What Archbishop Desmond Tutu says:

"In an ideal world, we have hoped that everyone would be responsible about sex . . . that everyone would behave as we would have hoped they would do. Unfortunately, in the real world that is not the case and it is to fly in the face of ghastly fates to pretend otherwise. So we are going to have to teach people so-called safer sex, we are going to have to speak about condoms and seek to make it possible for people to have access to reproductive sexual health."

— From a video address on Breaking the Silence, at an HIV/AIDS symposium in South Africa

CLERGYMEN may have ditched their militant stand over HIV/AIDS for a more compassionate approach, but they are adamantly holding on to their opposition to condoms as a means of preventing infection.

In a communiqué to Vice-President Ahli Mahama in mid-November, the leaders of major religious organisations said they would speak more openly about sex from the pulpit and encourage their leaders to accept people living with HIV/AIDS, besides continuing with their messages on abstinence and fidelity.

This new position comes as a welcome relief for health professionals and other stakeholders who have long complained of the attitude of some churches and faith-based organisations that routinely condemned people living with HIV/AIDS as immoral.

But the main challenge for health professionals and groups working with non-governmental organisations still remains how to convince the churches to embrace condoms in the fight against the pandemic.

Says Samuel Aboga-Mensah, general secretary of the Christian Council of Ghana: "There are still grey and unresolved areas which would not make it possible for the churches to give in to condom use as a means of HIV prevention."

Few people are willing to stir the hornet’s nest and the member churches on the council have settled on activities and education around abstinence and faithfulness. "Sections of the Christian community would not understand or accept the condom messages," says Aboga-Mensah. "Besides, we are really doing more to keep the youth occupied and, for the moment, our focus is on helping people living with the disease."

Health professionals argue, however, that this stance will not help the country deal with the rise in HIV/AIDS. Over half a million Ghanaians are infected with the virus. It is pointless, they say, for churches and faith-based organisations to speak about morality and ignore the condom issue.

They contend that when churches preach their anti-condom creed and rail against HIV prevention programmes that even remotely appear to promote condom use, they fail to appreciate the fundamental principles of risk reduction and health promotion.

Some churches have, however, approved the use of condoms in anti-Aids programmes. A couple of years ago, six Christian denominations in Zimbabwe unequivocally stated that condoms could be used within the family to prevent transmission. About 38 church leaders made the announcement at a workshop in Kadoma, 140 kilometres southwest of Harare. Zimbabwe is among some of the countries worst hit by the pandemic.

But Malawi’s Council of Churches says, however, that government efforts to promote condom use are immoral. Augustine Musopole, secretary-general of the council, is on record accusing the government of Malawi, which is in the throes of a massive crisis, of encouraging promiscuity by making available hundreds of thousands of condoms. According to the clergyman, research indicates that condoms are not 100 percent effective against HIV. His solution? Abstinence and strict monogamy.

The Catholic Church, in turn, has spearheaded a massive international campaign

By Eunice Menka

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SAVING CHILDREN FROM THE WORST

By Margaret Nankinga

ABOUT 30 women sit on the floor with their children at the Johns Hopkins University/Makerere University research centre. Each holds a mug of porridge and a bun. They eat as if their very lives depended on it. All is quiet, except for a few babies who are either crying or gurgling with satisfaction.

They are part of a research on Nevirapine, a drug used in preventing mother-to-child transmission of HIV/AIDS. The women and children have come for review, advice and medicine. Since having regular meals is critical to mothers suffering AIDS, the research institute also provides them with meals.

Philippa Musoke, principal research centre investigator of Nevirapine, says: “We enrolled 645 women in the study of Nevirapine versus AZT in March 1998. In late June 2001, 145 of the women in the AZT group. They are on a three-year and have recorded about half of the women (310) received Nevirapine. Their babies are doing fine, except for those who were HIV-infected despite the intervention. Children with HIV die sooner than the rest. But our infant mortality rate and under-five mortality rate is high, so even some of the HIV-negative children have died.”

The researchers have been following the children and mothers for three years and have recorded no major side effects of Nevirapine. They say the drug reduces the chance of transmission through breast milk during the time that it is in the circulation of the baby — two to three weeks.

