention". Or, a young infected woman could not stop her lover from making love with her by insisting him with the truth about her HIV infection. The reason most often given not for not refusing undesired sex was concern about hurting their partners' feeling - more so than shame or fear (Miriam Lewin, 1985 as cited by Nancy Golstein in Gender Politics of HIV/AIDS in women).

Presently, men continue to be the one who make decisions, both in family and in community. Although women today have been empowered more by education, job opportunity, Law on Marriage and Family, the exercise of their rights is still limited by interpersonal power which appears to influence women's options for safe and responsible sexuality. Moreover, the violation of Law and violence against women has occurred regularly. Rape, sexual harassment, deceiving or forcing women to work in prostitution, trafficking women seems to be increasing (Le Thi Phuong Mai, 1998)

Years of out-of-family in replacement of men in battle during Vietnam war offered women a chance to prove their potential capability. The status of women of HCMC is now apparently equal to men's educationally, professionally, scientifically, politically, however, the status is different depending on urban or rural areas. But, it seems that women have still been natural bearer of an ideology based on conformism and servitude when men, after war, return to take their power in economic position, both in family and community. Accordingly, women easily turn to be less self-assertiveness in their intimate life.

Using condom as HIV precaution is power in sexual relationship

The rate of infection of both women in prostitution and woman in family have risen up ceaselessly indicates that the condom precaution for heterosexual mode of transmission in the vicious circle of men –women in family- women in prostitution remains a question addressing to gender issue.

The finding of assessment of peer project among CSWs in HCMC showed that the submission to men was also found in CSWs in using condom with their customers, their husband and their boyfriends. The highest percentages (36%) of CSWs answered that they had never use condom with their husbands and their boyfriends. Only 24% of them practiced safer sex but did not practice with their husbands or boyfriends. Focus group discussion revealed that they had strong confidence in their husbands and boyfriends. That confidence may be shown by not using condom during sexual practice. They did not practice safer sex because "We believe and love each other". In other words, they did not want to get "a vote of no-confidence" for their sex partners. Thus, the practice of safer sex on the part of CSWs depends upon the sex partners. The submission of women to men

can also be a factor affecting sexual behavioral change. Women had tendency to let men decide everything. They are always ready to satisfy what men want. The focus group discussion also found that CSWs submitted easily when customers said "no" to condom, much more so when it is their husband or boyfriend who said "no" (Nguyen Thi Xuan Dao, 1995).

In 2000, the rate of using condom among CSWs has increased remarkably, it reached 60-70%, however, the rate of infection of CSWs has also increased. There are many factors affecting the increase, but the inconsistent frequency of using condom with sex partners of CSWs is not taken into account. The number of exposures necessary for transmission of HIV to occur is still unknown. Yet, cases attributable to just one exposure have been recorded, and it is known that the risk increase indirect proportion to the number of sexual contact with one or more infected person (Winkelstein, W.D.M Lyman, N. Padian et al.,1987 as cited by Nguyen Thi Xuan Dao in Assessment of Peer project in the HIV/AIDS prevention for CSWs in HCMC, 1995)

- ***Stigmatization in the family toward women that makes the accessibility to health care services impossible***

Women are usually considered as the source of transmission or condemned adultery if their husbands are detected HIV infected. In fact, most of them are infected by their partners and usually enter their AIDS stage after their husband death. During the last phase of illness, they were neglected by their husband's family and died in loneliness.

Also, pregnant women with HIV usually know that they are infected when they come for delivery or in prenatal examination and disappear after they are detected as seropositive.

Young women have much more risk of infection

HIV passes even more easily to young women than to adult women because of their bodies are not mature. Older men who have sex with young women and girls, for example those seeking virgins in the mistaken but widely held belief this will protect them from HIV, place

their partners at great risk (UNICEF, Progress of Nations, 2000). In addition, the insufficient of knowledge on sexuality that also puts young women at risk of becoming HIV contracted. In the research of 1999 on sexuality among students of secondary schools, aged 15-17, in HCMC, the findings revealed that their puberty and sexuality came earlier than what people have believed previously while knowledge on reproductive health among them was low due to improper attention of this aspect of education (Tran Anh Tuan, Nguyen Duc Tri Dung, 1998). In the same vein, a study on the reproductive behavior of unmarried students, aged 17 –24, in Ho Chi Minh city and Ha Noi, noted that their knowledge about contraceptive methods and sexually tranmitted diseases was quite limited, although their knowledge of HIV/AIDS was high (Vu Quy Nhan and Ngo Dang Minh Hang, 1996 as cited by Khuat Thu Hong in Study in sexuality in Vietnam: the known and unknown issues, 1998).

Response to AIDS

HCMC has applied various approaches in HIV/AIDS prevention. For more than a decade, the city has encountered the epidemic in any efforts. It must not be underestimated the achievements which have been made in detection, surveillance, research, IEC for prevention. But in social aspect, the gender sensitiveness remains almost untouched.

In general, the HIV/AIDS programs in the city have been much interested in women but not included the gender issue yet.

Peer project for CSWs

In 1993, peer education among CSWs was initiated by Save the Children Fund (UK). The assessment of peer project, at that time, noted that the peer group project for commercial sex workers is new model both in approach and in management. The project inputs focus on human resource development. This is aimed at a community outreach and an integration of delivery target clients and agencies. The effects basically indicate changes towards the practice of safer sex among peer educators and beneficiaries of the program. The incidence of safer sex is however not sufficient to prevent the spreading of HIV infection. Condom

usage will have to be combined with regular STD check-up and treatment as part of the method of HIV/AIDS prevention and control. The replication of the project, however, can be done by institutionalization through training of regular staff to carry on the task of peer educators to get control the spread of HIV infection among the special target group when the project phases out inevitably. But, perhaps, most important of all, the approach seen through the human development process is a meaningful introduction of the professional practice of social work towards a multifaceted issue. The model is able to replicate the condition that the professionally trained workforce becomes a key factors in the efficient and effective delivery of social services in Vietnam (Nguyen Thi Xuan Dao,1995). Later, the peer projects in the form of cafeteria for CSWs and drug users were run by the Women's Union. There are peer projects in 9 districts over 22 districts of the city presently. The cafeterias as drop-in centers where HIV/AIDS health education, counselling, condom distribution, needle exchange and STDs check-up clinic are conducted. The outreach program to red light areas for distribution of condoms to CSWs or needle exchange to drug users is another activity of these projects.

Prenatal prevention program for HIV pregnant women

The program has been conducted for 2 years on HIV pregnant women at two Gyn-Obs hospitals, Tu Du and Hung Vuong, in HCMC. Basically, the program aims to study the prevention of HIV infection through mother-to-child mode of transmission.

The average age of infected pregnant women is from 22 to 25. The average age is relatively young in women that raise a question: Do most women in those get infection by being married? If so, nothing can be a goad for all of us than it is!

So far, there are 21 cases in the two hospitals under treatment of the mother-to-child transmission program which is sponsored by UNAIDS. The first encouraging indication is the number of mothers in 2000 is higher than in 1999, it might be they can overcome the stigma barrier to save their children at last.

- **Reproductive health education for youth**

Reproductive health education for youth has been integrated into secondary school (9^{th} –12^{th} grade) by UNFPA Project VIE/88/P09 "Family Life and sex education" which includes the issues relating to sex, sexuality, friendship, love and family planning.

Recently, the informal short -term courses on reproductive health have been conducted by Youth Association of Vietnam in HCMC for out-of-school youth. This type of health education takes the form of small group discussion. The provision of information relating to love, marriage and family when it is needed is made through counselling unit of the Association. Although the courses have been held for both sexes, most of the participants are girls. It may indicate that boys are expected to be sexually experienced, leading them to be less receptive to information regarding to sexual health.

A number of activities of NGOs in HCMC have been contributed to the HIV/AIDS prevention with gender approach. In 1996, CARE International in Vietnam, cooperated with Women Union, initiated a training module on skill of self-assertiveness in prevention of STDs for women in 3 southern provinces and HCMC. The 5-day course content focused on female sexual organs, STDs, safer sex and skill of self-assertiveness. The partipatory method was used in this module. SCF (UK) has also developed a reproductive health pilot training course for children in difficult circumstances in attempt of preventing the young ones from the dreadful disease.

Conclusion

Women in HCMC are not an exception in the whirl of HIV infection. In the same boat with women all over the world, the risk of women and the part which they are playing in the spread and containment of AIDS is embedded in gendered power relationship. The gender issue is most identified as the role playing out in heterosexual transmission but gain least attention in the prevention strategy presently. The awareness of the gender and power relations which structure sexual interaction and relationship has not yet been included in most of the HIV/AIDS programs.

Specifically, the focus on women in prostitution of most HIV/AIDS programs in the city led women in family being considered at little risk from HIV infection. In addition, the behavior changes that design for women in prostitution failed to meet the needs of women in family. And, men in the vicious circle of heterosexual transmission are not mentioned properly under gender aspect.

Importantly, under the threat of HIV of the city, the young people have been attacked consistently over years, the challenge today is that the self-protecting behaviors of adult are necessarily managed at the same time with the nurture an environment benefit to self-protecting behaviors among the youth.

Laws relating to protection of women in marriage and family have been less successful where there have not been concurrent changes in social and cultural value. Accordingly, communities must support by enforcing such laws into practice.

A better understanding of gender issue should be strengthened among men and women that will be essential for improving the reduce of vulnerability of women to HIV infection. In doing so, we are able to save more than half of population in the world and save the continuity of life through our newborn, too.

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GENDER ISSUES IN HIV/AIDS

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Country's socio-economic profile

Viet Nam is located in South East Asia, sharing border with China in the North, with Laos in the North West and with Cambodia in the South West. According to the 1999 National Census, total population of Viet Nam is 76 million. Due to the high population growth in the last decades, Viet Nam has a high population density, 219 habitants per square kilometer. Major part of population concentrates in two plains, Red River Delta in the North, and the Mekong Delta in the South. Viet Nam is multiethnic state with about 60 different ethnic groups. Majority of Vietnamese people belong to Viet ethnic.

Political leadership belongs to the Vietnam Communist party. Regarding national legislature, Vietnam has a unicameral 450-member National Assembly; election takes place every five years. The National Assembly appoints the president and the cabinet.

The reform process known as Doi Moi launched in 1986 has clearly achieved considerable progress in improving the overall well-being of the vast majority of Vietnamese people. Poverty has been reduced from more than 70% in the mid-1980s to 37% in 1999. GDP has increased from less than US$200 in 1980s up to US$400 in the year 2000. Average life expectancy has been extended by around five years since the mid-1980s to reach 68 years today (Government of Viet Nam, 2001). Nine out of ten adults are now literate. Primary and lower secondary school enrolment rates have increased up to 97% and 62% respectively. Infant mortality rate has declined from 50 per 1,000 live births in the 1980s to 37 per 1,000 live births. More people now have access to clean water, sanitation and better health care (United Nations, 1999).

Still, there are many challenges Viet Nam has to overcome. The country ranks only 110th of 174 countries in the world according to a composite index of human development reflecting life expectancy, education and material well-being. Average income per capita is still very low, poverty and near-poverty remain widespread. Income gaps are slowly widening between urban and rural areas, and across regions. Landlessness is gradually increasing and contributing to pockets of persistent poverty in the face of slow growth in off-farm employment opportunities.

Many of these socio-economic characteristics have shaped the profile of HIV/AIDS epidemic in Viet Nam and at the same time have presented challenges to the national HIV/AIDS prevention program.

Gender relations in Viet Nam

There is a strong history of gender equity in Viet Nam, partly resulting from ancient matriarchal traditions. However, many of these were eroded through centuries of Confucianism that spread during the years of Chinese occupation. With the advent of the Communist Party, socialist policy enshrined gender equity in the Constitution of Viet Nam and many policies of the Government. This has led to the current relatively high gender development index (GDI) in Viet Nam, compared to other countries in the region and countries with a similar GNP.

Although women in Viet Nam benefit from high health, education and gender equity indicators - as illustrated by the GDI (below) - women still fare worse than men in education and health statistics even though the disparities are less pronounced than in many other countries of the region, and other countries with a similar level of economic development.

Table 1: Regional indexes of human and gender development

	Human Development Index Rank among 174 nations	Gender Development Index Rank among 143 nations
Viet Nam	108	89
Lao PDR	140	117
Myanmar	125	102
Thailand	76	62

Source: UNDP Human Development Report 2000

Viet Nam is a country in which gender roles are in transition. Gender stereotypes and gender values in Viet Nam have changed little from earlier decades or centuries, although what women do as part of their daily tasks, has changed dramatically in recent years. Juggling these multiple, and sometimes contradictory expectations, has created new stresses for the younger generations of Vietnamese women. The present full time productive workloads of women are conflicting with traditional roles and values causing anguish and confusion for many women trying to fulfill all expectations of themselves (Franklin, 1999).

Equality of course means changing gender roles for men as well as women, and women are recognizing this in the way they are approaching their relationships with the men in their lives. A study of gender conducted by the National Committee for the Advancement of Women looked at men and women's perceptions of the ideal man. While men perceived the ideal man as a person earning a lot of money for his family, women - particularly young women, considered the ideal man as a good father and husband who loves, understands and supports his wife actively (Franklin 1999).

