Part 6

Gender Issues in Health, HIV/AIDS and STIs

HIV prevention poster campaign: 'AIDS can get you totally wasted'

The National HIV/AIDS Control Programme 6.1

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Health is increasingly being seen as one of the cornerstones and prerequisites of economic growth and development. As the saying goes 'Health may not be everything, but without health there is nothing'. The health status of the population has a prominent place in the cycle of poverty and degradation that characterises Sierra Leone a decade after the war began. This cycle can only be broken if people can achieve and maintain a satisfactory level of health that will permit them to lead economically productive lives.

With regard to sexually transmitted infections (STIs), as the name implies, they are transmitted principally through sexual intercourse, that is, hetero- as well as homosexual; some can also be transmitted through blood and blood products. These include common infections like gonorrhoea and syphilis. AIDS (Acquired Immune Deficiency Syndrome) is caused by the HIV (Human Immune Deficiency Virus), which attacks and, over time, destroys the body's immune system. To reproduce, HIV must enter a body cell, which in this case is an immune cell. By interfering with the cells that protect us against infections, HIV leaves the body poorly protected against the particular types of infections that these cells normally deal with. On destruction of the immune system, the human body becomes incapable of defending itself from various diseases that are named 'opportunistic infections', many of which, like common influenza and TB, affect the lungs; they also include other sexually transmitted infections like herpes.

Since it was first diagnosed in the United States, HIV/AIDS has gradually spread worldwide. This pandemic is undoubtedly proving to be the most important threat to health and development, especially in Sub-Saharan Africa, where it continues to spread like wildfire. To date, the causes for the emergence and spread of this infection are still contentious, and form the basis of numerous heated debates. What we have to contend with is an extremely serious, escalating problem that needs to be urgently addressed to prevent catastrophic consequences.

When it was initially recognised, HIV/AIDS was considered a health problem principally; this is not the case anymore. It is now considered one of the most complex development problems caused by health, socio-cultural and economic factors, all of which fuel the spread of the disease and lead to adverse impacts on individuals,

communities and nations. To date, there is no known cure for HIV/AIDS; the very limited drugs, which could prolong patients' lives, are very expensive, and limited largely to the developed countries of the world. There have been some recent changes in this situation, with concrete steps being taken to make these drugs more readily affordable for poor, developing countries, including Sierra Leone. We are presently in the process of negotiating with Boehringer Ingelheim—a well-known pharmaceutical company that has committed itself to providing us with free anti-retroviral drugs that prevent mother-to-child transmission and with other drugs at reduced cost. At the sub-regional level, ministers from the Economic Community of West African States (ECOWAS) met with pharmaceutical companies at the 2001 summit on HIV/AIDS, tuberculosis and other infectious diseases and at the 54th World Health Assembly in Geneva, to work out a common strategy on drugs for HIV/AIDS.

In Sierra Leone the first cases of the disease were reported in 1987, diagnosed in the Southern (Bo) and Eastern (Kenema) provinces. Since then, numerous efforts have been made to determine the magnitude of the HIV/AIDS situation in Sierra Leone. Many of these studies have been restricted in geographic coverage and extent, and different groups have hotly contested the inconclusive results. One striking pattern that is agreed by all is that there is a gradual increase in the prevalence of the disease. Indeed, many of the predisposing factors for this already exist. These include the breakdown in civil society as a result of the war, massive population displacements with attendant losses in livelihoods and shelter, increase in prostitution (also amongst males), homosexuality, intravenous drug abuse, and the presence of peacekeeping troops from many countries where the problem is much more pronounced from the epidemiological as well as socio-economic points of view.

In the early 1980s, HIV/AIDS was considered primarily a health problem—consequently solutions were sought in the health sector. With support from the World Health Organisation (WHO) and other UN agencies and organisations, the Sierra Leone Ministry of Health established a National AIDS Control Program with offices at Connaught Hospital. This was considered the principal structure charged with the responsibility of controlling this emerging scourge. As the problem escalated, other adverse development-related consequences of the disease became more apparent. The realisation dawned that if the scourge is to be contained, the determinants that lie outside the health sector, especially the socio-economic causes and effects, must be addressed.

