Chapter Ten

Lives Shattered by Tragedy and Rekindled with Hope

Armchair philosophising is an intoxicating pastime. We often tend to argue over past tragedies, hoping to draw lessons from events that have passed. Could the lives of more than 6 million Jews have been saved had the railway tracks that led to Auschwitz been bombed? Could the partition of a strong south Asian nation have been prevented by timely counselling of the headstrong leader? Could the Vietnam war have been shortened by the creation of strong lobbies in the civil society of the USA? Could the two million Cambodians who were slaughtered by a mad dictator have been saved by aiming to eliminate the political dictator Pol Pot and his party, the Khmer Rouge? I have often wondered why these discussions are held after the worst is over and solutions offered in hindsight. Discussions held after the event can only be intellectual debates. They cannot be an antidote. In search of an answer, I have often pondered and felt that these kinds of humanitarian tragedies bring with them a sense of responsibility and an ensuing guilt for us all.

The situation is no different in the case of HIV/AIDS. The epidemic is constantly and repeatedly asking us just one question, 'Are you human?' We try to put up all our defences, snap out of our apathy, but the query is relentless. 'Are you human?' 'What verdict will your descendants pass on

you if you stand by silently while a generation of children is reduced to a biological underclass by this sexual holocaust?' In sheer tiredness and guilt we have been stirred into action. Perhaps this explains the upswell of interest after more than a decade of relative apathy towards the issue of the HIV/AIDS epidemic.

Propelled by the same compulsion, on the tenth day of the first month of the new millennium, the UN Security Council turned its powerful attention to the epidemic. It signalled an international recognition that the problem of the AIDS epidemic could no longer be ignored. The Security Council had never before dealt with a health issue. The issue of HIV/AIDS was proclaimed as an issue of human security and not just an issue of health alone. The Security Council was now signalling to the national leaders and the heads of private corporations that they must get their priorities right. Lives had been shattered by tragedies, but now these lives needed to be rekindled with hope.

I sat in the Security Council listening to the statements being made. The Executive Director of the UN Joint and Co-sponsored Programme on HIV/AIDS, Dr. Peter Piot, outlined the enormity and urgency of the problem. Ambassador Holbrooke, the Permanent Representative of the USA to the UN, stated, 'In my view the first requirement is to destigmatise the disease. All Americans will remember when Nancy Reagan held the AIDS baby; it was a major step towards destigmatisation. The epidemic threatens not only human lives but also the entire human community.' Vice President Al Gore declared that his participation in this unprecedented event was due to his long track record of arguing that national security in the post-Cold War world went much beyond its narrower definition. The Health Minister of Zimbabwe questioned the logic of the developed world in spending $600 billion on the millennium bug, a virtual virus, and only $150 million in Africa on the HIV virus, a real virus that was growing exponentially and shattering the lives and livelihoods of men, women and children. In the same august chamber, the

representatives of developing countries were raising questions filled with anger and indignation, 'Why was treatment for HIV/AIDS concentrated in the countries of the north, when the patients were in the countries of the south? Was this not another form of ethnic cleansing? When and how would pharmaceutical companies take responsibility and make drugs accessible and affordable to those who needed them the most? A fund for this kind of therapeutic solidarity needed to be created, suggested France. When would a vaccine be developed, considering that the international donor community had allocated $300 million a year for this purpose? Heated debates, arguments and counter arguments were put forth on very pertinent issues.

The chamber of the Security Council in the UN building in New York is a chamber that for me had always been void of any real humanitarian feeling. Its membership, I had felt, was politically orchestrated, its discussions were politically manoeuvred and its conclusions were politically biased. But on 10 January 2000, my impressions underwent a sudden transformation. I could see a new Security Council emerging in this era of HIV/AIDS. It is axiomatic that predictions of humanitarian tragedy rarely compel the world to mass action. On 10 January this axiom was being proved wrong. The chamber of the Security Council had suddenly become alive as mere facts and figures were transformed into a call for action. Hope was once again being rekindled.

