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Can PEPFAR Save the Most Vulnerable?

by Cindra Feuer

At the end of February, President George W. Bush promised $15 billion in aid over the next five years to treat 2 million people with AIDS, avert 7 million new infections, and care for 10 million people. Dubbed the President's Emergency Plan for AIDS Relief (PEPFAR), it proposes exporting a modified version of Uganda's prevention strategies to 14 other "focus" countries burdened by the pandemic. Uganda bases its campaign on the "ABC" approach: practice abstinence, be faithful, and use condoms. But PEPFAR emphasizes abstinence and fidelity, advocating condoms for only those who engage in high-risk behaviors. PEPFAR therefore ignores the group most vulnerable to HIV today — young married women.

"One of the biggest silent factors for new infection actually occurs between couples, especially married women," said David Serwadda, director of the Institute of Public Health at Makerere University in Kampala, Uganda. "Women do not suspect that they are at risk. She doesn't see herself at risk, she has one sexual partner, she's faithful — but when you look at our data, she's contributing a lot to the HIV numbers."

Marriage as a Risk Factor

Although lush, equatorial Uganda remains an extremely poor country, with a yearly per capita income of $259. It has earned favorite-nation status in the global AIDS community for cutting its HIV rate from 30% in the early 1990s — the highest in the world at the time — to a current 6.2%. Prevention successes and supposed economic promise helped Uganda garner international funding, attracting HIV researchers and nongovernmental organizations. Tens of millions in PEPFAR funding are now beginning to flow into Uganda.

"Uganda clearly was the country most cited by the president when he presented the [PEPFAR] program," said Jimmy Kolker, US Ambassador to Uganda and gatekeeper to the country's PEPFAR money. But little, if any, of the money is going to programs of significant scale that protect women, particularly married ones — the highest risk group — from domestic violence.

While Bush promotes Uganda as a prevention paradigm, HIV disproportionately affects women there. Of the estimated 1 million Ugandans living with HIV, 56% are female. This disparity is expected to increase because of gender inequality and, in particular, because of Uganda's exceptionally high rate of domestic violence against women.

The World Health Organization estimates that one in three Ugandan females suffers from abuse, one of the highest incidence rates in the world. The Rakai Project, a renowned Ugandan research center, surveyed 5,109 women, and 90% of them viewed beating a wife as justifiable in certain situations. Human Rights Watch (HRW) has condemned the Ugandan government for failing to criminalize or prosecute violence against women in the home. Its 2003 report, "Just Die Quietly," states: "The Ugandan government has ignored the role of violence,

and, in particular, unwanted sexual relations in marriage, in exposing women to HIV infection."

The PEPFAR mandate acknowledges that domestic violence is a problem. "Fear of sexual coercion and violence often precludes the option of abstinence or holds [women] hostage to their husbands' infidelity," it declares. But PEPFAR does not give domestic violence priority. According to Kolker, the first question African ambassadors raised in a PEPFAR meeting concerned spousal abuse. They asserted that domestic violence was a key factor in the spread of AIDS and PEPFAR neglects it. "There's no specific budget for violence against women in the PEPFAR budget. We see it as a gap in the legislation," said Kolker. "I see it as regrettable."

Uganda's Response: More than Just ABC's

Ugandan President Yoweri Museveni, who assumed power in a 1986 coup, is praised for his swift attention to AIDS. Some believe that the nation was ready for healing after 20 years of civil war and willingly followed the president's prescriptions for battling HIV. Nonetheless, Museveni's administration initiated multiple approaches to combat AIDS: massive public awareness campaigns, voluntary testing and counseling, research, treatment of sexually transmitted diseases, home-based care, clean-up of the blood supply, and condom distribution.

Aside from Museveni's actions, other circumstances contributed to Uganda's decreased HIV rates. Ending the war helped stabilize the country, and HIV began to take its natural course; numbers of deaths eventually surpassed new infections. "ABCs all increased, not because of intervention specifically, but because they saw the threat through the deaths of friends and relatives," said Kolker.