Currently, the World Bank, in partnership with UNAIDS, other agencies and partners, is spearheading the development of a multi-sector response to the emerging HIV/AIDS epidemic in Sierra Leone through the formulation of the Sierra Leone HIV/AIDS Multi-Sector Project (SHARP). This is to be a country programme within the context of the US$500 million Multi-Country HIV/AIDS Program for the African Region (MAP),

which was approved by the Board of the World Bank in September 2000. This project will help to organise the response against the emerging HIV/AIDS epidemic, as well as against sexually transmitted diseases and tuberculosis, which are important risk co-factors in the early stages of the epidemic. This is to be achieved through a multi-sector approach by:

- containing or reducing the level of the epidemic;
- mitigating its effects;
- increasing access to prevention services as well as care and support for those infected and affected by HIV/AIDS.

The emphasis of the project will be on prevention among youth and women of child-bearing age, groups that are particularly vulnerable to HIV/AIDS and that represent a large segment of the Sierra Leonean population. The intention is also to address the military and ex-combatants.

This contribution from the World Bank and other above-mentioned partners is not intended to replace, but to supplement existing, planned, or proposed activities of others. The proposed four components of SHARP are:

1. Capacity Building and Policy Development

This will enhance the institutional capacity to develop and implement a coordinated, multi-sectoral prevention and care HIV/AIDS campaign based on a national strategy and action plan. It will support the assessment, restructuring and strengthening of the National HIV/AIDS Council and Secretariat for coordination and administration; assist in the development of a National HIV/AIDS Strategy and Action Plan; provide advocacy training and technical support activities; and support monitoring and evaluation.

2. Multi-Sectoral Responses for HIV/AIDS Prevention and Care

This will support key line ministries in developing their plans and implementing HIV/AIDS-related activities for their staff and for their client groups, with respect to HIV/AIDS prevention and care, including support for people living with HIV/AIDS and their dependants.

3. Health Sector Responses

These will improve Ministry of Health and Sanitation (MOHS) health services related to HIV/AIDS/STIs, including management protocols, training, testing, counselling, HIV/AIDS patient care, and related improvements in delivering services. Other specific interventions will include capacity-building of staff, procurement of condoms, refinement of National Health Action Plan in relationship to HIV/AIDS and STIs, and

support to the development of guidelines and the strengthening of health infrastructure to make the use of anti-retroviral therapy safe, effective and sustainable.

4. Community and Civil Society Initiatives

These will support community-based initiatives proposed by civil society organisations and other groups for HIV/AIDS prevention, as well as care and support of people living with HIV/AIDS and their dependants. Emphasis will be on Information, Education and Communication and Behaviour Change Communications (IEC/BCC) campaigns; support to high-risk groups and vulnerable groups subject to sexual abuse; youth-related activities, and income-generating activities for People Living with HIV/AIDS and other dependants. It is expected that over 50 per cent of SHARP resources will be allocated for these activities, highlighting the importance of this component.

To date, implementation arrangements for the proposed National AIDS Control Programme include the establishment of the following structures:

- National HIV/AIDS Council (NAC) with the President as Chairman. Council members will be representatives of civil society and the government in equal numbers. The composition includes ministers, NGOs, civil society, the private sector, representatives of religious, women's, and youth groups, as well as people living with HIV/AIDS. Duties of the NAC will include overall responsibility for SHARP and the National HIV/AIDS Strategy and Plan of Action, defining broad proprieties of action for the SHARP, and monitoring both the performance of the SHARP, as well as national performance in responding to the HIV/AIDS epidemic, including that of the health sector.
- National HIV/AIDS Secretariat will have dual responsibilities in that it will both serve as the NAC Secretariat, but also be responsible for SHARP multi-sector activities including planning, coordinating, monitoring and evaluation, and research. It will be headed by a director who will report to the National HIV/AIDS Council. It will be administratively supported by the overall coordinating ministry, that is, the Ministry of Development and Economic Planning, and would not be an implementing agency.
- The National HIV/AIDS Control Program will continue to work under the Ministry of Health and Sanitation; principally, it will carry out testing, HIV/AIDS/STIs management, and patient care.
- HIV/AIDS Committees will be established in each district as the country situation warrants. Members of these committees will include representatives of NGOs/CBOs (Community-Based Organisations), representatives of principal line ministries, religious groups, women and youth, and people living with HIV/AIDS.

