Introduction

The world of HIV/AIDS is riddled with complexities. In the industrialised world, the discovery of and reasonable access to powerful anti-retroviral drugs have caused death rates due to AIDS to plummet, and opened up newer and greener vistas for people living with HIV/AIDS. The same discovery for our partners living with HIV/AIDS in the developing countries has been rather agonising. 'It is like seeing food when you are starving but you cannot eat it.' The drugs are astronomically expensive. The Health Minister of Uganda recently explained to the global community in the United Nations Security Council that providing these drugs to Uganda's two million people living with HIV/AIDS would cost 12 times the nation's annual budget.

The fight over drugs called anti-retroviral has generated a lot of publicity. Pharmaceutical companies like Glaxo and Bristol-Myers Squibb are under fire by activists. Though the development of some of these drugs was funded through public money by some governments, the pharmaceutical companies are today arguing that since they purchased the patents from the governments and invested heavily in clinical trials, it is they who should rightly control the price of the drugs, and all the more so as the profits feed new research.

But as these controversies rage, men and women are coping with some basic structural lacunae as they live with HIV/AIDS. With hospitals running at 170 per cent of their capacity, they are limiting the stay of their patients to two days only. Poverty stricken patients are opting to be dis-

charged as they near death because it is cheaper to transport a person when he/she is alive than it is to transport a dead body. A study in Zambia has recently pointed out that when a patient dies, the family mourns not only the loved one but also the end of food aid.

Men and women in large families living in crowded slums are struggling with the issues of minimum private space to be able to use a condom to have safe sex. Young girls have little or no option to guard their reproductive tracts from sexually transmitted diseases (STDs) with no water available to keep their genitals clean during menstruation. Malnourished and anaemic pregnant women are facing the risks of receiving a transfusion of unsafe blood every time they conceive, deliver or abort a baby. The concepts of patriarchy and masculinity remain entrenched in societies, and women and womanhood continue to be perceived as symbols of and providers of sexual gratification and emotional domination.

Development agencies have been working for decades on issues relating to poverty eradication; the concept of poverty has been redefined by the Human Development Report to include broader parameters of knowledge, longevity and access to basic resources. Issues of access to shelter, housing, water sanitation, food and education have been highlighted, critiqued and ostensibly addressed in global conferences. The international human rights instruments have been orchestrated, signed and ratified through intergovernmental processes. Yet, as newer challenges like that of HIV/AIDS appear on the horizon, these basic dilemmas of access and control; of equity and distribution; of power and power relations continue to plague the survival of men and women on this planet.

It is in this state of strange paradoxes that UNIFEM and UNAIDS have been trying to improvise ways and means to prevent the spread of the epidemic and minimise the negative effects on men and women. Arising out of a need expressed by the women's movement, UNIFEM has been a barometer for the emerging needs of women in various parts of the

world. And as the HIV/AIDS epidemic matures, UNIFEM has been recording the impact of this emerging development challenge on women. In the early 1990s, the epidemic was compartmentalising women into 'good' and 'bad' because of a wave of anti-AIDS messages that portrayed women as vectors of the disease. By the mid-1990s, the virus was affecting the lives of the 'good' women – women who had had only one sexual partner in their entire lives.

Data from Mexico indicate that by the mid-1990s, only 0.8 per cent of all reported AIDS cases were among sex workers, but 9 per cent were among housewives. By December 1997, in Francistown, Botswana, 43 per cent of pregnant women were testing positive in a major surveillance exercise. During the same period, UNAIDS had declared that heterosexual intercourse was accounting for 70 per cent of all global adult infections.

For UNIFEM, the challenge was further exacerbated by the figures put out by the World Health Organization (WHO) on sexually transmitted diseases in 1995. Increase in STD cases indicated an increase in unsafe sex. WHO had estimated that in 1995 there were 333 million cases of STDs, of which 65 million were in sub-Saharan Africa and 150 million were in south and south-east Asia. The presence of STDs increases the risk of HIV transmission five-fold. With a macro scenario boding a blow to the wellbeing of men and women, the information from the field was equally disturbing.

In some villages of Uganda, focus group discussions revealed that not a single woman had seen a condom. A behavioural survey in Tamil Nadu in India showed that 82 per cent of the male STD patients had had sexual intercourse with multiple partners within the preceding 12 months and only 12 per cent had used a condom. Data from the same country revealed that 90 per cent of the male clients of male sex workers were married. In South Africa 71 per cent of the girls had experienced sex against their will.

With this as the backdrop, and in response to the needs of women, UNIFEM launched a pilot initiative entitled 'Gender Focussed Responses to Address the Challenges of HIV/AIDS'. Partnering this effort were the United Nations Population Fund and the United Nations Joint and Co-sponsored Programme on HIV/AIDS. The aim was to co-ordinate the women's movement in a number of countries, thereby strengthening and expanding the response to the epidemic. The violence campaign launched by UNIFEM during the fiftieth anniversary of the Universal Declaration of Human Rights in 1998 became the entry point to the effort. Kraus, Goldamt and Bula in their analysis entitled 'Partner Violence in Joint HIV and Substance Abuse' had highlighted that 96 per cent of the women living with HIV/AIDS had experienced violence. At the same time, information was forthcoming from Rwanda where the HIV/AIDS virus was being used as a weapon of war, ensuring that large numbers of women would die of sadness.

During the following 18 months, a series of workshops on gender, HIV and human rights was conducted in 9 countries over three geographical regions aimed at enhancing understanding of the gender dimensions of the epidemic. A number of community-based studies on gender and HIV/AIDS were commissioned to capture the voices of women infected and affected by the mutating virus, and to provide a safe and credible space for these women within decision-making processes at the national level.

Education and communication strategies on the epidemic were undertaken with a new spirit of understanding, based on real life situations rather than on value-loaded judgements on people's sexual behaviour. A spirit of inclusion involving those affected by the virus was fostered to reduce the stigma associated with the disease. Myths and rituals around sexuality were explored, visited, revisited and understood as the organisation adjusted its approaches from being a learning organisation before it could become a knowledge provider.

And as we explored and sought information, a key issue that kept arising was that if sexuality and gender, the two most insidious forms of oppression against women, were at the core of the epidemic, what could be done to reduce women's susceptibility to HIV/AIDS? How could men be engaged in efforts that would reduce these vulnerabilities? How could paradigms be transformed to capture new and emerging controversies?

The chapters that follow detail the mysteries that were unravelled in the area of human sexuality and its interface with gender relations and other power structures. The discussions also highlight the strengths and weaknesses of existing policy and programme frameworks that have been set up to respond to the challenges being posed by HIV/AIDS. Personal anecdotes, observations by real people, empirical data, both community-based and at the macro level, have been used to present the truth, the core issues of unfathomable tragedies and emerging hopes of men and women living with the virus – the virus that is causing AIDS.