As in many countries of the region, the majority of men and women in Viet Nam live in rural areas. The paid positions that women hold are predominantly in hotels, restaurants, tourism, banking, schools, hospitals and health care centres, and in textile and garment manufacturing - where they run 80 per cent of the businesses (Desai, 1995). Men dominate in the areas of forestry, chemistry, science and technology, sport, culture, heavy industry, energy, irrigation and construction.

The socio-political structure of Viet Nam has shaped many of the current trends in the country. Viet Nam has a very stable government that contributes to socio-political stability and strong mass organizations such as the Women's Union, which has eleven million members (NCFAW 2000). The Women's Union has been a very popular counterpart for aid agencies working in women's projects, as it provides an easy mechanism by which to access women from the national to the commune level.

The rate of women in Vietnamese parliament is the most significant indicator for women in Viet Nam, which is the highest rate for the Asian region, and higher than or equal to many highly developed countries. However, ensuring women are involved in decision-making processes from a commune to a national level, remains a challenge, especially for ethnic minority and rural women who are most isolated from decision-making processes.

Country	% women in Parliament
Viet Nam	26.2
Cambodia	8.2
Lao PDR	21,2
Thailand	6.6
Sri Lanka	4.9
Sweden	42.7
South Africa	30.0
Turkmenistan	0.24
Australia	22.4
Panama	9.7
Kyrgyzstan	4.7
Kuwait	0.0

Source: UNIFEM, 2000. Progress of World's Women

Viet Nam has a highest rate of women in parliament among Asian countries and ranks second after New Zealand (29.2%) - in Asia Pacific region. There are only 10 countries in the world have higher rate of women in parliament (Cuba, Denmark, Finland, Germany, Iceland, Netherlands, New Zealand, Norway, South Africa and Sweden)

The National Committee for the Advancement of Women - the Government policy-making mechanism for women's and gender issues has been set up in 1993. The most important national policy on women is National Plan for the Advancement of Vietnamese Women. The first POA which covered the period 1993-2000 has just been reviewed. The second POA for

the period 2001-2005 has recently developed and submitted to the Prime Minister for approval. This policy covers six critical areas of concerns. These areas include equal rights in the areas of labour and employment to improve women's economic status and living standards; equal rights in education and training, improved health care, the role and position of women in leadership mechanisms and decision making, the protection and promotion of women's rights, and enhanced national machinery (National Committee For the Advancement of Women, 2001).

Gender issues in HIV/AIDS

The first case of HIV positive was detected in Viet Nam in 1990. Over the last ten years, Viet Nam has experienced a rapid increase in the number of new HIV infections. By April 2001, the cumulative number of reported HIV infections reached 32,359. The actual number of infected persons may be as much as three times higher. There have been 5,245 reported AIDS cases in Viet Nam, resulting in 2,759 deaths. All 61 provinces have reported HIV/AIDS cases (UNAIDS, 2001).

In both HIV and AIDS reported cases, the majority (65%) is related to injecting drug use. There are also indications of increasing risk for heterosexual transmission. The number of HIV positive women has been steadily increasing. The number of HIV positive pregnant women has increased from 0.02% in 1994 to 0.2% in the year 2000. Sexual transmission of HIV has also increased among female sex workers with a prevalence rate increased from 0.59% in 1994 to 4.33% in the year 2000. According to the Government estimations and projections, current HIV prevalence among adults is estimated at 0.22% and will rise to 0.27% by 2005.

Table 2. Distribution of HIV cases by Gender (%)

Year	Male	Female	Unknown
1995	86.2	13.8	
1996	85.0	15.0	
1997	87.3	11.7	1.0
1998	85.1	13.7	1.2
1999	88.1	11.7	0.2
2000	85.4	14.06	0.5

Source: Ministry of Health, April 2001

According to the UNAIDS in Viet Nam, the epidemic in Viet Nam has ample room for growth. The sex trade and the use of illicit drugs are extensive and mobility within and across borders could eventually translate into a higher number of HIV positive people. The data on HIV infection rates and mortality do not tell the whole picture of the epidemic in the country. The actual number of HIV infected people is believed to be at least three times higher than the number of detected cases in the country (Ministry of Health, 2000). Fully aware of the fatal impact of the epidemic to the socio-economic development of the country, the Government of Viet Nam has established HIV/AIDS as one of its priority programs.

In Viet Nam, HIV is perceived as a result of socially deviant behaviour, such as drug addiction and sexual promiscuity. As social acceptance of such behaviour is less lenient for women than for men, gender norms shape the way men and women infected with HIV are perceived. For example, HIV-positive women face greater disgrace and rejection than men.

Long-term care and expensive drugs and the therapy are required for the treatment of HIV/AIDS. Few patients or their families are able to afford to purchase necessary treatment and health services. Most care is provided within the family. As women are considered the primary care givers, women play a leading role in caring for family members who are infected with HIV/AIDS. Furthermore, in the case of poor households, if the husband contracts AIDS, the woman adopts additional responsibilities regarding income generation as well as domestic responsibilities and providing health care for the patients (NCFAW, 2000).

Since 1995, the Government of Viet Nam has taken important measures to curb the spread of HIV/AIDS, by creating a policy environment supportive to treatment and prevention efforts. Practical activities have been introduced, largely under the guidance of the National AIDS Committee. These include safe professional practices within the health care system, a prevention campaign, laws restricting high-risk behaviour such as prostitution and drug abuse, and treatment for HIV/AIDS patients. Information about HIV/AIDS has been integrated into Ministry of Culture and Information publications, the primary and secondary school curriculum, and national television and radio programming. Mass organizations such as the Fatherland Front, Youth Union and the Women Union have also implemented communication and counseling programs. Despite these efforts, the HIV/AIDS epidemic continues to spread in Viet Nam and the increasing trend of women's infection is alarming.

According to the recent situation analysis by the National Committee for the Advancement of Women, there are several factors explaining the gender issues in HIV/AIDS in Viet Nam:

First, although in Viet Nam the number of women with HIV/AIDS is lower than the number of men, many factors limit women's ability to protect themselves from infection. Many women especially rural women, lack adequate information about the transmission and the prevention of HIV/AIDS. A recent study of 266 men and 134 shows that, 80 percent of men know that use of condoms can protect oneself from HIV/AIDS infection, only 55 percent of studied women know that; 69 percent men know that use o clean needles can protect oneself from contracting HIV/AIDS, only 5% of women know the same thing.

Men generally do not recognise their responsibility in the protection women's sexual health. One study reported that of 91 male AIDS patients, 39 percent did not inform their family about the disease, and only 37 percent used condom when having sex with their wives after they knew they were infected (Le Dang Ha et al., 2000).

The social construction of sexuality with its inherent myths and values around morality, fertility and sexuality has been used to project social values and norms that have been different for man and women. Vietnamese culture considers female ignorance of sexual matters is a sign of purity and conversely, knowledge of sexual matters and reproductive physiology, a sign of easy virtue. At the same time, men are expected to be knowledgeable

of sexual matters and to be active in sexual relationship. Women are expected to be faithful while multiple sexual partnerships of men, in general, are tolerable. These stereotypes construct the gender relations which limit women's power in negotiation of safe sex with their male partners, to discuss sex or sexual responsibility or determine their own contraceptive or sexual behavior (Esposito et al. 2000). Therefore, women's chances of infection through husbands who engage in high-risk behaviour such as unprotected sex with many partners including sex workers or intravenous drug use is very high.

Rural women can get infection from their husbands who go to work temporarily in the city. Because the limited employment opportunities in rural areas, many men have to go to work in cities where they may engage in unsafe sexual contacts (Dang Canh Khanh et al., 2000).

Second, information, education and communication (IEC) campaigns for prevention of HIV/AIDS do not reach all sector of the population and have not met the needs of individual target groups, particularly women who do not practice high-risk behaviour, and poor women. Awareness campaigns often focus on individuals considered by society to be deviant and rarely address changing behaviour such as safe sexual behaviour and use of clean needles. Third, government resources allocated for combating HIV/AIDS are rather limited and knowledge about the prevention and treatment of the disease with thin health system is inadequate, especially at the commune level. Not all health centers are able to provide a safe blood supply or sterilised equipment. Through reproductive health and family planning procedures women are more likely to be vulnerable to infection through unhygienic conditions than men are.

Fourth, quality counseling services for both men and women is not readily available, particularly within reproductive health programmes. Health workers rarely address the risk to patients with reproductive tract infection of contracting and spreading HIV/AIDS, and rarely promote the use of condoms for birth control and protection against STDs. Men's responsibility for protecting themselves and their female partners from HIV/AIDS is not addressed through IEC or counseling.

Finally, protecting women from HIV/AIDS has not been considered by the national HIV/AIDS program to be an urgent task. Gender-sensitive policies have not been developed.

Gender issues of HIV/AIDS have never been officially mentioned in any legal document on HIV/AIDS prevention. Specific program or action addressing vulnerability of women in both epidemiological and social aspects as well as policies addressing the critical role of men in preventing HIV/AIDS through practice safe sex, have not been developed, except few small scale pilot interventions by non-governmental organizations. Majority of staff working in the government system of HIV/AIDS prevention is not aware about gender.

Many things are required for gender issues to be adequately addressed in policies and programmes of HIV/AIDS prevention in Viet Nam. There are at least three most critical points Viet Nam has to take into account. Raising gender awareness and improving skills of gender analysis for policymakers and program managers as well as implementers in HIV/AIDS prevention systems are the first priority. Strengthening research capacity on gender is another important task. So far, few research on gender and HIV/AIDS have been conducted in Viet Nam. This creates a shortage of scientific evidence serving basis for development of gender sensitive policies and programmes. Improving skills of advocacy for researchers and community activists is also a critical step to ensure that gender is addressed in process of designing and implementing HIV/AIDS policies and programmes.

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Sex Workers in the Northern Provinces of Vietnam: Social Aspects and Risk Behaviour related to STDs and HIV/AIDS

Khuat Thu Hong, Nguyen Thi Van, Le Thi Phuong and Khuat Hai Oanh

A. INTRODUCTION

I. Research purpose

The number of People Living with HIV/AIDS has increased steadily in Vietnam since the first case of HIV was reported in 1990. In October 1997, there were 7073 reported cases. Of those, more than 1000 had developed AIDS, including 500 who had died.

While epidemiological studies have noticed a decrease in the number of intravenous drug users infected with HIV, the number of infected sex workers has been slowly increasing and the has spread to other social groups. Among the high risk behaviours associated with the HIV/AIDS infection, sexual behaviour has become the focal point of the intervention program. However, so far we have not collected sufficient information on sexual behaviours in the community and particularly on the sexual behaviours of sex workers. A research on this particular topic is therefore urgently needed. Only when we have a good understanding of the sex workers' socio-economic characteristics and sexual behaviours will effective intervention programs be put in place to prevent the infection from further spreading in the community.

Over the last few years, the media in Vietnam have tried to warn the population of the increase in prostitution. Newspaper reports about prostitution are frequent. The number of sex workers and the number of places from which they operate have increased rapidly. While in the past, prostitution could only be found in the large urban centres, today it has reached provincial and districts towns and even the remote rural villages. It has developed beyond the illegal brothels and has taken different forms. The number of sex workers has increased and includes more and more young women, more experienced and "skilled",

who attract a growing number of customers. Prostitution in Vietnam has obviously become an urgent social problem and, given the spread of HIV/AIDS, it requires immediate action.

Effective policies and programs cannot be built on information collected from newspapers. Even the official data does not fully reflect the reality [1]. In recent years, several studies have been conducted regarding the social aspects of prostitution, but mainly in the South. Some studies were carried in the North in the early 90s but have become outdated has the situation is changing rapidly. In addition, high risk behaviours related to the transmission of HIV/AIDS and STDs have not received sufficient attention.

The purpose of this research is to study the social aspects of prostitution and behaviours related to STDs and HIV/AIDS, focusing on a group of sex workers in the northern provinces of Vietnam. Based on research findings, recommendations for effective policies and programs aimed at changing the behaviour of sex workers and their customers will also be suggested.

II. Research Design and Methodology

1. Research schedule

The research was designed in April 1997. The fieldwork was conducted in June and July of the same year. Data analysis was undertaken in August and the first two weeks of September. The report was written during the last two weeks of September and the first two weeks of October.

2. Research sequence

Before the research was designed, we had reviewed extensively the material gathered by previous studies on prostitution conducted in Vietnam and abroad so as to draw research objectives, questions, theoretical framework and research methodology. Fieldwork was

[1] According to official statistics, there were 56,000 female sex workers in Vietnam in 1996 (Ministry of Labor, Invalids and Social Welfare, 1996). However, by unofficial estimation, the number of sex workers is r to 500,000.

found necessary to carry out structured interviews with sex workers, using a questionnaire (104 questions, in 8 sections). An instruction document for the in-depth interviews was also written.

