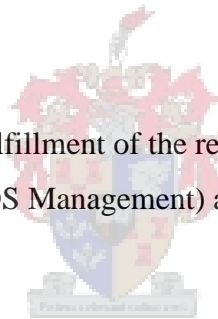


A study of the socioeconomic and socio cultural factors that influence the behavior of urban women in Bangladesh around HIV/AIDS and other sexually transmitted infections.

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Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Acronyms

AIDS Acquired Immuno-Deficiency Syndrome

BAPS Bangladesh AIDS Prevention Society

CSW Commercial Sex Worker

DHCWO Development of Human Characters and Welfare Organizations

HIV Human Immunodeficiency Virus

HPTP Health Providers' Training Program

ICDDR,B International Center for Disease and Diarrhea Research, Bangladesh

IDU Injecting Drug User

NAC National Aids Committee

NASP National AIDS/STD Program

NGO Non Governmental Organization

PLWHA People Living With HIV/AIDS

PPCT Prevention of Parent to Child Transmission

SMC Social Marketing Company

STI Sexually Transmitted Infection

UNDP United Nations Development Program

WHO World Health Organization

“Everyone is born into a culture – a set of shared ideas about the nature of reality, the nature of right and wrong, evaluation of what is good and desirable, and the nature of the good and desirable versus the bad and non desirable ... As totally dependant infants we are socialized – taught the rules, roles and relationships of the social world ...In the process we learn to think, act and feel as we are supposed to.”

(An excerpt taken from Peterson, V.S., and Runyan, A.S. (1999). Global Gender Issues: Dilemmas in World Politics.)

Summary

In this study, I will investigate the socioeconomic and socio cultural factors that influence the behavior of urban women in Bangladesh around HIV/AIDS and other sexually transmitted infections (STIs.) I will first identify the urban populations that are at most risk in Bangladesh and the linkage that there is between these and general urban populations. It is important to note that by “urban,” we mean slum as well as affluent populations. In particular, I will look at the roles that gender and the status of women, issues of domestic violence, and traditional and religious healers play, and how this influences preventative strategies to these diseases. Lastly, I will look at the focus of the approach to combating HIV/AIDS and other STIs in Bangladesh.

Opsomming

In hierdie studie ondersoek die navorser die sosio-ekonomiese en sosio-kulturele faktore wat die gedrag van stedelike vroue omtrent MIV/VIGS en ander seksueel oordraagbare infeksies in Bangladesh beïnvloed. Die navorser identifiseer eerstens die stedelike bevolking met die grootste risiko in Bangladesh en die verwantskap wat daar tussen die en die ander stedelike bevolkings is. Dit is belangrik om daar op te let dat “stedelike” na krotbuurte sowel as ryk bevolkings verwys. Die navorser sal hoofsaaklik fokus op die rol wat geslag, die status van vroue, geweld en tradisionele sowel as geloofsgeneesers speel en hoe dit voorkomingstrategieë beïnvloed. Laastens sal daar aandag geskenk word aan die fokus van die benadering om MIV/VIGS en ander seksueel oordraagbare infeksies in Bangladesh te bekamp.

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Introduction

According to the World Health Organization (WHO), Bangladesh is one of the fortunate countries where the infection rate has not yet reached 1 per 1,000 adult population. According to Government sources (till December 2003), 363 HIV positive cases have been reported in the country as of December 2003 and amongst them 57 developed AIDS and 30 have died of AIDS. The first HIV/AIDS case was detected in the country in 1989. It is important to note that most deaths were because of tuberculosis. Although Bangladesh still has a low prevalence of HIV infection there is cause for great concern regarding the development of a concentrated epidemic.

Bangladesh is geographically vulnerable to HIV/AIDS due to its close proximity to high HIV prevalence countries like India, Myanmar, Nepal and Thailand. The surveillance data indicate that condom use is low in the country (2.4-6% consistent condom use in all commercial sex acts in the previous week.) Almost everyone who buys sex in Bangladesh is having unprotected sex some of the time. The results of the fourth round of national HIV serological and behavioral surveillance also showed that the HIV infection rate among the Injecting Drug Users (IDUs) is 4%, an increase of more than 100% since the previous year. This is alarmingly high and just 1% away from being a concentrated epidemic. Injecting drug users are part of the general population and not an isolated group. Although HIV rates are low (<1%) among sex workers, STI rates are still quite high (>20%) among this group. Prevalence of syphilis is one of the indicators of risk for HIV. The fourth round surveillance data indicated that syphilis rates are still high among sex workers. Therefore, despite the low prevalence of HIV, behavior patterns and extensive risk factors that facilitate the rapid spread of the infection are widespread and make Bangladesh vulnerable to an HIV/AIDS epidemic.