Justin Parkhurst at the London School of Hygiene and Tropical Medicine questions Uganda's impressive decline in HIV prevalence. He concedes that Uganda has slowed the spread of AIDS, but claims that the original epidemiological data were misinterpreted. He doubts Uganda ever had infection rates as high as 30%. As for PEPFAR emphasizing abstinence and fidelity based on Uganda's success, the numbers they cite come from a few national surveys, which, although important, do not capture the whole picture. "Other more specific studies have shown groups with increased partners but higher condom use. Ugandans have increased the A and B, but some Ugandans have relied on condoms as well," stated Parkhurst.

PEPFAR restricts condom promotion to high-risk populations, diverting it from the general public — like married couples. "A high proportion of infections occur between married couples or couples in long-term partnerships, where A and B are not options," said Parkhurst. "Very often men have outside partners, contract the virus, and pass it to their wives. These women cannot abstain and they are already being faithful. Condoms are the only protection at the moment for such women."

To the dismay of public health advocates, who promote comprehensive prevention strategies, PEPFAR requires that one third of all prevention money fund abstinence-until-marriage interventions. Married women who have abstained from sex until marriage and who remain faithful (97% according to the 2000–2001 Uganda Demographic and Health Survey) are left unwittingly at risk if they cannot use condoms. Confounding this problem is polygyny — a legal practice allowing a man to have more than one wife. Of Ugandan women, 32% are in polygynous relationships.

UNAIDS, in partnership with The AIDS Support Organization, determined that most married women they surveyed understood the modes of HIV transmission but they could not control the risky behaviors of their husbands. Nationwide data reveal that condoms are not commonly used in marriage. Some husbands beat wives who request condoms because they suspect infidelity. "My husband had many co-wives. They all died," said HIV-positive Rabina. "I was aware that at any time I could become infected, so sometimes I refused [sex] but he used force." Sex is considered a marital obligation, so wives are at higher risk for HIV than their single counterparts who can choose to abstain.

Unequal Under the Law

Uganda's modern constitution aims to redress inequities among men and women. But it falls short in several areas, especially in customs pertaining to marriage, domestic violence, and property.

Bride price, a dowry the husband's family gives to the woman's family, allows a man to buy a woman like property and treat her as such. Her reproductive rights transfer to her husband's family. Because marital rape does not exist within the law, a woman has no legal recourse to protect herself from coerced sex. Under this paradigm, "chastising a woman is not derogatory; it's seen as controlling what you bought," said Margaret Oguli, of Uganda's Movement Secretariat at the International Conference on Bride Price in Kampala last February. Also, aside from economic reasons, wives

experience intense pressure to remain in their relationships because marriage and children gauge social approval. Ugandan women have seven children on average, the fourth highest fertility rate in the world.

In addition, many customary laws apply where constitutional law lapses. For example, the traditional practices of "property grabbing" and wife inheritance exacerbate a widow's already weakened social situation. A Ugandan woman has difficulty inheriting her husband's land, because property and matrimonial belongings generally remain with his family. Many widows are forced to marry and have unprotected sex with a relative of the deceased husband.

Because women have no access to education, employment, property, or custody rights, the alternative to marriage often seems dire: poverty, homelessness, and more sexual risks. Faced with these choices, fear of HIV does not adequately justify rejecting sex or leaving the home. But the Bush version of the ABC campaign does not recognize marriage as a risk factor for HIV. According to condom advocates, in a nation where the median marriage age for females is 17.8, PEPFAR's efforts are futile without a concerted campaign for condom use that targets couples. Instead, PEPFAR limits condom campaigns to people at "high risk," such as sex workers and truckers. "Use of condoms will also be promoted for sexually active discordant couples. In doing this, every effort will be made to deliver a consistent 'ABC' message so that the general population receives a clear message that the best means of preventing HIV/AIDS is to avoid risk all together," reads the PEPFAR mandate.

Tina Musuya challenges Godfrey Semujju on women's equality in marriage. Ms. Musuya is a local program officer for Raising Voices, an organization dedicated to ending domestic violence against women and children in Uganda.

But discordant couples are not readily identified, since 95% of Ugandans do not know their HIV status. PEPFAR policy therefore confines condom promotion to a fraction of the couples who need it. "Everyone is at high risk and everyone should have access to all available information and means of protection," commented Jodi Jacobson from the US-based Center for Health and Gender Equity. "In addition, this focus on 'high-risk' groups threatens to undermine global efforts to reduce stigma and discrimination."

