

“WE ARE ALL LEADERS”  
Remarks by  
Adrienne Germain, President, International Women’s Health Coalition,  
at  
South Asia Against AIDS Foundation’s  
Third Annual Lotus Gala and Auction  
On receiving the SAAIDS 2003 Excellence in Civic Leadership Award  
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I want to begin by telling you about a remarkable physician, Dr. Abraham Verghese, who was born in Ethiopia of Indian parents. After completing medical school in India, he accepted a position in Johnson City, Tennessee, one of the most poverty-stricken pockets of America. There, in that isolated and very conservative region, with its soaring mountains and rushing streams, he found AIDS, case after case. Many, but not all of them, gay men, who had left their hostile community to find freedom and respect in bigger cities. Instead, they contracted AIDS. And one by one, they came home to Johnson City to die.

HIV/AIDS strikes in the expected—and also in the most unexpected—places. It strikes in huge cities like Manhattan and Mumbai. But it also strikes in rural Tennessee and rural Rajasthan. It strikes gay men, IV drug abusers, sex workers, and their clients. But it also strikes married couples—husbands, wives, and their children.

I have watched with horror the gathering momentum of AIDS in South Asia. In 1981, when the first HIV/AIDS cases were identified in the U.S. and Africa, I was living in Bangladesh. Working there, and across South Asia, since 1973, I had learned from South Asian women about child brides, sexual coercion and violence, about sex discrimination in education and employment, and about the failure of national programs to promote condoms, or require men to respect women’s rights. I knew South Asian countries needed to act quickly against these problems. They needed to close the “gender gap,” inequalities that foster HIV/AIDS—and I said so. But no one with power listened.

Twenty years later, South Asia is on the brink of an unprecedented AIDS catastrophe. Large populations and inadequate national programs mean that the number of infections in South Asia could dwarf anything we have yet seen, even in Africa. India alone has an estimated four and a half million people living with HIV/AIDS, and some experts say the actual number may be as high as 10 million.

On a trip to India and Bangladesh earlier this year, I looked into the faces of HIV/AIDS. What I saw may be as unexpected to you as what greeted Dr. Verghese in Tennessee. I saw the faces of women, especially young women and adolescent girls.

I met Kamla, from a remote village in Western Rajasthan, married as a young teenager to a cousin working in Bombay. When he became too sick to work, they returned home

to Rajasthan, where he died of AIDS. Not long after, their 16-month-old child died. Now Kamla is a widow and HIV-positive. She is relatively lucky—her parents have taken her in, but she is often ill and also suffers the severe isolation of a widowed, childless, 20-year-old woman. She has no access to life-extending drugs. She desperately wants to marry and have another child.

In India, half of girls are married by age 18. I saw the face of Sharifa, a young girl from Rangpur, who was sent into domestic labor in a landlord's house at the age of 13. She was raped by the landlord's drug-addicted son, then blamed for the attack and fired. Her family will not take her back, and she has been forced into prostitution to survive. Only 14 years old, Sharifa is likely to be HIV-positive, but she does not know for sure because no testing services exist in her town. Her clients take sexually transmitted diseases, likely including HIV/AIDS, home to their wives. And so the cycle of infection will continue, on and on.

According to epidemiologists and national AIDS policy makers, neither Rajasthan nor Bangladesh is at high risk of HIV/AIDS. But let us—please—learn from the experience of countries as diverse as Brazil, Uganda and the U.S. Everyone is at risk—girls and young women especially. Consider one stunning fact—90 percent of Indian women living with HIV/AIDS are married. They have had sex only with their husbands. So, why do they have HIV?

In Bangladesh, 73 percent of girls are married by age 18. These child marriages are meant to protect girls. But, tragically, marriage dramatically increases their risk of HIV across the sub-continent. Why? First, if they were not married, most would not be having sex at all! Second, girls are normally married to older, sexually experienced men. Often, as adolescents, these men had sex with other adolescents or men. After marriage, men commonly engage in affairs or visit commercial sex workers.

Research shows that South Asian girls have little or no knowledge of sexuality, HIV, or condoms when they marry. Their first task is to produce a son; so, even if they had access to condoms, using them would be impossible. Many are physically immature and malnourished. Too often, especially if a husband drinks, or is a violent person, sex is forced and injures the girl's delicate tissues, making HIV even easier to transmit.

Another major reason that married, monogamous girls and women are at risk is labor migration. Men like Kamla's husband leave agricultural states devastated by drought, to seek work in large cities, or rural areas not stricken by drought. These husbands are not monogamous. They bring HIV and other sexually transmitted diseases home on their periodic visits. As a result, in India, the rate of HIV infection is increasing dramatically in rural areas—where 70 percent of the population lives, and where health facilities, education, and support are weakest.