Among the general population, certain groups have been reported in some studies to have high-risk behavior like buying sex from commercial sex workers. They are transport workers (truckers, rickshaw pullers), officials, students and businessmen. Moreover, men having sex with men is also prevalent in Bangladesh, of whom 46% are married and 43% are reported to visit female sex workers. It is also of great concern that young people are

emerging as a key vulnerable group for potential HIV infection. They form a large portion of the population in Bangladesh, with 15-25 year olds accounting for one third of the total population. Furthermore, Professor Nazrul Islam, Project Director of Bangladesh AIDS Prevention and Control Program, has been quoted as saying that “in one survey in STIs done in Dhaka Medical College, it was found that 50% of the total cases are students.”

Socioeconomic and social-cultural factors

Unfortunately, a low level of awareness on HIV/AIDS still prevails among the general population as well as the high-risk behavior groups. The 1999-2000 Bangladesh Demographic and Health Survey found that over 90% of rickshaw pullers could not identify a single correct method of HIV prevention. Only 31% of married women and 50% of currently married men had heard of HIV/AIDS. Yet, in a survey on premarital intercourse, Population Council found that 29% of women nineteen years and older and 69% of married men in rural and urban areas had engaged in premarital intercourse. In a population-based study of 1541 slum dwellers the mean age at first sexual intercourse for men was 19 and for women was 14.75 years. In in-depth interviews with 120 of these respondents, most women reported their partners to be their husbands, while most men reported their premarital partners to be CSWs, women who they pretended to love, women who they did love, and 8.5% of the 540 male survey respondents reported male sexual partners (Sharma et al., 1997). The evidence is mixed as whether there is a class differential in premarital sexuality. One study found the incidence of premarital sex to be higher in the lower socioeconomic class than in the higher class. However, a 1997 Population Council survey reported no major differences between people living in poor or well-off areas.

Based on this information, we see that the ongoing efforts in Bangladesh require a paradigm shift from a health response to addressing HIV/AIDS as a human development issue. This requires action to deal with the socioeconomic and cultural factors that render individuals and communities vulnerable to HIV/AIDS. We will look at some of these in turn, starting with gender:

Gender and inequality

In many developing countries, the role that women play differs significantly from that of men. Peterson and Runyan in their book, *Global Gender Issues* (1999) tell us that in order to “understand how gender works, we examine two interacting dimensions of social systems: the formation of gendered identities and the reproduction of gendered social structures. The first is about socialization: how individuals are taught, and how they internalize, culturally appropriate attitudes and behaviors. Family, schools, religious institutions and media are important sources of this socialization (p. 34.)”

Peterson and Runyan’s second dimension of social systems is about systematic or structural control: how practices and institutions keep gender hierarchy in place by generating conformity and compliance” (p. 34.) Again, we can see this in place in patriarchal societies in developing countries, where women are taught compliance from an early age. The authors tell us: “From infancy on, we are taught to make distinctions, enabling us to perform appropriately within a particular culture. At the same time, the lenses we adopt shape our experience of the world itself because they shape what we do and how and why we do it ... at the same time, the world we live in (reality) shapes which lenses are available to us, what we see through them, and the likelihood of our using them in particular contexts” (p. 2.) The data regarding how men and women are situated differently within global processes reveals, starkly, the extent of gender inequality.

Women and the epidemic

In a country like Bangladesh for example, the majority of women are not yet empowered to participate actively in social, cultural, economic and political life of the country. The official figures of different status indicators like health, nutrition, education, employment and political participation confirm the widespread gender discrimination in all spheres and at all levels of the country. The average age of marriage for girls is sixteen, even though the legal age is eighteen. Fifty percent of girls are married with parental consent. This is partly due to the low status of women in society, and the discrepancy between gender roles, with boys more desirable than girls. In response to this pressing problem, in

March 1997, a National Policy for Development of Women was developed. The objectives of this policy was based on the basic commitment to develop women as a human resource, establish women's human rights, eliminate all forms of discrimination against women and girls, and to recognize women's contribution in the social and economic spheres. A National Action Plan, in response to the Beijing Platform for Action (PFA) has also been prepared for the enhancement of women's position and status in society.

