Mainstreaming Gender Perspective and Fighting HIV/AIDS

by Dr. Khalilur Rahman

Women are more vulnerable to AIDS epidemic. AIDS and other STDs affect them more. There are specific reasons for this. Physiological factor, wider social, cultural, sexual and economic vulnerability, inequity, lack of job opportunities, poor access to education and training, male dominance prevent women from actively making choices and decisions about their lives, particularly with regard to limiting sexual risks and protecting their and their families' health.

A few days ago I was going through a recent publication of Geneva-based UNAIDS — the Joint United Nations Programme on HIV/AIDS comprising UNICEF, UNDP, UNFPA, UNESCO, WHO and World Bank. This publication has laid emphasis on the gender-based response to the challenges posed by HIV/AIDS. I was prompted by this publication to write something on AIDS linking it to gender perspective from our context. Thanks to the UNAIDS publication.

The gender issue has been on the world agenda over a couple of decades. Achieving equality for women and tapping their as-yet unrealised potential around the world has been focussed at various international fora through mainstreaming the gender perspective into all policies and programmes of the UN system. The UN position on this issue is that activities by the UN that do not take into account the specific situation and specific effects of those actions on women would not be as successful because they would not take advantage of a wealth of special expertise and untapped potential and that as long as programmes are aimed at "people" rather than at both women and men, discrimination against women would continue. It appears that the recent efforts by UNAIDS towards gender based response to challenges posed by HIV AIDS is in line with the UN declared goals for ensuring gender based policy in the activities of the UN system. The Member States of the UN have also been supportive of this policy.

The Beijing Declaration and Platform for Action adopted at the conclusion of the Fourth World Conference on Women in Beijing in September 1995 embodies the commitment of the international community to the advancement of women and to the implementation of the Platform of Action ensuring that a gender perspective is reflected in all policies and programmes at the national, regional and international levels. If implemented, the Platform of Action will enhance the social, economic and political empowerment of women, improve their health and their access to relevant education and promote their reproductive rights.

Present World AIDS Scenario

According to WHO, by June 1998, a cumulative total of 1, 893, 784 AIDS cases (adults and children) world wide had been reported. The actual number of AIDS cases is, however, unknown because of under-diagnosis, incomplete and delayed reporting. An estimated 11.7 million AIDS deaths had occurred in adults and children since the beginning of the epidemic. 2.3 million in 1997 alone. An estimated 29.4 million adults and 1.1 million children younger than 15 years were infected with HIV AIDS. Of the adults, 12.2 million were women — most of childbearing age. Thirty-six per cent of new infections in 1997 were in women.

In the industrialised countries, the epidemic as a whole is being contained. Moreover, these countries can also afford antiretroviral drugs ensuring decline in death rate from AIDS. But in other parts of the world including Asia, it increased over 100 per cent between 1994-1997.

In most of South-East Asia and India, with a high incidence of new infection, death rates can be expected to rise sharply in the 2000s. Another regional country, China, estimates that HIV infection doubled from 200, 000 at the end of 1996 to 400, 000 in early 1998.

Enough has already been written and discussed about the possible routes of transmission of HIV/AIDS. I know nobody likes repetition. So I do. I am, however, of the view that this is an issue that perhaps needs "repeated repetition" to make people conscious and aware of this killer epidemic. Repetition is perhaps more important and needed in a less educated society like ours where people have limited access to information and knowledge.

In most developing countries HIV is transmitted predominantly through sexual intercourse and from mother to child during pregnancy, delivery and breast-feeding. Needle-stick injury and use of contaminated sharp instruments in modern and traditional health settings also contribute a small amount to overall infection, mainly in resource-constraints settings. Injecting drug use is a significant route of infection. Infected blood transfusions are another potential risk, particularly for women, who have more transfusions than men because of childbirth complications and anaemia.

An unquantified but recently documented risk relates to caring for patients in impoverished homes; the care providers are almost always women. Male homosexual transmission occurs worldwide; but has declined significantly in developed countries where it was initially the major route of transmission. Transmission between lesbians has rarely been reported. This should not, however, encourage lesbianism.

In the absence of a vaccine so far against AIDS epidemic, the only viable way to control the epidemic could perhaps be its effective prevention and care for those who have already having this diseases and who are seropositive. As we all know, the disease devastates the immune system, in particular by destroying CD4 blood cells. When levels of these cells are extremely low, complications associated with AIDS like pneumocystis pneumonia and toxoplasmosis fatally overwhelm the victim's resistance.

