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## **The Invisible Challenge to HIV/AIDS Prevention: Clandestine Prostitution in Senegal**

By Gisele Maynard Tucker

### **Abstract**

Clandestine prostitution has become a way of survival as many women struggle economically without family or governmental aid. Clandestine or survival sex is practiced when women are facing an economic dilemma. These women are non-literate and have no job skills. Further, they do not see themselves as sex workers because they only “go out” (colloquial for prostituting) occasionally. In light of the HIV/AIDS epidemic, it is important to reach these women as they are exposed to HIV infection and violence. Based on literary research, observations, focus groups and interviews with the personnel working with registered and clandestine sex workers in Senegal in 2009, my paper discusses clandestine prostitution and its impact on HIV/AIDS prevention. Interventions efforts should link HIV/AIDS prevention programs for sex workers to NGOs’ grassroots projects offering adult literacy classes, skill training and microfinance.

*Keywords:* clandestine prostitution, women’s literacy, microfinance.

### **Introduction**

Senegal is a country where literate women have made some progress participating in political life and civil society organizations. At the government level, they have been looking for social and political emancipation along with political achievements through their acquired positions in social and cultural activities. However, women working in the informal sector, especially those in rural areas unlike their more educated and solvent urban sisters, represent a very insecure group employed at lower rates than men, and paying higher taxes. Although, a small group of women are working towards more reforms, in rural communities, women are discriminated against, repressed and very poor.

The goal of this paper is to examine poor illiterate women coping with the modern world. As globalization continues to extend, traditional beliefs and customs are being reshaped to adapt to a technological society and global economic stress. The impact of modernity and a cash economy has been more stringent for women who live below the poverty level than for men because of their lack of schooling and skills. Poor women in the developing world have little opportunities to be cash independent; they are marginal to politics and, for most, unaware of their legal rights. Their daily burden is the survival of the family.

This paper examines how poor women in Senegal are living on the edges of economic survival; they are forced to fend for themselves by practicing clandestine prostitution in order to take care of their children, their family, and sometimes even their unemployed husbands and/or partners. Sex exchange for money, gifts, or favors is not a new behavior here and has been reported in the literature (Homaifar and Wasik, 2005; Laurent et al., 2003; Renaud 1997; Wang et al., 2007; Wojcicki 2002(a), 2002 (b); and many others). In addition to examining sex work and its implications, this paper will also suggest ideas to empower poor women with basic education and opportunities for economic rewards.

The low HIV prevalence in the Senegalese population (1.4% UNAIDS 2008) and donors' focus on high-risk groups (men having sex with men (MSM), drug addicts and sex workers) can mask the fact that there are individuals who propagate the epidemic because they have to survive by selling sex. Prostitution is outlawed in most countries, although widely practiced everywhere. Laws regarding sex work differ among countries, ranging from illegal (fully prohibited) to criminalized, where sex work is not illegal but related actions are (e.g. soliciting). Governments are aware that in most cases prostitution is a social consequence of poverty but they have not reacted to it by creating social programs or job opportunities for women living below the poverty level.

In Senegal, the government took one step forward by legalizing prostitution in 1969. This was implemented with the registration, at the Institute d'Hygiene Sociale (Social Hygiene Institute), of sex workers above the age of 21 years, where they were issued a health card and had to visit a specific clinic for bi-monthly checkups for STIs (sexually transmitted infections) and HIV testing. They are given free condoms and if they are positive, ART (antiretroviral therapy) (Do Espirito Santo and Etheredge, 2004; Homaifar and Wasik, 2005).

Clandestine sex workers are housewives, widows, single women with children and young girls. They are clandestine because they hide their sexual activities due to shame and stigmatization associated with prostitution. They are not registered and do not consider themselves sex workers because they work occasionally, when in need of money. Both groups (registered and clandestine) use sex for exchange of cash, goods, and/or favors and both groups are affected by the global economic stress and extreme poverty. Clandestine sex workers are afraid of the police, being obliged to register as sex workers, going to prison for soliciting in the streets and having their family, friends, children know about their activities. Shame is associated with prostitution because high-risk groups are blamed through the media for spreading the epidemic.