Sex differences in pathology

With regards to STI/HIV/AIDS, the following data appeared in *Nirmul*, the quarterly health journal of the Bangladesh AIDS Prevention Society (BAPS): Women appear to be heading for an unwelcome equality with men. While they accounted for 41% of infected adults worldwide in 1997, women now represent 43% of all people living with HIV/AIDS. There are no indications that this equalizing trend will reverse. One out of every four HIV positives in India is a woman who in most cases has been infected by her own husband. Often the woman may not be in a position to insist on condom use in the case of a husband who has other sexual partners, because of low bargaining power (M. Prasanna Kumar SEA-AIDS Aug 09, 1999.) The AIDS epidemic in women is overwhelmingly heterosexual – almost entirely so in Africa and South and South East Asia. In other areas, a proportion of women are infected through sex with a bisexual or drug injecting partner.

Why are women more vulnerable to HIV infection? Biologically, they have a large mucosal surface; microlesions which can occur during intercourse may be entry points for the virus; very young women are even more vulnerable in this respect; there are more virus in sperm than in vaginal secretions; as with STIs, women are at least four times more vulnerable to infection, the presence of untreated STIs being a risk factor for HIV, and coerced sex increases risk of microlesions. Financial or material dependence on men means that women cannot control when, with whom, and in what circumstances they have sex. Many women have to exchange sex for material favors, for daily survival.

There is formal sex work but there is also this exchange which in many poor settings is many women's only way of providing for themselves and their children.

Gender and Bangladesh

To summarize, let us look at why the response to STI/HIV/AIDS should be gender based in Bangladesh. There are three main reasons:

1. Unequal gender (social, economic and power) relations are driving the epidemic.
2. Women are disproportionately affected by the epidemic: they are highly vulnerable to infection, they bear the psychosocial and physical burden of AIDS care, they suffer particular discrimination and are often blamed for spreading the infection.
3. Sex differences in pathology: Clinical management, for too long based on research undertaken on men, must be tailored to women's particular symptomatology, disease progression, and HIV related illnesses.

There are a number of proven interventions which together comprise key strategies to control the spread of the epidemic. These are particularly important to women:

1. Treatment and prevention of sexually transmissible infections:

Women are more vulnerable to STIs; the consequences are more serious.

Many STIs are asymptomatic in women and so go untreated.

Syndromic management of STI in women is more difficult than men.

Stigma associated with STI is greater for women (suggests promiscuity), so they are often afraid or unwilling to seek care.

2. Safe blood:

Women and children are the chief recipients of transfusions; women, during and after delivery.

3. Women as carers:

Women are responsible for the health care of all family members.

Care is only one of the many productive and reproductive activities of women which include farming, food preparation, collection of firewood and water, child care and cleaning.

Care is provided free, but it has a cost. During illness, women's productive labor is lost; this has serious impact on the long term well being of the household.

Care doesn't end with the death of a husband/child/sister. Care of orphans lies with grandmother and aunts.

Women carers are often HIV positive themselves.

4. Making men more responsible:

Little attention has been paid to men's participation in efforts to protect women.

Men are hard to reach and educate but some are concerned about sexual health – their own and their partners.

Raising awareness of their own risk has been shown to change certain behaviors.

Interventions must be aimed at both men and women if women are to be protected.

(Taken from Beijing +5 PrepCom Meeting in New York, March 2000

Source: Wed 08 Mar 2000 17:49:18 MET From: Gender-AIDS)

Women and domestic violence

The next socio cultural factor to be looked at is the issue of women and domestic violence in Bangladesh. I would like to approach this first from an epistemological perspective, looking at how women "know" or how they learn:

How women "know"

In their book, *Women's Ways of Knowing* (1986), Belenky et al. conducted research on undergraduate students at two colleges in Massachusetts and in Vermont, as well as on poor rural women in western Massachusetts. They had reached the conclusion that "the women's epistemological assumptions were central to their perceptions of themselves and their worlds." (p. xiii). As a group they asked: What kind of umbrella rationale and structure could encompass all the questions we had? One breakthrough insight that they had was: "Women don't just learn in classrooms; they learn in relationships, by juggling life demands, by dealing with crises in family and communities" (p. xi). This finding is central to the theme of this paper. Women learn in different ways, and are especially influenced by the sociological and socio cultural factors that they are raised to believe in.

This is especially apparent in the differences we see between Western women and their counterparts in developing countries. The authors examine how two institutions primarily devoted to human development – the family and the schools – both promote and hinder women’s development and found that “it is clear that many more women than men define themselves in terms of their relationships and connections to others” (p. 4).