Before PEPFAR, most AIDS funding from the US government flowed to developing countries through the US Agency for International Development (USAID), a state department agency. USAID heavily sponsored organizations that distributed condoms. "Under PEPFAR that has got to stop," USAID senior advisor to Uganda Sereen Thaddeus said. "Mass marketing of condoms is something they feel we've done enough of and we need to give more balance to the A and B." But when sponsored organizations were asked to confirm this, they declined to comment. PEPFAR has hijacked USAID's agenda, threatening to unravel years of grassroots efforts at harm reduction. At the same time, hefty funding from PEPFAR and USAID makes local organizations reluctant to speak out against them.

"The [A and B] strategy completely ignores the larger social context, such as poverty and lack of access to property, education, and training and other barriers such as school fees that leave women dependent on men for survival and are leading factors in their increased risk of infection," said Jacobson.

At best, PEPFAR includes only indirect measures to confront contributing social issues, such as domestic violence. An ambitious voluntary testing and counseling campaign emphasizes that couples get tested together. PEPFAR also advocates rectifying gender inequality through criminal and civil legal codes. But some believe this does not provide enough support for women's basic needs, including food and shelter. US-based Physicians for Human Rights has urged the US and other multilateral agencies to provide the necessary resources.

Constructing a Remedy

A comprehensive movement to address Ugandan women's vulnerability to HIV includes reforming the laws and changing attitudes toward women. According to HRW, in order to align itself with international human rights laws, Uganda would have to strengthen its criminal justice system by standardizing and implementing domestic violence laws and prosecuting perpe-

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Barely A Gleam of Light: Gender Inequality and the AIDS Pandemic

An Interview with Stephen Lewis

by Kristen Kresge

Stephen Lewis currently serves the United Nations as Secretary-General Kofi Annan's special envoy for HIV/AIDS in Africa. An impassioned public speaker and trusted advocate of international human rights, Mr. Lewis poignantly relates and openly criticizes the world's sluggish response to the AIDS epidemic. Lewis's recent focus has been on the devastating impact of HIV on African women and he has become a resolute voice for gender equality. In February, attendees of the 11th Conference on Retroviruses and Opportunistic Infections frequently interrupted his keynote lecture with standing ovations.

He formerly held the positions of Canadian Ambassador to the United Nations and Deputy Executive Director of the United Nations Children's Fund (UNICEF). Before joining the UN, Mr. Lewis worked in Canada as a diplomat, humanitarian, and politician (including leading the New Democratic Party). He holds 18 honorary degrees from Canadian universities and numerous awards for his international work. He lives in Toronto and is married to Michele Landsberg, an acclaimed Canadian feminist and journalist.

Can you explain why HIV/AIDS is disproportionately affecting women in Africa?

Everything about the pandemic conspires against women. There's barely a gleam of light in the entire horrific edifice. Obviously, the hugely disproportionate number of infections reflects women's vulnerability. A significant pattern of sexual violence reflects the brutally unequal sexual relationships. There is the absence of legislation on property rights and inheritance rights, and any aspect that would give to the women some kind of statutory defense. The obvious gender inequality underlying every single aspect of a woman's life makes it impossible for her to ward off a man, to insist that he wear a condom, or to negotiate safe sex. For the women, it is a nightmare of sexual inequality. On top of all that, the women assume the entire burden of care in the society. They look after their sick and dying partners, after themselves, after other ill women, and after orphans. They do most of the work, and they are a class unconscionably oppressed.

Prevention strategies like ABC [abstinence, being faithful, and using condoms], which is credited with reducing the prevalence of HIV in Uganda, do not seem to be protecting women. Is marriage actually putting women at greater risk for infection?

The ABC strategy, as such, doesn't apply effectively to marriage because abstinence is neither possible nor desirable, being faithful is assumed, and wearing a condom is something a woman can't order with such a power imbalance in the sexual relationship. And when they get married, women think that there may be safety in marriage or safety in a permanent partnership. But we find out from recent studies that women are disproportionately affected in marriage.

So is ABC an effective strategy?

