HIV/AIDS: A Global Tragedy

Margaret is a 33 year-old Ugandan woman. She is the mother of three children. She is an "AIDS widow". And she herself has AIDS. Margaret's life is not easy. Her in-laws falsely accuse her of killing her husband through transmission of the disease. Her only thoughts were of suicide when diagnosed with HIV. Margaret remembered the terrible suffering her husband endured towards the end of his life. Her poverty made her helpless to battle the disease. She saw no future for herself or her children. The only reason she can tell her story with optimism is that during those dark days someone cared. A counsellor provided Margaret with support and a link to the medication, health advice and food supplements she needed. Now, Margaret provides support to people who are facing the same despair she did.

Margaret's story is a microcosm of a global pandemic; a tragedy that is now more about justice than merely a health issue. It is estimated that over 40 million people around the world are living with HIV/AIDS. Sub-Saharan Africa is by far the worst affected region. According to UNAIDS 29.4 million people are living with the disease in this part of the world. Approximately 3.5 million new infections occurred there in 2002, while the epidemic claimed the lives of an estimated 2.4 million Africans in the past year. Put another way, 9,500 people are contracting the disease each and every day and over 6,500 people are dying from it or its related illnesses. It is placing enormous strains on every level of society. The need for already poor families and communities to care for over 10 million orphans in Africa whose parents have died of AIDS-related complications is but one indicator of its ramifications.

It is important, though, that HIV/AIDS is put into its proper perspective. Firstly, its prevalence is geographically uneven. There is no doubt that in some countries HIV is rampant. In Botswana nearly 38% of the population has contracted HIV – the world's highest. South Africa is numerically the worst affected with over 5 million people HIV positive, and other southern African countries such as Lesotho, Swaziland and Zimbabwe all have prevalence rates of over 30%. On the other hand, in Africa as a whole, 90% of the continent's population do not have HIV. The challenge is to ensure that it stays that way. And, as we know, HIV/AIDS is hardly mentioned as a health issue in Australia or in most other western nations.

Secondly, HIV is not an unstoppable juggernaut. The rate of infection can be slowed with appropriate and adequately funded interventions. In its darkest days during the early 1990s Uganda's yearly rate of infection was a staggering 30% in some areas. The government, supported by the international community, implemented a comprehensive awareness and health campaign that has now slowed the rate of infection to 6% a year. Positive signs are emerging in South Africa where rates of infection in pregnant women under 20 have slowed, and similar reductions have been achieved in Ethiopia. However, the extent of the spread is such that it will require a sustained level of political will and financial commitment to ensure these gains are consolidated and intensified.

Thirdly, HIV/AIDS is not an automatic death sentence. Margaret's story demonstrates that access to appropriate medicines, adequate nutrition and a purposeful life can enhance the life expectancy of HIV carriers, as well as their quality of life. The reality is, though, that only a fraction of the people that need anti-retroviral treatment are receiving it. There are also millions more who do not have access to health care to treat infections that the body cannot fight because of its lower resistance. There is no doubt that poverty exacerbates the spread of AIDS, and food crises – such is currently being experienced in southern Africa and the Horn of Africa – makes the situation all the more critical for HIV sufferers.

So why is HIV/AIDS so prevalent?

Poverty is a key contributor to the spread of HIV/AIDS. It often drives women (and men) into economic survival strategies that expose them to high risk sexual behaviour. For women, this includes not only commercial prostitution but also 'transactional sex' or sex in exchange for presents, goods or other forms of assistance. Risky behaviour is also more likely to occur with prolonged family separations due to economic and employment pressures.

Widespread and deeply ingrained cultural practices and social mores also contribute to, or are ill-equipped to address HIV/AIDS. It is the case that most cultural practices evolved to safeguard rather than destroy society. Unfortunately, HIV/AIDS makes it necessary to abandon, or at least adapt practices that facilitate transmission. These include polygamy, inheritance of widows, unsafe initiation rites, dangerous misconceptions – such as sleeping with a virgin will cure a man of AIDS - and lack of property inheritance for women limiting their capacity for independence and therefore increasing their vulnerability.

In regard to the latter point, there is clearly a gender aspect to the spread of HIV. Girls and women bear the greatest burden. Young women in particular are affected disproportionately; infected young women outnumber infected males by a ratio of two to one. And in the 15-19 years age bracket, girls are six times more likely to have AIDS than their male counterparts. The causes of this anomaly are complex and inter-related. In many societies women and girls are treated as second-class citizens, including – crucially - the denial of a basic education. As a consequence of societal breakdown and strife, where normal family and community protection mechanisms have broken down, young girls and women are ill-equipped to cope with their higher vulnerability. These factors in turn develop an environment in which they can be exploited. They are pressured for early sex, particularly with older men, either to obtain gifts from “sugar daddies” or through outright coercion.