The research team then made contact with the Anti-Social Evils Bureau and the Police Departments of all the northern provinces. The objective was to find a sufficient number of sex workers in each province, to learn how to approach them and to create a network of local research associates, or 'key people'. Although prostitution was reported to be operating in all these provinces, given the illegal status of prostitution we were not able to conduct a large sampled study but could only conduct our study in the Social Support Caps (re-education centres) of five provinces. Although we might have been able to find other sex workers using the files held by the Anti-Social Evils Bureau and the Police Departments, after several attempts we realised that we did not have enough time, finances and human resources to do this effectively.

It is rather difficult to contact sex workers in Vietnam, as prostitution is illegal and strongly stigmatised. In addition, as in many countries, sex is a sensitive issue. Therefore, we did not draw a sample representative of the sex worker population, but we took every opportunity to approach a sex worker whenever possible.

3. Research subjects

The research subjects were 261 sex workers in the five provinces and their capital cities (Hanoi, Hai Phong, Ha Tay, Thanh Hoa and Nghe An). 241 were working and undertaking re-education in the Social Support Camps Number II run by the Anti-Social Evils Bureaus in each province. The other 20 were practicing sex work in Hanoi at the time of the study.

4. Research methodologies

The data for this research was collected from two researches. The first research consists of structured interviews of 201 former sex workers in residence in the Social Support Camps. The second research consists of in-depth interviews with 40 former sex workers in these camps and another 20 who were then practicing sex work in Hanoi.

Study site	Questionnaire	In-depth interview
Hanoi		20
- Loc Ha camp	50	10
- Ba Vi camp	82	10
Ha Tay	7	5
Hai Phong	30	5
Thanh Hoa	18	5
Nghe An	14	5
Total	201	60

A test was conducted on a number of former sex workers at the camps before starting the actual interviews. We then carried out the in-depth and structured interviews.

Although we received valuable support throughout the researches from the national AIDS Committee, the Anti-Social Evils Bureaus, the Police Department and the camp's officers, collecting information from the former sex workers was challenging, as they felt their confinement resulted from social stigma. As the research ruled that we could interview the respondents only with their consent, the interviewers had to spend considerable time gaining their trust. Each interview was conducted with respect to the respondent's privacy: each respondent was interviewed in a room with only the interviewer present. The interviewers had not read the respondent's files before the interview and relied entirely on the questionnaire or guideline to collect information, in order to avoid any bias which might have been formed with previous knowledge of the respondent's history.

In effect, there were no incidences where the respondent refused to co-operate. On the opposite, most respondents sincerely trusted the interviewers. Some were even very open, telling the interviewers their thoughts and expectations. Only when the interviews were completed were the interviewers allowed to check the respondent's files and to consult the camp's officers for more information. When there were contradicting facts (which happened a few times), then the interviewers checked the information again with the respondents.

Approaching sex workers on the streets proved even more difficult. We had to use every imaginable contact to be introduced to them. Sometimes, men who considered themselves 'playboys' introduced us to their regular "girlfriends". However, these encounters turned out to be disappointing. When we first accompanied these men to meet the women in night clubs or karaoke bars, they were excited to see their customers. Some even agreed to be interviewed. But when the questions came up regarding their sexual behaviour, they invariably refused to co-operate.

Later on, through our contacts with some motorcycle-drivers and some women who had relationships with the sex workers, we managed to approach and interview some of them. The interview would take place in their home or the interviewer's house in order to assure privacy and a comfortable environment for the respondents. The interviewers would first introduce themselves, explain the purpose of the research and ask to be allowed to record the interview on tape.

Following this method, there were no cases of respondents refusing to co-operate. At the most, they would sometimes hesitate before opening up to us and telling us their story, what led them to become sex workers, their sexual practises and their knowledge of STDs, HIV and AIDS.

B. RESEARCH FINDINGS

Structured interviews were conducted with 201 women in residence in six camps in five provinces and cities: Hanoi (Ba Vi and Loc Ha camps), Hai Phong, Ha Tay, Thanh Hoa and Nghe An. Data analysis was undertaken afterwards, using the SPSS. In addition, the in-depth interviews recorded on sixty tapes were also analysed.

PART I: SOCIO-ECONOMIC CHARACTERISTICS OF SEX WORKERS AND THEIR WORKING EXPERIENCE

I. Demographic and socioeconomic characteristics

1.1 Age structure

The respondents we interviewed came from different age groups, the mean age being 25.7
years old. The oldest respondent was born in 1945 while the youngest was born in 1981. More than half of the respondent were aged from 16 to 24. The proportion of the respondents aged 35 and above was 15% of the total (see Table 1). It is worth noting that the proportion of the respondents under 18 was relatively high, accounting for 12.5%.

Table 1. Age structure of the sample

Age	Frequency (n)	Percentage
16-19	40	20
20-24	69	34.3
25-29	42	20.9
30-34	19	9.4
35-39	22	10.9
40+	9	4.5
Total	201	100.0

1.2 Educational level

The range of educational achievement was relatively wide. About one fifth of the 201 respondents were illiterate. Almost two thirds of the sample had primary education, while those having received education from sixth to ninth grade accounted for over 50%. The number of respondents of upper secondary level was very low, accounting for only one tenth of the sample, while those having vocational training or higher education was extremely low (Table 2).

Table 2. Educational attainment

Education	Frequency (n)	Percentage
Illiterate	35	17.4
Grade 1-5	61	30.3
Grade 6-9	82	40.8
Grade 10-12	21	10.4
Vocational and above	2	1.0
Total	201	100.0

1.3 Occupational structure

The highest proportion of respondents, almost 50%, was involved in agriculture. Others had jobs in small trade, private services, or as factory workers. Only a very small number of the respondents were students, state employees or unemployed (Table 3)

Table 3. Occupational Structure

Occupation/Job	Frequency (n)	Percentage
Farmer	95	47.2
Handicraft	7	3.5
Small business	39	19.4
Service	29	14.4
Worker	16	8.0
Government staff	2	1.0
Student	2	1
Unemployment	7	3.5
Non-trainned job	4	2.0
Total	201	100.0

1.4 Places of origin

Although the research only covered five cities in five provinces, there was evidence of a high level of geographical mobility. He respondents came from 28 provinces and cities throughout the country, including North, South, and Central Vietnam.

The largest groups of respondents came from Hanoi (25 people), Ha Tay (27 people), Hai Phong (17 people) and Thanh Hoa (26 people). The second largest groups came from Ha Nam, Nghe An, and Thai Nguyen. More than 70% of the sample lived in rural areas while 16.4 lived in cities. The remaining 30 lived in provincial centres and small towns (Table 4).

Table 4. Place of origin

Place of origin	Frequency (n)	Per cent
Rural	144	71.6
District town	14	7.0
Provincial town	10	5.0
City	33	16.4
Total	201	100.0

1.5 Marital status, age of first marriage and number of children

Single women accounted for almost half of the sample. The others were married women or women who had been married. Only one tenth of the respondents were married at the time of the survey. More than one third were separated or divorced women (Table 5).

Table 5. Marital status of respondents

Marital status	Frequency (n)	Percentage
Single	97	48.3
Currently married	23	11.4
Separated	27	13.4
Divorced	44	21.9
Widowed	10	5.0
Total	201	100.0

The average age for the first marriage of the respondents was 19.7, much lower than the average recorded in the Vietnam Inter-Census Demographic Survey (VNICDS 1994, Major Findings, GSO 1995), which was of 23.3 years old for women aged between 15 and 49. Nearly two thirds who used to be married got married for the first time at the age of 20 or younger. Those who got married at the age of 18 or younger accounted for 43.3%. About half of these got married between the age of 15 and 17 (Table 6).

Table 6. Age of first marriage

Age at 1st marriage	Frequency (n)	Percentage
15-18	45	43.3
19-24	51	49.0
25-30	8	7.7
Total	104	100.0

An overall of 95 respondents had children. Of these, about half had one child, 25% had two children and another 25% had three or four. Not all the mothers were married. Some had children with boyfriends or clients, thus sometimes could not identify who the father of their children was. Some respondents brought their children along to the camps since they did not have anyone to care for them.

II. Economic activities and family situation

2.1 Income and sources of income

In the last six months before they were taken to the camps, most of the respondents had been involved in prostitution or other jobs. About half the respondents said they had worked in other jobs while 40% had been involved in sex work (Table 7).

Table 7. Primary activities in the six months before living in camps

Main activity	Frequency (n)	Percentage
Working (other jobs)	99	49.2
"Receiving customers"	83	41.3
Stay home	10	5.0
Others	9	4.5
Total	201	100.0

When asked about their main source of income during the last year before they were taken to the camps, the majority (62.2%) of the respondents said it did not come from prostitution. Sex work was the major source of income for only about 30% of respondents (Table 8).

Table 8. Major income sources of the respondents in 1996

Source of income	Frequency (n)	Percentage
Work	125	62.1
Family	8	4.0
Scholarship	1	0.5
"Receiving" client	59	29.4
Other	8	4.0
Total	201	100.0

In the past, researchers have noticed that it was difficult to gather accurate information regarding one's income. This difficulty is even stronger with sex workers, as they feel guilty about the source of their income. Therefore we did not expect to get accurate information on income from prostitution. However, the data we collected can still be used to draw a general picture of the respondents' income as well as the money generated by prostitution.

In the last three months before they were taken to the camp, the average income of each respondent was 644, 217 Dong. Twenty respondents (13.3%) earned less than 100,000 a month, including 15 women (or 9%) who had no income at all. 15% of the respondents earned from 100,000 to 200,000 Dong per month. Another 40% had an income ranging from 600,000 to 1,000,000 Dong. The remaining 12% made more than one million Dong a month, with the highest income as high as 6 million Dong a month (Table 9).

Table 9. Average income of the respondents

Monthly income (VND)	Frequency (n)	Percentage
<100,000	22	13.3
100,000-200,000	25	15.0
250,000-500,000	64	38.6
600,000-1,000,000	35	21.1
1,200,000-6,000,000	20	12.0
No answer	35	
Total	201	100.0

Those whose income was inferior to 200,000 Dong a month were often young peasant girls who did not receive any money directly from their clients. Instead the money went to their master who in turn gave them a small amount periodically. Some of the respondents had just been doing sex work for a short period (less than a month) and had no income except tips from the customers. Some did not even know how much their master gave them. Some were severely exploited by their master who took money out for accommodation, food, drink, clothing, etc, and gave them very little. We will go into more detail about this later in the report.

If we compare our data with the information collected by the 1993 Vietnam Living Standards Survey, we can see that on average, a sex worker's income is seven times higher than the average income of the population of the Red Delta River (91,316 Dong a month or 1,095,800 Dong a year[2]) reported in the survey, not to mention the fact that some sex workers make even more money than the respondents. We will have a better picture of the respondents' income when we consider the rate they charge for their service.

2.2 Prices and rank of the sex workers and their control over the payment

On average, the respondents provided service to 2.1 customers a day and performed sexual intercourse 2.2 times. Nearly half the sample had two customers a day and about a fifth had 3 to 5 customers. Some respondents served up to 7 or 8 customers a day (Table 10).

Table 10. Average number of customers served by the respondents

Number of customers a day	Frequency (n)	Per cent
1	59	29.4
2	96	47.8
3-5	42	20.0
6 +	4	2.0
Total	201	100.0

The average amount of money paid by the client for sexual intercourse was 71,000 Dong. However, prices vary greatly from a sex worker to another. Those who were young and beautiful asked for higher prices, ranging from 50,000 Dong to several hundred thousand Dong. If the sex worker was a virgin, the price could reach several millions.

However, most of the women did not make that much money. Street workers often had to accept any price, sometimes only a few thousand Dongs. The only advantage was that they received the money directly from the client. Since the service was performed in public

[2] This figure was computed from the annual income per capita (1,095,000 Dong) of the Red River Deltaís population (see National Planning Committee and Statistical Office, 1995. Vietnam Living Standards Survey, 1992-1993: Table 7.1.3., Page 217)

places, there was not much time and the client would often ask for a single service. Therefore, there would be few instances of the client paying for one service but forcing the woman to perform numerous sexual acts - as is sometimes the case in hotels and brothels. The respondents made an average of 142,000 Dong a day for their service. Assuming that they worked 20 days a month, their monthly income would be 2,840,000 dong. Although this amount is probably not accurate, it is still very large, and is about 15.2 times higher than the income of the richest households in the Red river Delta (186,716 Dong a month in 1993 [3]).

About one fifth of the respondents were paid 5,000 to 20,000 Dong per service. More than one third were paid 25,000 to 50,000 Dong. Less than one third of the sample made from 60,000 to 100,000 Dong. The remaining tenth or so of the sample were paid 120,000 to 900,000 Dong (Table 11).

Table 11. Payment for a single "reception"

Money paid by customer for a single visit (VND)	Frequency (n)	Per cent
5,000-20,000	40	21.5
25,000-50,000	66	35.5
60,000-100,000	58	31.2
120,000-900,000	22	11.8
Total	186	100.0

There was a strong negative correlation between the age of the respondents and how much they charged for their services. The higher the age of the sex workers, the lower pay they would receive. On average, those younger than 20 years old would receive 114,030 Dong, twice as much as those aged 20 to 24 and three times more than those aged 30 years old and over. The proportion of over 30-years-old respondents receiving less than 20,000 Dong per service was eight times higher than for those who were less than 20

[3] This figure was computed from the annual income per capita (2,240,600 Dong) of the fifth household group in the Red River Delta (see National Planning Committee and Statistical Office, 1995. Vietnam Living Standards Survey, 1992-1993: Table 7.4.2., page 223).

years old. In contrast, the proportion of under-20 receiving 100,000 Dong or more per service was 16 times higher that for the over-20 (Table 12).

