

**Placing Young Women at the Centre:
Reducing Young Women's Vulnerability to HIV in India**

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Executive Summary

The Self-Employed Women's Association (SEWA), a trade union of close to one million women workers in India's informal economy, organises poor women to attain self-reliance and full employment. Over the past decade, HIV/AIDS has emerged as a growing concern amongst SEWA members and their communities. Although women who are not sex workers have traditionally been thought to be shielded from risk, SEWA's experience and increasingly, national data, show that the vulnerability of young women should also be assessed and further understood.

Using SEWA's field experience in Gujarat and a synthesis of existing research in India, this paper seeks to explore the factors that may render young women and adolescents vulnerable to HIV infection. Rather than categorise women only by age, we set forth a framework in which multiple layers of vulnerabilities can be recognised at the individual, social and programmatic levels. Within the home, early age at marriage combined with limited negotiating power, places women at risk within marriage or through unsafe sexual activity. Outside the home, women workers – whose occupational categories are fluid – may face sexual exploitation, without being addressed by existing programs. Programmatically, women's vulnerability stems from a health care system that simply does not target information and services to young women effectively. Although married and unmarried women have differing needs, overall it emerges that young women are largely not equipped to prevent HIV infection.

India's national AIDS program has made considerable progress in recognising that adolescents and youth – both married and unmarried – have specific information and service needs vis-à-vis HIV/AIDS. However, like most of India's health system,

implementation remains far behind policy. At the policy level, young women are not amenable to common behaviour pattern grouping. Marital status and relationship dynamics, sexual behaviour patterns, socioeconomic status and access to services – which all may be interlinked – must be taken into account.

SEWA's experience in HIV prevention with women workers provides four key areas in which program implementers and policymakers can improve current efforts. 1) Empower young women through holistic, community-based programs; 2) Promote women's organizing; 3) Develop bottom-up health services; 4) Improve communication tools and techniques; and 5) Involve men at the local level. Further, research with an operations component will be critical to designing effective, localised programmes to address young women's needs. The potential to implement widescale, integrated prevention programs for young women does exist in India. SEWA's experience promotes that, to ensure vulnerabilities are addressed; young women must be placed at the centre of policies and programs.

I. Introduction

The Self Employed Women's Association (SEWA), a trade union of close to one million women workers in India's informal economy, organises poor women to attain self-reliance and full employment. SEWA believes that a key component of full employment is social security – access to health, insurance, child care and pension – particularly for India's working poor. In SEWA's efforts to protect and improve the health of its members in the state of Gujarat, it has focused on women's basic needs, particularly primary and reproductive health. Over the past decade, HIV/AIDS has emerged as a growing concern amongst SEWA members and their communities.

India's diversity in societal, economic and demographic patterns renders it difficult to portray a generalised picture of vulnerability to any one disease. In the case of HIV, the infection has spread not through a specific pattern, but rather as an amalgamation of micro-epidemics that have varied by region and risk factors. India's National AIDS Control Organisation (NACO), supported by the Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), recently estimated that 2.5 million adults (aged 15 to 49) in India are infected with HIV¹, a prevalence rate of 0.36%. This revised figure, released in July 2007, is almost half of previous estimates. This current estimate is due to a revised methodology which utilises population-based surveys, expanded sentinel surveillance and improved data sources.

The Indian epidemic is largely concentrated amongst groups who exhibit "high-risk" behaviour as defined by NACO. The three primary high-risk groups and the largest bulk of persons living with HIV in India, according to NACO, are:

- (i) Men who have sex with men,

(ii) Sex workers and their clients

(iii) Injecting drug users.²

As a backdrop to the discussion that follows, we present some data on the spread of HIV infection. The majority of the HIV infections (87.7%) are in the age group of 15-44 years. The predominant mode of transmission of infection is through heterosexual contact (85.7%), followed by injecting drug use (2.2%), blood transfusion and blood product infusion (2.6%) and peri-natal transmission (2.7%). Other miscellaneous modes account for 6.8% of infection. In the HIV sentinel surveillance, 2003, males account for 73.5% of infections, and females 26.5%.³

Percent of AIDS cases by age group (as on August 2006)

Age group	Male	Female	Total
	%	%	%
0-14	59.20	40.80	4.48
15-29	60.09	39.91	31.83
30-49	76.45	23.55	56.73
≥50	78.31	21.69	6.97
Total	70.60	29.40	100

