02/04/1997

Shifting the social burden of AIDS

Sharon A. Bong

WILL the Ministry of Health be opening a can of worms when it embarks on a pilot project to test all pregnant women for HIV?

From a gendered perspective, the medical and social implications of such an apparently controversial national policy, still under serious consideration, warrants involved and honest debate.

It will, first of all, shift the spotlight momentarily from high-risk groups such as IDUs and CSWs (intravenous drug users and commercial sex workers, respectively) to "LRWs" (low-risk women), that is, mothers-to-be.

At the outset, this is a positive move as it confronts the public's false sense of security in assuming that HIV/ AIDS happens only to those who "deserve" it.

However, the public has to be fully sensitised to the intentions of the Ministry in order to avoid any undesirable backlash.

Is the testing of ante-natal mothers, which the Ministry insists is a preventive measure to check the AIDS epidemic, justifiable and feasible?

The Ministry's sentinel surveillance of 14 ante-natal clinics around the country provides the impetus to the testing of all pregnant women.

According to the study, the infection rate of pregnant women is 0.21 per cent. Ministry data reveals 33 cases of children born with HIV infection from 1986 to 1996.

Most of these are children of HIV positive drug addicts. The statistics were not fully representative because only HIV drug addict women were screened.

In addition, Datuk Dr Abdul Aziz Mahmood, Director of Disease Control in the Ministry of Health, projects that "for the past three years (1994-96), a total of 3,150 ante-natal mothers may have been HIV positive (from the 500,000 deliveries per year), and would have delivered 945 HIV positive babies of whom only 33 have been identified".

Hence the Ministry's justification for the testing of all other non-addict pregnant women.

However, the longstanding moral issue between women and AIDS problematises the Ministry's intentions, the point of contention being that women are either "reservoirs of infection" or "vectors of transmission" to their male partners and offspring.

This sexist perception and treatment of women negates or diminishes the equal responsibility of men to prevent HIV/AIDS.

It also conspires to distort the focus of intervention strategies; it is often designed to protect men from women than to empower women.

In consideration of women's greater HIV vulnerability resulting from her sexual, economic and biological subordination, the call to test pregnant women indiscriminately is an extension of such prejudice.

"Are we testing pregnant women because they are an easy cohort to `capture'? There are no equivalent male cohorts in the general population. How are we going to persuade the husbands of HIV positive women to get tested too? Are we going to see a rash of men divorcing their (infected) wives?" argues Marina Mahathir, chairperson of Malaysian AIDS Council and the spokesperson on HIV/AIDS for Asia-Pacific at the United Nations.

Amid this virtual testing of male spouses (for one can only make assumptions about their HIV status), are women relegated to the position of scapegoats?

In response, Deputy Health Minister Datuk Dr Siti Zaharah Sulaiman

advocates that women only voluntarily test themselves "for the safety of unborn babies".

Rashidah Abdullah of ARROW (Asian-Pacific Resource and Research Centre for Women), stresses on "gender-power relationships which impinge a woman's ability to make decisions regarding her own health.

"Her well-being has to be valued on its own merit (not merely appendaged to her offspring's). Her rights as a woman and individual are not apparent here."

Julian Jayaseelan of Pink Triangle stretches the argument further, that "she has a right to persistently reject being tested. In other words, she has a right to have a (HIV) positive child".

He insists on her having the final choice "believing that the mother will make the best decision. And to basically accord her the respect of doing so".

The issues at stake here are the justifiable shift of focus from high risk groups to high risk behaviour. In other words, the rise of promiscuity among sexually acitve heterosexual men and women.

According to Health Minister Datuk Chua Jui Meng, of 19,385 HIV positive cases detected since 1986, a total of 186 women, or five per cent of the victims, were infected through sexual contact.

An average of 383 persons are infected with HIV a month. Of this figure, 95 per cent were males and 79 per cent of them were drug addicts.

The call to test only pregnant women, as a preventive measure, is grossly insufficient, as it ignores the root problems of mutual fidelity and the disintegration of the family unit.

Barbara Yen of AWAM (All Women's Action Society) points us in the right direction in emphasising "shared rights and shared responsibilities between husband and wife for the welfare of the whole family".

The urgent need for the prevention of HIV/AIDS is irrefutable. The complacency of the middle class in presuming that only others can be infected, should not be left unabated.

We have much to learn from the dire and far-reaching effects of such abandonment or irresponsible living (the rise of promiscuity, multiple sexual partners, flirtation with drugs, sex tourism).