Let us take a closer look at how Belenky et al categorize ‘knowing’, and how this can be looked at in the global context. Belenky et al grouped ‘knowing’ into five major epistemological categories: Silenced, Received knowledge, Subjective knowledge, Procedural knowledge and Constructed knowledge.

Categories of knowing

In the first category, it was found that “silenced women were among the youngest and the most socially, economically, and educationally deprived of all those we interviewed” (pp. 23 and 24). In their experience, “Words were perceived as weapons. Words were used to separate and diminish people, not to connect and empower them. The silent women worried that they would be punished just for using words – any words” (p. 24). These women see blind obedience to authorities as being of utmost importance for keeping out of trouble and insuring their own survival, because trying to know “*why*” is not thought to be either particularly possible or important” (p. 28).

The silenced women are notable for their inability to speak out to protest. “Thinking for themselves violates their conceptions of what is proper for a woman.” (pp. 29 - 30). “The silent women see life in terms of polarities. Because the women see themselves as slated to lose, they focus their efforts on assuring their own continued existence during a losing battle. It is a stacked game waged against men who seem to be bigger and better, men who think they have a right to be winner, to be right no matter what the circumstances” (p. 30). This outlook is widely evident in many patriarchal societies. Women are conditioned to look to the dominant male figure in their life for the answers, and have no inherent belief that they might already be the source of their own knowledge. Among the silenced women, “talk had little value or was actively discouraged in the homes in which

they grew up. Because the families of silenced women see words as having an impact on others only when they are uttered with force and violence, they yell rather than talk when they wish to influence each other” (p. 158).

The United Nations is concerned over growing evidence of a new link between the spread of AIDS and rising violence against women. “This is one of the most insidious aspects of the AIDS epidemic,” said Peter Piot, Executive Director of UNAID, the Geneva – based UN body which coordinates the global fight against the deadly disease. Addressing a panel discussion on women and health, Piot said that violence against women is contributing to “the merciless spread” of AIDS and it is only now beginning to receive the international recognition it deserves. “Violence against women causes more death and disability in the 15-44 age group than cancer, malaria, traffic accidents and even war,” he said. “Violence against women is not just a cause of the AIDS epidemic, it can also be a consequence of it,” Piot said. (1999).

Family psychologist Salvador Minuchin and colleagues (1967) depict a pattern of family life among the urban poor that is remarkably similar to the pattern that was found by Belenky et al in these families among the rural poor. They describe disorganized slum families unable to withstand the demoralizing and shattering effects of poverty. The children tend to be action-oriented, with little insight into their own behaviors or motivations. Since they do not expect to be heard, and if heard they expect no response, the volume of their voice is more important than the content. They lack verbal negotiating skills and do not expect conflicts to be resolved through nonviolent means. Families that are relegated to the bottom of the social class structure are often shaken by the collapse of an outmoded way of life.

Poverty in developing countries is a way of life for the majority of people. In Bangladesh, for example, there are 13 million people in the capital city of Dhaka: of these, 48% are classified as slum dwellers. Each day for these people is a lesson in survival. Financial or material dependence on men means that women cannot control when, with whom, and in what circumstances they have sex.

National data regarding violence against women in Bangladesh does not exist. In Islam 2003, it was reported that sexual assault and rape are fast growing violent crimes in Bangladesh. 1152 victims of acid throwing were reported from 1996 –2001. The victims of this acid throwing are forced to give up education, occupation and important activities in life. In the past few years UNICEF has tried to establish crisis centers within hospitals. Authorities have not taken this very seriously, and no agency has been found to accredit the hospitals that put the necessary facilities and staff training in place. One Stop Crisis Centers funded by DANIDIA began operating in 2002. There are now two centers attached to the Medical Colleges in Dhaka and Rajshahi.

The last decade has seen improvements in women's status through changes in policies, programs, laws, and most importantly, in attitudes towards women. In Bangladesh, the school stipend program encouraging secondary school education for girls and the large influx of young women employees into the garment sector (although low paid) has probably changed women's status more than any specific health policy. It is crucial to ensure completion of secondary education for girls, as this was one of the most important predictors of improved maternal and child health all through the analyses.

