

Death of a nation: The AIDS crisis in Zimbabwe

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The descendants of the Italians who succumbed during the syphilis epidemic of the sixteenth century, or the survivors of the cholera outbreak of the early 1990s in Central and South America, can look back to those times when their ancestors or friends and family perished, shaking their heads both in sorrow and thankfulness that the anarchy did come to a definitive end. I, on the other hand, stare into the bleak future of my people, the people of Zimbabwe, with despair, as deaths from AIDS escalate and threaten to lay us all to rest.

Should I choose to bear a child in Zimbabwe, come the year 2010, my son or daughter could expect to enjoy a mere thirty years upon this earth before AIDS snatched his or her life away.¹ The life expectancy in this, my country of origin, is estimated to have plummeted 22 years in less than a decade. Every week, 300 to 500 people die from complications associated with HIV infection,² while 25 to 30 percent of Zimbabwean adults harbor the virus, and can only expect the same fate as those they have buried before.

The economy, not AIDS, is the topic of concern in Zimbabwe

Listening to statistics such as these being reeled off in journals and newspapers here in the United States, one would expect that there must exist, in the country of reference, a looming cloud of panic over prospects for the future, a plethora of voices calling for education on how to preserve one's health. And yet there is no such concern. I am a Zimbabwean by ancestry, and an American by birth, and spent all of my teen years, and almost every summer following, in the land of my parents. Attitudes about personal risk

of infection with HIV in Zimbabwe leave me astonished.

The most pressing problems to the people there are economic. Except for those concerns, life is seen as being peachy. There is a saying that I grew up hearing: "There's no rush in Africa"; and I have found that it bears true. The living is easy in Zimbabwe. Laughter is an integral part of our culture, and today, as always, one can hear women being overcome by joviality in the marketplaces as they gossip amongst themselves, the menfolk justifying their wide-mouthed grins with chuckles as they walk to work or meet at street corners, the children shrieking in abandon as they chase each other in schoolyards or play hopscotch. The sense that this silent killer, AIDS, is lurking among them is nowhere to be found.

Why is there this dichotomy between the dire facts of this disease's impact and the affected people's reaction to them?

Zimbabwe is suffering now for the languid approach taken by the government of the country during the 1980s in response to this new disease, for which some said there was no cure. The country denied that it had a significant problem, unlike Uganda to the northeast, which, in an effort to deal with the problem, opened up the closet doors and declared to the world that its population was being decimated by this virus. The stifling of precious information and deflated infection rates in my country led to the development of a false sense of security.

I remember when I was growing up in Zimbabwe that we used to thank God that our situation was not as bad as that of Uganda, where we would see on the news every night people crumbling under this disease, which was known as "slim," for its wasting effect on the body. Jokes amongst us schoolchildren about the poor Ugandans were rampant. Some in authority assured the people of Zimbabwe that this virus did not exist at all, and the acronym AIDS was jokingly inter-

preted to mean "American Idea for Discouraging Sex."

It was only in 1990, under heavy criticism from across the globe, that the government of Zimbabwe actually admitted publicly that it had a problem, that its AIDS situation was as bad as, if not worse than, that of Uganda. Zimbabwe began to tackle the problem seriously; media campaigns on the taboo subject of condom use became the norm, as did educational initiatives and the passage of the message of prevention in churches.

Diagnosis of AIDS in the street — almost a game

While I was in high school, we all began to recognize the signs of the disease amongst those in our community, signs that had been there all the time, but that ignorance had blinded our eyes to: the "AIDS perm," which was the description used for the reddish, straight hair commonly seen on the head of an infected individual; the swollen lymph nodes behind the ears; the familiar wasting syndrome; the skin infections that ran amok, covering one's body from head to toe in weeping scabs. We took to diagnosing people we saw in the streets, almost as if it were a game. Because deaths from AIDS have now become so common, the statement often heard is, "That one is very sick," meaning, in effect, that the person has AIDS.