About 30 percent of mothers who have HIV infect their babies. One of the problems is that some women and children develop resistance to the drug after a dose. Nevirapine crosses the placenta to the foetus. At 14 fold weeks, 11.1 percent of infants who received Nevirapine were infected with HIV, compared with 17 percent of those in the AZT group.

“We give guidance and counsel to the HIV-positive people,” says Betty Muusoke, operations manager of the Health Information Centre at Mengo Kisenyi in Kampala, “but we refer pregnant women to the Johns Hopkins University Centre at Mengo Kisenyi. They say the drug reduces the rate of mother-to-child transmission by up to 36 percent. However, the rate is high, so even some of the HIV-negative children have died.”

The October 2002 issue of the Royal Society of Medicine’s Journal of STD & AIDS says that an exhaustive review of data does not support the assumption that over 80 percent of infections in African adults is through heterosexual means. In fact, they say, heterosexual transmission could account for only one-third of the infections and unsafe medical procedures, including use of contamination injections and blood, could play a bigger role than has been previously acknowledged.

According to David Gisselquist and his team of researchers, surveys among African couples find low rates of heterosexual transmission, just like in the developed countries. At the same time, several studies report HIV infection in African adults with no sexual exposure to HIV and even in children with HIV-negative mothers. The new report is likely to put in the spotlight the preventive strategies being pursued in Africa, with greater emphasis on medical procedures that do not meet the standards for sterilization, safe blood, stopping the use of unsafe needles and related issues, such as unsafe abortions.

Global statistics from the World Health Organisation estimate that unsafe injections cause an estimated 250,000 new HIV infections each year — about five percent of all new infections — and that most of these occur in South Asia and Africa. The researchers argue that these estimates “may be an order of magnitude too low.”

In Africa, they say, many studies show that 20 to 40 percent of HIV infections in adults are actually associated with injections.

The report has generated a great deal of comment. Unsafe medical practices, analysts argue, are among the consequences of poverty in Africa — which, to a large extent, have been exacerbated by World Bank and IMF policies that have forced reduced spending on health care.

In Kenya, patients in many public hospitals are required to buy their own needles and syringes. Some medical centres also ask patients to bring their own gloves. Yet not all patients can afford the Sh10 ($0.80) it costs to buy a needle and syringe. It often boils down to a choice between medical supplies and food, probably the main or only meal of the day. It is common, therefore, for needles to be re-used or shared to cut down on costs — and they are unlikely to be sterilised each time.

Recent related studies have concluded that the average person in the developing world receives 5.5 injections per year and that the proportion of those that are unsafe is greater than 80 percent.

Injection technology has developed considerably since the Eighteenth Century, moving from glass syringes that require sterilisation with each use to plastic disposable syringes designed to be discarded after single use.

Compelling as its arguments seem, the Gisselquist team acknowledges that more research is required on the relationship between HIV infection and unsafe medical practices. Until the researchers have concrete data and analysis to back their case, this line of reasoning is likely to invite a great deal of skepticism.

One disbelief is that, in Africa as much as in any other continent, unsafe sexual practices and behaviour are overwhelmingly the predominant risk factor for HIV transmission.

“Certainly, blood safety and proper use and sterilization of needles and syringes are important issues, but they pale by comparison to sexual transmission as a current risk for HIV transmission in Africa,” Kline told Africawoman.
F or four months, I hesitated. Finally, I sought the advice of three friends. “Why should you go for an Aids test and stress yourself out?” Sheila shot back. A friend from my teaching days, Sheila was in her early forties and getting fatter by the day. “And what would you do about it even if you knew?”

I had no answer to that. “Just live and be happy,” she continued. “Life is too short to worry about such things. As for me, I will not go for an Aids test, if only to spare our family doctor. He wants to manage my weight and I need to wear headscarves.”

Mary, in her mid-fifties and with two daughters at university, chose to be neutral. “The issue is not knowing whether or not you are HIV-positive but to live well and not worry about too many things. Just eat well and look after yourself. For all we know, we may all be positive.”

Zenda, my long-time friend from university and a single mother, was more pragmatic. “Listen,” she said, “you will go for the test when the time is right. Time will send you. In the meantime, make sure you protect yourself. As for me, I never sleep with my boyfriend without a condom and I check physically every time to see that he is not going to use me as a guinea pig. When I went to him with a sore throat he told me to go for an Aids test. But when my husband went with the same complaint, he merely gave him prescription.”