A recent research by a Paris-based immunologist has, however, revealed that the AIDS-ravaged immune system, even late in the disease, can be significantly restored, if potent new antiviral drug combinations can diminish the viral load in the victim's body sufficiently and for long enough. What does Gender-based Response involve? According to the UNAIDS publication referred to above, gender refers to shared ideas and expectations about women and men; ideas about "typically" feminine and masculine characteristics and abilities and expectations about how women and men should behave in various situations.

These ideas and expectations are learned from families, friends, opinion leaders, religious and cultural institutions, schools, workplace and media. They reflect and influence the different roles, social status, economic and political power of women and men in society. As we all know, financial capability, status and power affect individual's risk of infection and ability to cope with the epidemic.

Low status and power of women lead to their subordination and restrict their possibilities of taking control of their lives in regard to HIV/AIDS. Societal tradition and norms and sexual behaviour of men also complicate the plight of the women. In a society like ours, economic dependency, traditional ideas and perceptions about men, make it difficult for women to demand men to share responsibility for preventing sexual and peri-natal transmission of HIV/AIDS including other STDs.

Why Gender-based Approach is needed to fight HIV/AIDS?

The answer is simple. Women are more vulnerable to AIDS epidemic. AIDS and other STDs affect them more. There are specific reasons for this. Physiological factor, wider social, cultural, sexual and economic vulnerability, inequity, lack of job opportunities, poor access to education and training, male dominance prevent women from actively making choices and decisions about their lives, particularly with regard to limiting sexual risks and protecting their and their families' health. Gender analysis and gender-based programmes can help women and men redefine their relationship and responsibility in a mutually beneficial way. As women has started to move into traditionally "male domains", men should be encourages to begin sharing responsibilities in the "female domain". This is perhaps also important even for men to break the bondage of social and cultural conventions that have in a way made women so-called subservient.

Bangladesh Scenario

According to Government statistics, the number of people with AIDS disease and other seropositive people is not alarming and comparatively much less than other neighbouring countries. We, however, have to accept the fact that because of inadequate diagnostic tools and equipment, organised screening mechanism, inadequate and delayed reporting, perhaps many people carrying HIV/AIDS are yet to be detected. We have also a tendency to say that our society is less vulnerable to AIDS because of our social taboo and values, religious belief and restraint in any moral wrong-doings. This is good. But excessive complacency may cost us darely.

The fact that we urgently need to find out the HIV/AIDS positive cases. This is very important for a densely, poor and less educated society like ours. Our society may prove much vulnerable than what we believe. There should not be any scope for complacency with regard to fighting against AIDS. According to latest WHO prediction, India may be the worst affected country in our region by AIDS in the near future unless the menace is checked adequately. It may have implications for the whole region. We need to have effective reporting and screening mechanism for detection of HIV/AIDS positive cases.

Mainstreaming gender perspective is a world concern. But, I believe, we are ahead of many countries in ensuring this in our activities and policies. For a least developed country, it is a great success. The examples of Bangladesh are cited in many international fora with regard to mainstreaming gender perspective. In order for living up to our promise made in Beijing at the Fourth World Conference on Women, Government has institutionalised a mechanism for mainstreaming women in development programmes in all our national plans and programmes.

The present Government has also adopted for the first time, the National Women's Development Policy aimed at equality, empowerment and advancement of women in all spheres of our national life. It is now acknowledged world wide that our society is gradually and steadily transforming towards democracy, modernity and pluralism ensuring gender perspective in all spheres of our lives. This is a very significant development in our time. Our national leaders, media, academia, intelligentsia, NGOs have been playing a catalytic role towards this direction. The outcome of our words and actions, our pledge and determination in this regard is reflected in our society. Today the participation of our women folk at all walks of lives including in the highest policy making level and body is significant. In some areas we have even surpassed many developed countries.

It is, however, equally true that alike around the world, our women are also more vulnerable to AIDS pandemic. We need to strengthen and ensure appropriate gender-based response in fighting AIDS. This gender-based approach should be adequately reflected in all programmes for controlling AIDS. We need an environment that can enable both women and men to protect themselves and each other. Their collaboration on an equal footing in providing care and support for those directly affected by the epidemic is also to be promoted. A supportive and enabling environment for effective prevention of AIDS and care for those carrying the disease is urgently needed. Our political, economic, social, legal structures should make provisions for women so as to enable them to benefit from these structures to the same extent as men.