Sex work is dangerous because it is associated with violence from clients' intoxication to assault, rape, and physical violence. Legal sanctions against rape, assault, and violence are not enforced in many countries due to lack of willingness at the level of governance and because of police corruption. Wojcicki (2002 (a): 284) writes about the rape and violence informal sex workers were confronted with in Gauteng, South Africa's bars and taverns: "The general silence that shrouds sexuality in southern Africa contributes to an acceptance of violence against women."

Abrahams (2004), describing violence usually inflicted by intimate partners, concluded that violence in South Africa has been unchallenged and tacitly accepted. It is interesting to note that violence is ever-present in the lives of women. "Violence against women is present in every country, cutting across boundaries of culture, class, education, income ethnicity, and age" (UNICEF, 2000:3).

Violence can be seen in the devastating health effects of prostitution (Raymond 1999). Furthermore, women are not aware of their legal rights in case of rape or physical abuse "Violations against women's human rights are often sanctioned under the garb of cultural practices and norms or through misinterpretation of religious tenets" (UNICEF, 2000: 3). In rural and semi-rural African communities, the most girls are unschooled and have no skills that might help them get jobs. Being born in an ethnic or religious society that promotes child marriage or arranged marriage, polygamy, bride wealth, and female genital mutilation are a curse for a girl who wants to become educated and independent

(IRIN/Plus News 7/5/2010). In addition, many countries do not enforce laws and policies about women's human and legal rights, and most governments do not sanction criminals for violence against women (e.g. rape, physical punishment) even if they have instituted laws to protect women (Kimani, 2007; Mustapher, 2010; UNICEF, 2000, 2001; US Dept. of State, 2008; Wojcicki, 2002 (b)).

For the purpose of this paper I chose to investigate the issues of clandestine sex work as a challenge to HIV/AIDS prevention programs because women who practice clandestine sex work do it secretly, are difficult to track and avoid STI clinics and HIV testing. Major determinants to clandestine sex work are poverty, illiteracy, lack of skills, broken kinship ties and abandonment by partners. In many instances, they are women without resources who have to care for their children, women whose relatives rejected them when they refused to conform to the traditional arranged marriage, or polygamous union, women divorced and abandoned by husbands because they are infected by HIV, or women who suffered from domestic violence.

The following sections will present issues associated with sex work that might encourage donors and local governments to develop new strategies concerning the empowerment of poor women, in order for them to adhere to the medical services.

## **Methods**

Data presented here are based on direct observations during the evaluation of a USAID HIV/AIDS program in Senegal in 2009, literature and Internet research, interviews with the personnel working with registered and clandestine sex workers and the author's experience with the topic in two other countries - India in 2011 and Madagascar in 1996.

In Thies (a Senegalese rural community), twenty clandestine sex workers participated in focus groups organized by ENDA Santé, an NGO that specializes in working with both registered and clandestine sex workers. They were asked several questions in Wolof as the majority spoke Wolof and a few spoke French.

One of the promoters translated their answers from Wolof to French for the author. The questions were about frequency of work, clients, use of clinical facilities in case of STIs, their knowledge of HIV/AIDS, their use of condoms (male and female), and how they see their future. The staff of ENDA Santé were interviewed in Dakar about their methods for recruiting clandestine sex workers and their methodology about counseling and giving support. I also interviewed the staff of AWA (The Association for Women at Risk from AIDS) and SWAA (The Society for Women against AIDS in Africa) as these organizations are working with sex workers in Dakar and in various communities such as Thies, Kaolack, Kolda, Kedougou.

In addition, 30 members of the medical staff (doctors, nurses, and promoters of the public and private sector) were interviewed.

The organizations offer information, services and care about STIs and HIV/AIDS prevention as well as testing of sex workers for HIV. The NGOs' personnel reported training peer educators to distribute information about HIV/AIDS prevention, STIs knowledge, and condom usage, and giving referrals to medical clinics.

Interestingly, the problems and the issues facing clandestine sex workers in Senegal were similar to those of the women I interviewed in Madagascar and India (Maynard-Tucker, 1996, 2011) and were also similar to related issues discussed in the

published literature. The following sections describe the background, clandestine sex workers' behavior and some major issues related to sex work.

