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Why Women & Children Are India's Most Tragic AIDS Victims



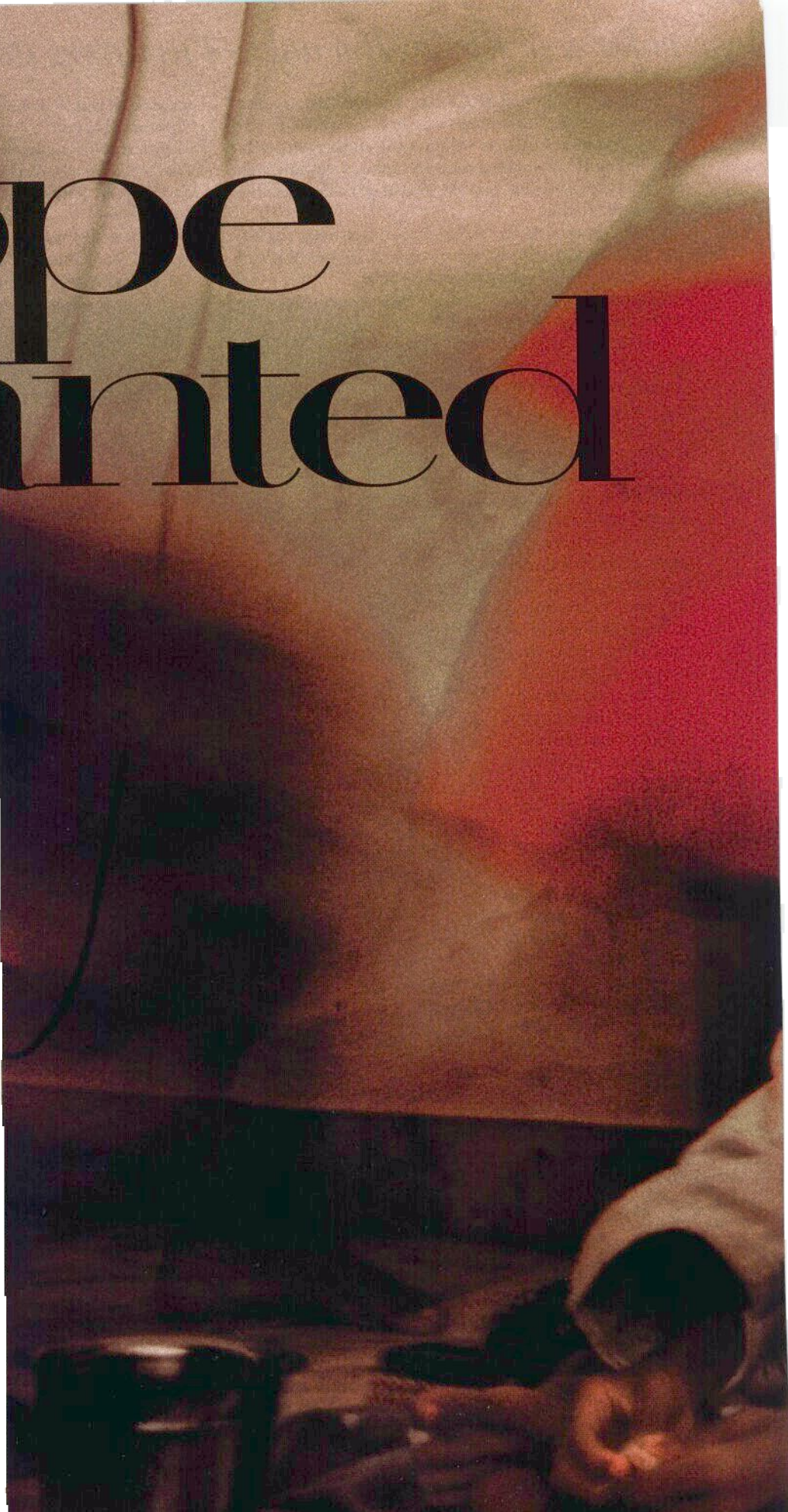
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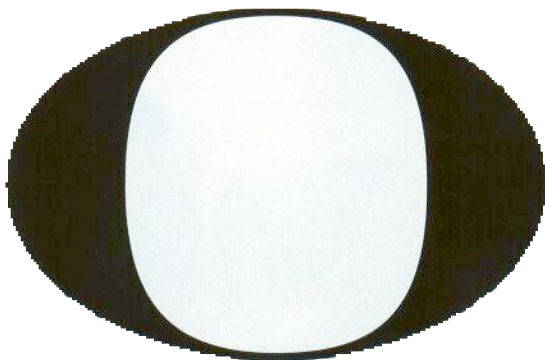
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hope wanted

Exacerbated by stigma and denial, India's mounting AIDS catastrophe may now be the biggest in the world. The worst hit? Women and children. Janine di Giovanni reports. Photographed by Alex Majoli.