Religious leaders and traditional healers

The last socio cultural influence I would like to examine with regard to women and their behavior around HIV/AIDS and other STIs is that of religious leaders and traditional healers. In developing countries, religion plays a most important part in determining the roles and behaviors of men and women, and roles of behavior are encultured from an early age. Bangladesh is a deeply religious country, with 90% of the population being Muslim. Islam is a religion which is a way for life, and the two are deeply related with each other. There are almost 300,000 mosques in Bangladesh, and 600,000 Iman and Moazzen. If these leaders are willing to speak about HIV/AIDS during the Friday prayer, a wide section of the population will be reached. Religious leaders are very influential, and when they openly speak out about prevention being better than cure, many people will listen to them. It has also been suggested that religious leaders should be involved in

policy making regarding HIV/AIDS intervention programs aimed at both men and women.

Religious leaders

Bangladesh AIDS prevention and control programs have incorporated the role of religious leaders such as the Imam and Khatib in the intervention of AIDS transmission through creation and awareness. These are a large and vital group who can disseminate the correct message at root level. The first seminar on the role of religious leaders on HIV/AIDS prevention was held in Dhaka in December 1997, organized by the Development of Human Characters and Welfare Organizations (DHCWO). The objectives of the seminar were to provide up- to- date and basic knowledge about HIV/AIDS among religious leaders; to encourage religious leaders to participate actively in AIDS prevention in Bangladesh, and to formulate their recommendations for future planning of HIV/AIDS prevention in Bangladesh.

The use of condoms is a controversial issue in Bangladesh. It has been suggested by religious leaders that use of condoms increase social crime, and should be discouraged, only to be used as an essential part of treatment when prescribed by a physician. There is religious opposition to handing out condoms and implementing family planning programs in schools. CSWs tell of being paid premiums for sex without condoms.

In this Muslim nation, there are certain social and cultural barriers to discussing problems relating to sexuality, STIs, and HIV. Allocating significant resources to something that is not widely perceived as a problem (or understood as an important threat) and that may be controversial due to its association with high-risk sexual behavior, could be perceived as risky to the government or at the least to offer limited political gain.

Traditional healers

In many developing countries, the first encounter for urban dwellers for treatment of STIs is pharmacies, with the poor usually going to the traditional healers and the homeopathic doctors. Over the counter (OTC) purchase of antibiotics from pharmacies is almost

universal despite laws that regulate their distribution. In the urban areas of Bangladesh, the pharmacies are ubiquitous, one on almost every street corner. The findings of a study show that there is one pharmacy for every 1,000 persons, and one qualified physician for every 2,000 persons in the city of Dhaka (Majumber et al., 1996.) Pharmacies also play a role in reproductive health services, providing referrals for clinical family planning methods, advice on pregnancy, and treatment and referral for STI-related symptoms (Mookherji et al., 1997.)

The Shurockkha study

In Bangladesh there is limited information regarding medicine-sellers' knowledge on STI/AIDS and their practices in dealing with clients with STIs. The Social Marketing Company (SMC) began the Health Providers' Training Program (HPTP) involving medicine sellers in 1986. Its exclusive training program on STI/HIV/AIDS for medicine sellers is a key component of 'Shurockkha' – the STI/AIDS Prevention Program of the SMC (Social Marketing Company, 1997). The present study explores the medicine sellers' knowledge on STI/AIDS and their practices in providing services to their clients with STIs. This study was conducted by Operations Research Project of ICDDR,B in collaboration with SMC.

The objectives of this study, carried out in 1998, were to:

1. Describe the profiles of the medicine sellers of the Tongi municipality area and assess their knowledge of STI/AIDS; and
2. Assess the STI management practices of these medicine sellers.

Two hundred and one medicine sellers of 157 pharmacies of the Tongi municipality were surveyed. Tongi is an industrial area adjacent to Dhaka. It is one of 19 urban areas prioritized by AIDSCAP/USAID in 1996 for behavior change communication, condoms, and STI services to prevent an epidemic of HIV in Bangladesh (Bennett et al., 1996). This area has a substantial number of transient male workers, traders and floating commercial sex workers (CSWs.)

The sampled medicine sellers defined STIs as only gonorrhoea, syphilis or vaginal discharge. Of the 201 medicine sellers, 84% could mention the complications of STIs, such as infertility and abortion. 55% associated condoms with the prevention of STIs. 43% could describe AIDS, and 65% could mention at least one preventative measure for AIDS. Of the medicine sellers who counseled clients with STIs, 46% reported that they counseled in addition to providing treatments. Counseling included: avoiding extra-marital sex, condom use, drug compliance, treatment of partner, and follow up visits. In order to obtain results, “mystery-shopping” events were conducted in 33 randomly selected pharmacies. Mystery-shopping was an event where a trained person pretending to be a client with STI sought services from the selected pharmacies.