## **Background**

With globalization, gender roles are slowly eroding due to the impact of economic stress, labor migration (male and female), urbanization, and modernization reaching the most remote parts of the world (Rabenero, 2004). Women married to migrating husbands became head of households. This modern urban world is full of violence for women who cannot read or write. Isolated in an urban area without help from kin, their objective is to make enough cash daily to survive. Legal options are limited to reselling food or produce at markets or in the streets for very little money. What they are able to earn daily (around 2 US\$/day or less) is spent to feed the family and does not stretch to cover emergency expenses (i.e. medicine for sick children). In emergencies, some women take to the streets to find additional cash (Do Espirito Santos and Etheredge, 2004:141) or live in a community that tolerates prostitution (Renaud, 1997).

Because of the high level of poverty in many African countries, prostitution has become a means to survive economically (Ayadele 2009; Raymond 1999). ). In Senegal, the proportion of the population living in poverty, (US\$2/day) was 60% in 2008, and living in absolute poverty rate (at 1.25US\$/day) was 34% (World Bank 2010).

Poor rural women living in urban settings away from kin and abandoned by partners have no opportunities to find jobs, especially if they are illiterate and unskilled (Ebin 2000). It is difficult to get statistical data on clandestine prostitution because women usually do not visit health facilities and tend to deny their own activities because of shame and stigma.

Interviews with the medical staff of the public sector in Dakar and the provinces revealed that for every registered sex worker there are numerous women and young girls who are not registered and do not visit the services. A doctor in Kedougou told us “ Des qu’il fait nuit il y a des centaines de femmes et jeune filles qui font le trottoir (as soon as night falls there are hundred women and young girls who are soliciting in the streets).

In Dakar, it was estimated that from 2006 to 2009, the number of registered sex workers grew from 1,800 to 6,412 (Ndiaye 2010). Registering sex workers for medical checkups helps to control the spread of STIs and encourages testing for HIV. If sex workers are found to be HIV positive they are not prevented from working as long as they are treated, examined at the clinic, and get counseling and support (Homaifar and Wasik, 2005:123). But, if their carnet sanitaire (health card) is retained by the medical staff because they have an STI, they must stop working, however, if they are pressed for cash, they might still “go out.” The prevalence of HIV infection among registered sex workers ranges from 11% to 30% depending on the locations (CNLS 2010). Enda Sante (2007) estimated that unregistered sex workers represent 80% of the sex workers.

## **Clandestine Prostitution**

“We know that we infect our clients, but we do not have any choice, we have no ways to make a living.”

This statement was given during a focus group discussion (October 2009, Senegal).

The women sitting in a circle at ENDA Santé 's premises in a rural community outside Dakar were at first bashful about answering the questions, almost in denial of their activities. However, during the discussion led by one of the promoters, they started to open up about their daily problems and why they were selling sex. The women of the focus group were not fancy and looked like any woman one would encounter in a store. They were widows, abandoned women with HIV, women with HIV-infected children, students, and single women. Most had un-wage jobs (i.e. reselling produce, cleaning) and some were unable to pay for the children's medication (in case of HIV treatment) or clothing and food needs of the family because their husbands/partners abandoned them or could not find employment.

"I go out because I need money for the children's medication," said one participant, while another explained "My husband abandoned me 5 years ago, I was left with three children and I had to take care of them."

The twenty women who participated in the focus group discussions were between 20 and 48 years of age. About a third were migrants from nearby countries. They "go out" on average several days a week depending on their need for cash. Two women had a market stall where they were reselling produce but they said, "We do not make enough money to feed the children." The majority was non-literate and had no specific skills. They usually solicit clients anywhere—markets, streets, in bars—away from their living locations in order to keep their activities secret. Women in relationships lie to their partners about their extra activities. They use cheap hotels or isolated places for their encounters. The women had no fixed fee but said they sold sex for the amount of money they needed at the time. Clients were males that frequent bars in search of prostitutes, as well as office clerks, market sellers, truckers, mechanics, students, hotel employees and taxi drivers, among others.

Clandestine sex workers usually do not have as many clients as registered sex workers. They average 4-6 clients a week versus 15 plus clients for the registered sex workers. When recruited by peer educators, most do not have a clear knowledge of STI symptoms, modes of transmission of HIV, and the methods of contraception. In the case of STIs, they do not go to the clinic for checkups. They said "It was too costly." Instead, they try first to cure themselves with traditional medicine such as herbal teas or potions. Some of them still "go out" although infected. When asked why they would not go to the clinic to get tested for STIs, they mentioned that they cannot afford the cost and/or the medical staff does not treat them well " On doit faire la queue pendant des heures pour voir le doctor" (we must stay in line for hours to see the doctor). Another constraint was that they could not establish friendly ties with the doctor "Ils changent de docteur tres souvent", (they rotate doctors very often) in addition " Les infirmieres ne sont pas aimables" (the nurses are unfriendly). Furthermore, they were afraid to be questioned about their behavior and/or forced to register, which would have brought "shame" to their family and children.