My fellow medical students here in Boston often tiptoe around the glaring issues raised by the astonishing figures that emanate from the World Health Organization or other sources when discussing issues about Africa and the AIDS epidemic. My country gained, last year, the terrible reputation of possessing the highest prevalence of HIV infection in the world, and I recall tearing out the newspaper article and running to show it to and discuss it with my friends. Most were reluctant to approach the subject out of consideration for the feelings they perceived that I might have about it. But I find that such information is more empowering than regressive; I have seen, as has the entire world, the effects of concealment

and embarrassment over issues such as the AIDS crisis. The only way to deal with a problem of such magnitude is with one's eyes and spirit open, to allow for such statistics to be quoted in their entirety, for once that voice ceases, there comes the question that I find to be most important: What do we do now?

Babies and children — the innocent victims

My heart has always ached over Zimbabwe's predicament, especially when I think of how many young lives are inevitably going to be extinguished by this disease. Children are the most precious beings in African culture, and to have many children born to one is to have received manifold blessings from God. The distribution of AIDS cases in Zimbabwe is bimodal: the most affected are sexually active adults between the ages of twenty and thirty-nine, and the very young under the age of four.³

The circumstances are unforgiving. Those babies who do not seroconvert after being born to an HIV-positive mother are likely to acquire the virus through breast milk. Feeding a child with one's own breast milk rather than artificial formula has been sanctioned practice for years, and is beneficial to the child as well as to the many mothers who cannot afford to buy powdered milk, let alone the plastic bottles in which it must be prepared. As mothers lovingly nurse their children, many are unknowingly passing on the virus that will end their child's life. Antiretroviral therapy is an unattainable dream to the majority of Zimbabwean women, most of whom have no idea that such a treatment even exists. Even for the handful of women who are lucky enough to be part of the experimental group in current clinical trials that utilize zidovudine, one wonders what position they will be left in when the investigators pack up and leave for home.

Another victim: the wife of a

promiscuous man

Married couples, ironically, have the highest rate of HIV infection of any demographic group in Zimbabwe. Even with the sacrosanct esteem within which marriage is held in Zimbabwean society, the matrimonial bond confers more danger to an individual's life than does the unmarried state. Unmarried people are looked down upon, especially women, who, it is believed, have obviously been cursed by somebody if they have not found a husband. Although polygamy is officially against the law, the persistence of pre-Christian-era cultural beliefs has remained rooted in the psyche of most Zimbabwean men, causing many of them to seek gratification outside of marriage. The innocent victim in this slowly changing patriarchal society is, more often than not, the wife, whose power to demand condom use within the marriage is paltry at best.

For a family in Zimbabwe not to have been touched by the effects of the AIDS epidemic may very well have required divine intervention. Almost every time I call home, my parents tell me of yet another neighbor, yet another relative who has just died or is "very sick," yet another funeral they are on their way to attend. One cousin of mine died recently in terrible pain, the husband who exposed her to the virus having disappeared, and her three children having been left to be cared for by her parents. Her oldest son placed first in his class at school that semester, but neither parent was there to praise his achievement. Another cousin visited my father at his office a few months ago, terrified at the progression of the skin lesions that covered his back and chest. Nobody has heard from him since then, and he is not spoken of.

There are stories to tell in every family. People wonder how AIDS can kill so rapidly, so deftly. The idea of persons living with the virus in their system for ten to twelve years, as one might in the West, is absurd to most Zimbabweans. Infected individuals here are usually dead within two years. This pattern has led to radical notions about the cause and progres-

sion of the disease, as people grapple with its inherent malevolence. Is it spread by mosquitoes? Through the air? Does the warm weather quicken one's death? Is witchcraft to blame?

Despite the widespread knowledge of the existence of AIDS, few people other than health officials actually vocalize the acronym in reference to an individual's terminal illness. Children who are orphaned are left to guess at what it was that ended their parents' lives, for the shame that is associated with the disease keeps shut the mouths of the relatives who take over their care. Due to the fact that most of those who fall prey to AIDS are young skilled men and women in their reproductive years, the burden of caring for the children they leave behind has fallen onto novice teenagers and the very old. This shift has placed a strain on the traditional social structure, for those who were once meant to care for children and grandparents are the ones who are now dying in droves.