Table 12. Correlation between age and payment of the respondents

Payment for one "reception" (VND)	Age group				Total
	<20	20-24	25-29	>=30	
<=20,000	5.0%	8.7%	23.8%	44.0%	19.9%
20,000 -50,000	30.0%	31.9%	31.0%	38.0%	32.8%
51,000-100,000	32.5%	37.7%	26.2%	16.0%	28.9%
100,000 +	32.5%	21.7%	19.0%	2.0%	18.4%
Total	19.4%	32.3%	21.5%	26.9%	100.0
	36	60	40	50	186
Mean	114.03	73.97	70.38	37.12	71.04

The respondents' right to receive and use the money they made depended on the place from which they operated. When they worked in hotels, restaurants or brothels, and therefore were controlled by 'owners' or pimps, they could not always receive all the money paid by the client.

About 10% of the sample had no right to the money they made: it all went to their master who only paid their accommodation and food. In many cases, the clients paid the master directly. Sometimes they would give the master part of the money and tip the sex worker. Independent sex workers could be classified in two groups. The first group consisted of the high-class sex workers working in hotels. They often received all the money and sometimes would pay a commission to their pimps. Similarly, street workers would receive all the money (although less than the high-class workers), unless they had to share it with the 'bear heads' (name given to pimps or street gangs).

More than 60% of respondents could use all the money they made. About 30% did not know at all how much they made and were only paid a small amount by their 'owners' (Table 13).

Table 13. Proportion of payment received by the respondents for each "reception"

Proportion of money CSW could keep (%)	Frequency (n)	Percentage
0	18	9.7
20-50	24	13.0
60-95	18	9.7
100	125	67.6
Total	185	100.0

2.3 Family situation

Before being taken to the camps, one third of the respondents lived with their family, with parents or relatives. Nearly half of them lived in the restaurants or brothels where they worked. Only a few lived with their husband and children (as mentioned above, only a small number were currently married). Some lived with their children, some with their boyfriend or sexual partner.

The majority of the respondents lived in the countryside. Only a small number had family living in provincial centres or small towns. More than a fifth had family living in a city.
Almost 40% of the respondents' fathers were farmers while 20% were state employees (active or retired). The proportion of respondents' mothers who were farmers was considerably higher (about 60%). In general more mothers than fathers worked in small-scale trade, while the number of mothers working as state employees was about half the number of fathers.

Over 50% of the respondents considered their family poor. Nearly 40% of the sample thought their family had enough food. Only 5.5% considered their family affluent.

Less than 30% of the respondents' households had an income per capita inferior to 100,000 Dong a month. For more than 50% of households, it ranged from 100,000 to 300,000 Dong. The remaining 20% had an income per capita ranging from 3000,000 to 2 million Dong a month. One third of the respondents thought they were the highest income

earner in their family, followed by their parents, mothers, brothers and sisters. Only in a few instances did their husbands have the highest income (Table 14).

Table 14. Person with highest income in the respondents' families

Person has highest income	Frequency (n)	Percentage
Respondent	67	33.3
Husband	14	7.0
Father	38	18.9
Mother	39	19.4
Sibling	27	13.4
Other relative	7	3.5
Don't know	8	4.0
No answer	1	0.5
Total	201	100.0

2.4 Husbands' profiles

Of the 121 respondents who were married or used to be, 30% had husbands working as farmers, 25% had husbands in the army or working as private service providers such as cyclo drivers or porters. Only 14% of the respondents were married to men who earned the highest income in the family.

It is worth noting that many husbands were drug users, to different degrees, ranging from smoking, sniffing to injecting drugs. Many were gamblers with huge debts, sometimes forcing their wives into prostitution. Some respondents said that a large part of their income made from sex work was either used to pay back the debt contracted because of their husband's drug addiction, or to support them financially while in drug rehabilitation camps.

There were also instances of husbands having sexual relations with sex workers. This led to the collapse of the family, and, further down the track, to the wife having to do sex work.

Some husbands were alcoholics, beating up their wives, extremely irresponsible towards their family, forcing their wives into prostitution.

Following are the two examples collected from our in-depth interviews:

Question: You said that you divorced you husband because of his gambling, didn't you?
Answer: Yes
Q: Has he ever been to a prostitute?
A: No prostitute. Just drinking, gambling, and beating me up.
Q: What about drugs?
A: No. He doesn't work. I have to support him but he still beats me.
(In-depth interview at Loc Ha Camp in Hanoi. The respondent was a 30-year-old divorced woman from Gia Lam, Hanoi).

"When I got married, I was making a living independently by selling fruit. My husband was a serious drinker. He had just left the army and was unemployed. He worked at the market's bicycle-keeping lot. He had some friends in the army. Then he followed his friends drinking and gambling....He destroyed my fruit stall and burnt it to the ground... I had to leave the house, living like a tramp (crying)..."
(In-depth interview at Ba Vi camp, Hanoi. The respondent was a 23-year-old divorced woman from Thai Nguyen)

III. Reasons to enter prostitution and working experience

3.1 Starting age and time spent working in the sex trade

The average age of respondents when they became sex workers was 23.9 years old.
If we consider those aged between 15 and 24 as adolescents, then 60% became sex workers during their adolescence. Nearly 20% of these started between the age of 15 and 18 (Table 15).

Table 15. Ages when the respondents were first paid for sex

Age	Frequency (n)	Percentage
Under 18	38	19.0
19-24	80	39.8
25-29	41	20.3
30+	42	20.9
Total	201	100.0

Cross-group comparison between different age groups showed a tendency to become sex-workers earlier in the younger groups: the average starting age was 17.4 for those younger than 20 years old, compared to a starting age of 32.5 for those aged 30 and older.(Table 16).

Table 16. Correlation between age groups and ages when first doing prostitution

Age when first doing prostitution	Age group				Total
	<20	20-24	25-29	>=30	
<20	100%	20.3%	4.8%	.0%	27.9%
20-24	.0%	78.3%	11.9%	6.0%	30.8
25-29	.0%	.0%	83.3%	12.0%	20.4%
>=30	.0%	1.4%	.0%	82.0%	20.9%
Total	20.2%	34.3%	21.2%	24.2%	100.0%
	40	68	42	48	198
Mean	17.40	20.63	25.74	32.50	23.94

We also found that many respondents, whatever their age, had become sex workers fairly recently, particularly during 1994-1997 (Table 17). This finding is consistent with the development of prostitution in the country in recent years: at the same time as the number of sex workers increased, commercial sex work expanded its operations and diversified its services.

Table 17. Years of entering prostitution

Year of entering prostitution	Frequency (n)	Percentage
1983-1986	4	2.0
1988-1990	7	3.5
1991-1993	10	5.0
1994-1997	178	89.4
Total	199	100.0

By the time they were brought to the camp, the respondents had been working in commercial sex work for an average of 12.7 months. 66,5% of them had been sex workers for 1 to 6 months. Those having operated for 7 to 24 months accounted for 19.6% of the sample. The others had been working for more than 18 months, with 15 years being the longest time.

3.2 The roads to prostitution and reasons for entering the industry

About 60% of the respondents said they were doing sex work voluntarily. Over 20% became sex workers by following others, mainly friends or sisters, from the same village. A few respondents went into it persuaded by friends. About 13.5% of the sample (seven women in Ha Tay and some others in Hanoi) were lied to and sometimes forced into prostitution (Table 18). They had been kidnapped or told that they would get good jobs, then, were forced to perform sex services for clients. Some were beaten up or raped by the "bear heads". Some were locked up in brothels and forces to do sex work for a long time without being told were they were.

Table 18. The way leading to prostitution

	Frequency (n)	Percentage
Someone guided	42	20.9
Decided herself	118	58.7
Friends advised	14	7.0
Being cheated	12	6.0
Being forced	15	7.5
Total	201	100.0

Throughout the study, we collected a lot of information from in-depth interviews.

"I used to live in Moc Chau... I was lied to when I came here... This person also worked in Moc Hau and was doing business with my family... She persuaded me to follow her to Hanoi to get a new hair cut. I followed and then I was sold...For the first one or two days, I did not have to do anything. Then they forced me to 'serve' the clients".
(Interview at Ba Vi Camp, Hanoi. The respondent was a 20-year-old single woman from Son La with 7th-grade education).

"I was her neighbour. She told me to sell goods and that I would be paid one million Dong a month. I believed her. But it turned out that after dinner, they asked me to get changed and 'serve' a client... I said that I would not, since I was told to come there to sell goods. But the boss lady had already received the money, so I had to do it"
(In depth-interview at Ba Vi Camp, Hanoi. The respondent was a 24-year-old single woman from Hoa Binh with 5th-grade education).

"I went to Mo market in Hanoi to sell vegetables. One day that guy, Luat, asked me to work at his home, to transport brick. I believed him and went to his home for three days. I was lied to on 21st February. That afternoon he asked me for a vehicle and took me to the house of Master Minh, to the Mai Dong bridge. Master Minh gave him a refrigerator as payment, which he took home right away. He left me there. I had to serve clients at night and was locked in the house during the day."
(In-depth interview at Ba Vi Camp, Hanoi. The respondent was a 26-year-old divorced woman from Ha Tay with 8th-grade education. She had one child).

Reasons for entering the sex industry are complex. Some respondents argued that there was not one, but many reasons that made them become sex workers, such as poverty, unemployment, the departure of their husband or boyfriend, etc...But the three following causes were the most frequently mentioned: poverty (36%), family trouble (32%) and the need for money to pay back depths contracted for medical treatment of because of the husband's gambling or drug addiction. There were cases when the respondents blamed their situation to justify their own weakness (Table 19).

Table 19. Reasons of entering prostitution

Reason	Frequency (n)	Percentage
Poverty	72	36.0
Can not find other job	20	10.0
Need more money	55	27.5
Disappointed about family	64	32.0
Abandoned by husband/lover	26	13.0
It is easy to earn money by selling sex	8	4.0
Other reason	55	27.4

There are some important findings if we consider the link between the age of the respondents and their reasons for starting sex work. For the age group 25-29 and for those over 30 years old, the proportion of respondents who became involved in prostitution out of poverty was considerably higher than for the age group 20-24 or younger. Similarly, more respondents of the former had become sex workers because of family problems than in the latter.

Most women aged 25 and above were married or had been married and had children. As such, they had more family responsibilities. Some got married to men who were drug addicts, alcoholics, gamblers, or who had girlfriends, thus disappointing them.
These facts can be used to put in place educational programs adapted to the respondents of different age groups. For those aged 25 or older who are married, the first action should

be to assist them getting jobs with stable income in order to improve their family's financial situation. It is also important to help them solve their family problem, for example by education and supporting their husband. For those aged 24 and under who live with their parents and therefore partly rely on them, the program should focus on moral values and social knowledge as well as vocational training and job instruction.

In-depth interviews provide more information on the reasons why these women got involved in prostitution.

" I did not think it was an occupation. I thought it shameful, I had a bad conscience. Sometimes I thought "I am a woman too, like the others". But there are two classes. Some have a bright life when mine is so dark. I was born in a very poor family and got married with such a husband (her husband is a gambler and a drug addict and is currently in prison) . I am so sad. My life is miserable. No one persuaded me or forced me, I did it by myself for my child. I had to work like this to get rice and clothes for my child, not to become rich."

(In-depth interview of a sex worker in a 'risky hamlet' in Hanoi. The respondent was a 29-year-old married woman from Ha Tay with 5th-grade education. She has a child. Her husband is in prison).

"Friends of all kinds came to the restaurant where we worked as waitresses. They enticed us. We were naive then, so we went."

(In-depth interview at Thanh Hoa Camp. The respondent was a 20-year-old single woman with 7th grade education).

"I came here... I was wandering carrying my child. I was sitting in the Nguyen Binh Khiem Park. Then they told me to come to "that" place, to make money for the kid. If not, when my child is sick, where could I find money to buy medicine?"

(In depth interview at Cheo Park in Hai Phong. Another name for this park is "pho (whore) market". The respondent was a 25-year-old divorced woman with 2nd-grade education. She had a child and was six months pregnant. She was also addicted to drugs).

"To tell you the truth, I did not do this because of my children or my husband. I did it out of poverty. My old mother and I lived in a small hut, we got wet when it rained"
(Interview in Nghe An. The respondent was a 35-year-old single and illiterate woman).

3.3 Places of work

Places used to sell sexual services can be used as an indicator of the different types of sex workers. Although there were a variety of places where prostitution took place, the respondents in our sample can be classified according to the two major places where they performed their services: the first group were young and either were under the control of a madam/master or worked independently, but all worked in restaurants, hotels, karaoke bars, etc. The second groups consisted of older women, who received their clients anywhere possible, in places such as public baths, parks, streets, rice fields, river canals, stair of the government blocs... just to name a few.