ABC doesn't work as well in marriage, but on the other hand, the prevalence rate has dropped dramatically in Uganda. So something is working and everybody has a different take on what it is. Some people say it's abstinence and fidelity; other people say that condoms became widely used in the country. A lot of people say that kids are starting sex rather later in life and that this makes a difference. I saw recently a study purporting to show that in Uganda the numbers of partners were significantly reduced. That suggests that fidelity is of real significance. It's hard to judge which of the various preventive measures has worked most effectively. I suspect in Uganda, as everywhere else, you need a combination of everything.

Is there anything else women can do to protect themselves?

There are three things that should be more emphasized than they are on a regular basis. Number one is the female condom. Where it is in use, in countries like Namibia, the female condom is very much accepted by women, and it seems to be accepted by men. The problem is the cost: it is so much more expensive than the male condom. But we cannot depreciate the value of the female condom, and it remains one of the obvious ways for women to protect themselves. Even more important in the long run — because this pandemic will be with us for generations — are microbicides. Microbicides are the most exciting potential prevention method. In five to seven years microbicides could be on the market. This is a reassertion of women's control and is hugely important in the absence of a vac-

cine. It's not the ultimate answer, but it is a huge transfer of sexual power. And then there are vaccines. It worries me that vaccines are so often seen as a throwaway. Because even if they are up to ten years down the road — and I noticed [executive director of the Joint UN Programme on HIV/AIDS] Peter Piot recently was fairly skeptical even of ten years — however long it takes, a vaccine is the ultimate intervention, the ultimate answer.

What can be done legislatively in these countries to empower women and stop the cycle of sexual abuse?

A single-minded, absolutely determined campaign for gender equality. It must be mobilized with the women activists in the country, the feminist organizations, and the human rights organizations in a very, very loud and insistent struggle to push the government, using women parliamentarians above all, to bring in legislation and to enforce it. Whether it's on property rights to prevent property theft or on sexual violence to reduce the incidence of rape and, where rape is committed, to put somebody away for life. That's just a major mobilization. Now, what has been lacking all these years is leadership. The leadership has not come from the UN agencies, as one might have wished. It has not come from the major nongovernmental organizations or from international human rights organizations. The leadership simply hasn't come, and the women in the country who want to provide the leadership frequently have no resources to do so and are not supported.

Is the World Health Organization's (WHO) goal of treating 3 million people by 2005 — otherwise known as '3 by 5' — addressing equal access to treatment for women?

WHO must make access an imperative and give equal or greater access to women since they are disproportionately infected. That must become one of the cardinal principles of 3 by 5. If it isn't, WHO will be lacerated by a lot of people for failing to understand the importance of what they're doing. There have been some recent, random surveys in Zambia of treatment access. It's just the beginning, of course, but they looked at 40 patients receiving treatment at one hospital and found that 37 were men and 3 were women. Frankly, that's just not tolerable or sustainable. Governments that permit it and UN agencies that abide it are culpable. We run a tremendous risk that treatment access is going to favor the men, as everything has favored the men, and that will be doubly discriminatory, just absolutely unconscionable for the women.

Is WHO prepared to work with women's groups that are already advocating for women's rights in these countries?

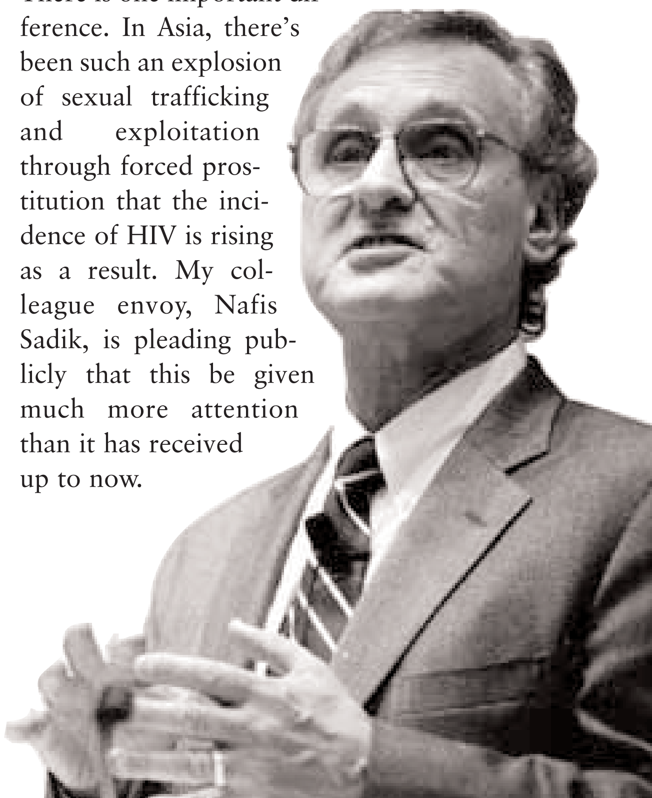
We've been pressing them to do so, and they claim that they will take the equality of access very seriously. But, of course, they've just begun. It's impossible to assess yet. The whole principle of 3 by 5 is just at the beginning.