To illustrate the point, the newsletter India Today (March 15 issue), chronicles the harrowing accounts of HIV/AIDS striking at the heart of homes, afflicting low-risk groups such as mothers and children, the woman being infected by her own husband/partner, father to their children.

The testing of pregnant women merely circumvents this social malaise as women (particularly sex workers) need to be empowered to negotiate safer sex with their own spouses or sexual partners/clients.

WHO estimates that almost half of all newly infected adults globally are women. And as infections in women rise, so do infections in the infants born to/of them.

As such, the Ministry's call for the consensual testing of all pregnant women is, to an extent, not totally unreasonable.

Prof Rokiah Ismail of UH's Department of Medicine, maintains that "the basic objective of counselling (the corollary of testing) is to effect behaviour change. Testing itself is not that important".

There is in fact enormous potential in educating and sensitising the public as well as medical personnel via information dissemination.

A prenatal HIV testing programme should have, as its prerequisites, partner involvement, confidentiality, health and legal services for HIV-infected women and children, laboratory services and programme evaluation, besides education and counselling.

Unfortunately, there is much reservation, even scepticism, towards the Ministry's capability in following-through this ambitious programme.

It is worthwhile to resuscitate the Malaysian AIDS Charter, particularly with reference to the rights and responsibilities of each individual in protecting himself or herself and others.

The call for top level political commitment and the support to counter stigmatisation at all levels are indispensable in our joint battle against the pandemic of HIV/AIDS.

The HIV test for pregnant women also has significant medical repercussions.

Clinically speaking, one's HIV status is identified by serological tests of blood samples; namely, the ELISA and LIA (Line Immuno Assay).

The former detects one's previous exposure to HIV. The latter, a supplementary test, confirms the presence of p24 antibodies or the HIV (Human Immunodeficiency Virus).

Provisions should be made for the inaccuracies of testing during the "window period" (where the antibodies are not formed yet, although the viral load is high).

The window period is approximately three weeks to six months after the unprotected (sexual) exposure to someone who is infected. Dr Abdul Aziz, however, states that "the Ministry is only going to screen for HIV once as early as possible in the pregnancy while those within the window period may be identified in the next pregnancy".

Such a non-committal concession is cause for concern. The risk of vertical transmission to the foetus is between 20 and 30 per cent for mothers who are HIV positive but asymptomatic (seemingly healthy but infected).

According to the Health Minister, 95 per cent of HIV carriers of a total of 19,385 persons are male and 33 per cent are infected through sexual contact.

The impact of this on monogamous, hapless women who may have been infected by their husbands, warrants in-depth study.

Pregnant women who are HIV positive, are counselled, regularly followed up on and if necessary, are administered anti-retroviral treatment in the form of AZT (zidovudine), or combination therapy/drugs.

The latter is markedly more effective and as such, more costly (almost RM3,000 per month). The limits of drug supply in turn, result in its discriminate prioritisation.

Equitable guidelines in minimising such adverse outcome need to be outlined. What will the criteria of judicious drug dispensation be? Which group of women stands to benefit?

Unless her CD4 cell count is at a critical level (200 and below), the woman stops receiving AZT after delivery. She will of course, be advised in consultation with her physician.

The infant at birth is immediately given AZT until six weeks, whereupon it is monitored closely and treated accordingly.

Would it be simplistic to infer that the health of the child is privileged over that of the mother's? She is after all no less susceptible to opportunistic infections (that is, TB, diarrhoea, fever, PCP or Pneumocystis Carinii Pneumonia).

The issue of mother-child health (MCH) should ideally be complementary, where the well-being of both is paramount. "Are we going to go all out to keep these mothers healthy?" challenges Marina.

That "the mother, child and husband will be counselled and followed up for the rest of their lives", as Datuk Abdul Aziz claims, is a sheer human impossibility.

The availability of culturally sensitive pre- and post-test counselling that are vital for the informed consent of pregnant women, already exhaust the capabilities of counsellors.

Irene Fernandez of Tenaganita asserts that "the follow-up is much more than a medical exercise. There is an overly caution of let's-not-get-more-infected. What is needed is a holistic approach, one that encompasses both treatment and adequate support systems".

The policies and guidelines to HIV testing as specified by WHO (1994), pointedly states that, "the best time for prevention is prior to pregnancy.

Married or unmarried, people need to be aware af all the implications of HIV infections before they decide whether to have children".

The random testing of pregnant women therefore, is not only ineffective but inappropriate and prohibitively expensive.

(END)