

PART I: HIV/AIDS AND TRANSPORT

Chapter 1:

Why does HIV/AIDS need to be addressed in ADB transport sector projects?

1.1 HIV spreads around construction sites and along transport corridors

- The spread of HIV and sexually transmitted infections (STIs) through major transport and infrastructure projects is well documented.¹ The connection is so well established that these infections are sometimes called “highway diseases.”
- Better roads bring many benefits but also increase risks through greater mobility and connectivity. Mobile people, especially “mobile men with money” (e.g., truck drivers), are more likely to engage in risk behaviors, such as unprotected sex with casual partners and sex workers, and drug use.
- A large influx of males into a rural area for a construction project increases the demand for sex, especially if they are far from home and lonely. Local communities are affected when women and girls (and sometimes young men and boys) meet that demand, either willingly for money or favors (such as payment of school fees), or unwillingly through rape or abduction into sex work.
- Commercial sex work and the trafficking of drugs and humans, particularly women and girls for sex work, also follow big construction projects and transport routes. “Lack of gender equity is an important element in the spread of HIV along truck routes.”²
- In India, a recent study found HIV prevalence rates of 16% along one particular route in southern India, while the national rate was less than 1%.³ In Bangladesh, a national surveillance study found that those with the highest prevalence of HIV were long-distance truck drivers. In the People’s Republic of China

¹ Two recent examples are: United Nations (UN) Regional Task Force on Mobility and HIV Vulnerability Reduction. 2006. *Regional Strategy on Mobility and HIV Vulnerability Reduction in South-East Asia and Southern China 2006–2008*; and the World Bank Global HIV/AIDS Program. 2005. *Lessons Learned to Date from HIV/AIDS Transport Corridor Projects*.

² The Synergy Project and the University of Washington. 2003. *Putting on the Brakes: Preventing HIV Transmission along Truck Routes*, 34. Available: www.synergyaids.com

³ Cited in International Labour Organization (ILO). 2005. *HIV/AIDS and Work, Using the ILO Code of Practice on HIV/AIDS and the World of Work: Guidelines for the Transport Sector*, 2.

(PRC), a study of truckers found that the STI rates were between two and four times the rates in the general population.⁴

- The Mandalay–Muse Highway was constructed in 1997 to connect Myanmar to the PRC. Drug use expanded along the highway. A year after construction ended, HIV prevalence among injecting drug users (IDUs) in three provinces in Myanmar rose from 51% to 88%, 34% to 74%, and 86% to 92%, respectively.⁵
- The spread of HIV from these high-risk groups (IDUs and sex workers) to the general population happens through the clients of sex workers to their wives and then to children. Men-who-have-sex-with-men (MSM) also play a role because many also have sex with women, including their wives.

1.2 HIV/AIDS may affect infrastructure sector performance

- In construction projects and transport, social norms may become loose and workers and employees may be tempted to engage in high-risk behaviors. If STI and HIV infections increase, workers' and employees' absences and sickness may threaten output and profits.⁶
- The costs of replacing workers (advertising, recruiting, and training) can also be substantial, especially for skilled workers and management. Several studies have found that risk levels can be higher among managers than laborers, possibly because of their greater disposable income.⁷

1.3 ADB has a significant role in transport and infrastructure in the region

- ADB is a major supporter of transport and infrastructure sector development in the region, with three quarters of all lending in 1970–2005 going to roads and highways.⁸
- Transport is the largest and fastest-growing sector in ADB operations. Its share of lending rose from 16% in 1970s to 20% in the 1990s, and 33% in 2000–2005.

⁴ Footnote 2.

⁵ United Nations Development Programme South East Asia HIV(UNDP-SEAHIV). 2001. Building and Alliance with Transport Sector in HIV Vulnerability Reduction. Thailand

⁶ Footnote 3.

⁷ Footnote 2. Also Katz, C. and X. Sun. 2006. *The Baolong Healthy and Safe Action Project*, 6. Available from che.katz@attglobal.net

⁸ Regional and Sustainable Development Department (RSDD). 2006. Transport Sector Under the ADB's Medium-Term Strategy II, a Management Information Paper. November.