Monthly updates on AIDS, NACO, 31 August 2006

The National Family Health Survey carried out on a national level in 2006 included HIV consent-based testing on a representative sample of more than 100,000 women and men in the age group of 15 to 49. According to the findings, the prevalence rate among men (0.36%) is higher than the rate among women (0.22%). For both men and women, the prevalence is highest in the 30-34 age groups, and the rate is 40 per cent higher in cities than in rural areas. Rates vary widely between regions, and exceed 20% among female sex workers in Maharashtra, injecting drug users in Delhi and Manipur, and men who have sex with men in Delhi.⁴

HIV Prevalence in different population categories (as in 2005)

Transmission Categories	HIV Prevalence (%)
Women attending ante-natal clinics	0.88
Persons attending STD Clinics	5.66
Female sex workers	8.44
Men who have sex with men	8.74
Injecting drug users	10.16

HIV/AIDS epidemiological Surveillance & Estimation report for the year 2005, NACO, April 2006

At present, however, little is known about the patterns of movement of various at-risk populations, the nature and extent of the interaction among them, and the implications of such migration on HIV transmission.⁵

According to NACO, the bulk of HIV infections in India occur during unprotected heterosexual intercourse – which means that infections are on the rise amongst women. In India, young women who are not sex workers have traditionally been thought to be shielded from risk. Fortunately, this oversight is being corrected, and there is increasing recognition that young people, particularly young girls, deserve special attention because they have the highest rate of new HIV infections in the developing world.⁶ In India too, there is evidence of this trend. “There is a growing feminization of the epidemic with 38.4% of those living with the virus being women. The virus is also increasingly moving towards the rural areas with 57% of the virus load being shared by the villages.⁷ While studies previously on women focused primarily on sex workers, there is a growing trend in understanding why married, typically monogamous, women are presenting with HIV infection.⁸ Further, in India, AIDS affects the poor disproportionately.⁹

Given these factors, SEWA, a trade union working with poor women, has become increasingly concerned with the potential spread of HIV infection amongst our members and their families. While we have certainly witnessed a rise in infection amongst our younger women members, till date there is limited data or research available in India on the vulnerability of women to HIV. There is even less evidence on programmatic strategies. Therefore, this analysis is an opportunity to dissect the factors that may render women, particularly young women and adolescents, at risk to HIV infection. It should be noted here that we do not posit that young women are the *most* at risk, but rather, as an increasingly vulnerable group, do warrant increasing attention and thought. We seek to create a framework to think through how and why women are vulnerable to HIV infection in India, both to inform SEWA's programs and ultimately, larger national prevention strategies.

Methodology

Using SEWA's field experience in Gujarat and a synthesis of existing research in India, this paper will present a picture of what renders young women and adolescent girls vulnerable to HIV infection. We use a vulnerability analysis developed by Mann and Tarantola to link epidemiological risk to broader and deeper factors that increase the likelihood of exposure to risk-generating situations. Vulnerability is defined here as a lack of empowerment and indicates the extent to which an individual is capable of making informed decisions about his or her life.¹⁰ In this framework, vulnerability is manifest at three levels: individual, societal and programmatic. We will present women's vulnerability as a combination of: individual decision-making power, socio-cultural and economic factors that induce risk; and the extent to which existing policies and programs do or do not protect young women and adolescent girls.

The paper will focus both on young women, married and unmarried, and adolescent girls who represent the working poor with whom SEWA works. As background, SEWA has compiled existing evidence and research on HIV/AIDS and adolescents and young women. The crux of the paper, SEWA's experience, is based on three main sources: 1) recent research conducted among adolescents (only girls) in rural and urban Gujarat; 2) data from SEWA's grassroots HIV/AIDS program in Ahmedabad city; and 3) a compilation of other programmatic experience and studies conducted amongst SEWA's members (all women) and their daughters. In the next section, the paper identifies three main areas by which women are vulnerable. A brief analysis of policy implications is followed by concluding recommendations for policy and programs for HIV prevention among young women and adolescents.

India's diversity makes any generalisation difficult. In this paper, we present a broad picture, with the understanding that nuances and differences exist within and between groups of young women in India. The lack of existing data and research on young women vis-à-vis HIV/AIDS limits the breadth of this analysis, a gap we have attempted to fill by offering SEWA's experience over the past several years.