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“My husband of 18 years suddenly lost half his weight towards the end of 2001. By the beginning of 2002, he was looking ancient. And, as if that was not enough, he shaved his head, donned long white garments and joined one of the many emerging ‘Glory Alleluia’ churches that go up the hills every weekend for all night prayers.”

By Ruth Gabi, Zimbabwe

I began worrying seriously at the beginning of February. My hair was thinning and falling fast. The children joked about it, saying my head was now the Kalahari Desert. I had never had much hair. In fact, I was often referred to in Nyansa as uja alibe sisi, meaning “that one with no hair”, when I had never had much hair. In fact, I was often referred to in Nyansa as uja alibe sisi, meaning “that one with no hair”, when I was in secondary school in Zambia. To cover the bare patches on my head, I took to wearing headscarves.

In March, I started suffering night sweats and heart palpitations. I would wake up at 10 o’clock. There, looking at the green heater in the room was on. I, on the other hand, had only a skirt and bloused and yet I was sweating. I told her I was hot and she switched off the heater.

“I want to know the answer to some questions,” she began. “If some of them are too personal you can just tell me to skip them.” She read something that sounded like a charter about abortion. I hardly listened. All I wanted was for the test to be over and done with.


For fear of prolonging the interview, I didn’t tell her that my husband had not used condoms with her and that I was worried. “Now, I will take a little bit of blood and we will know the results in 10 minutes,” said the counsellor, prickling my left thumb. I was too numb with worry to tell her to take it from my right thumb, as I am left-handed.

“You can go to the waiting room,” she said, putting the slide on a table full of gloves and syringes. I said I preferred waiting where I was. I did not have the energy and courage to stand up before I knew my status. Even if I had wanted to go out, I don’t think my body would have obeyed me. It didn’t belong to me any longer.

I watched the minutes tick by on the wall clock. I looked at the bit of blood on the slide that would decide my fate. I tried not to think, but I kept thinking. “What if...” I had to stop thinking. I picked up a pamphlet titled Nutrition Guide for People with HIV and began reading. The least I could do was prepare myself.

The counsellor returned at 9.45am. She picked up the slide and circled something on a form. I looked at her anxiously and tried hard to read her face. It was completely impossible. She then came and sat opposite me. “The results are negative,” she said quietly. I looked at her in disbelief. As the word “negative” finally registered, tears of joy welled up in eyes. “Thank you,” I said, looking her in the face. “You are very brave to be doing this every day.”

“My husband of 18 years suddenly lost half his weight towards the end of 2001. By the beginning of 2002, he was looking ancient. And, as if that was not enough, he shaved his head, donned long white garments and joined one of the many emerging “Glory Alleluia” churches that go up the hills every weekend for all night prayers.”
Let African women live

This issue of Africawoman is dedicated to a subject that is as tragic as it is pervasive. HIV/AIDS is devastating not only in the number of people it takes to the grave but also the destruction of a way of life for those left behind. In the articles in this edition, you will read of the pain of families ripped apart by HIV/AIDS; you will feel the fear associated with an illness that takes away parents and leave children either in the care of elderly relatives well beyond child rearing or children left all on their own in the world.

More than anything else, HIV/AIDS has brought out into the open the aspects of culture and traditions that have often meant that African women have little or no power of negotiating safe sex.

Even though they may live in a regime that means they must accept that their men will not be monogamous, these same women often bear the brunt of social prejudice that is quick to apportion blame to them. And just as quick to throw them to the wolves when they fall ill or they become widows.

Traditional practices such as early marriage and female genital mutilation, once upheld as the only way to keep women chaste and pure, are these days blamed for the social and health problems that many women continue to endure.

No doubt, the African states must engage in the social work and social action in order to ensure that the women in their countries have a say in the social and political change. It is then that the needs of poor women living with HIV/AIDS at the international level, but it is also in a day's work for the executive coordinator of the International Community of Women Living with HIV/AIDS in the United Kingdom.

Back in Uganda, women fought hard to see that the needs of poor women living with HIV/AIDS were met. Because of her efforts, over 15,000 women now come together under the umbrella organisation National Community of Women Living with HIV/AIDS. It has been a long journey for Were, who took the brave step of saying “No” to violence at the first Feminist conference for Latin America and the Caribbean. November 25 was declared the International Day Against Violence at the first Feminist conference for Latin America.