- As a 3-year moving average, lending for transport and communications increased 105% (1996–2004) while for all other sectors combined, it declined by 42%. All large developing member countries (DMCs) have borrowed heavily for transport sector projects, and smaller DMCs have borrowed at least once. Those that have not used transport loans, like a few Pacific countries, have taken multi-sector loans that included transport components.⁹
- At the end of 2005, 104 transport loans were under disbursement, worth \$1.11 billion. Loan approvals in 2004 and 2005 amounted to \$2.03 billion and \$1.87 billion, with 18 projects approved each year.¹⁰

1.4 Reducing the impact of HIV/AIDS requires a multi-sectoral approach

- At the beginning of the epidemic, HIV/AIDS was considered a health problem, to be addressed by the health sector. Clearly, the health sector alone cannot effectively control the spread of HIV. An effective response to the AIDS pandemic calls for involving other sectors, including education, transport, agriculture, communication, finance, and tourism.
- “Multi-stakeholder and multi-sectoral response involving a range of partners from government, civil society, private sector, and others is therefore an essential imperative.”¹¹ Engineers also need to become involved and understand how they can help fight the spread of HIV in their own sector of activity. ADB’s experience in supporting transport ministries in the Greater Mekong Subregion (GMS) to develop policy frameworks and action plans is a good example of a multi-sectoral response.

1.5 ADB has made commitments to address HIV/AIDS

In August 2006, at the XVI International AIDS Conference in Toronto, Canada, ADB joined five other development agencies¹² to sign a Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS. The signatories committed to “mainstream HIV/AIDS prevention and treatment programs in infrastructure sectors to reduce the impacts of HIV/AIDS as a result

⁹ Footnote 8.

¹⁰ Footnote 8.

¹¹ UN Regional Task Force on Mobility and HIV Vulnerability Reduction. 2006. *Regional Strategy on Mobility and HIV Vulnerability Reduction in South-East Asia and Southern China 2006–2008*, 22.

¹² African Development Bank, UK Department for International Development (DFID), Japan Bank for International Cooperation (JBIC), German Development Bank (KfW), and World Bank.

of infrastructure interventions, to take opportunities for implementing further counter measures against HIV/AIDS and to contribute to strengthening the HIV/AIDS strategies of partner countries.”¹³

- In April 2005, ADB adopted a strategic directions paper for ADB activities on HIV/AIDS, *Development Poverty and HIV/AIDS: ADB's Strategic Response to a Growing Epidemic*.¹⁴ This document specifically recommends, as a priority for action, targeted programs to “integrate HIV/AIDS activities in ADB infrastructure projects that potentially interact with, create, or enhance high-risk environments for HIV/AIDS,” and “support for HIV/AIDS projects that specifically target women and girls.”
- In February 2005, ADB signed an agreement with the Government of Sweden to establish a multi-donor Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific, with an initial commitment of \$14.4 million. The Fund resources support ADB's efforts to fight the spread of HIV and AIDS in its core sectors of activities, taking opportunity of ADB's comparative advantage to adopt a multi-sectoral approach to fighting HIV and AIDS.

¹³ Asian Development Bank (ADB). 2006. Development Agencies Help Infrastructure Sectors to Fight HIV/AIDS. 15 August. Available: www.adb.org/media/Articles/2006/10438-regional-AIDS.

¹⁴ ADB. 2005. *Development, Poverty, and HIV/AIDS: ADB's Strategic Response to a Growing Epidemic*. Manila.

Chapter 2: Who is vulnerable and why?

A range of sociocultural, political, and economic factors increase people's vulnerability of some groups to HIV and AIDS:

- Cultural or religious resistance to talk openly about sexual matters, especially in mixed company;
- Lack of accurate information and the proliferation of inaccurate information about prevention of STI and HIV/AIDS;
- Difficulties in accessing good quality male and female condoms;
- Lack of access to good quality, confidential, and gender-specific services for treatment of STI and for voluntary counseling and testing for HIV; and
- Stigma of having (or even being tested for) STI and HIV, especially for women.