II. Understanding Women's Risk

SEWA's experience in working with young women and adolescent girls, both on reproductive health and specifically on HIV prevention programs, has shown that there are various factors, many of them fairly deep-rooted that render women vulnerable to HIV/AIDS. It is believed that younger women more vulnerable to HIV infection. The Indian evidence for this has primarily come from studies on female sex workers, an identified risk group, and thus a group for which data is available. According to a NACO

study of women sex workers in 2001, the median age at first sex was 17 years (range 7 to 31 years). 65% of respondents reported they were between 16 to 21 years the first time they engaged in commercial sex.¹¹ According to a recent study by the Harvard School of Public Health, 38% of girls and women who were sex-trafficked from Nepal to India were found to be HIV positive. The infection rate exceeded 60 percent among girls forced into prostitution prior to age 15 years. One in seven of the study's participants had been trafficked into sexual servitude prior to this young age.¹² According to a recent UNAIDS study, in countries where recent success has been reported in preventing new infections, behaviour change among young people appears to have driven broader progress against the epidemic.¹³ Thus we have chosen to focus on the particular vulnerabilities of young women and adolescents to HIV infection in India, detailed below at the individual, social and programmatic levels.

Individual Vulnerability

Experience has taught us that simplistic risk profiles and narrow definitions of young women's behaviour mask complexities, from which weak programs result. We highlight three areas in which more nuanced understanding, and definitions, are required to understand women's complex vulnerabilities.

1. Age vs. marital status

At the core, the definition of 'adolescent girl' or young woman is based on age. However, an important difference, i.e. whether they are married or not, is not captured by these definitions based on age. Married and unmarried young women exhibit different needs vis-à-vis service and information. Age at marriage may vary across the country, but marriage largely brings similar social circumstances for young women. In India early marriage is common among many population groups, and marriage for a majority marks

the onset of sexual relations. 44% of women in India are married, and thus sexually active, by age 18.¹⁴ 16% of women aged 15-19 were already pregnant or mothers at the time of the last National Family Health Survey (NFHS) in 2006.

Sexual relations: Before, within, and outside of marriage

Categorising women only by age, rather than marital status or behaviour patterns, overlooks the primary risk to HIV infection: unsafe sexual intercourse. Biologically, young women are more vulnerable to infection through sexual intercourse than men.¹⁵ Small, community-based studies have found varying levels of premarital sexual activity among youth, ranging from 10% and below among women, and 15 to 40% amongst men.¹⁶ Findings suggest that amongst those sexually active before marriage, sexual debut is at late adolescence. Although limited research exists on non-consensual sex in India, findings indicate that young people, particularly women, are certainly vulnerable to unwanted sexual activity.¹⁷

Within marriage, sexual coercion appears to be widespread. In a study conducted in Uttar Pradesh, two-thirds of respondents reported that their husbands had coerced them into having sex at least once, one-third by means of physical abuse.¹⁸ Sexual coercion in marriage most likely occurs without condom use; intercourse that is rough may cause lacerations or wounds that facilitate disease transmission. Poorer and younger women are more likely to be victims of forced sex.¹⁹ Further, use of condoms is not common. Within marriage, barrier methods are not preferred: in Gujarat, of the 56% of married couples who utilise modern contraceptive methods, 6% utilise condoms.²⁰ Younger women are less likely to use contraception – 15% of births by adolescents in India were unplanned.²¹

Contrary to common belief regarding Indian culture, marriage does not necessarily connote sexual monogamy. There has been little focus on understanding women's extramarital sexual activity. In one recent study in Gujarat, frequent multi-partner relationships, with low condom use, is found to be very common amongst married women in rural Gujarat.²² Amongst SEWA's membership in two areas of Ahmedabad city, at least 25% of women reported having more than one partner. While a majority cited work-related reasons, a fair percentage (10-15%) also cited the need for cash, love, and enjoyment as the reasons they engage in extramarital affairs.²³ Yet research thus far on married women reporting HIV infection finds that the large majority are monogamous, with marriage the primary risk factor for infection.²⁴ In Maharashtra, research has shown that 82% of HIV-infected women who are not sex workers were married and monogamous.²⁵ In a retrospective study of married, HIV-infected women in South India, 81% were married housewives, with close to 90% reporting monogamy.²⁶ Clearly, this area warrants further research and understanding.