Women and children bear most of the burden of HIV/AIDS.

Do this in memory of our mothers

By Joan Mugensi, executive coordinator of the International Community of Women Living with HIV/AIDS

At the fourteenth International Aids Conference held in Barcelona, Ugandan activist Beatrice Were was one of a core group of people desperately in demand. Though frail and easily tired, Were moved from working sessions to press conferences and planning sessions. This was vintage Were. It’s been 11 years since she left Africa to push the agenda of women living with HIV/AIDS at the international level, but it is all in a day’s work for the executive coordinator of the International Community of Women Living with HIV/AIDS in the United Kingdom.

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McLintock’s home of compassion

Have for children with AIDS

By Edith Kimuli, Uganda

SIX THOUSAND babies are dumped every month in South Africa – some go hungry, some die. Some are abandoned in hospitals while others are abandoned on streets. And a few are lucky enough to land at Johannesburg’s Sparrow Village.

The Reverend Corine McClintock’s Sparrow Village, is a haven for children with full blown AIDS and other abandoned children. Adults with AIDS also find refuge in the Village which McClintock founded in 1992.

The centre – registered in the apartheid years as a guest house – has 43 nursing staff, three professional medical doctors. Its job is to accept the people others reject – and increasingly that includes HIV negative children.

The Aids stigma is so big in South Africa many mothers dump their babies when they realize they themselves could be infected with the Aids virus. Even though some of these children turn out to be free of HIV.

According to Nel Lynette, co-director of Sparrow Village, “some children test positive because of an- io-bodies from their mother’s blood, but later they test negative.”

Mothers with a high viral load usually pass the HIV on to their new babies as the infant passes through the mucus in the birth canal.

But the child’s status can convert to negative within the first six months of their lives.

The necessary anti-body test costs $20 but the more appropriate Polymerase Chain Test (PCR), costs $90. The PCR tests scrapings tissue like the lining of the mouth and is much more accurate.

So sometimes healthy children are treated with those who have the virus. “We do not turn away people, we refer them to other in- stitutions,” says 72-year-old Mc- Clintock.

Some of the children have been adopted, others have been settled in homes where Sparrow staff can help look after them.

The village started with 25 people and now houses over 800. “They arrived one by one, shared their lives with us, absorbed all the love and that love that they could give and receive, then left us one by one,” says Lynette.

The quick spread of Aids in South Africa has been attributed to the mining industry, which separates families for long periods, a high rape rate, low education and poor Law enforcement.

AIDS ravages education in Africa

The United Nations has warned that HIV/Aids is killing teachers faster that they can be trained, making orphans of students and threatening to derail efforts by highly infected countries to achieve education for all. It warns that a new global education strategy is needed to curb further infections, reports Anne Mugisa from Uganda.

The spread of Aids in parts of Malawi and Uganda are thought to be HIV positive, 20 percent in Zambia and 12 percent in South Africa.

That means countries like South Africa and Botswana are seeing a reversal of hard- won educational gains, according to the UN.

“Without education, Aids will continue its rampant spread. With Aids out of con- trol, education will be out of reach,” said [Peter Piot, Executive Director of the joint UN Programme on HIV/AIDS (UNAIDS)].

HIV/AIDS and education is a challenge for Policy makers in both education and AIDS, but its message speaks to everyone touched by the epidemic-teachers, education admin- istrators, school children, young people out of school, adult learners and community leaders living in a world with AIDS,” he said.

It’s getting worse. Half of the World’s 15,000 new infections every day occur among 15-24 year olds. Young people like Nichola Birungi, 12, one of 16 orphans living in homes where Sparrow staff can help look after them.

According to Lynette, the pathet- ic state of the children sometimes gets her very depressed.

Lynette says that at the home the victims learn not to worry about every little thing. “One little girl died, I told her go home to Jesus he’s waiting for you …”

The village started with 25 peo- ple and now houses over 800. “They arrived one by one, shared their lives with us, absorbed all the love and that love that they could give and receive, then left us one by one,” says Lynette.

Fifty-one people died and released a new action plan on HIV/Aids and education. They say more than 150m children aged 6-12, are out of school in de- veloping countries, two thirds of them girls. Of those who enter school, one out of four drop out before attaining literacy. And at least 55 of the poorest countries were un- likely to achieve universal primary enroll- ment by 2015 even before the HIV epidemic struck. Twenty-eight of these countries are also among the 45 worst hit by HIV/Aids.