Of the 33 sample pharmacies, 25 stated that the use of condoms can prevent STIs. Of them 11 provided this information spontaneously, and 14 responded after being probed. Eighteen of the 25 discussed how to use a condom – seven of them discussed this spontaneously, and the rest after being probed by the shoppers. Twenty-four pharmacies had condom-dispensing boxes on display, but none of the pharmacies had any posters regarding condom promotion. Four of the pharmacies displayed stickers regarding condom use.

It is evident from this study that pharmacies are a source of medicines, advice, referral, and information for STIs. However, the quality of services available at pharmacies needs to be improved. The pharmacy is one of the important sources of primary healthcare for the population, especially men in Bangladesh. Therefore, the medicine sellers’ current and potential roles in the prevention of STIs and AIDS have to be identified and advocated. The findings of this study can be used to identify and advocate such roles. For an effective prevention program on STI/HIV/AIDS, medicine sellers in pharmacies can be potentially involved. However, such involvement needs building the capacity of the medicine sellers in the prevention of STI/AIDS. Furthermore, research is needed to identify the factors that influence medicine sellers’ knowledge and practices relative to STIs, as well as identifying the factors that influence clients’ choices for reproductive

healthcare. All these are required in advocating the national policy to involve medicine sellers in the national STI/AIDS prevention program.

Conclusion

The constitution of Bangladesh guarantees people rights to health care and a disease-free environment. It also promotes respect for the dignity of people. There is considerable political commitment in Bangladesh to respond to the threat of HIV/AIDS. The Government's response to HIV/AIDS has been positive. Bangladesh is one of the first South-East Asian Association for Regional Cooperation (SAARC) countries to take the threat of a HIV epidemic seriously, and initiated a national response in 1985. Bangladesh is the first country in the region to develop a well-defined policy document on HIV/AIDS and STI-related issues. Understanding the importance of the threat of a major epidemic, the Government of Bangladesh formed a National Aids Committee (NAC) as early as 1985. Since then, with the assistance of development partners like WHO and UNDP, surveillance systems have been set up, behavior change communication activities have been conducted and blood safety has been improved.

But there is still much to be done. There are limited care and support provisions for People Living With HIV/AIDS (PLWHA) in Bangladesh. Although antiretroviral drugs have been registered they are not yet available through the public health care system. An antiretroviral task force has been established to develop a framework for delivering antiretroviral treatment. The national policy on HIV/AIDS envisages capacity building of the existing government structure to meet the needs for counseling, testing, and providing care and support. Moreover, the National AIDS/STD Program (NASP) has initiated action to prevent the transmission of HIV from Parent to Child by the formation of a working group to develop a framework for Prevention of Parent to Child Transmission (PPCT) in Bangladesh.

It is hoped that working effectively with communities at high risk and providing effective clinical as well as outreach services would ensure a holistic approach to save Bangladesh

from an imminent epidemic. Suggested areas to be addressed should include the following:

- High incidence of domestic violence
- Low status of women
- Low use of condoms
- High incidence of HIV/AIDS infection from husbands to wives
- High levels of tuberculosis
- Integration of religious and traditional healers
- Stigma and shame associated with disclosure
- The need to involve men in family planning programs
- Equal education for all

Finally, I would like to quote from Ms. Carol Bellamy, Executive Director of UNICEF. In her opening speech at the February 2003 UNICEF Conference in Kathmandu, Nepal, *'Accelerating the Momentum in the Fight Against HIV/AIDS in South Asia'*, Carol Bellamy called for a quantum shift in both the speed of action and in the commitment to confront HIV/AIDS and the ongoing wall of silence. She emphasized that "there is only one effective tool for curbing HIV/AIDS – that is education." She continued to say that "leaders must break the silence that denies the existence of HIV/AIDS and prevents discussion of human rights violations; ensure that every child goes to school with special efforts to enroll girls in school and keep them there; fulfill young people's rights to information and services for HIV prevention; address the special needs of young people with unsafe sexual and needle sharing practices; put an end to all forms of gender-based discrimination, the exploitation and abuse of girls and women, and finally, mobilize all sectors of society in a stepped up drive against HIV/AIDS, accelerating the pace to halt the virus before South Asia's window of opportunity slams shut."

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