Table 20. Sites of selling sex services

Place of selling sex services	Frequency (n)	Percentage
Hotel/guest house	108	53.7
Bar, pub, beer shop	29	14.4
Massage parlour, bath	9	4.5
Karaoke shop	13	6.5
Park	34	16.9
Customer's house	27	13.4
Coffee shop	19	9.5
Other public places	19	9.5

When they were young and, often, had just started working in the sex trade, the respondents often worked under the management - and control - of the restaurant's or bar's owner. The place where they performed their services where therefore generally often safe and comfortable with beds, a bathroom, running water, etc...Some were even taken by their clients to a hotel and worked in air-conditioned rooms.

After a few years, as they got older and their beauty faded, they were asked to leave the restaurant/bar where they worked and had to find work in public places where they could easily be spotted and arrested. They were also vulnerable, and more likely to be harassed by street gangs. For example, one respondent from Hai Phong first worked in restaurants and bars, before she was arrested and put in a Social Support Camp Number II. After leaving the camp, she turned back to prostitution to make a living, but that time she worked in the "whore market".

Nearly 60% of the respondents worked by themselves. However, they were still dependent on a network of intermediaries that included pimps and local street gangs. The other 40% operated in restaurants and brothels managed by their 'owners'.

Table 21. Working arrangements

Working ...	Frequency (n)	Percentage
Alone	119	59.2
In brothel	80	39.8
Depend	1	0.0
Total	200	100.0

3.5 Perceptions and attitudes towards prostitution.

The majority of respondents did not consider prostitution as a permanent job but as a temporary one that they intended to leave as soon as they found something better. On the other hand, almost one tenth of them considered it a profession. Some respondents were sad and regretful, as they knew prostitution was "dirty" and illegal. Most of the respondents thought that they would do it for some time, making a certain amount of money, before finding a new job. However, not all of them had enough courage or a good enough situation to the trade.

"I would like to tell you the truth. Poverty forced me to do this, but just temporarily, then I will leave. Many nights, I cried hard. My mother at home is old. I had to give my child for her to take care of. They live in a small hut. When it rains, they are soaked. When it's

sunny, they lie openly in the sun light (she's crying hard). It is so miserable to hear this from my mother."
(In-depth interview in Nghe An. The respondent is a 35-year-old illiterate woman from Quang Binh. She has a child and no husband).

"I don't think this is a serious job. Generally, it's dirty. It's not a job".
(Interview at Ba Vi, Hanoi. The respondent was a 23-year-old married woman from Tu Liem, Hanoi with 8th-grade education. She had a son, her husband was a drug addict).
"I shake whenever I think about it. I am so afraid. First, it can bring diseases. Secondly, it degrades the body. So miserable."
(In-depth interview at a 'risky hamlet' (slum) in Hanoi. The respondent was a 39-year-old divorced woman from Thanh Tri, Hanoi).

When asked why there were so many women in the sex trade, most of the respondent thought that it was because of economic difficulties. Nearly a quarter of the sample also mentioned that many young girls did sex work because they wanted money to imitate "fancy girls". Some blamed brothel's 'owners', pimps, kidnappers who lied and forced rural women into prostitution. Early and naive love also made many young girls turn to a Tu Ba (Madam) once they had been deserted by their husband or boyfriend.

Sometimes, several reasons combined to give the women no choice but to sell themselves to survive. Some women were beaten up by drunk/drug addicted husbands or abandoned by boyfriends and/or relatives, and found that they had to leave for the city in order to make money for their children and for themselves. Being vulnerable in this new environment, with non one to rely on and no chance of work, they turned to prostitution for survival.

"Each one (of us) has her own fate. Some are abandoned by their husband. Some are disillusioned. Some have no money to feed their children. In general, each one has her own misery. So they have to do this. Doing things like this, we are not happy at all, you know. Working on the streets like this, there are so many problems, like "bear heads", "cat heads", all kinds of hooligans..."

(Interview at Loc Ha, Hanoi. The respondent was a 21-year-old single woman from Ha Tay with 7th-grade education).

"I think (prostitution) is a social evil. But if we work honestly, probably we cannot make enough money to buy food. It's not that I cannot stand the poverty. But coming here (to Hanoi), I fall into a new environment that is different from the countryside, requiring a different way of living. Also, coming here, I have to pay for housing. Also, my children are there".

(In-depth interview at a 'risky hamlet' in Hanoi. The respondent was a 32-year-old divorced woman from Phu Xuyen, Ha Tay, with 7th-grade education. She has two children).

"I have been in this job since I was a very young girl, in 1991. I was pregnant with my boyfriend, so my parents asked me to leave. When I was three or four months pregnant, my boyfriend left me. I was so furious. My parents beat me and yelled at me "Take your clothes and get the hell out of here, wherever. Your pregnancy is shameful". So I left. Even when I was pregnant, I had to 'serve' the clients. If not, how could I get money to deliver my child? Sometimes I would feel a bit of pain in my stomach. It bled. But the day I delivered, the doctor said it would be no problem. During the pregnancy, I only had 2 or 3 clients a day, just to make enough money".

(Interview at a 'risky hamlet' in Hanoi. The respondent was a 28-year-old woman from Ha Dong with 5th grade education. She has one daughter. Her boyfriend has left her).

3.6 Number of arrests and number of times sent to the camps.

On average, each respondent in our sample was arrested by the police 1.6 times. About half the respondents had been arrested only once, but a few had been arrested up to nine times. 40% had been arrested twice.

The average number of times they had been sent to a camp was 1.5. For more than 60% of the sample, this was their first time in the camp, while 30% had been there once before. For a few respondents, it was the fifth or sixth time.

What these figures imply is the low effect of these arrests and camp times on the sex workers, since many returned to prostitution after their release. Or does it mean that the respondents were unable to go back to a righteous life? If so, why? Is it because - on top of their difficulty in finding another job - social stigma, prejudice and the inability of their own family to support and protect them created a situation that they could not overcome? Only when comprehensive solutions - including appropriate education programs, accessible work opportunities, community tolerance and family support - are reached, can we "liberate" these women.

In short, with each woman we interviewed we heard a different story. Some were pitiable, some were detestable. But most of the respondents recognised that prostitution was not a moral profession. They were distressed and had regrets, but had no opportunity to change. All these women were of reproductive age, including a high number of young women aged 18 or under. The majority of them had primary education but a high number were illiterate. About half of them were originally peasants. The others were either unemployed or had jobs with unreliable income. Over two thirds of the sample came to the city from the countryside due mainly to a lack of arable land (in many provinces of the Red River Delta, the arable land area per capita is as low as 360m2 (one *sao*). Poor education could be one of the reasons that prevented these women from finding a stable job while making them vulnerable to the lies and coercion of the pimps and madams, as well as the material temptations. Although the survey was conducted in only 5 provinces, the sample contained women coming from 23 provinces in Vietnam. This suggests further research focusing on occupation and inter-provincial migration.

IV. History of sexual activity

4.1 Age of first sexual intercourse

In order to gather information about the respondents' level of sexual knowledge when they had sexual relations for the first time, the interviewers asked them this question: "How old were you the first time you heard about sexual intercourse?". Many respondents said they

did not know about it until their first sexual relations. Only a few learned about it through friends or books, journals, newspapers or movies.

The average age for the first sexual intercourse was 19.08 years old, which was very to the average age when they first heard about it (18.95 years old). It is worth mentioning that 15% of the respondents had had sexual intercourse by the age of 16. By the age of 18, more than 50% had had their first sexual relationship. In some cases, the respondents lost their virginity when they were only 12 or 13 years old. The majority had their first sexual relations when they were aged 15 to 24.

Table 22. Age of first sexual intercourse

Age at first intercourse	Frequency (n)	Percentage
12-18	105	52.5
19-24	67	33.5
25+	28	14.0
Total	200	100.0

Comparison between age groups shows that the younger the respondents are, the younger they lost their virginity. In other words, the age of the first sexual relations increases the older the respondents are. Those aged under 20 had sex for the first time at the age of 16.77, almost five years less than those aged 30 and over. Almost 70% of respondents aged under 20 has their first sexual intercourse before the age of 18, while this was the case for only 8% of those aged 30 and over. Similarly, the proportion of respondents having sex for the first time when they were over 20 was only 17.4% in the 20 to 24 age group, while it increased to 44% among those aged 30 and over.

Table 23. Age and age of first sexual intercourse

Age at 1st intercourse	Age group				Total
	<20	20-24	25-29	>=30	
<18	65.0%	21.7%	29.3%	8.0%	28.5%
18	30.0%	23.2%	17.1%	26.0%	24.0%
19-20	5.0%	37.7%	34.1%	22.0%	26.5%
>20	.0%	17.4%	19.5%	44.0%	21.0%
Total	20.0%	34.5%	20.5%	25.0%	100.0%
	40	69	41	50	200
Mean	16.77	18.81	19.0	21.38	19.09

Nearly half the respondents said that the first time they had sexual intercourse was with their boyfriend. This supports previous studies on pre-marital sexual relationships of the youth, which showed that sex played an important part in a love affair. The tendency now is for an increasing number of young people to have sex earlier in both urban and rural areas.

We are not implying that pre-marital sex is a precondition for prostitution. However, as long as virginity continues to be a symbol of a woman's dignity, and as long as young people are not well prepared for a sexual life, the negative effects of pre-marital sex are one of the contributing factors to why many young girls become sex workers.

4.2 Sexual behaviour and experience of the sex workers

For the majority of respondents, the age of their first sexual intercourse (19.09 years old)was not the same as for their first paid sexual service (23.9 years old.). Many respondents started having sexual relations long before they actually became sex workers. On average, each respondent had 2.1 clients a day and performed 2.2 paid sexual services. Almost half the sample had on average two clients a day. Almost a fifth of the respondents had 3 to 5 clients. Some even had 7 to 8 clients a day.

More than 70% of respondents said they had a right to choose their clients. They all said they accepted only clients who were "serious" or "gentle" and "polite". The remaining 30% were forced to accept whoever paid.

In our in-depth interviews, many respondents said they had no rights to choose customers and were even severely beaten by their 'owners' or pimps if they did not comply.

"When the client left, they beat me up. I was really tired but they thought I was pretending so. He asked: "Will you do it?". I said: "I will not". So he punched and kicked me. He beat me whenever I refused to receive a client".
(In-depth interview in Ba Vi, Hanoi. The respondent was a 26-year-old divorced woman from Ha Tay with 8th-grade education. She had one child).

"Under their control, I had to do whatever they wanted. If I refused, they threatened me, so I had to... Even during my period, they still forced me to... I had to do it".
(In-depth interview in Loc Ha, Hanoi. The respondent was a 21-years-old, separated woman from Yen Bai with 5th grade education. She had one child).

Some women were even raped by their 'owners' who wanted to degrade them, particularly if they were young girls.

"The first night, he (the master) forced me to sleep with him... I had a boyfriend but we had no sexual relationship. He is the first man I slept with. In general, whenever he wants, he forces me to 'serve' him... Some days I had to receive many clients. Some days I had less. On average, I was forced to serve about four clients a day".
(Interview in Ba Vi, Hanoi. The respondent was a 20-year- old single woman from Son La with 7th grade education).

Most of the respondents had intercourse. Few had to perform oral and/or anal sex. Only a small number of respondents said their "price" depended on the type of services they performed at the client's request. Some respondents (13.9%) said they could not refuse to perform certain services, since the client could abuse and beat them or go to another sex worker.

In our in-depth interviews, many respondents said that they were asked to perform vaginal or oral sex and could not refuse since, if they wanted to be paid, they had to please the clients. It is important to note that not all of them used condoms during intercourse or oral sex. Sexually Transmitted Diseases (STDs), including HIV/AIDS, could therefore be spread freely, but the respondents did not know this.

4.3 Pregnancy, abortion and child birth

Of the 201 respondents, 36 (18%) became pregnant during the course of their work, including 11 who had been pregnant twice or more. Most of them had an abortion, some of them up to six times (Table 24). At the time of the survey, some of the respondents were pregnant. Some wanted an abortion but since they had no family guarantee, they had to keep their baby. For some of them, it was too late to have an abortion.

Table 24. Pregnancy, abortion, and child birth

	Frequency (n)	Percentage
Pregnancy		
1	25	12.5
2 or more	11	5.5
Abortion		
1	14	7.0
2 or more	10	5.0
Giving birth		
1-3 children	10	5.0

There was a clear positive correlation between age, pregnancy and abortion. The older the respondents, the higher the occurrence of pregnancy and abortions. In our in-depth interviews, at least three respondents were pregnant at the time of the survey. One, in Hai Phong, was six months pregnant, but was still working as a prostitute. According to her, some clients preferred having sex with a pregnant woman. Some even believed that pregnant women did not have STDs (in-depth interview in Hai Phong).

Some respondents had two or three children from different clients. In Nghe An, some respondents wanted to have a child in order to have someone to rely on in their old age.