According to the Ministry of Education of Uganda, HIV/AIDS related absenteeism is rift in schools especially for the girls who are also more vulnerable to HBV infection than the boys. The children are forced out of school when their parents or guardians fall ill in order to care for them and assume other domestic duties and as the family in- come falls girls are the first victims of the need to save income.
GHANA

What comes first: human rights or innocent lives?

By Golda Arinrah

ALBERTA

Hunuu died a lonely woman. Her husband divorced her soon after she was diagnosed with HIV/AIDS. Only 35 and a talented fashion designer, she died a pauper because she had spent all her money on medical costs.

Speaking two weeks earlier, Hunuu told a group of visiting students: “If you are in love, try not to keep watching myself waste away when I could do nothing about it.”

Her husband and his family would not even allow her to visit her children. She had been condemned out of hand as an adulterous wife, even though no one seems to find out if her husband was also HIV-positive.

Anecdotal evidence suggests that there has been a sharp rise in the number of women thrown out of the marital homes because they have tested positive for HIV”, says Gloria Ofori Buadu, executive director of the Federation of Women Lawyers-Ghana.

Many of these women are unable to sue for upkeep from their husbands, who generally do not consider it necessary to have the HIV/AIDS test. According to FIDA sources, they are more likely to discontinue the HIV/Aids test. According to FIDA, the Ghanaian government has national HIV/AIDS and Sexually Transmitted Infections policy, which says: “mandatory testing highlights discrimination, creates fear, resistance, and is also counter-productive to the aims of HIV/AIDS prevention, and does not help control the epidemic.”

Sakyi Anoma, director-general of the Ghana Aids Commission, argues that compulsory disclosure will not help reduce stigmatisation and discrimination against people living with HIV/AIDS.

Half a million HIV/AIDS cases have been reported in the local and international media since 1996. Initially, the ratio was six females to one male but this dropped in 2000 to two females to one male. Though the prevalence rate is 3.6 per cent, there are fears that there might be a knock-on effect from neighbouring countries that have a rate of more than five percent.

Some researchers have suggested, however, that it is dangerous for Ghana to be complacent about the low rate.

The reported cases, they argue, may represent only 30 per cent of actual cases in the country because most Ghanaians are more likely to seek help from traditional healers and pray centres rather than hospitals.

The Ghanaian government has already pumped $60 million into programmes to control the spread of the disease, but still has some way to go towards the $120 million required. By March next year, Ghana will start producing three anti-retroviral drugs for the management of HIV/AIDS. Nigeria and Cote d’Ivoire are already doing so.

Cote d’Ivoire has six treatment centres offering anti-retroviral drugs at reduced rates, through the HIV Drug Access Initiative of UNAIDS and the Ministry of Health.

Though significant investments have been made in the campaign against HIV/AIDS, the true battle remains at the social level, where stigma and discrimination is fuelled by the belief that the disease is the result of immorality.

The Love Life Stop Aids campaign, a presidential initiative launched two years ago, is aimed at creating a compassionate and supportive environment for those infected with HIV/AIDS. The theme of the second phase of the campaign is “Creation of Caring Communities” and is targeted at religious groups.

Most people who consider themselves pious tend to perceive the disease as divine punishment. Should a congregation admit to having members living with HIV/AIDS or be seen to “unudly concerned” about the disease, it may be considered an admission that it is immoral and weak in the faith it professes.

Whereas a law to compel spouses to disclose their HIV/AIDS status would help young women to peer pressure, would help young women to open up. As she puts it, “It was so soul destroying because she had spent all her money on medical expenses.

Her husband and his family would not even allow her to visit her children. She had been condemned out of hand as an adulterous wife, even though no one seems to find out if her husband was also HIV-positive.

The dilemma is compounded by the belief that the disease is divine punishment. But still, Makoude believes the answer is more and more education.

The marriage was not a happy one. Her husband kept her a virtual prisoner at home, fearing she would lose her to a younger man.

Two children later, she fled to Burkina Faso. “I found true love there — at least, that’s what I thought,” she confided to a friend. She soon fell pregnant and learned that she was also HIV-positive.

The baby lived only for nine months.