The consequences

The implications of the disease on individuals, communities and societies are enormous. In most developing countries the rural poor rely on subsistence agriculture for their livelihoods. When people are sick they are unable to cultivate the land, which can mean missing an entire growing season. This begins a vicious cycle. In order to pay for their immediate food and household needs assets are sold, which diminishes the base from which they can recover. The lack of an adequate diet and an inability to buy medicines creates an environment for attack on the body by ‘opportunistic’ infections, which further depletes their capacity to lead productive lives.

The increase in the number of dependents places great pressure on a community’s capacity to meet their needs. In Uganda over 1.7 million children have lost their parents to AIDS. Families that have adopted orphaned relatives struggle to cope with the additional mouths to feed. In many cases elderly grandparents carry the burden of caring for young children where they have no capacity to do so. And the growing number of child-headed households throws up the challenge of how they will engage in productive activities that meet their immediate needs, as well as invest in their futures through a proper education.

At a national level, HIV/AIDS creates an immediate dilemma about how to provide the services required to fight the pandemic. The increased demand for health care is placing pressure on already over-stretched health budgets. Although the cost of antiretroviral drugs may reduce as generic products are increasingly available, the sheer number of people requiring treatment is near overwhelming. In addition, there is also the need to fund health education and other preventative behavioural change programs, as well as counselling services, as part of an overall HIV/AIDS strategy. The education system is also placed under strain, both financially and in the supply of teachers. The reduction in economic activity caused by lower agricultural output and diminished productivity in other sectors present governments with falling revenues with which to meet the needs of their people – a growing proportion of which are non-productive and therefore dependent on others.

Breaking the silence

It is clear that HIV/AIDS has placed a major challenge before the churches. The church’s influential role in many societies means it carries an additional responsibility to encourage and work toward a culture of compassion, care and reconciliation in their communities and wider population. Unfortunately, the initial response from some churches was to accuse and exclude. These attitudes are now changing. Last year, the Lutheran Churches of Africa released a landmark statement titled “Breaking the Silence”, which acknowledged that often the church leadership contributed to stigmatisation and discrimination. The presence of HIV/AIDS in our own Lutheran family and its surrounding community calls us to live out God’s love through speaking out for justice, and helping to create communities that provide support and protection for people living with

AIDS. The churches have committed themselves to being a prophetic voice, standing in solidarity with those who are being marginalised and exploited and advocating for accessible and affordable drugs, medical support and infrastructure.

Understanding HIV/AIDS

AIDS (or Auto-Immune Deficiency Syndrome) is caused by Human Immuno-Deficiency Virus (HIV), which attacks the body's immune system. Its lethal nature arises from the body's subsequent inability to fight off other infections and diseases. A person with HIV may be well for many years, but eventually signs emerge such as skin complaints, chest infections and diarrhoea. As the illnesses become more and more frequent it becomes increasingly difficult to live a normal life, and the person will be described as suffering from AIDS.

Can you cure HIV/AIDS?

There is currently no cure for HIV. However, in Europe and North America, where health levels are good and appropriate drugs are available HIV is no longer necessarily a terminal condition. In other words, good nutrition, adequate health care, a reasonable quality of life, a positive attitude and belonging to a supportive community can delay the onset of symptoms and mitigate their severity. Conversely, poverty, malnutrition and hopelessness can hasten the progress of the disease, and ultimately prove fatal.

Is there any treatment for HIV/AIDS?

People with HIV are reliant on the availability of treatments for opportunistic infections like pneumonia and tuberculosis. In the developing world access to an affordable and reliable supply of basic medicines for these purposes is limited at best. In addition, most HIV positive people in Europe today have access to combination therapies, which enable them to live normal lives by delaying the breakdown of the immune system. The problem is that these therapies remain expensive and out of reach for much of the developing world.

AIDS at a glance

- Sub-Saharan Africa has more than 70% of the world's HIV-infected people
- It is estimated that between 30 and 40% of HIV infected women pass on the virus during childbirth.
- Children who are infected at birth generally develop full-blown AIDS and die before their fifth birthday.
- In countries where the rate of HIV infection is above 10%, life expectancy at birth will plunge below 50 in the next few years, compared with about 62 years in the 1980s
- Ten million young people between the ages of 15 and 24 and three million under the age of 15 are living with HIV.
- AIDS strikes people in the prime of their life, when they are most productive. More than half of all new infections occur in people under 25 years of age
- There are fewer cases of AIDS from early childhood until the onset of sexual activity during adolescence. The 5 – 15 year age period is therefore the "window of hope" – a time for ensuring education, attitudes and behaviours are entrenched in the minds of the young before HIV has a chance to invade their bodies.

Uganda: Signs of Hope

The first cases of AIDS in Uganda appeared in a small lakeside fishing village near the Tanzania border in Rakai District in 1982. The following year AIDS appeared in a few commercial centres along the main trade route towards the nation's capital, Kampala. Although the government established an AIDS control program already in 1986, the HIV infection rate continued to increase peaking at 25 to 30% in 1992. It was only in 1995 that a decline in infection rates were confirmed, which has continued to this day. The problem is that the damage has already been done, with over 1.4 million people living with HIV, and even with infection rates at 5% it still means thousands of new cases are emerging each year. The reality is that a continued program of prevention and control will need to continue for the foreseeable future, as there is still a dangerous level of ignorance, cultural constraint, poverty and gender inequity that, if left unchecked, could lead to a renewed spike of infection.