The CHES orphanage on the outskirts of Chennai fosters children like terminal Dilli Babu, who at four years old weighed just twelve pounds





ne night in April 1986, Suniti Solomon, M.D., an American-trained microbiologist working for the Indian government in Madras, received a late-night phone call. She assumed it was an emergency

for her husband, a cardiac surgeon. But the call was for her. And it was one that would alter not only the course of her life but ultimately the future of India.

On the phone was Nalini Ramamoorthy, Solomon's research assistant at the Madras Medical College. For six months, ever since the news of AIDS had burst upon the international medical horizon, the two women had been hunting for evidence of HIV in India. That night Ramamoorthy confirmed that six prostitutes—sex workers, as they are more correctly called—were HIV-positive. None of the women had had sex with a foreign client. The implication was clear: The disease was well rooted inside the country.

Solomon is now 65 years old and runs the Y. R. Gaitonde Centre for AIDS Research and Education (YRG CARE), the largest AIDS clinic in southern India. She has devoted the past two decades not only to research but also to enlightening the Indian public about AIDS, trying to destroy a stigma so fierce that even doctors and health-care workers often refuse to treat HIV sufferers. In a country where a televised kiss is shocking, it's difficult to get people to talk about sex, let alone AIDS.

The AIDS problem in India is now catastrophic, not just for Asia but for the entire world. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), India ranks second only to South Africa in the number of people infected by HIV. There are an estimated 5.1 million people in India infected with HIV, the virus that causes AIDS. Of that figure, approximately 1.9 million are women aged fifteen to 49. And those may be low estimates—some experts believe the real number of cases now exceeds South Africa's. Because of the stigma, many people are too ashamed to come out and report their illness.

The situation is so grave that on the eve of Indian elections last April, *The Economist* reported, "Indians start voting next week to choose a new government. Its first priority should be AIDS." At the XV International AIDS Conference in Bangkok last July, AIDS in India was one of the main topics. (Sonia Gandhi, president of the Indian National Congress party, was a featured speaker at the closing ceremony.) And according to Judith Auerbach, Ph.D., the vice-president of public policy for the American Foundation for AIDS Research (amfAR), "with India poised to overtake China as the most populous nation on Earth in the next 30 years, its AIDS epidemic has the potential to jeopardize the stability of the region, indeed the world."

World economic growth is increasingly dependent on India, Auerbach points out. Solomon feels this oppressive weight on

her slight shoulders. At one time, she was named India's Woman of the Year, and Richard Gere publicly called her a hero, but Solomon still gets teary when she talks of the HIV-infected children who are left abandoned at her clinic, or mothers who beg her "to kill their AIDS-infected son, who makes the room smell." Hers is the sort of work for which one never really feels a sense of accomplishment. Since the virus was discovered, Solomon says, she has finished only one-quarter of what she set out to do.

After her AIDS discovery in 1986, Solomon was awarded a grant from the Indian Council of Medical Research. She spent a decade tracking the virus, and one of her most important findings was its presence in pregnant women who had a single partner. But during those ten years, the virus continued to spread, and today in Chennai (formerly known as Madras) alone there are an estimated 20,000 HIV-infected people. The number of HIV pregnancies is also steadily increasing. Sometimes Solomon thinks she should have spent her time on the streets instead of in the lab.

"I wish I had been out talking to people," she says wistfully. "In terms of awareness or the discrimination of HIV sufferers, we have not come far." She remembers one night in 1996 driving for hours around Chennai with an HIV-positive woman who was in labor. No hospital or clinic would accept her to deliver the child. Solomon finally got her admitted, only after "neglecting" to tell the staff at one clinic that the woman was positive.

The disease has not yet reached a plateau. Instead, there is fear

that within ten years, the number of HIV sufferers will be five times what it is now. Particularly vulnerable are women. At the Bangkok conference, attention was drawn to the fact that "as the AIDS pandemic spreads, it has assumed a woman's face, with almost six out of ten new HIV infections occurring in women." (Auerbach says women are two to eight times more likely to contract HIV from men than the other way around, in part because of the greater vulnerability to infection of the female genital tract.)

But there are other reasons women worldwide are more susceptible to AIDS: a heady combination of social and physiological factors. Cultural practices such as early marriage and gender discrimination contribute to their economic dependence and their lack of resources to protect themselves. In India, middle-class married women are particularly at risk: While they may be monogamous, their husbands are often not. Men have sex with commercial sex workers, and married couples do not generally use condoms.