For me the event had astronomical implications. Earlier, as an activist and then as an employee of the United Nations, trying to champion the cause of people living with HIV/AIDS had always been an uphill drive. Lack of political commitment had always been the bottleneck to sincere efforts and their sustainability. This event had finally put the issue of HIV/AIDS on the world's radar screen.

My elation on this day was, however, tarnished. It was not absolute. Why? Because the entire debate remained blind to the gender dimensions of the epidemic. Except for the 'reading out' of some very basic data on

prevalence disaggregated by gender, there was no attention drawn to the unquestionable need to put the concerns of women on the global agenda in a world where the epidemic was now empirically proving to affect women more negatively than men. Gender inequalities were being exacerbated by the epidemic and it was now growing and taking roots in the cracks and crevices of these inequalities. What was most disturbing was that a number of the member states present in the Security Council on this momentous day had also been associated not too long ago, in fact less than a year earlier, with a resolution on the girl child and HIV/AIDS, passed and endorsed by 45 UN member states, as a result of an active intergovernmental process, at the forty-third session of the Commission on the Status of Women, in March 1999.

In its resolution 43/2, dated March 1999, on 'Women, the Girl Child and the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome', the Commission on the Status of Women had noted the growing proportion of women being infected with HIV in every region, especially among the younger age groups. The Commission had asked governments, relevant UN agencies, funds and programmes, intergovernmental and non-governmental organisations, individually and collectively, to make every effort to make combating HIV/AIDS a priority and to implement effective prevention strategies and programmes. It had called, in particular, on the international community to intensify its support of national efforts against HIV/AIDS, particularly in favour of women and girls. The intergovernmental body had invited the UN Secretary General to report to the Commission on the status of women in its forty-fourth session. The Commission had urged governments, with the assistance of the relevant UN agencies, funds and programmes, to adopt a long-term timely and coherent AIDS prevention policy with a public information and education programme specifically tailored to the needs of women and girls within their socio-cultural contexts, keeping in mind the sensitivities and special needs in their lives.

Why then was so little attention being paid to the gender dimensions of the epidemic at the UN Security Council? The onus of blame and responsibility falls on us, as we have perhaps underestimated the level of advocacy needed to make these issues central to any discourse.

The resolution of the forty-third session of the Commission on the Status of Women and the discussion in the Security Council on the HIV/AIDS epidemic has created a normative environment. This can enable affirmative action to refocus the monitoring of the epidemic into different groups, with attention to the implicit gender biases in current surveillance procedures. The new focus should definitely include the younger age groups with a systematic gender disaggregation. The lower average age of infection among women as compared to men makes this a priority. Similarly, a closer integration of the monitoring of the HIV/AIDS epidemic with data collection on maternal and child mortality will highlight areas where AIDS-related deaths are currently being missed. This is because there is a possibility that female deaths caused by AIDS are marked by mortality associated with other causes of maternal death, and infant mortality may go similarly undetected, leading to inaccurate assumptions about HIV among mothers. At present the detection of the epidemic is biased. Men living with HIV are detected more readily than women are. This is because whereas sero-prevalence surveys reach men in the general population through samples drawn from the military, prisoners, etc., such surveys for the detection of the number of women living with HIV are conducted only in antenatal clinics. This does not take into account fertility differences between HIV-positive and HIV-negative women. It also ignores the realities that surround sexual networking patterns within the framework of a gender-based construction of sexuality, for example the assumption that housewives are not at risk of contracting the virus.

The above-mentioned international instruments and historic events have also cleared the ground for a gender sensitive re-examination of the

legal and ethical environment surrounding the lives of people living with HIV/AIDS. Today there is reason to believe that the creative use of law, based on an appreciation of complex social values, may be able to bring about changes so that the abuse of human rights is minimised, if not altogether eliminated. The law can, therefore, play an important role in seeking to change the underlying values and patterns of social interactions that create vulnerability to the HIV/AIDS epidemic.