Women as workers

In addition to age and sexual activity, another layer of young women's identities that is often overlooked or simplified is their economic contribution. Between 22% and 41% of women in India are a part of the labour force, excluding household responsibilities. By age 15-19, at least a quarter of girls are economically active. Women's wages are generally 30% lower than those of men.²⁷ 96% of women workers in India's labour force are in the informal economy²⁸ the vast majority of whom eke out an existence through long working hours, low wages, and no social protection. Social protection essentially does not exist or fails to reach India's working poor. Thus poor women workers must manage their own health care, child care, pension and insurance to shield themselves from added risk.

The poorly paid and insecure work done by poor young women clearly impacts on their risk to HIV. Women workers who deal with middlemen or contractors very often face exploitation. In one SEWA study in Ahmedabad, over 80% of women with more than one partner cited compulsion related to work – exploitation by middlemen – as the reason.²⁹ Notably, young women are generally less able to counter exploitation by older contractors.

The only occupational category that has been included as high-risk by national programmes for HIV prevention (other than commercial sex workers) is that of migrants. The Gujarat State AIDS Control Society, for instance, had designed interventions specifically targeted at migrant workers. Yet in SEWA's experience implementing a government migrant worker project, we found that this narrow approach can easily overlook the bulk of women workers who are also at risk. Workers in the informal economy often have multiple occupations, varied by season, location and need. Through surveys, we found that women and men in a range of occupational groups – not just migrants – fit the definition of high-risk group, based on sexual behaviour. Dye workers, sweepers, headloaders and construction workers were found to be particularly susceptible to risk.³⁰

It is critical to recognise that women's work, particularly through sexual exploitation, is also an indicator of risk of HIV infection. Further, given that women in the informal economy – the majority of India's workforce – are often engaged in more than one occupation at a time, defining HIV risk by single occupations is inadequate.

Societal Vulnerability

Women in India, on the whole, do not enjoy societal equality. At birth, the girl child is discriminated against, particularly in families who have the financial means to access prenatal testing. The sex ratio at birth is 927 girls to 1,000 boys.³¹ The dowry system – widely in practice – perpetuates the idea that women are an economic liability for families.

As girls grow older, access to education is sharply limited after primary schooling, as compared to boys. Between the ages 13-19, at least one half of adolescent girls have left school. According to the National Family Health Survey, 41% of all women in India have never been to school, while about one quarter has studied eight years or less. 18% of all men have never studied. The literacy rate amongst women is 54%, compared to 76% for males.³²

Within the household, young girls and women are primarily shoulder household responsibilities, in addition to their economic contribution. Yet only 52% of women in India report that they regularly participate in household decisions. Perhaps the most telling indicator of women's status is domestic violence. According to the largest household survey of its kind, 37% of all women reported having experienced spousal violence. A range of studies across India has placed the prevalence of domestic violence as even higher. In a multi-site household study, the International Clinical Epidemiologists Network (INCLIN), found that up to 50% of women in India experienced at least one incident of physical or psychological violence. Rural women, followed by women living in urban slums, report the highest incidence of violence among women.³³

Furthermore, data suggest a relationship between domestic violence and HIV infection. Research has found that men in Uttar Pradesh who reported extramarital affairs were 6.2 times more likely to report abusing their wives. Also, men with sexually transmitted infections were 2.4 times more likely to abuse their wives.³⁴ Given that sexually transmitted infections are directly linked to HIV, women who are vulnerable to violence at home are also likely to be vulnerable to HIV infection by their partners. The high prevalence of domestic violence in India, an indicator of women's vulnerability within marriage itself, thus can translate into risk of HIV infection. No research specifically on younger women's status in marriage exists. However, SEWA's experience working with younger members does indicate they typically have less say within a joint household; thus these factors would apply as equally, if not more.

As in many other countries, unequal power relations and the low status of women, as expressed by limited access to human, financial, and economic assets, weakens the ability of women to protect themselves and negotiate safer sex both within and outside of marriage, thereby increasing their vulnerability.³⁵

Programmatic vulnerability

Awareness about HIV/AIDS

According to the latest NFHS, only 57% of ever-married adult women in India have heard of AIDS. Further, only 35% of women are aware that consistent condom use can reduce the likelihood of HIV infection. It is evident from this, that despite a longstanding national AIDS program, awareness remains low. Further, research has shown that lower economic status is correlated with less knowledge of AIDS.³⁶

Access to information

In SEWA's experience, information on HIV/AIDS does not target young women with appropriate, tailored messages. Formative research conducted in 2006 for Swasthya Sanchar, SEWA's HIV/AIDS communication programme in Gujarat, found that women are exposed to very little information on HIV/AIDS; most women simply had heard of the disease.³⁷ Given high levels of illiteracy among the poor, written language on posters or pamphlets had little impact. At present, messages being broadcast by national AIDS programmes, although an important step, are not sensitive to these needs, and certainly do not target young women.