Increasing girls' access to education and vocational training is an important element of a gender-based response. Likewise, decreasing women's economic dependence is also an important one in its own right to enable them to reduce infection risks for themselves and their families. We need to appropriately incorporate gender and women's concerns into our national responses. Effective mechanism has to be in place in order to create gender awareness. We also need to evaluate and re-evaluate policies and assess whether the existing policies and programmes are gender sensitive.

There should also be human side of the issue. People living with AIDS, their families should not face stigmatisation and discrimination. We need to fight against this discrimination as a public health strategy. Follow-up counselling and support need to be expanded for both men and women living with AIDS. Economic, Social and legal assistance should be made available for them. We also need to learn to live positively with HIV/AIDS. In a country like ours, people with AIDS are usually isolated and seen at a look-down upon view. The plight of women with AIDS are worst. We need to give a human and female face of the epidemic.

Our policy regarding control of AIDS should make special provisions for women. Women's organisations and NGOs should also play a role in providing enhanced support to women with AIDS. I believe there are already some organisations in this area doing a good job. We should bear in our mind that the objectives of programmes on AIDS control should be to minimise vulnerability to infection, reduce stigmatisation and discrimination and curb the socio-economic impact of the epidemic.

As it appears, these objectives can be better achieved through gender-based approach that promote sharing of responsibility for prevention and care by both men and women. These programmes should encourage social changes supportive of HIV/AIDS. We also need to clearly evolve both short term and long term strategies to fight against AIDS. Short term strategies may include wide dissemination of basic information on HIV/AIDS and its overall dangerous consequences in the society, access to sexual health education, acquiring condoms and obtaining back-up support for home-based care. Our religious leaders can perhaps also play an important role in fighting against AIDS.

On the other hand, long term strategies should focuss on the cultural and social structures encouraging shared decision-making power and shared responsibilities in all matters by men and women. In order to make a difference in this field, our efforts at the national level must, however, be innovative and have civil society and NGOs outreach. Success of our micro-credit programmes is an example in this respect. What is also important is commitment to mainstreaming a gender perspective by the highest political level in order to ensure its full and effective implementation.

We have a National Committee on AIDS headed by the Health Minister if I am not mistaken. There is a need for enhanced civil society and NGOs' involvement in this committee and in the campaign against AIDS. As we all know NGOs have been doing a good job in our country in mainstreaming gender perspective in development activities. Moreover, they are the organisations that can easily reach the target groups most vulnerable to AIDS epidemic. Their views should be incorporated in our national policy on AIDS control since they have field level experience in handling this issue including that in working for women with AIDS and with sex workers.

Our national AIDS control programmes needs to be strengthened. We should explore possibility of seeking international support for our AIDS control programmes. If approached, we may receive enhanced support from UNAIDS. We, however, need to assess our requirements first. Every year, a delegation headed by the Minister for Health and Family Welfare comprising delegate like Director-General of our Health Services participate in the Session of World Health Assembly (WHA) in Geneva. This year this session will be held in the third week of May. We should make full use of such a high level visit. A meeting between the Minister and the Executive Director of UNAIDS can be organised during the Minister's visit here. In this meeting, perhaps he can seek for enhanced support and assistance for our AIDS control programmes.

First and foremost, however, is that we have to work out detailed outlines of our national AIDS control programmes including the extent of assistance we need for these programmes from the international community. Unless we can present any concrete programmes and are sure of our need for assistance for them, a meeting of this kind would be of no use. The ball is clearly in our court. In order to avoid conceding further goals, we need to act. Our action must be prompt, well planned, and demand-driven.

Views expressed in this article do not reflect any government's position. The writer is Counsellor in the Bangladesh Permanent Mission, Geneva.

Indo-US Reconciliation Looks Possible

by C. Uday Bhaskar

India has been perceived by Washington to be the main transgressor in having tested first and the Pakistani response in Chagai is often interpreted as fait accompli — more so since Islamabad has steadfastly locked its entire nuclear posture and rationale to the India-factor.

THE visit of Strobe Talbott, the indefatigable U.S. Deputy Secretary of State, to the Indian subcontinent has been followed by cautious optimism all around over the nature of the high-level U.S. dialogue with its South Asian interlocutors on the contentious nuclear weapon issue.

The May 1998 nuclear tests by India and Pakistan were an unambiguous indication of the reality and credibility of their respective nuclear scabbards and it is nine months since the global community, led by the U.S., has attempted to grapple with this nuclear nettle. India has been perceived by Washington to be the main transgressor in having tested first and the Pakistani response in Chagai is often interpreted as *fait accompli* — more so since Islamabad has steadfastly locked its entire nuclear posture and rationale to the India-factor.