The chairpersons will be selected from among the members for a one-year period, on a rotational basis.

In addition to the aforementioned, in 2001 the cabinet established a sub-committee on HIV/AIDS to support national policy formulation.

The World Bank fielded an Identification Mission from 3 to 18 May 2001 headed by a lead specialist with experience in the formulation of HIV/AIDS Control Programmes in The Gambia and other Sub-Saharan African countries. The purpose of this mission was to explain the MAP process and structure, to work with Sierra Leonean counterparts in gathering baseline information, developing the project design objectives, prioritising proposed activities, formulating the financial and procurement architecture, the monitoring and evaluation systems, and to identify what further work needs to be done to adequately prepare the project. Workshops were held with line ministries to reinforce the partnership nature of the process, as well as to provide guidelines for the preparation of line ministry project plans.

Conclusion

Whilst the current rate of HIV/AIDS infection is unknown, it is certain that, if unchecked, the continued spread of the disease will dramatically alter the country's prospects for post-conflict recovery and development. It will slow economic growth, act as a further disincentive for foreign investment, further weaken the already fragile human resource base, intensify poverty and inequality, place an enormous additional burden on the government's health budget, reduce life expectancy even further, and leave the next generation of Sierra Leoneans more vulnerable to the epidemic and with less hope for the future.

HIV/AIDS is not just a health problem, but one that cuts across almost all sectors, and is a major link in the poverty cycle. This link, in conjunction with numerous others, must be broken if Sierra Leone is to survive and develop. This can only be achieved through the formulation of a multi-sectoral policy, with relevant strategies and activities, effectively coordinated and implemented. Let us all join hands in concerted efforts to control this scourge, and thereby contribute meaningfully towards achieving our overall goal of a speedy post-conflict reconstruction and development of Sierra Leone.

Inmates of Kissy Mental Hospital

HIV/AIDS: A Strategy for Sierra Leone

6.2

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HIV/AIDS has become one of the greatest health problems in the world. Although originally identified among gay communities in the USA and some rural communities in East Africa, the transmission routes of HIV have made it a cause of global concern. It has spread to virtually all countries in the world within 20 years of its identification, in varying degrees of prevalence. At the end of 1999, there were an estimated 33.6 million adults and children living with AIDS.

No cure has yet been found for HIV/AIDS, although the transmission routes are well known. This in itself could have been a means of controlling the virus. Unfortunately, however, AIDS is not only a medical condition, but also a social problem and can be compounded or contained by social factors and attitudinal patterns.

According to statistics published by WHO for 1999, the cases of new infections in developed countries has decreased, whereas the opposite seems to be happening in the developing countries, especially in Sub-Saharan Africa. Out of a total of 5.6 million new infections in 1999, 3.8 million were from Sub-Saharan Africa, that is, about 68 per cent. In the developed countries, it is also observed that new infections are higher among minority-disadvantaged groups such as Hispanics and African-Americans. This lends credence to the social and attitudinal patterns of AIDS.

Sierra Leone, by virtue of its location in Sub-Saharan Africa, is in an HIV/AIDS zone. The prevalence of the virus in the country cannot be adequately assessed because of lack of laboratory and other associated facilities to carry out regular surveillance among selected groups. The indicators from available statistics, however, suggest that we are heading for a problem. According to figures culled from one of the local tabloids in 2001, the Deputy National AIDS Control Programme Manager stated at a workshop for health personnel, organised by the Sierra Leone Medical and Dental Association, that over 1,700 cases have so far been diagnosed. In addition, the figures for service personnel, which will be discussed later, were alarmingly high.