" I think it's good to have some children so that when I am old, they will support me. Some relatives told me that even though I am single I have to have children, one or two, to rely on them later...I take him (my second child) to the park. I put him on a hammock, and I ask people around to swing the hammock... When I have a client, I ask people, sometimes my friends, to take care of my child. There was a beggar mother who collected plastic bags, I asked her to help me and gave her several thousands Dong."
(In-depth interview in Nghe An. The respondent was a 35-year-old single and illiterate woman from Quang Binh. She has two children. She left the oldest child at her mother's home).

The future of these children is a concern. Is there much hope for them?

4.4 The use of contraception

The major contraceptive method used by the respondents was condoms. Only a few used other methods, such as IUD or the pill. Nearly a third did not use any contraception at all (Table 25). A small number of respondents used condoms as well as a more permanent method like sterilisation, the pill or IUD.

Table 25. Contraceptive use

Contraceptives used	Frequency (n)	Percentage
IUD	10	5.0
Pills	4	2.0
Condom	119	59.5
Sterilization	2	1.0
Don't use	65	32.5
Total	200	100.0

Although the proportion of condom users, as shown in the data, was not low, the safety of the respondents was still depending on the good will of the client. Most of the respondent who became pregnant did so when the client refused to use a condom.

So far in Vietnam, contraception facilities are directed primarily at married couples, and single men and women are often ignored. Another impediment to such services reaching sex workers is their high geographical mobility, which make them difficult to reach. The find themselves out of the areas that these services cover, when in fact they should be a prime target due to their high sexual activity.

We hope that the information on pregnancy, child delivery and contraception contained in this research, along with the findings from other studies, will be used to introduce intervention solutions for the sex workers, so that the occurrence of pregnancies from clients can be reduced. While we cannot totally eliminate prostitution, we can protect the workers from the risks associated with their trade during their reproductive years, and help them to avoid unwanted pregnancies.

PART II. KNOWLEDGE AND PRACTISES RELATED TO STDs AND HIV/AIDS

I. Knowledge of STDs, HIV/AIDS and of prevention methods

1.1 Knowledge and sources of knowledge regarding STDs and HIV/AIDS

In this survey, when we were trying to assert the level of knowledge the respondents had of Sexually Transmitted Diseases (STDs), we did not list the diseases for them but asked them to tell us spontaneously which ones they knew of.

Although the majority of the respondents had been informed of the existence of these diseases and of ways to avoid them, the survey results suggest that the education was not very effective. AIDS was the disease most respondents could name (81%), while around 60% knew about syphilis and gonorrhoea. Very few women had heard of herpes and chlamydia (Table 26).

Table 26. Knowledge of STDs

STD listed by respondents	Frequency (n)	Percentage
HIV/AIDS	162	81.0
Syphilis	119	59.2
Gonorrhea	124	61.7
Candidas	67	33.3
Other RTI	35	17.3

The results of the in-depth interviews show that many women in our sample had no knowledge of STDs. They used condoms to protect themselves from becoming pregnant and from some vague diseases they did not know, as shown in the following excerpts.

The respondent had come to Do Son (Hai Phong) from Thanh Hoa to work in the sex trade. She did not know what an STD was and was only using condoms because her friends had advised her to do so.

" I have just come here, just to do it; so I know nothing. But my friend who has worked here before me said if I do it, I should use a condom. I have just been here for five days and my friend just said that without explaining why".
(In-depth interview in Do Son, Hai Phong. The respondent was a 18-year-old single woman from Thanh Hoa).

Another woman in Nghe An:
Q: Which STDs do you know?
A: I don't know... I forget things easily. It's my character
(In-depth interview in Nghe An, with a 28-years-old single woman).

There was also a clear positive relationship between the age of the respondents and their knowledge of STDs. The proportion of respondents aged 20 and under who knew of STDs was considerably lower than that of the respondents of the older age groups (20-24, 25-29, and 30 and above), as shown in Table 27. One of the reasons for this is that the majority

of women aged 20 or younger came from rural areas, and had just started working in the sex trade. Their experience and knowledge of the diseases were poor.

Table 27. Correlation between age group and knowledge of STDs

STD listed by respondents	Age groups				Total
	<20	20-24	25-29	>=30	
AIDS	70.0%	88.4%	90.5%	71.4%	81.0%
Syphilis	47.5%	62.35	61.9%	62.0%	59.2%
Gonorrhea	45.0%	58.0%	81.0%	64.0%	61.7%
Candida	30.0%	33.3%	38.1%	32.0%	33.3%
Other	10.0%	15.9%	14.3%	12.0%	13.4%
Total	40	69	42	50	201

Education was an important factor in the respondents' knowledge of STDs. The higher their education, the better their knowledge of the diseases. Those who had as far as 10th grade and higher knew much more about these diseases than the others, particularly the respondents who were illiterate (Table 28).

Table 28. Correlation between educational level and knowledge of STDs

STD listed by respondents	Education level				Total
	Illiterate	Grade 1-5	Grade 6-9	Grade 10+	
AIDS	61.8%	70.5%	92.7%	95.7%	81/0%
Syphilis	40.0%	57.4%	64.6%	73.9%	59.2%
Gonorrhea	45.7%	62.3%	64.6%	73.9%	61.7%
Candida	22.9%	32.8%	39.0%	30.4%	33.3%
Other infection	5.7%	16.4%	15.9%	8.7%	13.4%
Total	35	61	82	23	201

There were various sources of information regarding STDs and HIV/AIDS, including books, journals, newspapers, radio, television, or simply though friends, but the major source was the Social Support Camps ('education centres').

Table 29. Sources of knowledge on STDs

Sources of information on STD	Frequency (n)	Percentage
Books, newspaper	38	18.9
TV, Radio	60	29.9
Friends	34	16.9
Customers	6	3.0
Owner	1	0.5
Medical personnel	4	2.0
Education center	106	52.7

The proportion of respondents who had gained their knowledge of STDs from the media and other sources was low. This means that sex workers who have never been to a re-education camp are likely to know very little about these diseases. If they know anything, it is more likely the names of the diseases, without any further knowledge of their effects and how to avoid them.

The in-depth interviews brought similar results: those who had not been through educational programs at the camps knew only a few diseases. They could not tell any of the symptoms of the modes of transmissions. They did not know how to protect themselves from them. In fact, the number of sex workers who were taken to the camps accounted for only a very small proportion of all the sex workers operating throughout the country.

A network of information provision regarding STDs need to be developed. This includes strengthening the role of the media in this area, providing more detailed information and making sure that flyers are dropped in places frequented by sex workers. At the same time, peer education in the sex workers' community should be developed.

HIV/AIDS is relatively new to Vietnam and, as the symptoms do not appear for several years, awareness among the Vietnamese population is very limited. Therefore, as well as questions about other STDs, we included in our survey additional questions specifically on HIV/AIDS, in order to have a better understanding of the respondents' level of knowledge.

Although education on HIV/AIDS was one of the focuses of the camps' program, many respondents did not realise fully the importance of the information. For instance, the respondents' awareness of the modes of transmission was inadequate. Only 80% knew that HIV could be transmitted through sexual intercourse. Less than 50% of the samples were aware that the HIV/AIDS could be transmitted through sharing needles. Some still believed that one could get infected by sharing clothing with an infected person, through kissing or mosquito bites, etc...(Table 30)

Table 30. Knowledge of HIV/AIDS mode of transmission

HIV/AIDS is transmitted through	Frequency (n)	Percentage
Sexual intercourse	162	80.6
Blood transmission	98	48.8
Mother to fetus	51	25.4
Injection	72	35.8
Other (sharing clothes, mosquito bite ...)	13	6.5

The findings also points out that respondents of the age groups 20-24 and 25-29 showed a better awareness of HIV/AIDS than those aged under 20 or above 30.

There is also a strong positive relationship between the respondents' educational level and their knowledge of HIV/AIDS: the higher their educational achievement, the stronger their awareness of the infection. The group of respondents who had completed at least 10th grade education knew more about the modes of transmission than any other group.

Table 31. Relationship between educational achievement and awareness of HIV/AIDS

HIV/AIDS is transmitted Through	Education level				Total
	Illiterate	Grade 1-5	Grade 6-9	Grade 10+	
Sexual intercourse	54.3%	78.7%	89.0%	95.75	86.6%
Blood transmission	40.05	45.9%	50.0%	65.2%	48.8%
Maternal	22.9%	24.6%	24.4%	34.8%	25.4%
Injection	22.9%	34.4%	39.0%	47.8%	35.8%
Total	35	61	82	23	201

Most of the respondents with 10th grade education or higher believed that there were ways to avoid becoming infected with HIV/AIDS, while only half the illiterate group agreed. The group with the highest educational achievement also had the strongest knowledge of ways to avoid the infection, especially compared to the illiterate group.

It also appeared that there was a significant gap between different occupational groups regarding their awareness of HIV/AIDS and other STDs. This was particularly evident with the respondents working in agriculture, who had the lowest level of awareness.

Table 32. Relationship between occupation and awareness of HIV/AIDS

HIV/AIDS is Transmitted through	Occupation				Total
	Farmer	Business	Service	Other	
Sexual intercourse	74.7%	87.2%	86.2%	84.2%	80.6%
Blood transmission	47.4%	46.2%	48.3%	55.3%	48.8%
Maternal	22.1%	35.9%	24.1%	23.7%	25.4%
Injection	27.4%	51.3%	34.5%	42.1%	35.8%
Total	95	39	29	38	201

Very few respondents knew that a blood test was the only way to find out if one was HIV positive. Some thought they would get symptoms like fever, itchiness, etc... Some did not know at all. One of the difficulties with HIV/AIDS awareness is that until the infected person develops AIDS, there are no outside-body symptoms (as opposed to other STDs). It is crucial to emphasise this in educational programs.

1.2 STDs and HIV/AIDS prevention

The respondents' knowledge regarding STDs prevention was very limited. The best-known contraceptive method, condoms, was cited by only 81.6% of them. Only about 3.5% were aware of the risks of injecting drugs. About 30% of the respondents thought fidelity was a mode of prevention, although it is obviously impossible to enact for sex workers. Some thought that avoiding using the same bath or toilet as an infected person was one way of avoiding infection.

Table 33. Ways to prevent infection with an STD

Ways to prevent STDs	Frequency (n)	Percentage
Use condom	164	81.6
Faithful	62	30.8
No injection	7	3.5
Others (not sharing clothes, bathroom, toilet etc.)	11	5.5

The level of knowledge regarding HIV/AIDS prevention was even lower. Only 70% of respondents knew that it was possible to avoid being infected. Only 66% knew that infection with HIV/AIDS could be prevented by using condoms during sexual intercourse. The proportion of those who were aware of the risk of becoming infected through sharing needles or through blood transfusion was also low (Table 34).

Table 34. Ways to prevent infection with HIV/AIDS

Avoid HIV/AIDS by	Frequency (n)	Percentage
Use condom	134	66.7
Faithful	62	30.8
No injection	48	23.9
Blood screening before transmission	22	10.9
Other	24	11.9

Other independent variables such as age and educational level proved to play a significant part in the respondents' awareness of STDs and HIV/AIDS prevention. The proportion of respondents ages 20 or under who cited condoms and avoiding exchange of blood as ways to avoid getting infected was much lower than in the other age groups. Similarly, the proportion of illiterate respondents aware of HIV/AIDS prevention was the lowest was that of those with 10th-grade education or more was the highest (Table 35).

Table 35. Relationship between educational level and knowledge of HIV/AIDS prevention

Ways to avoid HIV/AIDS	Education level				Total
	Illiterate	Grade 1-5	Grade 6-9	Grade 10+	
Use condom	63.0%	73.6%	78.45	90.95	76.1%
Faithful	25.9%	37.7%	35.1%	59.1%	37.5%
No injection	11.1%	26.4%	31.1%	36.4%	27.3%
No blood transmission before screening	7.4%	13.2%	12.2%	18.2%	12.5%
Total	27	53	74	22	176

The geographical environment (rural or urban) also had an influence on the respondents' level of awareness. Generally, the knowledge of STDs and HIV/AIDS of those living in rural areas was poorer than for those living in urban areas.

The proportion of respondents who thought AIDS could not be successfully treated was only 75.6%. Only 70.1% of the sample knew that they could become infected with HIV/AIDS through their activity as sex workers. Over 70% of the respondents knew that they could protect themselves against HIV/AIDS. The others either did not know how to prevent infection or simply thought that it was impossible for them to protect themselves from these infections once they started sex work.

II. Sexual behaviour related to HIV/AIDS and STDs infection

In order to determine which sexual behaviours made the respondents most vulnerable to infection, we asked them about condoms, drugs, sexual intercourse and health care.

2.1 The use of condoms

Several cross-checking questions regarding the use of condoms were asked in order to check the information provided by the respondents. The results showed that there were no contradictions in their answers and that the respondents' knowledge of condom use was changing. However, we are not very optimistic since the frequency of condom use as well as the ways there are used during intercourse varied greatly from one respondent to the next. The risk of infection for those whose knowledge was poor and those who did not regularly use condoms was still very high.

Over 80% of the respondents said they always used condoms during intercourse with their clients. Only 60%, however, used condoms with their regular clients, while 12.9% never did. Nearly 60% of the respondents never used condoms during intercourse with their husbands, and 85% never did with their boyfriends. (Table 36).