The role of Lutheran World Service/Uganda

LWS/Uganda commenced its first-AIDS oriented project in 1992. Its focus was in Rakai, south-east Uganda, which had been described at the time as the place with the highest incidence of HIV and AIDS in the world. The AIDS epidemic had taken hold and the population was suffering terribly. Virtually every household has been directly or indirectly affected by the epidemic. Rakai was, and remains, an area of endemic poverty: over 70% of the population live below Uganda's poverty line.

The role LWS saw for itself, in cooperation with the government and other agencies, was to assist communities address the crisis through an expanded and strengthened infrastructure. Initiatives were taken for the establishment of clinics, the repair and building of schools, roads and bridges. Schoolteachers were to be educated as health instructors and courses in hygiene were held for traditional healers. As a Christian organisation, LWS also recognised the important role churches could play in fighting AIDS. As is the case in many countries, church leaders have a central position in local communities. And it is to them many people look for advice and support in times of disaster such as this.

Over a decade on, and the Rakai program is viewed as a success story. The number of people affected by HIV/AIDS has reduced dramatically. In 1992 infection rates had risen to 25% of the population. At the present time it is about 9%, which is a significant improvement but still well above the national average. The project in Rakai has served as a model for many other HIV/AIDS activities, which are now incorporated into all of the global LWS programs. Yet, there remains much to be done in Uganda. And Lutherans in Australian and New Zealand have an opportunity to show solidarity with those suffering from AIDS through this landmark program.

Kato's Story

As highlighted elsewhere, the huge number of orphaned children is an especially acute part of the unfolding tragedy that is HIV/AIDS. The LWS program in Rakai is currently in touch with over 300 households headed by children under the age of 17. They are especially vulnerable to exploitation, and a lack of the necessary support to sustain them. A guiding principle is to try and keep the family intact, rather than separate the children or institutionalise them, for example in orphanages. Kato's story provides a brief glimpse into the hard life these young people are forced to lead:

Kato is an AIDS orphan. He also became the head of his family when both of his parents died from AIDS. It is painful for Kato to reflect on the suffering his parents experienced towards the end of their lives. Although there was plenty of emotional support for him at the time of the funerals, it became soon apparent that he was now responsible for his survival, and that of his three siblings. It was not a responsibility he wanted. Kato often rued the fact he was the eldest son, and despaired at the thought of how he was going to manage if any of his brothers or sisters became sick.

His parents were not poor. However, as their health deteriorated, they sold off almost everything they owned. Including the roof of their house. It was only with the kind assistance of neighbours that a grass-thatched roof was hastily constructed. And so Kato and his "dependents" began their new lives fending for themselves. It was an inauspicious beginning. They tried to cultivate some food, but it was a failure because they did not have the necessary skills. They basically went without a regular food supply for three months.

Kato and his family, however, were fortunate in one respect. A trained volunteer AIDS counsellor working in their village was made aware of their plight. As a result they were connected to the LWS program, who facilitated the construction of a better house. As Kato remarked "we lived like wild animals in our old house", such was its deteriorated condition.

Kato and his brothers now go to school together. An education is the key to their futures without their parents. In order to meet their day-to-day needs Kato has been taught how to raise poultry, which he sells and the profits used to meet essential household requirements. However, he says that there are some needs that are beyond his means such as bedding, scholastic materials, clothing and other items. Whenever they get into difficult situations, they visit the counsellor. Kato

says that their counsellor is the mother, father and close friend. It is an essential source of support for such a vulnerable young family.

Kato has tried to forget the past but admits he will always remember the experience of his parent's death. And, in fact, it serves as a motivation for what he wants to be when he grows up. "I saw my parents die. If I were a doctor I would have saved the life of my beloved mother". Although it may not be achieved, having a dream or purpose in life is a positive sign for this young man with all the responsibilities of an adult.

For more information on HIV/AIDS…

This article only provides a brief introduction to HIV/AIDS, and we encourage readers to 'dig deeper'. If you would like additional resources, please contact ALWS at alws@albury.net.au. The following web-sites also provide useful information about this important issue:

www.unaids.org The United Nations Joint Program on HIV/AIDS provides a wealth of information, resources and links to other relevant sources.

www.lutheranworld.org The Lutheran World Federation's "HIV/AIDS Plan of Action" is available from this site, as well as other links and information.

www.e-alliance.ch This is the web-site of the Ecumenical Advocacy Alliance, of which ALWS is a member along with other churches and church agencies. HIV/AIDS is priority theme for the Alliance. Again, it provides useful resources and links to other web-sites.

See also **Speaking and Doing God's Word in Plague Time**