The poor social and health conditions in the country create an environment conducive to the spread of the virus. These are greatly assisted by social norms and traditions that encourage multiple sexual partners, promiscuity in both sexes, low status of women and

violence against women. The aforementioned in turn lead to a syndrome of women's dependency on men, and reduce women's ability to control their lives, including their sexual wellbeing.

HIV has far greater implications for women, as the biological and social status of women make them more vulnerable to the infection and its consequences. Women are more likely to contract HIV from an infected male partner than vice versa. The likelihood of cuts and abrasions due to sex, which provide access for the virus, is greater in women than in men. Women are also more likely to need blood transfusions and therefore are at greater risk of exposure to contaminated blood. In addition they are burdened with the task of looking after sick family members.

HIV/AIDS is not the major cause of death in many countries including Sierra Leone. There are many other diseases such as malaria, tuberculosis, diarrhoea and meningitis, to name a few, that continue to claim lives at an alarming rate. The importance of these diseases is in no way minimised by the attention that is being given to HIV/AIDS and in relation to it, sexually transmitted infections (STIs). AIDS is being given special attention for a variety of reasons.

It is a hidden disease that affects an individual long before it becomes visible. During this invisible stage, the individual appears healthy but can spread the disease through the normal and sometimes essential processes of everyday life: sexual intercourse, blood transfusions, through the placenta of a mother to the unborn baby, in breast milk, and so on. In fact, the natural means of human procreation is the most common mode of HIV transmission, that is, sexual transmission. In Sierra Leone, this accounts for almost 100 per cent of the diagnosed HIV cases.

AIDS becomes visible, in the majority of cases, when the HIV virus has already been passed on to the vulnerable persons associated with the infected individual. These include the sexual partners, the carers, the unsuspecting health worker who does not observe the highest clinical standards or who does not possess the required protective clothing, and persons who share blood-letting instruments, to name a few. In effect it is those who are closest to the infected individual who run the risk of infection. This has made HIV/AIDS all the more painful and caused to some extent the stigma and fear that is associated with the condition.

The epidemiology of AIDS shows an initial low prevalence with the attendant factors of denial or inadequate responses from the relevant authorities, leading to a pandemic some 10 years later.

In Botswana, the prevalence among pregnant women rose from 8 per cent in 1991 to about 35 per cent in 1993[1] In South Africa, 1 in 5 persons is estimated to be infected with HIV. In Sierra Leone, sentinel serosurveillance among pregnant women in antenatal clinics showed an increase in prevalence of 6.8 per cent over a period of 8 years between 1989 and 1997. This increase is highly significant and reflective of the potential of the virus to spread at an alarming rate in the country. The diagnosis of a single HIV case should therefore be a cause for general alarm, as experiences from most countries show that AIDS has the potential of exploding in a population within a relatively short period of time.

In some African countries like Côte d'Ivoire, Zaire and Uganda, AIDS has now become the leading cause of death among the adult population. Levels of HIV infection are even higher in Botswana.[2]

The potential of AIDS to spread at such an alarming rate among the sexually active population of a country has grave consequences for its development. It can cause a whole generation to be wiped out, as is happening in Uganda and Botswana. The generation is usually the most productive in terms of age and work. The country then faces serious manpower shortages as the skilled and trained personnel die away leaving a gap of a whole generation before they can be replaced.

The social consequences of this scenario are just as grave. As this generation passes away, it leaves behind the young and the old, the two categories of people that need to be cared for. Grandparents are put in the situation where they are the only ones left to care for their grandchildren and, in badly hit areas like Uganda, where there is a large population of AIDS orphans, there can be found many child-headed households.