In the context of roads and transport sector projects, some groups are at higher risks, during construction and/or after project completion, and require our attention:

- Migrant workers (construction personnel, truck drivers¹⁵) and people ready to provide them services (including sex workers [SWs] and food and other service providers);
- Men, women, and youth in communities around the construction site and along the transport corridors;
- The wives/husbands/partners in the home communities of migrant workers who are vulnerable through their partners' high-risk behaviors while away from home.

¹⁵ Construction personnel and truck drivers are mostly male and commercial and/or casual sex transactions are mostly with women.

Beware of stigmatization!

It is important to understand that some particular risk factors are listed below to draw attention of staff and professionals on the risks that have been observed in various transport sector projects to help them understand why some interventions are necessary to mitigate these risks. Majority of workers and migrants involved in construction projects or mobile workers do not adopt these high-risk behaviors.

And surrounding communities do not necessarily engage in high-risk behaviors.

Why are these people more vulnerable to HIV and AIDS?

Construction personnel

- Disposable income available for spending on sexual services, alcohol, and drugs, including injected drugs; this can be especially relevant for higher-paid male personnel, such as managers, engineers, and supervisors;
- Accessibility to, and availability of, formal and informal sex workers¹⁶ near the construction sites;
- Possibility of anal sex between males, if females are not available¹⁷;
- Separation from partner, families, and familiar norms of sexual behavior;
- Peer pressure in all-male groups to impress each other with sexual exploits;
- Isolated and difficult work conditions, with pressure of tight deadlines;
- Lack of attention to the needs of female employees for protection against sexual violence (e.g., sexual harassment policies and procedures, safe ablution, and accommodation areas);
- Difficulties of ensuring privacy and confidentiality for persons seeking STI and/or HIV testing in the close confines of a construction campsite; and
- Fear of losing employment if found to be HIV positive.

¹⁶ Formal sex workers are those who belong to an organized form of sex work. Informal sex workers often work as freelancers and/or use sex work to supplement other sources of income.

¹⁷ Anal sexual relations without condoms are riskier than oral or vaginal relations because they often create abrasions that facilitate transmission of HIV.

Truck drivers and their assistants

- Reliance on illicit drugs to cope with long hours of driving;
- Lack of safe options for rest and recreation;
- Long waiting times in weighing facilities, customs, and border checks, etc;
- Accessibility and availability of sex workers along the transport route and at rest and recreation facilities;
- Separation from partner, family, and familiar norms of sexual behavior; and
- Sexual relations between drivers and their assistants (in some countries).

Sex workers

- Little power or skill for negotiating condom use with clients;
- Exposure to violence by clients, and exploitation by police and other authorities;
- Reliance on illicit drugs to cope with difficult life situations;
- Vulnerabilities associated with being mobile—many are migrant sex workers who follow the movement of construction camps (e.g., language barriers and social isolation);
- Stigma and discrimination attached to sex work and being sex workers (especially for male sex workers);
- Fear of not being able to engage in sex work once found out to have an STI and/or HIV; and
- Vulnerabilities associated with being an illegal immigrant to an area, particularly via human trafficking.

Sex partners of the above groups

(Wives/partners of male workers, especially seasonal workers)

- Social, cultural, and economic barriers that inhibit women from questioning the sexual decisions of men, particularly their husbands, and that limit their access to STI and HIV-prevention information and services;

- Husbands/partners of male workers whose wives faced hardship in the absence of their partners, and engaged in sex for money or food;
- Homophobia, which motivates many MSM to hide their behavior and to seek social approval by maintaining heterosexual relationships;
- Sexual and physical violence against women and girls, and sometimes boys; and
- Widespread resistance to using condoms with a regular or stable sex partner, including between sex workers and their spouses.