Most felt ashamed about their activities, although, among them one woman with an HIV-infected child, was outspoken and explained that they were driven to clandestine sex work because they could not get any medical or social welfare for their sick children.

Asked if they were using condoms, they said that they have to convince their clients to use condoms and some clients refuse or offer more money for unprotected sex. Similar findings have been reported (Do Esperito Santo and Etheredge, 2004:144; Laurent et al.,2003:1813; and Quist-Ardon, 2001).

Asked if they were using female condoms, they said they knew about them, but not all of them were using them because of the expense. Others said the female condom is noisy, the client did not like it, and it hurt them because it was too dry. However, one said she lubricates the female condom before inserting it and holds it in place during sex with no problems. All of them said they were thankful for the directives and organized meetings where they learned about HIV prevention and received counseling and support.

They all agreed that their lives were lonely and they felt marginal to the mainstream society because they could not talk to anyone about their activities and their stress. They said that those weekly meetings scheduled with other clandestine sex workers were extremely beneficial because they could talk about their family's situation, their stress and they were learning how to protect themselves from STIs and HIV transmission. In addition, they were supporting each other by talking about their life burden. Some of the women had been tested for HIV during their last pregnancy and knew that they were HIV positive, but the majority did not know their status. Finally, the group expressed their wish that they could get financial aid such as microcredit loans that would assist them in becoming economically independent.

### **Issues Associated with Sex Work**

According to UNAIDS/WHO (2008) the total adult literacy rate in Senegal for 15 years old and older was 41% in 2006, while male literacy rate was 52.7% and female was 31.5%. In rural areas, illiteracy was estimated to be from 81%-90% for rural women in 1997 (UNHRC 1997). Discrimination and male privileges persist in Senegal such as customary law that prevails in rural areas. Some reforms still bar women's access to land in cases of inheritance (Anayangu and Kyalimpa 2010). In addition there is no law that specifically addresses violence against women.

The following findings reported in the literature were also mentioned during fieldwork in Madagascar and India. Clandestine sex workers sometimes have unemployed husbands or partners, while among the young girls some sell sex to pay their school tuition or the family's bills (Do Esperito Santo and Etheredge 2004:142).

Transactional sex between "sugar daddies" and young girls is often driven by extreme poverty and the need for luxury items. A woman might have 1 or 2 partners a night, depending on her need for cash. Wojcicki writes (2002 (a):274): "It is quite common for a woman to have only one partner a night." Because clandestine sex workers have less experience than registered sex workers, they do not always ask for the money up front and sometimes clients robbed them "Very often, customers, after having obtained satisfaction, strike them and strip them of their money under threat" (Do Esperito Santo and Etheredge 2004:140). In addition, "Clandestines (sex workers) often accepted unprotected sex because they can't afford to be picky when supporting parents" (Renaud1999: 151). Nevertheless, registered and/or clandestine sex workers are high risk groups because they will practice unprotected sex when in need of emergency money or with their regular partners (Laurent et al.2003: 1815).

Registered sex workers also tend to experience the same economical stress, violence and related problems. However, registered sex workers have access to medical services that include HIV testing and the detection of STIs for about 80 cents a month. In addition, if they are infected with an STI, they must buy the prescribed medication.

Officially, registered sex workers can work legally, however, they fear the police because the police is at times abusive. Police raids are frequent in brothels, bars, and nightclubs to check on their health cards. "The girls are picked up either soliciting or because their health record is not up to date" (Do Espirito Santo and Etheredge, 2004:140; Ebin, 2000). If the health card is not up to date, the girls risk legal sanctions. For many of them, in order to avoid the withdrawal of the health card, they deal with police's corruption, paying them with money or sexual favors. Also, in case of rape or robbery, the police will not get involved primarily because prostitution is stigmatized by the society, and also because sex workers have no legal recourse. When prostitution was legalized it was assumed that regular check-ups of sex workers at clinics along with the mandatory health card would keep HIV/AIDS prevalence low because sex workers would be under frequent medical control. However, the medical staff complains that about a third of the registered sex workers do not check in regularly and, consequently, are missing medical care and free condoms. "Il y a beaucoup de perdues de vue," (there are many lost to follow up).

