AY DA

Chapter Nine

On Track to Dwarf every Catastrophe

Not too long ago, in early 1997, I was working closely with the United Nations Development Programme and the National AIDS Programme of Nepal. The number of AIDS cases written in white chalk on a small blackboard in the room of the Director of the National AIDS Programme was 546. I remember the light-hearted laugh of the Director as he commented, 'Ms Nath, HIV/AIDS is just one bus accident for us. It is not a catastrophe'. Perhaps countries in other parts of the world were experiencing similar manifestations of the 'denial syndrome'. A study in 1997, undertaken by UNAIDS and Harvard, showed that in that year the international donor countries devoted only $150 million to AIDS prevention in Africa. This was less than the cost of making the Hollywood extravaganza, called *The Wild West*! This was in fact the cost of building 12 kilometers of a double track motorable highway in the United States of America.

Today, in the morgue of Parirenyatwa Hospital in Zimbabwe, head mortician Paul Tabvemhini opens the door to the large cold room that holds dead bodies. But it is impossible to walk in because so many bodies lie on the floor; wrapped in blankets from their deathbeds or dressed in the clothes they died in. Along the walls, corpses are packed two to a

shelf. In a second cold storage area the shelves are narrower, so Tabvemhini faces a gruesome choice. He can stack the bodies one on top of each other, which squashes the face and makes it hard for relatives to identify the body or he can leave them out in the hall unrefrigerated. He refuses to deform the bodies so a pair of corpses lies outside on gunnys behind a curtain. The odour of decomposition is faint but clear. This in fact is the level of the AIDS catastrophe in Africa.

There is no reason why the tragedy or catastrophe should be any different in the other regions – it is perhaps only a matter of time.The wide crescent of east and southern Africa that sweeps down from Mount Kenya and around the Cape of Good Hope is the hardest hit. Here the virus is cutting down more and more of Africa's most energetic and productive people aged between 15–49.

According to a recent analysis undertaken by the World Bank in Africa, AIDS will have killed 15,000 teachers in Tanzania by the year 2010 and the training of new teachers to replace them will require $37.8 million. In Côte d'Ivoire a teacher dies every school day. In Zimbabwe half of the patients in hospitals are infected by HIV/AIDS. Kenya will need to spend half of its national budget to treat HIV/AIDS. Households in Côte d'Ivoire are already experiencing a 67 per cent drop in income because of HIV/AIDS. Between 20–30 per cent of workers in South Africa's gold mining industry – the mainstay of the country's economy – are estimated to be HIV-positive; replacing these workers will cut into the industry's productivity.

Catastrophes and challenges have riddled human history over the ages. The challenge that this epidemic is posing is unique. For example, the slave trade also targeted people in their prime, killing or sending into bondage perhaps 25 million people. But that happened over four centuries. Seventeen years have passed since the AIDS virus was first found in Africa on the shores of Lake Victoria, yet the virus has already killed more than 11 million people in Africa alone. Close to 23 million people

in Africa are now living with the virus.

War and conflict are no doubt catastrophic. Last year the combined wars in Africa killed 200,000 people. AIDS has killed ten times that number in the same region over the same span of time.

Other catastrophes – floods, famines, earthquakes, volcanic eruptions – kill large numbers of people in one swift sweep, leaving behind pain and agony, but in the wake of the HIV/AIDS epidemic these environmental disasters seem, to me, much easier to cope with. They have a certain level of in-built resistance for the affected. Food aid, rehabilitation opportunities like credit assistance, medical assistance, setting up of refugee establishments, above all a kind of sympathy, love, concern and affection make reconstruction possible. I have met victims of disasters caused by earthquakes, floods and famine, and they do reminisce about the tragedy of the past, but they seem to be able to look at it as a pain left behind. The tumultuous moments faced as a result of mass dislocations of populations amidst massacre and terror are related by the victims of such tragedies with an almost anecdotal value and spirit. The events are usually dramatised and told by grandparents to their grandchildren, and often used to stir a sense of gratitude in the next generation for not having gone through those moments. These tragedies often bring with them an inbuilt resilience. As I relate this my mind is conjuring up the vision of the Indo-Pak conflicts, the stories of the partition of the two countries related to me by my grand-uncles, who lived through it all, lost a lot but regained all that was lost in less than a generation. I do not see this kind of resistance in households and nations reeling under the shock of the HIV/AIDS epidemic. The epidemic is truly on track to dwarf every catastrophe. In other catastrophes the worst consequence is death, in HIV/AIDS the worst consequence is not just the dead, but the living who are left behind.