Yet the reason for cautious optimism stems from the distance that has been traversed since the invective and ire that the Clinton administration spewed against New Delhi in the wake of Pokhran-II, to the consensual nature of the joint statement issued at the conclusion of the Talbott visit.

The actual details of the talks between Talbott and External Affairs Minister Jaswant Singh remain within the envelope of 'quiet diplomacy' and the inferences have to be drawn from reading between the lines of the joint statements issued at the conclusion of the deliberations — which for the sake of the statistical record are the eighth round and represent the most sustained high-level dialogue between the U.S. and India since 1947.

Expressing satisfaction with the outcome of the talks, the joint statement noted that as with earlier meetings, "The security perspective of the two sides were further elaborated and clarified and proposals for harmonising these perspective were explored. The delegations believe progress was made in several of the subjects under discussion and remain committed to achieving more progressive to the weeks ahead."

If diplomacy is the art of reconciling the irreconcilable, the fine print of the joint statement in New Delhi is encouraging on other strands as well. General Joseph Ralston, the Pentagon representative in the delegation, had separate consultations with the Indian military top brass and the resumption of bilateral cooperation in some areas was mooted. Simultaneously, a road map for the coming months was agreed upon that includes joint consultations on export controls and multilateral initiatives under the umbrella of the Conference on Disarmament in Geneva, such as the fissile material cut-off treaty (FMCT).

The need for a ninth round was also envisaged and the cautious optimism one suggested at the outset was further reflected in the assertion that "It is the view of both delegations that this is time well spent, laying the foundation for a new, broad-based relationship that has eluded the United States and India in the past which both sides are determined to achieve in the future."

The estrangement between India and the U.S. — the world's largest and oldest democracies — for the last 50 years, due to their divergent world views and concomitant security perceptions, is familiar narrative. While the post-Cold War years offered an opportunity to recast the template, the techno-strategic compulsions of the late 20th century as evidenced in the weapons of mass destruction (WMD) acquisition and proliferation pattern introduced in inevitability that pitted the U.S. non-proliferation zealotry against India's determined quest to acquire a 'minimum credible deterrent' to assuage its own insecurity and bolster New Delhi's strategic autonomy.

One may infer that for the first time there is the beginning of some empathy on the U.S. side to tentatively acknowledge both the security compulsions and domestic political constraints that India is now addressing. For long it has been argued that while India and the U.S. have a number of affinities and common values, the highly desirable broad bandwidth that could underpin a mutually beneficial relationship remains elusive.

Instead, the entire relationship has been predicated and held hostage to the needle-point of nuclear non-proliferation versus disarmament. The commitment to lay a foundation for the next century that could realise this potential augurs well for this complex *pas de deux* that will call for considerable patience, and perhaps humour, in the months ahead.

The Islamabad talks also exuded a positive ambiance with certain nuances which predictably reflected the nature of the special relationship that Pakistan has had with the U.S. during the Cold War decades. While Talbott reiterated that there would be no dilution of the U.S. commitment to the Nuclear Non-Proliferation Treaty (NPT), he made what seems a significant observation about the determination "to find a way of managing our disagreement."

More so in the light of three "immutable, inescapable facts of life" after May 1998: Pakistan's decision to develop nuclear weapons and satellite missiles; the U.S. commitments to the NPT; and the mutual desire to restore the U.S.-Pakistan relationship to one of unfettered, unambiguous mutual respect and mutual benefit, which means, in the first instance, lifting of sanctions.

The prescription of signing the CTBT, commitment to the FMCT, export controls and strategic restraint as regards weapons of mass destruction deployment remains consistent in terms of U.S. benchmarks and would have to be dealt with in the negotiations ahead.

Thus, if the U.S. can find a *modus vivendi* with Pakistan despite the muddied narrative of that country's WMD acquisition pattern that also brings into play China's complicity and a breach of the NPT strictures, nuclear reconciliations with India ought to be less problematic provided the same political will permeates the U.S. stance.

India has to stay the course in urging its principal interlocutor to respect its determination not only to acquire what it deems to be a minimum deterrent but simultaneously recognise that the nuclear weapon has to harmonise with the politico-diplomatic and socio-economic determinants of the collective Indian endeavour.