In another study conducted by SEWA last year in urban slums of Ahmedabad amongst 135 adolescent and young women aged 13 to 20, several patterns emerged that indicate gaps in awareness.³⁸ Adolescent girls did not have adequate knowledge on body changes such as menstruation, reproductive health and sexuality. The topics remain taboo amongst older family members, leading them to gain information from peers. However, at least 1/3 of women surveyed do not discuss sexuality with friends either, in fear that others will be told or because of societal taboos. Notably, at least a quarter of adolescent girls were not familiar with sex education as a term or topic. Overall, findings indicate that sexual activity is an area of considerable interest and anxiety to adolescent girls; yet access to proper information is clearly limited.

SEWA has found that programs aimed at "youth" are more likely to reach the unmarried, as they are implemented through youth clubs. SEWA regularly conducts "know your body" and health education sessions for adolescent girls. We have found that unmarried adolescent girls in a village or urban slum areas are more likely to attend. When married girls do attend, their questions, experience and concerns are expectedly different; which

leads us to hold separate sessions or longer question-answer sessions with them. However, one advantage of mixing unmarried and married women is that they also learn from each other and feel comfortable sharing their experiences.

Access to health services

SEWA has found that poor women engage with the health system only when necessary. Sexual health, though a perceived need by SEWA's members, is rarely a reason to seek medical care, both due to difficulty to access services and 'shame'. Working as day labourers, home-based workers or migrants in the informal economy, most women do not fit into one pattern of time or geographic availability, making it difficult to access services. Pregnancy within marriage is typically the first entry point into the health system for women. Even then, many pregnant women do not access the formal health system: 51% of all pregnant women had at least three antenatal checkups, and 41% of births were in institutions. Unmarried young women, on the other hand, have trouble accessing reproductive and sexual health services due to social taboos. Our experience shows that, when they require services, not being married is an overwhelming barrier to services for unmarried sexually active girls.

In rural areas, primary health centres are far from functional; the majority of India's poor utilise traditional or private providers. Further, the provision of sexual health services such as testing for sexually transmitted infections is dependent upon the presence of trained physicians – which is the largest obstacle to successful implementation of India's health policies. Access to proper services first requires a functioning health system, and then an implementation focus that is responsive to the sensitivities and needs of adolescents. At present, as the Indian system is focusing on improving its basic

infrastructure, the service access needs of young women and adolescents remain low priority.

Due to national health structures, programmes for HIV/AIDS and those for reproductive health programs function either in isolation or parallel to each other. Integration of these two health areas has only become a recent issue for health policy, and implementation thus far has not progressed significantly. Mother to child transmission and condom promotion are two areas where integration is increasingly being promoted.

III. Existing Policies

NACO and the government health system have made considerable progress in recognising that adolescents and youth – both married and unmarried – have specific information and service needs vis-à-vis HIV/AIDS. Through the School AIDS Education programme, a toolkit on HIV/AIDS and life skills was developed for states to implement for in-school youth. For girls in school, the National Population Education Programme of the Government of India, for example, aims at sensitising youth to reproductive and sexual health and gender issues. University-based programmes and mass media campaigns aimed to unite youth also work to raise general awareness on HIV/AIDS.

For out of school youth, national youth groups such as the Nehru Yuvak Kendra implement a Village Talk AIDS Programme. NACO has also initiated efforts to reach rural youth through youth development centres, with a focus on migrants. The national Reproductive and Child Health (RCH II) program and National Rural Health Mission recognise that both married and unmarried adolescents and youth have special

information needs, and accordingly support awareness-raising activities conducted by village level health workers.

RCH II outlines a two-pronged strategy to reach youth with adolescent reproductive and sexual health services. Throughout the government health system, services meant for adults are directed to improve outreach for adolescents and youth. For areas with low age of marriage and high prevalence of adolescent pregnancy, youth friendly services are to be provided through the government primary health centres at dedicated times. According to national policy, services should include contraceptives and diagnosis and treatment of reproductive and sexually transmitted infections, for both unmarried and married boys and girls.