Is the goal of 3 by 5 possible?

Yes, unless WHO is frustrated in its capacity to coordinate and stimulate activity by not having the seed money. If WHO can't collect the 200 million dollars it needs to get everything under way in 2004 and 2005, then we won't make it. But the combination of treatment being unleashed by the Global Fund and World Bank moneys, the PEPFAR moneys from President Bush's intervention, and the Clinton Foundation (which recently negotiated a remarkably low price of $140 per person, per year for the fixed-dose combination) has all resulted in generic drugs at a sufficiently low cost. Put that together with the money beginning to emerge, and if WHO can organize the treatment regimen, they'll make it. That's what their challenge is.

The epidemic is now also growing rapidly among women in Asia and that is garnering attention from the UN. Are the causes and approaches to dealing with this the same as in Africa?

There is one important difference. In Asia, there's been such an explosion of sexual trafficking and exploitation through forced prostitution that the incidence of HIV is rising as a result. My colleague envoy, Nafis Sadik, is pleading publicly that this be given much more attention than it has received up to now.



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HIV Drugs Trickle Into Uganda

by Cindra Feuer

Despite reduced HIV transmission rates, Ugandan AIDS cases have peaked, according to Alex Godwin Coutinho, executive director of The AIDS Support Organization TASO — the largest such agency in Uganda. "Lack of antiretroviral therapy is an emergency for the 100,000 who are going to die in the next two years," he said. Of the million Ugandans now living with HIV, only 12,000 to 15,000 people receive free treatment from a motley mix of nongovernmental organizations. A handful pay out of pocket at private clinics. With current health spending a mere $12 per capita, and a government-donor commitment to treat 100,000 people in the next five years, Uganda confronts a steep climb to reach its goals.

As PEPFAR, the Global Fund, and the World Bank designate hundreds of millions of dollars to scale up access to HIV drugs, Uganda scurries to prepare for delivering treatment. The initial strategy is to tap the existing facilities experienced in dispensing treatment — mostly nongovernmental organizations such as Médecins Sans Frontières (Doctors without Borders), TASO, and the Reach Out clinic. In March, Reach Out became the first organization in the 15 targeted countries actually to receive PEPFAR funding. The money arrived on a Friday, and by Monday the first 15 people received PEPFAR-sponsored drugs.

Treatment capacity at the dozen organizations will max out quickly, so Uganda plans to beef up government clinics and hospitals. But there are many hurdles. Coutinho believes that in order to create demand for antiretrovirals, organizations face a chain of factors. First, they must change the climate by helping Ugandans realize that they are at risk for HIV and by quelling stigma attendant with the disease. "It's the greatest obstacle to scaling up. People still don't want to be tested," he said. Next, they face a health care infrastructure lacking trained providers with appropriate experience. Exacerbating the problem, the World Bank has imposed a hiring freeze on the Ministry of Health. And the high cost of drugs and lab tests are still being negotiated. "We're building the ship as we sail," said Christine Nabiryo Lwanga, a TASO clinician.

The sudden flood of money into Uganda makes for heady times. The largest infusion comes from PEPFAR, President Bush's five-year plan for 2 million treated, 7 million new infections averted, and 10 million cared for worldwide. Inclusive in the plan is to treat 60,000 Ugandans by 2007. Of the total PEPFAR funding ($95 million this year and a proposed $500 million over the next five years), 55% is allocated to treatment. "It's been a priority of the advocacy communities in the US, and it's clearly what the HIV-positive community in Uganda are most eager to get, so there's a congruence that I'm glad we're responding to," said Jimmy Kolker, US Ambassador to Uganda.