The India-U.S. dialogue is to an extent a manifestation of the adage that democracies, like porcupines, have to get to know each other very slowly and the process may have just started. India is undeniably the subaltern state in an unequal situation and if New Delhi's responses must be guided by pragmatic, yet principled, nationalism, Washington's WMD management skills must be animated by prudent and equitable globalism. — IANS

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In Baghdad Today

Images to Haunt for All Time

The Pentagon says that its almost daily bombing raids on Iraq since mid-January have caused more damage than the four-day Operation Desert Fox blitz in December. Yet media attention has dwindled to a trickle. In this moving report, a Gemini News Service correspondent, Felicity Arbuthnot, writes on the human cost.

Iraqi suffering: Special report

Gemini News Service correspondent FELICITY ARBUTHNOT reports from Baghdad and Basra on the health problems of Iraqis, who face daily bombing raids and the debilitating effects of nearly nine years of sanctions.

"Death stalks Iraq's children from the moment of birth ... One doctor compares the congenital abnormalities, cancers and malignancies since the Gulf War to Hiroshima"

IRAQ, embargoed since August 1990, has been called by many commentators a vast con-centration camp. A vast death camp seems more appropriate. Images of Baghdad today haunt for all time.

"We have a new phenomenon," remarked one doctor. "People are just dying. They are not ill. They just give up — especially young men between the ages of about 30 to 35.

"Their youth has been sacrificed to the embargo and they see middle age approaching with no hope dreams, no aspirations or ability to provide for those they love."

From Jordan, I telephoned Mustafa, an old friend and gentle academic, whose childlike joy of life illuminated every experience.

During the December bombing his voice had broken as he described the destruction of some of the most ancient buildings — World Heritage sites — in his beloved Baghdad. Mustafa always celebrated my arrival with an aubergine dish to dream of.

Surprisingly the call connected immediately: "I'm on my way, get the aubergine ready ...." There was a silence, then his daughter Doha, said: "We have had a catastrophe, Mustafa is dead."

He had died five minutes earlier. A month before he had undergone a full medical and had been told he had "the heart of a lion.

"He was haunted by the thought we would be bombed again after Ramadan and he had no way to protect us," said Nasra, his wife. He died on 17 January, the anniversary of the start of the Gulf War.

I travelled to Baghdad for the mourning, a four-day grieving of an intensity defying description. When Nasra — feisty, gutsy, witty, beautiful and beloved friend — entered, she was unrecognisable, bent double, unable to walk without support, wracked by the unimaginable; the weight of grief encapsulated.

It is killing us all, one by one," she gasped. "We lost five friends this year." All were under 40, all had "just died."

I heard haunting human tales of the bombing. "We had seven children in our house during the bombing, the youngest six months, the oldest seven years," said Jameel. Their terror was such that when the bombs stopped, we were left in the dark (the electricity sub-station was reportedly hit again) with great pools of urine and faeces."

At the Saddam Paediatric Hospital, three-year-old Sahara was dying. She had acute myeloid leukemia and was bleeding internally from the nose and gums. She needed 10 to 15 units of platelets a day — the doctors could obtain just one.

"In the UK and US leukemia is a treatable disease, yet due to lack of chemotherapy we have not achieved one cure — only some remissions — in the last eight years," said Dr. Rad Aljanabi, chief resident. "In '94 and '96, we had no treatment at all, so every single patient died."

Iraq's cancer, leukemia and malignancy rates have risen by as much as 70 per cent since the Gulf War. The increase is associated with the depleted uranium weapon used primarily by the US and the UK, which left a residue of radioactive dust thoughout the country.

According to studies — including work by Johns Hopkins University in the US — the residue has entered the food chain via the water table and soil.

Leukemia was a rarity before 1991. "This is my first residency and I saw 39 new cases in three months," said one doctor." I admitted eight last month, I remember all their names. We are suffering — I cry so often."

There were other horrors. Five-year-old Heider Latif, weighing just 13 kg. Starvation, multiple congenital abnormalities, cancers, heart defects, leprosy waterborne, diseases. Death stalks Iraq's children from the moment of birth.

In the beautiful, relentlessly bombarded southern city of Basra where the biblical Tigris and Euphrates rivers meet, the state of health takes on another dimension. One doctor has completed a thesis comparing the congenital abnormalities, cancers and malignancies since the Gulf War with Hiroshima.

Dr. Jenan Ali, a world-renowned surgeon trained in Glasgow, has been keeping a record of "mysterious" congenital abnormalities. He photographs for 1998 are chilling: full-terms babies undeveloped, babies reminiscent of those born in the nuclear testing areas of the South Pacific, a baby with no face, another with no eyes, twisted limbs, or no limbs, tiny mite with huge head and no brain. Page after page of tragedy. "All young parents with no history of abnormalities in the family as far as we can tell, since we have few laboratory facilities now."