World events, dislocations, and drug trafficking also fuel the contagion. I already told you Sharifa's story. In Pakistan, the estimated percentage of intravenous drug abusers who share needles—a significant vehicle for HIV infection—has shot up from 57 percent

before the Afghan war, to 76 percent today. HIV-infected drug users have sex with girls and women, whom they infect, and they conceive children later born with HIV. Further, in Pakistan, 30 percent of injecting drug users sell their blood, endangering the country's blood supply and all who use it, including thousands of women who need transfusions during complicated childbirths.

Despite these mounting dangers, South Asian governments have been slow to address the problem. Since I left Bangladesh in 1985, I have worked to sound the alarm with the International Women's Health Coalition, colleagues, and friends worldwide. Women have heard and demanded action. But those in power have still refused to act. In India, the Prime Minister has delivered several speeches on HIV/AIDS, most recently this weekend at the first-ever national conference on HIV/AIDS, but other officials minimize the threat, leaving private charities, NGOs, state-level agencies, and external donors to bear most of the burden.

Why such a reluctant response? Some believe HIV/AIDS cannot take root in a Muslim or Hindu society. Social taboos, class, and caste biases also play a part. Many Americans, for instance, viewed AIDS, for years, as a disease of gay men, because it struck the gay community first. Now women have the fastest growing rate of new infections in the U.S.

Dr. Suniti Solomon, who diagnosed the first case of AIDS in India and sees at least half a dozen new patients every day, says, "Most of the people think this disease is a disease of prostitutes and truck drivers, so it can't happen to me."

As I hope my remarks clearly show, that is a disastrous misconception. Today, HIV is spreading across all rungs of Indian society.

There is another explanation for foot-dragging by South Asian governments—and they are hardly alone in this regard. Politics—particularly the desire to placate conservative religious constituencies—has prevented open discussions of sexuality, risk, and prevention in countries around the world, including in the U.S. Under pressure from conservatives, one third of the much-publicized new U.S. HIV/AIDS prevention money is slated to go to conservative religious groups that lie about condoms' effectiveness and push "abstinence." In a similar move—pressed by Hindu conservatives who argue, like American conservatives, that condoms encourage promiscuity—the Indian government last year prohibited a television ad on the protective benefits of condoms.

And what about abstinence—how many girls and women in South Asia can actually practice it? The yawning gap in the power of men and women makes abstinence impossible for most girls and women in the region. Abstinence implies choice—which girls and young women like Kamla and Sharifa do not have. Nor does Robina, in Lahore, who has been beaten by her husband just for asking about contraception. In these conditions, only men can choose abstinence. Only they can decide to use condoms—but only a tiny fraction do.

The gender gap is driving South Asia toward an Africa-like explosion of the epidemic.

The good news is that a catastrophic AIDS epidemic can still be avoided—if we work together for frank talk, including enlightened campaigns that tell people how to protect themselves, that promote respect for women’s human rights, and that educate everyone to reduce stigma and human rights violations against individuals living with HIV/AIDS. Even more important, we must ensure that all young people have comprehensive sexuality and health education—before marriage—that promotes gender equality and human rights, along with health services.

Today, South Asian governments still have a choice: Deny what is happening, just as Johnson City officials did when Dr. Verghese first approached them, or address the problem openly and vigorously as Uganda and Brazil have done.

In Uganda, thanks to government leadership and an aggressive, multifaceted, candid prevention campaign, HIV incidence has dropped from 30 percent to 5 percent in little more than a decade. Political leaders from the capital to the villages have talked openly about sexual behavior and the need for condom use, which has increased from 5 percent in 1990 to 54 percent today. Brazil achieved a 70 percent reduction in AIDS deaths over the past decade by implementing intensive, nationwide prevention measures that acknowledge the realities of sexual behaviors, by addressing underlying causes including gender inequality, and by providing counseling and treatment for all in need.

South Asia is blessed with vital resources: dedicated physicians and nongovernmental organizations, a thriving pharmaceutical industry, and a recognition at the rhetorical level that both gender equality and health are national concerns. Yet so far, the core realities of girls’ and women’s lives that I have mentioned go largely unaddressed.

When I worked in Peru in the late 1960s, I saw for the first time the realities of women’s lives in South America, so similar to women’s lives in South Asia—day-to-day struggles to survive in the presence of violent, coercive, and promiscuous men. I saw how these realities were ignored by those in powerful positions who could have leant a helping hand. It was as though these women and their problems were invisible and their lives worthless. I vowed then to dedicate my life to making girls and women visible, and their voices heard.

Every nation needs leadership in order to tackle major challenges. And all of us can be leaders. We must work together to counter the attitude, “AIDS can’t happen to me” or “it only happens to bad people” who get what they deserve—to promiscuous women, or to girls who “tempt” men. By supporting SAAIDS, you have become part of the powerful, growing movement for girls’ and women’s health and rights that will slow the engine of this terrible pandemic. By going to IWHC’s website, you can also protest and help to change the backward and extremely dangerous policies of the current U.S. government regarding sexual and reproductive health and rights worldwide.

Let me end where I began, with Dr. Verghese. He said of his experience with AIDS in Tennessee, "It is the acts of human kindness that illumine our world." And I would add, it is only such acts that will save us all.

Thank you.