She returned to Accra and, turfed out of her aunt’s house, moved from one friend to another. Sometimes she found herself in the streets and at lorry stations, where she and other women took refuge.

Bernice Helen, executive director of Pro-link, a local NGO working with people living with HIV/AIDS, said: “I met her in the last years of her life and she was a joy to be with. Even when she was not feeling well, Habiba would not admit it. She was ever ready to be of service. Most of the times we talked about other things and not the disease.”

“But the discrimination she suffered was intense. Habiba would be by the roadside all day looking for transport to town, but no driver would pick her. They would stop, take a close look and drive off. But this never deterred Habiba. Even if she had to walk to get where she was going, she would do so.”

Habiba opened her home to many other women living with the disease: “Love is more powerful than any medicine we can give them,” she says simply. But she also thinks the women can only be helped if they open up. As she puts it: “They have to help themselves by opening up.”

Unlike many others, Alhassan died in the arms of her relatives. The aunt who had earlier rejected her took her back and nursed her until she died.

KEEPING A NATION’S HOPE ALIVE

By Grace Githaiga

THE image of 15 year old Mary* has remained etched on my mind since I watched her on television three years ago. The memory is of how she stood in front of a picture of her mother and a nun, and said: “I am happy to be alive, and I want to live longer to look after my two children,” she pleaded. But no one in the audience knew this 15-year-old woman’s wish. In October, she died after a 10-year battle with HIV/AIDS.

The mother of two teenage chil-
dren, Alhassan had every reason to live. She was beautiful, brilliant, enterprising, assertive and full of ideas.

At Tamale Secondary School in northern Ghana, her teachers believed she had the potential to go on to University. But after third year, she was sent to join her aunt in Accra in preparation for marriage to an old man who had another wife in neighbouring Togo.

The marriage was not a happy one. Her husband kept her a virtual prisoner at home, fearing she would lose her to a younger man. Two children later, she fled to Burkina Faso. “I found true love there — at least, that’s what I thought,” she confided to a friend. She soon fell pregnant and learned that she was also HIV-positive.

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Throwing money at AIDS is not the answer to problem

By Charity Binika, Ghana

Recent visit to three communities in dormaa District, on the border of Ghana and Cote d’Ivoire, confirmed my worst fears — there is no escaping HIV/AIDS, which has spread to virtually all cities, villages and hamlets. Yet we are all trying so hard to wish the disease away.

I was in the district with a team of experts from ActionAid who were on a re-connaissance mission preparing for a study on how people and households cope with the disease. The study will look at the expenditure pattern of affected and infected individuals and households.

My heart still bleeds long after my visit to Kofi Badukrom, Bebianeha and Benromen. I cannot erase the images of people suffering from the disease but who cannot talk about it for fear of stigmatisation.

Some are weak and need constant attention, yet they do not have the courage to disclose their status even to spouses and close relatives offering intimate care. A husband does not want his wife to know that he has HIV and a wife, who is ship-shownly, would not even keep it a secret from the husband. Some sufferers refuse to accept laboratory results while others simply refuse to return for the results after they are discharged from hospital.

Those who have HIV but still look healthy pretend nothing is wrong and have sex without taking precautions, spreading the virus further. Even when it is obvious that someone has the disease, no one dare ask. As one of the chiefs put it: “We can tell who has the disease by the way the person looks, but we dare not ask.” But another chief simply saw the face of the epidemic is increasingly female as the numbers of those infected equal those of men.

HIV/AIDS as “one of the numerous diseases that one is bound to suffer from ones one in four”.

It is terrifying indeed to know that people are literally “toying” with death because communities in Ghana are not ready to accept that HIV/AIDS is real and anyone can be infected — including that big man or woman, that MP, that seasoned journalist, that doctor, that renowned lawyer, musician, actor, actress and that prominent chief with many wives. Families quietly bury their beloved ones who die of AIDS, announcing to those who care to listen that he or she was cursed with a strange disease.

A Ugandan health economist who was on the trip summed up the seriousness of the situation when he said: “I feel really sad that people in Ghana are still at the denial stage. This is where we were more than 10 years ago. Everybody pretended the disease was not there. We just talked about it but did nothing about it. The consequences were devastating.”

Ghana is sitting on a time bomb and something has to be done beyond seminars, workshops and conferences. The fact that HIV is contracted mainly through sex makes it even more delicate subject. Sexual escapades are not activities easily spoken of in public. Indeed, the greatest challenge is breaking the silence over the disease.