At the very onset, we need to examine with a gender-sensitive lens the laws relating to the prevention and suppression of sex work; the laws that reduce women's access to productive assets, for example, the laws on inheritance, marriage, divorce and traditional sexual practices; the policies or laws regulating sex education in schools; and the rules relating to the professional and ethical orientation of service providers. The process, we are convinced, will not be an exercise in futility. What is needed is to make the discussion as broad-based as possible. It was this kind of broad-based dialogue that led to the declaration of rape as a war crime in Vienna in 1994. It was such an exercise that led to the Thai government proclamation of laws requiring brothel owners to insist upon condom use by the clients of sex workers. Similar successes have been recorded in Australia where sex work has been deregulated or in the Philippines and former Hong Kong where a convention on HIV and the workplace has been endorsed by the legislature. In South Africa, the constitutional rights of homosexuals have been upheld. This has been possible because the voices of men and women have been able to break out of the silence that has been enshrouding the intriguing area of sex and sexuality.

And as hope is rekindled, the issue of better access to curative and palliative medicines will need to be confronted. Very recently the leading US daily, *The New York Times*, carried the headline, 'Pain Relief Underused for Poor – Study Says'. The news item highlighted how a study conducted recently by the International Narcotics Control Board revealed a severe shortage of morphine and other pain killers in poor

countries. The 10 largest consumer countries accounted for as much as 80 per cent of the analgesic morphine consumption of the world. We will need to tilt this balance because 90 per cent of HIV infections are occurring in countries that are resource poor and consume a small fraction of the world's resources. People living with HIV/AIDS need to live and die with dignity through continued access to at least the basic medicines required to treat opportunistic infections – ORT packets, drying powders, bandages, pain killers etc. In addition cheap antibiotics need to be made available to women and men to treat STDs such as chlamydia and gonorrhoea which make them more susceptible to HIV/AIDS. Studies suggest that treating such conditions with cheap antibiotics can cut new HIV infections by as much as 40 per cent.

I do not feel comfortable taking the discussion to a more compelling and aggressive advocacy of access to AZT, or to vaginal microbicides or, for that matter, even to the rather costly female condom. For if I do, I would be moving onto an unreal though desirable plane. The cost of triple drug therapy amounts to $500 per person per year even after the recent reductions negotiated with the drug companies. The prospects of resources being available to treat each case of HIV/AIDS per year in the less advantaged part of the globe is dismal.

Table 6

Botswana	$14.27
Kenya	$13.43
Malawi	$8.94
Mozambique	$2.40
Namibia	$8.00
Rwanda	$27.63
Zambia	$8.07
Zimbabwe	$9.32

Source: Jeffrey Bartholet, *Newsweek*, 17 January 2000

As flickering flames are rekindled, needs assessments of orphans and caregivers in the worst affected countries are being undertaken. Emotional and practical support is being promised to those who come out with their HIV status and a spirit of social inclusion is being fostered. Efforts have begun to empower women to be able to negotiate safe sex with their partners. Adolescents are being helped to make informed sexual choices. Data collection processes and procedures on the epidemic are being revised. In some of the worst affected countries AIDS is being declared as a national disaster, backed by the establishment of Crisis Management Committees. The mandate of these committees is to crest the epidemic at a lower level than projected.

Some options seem to be closing. Believing that HIV/AIDS is someone else's problem is no longer an option. Believing that HIV/AIDS is just another disease is no longer an option. The only options are acknowledging that HIV/AIDS is a crime against society; acknowledging that the orphans of the new generation have a boundless horizon before them; acknowledging that the walls of sexual oppression need to be scaled, if not torn down; acknowledging that the way ahead needs to be built on expanded partnerships compatible with national priorities, sensitive to local contexts, driven by innovation and above all ethically unassailable. Only then will we be able to translate human tragedy to human hope.