The Global Fund approved over $200 million for Uganda, but the money is mired in Ugandan bureaucracy and has yet to hit the ground. To control Uganda's macroeconomy, the Ministry of Finance imposed caps on the budgets of all ministries. The Global Fund grant exceeds Uganda's entire health care budget of $180 million. Warring ministries are in negotiations, and when the dust settles, the Global Fund aims to sponsor 33,000 people on treatment.

Through its Multi-Country HIV/AIDS Program, the World Bank plans to loan Uganda $50 million over the next two years, $3 million of which will provide treatment for 6,000 people. Most of this money will go to buttress infrastructure scale-up in government hospitals in all 56 districts. After 2006, the next World Bank installment for antiretrovirals will be a grant.

Drug costs will determine how many people receive treatment. The private sector, the Global Fund, and the World Bank are committed to purchasing drugs at the lowest possible prices, which inevitably means procuring generics. But PEPFAR has been equivocating about generics, and the US attempts to impede other donors from purchasing generics by claiming that the World Health Organization's quality-assured generics do not meet FDA standards. The generics, particularly "fixed-dose combinations," can cost as little as $140 a year, while the identical brand-name combination costs at least $560 per year. Using generics could treat four times as many Ugandans.

Some worry that throwing money at the problem before Uganda is in a position to field it will spawn drug resistance. Coutinho counters that concern, "There are 400,000 Ugandans adherent to their cell phones. They can adhere to [antiretroviral therapy]." Others worry about sustainability. What happens in five years when the plan is over? By 2007, Coutinho warns that 100,000 Ugandans may be on treatment, but 150,000 more will need it. Hopefully by then the ship will be built.

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trators. HRW also advocates passage of the Domestic Relations Bill. Long heralded by Uganda's women's movement, this legislation addresses issues of polygyny, bride price, wife inheritance, property grabbing, divorce, and age of consent. The controversial bill has been pending for years; even Museveni opposes it. Amending the Land Act to entail spousal co-ownership of property would also alleviate the situation.

Because many women are estranged from their homes after testing positive for HIV, they may avoid knowing thier serostatus. As Uganda steps up HIV testing, it should also create women's shelters. "There has to be a support mechanism, especially for women, which will help in the eventuality they are thrown out," says Serwadda.

HRW also advises donors to support groups or nongovernmental organizations that specifically combat domestic violence. "We don't get funding from USAID because it's about social change," says Lori Michau, co-director of Raising Voices, a nongovernmental organization in Kampala that targets domestic violence. "People don't get the HIV linkage." Conventions often trump the law, so "prevention" of domestic violence is as important as legal reform, according to Michau.

Since 2000, Raising Voices has been awakening the Kawempe community of Kampala to cultural issues that oppress women, and they have noticed less acceptance of domestic violence. Volunteers campaign throughout the community, talking regularly with the police, faith-based organizations, schools, health centers, and men's gathering places such as saloons. Raising Voices focuses on benefits, challenging men and women to consider the disadvantages of certain cultural practices. For example, they explain that polygyny increases the number of children requiring care, leaving everyone with fewer resources. "We use the window of domestic violence to talk about all issues that come after that," says Michau.

Ultimately, many believe that Uganda must integrate women's needs into AIDS programs to see a genuine, sustainable decline in the nation's HIV rates. "PEPFAR may have repercussions because it is not addressing the reality of the disease. A significant number of infections are occurring in people where abstinence is not an option," says Serwadda. Until then, neither PEPFAR nor any other program will control HIV.

Breaking the Silence Along the Mekong

by Kristen Kresge

"The status of women in Asia has been in crisis long before HIV. It's only made the situation more lethal," said Joanne Csete, director of the HIV/AIDS program at Human Rights Watch. In Africa, the number of women living with HIV or AIDS has far surpassed men. In Southeast Asia, where the epidemic is spreading most rapidly, the same trend exists. The HIV infection rate is growing faster among women than men, and in some countries, women will soon represent the majority of infected individuals. In Cambodia, women represent 46% of the people living with AIDS. Thai women account for 37% of the country's total infections.