Throwing money at HIV/AIDS is clearly not enough.

Also important is the issue of support and care. It is only when those who are infected are sure of care and support that they will come out of the closet. When people begin to accept the fact that the disease can afflict anyone, regardless of status, they will come forward for voluntary testing and counselling.

This is why the work of Christian Health Association of Ghana stands out so vividly. The association is at the forefront in providing care and support for selected communities and has trained 30 volunteers in the Dormaa district to give solace to people living with HIV/AIDS.

Referred to as “friends of the sick”, they were used to call “friends of the people living with HIV/AIDS” but people would not accept them into their homes because of the stigma. These volunteers spend their time and money taking care of HIV/AIDS sufferers, who otherwise would have been abandoned. The sufferers are not willing to disclose their status to the volunteers. But they are more than willing to receive the needed support from the volunteers.

The work of the volunteers is valuable indeed in an area that is not well endowed in health services. They make a strong case for investment in HIV/AIDS control. For one, some of those infected have started opening up as a result of the confidence they have in the volunteers. They begin to talk, even in the home and every door is opened to them. As one of them rightly pointed out, “once people are assured of care and support, they will open up.”

The conferences, workshops and campaigns on condom use are all very useful. But even more effective is giving HIV/AIDS a human face and giving hope to sufferers. What is important is accepting the situation and learning to live a responsible sexual life to check its spread.

Even more heart warming is the news that with proper care, a person with full-blown AIDS can reduce their viral load and carry on with their lives. And that is the message of the volunteers. More than 90 percent of Ghanaians have heard about HIV/AIDS. Unfortunately, this knowledge has not been translated into behavioural change.

The silence surrounding HIV/AIDS is alarming. It is like sitting on a time bomb. We have a moral responsibility to each other: To live and let live, just as this year’s theme for World Aids Day put it.

AIDS leads to increase in mental health ills

By Ruh Gabi

Four times a year, Shamsio Mudepu travels 86 kilometres from her home in Bindura to the Harare Psychiatric Unit to collect her dose of antiretrovirals. This year, the 50-year-old has suffered two relapses and had to be admitted in hospital.

The first, in May 2002, was triggered by the death of her eldest son, who left a young wife and two children. He had been ailing from an Aids-related illness. He used to manage the farm, handle the livestock and look after the two children.

The second relapse came in August, when her 16-year-old daugh-
ter Lynette was made pregnant by one of the young assistants of the many self-styled n’angas (witch hunters) who traverse the country sniffing out so-called witches and evil spirits. Her husband, Jacob, ac-
vues Mudepu of “selling” their daughter for cash to buy bread and sugar for her older sister, who is bedridden and suffering from tuberculosis.

For a fee, the witchdoctors claim to cleanse families that have suf-
ered a spate of Aids death. At a weekly death rate of 2,000, few fam-
ilies have been left untouched by the pandemic. With all the ill for-
tune dogging Mudepu, her hus-
band’s relatives now say evil spirits from her original home have pos-
tured her.

Zimbabwe is in the grip of an eco-
nomic crisis, with the inflation rate of 1 percent, and families are having a hard time of it caring for ailing relatives.

Mature’s organisation has stepped up a campaign to get MPs to amend the Mental Health Act of 1976. This means people will be able to call on police to help them institutionalise a mentally ill rela-
tive. As it is, managing a mentally ill patient is considered a domestic matter.

The medicine Mudepu takes causes unpredictable mood swings and she often sinks into long peri-
ods of vacant silence. “Many people have very lonely lives these days,” says Prisca Munonyara, director of the Aids Counselling Trust. “Stig-
matisation is a challenge that needs to be addressed urgently. When a patient dies, support group coordinators are sometimes called and told ‘your colleague is dead and we do not know what to do with him or her’.

While Mudepu has retreated in to a world of her own, trained nurse and mother of two Julia chose to take an overdose of sleeping tablets. Sinking ever deeper into depression and increasingly dis-
tracted at her husband’s extramar-
ital affair and her HIV positive sta-
tus, she decided to end it all. When her husband discovered her body on their marital bed, the baby was still suckling her breast.

She was widely condemned. “How could she kill herself over a mere girlfriend?” asked a col-
league. “Now the girlfriend has all the time to enjoy herself with the husband.”