HIV/AIDS has also brought a new dimension to sexually transmitted infections, the majority of which could be successfully treated with antibiotics. In addition to AIDS being primarily a sexually transmitted disease itself, the presence of other STIs, such as gonorrhoea, chlamydia, syphilis, chancroid, and trichomoniasis, increases a person's vulnerability to HIV about three to four fold; and, unlike other STIs, HIV has no cure

In Sierra Leone, the prevalence of STIs is speculated to be high. In a study done by Dr Euphemia Gooding over 20 years ago, in one of our tertiary institutions, the ratio of students suffering from some form of STI was 2:3. The current sexual attitudes and practices of students in higher institutions may indicate that the ratio still holds true. Dr Arthur Williams, speaking at a media press conference organised by PPASL in October 2000, estimated that 5 to10 per cent of all hospital attendances were as a result of STIs.

PPASL, in their report on a baseline study carried out in the Western Area, Bo, Kenema and Port Loko, reported that 25.9 per cent of their total sub-sample of sexually active youths in the project sites had had at least one incident of STI and 12.3 per cent in the 6-month period ending September 1999. Figures from Marie Stopes, a reproductive health clinic, reported far lower figures: 6 per cent of their total client population in 1998 and 2 per cent in 1999. It was stated, however, that the vulnerable groups do not turn up for treatment, viz. sexually active teenage girls, women with several sexual partners, commercial sex workers and local migrant workers.

The consequences of STIs, if untreated, are serious. In women it could cause chronic abdominal pain, infertility, ectopic pregnancy, spontaneous abortion and its sequel, congenital abnormalities, cervical cancer, anal cancer and kaposis sarcoma, as in AIDS. Men could also suffer from urethral stricture and infertility (in cases of chlamydia and gonorrhoea).

STIs have far greater implications for women than men. The symptoms may be more bearable for them and less obvious. As a result, they may be less likely to present themselves for treatment, leading to the long-term consequences just mentioned.

STIs are not a health condition exclusive to developing countries. Many developed countries, however, have facilities and resources to deal with them. The health care facilities in many developing countries is not sufficiently developed to provide all that it takes to successfully control STIs. In Sierra Leone, reproductive health facilities are found in the major towns, provided by the government and international and local NGOs. Villages and remote areas do not have access to these services.

The control of STIs entails more than the provision of health care facilities. The drugs for STIs can be expensive and therefore out of the reach of most Sierra Leoneans. Treatment for most people is therefore not complete, and the infection may recur in a more virulent form. To control STIs effectively the treatment and drugs must be made accessible to all. This means that health care workers in remote areas must be trained to diagnose and treat STIs in the early stages. This training must take cognisance of the attitude people have to STIs. Many tend to cloud their condition under other ailments, and unless the health care workers ask probing questions, they may never really get to the crux of the problem. The communication skills of health workers are therefore just as important as their medical knowledge. Referral centres need to be provided within reasonable distances for chronic cases.

The public also needs to be educated about the dangers of STIs. At present, many people shy away from presenting themselves for treatment. Some consider STIs a normal part

of growing up, especially men, and do not give it the necessary attention. They resort to self-medication and therefore incomplete or inappropriate treatment. The symptoms may go away but the infection persists and also the possibility of infecting others.

The control of STIs is dependent on partner notification. Many people find it hard to communicate to their partner the fact that they may be infected with an STI, including HIV. This could be due to the fact that they have multiple partners or to the fear of the stigma associated with STIs, including AIDS. Also, in many of our local cultures sexual matters are not a topic for discussion between sexual partners. Men and women discuss such matters among their own sexes. Greater emphasis has to be put on sensitising people to discuss sex-related problems with their sexual partners and to have a more positive attitude to infected people.