Local communities affected by the project

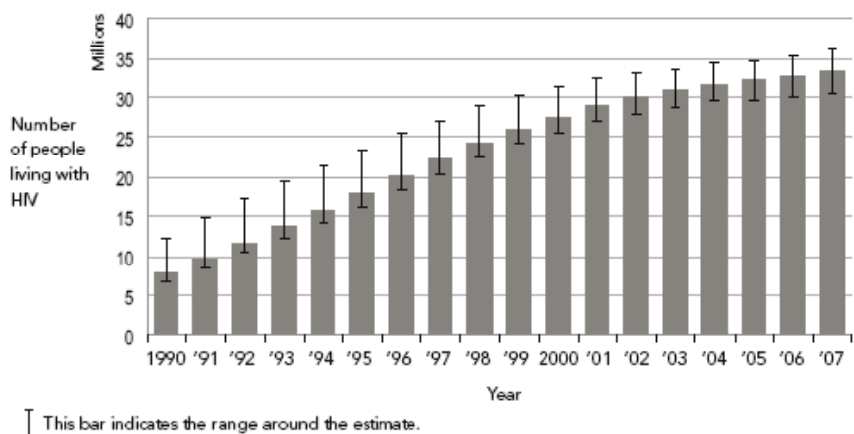
- Greatly increased opportunities for mobility, increased income, and risk-taking behaviors, for both males and females:
 - a. during the construction phase (e.g., informal businesses supplying the project);
 - b. long-term post-construction increase in “connectivity” (as locals and outsiders use the road);
- Where resettlement is involved, loss of immediate income and shelter threatens the financial security of families, and disproportionately disadvantages women;
- Young girls and women engaging, either by choice or by force, in transactional sex with migrant workers for material benefits (e.g., school fees, clothes, food, etc.);
- Increased potential risk to women and girls of being trafficked;
- Traditions of male leadership, which limit women’s ability to express their needs or participate in formal consultations or decision making;
- Introduction of illegal drugs into local communities, or expansion (facilitation) of existing drug trade; and
- Traditional values and social systems may be disrupted or weakened because of activities related to the project.

Chapter 3: HIV/AIDS in Asia and the Pacific

3.1 Overview of the epidemic

- At the global level, the latest figures published by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimate that 33.2 million were living with HIV in 2007—30.8 million adults (15.4 million women) and 2.5 million children.¹⁸

Figure 1: Estimated Number of People Living with HIV Globally, 1990–2007



AIDS = acquired immune deficiency syndrome, HIV = human immunodeficiency virus, UNAIDS = The Joint United Nations Programme on HIV/AIDS.

Source: UNAIDS. 2007 AIDS Update.

- HIV and AIDS do affect Asia and the Pacific: UNAIDS reported in August 2007 that 5.4 million people in the region are living with the disease. Nearly a million new infections occurred in the last 2 years—50% of whom were young people. In addition 640,000 people died from AIDS-related diseases despite scaling up treatment services by many countries in the region.¹⁹
- The numbers of new infections continue rising in the PRC, Bangladesh, Indonesia, Nepal, Pakistan, and Viet Nam, even if the decreasing prevalence in Cambodia and Thailand seems to be real (lower figures for India result from better surveillance

¹⁸ http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

¹⁹ The Joint United Nations Programme on HIV/AIDS-International Conference on AIDS in Asia and the Pacific Congress, August 2007.

Table 1: Classification of the HIV/AIDS Epidemic in ADB Developing Member Countries

Stage of Development	Stage Description	Country or Region
Generalized epidemic	HIV is firmly established in the general population. Proxy indicator: HIV prevalence is consistently over 1% among tested pregnant women in sentinel sites.	Cambodia, Thailand, Myanmar, PNG, and six states in India
Concentrated Epidemic	HIV/AIDS has spread in a defined subpopulation, but not in the general population. Proxy indicator: HIV prevalence consistently over 5% in at least one defined subpopulation, such as MSM, IDUs, SWs, etc; and HIV prevalence less than 1% among pregnant women attending urban antenatal clinics.	Indonesia, Nepal, Malaysia, Viet Nam, PRC
Low prevalence	Proxy indicator: HIV prevalence is less than 5% in any defined subpopulation.	Other ADB DMCs in Asia and the Pacific

DMC=developing member country, HIV = human immunodeficiency virus, IDU = injecting drug use/user, MSM = men-who-have-sex-with-men, PNG = Papua New Guinea, PRC = People's Republic of China, SW = sex worker. Source: Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization(WHO). 2000. Guidelines for Second Generation HIV Surveillance. Geneva; and UNAIDS. 2004. Report on the global AIDS epidemic. 4th global report. Geneva.

and methodology, not from control of the epidemic). Table 1 indicates the level of the HIV/AIDS epidemic in ADB's DMCs.