Jenan said she believes many of the cases are "not recorded in textbooks, but we cannot be sure since we haven't had textbooks since 1990." Textbooks and medical journals are vetoed by the UN sanctions committee.

"I can show you a baby born one hour ago if you are strong and not prone to fainting" said Jenan. A nurse brought in a small bundle in sterile wrappings (baby clothing is just a memory in this formerly internationally renowned hospital).

The tiny being making little bleating noises had no eyes, no nose, a sweet little mouth, but no tongue or esophagus, no hands or genitalia. Hopelessly twisted small legs were joined together from the knees upwards by a thick "web" of flesh. "We see many similar," commented Jenan.

"My colleague delivered the baby you saw," said midwife Bushra Nasser in the maternity unit. "I am frightened of what I may deliver." With no ultrasound or scanning facilities — also banned under sanctions — nothing is known until birth.

When mothers ask: Is it all right?" there is terror in the question. Some soil samples in areas of Basra show 84 times background radiation from uranium elements.

One in four babies is born prematurely and underweight, due to malnutrition or environmental factors. No oxygen incubators work at optimum capacity, there is not rehydration, no gastro-nasal nutrition.

As we stood in the premature unit, containing 17 babies, the doctor remarked: "We have not had one premature weight birth survive since 1994."

I looked round the ward at each small life, at twins sharing an incubator, noted each face and tiny form. Each is by now almost certainly another statistic in embargo-related deaths.

The baby we watched born was a healthy eight pounds, but the odds were stacked against him. Cockroaches crawled over the metal of the delivery bed. Electricity and hot water is off 18 hours a day. Disinfectant is vetoed by sanctions.

A doctor ran to us, saying: "Do any of you have O-negative blood?" A newly born baby, bright yellow, with acute jaundice would die without an exchange transfusion. There was no blood. I thought I might have the right blood type, but was unsure.

"Test me," I said. There were no laboratory facilities to do so.

A 23-day old baby died two minutes before we reached the ward. His mother had run, inconsolable, screaming from the hospital. The grandmother, upright, proud, Shia, in her black abaya, stood by his cot, tears streaming down her face, as I vainly stroked his small perfect head and face, so warm, feeling somehow he could be brought back. All he had needed was oxygen. There was none.

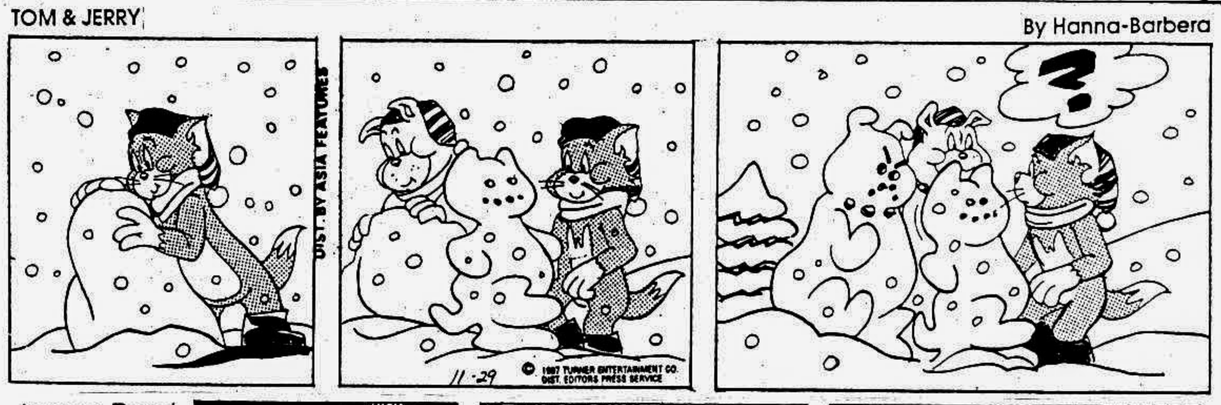
"You have seen the state of our hospitals, what will we do if they bomb again?" asked Jenan. I said it was impossible to believe it could happen.

We left Basra and returned to Baghdad. The following morning Basra was bombed.

The writer is a journalist specialising in social and environmental affairs with a special interest in Iraq. She was nominated for last year's Lorenzo Natali award for human rights journalism.

TOM & JERRY

By Hanna-Barbera



James Bond

BY IAN FLEMING

DRAWING BY HORAK