In communities near the borders where sex work is very popular, the population is extremely unsettled, composed of migrants who move among various mining communities with seasonal work or to neighboring countries, and sex workers are difficult to track. Doctors also felt that the programs do not have enough personnel in rural areas to take care of the sex workers' services, including not enough laboratories, and should provide more privacy for the sex workers (i.e. specific days and hours for their visits). Compared to other African countries, HIV prevalence for the general population in Senegal is low, it was estimated at 0.7% in 2005 and in 2007 at 1.4% (UNAIDS 2008), however, prevalence rates vary on a regional basis, for instance in the regions of Kolda and Ziguichor, HIV rates for the population has reached 2.8% and 2.35% respectively (USAID 2008). Other countries such as Nigeria and Malawi have HIV rates of 3.6% and 11%, respectively (UNAIDS 2010).

## **Discussion**

More women than men worldwide were HIV positive in 2007. There were around 12 million women living with HIV and AIDS compared to 8.3 million men, and UNAIDS estimated that around three-quarters of all women with HIV lived in sub-Saharan Africa (UNAIDS 2008). Women who are pregnant and seek medical care are tested for HIV, but if they turn out to be positive they are usually blamed for getting the virus through unfaithful sexual relationships, although some are infected by their husbands or partners. For example, in Rwanda, 25% of girls who became pregnant at age 17 or younger were infected with HIV, although many reported having sex only with their husbands (UNICEF, 2001:10).

In those situations, women faced physical violence and/or abandonment by their husbands/partners and their kin because of stigma and fear of infection. IRIN/ Plus News (6/16, 2008) reported "One in four women suffers domestic assault and battery in Senegal yet most suffer in silence because of a deeply entrenched culture of impunity and a



phlegmatic response from the government.” The medical staff of a clinic on the outskirts of Dakar delivering medical services to mothers and children infected by HIV, told us that women frequently asked for help because their husbands abandoned them as soon as they knew they were HIV positive. When we interviewed the staff of the clinic, we learned that they were worried about Aisha, a mother of three children, 5 and 3 years old and a 12-month old baby, who came to the clinic asking for help because her husband abandoned her when he found out that she was HIV positive. She said that her husband infected her, but refused to get tested. She could not get any help from her family because they were afraid that she might infect them. After he abandoned her and the children, she was penniless and had to sell her belongings to buy drugs for her sick children. Not having any support from family or husband, she was considering sex work as an option to generate some income.

The lack of social welfare and the legalization of prostitution in Senegal did not remedy the problem of poverty. How can the government empower women with pro-prostitution policies if prostitution is stigmatized and degrading to women? Society and the religious community have not accepted prostitution, but are tolerating it because of its legalization. Prostitution encourages violence against women who have no resources, no legal or human rights and are oppressed by the police. This type of societal violence condemns women to be degraded, denied of self-esteem, and marginal to the mainstream society. Women are responsible for the children and because they have no alternative, many are using sex work for survival. Legalization of sex work and health control under the strict supervision of the police adds to the burden of the women who have to deal with police corruption and violence. In this modern world, poor women are not able to adapt because they are marginal. It is well known that education is the prime mover for women’s empowerment in developing countries (Kristof and Wudunn 2009; Pisani 2008; UNICEF 2004; UNFPA 2004; Ynus 2007). Being educated and learning a skill brings opportunities for jobs, independence, understanding, self-esteem, and equality. Numerous studies (Shapiro and Tambashe 2003; Martin and Adhikari 2008) have shown that once women acquired a basic education, their behavior changes and they are more opened to health prevention, contraception, nutrition and creating a stable environment for their family.

### **Education Strategies and Microcredit Loans**

Most HIV/AIDS prevention and care programs focus on the health problems of the target population - in this case sex workers. Although, it is a great advantage for the target population, it is not enough to encourage behavior change. Poor women should be able to access adult literacy classes and skills training along with information about health.