3.2 How is HIV spread in the region²⁰

Injecting Drug Use

- Injecting drug users (IDUs) become infected through sharing contaminated injecting equipment (syringes and needles). Often marginalized, many of them poor and young, they often turn for sex to SWs, or offer themselves sex services to pay for the drug.
- IDU is the major driver of the HIV epidemic in Asia. Countries with documented HIV infection among IDUs include Bangladesh, Cambodia, PRC, India, Indonesia, Kazakhstan, Lao People's Democratic Republic (Lao PDR), Malaysia, Myanmar, Pakistan, Tajikistan, Thailand, Uzbekistan, and

²⁰ ADB. 2005. *Development, Poverty and HIV/AIDS: ADB's Strategic Response to a Growing Epidemic*. Manila. Available: www.adb.org; UNAIDS. 2006. *Global Report on HIV/AIDS*; and ADB's Gender Network News. 2005. *Special Issue: Perspectives on Gender and HIV/AIDS*. September 2005.

Viet Nam. As each epidemic progresses, the proportion of infections due to IDU drops while sexual transmission rises.

Sexual Transmission

- From IDUs and SWs, the epidemic will start spreading to the other people with whom they have sex: their regular partners and the clients of sex workers. Clients of SWs come from all backgrounds (though “mobile men with money” predominate), and usually have other sexual partners and/or are married.
- The HIV virus passes from the sexual secretions of the infected partner into the blood stream of the other partner if there are minute breaks or sores (such as those caused by STI) in the skin or mucosa. Unless condoms are used, HIV will eventually spread to the general population through sexual intercourses, especially where rates of untreated STI are high.
- Another important but neglected group “bridging” transmission to the general population is MSM. They are referred to in this way because many of these men have sex with women too, and do not see themselves as homosexual. Studies show that 3–5% of men in Asia have sex regularly with men and that 20–50% of them have sex also with women, including their wives.²¹ Anal sex is more common in isolated, predominantly male settings, such as construction camps, prisons, or the military.
- The recipient of anal sex is up to 15 times more likely to become infected with HIV,²² and again, unless condoms are used, infected MSM will pass the virus to their wives and other sex partners. Discriminatory laws and attitudes mean that sex between males usually remain hidden, making it difficult to reach MSM with appropriate information and services.

Prevention of Mother-to-Child Transmission

- About one third of babies born to HIV-infected mothers will acquire the virus during childbirth or later through breast milk. Transmission risk can be cut by more than 50% by treating the mother and the baby with inexpensive drugs at the time of birth, and by using safe breast milk substitutes. However,

²¹ Brown, T. 2004. Overview: Epidemiological and Behavioral Research among MSM in Asia. In *XVth International AIDS Conference Abstract # WePC2068*.

²² The Synergy Project and Washington University. 2000. *Putting on the Brakes: Preventing HIV Transmission along Truck Routes*, 38.

fear of stigmatization deters many women from giving birth in a health facility, or from using alternative infant feeding methods.

- To reduce the blame and other harsh consequences often experienced by HIV-positive mothers, WHO and UNAIDS recommend referring to this mode of transmission as “parent to child,” since in most cases the father is also HIV-positive, and may well have transmitted the infection to his wife.