Table 36. Condom use with different sexual partners

Use condom with	Always	Sometime	Rarely	Don't use
New customers	83.2	14.1	0.5	2.1
Regular customers	58.4	27.7	1.0	12.9
Husband	11.8	23.5	5.9	58.8
Lover	7.5	7.5		85.0

The research finding showed no relationship between age, education and the use of condoms. In contrast, there was a clear relationship between the respondents' previous occupation and their use of condoms. Compared to other occupational groups, those who used to be farmers had the lowest level of condom use with their clients (Table 37).

Table 37. Relationship between respondents' previous or current occupation and condom use

Use of condom with	Occupation				Total
	Farmer	Business	Services	Other	
New customer	81.3%	75.0%	88.9%	91.9%	83.2%
Regular customer	50.0%	65.4%	56.3%	66.7%	58.4%
Husband	0.0%	0.0%	16.7%	100.0%	11.8%
Boyfriend	9.1%	12.5%	0.0%	9.1%	7.5%

In our in-depth interviews, many respondents said that their use of condoms with regular clients or with the man they regarded as their "boyfriend" was less frequent, since they considered not using a condom as a way of showing their affection.

Q: Is it because you did not use condoms consistently that you got pregnant?
A: No, I was only pregnant with someone I liked, I loved him, I wanted to act like his wife. Then get used to him... like dating. Only because of it I got pregnant. I liked him like I was his girlfriend.
Q: How many men like this did you have? You got pregnant three times.

A: Three men (smiling)

(Interview at Loc Ha with a 30-year-old divorced woman from Ha Tay. She has one child).

Q: Did you have sexual relationships with the man from the college you mentioned?

A: We loved each other, like husband and wife.

Q: Did you use condoms?

A: No. Because we were sincere to each other, so there is no problem. With others, I always used condoms.

Q: But you never used condoms with that man?

A: No.

(In-depth interview at a 'risky hamlet', Hanoi. The respondent was a 28-year-old divorced woman from Ha Tay with 5th grade education. She has two children).

Q: What type of clients did you no use condoms with?

A: Those I was not suspicious about.

Q: After how many encounters with him do you feel you can trust a client?

A: About 5 or 6 times. And when I know he has a wife and children.

Q: They did agree not to use a condom?

A: Yes. They said they trust me, so they did not use condoms.

(In-depth interview at a 'risky hamlet', Hanoi. The respondent was a single 28 year-old woman from Ha Dong. She has one child).

It is a fact that condom, when used correctly, are effective in preventing STDs and HIV/AIDS infection. HIV is found not only in blood and sperm, but also in vaginal discharge and pre-cum. Therefore, to avoid being infected, one should use a condom before penetration (not only during ejaculation) and must use it during the entire duration of intercourse. Unfortunately, this rule was not strictly followed by the respondents.

Table 38. The way of using condom with different sex partners

Sex partner	Whole process of intercourse (%)	Before ejaculation (%)
New customer	99.5	0.5
Regular customer	96.5	3.6
Husband	14.3	85.7
Boyfriend	37.5	62.5

One of the main risk factors is the carelessness of the sex workers themselves. On one hand, many believed that having sex with their husband or boyfriend was relatively safe, therefore putting their own safety at risk. On the other hand, they did not care about the safety of their clients.

There has so far been no research in Vietnam on the use of condoms by men and women according to the different types of sexual relationships (monogamous relationship, casual sex, sex worker...) or on the use of condoms by sex workers' clients with their wives, girlfriends or with sex workers. However, we can safely assert that the behaviour and beliefs of sex workers as shown above are common.
When asked about using condoms with clients, some respondents immediately replied that they did not want to or did not even ask the client to use one, despite the risk of infection.

When asked what they would do if a client did not want to wear a condom, 70% of the respondents said they would refuse to have sex. About 16% said that they had to please the client (Table 39). We believe that in reality, the proportion of sex workers refusing intercourse would be lower while that of sex workers who would do as the client pleases would be higher.

Table 39. Sex worker's reaction to a client's refusal to use a condom

You would	Frequency (n)	Percentage (%)
Refuse intercourse	134	71.3
Persuade them until they agree	21	11.1
Obey them	30	16.0
Other	3	1.6
Total	188	100.0

In the in-depth interviews, some respondents admitted that since they needed money, they had to accept that clients might not want to wear a condom.

Q: What did you do when the client refused to wear a condom?

A: I had to consider. But if I needed money, I took the risk. But usually I would consider and check the client.

Q: How?

A: Yes (laugh), I examined him.

(Interview in Loc Ha, Hanoi. The respondent was a 21-year-old single woman from Ha Tay with 7th-grade education).

"Some want to use a condom, some don't. If they did not want to, I had to accept it. If I refused, the client would not buy me"

(Interview at a 'risky hamlet' in Hanoi. The respondent was a 28-year-old single woman from Ha Dong. She has a child).

Most of the respondents bought condoms themselves. Only a few of them would have their 'owners' provide condoms. On a positive note, up to 40% of clients would have condoms with them when going to a sex worker (Table 40).

Table 40. Condom provision

Who provide condom	Frequency (n)	Percentage (%)
Customer	78	40.2
You	128	66.0
Owner	33	17.0
Hotel	3	1.5
You buy or borrow	7	3.5

2.2 Sexual hygiene and gynaecological examination

One of the factors which can contribute to prevent the spread of STDs is a good sexual preventative hygiene performed by the sex workers themselves. Good sexual hygiene will not prevent infections, but it will slow the developments of some diseases and help infected women address the symptoms in time. It might also reduce the rate of "sex worker to client" infection.

Our research showed that not a single respondent changed her underwear before intercourse and only one in four would was their genitalia. After intercourse, they would wash their vagina with plain or soapy water and sometimes with hygiene fluid (Table 41).

Table 41. Personal hygiene before and after intercourse.

Hygenic habit	Frequency (n)	Percentage (%)
Before having sex		
Wash genital	55	27.5
Change underwear	0	0.0
After having sex		
Wash by soap	63	31.5
Wash by water	45	22.5
Wash by hygiene fluid	80	39.8
Change underwear	0	0.0

Generally the respondents were unable to wash or change underwear before sexual intercourse as they operated from a place without water or hygienic facilities. Only a small number of them working in hotels and restaurants had access to such facilities. Most of the respondents said they would only wash when they got home to sleep. In general, after receiving a client, they would just wipe themselves with a towel or paper.

"I tell you this, very true. When we work on the street or in bushes, we have no way to wash but can only wipe ourselves dry. Myself, I don't like the same towel being used by many people. So I always have sanitary pads with me. When I finish with a customer, I wipe myself with a pad and throw it away, and use a new one with the next customer. This is the best way, the cleanest way for both people".
(Interview in Nghe An with a 38-year-old divorced woman from Nghe An with middle-school education. She has two children).

Q: Did you wash before or after receiving a client?
A: There was no water at the park. I just wiped myself quickly with a sanitary pad.
(In-depth interview at Nghe An. The respondent was a 36-year-old divorced woman from Nghe An with 4th-grade education. She has two children).

Q: You just wiped yourself dry after each client, didn't you?
A: Yes, just wiped. That's why I've got syphilis.
(In-depth interview at a 'risky hamlet' in Hanoi. The respondent was a 39-year-old divorced woman from Hanoi with 6th-grade education).

2.3 STD infection and gynaecological examination

According to the respondents, only a small number of them have ever had an STD. One in five had common reproductive tract infections (Table 42). However, we believe that these figures are not reliable, since psychologically women do not want to disclose diseases related to their genitalia, especially diseases such as syphilis which is often regarded as a 'social disease' that indicates a dirty, 'debauched ' lifestyle. Sex workers having symptoms of these diseases often hesitate to disclose them.

Table 42. Type of STD infections.

	Frequency (n)	Percentage (%)
Ever infected		
Syphilis	15	7.5
Gonorrhea	15	7.5
Genital wart	5	2.5
Other	40	20.0
Currently infecting		
Syphilis	2	1.0
Gonorrhea	7	3.5
Genital wart	3	1.5
Others	27	13.5

Many studies have shown the importance of education in the reproductive health of women. In this research, it appeared clearly that those with a higher level of education were less likely to have an STD than those with lower education, particularly in the case of the illiterate group.

Table 43. Relationship between education and STD infections.

Ever infected with STD	Education level				Total
	Illiterate	Grade 1-5	Grade 6-9	Grade 10+	
Syphilis	17.1%	6.65	6.1%	0.0%	7.5%
Gonorrhea	8.6%	8.2%	7.35	4.3%	7.5%
Genital wart	2.9%	0.0%	2.4%	8.7%	2.5%
Other RTI	25.7%	18.35	22.0%	8.7%	20.0%

Women in general do not like undergoing a gynaecological examination. If they have to, they do not go to the doctor's regularly. They tend to go for an examination only when they think they might have an infection or a disease. This is also the case for sex workers, even though they should be even more concerned than most women about such diseases.

Although 81.6% of the respondents said they had undergone gynaecological examination, over half of them did so at the camps. Only a few respondents had monthly examinations. Some went to the doctor's only when they thought they had a disease.

Table 44. Time and place of gynaecological examinations

Having gynecol. exam	Frequency (n)	Percentage (%)
In public clinic		
Monthly	37	22.4
Every three month	6	3.6
Every six month	7	4.2
Annually	5	3.0
When have a disease	15	9.1
In the camp	102	60.5
In private clinic		
Monthly	7	4.3
Every three month	3	1.8
Every six month	1	0.6
When have a disease	2	1.2
Never go to private clinic	144	91.7

Contrary to our expectations, a number of respondents underwent examinations with private doctors. We thought it would be rare as private doctors are often much more expensive than the public system. Furthermore, we believe that the privacy of the patients is better insured in the public health system.

III Client's profiles and clients behaviour regarding STDs and HIV/AIDS

When researching sex work, it is important to study the clients and their behaviour. Some even believe that clients play an intermediary role in the spread of STDs and HIV/AIDS. Unfortunately, there is only one research focusing on this subject, carried out by Care International in 1991. Although our survey concentrates on sex workers, we think that

information about clients will help us get a better understanding of the behaviours associated with STDs, HIV/AIDS and commercial sex work.

The information about clients reported by the respondents in our survey is not very reliable, but it can at least provide some knowledge of their sexual behaviour, especially regarding condom use. It can also suggest issues to be addressed in further research.

3.1 Who are the clients?

According to the information collected from sex workers, clients come from a variety of social groups. They also belong to different age groups, with the majority being between 31 and 50 years old. The second largest group consists of those aged 21 to 30 (Table 45).

Table 45. Age of the clients

Age of clients	Frequency (n)	Percentage (%)
<20	31	15.4
21-30	112	55.7
31-50	137	68.2
50+	38	18.9

While our respondents could not indicate the educational level of their clients, they had a good idea of their occupations through the conversations they would have with them.

Some clients even left their business cards to the sex workers, so as to maintain a relationship. According to the sex workers, government employees formed the largest group of clients. The second largest group consisted of self-employed manual workers such as cyclo-drivers, porters, etc... (Table 46).

Table 46. Clients' occupations

Occupation/job of the customers	Frequency (n)	Percentage (%)
Businessmen	26	12.9
Government employee	104	51.7
Non-trained job	61	30.3
Student	42	20.9
Foreigner	9	4.5

It is worth mentioning that there seems to be a debauched lifestyle among men aged 30 to 50. Many of them have good economic status, thanks to highly paid jobs or important positions in government. They make money easily and spend it lavishly. They are in the habit of celebrating successful business dealings at restaurants and go to a sex worker. Some customers buy the services of a sex worker to thank someone who has helped them or done them a favour, or as a bribe to get a deal. Some believe seeing a sex worker will turn around bad luck in business. A considerable number of clients work for the army or the police force.

"They are all high-ranking people. They are government employees, some are company managers...Some from private companies. The majority are government employees. Sometimes, students come, but not often".
(In-depth interview at Ba Vi, Hanoi. The respondent was a 23-year-old divorced woman with 7th-grade education).

"I am sorry to say this but many clients have high position and power. They are government employees or private businessmen. Students and foreigners also come".
(In-depth interview at Thanh Hoa. The respondent was a 20-year-old single woman from Thanh Hoa with 7th-grade education).

"They are all government employees. No bumpkin...students too...even policemen. They wear a uniform, very polite. A policeman gave me his phone number, but I did not write it down. Because he forced me to have intercourse with him, I got angry, so I did not write it down".

(Interview at Ba Vi, Hanoi. The respondent was a 26-year-old divorced woman from Ha Tay. She has one child).

"Clients at our restaurants are all government employees. They are all in high-ranking positions in different ministries. Their education is at least upper secondary. I think they want to relax after hard work. Some only want to have a chat and that's it...Most of them are married, because they are all middle-aged... They all have big money. They all come to celebrate after business meetings".
(Interview in Ba Vi, Hanoi. The respondent was a 27-year-old divorced woman from Phu Tho. She has one child).

Nearly half the women in the sample had regular clients. More than two thirds said that their regular clients came to see them two or three times a month. About 15% of the sample had regular customers who visited them six to fifteen times a month.