The present attempts at sensitisation should be geared to all categories of persons. The prevalence of STIs and HIV in Sierra Leone is not restricted to a certain class of people. In a pilot study conducted by the Society for Women and AIDS in Africa–Sierra Leone branch, in collaboration with Marie Stopes on a sample of commercial sex workers, the prevalence of STIs was found to be low. Many of the commercial sex workers were found to be suffering from ailments related to unclean social conditions such as scabies, and malaria, and only 12 per cent had any signs of an STI. The incidence of STI is, however, high in the country. It appears, therefore, that other classes of persons may be more vulnerable, such as students of tertiary institutions, married persons who consider themselves not be at risk and so on. More research needs to be done by medical personnel to ascertain which are the vulnerable groups.

At present, as a result of misconceptions as to who is most vulnerable, emphasis is being put on the wrong categories of persons.

Present IEC campaigns, especially jingles and posters, do not appear to be properly screened or tested. Many contain incomplete and therefore wrong messages, which could be dangerous. HIV/AIDS is such a serious issue that misleading information that might affect people's perception of their risks should not be allowed.

IEC campaigns should be tested to ensure that they reach the target groups. Many women in rural as well as urban areas do not have access to or make use of modern communication methods such as television, radio or print media. Channels used by these women for communicating, especially information on health and sexual matters, should be used to target them with this important information.

The current civil war, which has plagued us for over 10 years, has also added its own dimension to the problem of STIs including AIDS. Not only has the war seen to the

destruction of many of the health facilities, it has also increased considerably women's vulnerability to STIs.

The war has been characterised by many instances of physical and sexual abuse on women, leading to forced pregnancies, transmission of sexually transmitted infections including HIV/AIDS, and extreme mental torture. In the Forum of African Women Educationalists (FAWE) programme for rape victims, initiated after the 6 January 1999 invasion of Freetown, 2,350 victims were treated between March 1999 and March 2000. Of these 2,085 were between the ages of 0 and 26 years and 165 were over 27 years of age. They came forward for treatment after a sustained sensitisation programme over the radio. Many others have not reported or presented themselves for treatment.

Another serious stumbling block to STI control is the inability of women to control their sexual health. Many, even when aware of their vulnerability to risks, are incapable of doing anything about it. Many women depend on men for their sustenance in exchange for sexual favours. In such unequal relationships they cannot negotiate for safer sex.

Commercial sex workers also report that local persons are willing to pay a higher price for sex without condoms than sex with condoms. The belief is also rife among some men that have never even used condoms, that they reduce their sensitivity.

Men's greater power and influence in all strata of society has reinforced a belief in the inferiority of women. Consequently, even in the struggle for development, many women in high positions barter sexual favours for opportunities, which should otherwise be open to them unconditionally. They increase their vulnerability to STIs, including AIDS, and reinforce male superiority, making it difficult for the cycle to be broken. This cycle puts both men and women at risk, because in sexual relations between such categories of persons, the issue of safer sex is usually far from the agenda, and may even be cause for embarrassment.

Many of our customary laws make it difficult for women to negotiate for safer sex or control their sexual health. In Mende customary law, for example, a man can divorce his wife if she is found to be suffering from an STI. In the case of the reverse, however, the woman cannot divorce the man and is expected to look after him, including providing sexual services. Wife inheritance is also a common practice in our rural communities. The wife is a chattel of the husband, and therefore cannot legally inherit from him. She has to depend on the generosity of the family, which normally means marriage to one of them. This carries risks for STIs, including AIDS.

AIDS should force us to reconsider some of our customs. Women suffering from STIs will usually not disclose their status for fear of the legal repercussions, i.e., being divorced. The fear of being disinherited will also force others into marriages that put

them at risk of infection. The whole question of polygamy increases the problem, putting both men and women at risk.

The war has made many women lose their perception of risk as far as STIs and AIDS is concerned. The fear of death as a result of war is far greater than the threat of death by AIDS, which may be 10 years down the road. But, unfortunately, AIDS-related deaths carry many more to the grave.