"The painful irony in India is that marriage and monogamy can actually increase a woman's vulnerability to the HIV infection," says Auerbach. Here it is estimated that 80 percent of HIV is spread by heterosexual, mainly married couples, and Solomon reports that 90 percent of her patients are married with a single partner. And despite the wide swath the disease cuts across all levels of society, the subject is still a huge taboo. "Rich people get it," Solomon says. "Actors, lawyers, doctors get it." Last year two HIV-positive children were kicked out of their school in Kerala state, even though Kerala has the most progressive sex-education programs in India. "The problem is that prominent people who have it don't talk about it," she says. "We don't have a Rock Hudson in India."

"The painful irony in India is that marriage and monogamy can actually increase a woman's vulnerability to the HIV infection"



Suniti Solomon, M.D., was the first to discover AIDS in India, in 1986. "In terms of awareness or the discrimination of HIV sufferers, we have not come far," she says.

This is a worrying concept, particularly for women. India is still a deeply traditional society. Women usually marry by the time they are eighteen, and most are virgins. The marriages are more than likely arranged, and the man, who customarily marries at an older age, will have probably visited one or more of the two million sex workers who operate throughout the country. If he has the virus, he is still unlikely to wear a condom.

"A sex worker can tell a client to use a condom, but when it comes to family, an ordinary Indian woman must oblige her husband's wishes," Solomon says.

One sweltering summer morning, I arrived early at the Madras Medical Mission to see Solomon lecture on how to prevent transmission between pregnant HIV women and their infants. There's an ob-gyn trade fair going on outside the auditorium (START YOUR OWN SPERM BANK!), and the audience is packed with mainly female doctors, who listen attentively. Solomon is a soft-spoken woman, but when she stands on the podium in a neat navy-and-gold sari, her dark hair carefully brushed into a flip, she speaks with a sense of urgency. "These are the dilemmas faced by Indian women today," she says, using a projector to highlight her points.

ARRANGED MARRIAGE
 WIFE FAITHFULLY SUBMITS
 MAN DOES NOT WANT CHILDREN (KNOWS HE HAS HIV)
 BUT SOCIETY FROWNS ON "BARREN" WOMAN
 SHE GETS PREGNANT
 HIV
 THE WOMAN IS VOICELESS

There's silence in the room; then people ask questions. Solomon instructs them on how much Nevirapine—the drug that reduces

transmission between mother and child by 50 percent if given during labor—to administer, and doggedly insists that HIV women must not breast-feed. "There is HIV in breast milk," she says staunchly. "They must use formula."

Later, she tells me this is not so easy to ensure. "It's OK for an HIV doctor with a good salary to use formula to feed her baby, but for a woman from the slums, it's too expensive." When I comment later on the surprising number of women obstetricians in the room, she regards me carefully.

"Yes, but if I asked how many of them would deliver an HIV woman's baby, none of them would do it," she says.

Solomon comes from a privileged background—her father ran a successful leather business—and in 1994, her elder brother started a foundation that helped her open the YRG clinic, which is named after her father. Housed in a former leprosy unit, it has so far treated 17,000 patients and conducts extensive research as well as counseling. When I walk through the wards, I see very sick people—mostly men tended by their wives, who probably also have the disease—but these patients are the lucky ones. Those who can't get to a place like YRG go to government hospitals, where doctors see up to 1,500 patients a day and where they are subjected to moralizing lectures. "Women with HIV who live in the slums are really isolated from society," Sethu Lakshmi, an ethnography coordinator at YRG, tells me. "There's no support from their immediate or extended family. If they aren't educated, there's no way of earning a living. They have no access to HIV treatment."

Rochelle D'Souza Yepthomi, an aide who works with Solomon, says that the burden of care in the family always falls on the woman. If both the man and the woman are sick, she will care for him and often give him her share of medication, rendering her own utterly ineffective.



“There is an unwillingness to help a woman who’s going to die anyway,” Yephthomi says. “They don’t see her as a breadwinner; they see her as a liability. Women are not as empowered here as in other parts of the world.”

There is some work being done on a grassroots level. Groups like the Positive Women Network, founded in 1998 in Chennai, now has branches throughout India. They offer counseling, training, and support groups, mainly to lower-income women. In theory, it sounds good, but the reality is often not that effective. When I set out to visit their offices, I have trouble finding them: They are located in the back of a crowded tenement block, and there is no sign on the door. The Positive Women Network’s bright-colored brochure tells women, “We dream of a life not secluded; free from stigma and discrimination; with all rights intact.” But one of the project managers tells me that when they send out letters to members, they don’t mention the name of the organization. “If the woman can’t read, the postman must read it out loud, and then everyone would know her situation.”