But, as it turned out, this was a case where there were going to be no clear-cut winners. Four years down the road, the widower — a medical doctor — died of Aids.
ZIMBABWE

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Locked into poverty and suffering
Little hope of treatment for most working women with HIV/AIDS

Janet, 30, returned from Malera trading centre at 7pm, greeted her mother and handed her smoked fish for dinner.

Thirty minutes later, the fish trader excused herself and went to “rest” in her nearby two or more wives is still an option for dinner, as it would disrupt her sleep. She was found lying dead on the rough floor the next morning.

Janet’s death has raised a lot of dust in her village. “Why did the old woman sell Janet’s only goat without her consent,” asked mourners. Moses Okello, a local councillor said Janet had bought and kept the goat for her mourners to eat at her burial. Many blamed the 83-year old woman for contributing to her daughter’s suicide by poison.

Josephine Naluw, a neighbour, revealed that Janet had endured many problems. She watched as one of the men who raped her died of Aids. Her husband and parents shunned her after learning she had HIV/Aids. Finally, her life was just too much to cope with.

Janet is not alone. Mariam Mukibi, 52, a mother of two, lives in Jinja, in Eastern Uganda, where she is employed as a tailor at a local training centre.

Mariam volunteers’ information about her HIV/AIDS status to whoever asks. “Auntie, I’m going to die. I see my life has ended now. I do not have money to buy food for the family and I don’t have money to buy medication. I’ll surely die. I see my life has ended now. I,” she said.

The unfortunate thing with HIV/AIDS is that one needs money, and for most women, they simply do not have the money,” Nassanga says. That is why she is urging trade unions in Africa to give women education on HIV/AIDS in the workplace. “This will entail trade unions organising workers in the informal sectors where the biggest percentage is women,” she says, adding that trade unions will also have to start genuine campaigns to outlaw sexual harassment in the workplace.

Polygamists defy the threat of HIV

By Reginald Njeruda

THE average Zimbabwean may be better educated and exposed to international trends, but men marrying two or more wives is still in vogue — it is proof that one is a man; for women, it is just a matter of buttressing one’s security.

Ester Kandiro, 37 and a vendor in Masvingo, said the threat of HIV/AIDS is a health issue first and foremost, ignoring social and cultural reasons for its spread and gender issues.

“Women themselves up for the danger of contracting HIV/AIDS. ‘Women should be responsible for their own health and their own lives and stop being dependent on unfaithful men. We, as women, should stand up for our rights. If your husband marries a second wife, you should not just accept it, you should refuse to be exposed to a health risk.’

Although Zimbabwe has made great strides in other spheres of life, the issue of mistresses and extra wives remains rooted in everyday life. Even as a son is born, having died of HIV/AIDS, the relatives are thinking of handing over his wife to a brother who is already married. While some women have stood up against being inherited by a brother-in-law, others have been forced into these unions due to lack of financial security.

Rose Mutera, a faith healer, believes it is unacceptable for men to be polygamous. She adds that polygamy promotes jealousy and witchcraft among the women involved and that offspring of polygamous relationships rarely get along. “While the women are busy fighting for the man’s attention, the children have to fight for equal treatment and their father’s love. It also becomes easier to spread HIV/Aids,” said Mutera.

Traditional polygamy was an acceptable way of expanding the domestic labour required for farming. It was also a means for getting more sons. The first wife was usually consulted and at times even suggested that the man marry one of her sisters;

Consulting the first wife reduced the possibility of conflict and meant the other woman would be immediately welcomed into the family circle. The first wife made the rules and the rest had to channel their requests to her if they had any material needs. The children were raised together and encouraged to get a share of the inheritance so that they would not become destitute.

“Polygamy is an old practice used to top up the workforce by men, but times have changed and there is no need for big families now, especially in the light of the dreaded virus and the burden of educating so many children,” says Ndumiso Gumede, a national social worker. As long as women continue to value a man by his side at whatever cost, the HIV/AIDS pandemic will continue to kill more women than men. By this year, there were more than 2,000 Zimbabwean men living with HIV/Aids and 1.2 million women.

In an effort to respond to the desperate situation, the Zimbabwean Ministry of Health and Child Welfare, Population Services International (PSI) and USAID Zimbabwe are working together to manage a national voluntary HIV counseling and testing network.