This could be done by linking HIV/AIDS programs for sex workers to grassroots NGOs such as Peace Corps, CIDA, TOSTAN and/or women’s associations and/or students associations that specialized in adult literacy classes and skills training. This strategy would not involve a great amount of money and could also be dealt with through voluntarism or group saving incentives. Furthermore, clandestine sex workers during focus group discussions requested access to microcredit loans in order to improve their cash flow. Thus, this step also requires minimal literacy and numeracy to deal with a contract, sign their name, make decisions, and plan their future.

There are numerous examples in the literature (Daley-Harris and Awimbo 2006; Dowla and Barua 2006; Kongolo 2007; Kristof and Wudunn 2009; Mayoux 2003; Parpart 2002, Ynus 2007) of community development advocating women's primary education and development of skills, along with the availability of microfinance through informal credit or tontines (tontine is the name for a group savings model where members of the group contribute a fixed amount of cash to a common fund at regular intervals weekly or monthly). Tontines are very popular in Africa as a mechanism for saving money collectively. The tontine money is available as loans to group members when needed (Guerrin 2006; Dowla and Barua 2006; Owen 2006). Kongolo writes "informal credit has created entitlement to resources for economic emancipation of the poor in general and black South African women in particular, by providing them with the opportunities to carve out dignified ways of living," (2007:130).

The following mechanisms aim at empowering clandestine sex workers through the continuation of peer education and counseling, which is already functioning in NGOs such as ENDA Santé, AWA, and SWAA and others. Clandestine sex workers are recruited by peer educators in bars and night clubs and asked to join meetings organized by the NGOs, at which they are given information about STIs and HIV prevention, use of condoms male and female, along with referrals to STIs clinics for medical check ups. Those meetings could be linked to NGOs' adult literacy classes and skills training.

Once women graduated from literacy and numeracy classes they could be introduced to microfinance by a local NGO. The option of organizing a tontine along with microcredit loans would double women's opportunities to become economically independent. However, one must be aware of the cultural norms of reciprocity. Guerrin writes: "Women are burdened with [making expected] donations at life-time ceremonies, births, baptisms, marriages, funerals" (2006:554), another problem is to adhere to the regulations of microcredit loans (Lairap-Fonderson, 2002) and group responsibility in reimbursing individual loans. Because, there are different types of microfinance, one should take into consideration what is most appropriate for the community and its members: tontine, microcredit loans/informal credit or self-help groups (Dowla and Barua, 2006; Guerrin, 2006; Harper 2002; Owen, 2006).

## **Conclusions**

This paper has presented clandestine sex work as a challenge to HIV/AIDS prevention programs. Based on the data gathered here, coping with this challenge will require new thinking about broadening the concept of "health" and health promotion to include giving attention to the social and economic life of at-risk women.

Senegal is considered a success in HIV prevention because of its low prevalence (1.4% UNAIDS 2008) which is attributed to three major determinants (a) the creation of a safe blood bank supply, (b) the registration and regular check ups of sex workers and (c) the promotion of condoms use to high risk populations (sex workers, men having sex with men and drug users). However, this low general population prevalence does not account for clandestine sex workers (male and female) who avoid STI clinics and HIV testing because of ignorance, shame and secrecy and does not account for registered sex workers who become clandestine because of stigmatization and police raids.

Advocating for women against violence should be a priority for all women's associations and for future policies. Clandestine sex work is a form of violence to poor

women that results from the governments' inaction to resolve poverty issues and failure to punish violence inflicted on women, both of which assist in the disintegration of women's self esteem. Preventing the transmission of violence against girls should become part of childhood enculturation by parents—especially the mother—and should be the focus of school curriculum and teachers. Girls need to be schooled just like boys and to learn through education that raising children with a paternalistic ideology perpetuates gender inequality. Educated and elite women must not forget their rural sisters. New strategies can be developed for men who refuse to practice protected sex during casual sexual encounters. For example, the stepping stone method that enables change for individuals/communities (with the use of participatory learning, role-playing and critical reflection) could be adapted to transmit information about HIV prevention, male and female condoms use and behavior change.

The ideas given above are meant to stimulate the international and civil society to link national HIV/AIDS programs for sex workers with NGOs and/or associations that work at the grassroots level—encouraging women's education, giving microfinance opportunities, organizing tontines, training, capacity building, income generating activities and giving women an understanding of their rights. Improving the conditions of women would improve the health of the family, would increase communities' development and ensure the success of HIV/AIDS prevention programs.

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