However, like most of India's health system, implementation remains far behind policy. Less than half of schools in India have implemented adolescent education programmes, and several states have yet to include sex education in textbooks. Recently, a national debate has been sparked on whether sexual education is acceptable in schools; states are left to decide locally. Experience also shows that even when material is in textbooks, many teachers do not feel comfortable discussing sexual education in the classroom. A WHO review of successful interventions for HIV prevention among youth finds that curriculum-based interventions need to be led by adults to be effective. At the community level, HIV education programs implemented through youth groups tend to reach more males than females, as well are more unmarried than married youth.

IV. Recommendations

Programs that aim to reach young women and adolescents must recognise their multiple layers of vulnerabilities. At the individual level, literacy levels amongst young women are low. Combined with early age at marriage and an increased biological vulnerability to HIV infection, it is clear that young women who are sexually active are at risk of HIV. At the household level, young women and adolescents have limited negotiating power within the family and the household. Outside the home, working conditions and sexual exploitation place women workers at risk. Without a social security net, access to basic health services is limited. Programmatically, young women's vulnerability stems from a health care system that simply does not target information and services to young women effectively. Although married and unmarried women have differing needs, we find that that young woman in neither category are equipped to prevent HIV infection.

At the policy level, young women cannot be treated as a single category with a common behaviour pattern. Occupation categories are fluid; sexual behaviour is varied; and social environment is a defining factor in women's lives. Thus when defining "risk" for young women to HIV infection, it is not pragmatic to create a singular demographic profile. Marital status and relationship dynamics, socioeconomic status, and sexual behaviour patterns – which all may be interlinked – must be taken into account. Localised strategies integrated with broader health concerns are more likely to reach the diverse range of young women. In designing programs, this complexity need not be an obstacle. In SEWA's experience, it is the approach to women that is paramount.

Our recommendations span the factors that render young women vulnerable to HIV infection – individual negotiating power; societal inequality; and design/implementation of

prevention programmes. These suggestions are aimed at policymakers and more directly at those who implement programmes on the ground.

1. Empower young women

SEWA's experience over thirty-five years demonstrates that empowerment – economic and social – is crucial to putting women in control of their own lives. With younger women, in addition to the traditional focus on community groups and psychosocial life skills training, vocational and financial training are critical to improving their social status within the home. Economic empowerment for women can alter the deeper structures that are related to domestic violence, as well ensure a social safety net through formal employment and improve health status. Protection from debt, for instance, can remove women from vulnerable situations that may lead to sexual exploitation. It is not clear whether financial power within the home, as from having one's own bank account, may instigate or protect from violence. Yet what is clear from SEWA's experience is that economic empowerment does trigger a larger process of social empowerment – and thus cannot be ignored in health strategies. Thus while the positive effects of economic empowerment have not yet been linked to HIV prevention directly, they must be identified as critical within the web of deeper vulnerabilities women face.

SEWA has also found that community-based adolescent groups are an extremely powerful medium to bring women, both married and unmarried, together to discuss sensitive issues. Yet the key is not to have one-time sessions only on health. Rather, a regular club that meets to conduct activities – such as discuss a youth magazine learn an income-generating skill, plan community events and share information – will provide girls with an enabling environment to become more empowered, developed women. Further, groups themselves provide a space for girls to identify and analyse their own vulnerability, ultimately in efforts to create change.

A third area of empowerment is linked to women's physical safety. The high prevalence of violence, eve-teasing and sexual harassment of women and girls must be addressed to decrease vulnerability to HIV infection. Further, prevalence of domestic violence is unacceptably high; women's safety within the home must be translated into an issue of public health policy. Sexual coercion, within and outside of marriage, must be both recognised and addressed to reduce women's risk. Strategies that develop "safe spaces" for women, such as community centres, increased enforcement of laws, village level counselling and community-based strategies, and women-friendly local security should be assessed as options.

2. Promote women's organising

SEWA's experience organising women workers has shown that a collective voice, especially for poor women, can transform social and economic structures. In the context of young women's vulnerability to HIV, formal or informal organisations of women can stand in the way of exploitation by contractors or middlemen, as well as give women the strength to negotiate within their own homes. Organising women around employment, access to financial services or social issues promotes a collective strength that can empower young women in particular, and ultimately address root causes of vulnerability to HIV related to work. Further, women's organising can be a key strategy against violence against women.