Contact with Infected Blood

- The HIV virus can pass directly into a person’s bloodstream, through transfusion, or injection, or accidentally through sores or damaged skin. Blood transfusions and the use of contaminated needles in formal or informal health care settings remain a source of infection in many parts of the region. WHO estimated in 2000 that 5–10% of HIV infections in Southeast Asia were acquired through contaminated blood,²³ while for Pakistan, UNAIDS reported a figure of 17% in 2003.²⁴
- Cultural practices, which involve cutting the skin with shared unsterilized implements, such as tattooing, piercing, traditional initiation rituals and circumcision, and body scarring, also carry a potential risk of HIV infection. These practices are common in all-male setting, such as construction camps, and in many Pacific island countries.

Additional Risk Factors

- **Mobility and migration:** “The vast numbers of people in Asia who are on the move for economic reasons create wide networks for the spread of diseases.” A growing proportion of these people are victims of trafficking, often for the purposes of sex work, which further increases their risk. Both men and women migrate, but men tend to dominate in long-distance and cross-border migration in most regions of the world. Male migrants and groups of mobile men have also been the focus of discussions and research on the migration-HIV/AIDS connection. Long-distance lorry drivers are one such male migrant group, often showing higher HIV prevalence.

²³ Sharma, R. 2000. South East Asia Faces Severe Shortage of Safe Blood. *British Medical Journal* 320, 15 April, 1026.

²⁴ Terzieff, J. 2003. AIDS in Asia: The Continent’s Growing Crisis. Pakistani Woman Battles AIDS Stigma in Her Country. *Chronicle Foreign Service*. 22 March.

- **Youth:** Like everywhere, young people in the region are sexually active, yet often denied, for cultural and religious reasons, the knowledge and services for preventing HIV infection. Young people between 15 and 24 years old represent 22% of those in Asia living with HIV/AIDS.
- **Weak health systems:** STI increases the risk of HIV transmission by a factor of 5, yet health services throughout most of the region are not adequately equipped to treat STI. Services related to the control of HIV, such as voluntary counseling and testing (VCT), prevention of transmission to infants, safe blood supplies, and universal health and safety precautions, are also too often inadequate.
- **Gender inequality:** being female, particularly a poor female, in a male-dominated society is itself a risk factor for HIV infection, for reasons that will be explained in the next section.
- **Stigma and discrimination:** As soon as scientists identified HIV and AIDS, social responses of fear, denial, stigma, and discrimination have marked the epidemic. Discrimination has spread rapidly, fueling anxiety and prejudice against the groups most affected, as well as those living with HIV or AIDS, often preventing them to obtain appropriate information and services.

3.3 “Feminization” of the epidemic

- In the early stages of an epidemic, infection is concentrated among high-risk groups such as IDUs, SWs, MSM, and mobile populations. As the epidemic spreads to the wider population through sexual transmission, women represent an ever-growing proportion of those infected. This is clearly the case in Asia and the Pacific.
- Patterns of economic, social, and cultural discrimination against women generally make it difficult or impossible for them to control the conditions under which they have sex. Marriage increases the risk for women when it is combined with cultural requirements for wifely obedience and tacit cultural tolerance of male extramarital sex, as is often the case throughout the region.
- Sexual and physical violence against women and girls increases the risk of HIV for females, and therefore of further spread to men, and to unborn infants. Rough or forced sex directly increases the risk of genital trauma, especially with children or teenagers. Evidence from around the world indicates that between one third and two thirds of sexual assault victims are 15 years or younger.²⁵

²⁵ Heise, L., et al. 1999. *Population Reports: Ending Violence Against Women*.

Women and girls are not the only victims of male violence. Male-to-male acts of violence impacting on HIV transmission are, for example, rape in prisons and rape of boys. To ensure effective HIV/AIDS interventions, all situations need to be considered.²⁶

- Risk and vulnerability are different for men and women, as shown in Table 2.