In some rural areas the concept of rape has taken on a new meaning. Women have been forced to accept that sexual favours have to be given to those who protect them, be they rebels, soldiers or Civil Defence Forces (CDF). They have lost all rights to the privacy of their bodies and the right to say no to unwanted and possibly unsafe sex. They consider rape as what happens in the bush. This may be one of the greatest evils of our war.

In the urban areas the possibility of early death makes young people oblivious of the dangers of early sex. Many are in hurry to experience life, thus indulging in early and unprotected sex.

The disruptions the war caused in social and academic life caused a breakdown in the social fabric of society. Many people lost control or influence over their families. In situations where men could not support their wives and children, the latter turned to prostitution as a means of survival. This explains the high incidence of STIs in camps and among refugee populations.

It is sad to see many of our young girls engaged in prostitution. Some have been so traumatised by the experiences of the war that they cannot envisage themselves in meaningful relationships. Others have been driven by social circumstances to indulge in the only trade that does not demand many years of unbroken study and high fees that are outside their reach. The answer is not to raid the brothels but to provide them with workable alternatives.

The above problems need to be addressed in postwar Sierra Leone. Many of the problems discussed above are social problems having their roots in the relationship between men and women. Their resolution is also dependent on the present relationship being overhauled, with women and men coming together as partners.

Many of the programmes designed to address AIDS have failed. Any successful programme needs to examine the underlying causes for the spread of the virus and possible obstacles to prevention strategies. These underlying causes and obstacles differ from country to country. Attempts to import successful programmes piecemeal into our context would probably meet with disaster–failure.

The social relations between men and women in our cultural settings would make it impossible for the best STI clinic to achieve its desired goal. Without a change in attitudes that would allow a woman to disclose her STI status and come forward for treatment without fear of reprisals, the provision of such a facility would be a waste of time.

AIDS is giving us an opportunity to address long-standing problems that we have swept under the carpet in the past. The inequalities in the relationship between the two sexes at all levels do not auger well for the control of a virus that demands responsible sexual behaviour of men and women. Our customs and culture have aided male promiscuity and given a woman the responsibility for her sexual health without the power to control it. Women need to work with men to reduce their mutual risk to the virus. Women also need to work with men in designing programmes that will take women's needs into consideration. Male designed and male dominated programmes will not address the constraints on women and will therefore continue to be mere paper documents.

Men dominate the AIDS control programme in this country. It is being designed to meet administrative targets rather than address the real issues determining the pandemic. Gender stereotyping rather than any scientific criterion has determined perceptions as to who constitute high-risk groups, i.e., commercial sex workers.

We will continue to remind the government that the issue of AIDS must be given priority. The AIDS control programme needs to be more gender-sensitive. One of the ways of achieving this is to include women at a high level in the decision-making processes of the programme. Women understand the implications of unsafe blood, the complications of STIs, chief among them infertility, the need for better reproductive health facilities and the need for more effective IEC campaigns.

Reproductive health facilities need to be more accessible to women at all levels of society. The use of condoms must be promoted at village level where the introduction of other family planning methods may not be feasible, as access to regular check-ups will not be possible. The female condom, which is now available, should be introduced at an affordable price to increase women's ability to decide on and insist on safer sex and family planning.

Women and men need to be informed about risk factors. Many adults and young girls engage in sexual activities with little knowledge of the consequences of those activities in the light of AIDS. Adequate sensitisation campaigns need to be embarked on to inform people about the risk of HIV in sexual practices.

The National AIDS Policy that is being developed should provide for the protection of the rights of all, the infected, the affected and the vulnerable. In a country where knowledge of HIV is low, especially among the rural population who have little access to information, policies should be considered that would enable them to make informed choices on whether or not to be tested for HIV when they have been exposed to risk situations such as rape, including gang rape. The current practice of a blanket protection of their right to be tested, which translated in real terms is a right not to be tested, is in my opinion an infringement of their right to sexual health as, in most cases, the so-called exercise of this right is not from an informed position.