3.2 Reasons why clients used sex workers

According to our respondents, clients came to them for a variety of reasons. The main reasons were for sexual satisfaction and because their wives were away. Unhappy marriages were another reason why men would go to sex workers.

The figures are not highly reliable but we have reasons to believe what the sex workers said about their clients. Men who go to commercial sex workers do not necessarily have high sexual demands. Psychological stress such as business difficulties, family trouble, or work related stress can prompt them to visit a sex worker. Some buy sex services simply because they want to have "new stuff".

"I am sentimental, so some clients came to me many times. Then they would say: 'That's enough, Babe. Like eating rice is boring, I need to go with someone else'. I'd say 'yes'".
(In-depth interview at a 'risky hamlet' in Hanoi. The respondent was a 45-year-old married woman).

"They're sad and they're bored with life. Some left their wives. Some said they were sick of their wives and children... Some were construction workers, some worked in different jobs, some were government employees... Some came from the countryside to work here. They were away from their wives, so they went to sex workers".
(Interview at a 'risky hamlet' in Hanoi. The respondent was a 28-year-old single woman from Ha Dong. She has one child).

"I saw many high-ranking men. They came to us after work... I heard they said they enjoyed for fun, or to turn bad luck around".
(Interview in Loc Ha. The respondent was a single woman from Loc Ha with 5th-grade education).

3.3 The use of condoms by clients

Only 30.2% of clients initiated condom use. When the initiative came from the sex worker, 80% of clients agreed to it. However, when asked: "Have your clients ever refused to use a condom?", 85.8% of respondents said yes. About 60% of respondents said that 10 to 30% of their clients refused to wear condoms.

On average, each respondent in our sample received 2 clients a day. Therefore in a single day, out of 201 respondents, 103 had intercourse with 20 to 60 customers without condoms. If we know how many people these clients are having sex with without condoms, we could multiply this number by the risk of being infected with HIV through each sexual encounter and we would get an approximation of the number of people who may become infected in a day.

Almost all the respondents in our in-depth interviews said many of their clients did not use condoms, particularly their regular clients. Some clients believe that country girl or pregnant women did not carry STDs.

This is the story of a country girl who came to Hanoi to sell vegetables. She was abducted, then forced into prostitution.

Q: Did you ask your clients to wear a condom?

A: I did. I said they should wear condoms so that I would not get pregnant and they could protect themselves from diseases, but they did not listen to me.

Q: What did they say?

A: They said I could not have diseases since I was from The countryside. They believed that there was no way to get diseases from the countryside.

(Interview in Ba Vi, Hanoi. The respondent was a 26-year-old divorced woman from Ha Tay with 8th-grade education. She has one child).

This is the story of a woman deserted by her boyfriend. She had a child and was pregnant , but still forced to receive clients.

Some liked me. They quoted a popular saying: "To 'fuck' with a pregnant woman is like getting all the excitement of half a lifetime". They also said pregnant women could not have diseases.

(Interview at the 'whore market' in Hai Phong. The respondent was a married woman from Tuyen Quang. At the time of interview, she was 6-month pregnant from a client. She also has a child).

Sometimes, the sex workers would have to have intercourse with the street 'bear heads' or with sexually violent clients. In these cases, they would be beaten up, insulted, degraded, and would not be protected from STD infections.

The restaurant were I worked usually at 9 PM. That day they came at 10.30 PM. In the dark, I first did not pay attention to him. They came to stay overnight. They bought me for the whole night. When they turned the lights on, I saw their backs full of tattoos of dragons and snakes. Their arms and legs were also tattooed with human skulls. I was frightened to death but the master has been paid so I had to see them. They tortured me. Next day my face was extremely pale. They beat me, scratched me. They forced me to have sex with them all night. I could not stand it, they yelled at me, scratched and squeezed me. They thought that because they had paid, they could force me to do whatever they wanted, like blowing, sucking. When I refused, they insulted me. I cried, and they beat me. Once they beat the blood out of my lip. Then I had to go to the Coal Company III Hospital to have the

injury looked at. They hit my lip against my teeth. They were drug addicts. I remember they came from Hanoi. They bought me for the whole night. When I could not please them, they beat me up. At night I cried out, the master came up to see me in blood. My eyes and mouth were swollen. The next day the master took me to the hospital so that I could get some shots to relieve the pain and had my injuries treated. It was about the beginning of this year. It happened at the restaurant.
(In-depth interview in Ba Vi, Hanoi. The respondent was a 23-year-old divorced woman with 7th-grade education).

The most frightening incidents occurred when a group of clients bought a sex worker collectively. This is called *tablo*, or group sex. Most of these clients never use condoms. Some respondents were angry when revealing their stories.

If they do tablo, they never pay. Why pay? I experience two or three tablos since Tet. I had to accept. They never wear condoms. Sometimes, in order for them to wear condoms, I say that I have a disease, and that if they don't wear condoms, they will get diseases and will come here again to blame me. They said 'Fuck' your mother. Once I 'fuck', I know. It's difficult for you whores to get diseases. You 'fuck' a lot, but don't fool us. I, you 'fucking' father, do whatever I want. Don't ever tell me what to do, even though I lied that I had a disease.
(Interview at a 'risky hamlet' in Hanoi. The respondent was a 45-year-old married woman from Ha Tay).

I experienced a tablo once. They forced me in the park. Four or five guys. They did tablo then they left. I asked them but they did not wear condoms. They said they did not care. They were all young.
(Interview at a 'risky hamlet' in Hanoi. The respondent was a 28-year-old single woman from Ha dong. She has one child).

The teenagers, they did tablo. They did not use condoms. That's why I got a disease then.
(Interview at a 'risky hamlet' in Hanoi. The respondent was a 39-year-old divorced woman with 6th-grade education).

3.4 Clients and drug use

Around 10% of respondents said their clients were drug addicts. Some said they were afraid of these clients most, since these men would have sexual intercourse that lasted a long time, which would be painful and made them feel very uncomfortable. Sometimes they would be violent and beat up the sex workers if they were not satisfied. In cases when the respondents' boyfriends were drug addicts, most of the women's money would be used by their partner to buy drugs.

In the Social Support Camp Number II in Hanoi, we met a sex worker from Ha Tay whose boyfriend was a drug addict. She was HIV-positive (she might have become infected through her boyfriend). Some respondents were drug-addicts themselves and were doing sex work to pay their debts. This was the case of a beautiful woman we met who used to be a singer in an army band. She became addicted to cocaine and soon owed millions of Dong. She had to sell her furniture and turned to prostitution to support her habit.

Out of the 201 respondents we interviewed, 13 (6.5%) had tried drugs, including 4 who were drug pushers. Twenty-seven respondents (13.4%) said between 5 and 90% of the sex workers they knew used drugs.

C. CONCLUSION AND RECOMMENDATIONS

I. Conclusion

1. Our sample of sex workers is far from homogenous and consists of women from different social backgrounds. All of them are in reproductive age. More than half of them are between 16 and 24 years old. 12.5% are under 18. These findings, together with other studies conducted in Vietnam, show that the number of young women (including teenage girls) working in prostitution in the country is increasing.

   Almost one in five respondents is illiterate, while one third have only primary education. This may be one of the consequences of the rapid socio-economic changes that took

place in the rural areas during the early stage of the reform programs. Poor education has limited women's information, while at the same time reducing their ability to find work. This could have prompted them to make the wrong decisions.

Two thirds of the samples come from rural areas, and a considerable number of these women became involved in prostitution out of economic difficulties. Others were lied to or forced into prostitution while seeking jobs in the cities. There is also a number of respondents who became sex workers out of a desire for material goods.

For some, a drug addiction motivated their decision to become sex workers. Others see prostitution as a profession and have no intention of looking for another job, since they find they can make money easily through sex work.

Whatever their motives, we found that the respondents had a common characteristic: they were depressed, took risk, and behaved in an irresponsible manner for the sake of short-term benefits.

2. There is a relationship between the sex workers' socio-economic characteristics and their vulnerability to STDs and HIV/AIDS. Age, education, previous occupation, place of origin all have a significant influence on the following dependent variables: why they are doing sex work, pregnancy, abortions and their awareness of STDs and HIV/AIDS, as well as their condom use. Our research shows that age had a positive relationship with these dependent variables. For instance, the level of awareness of STDs and HIV/AIDS of those aged 20 and under is much lower than in the higher age groups.

   Education also has a positive relationship with STD and HIV/AIDS awareness, particularly regarding prevention methods and condom use. Many women in our sample were either illiterate or poorly educated (17.4% and 30.3% respectively). This has considerably limited their access to information in general and regarding STDs and HIV/AIDS in particular.

Almost half the respondents were originally farmers. Compared to those who used to work in the small trade or as service providers, this group has a much poorer level of awareness, and has a much higher rate of STD infection.

3. The respondents showed a large geographical mobility across provincial borders. In our sample, 200 respondents came from 28 provinces and cities. The majority did not work in their province of origin, making it difficult to keep track of them.

4. Clients also showed a variety of socio-economic characteristics. Contrary to popular belief, they are not necessarily men with high sexual demands. Although the data collected is not sufficient for us to draw a definite conclusion, we can predict that the number of men using sex workers will increase. Studies on the sexual behaviour of men in general and of sex workers' clients in particular would help understand this issue and would provide information on what sexual behaviours facilitate the spread of STDs and HIV/AIDS.

This research shows that the level of awareness of the clients regarding STDs and HIV/AIDS plays a decisive role in the sex workers' use of condoms. Only a small number of clients have condoms with them when they visit a sex worker. The majority of clients do not want to wear a condom during intercourse. We can safely assume that these men will not wear condoms with their wives or girlfriends. Some naively believe that coming from the country or being pregnant is a guarantee that a sex worker will not carry a disease or an infection.

We can therefore conclude that it is the clients themselves - not the sex workers or drug addicts - who are the major channel through which HIV/AIDS is spread in the community.

II. Recommendations

With this research, we do not pretend to provide strategic resolutions on how to deal with prostitution in Viet Nam . We confine our action to making suggestions on how to prevent

the spread of STDs and HIV/AIDS to the wider community. We would also like to suggest some possible steps which might help change the sexual behaviour of sex workers and their attitude towards the risk of infection from STDs and HIV/AIDS.

1. The relationship between the sex workers' socio-economic characteristics and their sexual behaviour indicates that any effective intervention needs to take into account variables such as age, education, previous occupation, place of origin, etc.

2. Education and information programs on STDs and HIV/AIDS need to be developed so as to reach sex workers. Books, documents, flyers with easy-to understand information and pictures can be effective ways to get the information across, but only if they reach the sex workers. It is therefore crucial to ensure that this information is distributed in places where sex workers operate, such as restaurants, hotels, entertainment areas and other locations.

3. Awareness campaigns can be carried out to encourage a wider use of condoms. Experienced women can be used as 'peer educators' to convince clients of the importance of condom use. The experimental production and distribution of condoms of different appearance to make them more attractive to clients need to be encouraged.

4. Educational programs on what contraceptive methods are available to sex workers need to be strengthened, and there is a need for easier and wider access to contraception services.

5. Educational programs need to be reinforced to develop sex workers' knowledge of reproductive health. They must also be encouraged to develop a sense of responsibility towards the community, for instance by undergoing more frequent gynaecological examinations. The experience of some Non Governmental Organisations who have sent medical personnel to the places where sex workers are operating need to be considered.

6. Actions need to be taken to warn brothel owners and clients about their responsibilities in preventing the spread of STDs and HIV/AIDS, and to encourage them to actively participate in the distribution of condoms and the promotion of safer sex.

7. Further research on the clients' needs need to be conducted in order to study their sexual behaviour and their condom use, so that interventions such as IEC and further consultations can be carried out.

8. Further research on prostitution need to be conducted, as well as research on the sexual behaviour of the general population, in order to define high risk behaviours and to construct effective IEC campaigns.

9. Intervention studies need to be taken out to find out what the obstacles are to safer sex and to build intervention strategies with the aim of changing the risk-taking sexual behaviours of sex workers and clients alike.

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Asian Women's Fund

The Asian Women's Fund was established in July 1995 by prominent citizens who were concerned about continued suffering of the former "comfort women", victims by Japanese military during the World War Second, with the support of the Government of Japan. The primary aim of the Fund is to extend atonement and support to those victimized women. The victims have suffered in silence for so long and are now of an advanced age, and it is therefore the Fund's sincere wish to act urgently, in accordance with their needs, to alleviate their pain in whatever small way it can. At the same time, recognizing that prevailing attitudes of discrimination and violence against women is a part of the background to the suffering inflicted on the "comfort women". The second pillar of the work of the Fund is to actively address contemporary issues of violations against the dignity and rights of women.

The Fund's activities include:

- hosting international forums on contemporary issues on women;
- financial support to NGO projects addressing contemporary women's human rights issues;
- research and analysis into the causes and prevention of violence against women, and other contemporary women's human rights violations, and;
- training and development of new counseling approaches for women victims of violence and human rights violations.

For further information, or a list of publications, please contact the Fund at the address below, or visit its site on the world wide web.

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