Fortunately such statistics are drawing attention to the plight of women in Southeast Asia. The recently launched Global Coalition on Women and AIDS, a collective of prominent leaders, will press policy makers worldwide to confront issues contributing to women's vulnerability to the virus. Operating under the umbrella of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the coalition aims to erase gender disparity, thereby preventing new HIV infections among women and girls. The Mekong Coalition, a branch of this initiative, represents an organized local response in Myanmar, Laos, Thailand, Cambodia, Vietnam, and southern China. Coalition members tackle rampant domestic violence, unequal property rights, arranged marriages, and sex trafficking — all of which put women at high risk for HIV.

"Women in some parts of Asia face worse conditions than in Africa, even though they don't face the same degree of poverty. Still, there's a real blindness to learning the lessons from Africa. There's a tendency to say we're not like them," added Csete.

Ignoring Africa's situation could have dire consequences, but dismantling cultural norms in Asia proves formidable. Motoko Seko of the Mekong Coalition in Bangkok acknowledges the profound challenge but, in partnership with leaders of women's groups, she is confronting this task. She knows that including the voices of HIV-positive women is crucial to the fight. Women frequently learn that they have HIV earlier in the course of infection than men, often through testing at antenatal clinics or after their husbands become sick or die. This has motivated women to speak out about their status. Both Thailand and Cambodia have networks for HIV-positive women, and sex worker collectives are also organizing to provide HIV training. The Mekong coalition endeavors to empower these groups.

Seko will first focus on domestic violence. "One of four Cambodian women has experienced physical violence. The fear of violence is preventing women from practicing safe sex in marriage, increasing their vulnerability," she added.

In Asian society, men's promiscuity is socially acceptable, but women are prohibited from discussing sex, even within families. Sex education in schools, where both girls and boys are present, is an anomaly. This "culture of silence" puts women at a severe disadvantage. Men may also inject drugs or be homosexual, according to Dr. Nafis Sadik, special envoy of the UN Secretary-General for HIV/AIDS in Asia. In countries where homosexual behavior results in discrimination or even imprisonment, many men who have sex with men also have wives. These men, or those who visit sex workers, bring HIV home to their wives, who do not see themselves at risk for HIV. Thai Ministry of Public Health data indicate that 40% of new infections occur between spousal male-to-female transmission, and 80% of women testing positive for HIV at antenatal clinics report being monogamous.

Yet unequal property rights, inadequate or nonexistent divorce laws, and inheritance laws that favor men often force women to marry. These practices must change, according to Csete, who advocates amending any laws that reinforce women's economical dependence on their partners. "There are probably no countries where there isn't a double standard for men and women," she said.

This double standard reaches extremes when it permits trading or kidnapping girls into brothels. Sadik warns that sex trafficking is a much larger industry in Southeast Asia than drug trafficking and must be exposed. Brothel owners scour rural Cambodia and the Mekong region looking for attractive young girls. The girls are lured away with the promise of work, sometimes with the family's permission, according to Sadik. They immediately sell the girls into brothels and enslave them as sex workers, even though prostitution is illegal in all countries of the Mekong region. "There's still this culture where young girls are treated as goods and commodities. Bidding goes as high as $1,000. This is a difficult topic but the countries in Asia must face it," said Sadik.

Despite "100% condom policies" for sex workers in Thailand and Cambodia, women in brothels are often discouraged from using condoms. Men pay much less for sex with a condom, and if a brothel owner discovers a worker using condoms he will fire her immediately, said Sadik. A survey of sex workers in Thailand reported that only 25% use condoms. "A large number of these girls end up with HIV. It's horrible," she added. Thai brothels screen the women monthly, and a positive test result lands them out on the street. Many remain on the streets to continue sex work.

Thailand's condom policy is credited with controlling the epidemic, but it must confront an unintended consequence. The strong association between condoms and sex workers caused people to believe that the sex trade is the only way to get HIV, said Seko, further deterring men from using condoms with their wives.

She and others doubt the coalition can reach leaders of Asian countries in time, though it is too early to predict the outcome. "The sad reality is that things only happen when death is so visible that it has hit the families of people in power," said Csete.

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