There can be only one thing worse than having HIV, and that is having the virus and not knowing that you have it. The subsequent trauma of discovery when it is too late to alter your lifestyle is worse than the knowledge of knowing that you were infected. Current scientific information reveals that early knowledge of infection can enable a person to extend his or her life by adopting healthier lifestyles and so slow down the progression of the virus in the body's immune system.

Many of our young girls and women have been raped or forced by circumstances into sexual relations over which they had no control. The vast majority, especially those in the provinces and in refugee camps outside the country, have never had the opportunity of counselling with the option of taking an HIV test. The subsequent trauma of being HIV positive will be more than they will be able to handle.

Our AIDS policy should consider the peculiar nature of our war. If statistics on the HIV status of our armed personnel are accurate, then we are on the threshold of an epidemic. Over 60 per cent of the soldiers tested are reported to be positive. The sexual behaviour of soldiers, both local and foreign, therefore makes them the highest risk group.

The United Nations has declared AIDS to be a security issue, because of the potential of conflicts to create the enabling environment for the spread of AIDS and other STIs. Codes of conduct are being developed to assist UN peacekeepers to become part of the solution rather than channels of the problem. The sexual behaviour of our own soldiers, especially now that a new army is being trained, must be addressed by incorporating an HIV/AIDS component into their training programme. I was privileged to attend the first UNAIDS Steering Committee meeting on HIV/AIDS as a security issue. It is amazing the seriousness with which other countries are approaching the problem of AIDS within their security forces.

As we engage in post-conflict reconstruction, we need to address with honesty the areas of conflict within our society. The government has to make a deliberate effort to

enhance the status of women by recognising their potential to contribute to national development. Women should be given positions of influence at all levels so that women's issues can be considered. Women should be given such responsibilities not as a reward for partisan or other considerations, but out of merit. This will in turn improve the status of women across the board and reduce their vulnerability.

Women in positions of privilege should use this period of reconstruction to push for a change in laws and policies that cause serious disadvantages for women—laws related to succession, illegitimacy, maintenance of children and the status of women in the various forms of marriage in Sierra Leone. These in turn determine to a large extent the relationship between men and women, their perception of sexual responsibility and their own risk factors in such relationships.

Finally, any effective participation of women in post-conflict reconstruction will have to be initiated by women. Gender equality does not mean male or female superiority. It means recognition of the potential of both sexes to contribute to the common good. It means the ineffective participation of either will be detrimental to the common good.

Women need first of all to address the problems that affect them directly, especially health issues, devoid of social and cultural biases. Many of the beliefs we hold are designed to entrench male hegemony over our sexual and reproductive rights. Let us take an honest look at them and find suitable alternatives or abandon them.

We can also empower each other by addressing our health issues, especially STIs and HIV, within our organised communities. We do not have to wait for expensive projects that may not benefit us. I would like to encourage us all with the example of the late Sir Milton Margai, first prime minister of Sierra Leone. Apart from his role in ushering us to independence, he is known all over Sierra Leone by grassroots women as the first to train traditional birth attendants, at a time when there were no expensive workshops or fancy project documents.

Women should advocate for greater participation of women at all levels of decision-making. Women's groups, especially the more privileged, should sensitise the government to include women of merit and substance who can deliver the goods in key positions. Many times, women in pioneering roles have let us down woefully.

As we approach yet another general election, women need to start organising themselves for effective participation. Let us not just make it happen for the men. Let us go where our voices will be heard and where we will have the opportunity to address our concerns.

My final word goes to His Excellency the President, through the Minister of Social Welfare, Gender and Children's Affairs. We have been disappointed in the lack of government commitment to AIDS, especially the lack of workable strategies and the marked absence of female participation at a high level. We welcome with caution the new National AIDS Commission set up in your office. We ask that it does not become another lame institution meeting administrative targets. We ask for the inclusion of a high-profile female at the highest level in this Commission to ensure that women's needs are addressed. There are women and men who have worked on the pandemic at high levels in other countries whom we have failed to utilise in our own elusive search for strategies.

References

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