According to Geoff Foster, the founder of the Family AIDS Caring Trust (FACT): 'The orphans of the AIDS epidemic are more likely to be poor, more likely to be deprived of education, more likely to be abused,

neglected and stigmatised and when they get HIV and die who will care for their children? Nobody, because they will be children of orphans with no grandparents.' The immensity of this catastrophe was brought out with stark data analysis by Dr. Mechai Viravaidya on the floor of the UN when he declared that there had been a 400 per cent increase in orphans in Cambodia, a 300 per cent increase in Vietnam and Myanmmar, and that in his own country, Thailand, by the end of the year 2000 there would be 90,000 orphans. I heard Mechai in astonished silence. The adage that 'it took a village to raise a child' seemed to fade away from my consciousness. The projections go on. Ms Eimi Watanabe, the Assistant Secretary General of the UNDP highlighted the catastrophe on World AIDS Day in 1999: 'Before HIV/AIDS was on the horizon one in 50 children were orphaned, but today it is one in 10 and by 2010 it has been projected that in some countries in sub-Saharan Africa one in every three children will be orphaned.' She was quoting from empirical work recently undertaken by the World Bank in the African region.

In 2000, the South African researcher, Martin Schontiech published a paper that begins by noting 'In a decade's time every fourth South African will be aged 15–24. It is in this age group that people's propensity to commit crime is at its highest. While some causes of crime can be curtailed, other causes such as large numbers of juveniles in the general population and a high proportion of children brought up without adequate parental supervision, are beyond the control of the state. No amount of state spending on the criminal justice system will be able to counter this harsh reality.'

More AIDS and more crime are among the most dramatic consequences of the orphan explosion. An increasingly poor population experiencing intergenerational poverty and less investment by the capitalists in countries with mature epidemics is crippling any possibilities for the alleviation of human suffering.

Today, every minute, 5 more people under the age of 25 are being

infected. More than half of these are women living in the developing world. These women are facing a host of ethical dilemmas as they confront the HIV/AIDS epidemic. I echo a few of their concerns and anxieties. Should they risk giving birth to a sick child? Can they ever get access to protocol 076 that could prevent this from happening? Would they be cheated and used as a placebo if they volunteered to participate in research trials? Will their child die if they did not breast feed him/her for fear of mother-to-child transmission? Will their community forgive them for not breast-feeding their child? If they do opt for not bringing a sick child into this world who will ensure that they have access to a safe medical termination of pregnancy?

What gives meaning to our work is that these are only dilemmas and not dead ends. The dilemmas do have answers and these answers can be found if we decide to re-engineer development with the richness of the perspectives of people living with HIV/AIDS. For me, the story of the epidemic is none other than a story of lives shattered by tragedies and lives rekindled with hope.

Esther's Story

Working with development issues there comes a time when one gets a little frustrated. It's difficult to mark success. Sometimes we do not know for years whether the work done has made a change or touched a life. That is one reason why Esther's story has so much meaning for me. But that, of course, is not the only reason. Esther's story is perhaps the landmark milestone from tragedy towards hope.

Esther's story is real.

The year – 1998. The place – a doctor's clinic. The purpose – a check up for her sick child . . . and it was then that lightning struck. Her sick child needed a blood transfusion and she gave her sample. The sequence of events seem almost like a third-class soap opera. The doctor informed her that she and her

child were both HIV-positive. Bewildered and scared, she asked him what to do. He callously replied that she could not do much as AIDS could not be cured and anyway she would not live long. Esther's nightmare was far from over. She turned to her husband for solace and support but he left her after coming to know that she was HIV-positive. Esther spent the next four years in agony, in pain, in despair. Until she came across a newspaper clipping which read 'HIV/AIDS – THERE IS HOPE'. There was a phone number and a name beneath the heading. Esther wasted no time and spoke on the number to Linda Francis, a social worker at the organisation called 'THE CENTER'.

Then life changed. She was told categorically that being HIV-positive does not mean that one was dying. After long hours of counselling Esther emerged a much stronger and a more positive human being. Today Esther is employed as a counsellor. She is not dead as had been predicted, instead she is more alive than many of us.

Esther's story is not hers alone – this is the story of many AIDS victims across the divide. They have lived through it all – pain, rejection, desolation and fear. They have triumphed over them, to move from tragedy towards hope.