Table 2: Gender-Linked Differences in Vulnerability to HIV/AIDS

Women	Men
<i>Physiological factors</i>	
<ul style="list-style-type: none"> • Usually infected 5-10 years earlier than men because of biological and sociocultural factors. Infection often detected during routine antenatal testing. 	<ul style="list-style-type: none"> • Infection usually detected at a later age (30<), when testing for illness, or in VCT.
<ul style="list-style-type: none"> • Women are up to four times more likely to contract HIV from unprotected vaginal intercourse than men because of larger surface area of reproductive organs, higher concentration of the virus in semen than in women's secretions, and abrasion of the mucosa (including damage through forced sex, particularly for young women/girls). 	<ul style="list-style-type: none"> • Anal sex, commonly practiced by MSM or boys, has a very high risk of transmission for HIV, particularly for boys (up to 15 times higher than unprotected vaginal sex).
<ul style="list-style-type: none"> • Higher rates of untreated STI (facilitating HIV transmission) because symptoms are often not clear in women. 	<ul style="list-style-type: none"> • Where several men have sex with the same woman or man, men can be infected from the semen of men ahead of them.
<i>Sociocultural factors</i>	
<ul style="list-style-type: none"> • Norms of female sexual behavior encourage passivity, modesty, fidelity, and innocence or ignorance about sexual matters, and discourage females from controlling the conditions under which they have sex. 	<ul style="list-style-type: none"> • Norms of male sexual behavior often allow/encourage men to have multiple sex partners, to seek sex frequently, and to demonstrate control over women through sex; they discourage men from admitting lack of knowledge about sexual matters.
<ul style="list-style-type: none"> • Cultural norms require women to marry and have children, preventing condom use. • Cultural norms push MSM, in some societies, to marry and so doing put their wife at higher risk. 	<ul style="list-style-type: none"> • Peer pressure and "macho" culture in male-dominated environments encourage risk-taking behavior.
<ul style="list-style-type: none"> • Tolerance of male physical and sexual violence against women/girls increases women's/girls' risk of HIV infection. 	

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²⁶ Swedish international development agency (Sida). 2007. AIDS and Gender relations.

Table 2 continued...

Women	Men
<i>Sociocultural factors</i>	
<ul style="list-style-type: none"> • Less access to information about HIV prevention and treatment because of lower levels of literacy and education and limited involvement in public life. 	<ul style="list-style-type: none"> • Cultural practices involving cutting the skin, e.g., tattooing, body piercing.
<ul style="list-style-type: none"> • Less access to STI or VCT services because of restrictions on mobility. 	<ul style="list-style-type: none"> • Fear of job consequences inhibits men's use of VCT.
<ul style="list-style-type: none"> • Less confidentiality when looking for STI or VCT services because of the need for women/girls in some cultures to be accompanied by their husband or a female relative. 	
<ul style="list-style-type: none"> • Stigma linking HIV with promiscuity makes it more shameful for women to use VCT. 	
<ul style="list-style-type: none"> • Discriminatory laws which penalize FSWs but not their clients make FSWs vulnerable to violence and exploitation. 	<ul style="list-style-type: none"> • Homophobia and discriminatory laws marginalize MSM.
<i>Economic factors</i>	
<ul style="list-style-type: none"> • Economic dependence on men, inability to negotiate safe sex, whether with husbands or in sex work. 	<ul style="list-style-type: none"> • Greater economic power and control over resources, therefore, money to spend on sex, alcohol, and drugs.
<ul style="list-style-type: none"> • Few or no legal rights to own or inherit land or property, which increases female insecurity and makes widows especially vulnerable. 	<ul style="list-style-type: none"> • Occupations often require men to leave home, (e.g., road or infrastructure construction, truck driving, mining, and logging) with increased opportunities/perceived need for casual or commercial sex.
<ul style="list-style-type: none"> • Limited opportunities for earning income other than through formal or informal sex work, especially for migrant or refugee women, and for women/girls left behind when men migrate. 	<ul style="list-style-type: none"> • In conditions of poverty, young men and boys may also sell sex.
<ul style="list-style-type: none"> • Drug use may lead to selling sex. 	<ul style="list-style-type: none"> • Drug use may lead to selling sex.
<ul style="list-style-type: none"> • Greater number of women and girls in absolute poverty. 	

AIDS = Acquired immune deficiency syndrome, FSW = female sex worker, HIV = Human immunodeficiency virus, MSM = men-who-have-sex-with-men, STI = sexually transmitted infection, VCT = voluntary counseling and testing.

Source: ADB Consultants