Education of the people is blocked by cultural norms that forbid talk about sex

The deep-rooted fatalistic attitude common throughout Africa that makes people react to the news of another death with a sigh of resignation rather than of ire, is something that I find both frustrating and comprehensible. Most Zimbabweans really do not realize just how devastating the situation is, regardless of the fact that people are dying incessantly. Each person deals with his or her own family's tragedy in private, and the commonality of the scourge is never discussed openly. The government's efforts to educate people are confounded by cultural norms, which forbid talk between the generations of sexual matters or the possible consequences of the act. Condom use is in direct contradiction to the desirable notion of fertility in this society, and the image of a trained youth worker showing married couples at a workshop how to use a condom properly prompts hands to be brought up to cover eyes in embarrassment.

Youth workers, or students who have been trained in AIDS prevention, are but a few of the individuals who are trying, in spite of the obstacles they encounter, to save people's lives. Organizations have been set up to provide community-based orphan care to parentless children. Theater groups tour the country performing in plays that depict the consequences of unsafe sex and marital infidelity. Popular singers now release songs promoting faithfulness within marriage and the prudent use of condoms. Many of these same entertainers have fallen prey themselves to AIDS, and it is often these victims who seem to bring men and women in the street together in one consciousness, forcing them to realize that AIDS affects everybody, and not just family members whom one can remain mum about.

It is no great surprise to my peers that I plan to focus on the African AIDS crisis, along with other infectious diseases, in my future practice as a physician

Nothing else causes me to become as impassioned; nothing else tugs as strongly at my resolve as the predicament of my relatives, my people. I often vacillate, in my need to address this problem that is so dire and urgent, between the different roles that I might be able to assume in the future. Where can I do the greatest and most good? Might it be at the grass roots level, among the people, treating the sick in order to better their health as much as is feasible, while at the same time educating those who are well on how to remain well? Is it at the national level, as a member of governing boards, where I might work with others to bolster lagging prevention efforts? Or might it be at the international level, where my status as an African physician who was educated in the United States might access for me a niche appropriate for what I hope to accomplish?

I study now with the goal to ease the burden of AIDS among the people I call my own. Recently, I heard of a former schoolmate who had died of the disease; he was my age, and we used to play soccer together. His death

brought the situation all that much more close to home. He and I were both intelligent individuals; why did he succumb to a disease that he might have avoided? What could someone have said to him to ensure that he would still be breathing today?

What is happening in Zimbabwe, in Africa, is criminal. It is a crime for which nobody wishes to take the responsibility for its perpetuation and accretion. The notion that the AIDS epidemic in Africa is a third-world problem, although covert, is harbored the world over. Hence, we Africans must make do with what help does come our way, be it zidovudine for a group of pregnant women, or medical personnel from outside Africa who empathize enough to drop everything and come to provide succor.

I shall be one of those medical professionals one day in the near future. And that day cannot come too soon. I feel this with all my strength. I feel it for the weeping mothers who bury their newborn children. I feel it for the elderly who bury their sons and daughters before their time. And I feel it for the child who wishes to live beyond his thirty-first birthday.

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By and about the author

The questions are many and the explanations long whenever I am asked to explain where I am from. Above all else, I consider myself African, my parents and relations being from Zimbabwe. During the 1970s, my parents attended university in the midwest United States, and my younger sister and I were born during that time.

We all returned to our homeland in 1981, and it is there, from the time that I was a precocious eight year old, that I spent the next eleven years of my life. My love of reading began a long time before, and from this passion for words grew a desire to create my own stories. Throughout my years at McGill University, and now at medical school at Tufts, I've used most of my free time to write poetry and short stories, to begin and re-begin that novel I vow one day to finish. My life and my writing both have been affected by the societal turmoil I grew up witnessing in Zimbabwe, the turmoil created by AIDS. I plan to use both my medical and public health degrees to ameliorate, even if in a small way, the suffering of African people affected by this scourge. Enhancing awareness through an essay such as this one will be, I hope, the first step of many to come.