3. Bottom-up health services

SEWA consistently finds that even when health services are available, they rarely reach young women due to insensitivity, poor timing and lack of awareness. Again, the overall approach to young women must begin from the bottom up, to ensure their needs are

met. Local community health workers, like the ASHA¹ workers of the National Rural Health Mission, are one avenue to raise awareness about available services and directly reach young married women. For unmarried women and adolescents, local clubs and education sessions in the community have proven most effective. Integration of services for HIV/AIDS and sexual health with broader primary health will improve access for married young women, who traditionally only utilise the health system for reproductive-related concerns. Further, improving the overall health status of adolescents and women is a key component of HIV prevention, as well as for care and support. Most importantly, community-based health services that actually involve adolescent girls and young women through outreach activities will engender trust and raise awareness.

In the Indian context, improving access for young women to sexual health and HIV services is dependent on public services being available and functional. Alongside slow improvements to the public health system, community based organisations must promote localised strategies through health workers and adolescent/young women groups.

4. Improve communication techniques and tools

Understanding *how* to deliver messages is as important as knowing young women's response patterns and information needs. For example, married young women will be better reached through mass media, while unmarried youth are likely to take part in community clubs. Mass media has high potential for reaching both groups, granted that messages are targeted and appropriate for women – which is best guaranteed by involving them in a bottom-up design process.

¹ ASHA (Accredited Social Health Activist) workers are a community health worker for each village, promoted by India's National Rural Health Mission, to link communities to health services and raise awareness.

SEWA has learned that with young women, information should be packaged as entertaining, locally based media in the appropriate dialect. SEWA's impact research also found that using a variety of media, such as posters, street plays and television messages, promotes message recall among young women. Women reported that they respond best to television and film, followed by radio. Our research found that existing messages, including those on television and radio are often vague, and do not address sexual behaviour directly.

Impact research on SEWA's HIV/AIDS communication programme found that messages in local languages and dialects are much more effective, rather than the generic awareness programmes broadcast through the country. Most importantly, message response varies widely according to age and gender. Simple, targeted local language messages, repeated frequently through a visual medium, had the most impact. Pictorial posters, wall paintings and film were among the most appreciated and understood media for messages on HIV/AIDS amongst our members. When working with adolescents in particular, our research found that group education sessions in the community were the most effective way to raise awareness on HIV/AIDS.³⁹

With young women, unmarried and married, one-to-one and group contact has also proven as an effective support to open the environment. When possible, sexual activity should be dealt with frankly, in direct language. As in service delivery, involvement of young women themselves in designing and spreading communication messages ensures a more effective response. SEWA has found that understanding woman's needs first, followed by market segmentation and development of localised communication strategies is a critical process. Lastly, it is critical to recognise that

communication alone will likely not lead to behaviour change, unless complemented by strategies that empower.

5. Involve men – locally

While most of these recommendations to address unequal gender relations target women directly, it is well recognised that male involvement is also critical. Yet rather than superficial strategies to include men through awareness, SEWA experience supports strategies that empower men with knowledge through community-based organising. Having initiated a men's health cooperative in Ahmedabad three years ago, we have found that 1) peer education is clearly effective and 2) men's groups, cooperatives and "safe spaces" to discuss a range of issues, including reproductive and sexual health, are required. Peer education, in which men conduct training sessions in their own communities at times convenient to working men, provides adolescent boys and young men the rare opportunity to discuss their questions and issues with an informed peer. Regular meetings of such groups, or in SEWA's case, a men's rural health cooperative, also provide an empowering space for men to consider their own socialisation and gender relations, especially when facilitated by a local, rather than external, trainer. Regular, community based meetings of men to discuss a range of issues will not only fill an information gap, but also create a social structure in which men can promote positive roles and behaviour.

V. Conclusion

In order to advocate for effective policies and programs to reduce vulnerability to HIV among young women and adolescents, information will be the first step. This paper attempts to identify broad themes renders young women vulnerable. Much deeper, nuanced research with an operations component will be critical to designing effective, localised programmes to address these needs. To start, participatory assessments among young married and unmarried women and adolescents in both rural and urban areas will provide basic information. Operations and action research on programs through the government and community based organisations, aimed at scalable models, is sorely lacking. Yet the potential to implement widescale, integrated prevention programs does exist. Political commitment to HIV, combined with a slowly improving government infrastructure, can ensure that India equips young women and adolescents to prevent HIV. Learning from people's organisations such as SEWA, we can and must develop a sustainable approach to understand and reduce vulnerability – by placing young women at the centre.

References

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