Lavanya Vijayshankar, a social worker for PWN, explains to me that an HIV-positive woman in India has no rights. “Often respondents feel that human rights or legal rights are entities beyond their comprehension,” reports a survey from the Indian Network of Positive People. “Most respondents suffered from low self-esteem due to lack of information about human rights and life after infection.”

Even death brings complications, Vijayshankar says. “If her husband dies, the woman loses all rights of joint property and is usually, quite unfairly, blamed for his HIV. Her dowry is not returned.” Legal battles take too long to contemplate, and as Vijayshankar wearily points out, most of her patients are illiterate.

“We’ve got to fight against fear,” she tells me, closing a large stack of files that she has on her desk. “The information given out to society is that you get HIV, you die. We’ve got to teach women that you have to be careful: Even when you go into marriage, you have to be careful.”

a few days after I meet Solomon, I visit an orphanage for HIV children, run by an unusual Indian couple, Patrick and Victoria Samuel, who say they are working for a Christian organization based in Omaha called Word Made Flesh.

The Samuels are half-dressed when we arrive at 2:00 P.M., and furious that Alex, the photographer, and I have arrived without an appointment. As they pull on rumpled, dirty clothes behind a screen, I take stock of the place: It is filthy; the children are barefoot, dressed in rags. Three dogs bark shrilly. The sitting room is strewn with papers, old books, moldy clothes, and half-eaten food. Containers of dirty water serve as the water supply. It is appalling.

The couple refuse to answer questions about the children’s health care and order us to leave the property, but not before giving me a pamphlet to send money “to the children,” addressed to “The Director”—i.e., Mr. Samuel. His last words express concern that the neighbors would find out he was housing sick children.

The following day, I drive to the outskirts of Chennai, to the Community Health Education Society (CHES) orphanage, which

houses 33 children, from nine months to fourteen years old. All but one are suffering from HIV. After my experience with the Samuels, the CHES orphanage is a pleasant surprise. The smell of good food drifts through a room flooded with sunlight. The children are dressed in colorful clothes, and the older ones diligently help feed their younger companions. There is much laughing and hugging with the four baby-sitters. In a corner a group of infants are taking naps on the floor. Some lie on their stomachs; others are curled around pieces of vivid sari cloth.

Then I see Dilli Babu.

I assume Dilli Babu is around nine months old, but, in fact, he is four years old. Stick limbs, covered in boils and open sores, jut from his cotton shorts, which dwarf his emaciated body. He weighs no more than twelve pounds. His head is large, his hair falling out so that only a few wisps cover his scalp. Unlike the other babies, Dilli Babu sleeps fitfully, trying to find a comfortable position for his knobby spine.

Natarajan Rajeshkannan, a volunteer with CHES, whispers that Dilli Babu is terminal, "in the last stages of his life." I find it hard to comprehend that a four-year-old is in the last stages of his life. I find it hard to comprehend a four-year-old weighs less than my own six-month-old baby. I have seen many sick and disturbed children all over the world, victims of war and disaster, and have visited many AIDS hospices in Africa, but it is harrowing to watch Dilli Babu struggle to breathe. It is the moment when I really understand what AIDS does to a human being, and how enormous the problem is in India.

Dilli Babu wakes, opening expressionless eyes, and motions for water. He drinks with a shaky hand. It takes him 45 minutes to chew a slice of white bread. When one of the babies tries to pull his food dish away, Dilli Babu makes weak yelps, like a bird. He cannot stand on his stick legs. The virus has affected his hearing. When I call his name several times, he turns to me and regards me with the air of a very weary old man.

"He doesn't have the energy to show his emotions," Rajeshkannan explains. I ask why the other children leave Dilli Babu alone in a corner. Do they sense that he is going to die?

Rajeshkannan thinks for a moment. "No. He just likes loneliness."

The day before, I had sat with the CHES director, an efficient pediatrician named Pinagapany Manorama, M.D., who told me that most of the children are not aware of their status until they are about fourteen—if they live that long. She talked about stigma, fear, and how medical personnel need to learn how to touch AIDS sufferers without fearing they will catch the virus.

She talked about life expectancy for AIDS children: "When we started, they told us they could live five years," she said. "Now we have some kids who have been with us fifteen years." But most of all, she talked about how India desperately needed to face up to the AIDS problem in order to overcome it.

Then she showed me a video called *The Last Minutes of a Dying Flower*. It was a stark, homemade film of a eight-year-old boy dying of AIDS. Tubes ran in and out of his nose. White stuff came out of his mouth. In the background, mournful Hindi music

played. It was the AIDS equivalent of a snuff film—horrible, but horribly effective. Manorama told me she hopes to get it released on Indian TV. She hopes it will shock the public out of their fear, their unwillingness to take responsibility for the spread of the disease. She thinks that if they watch this, instead of Bollywood musicals, it might start educating people. She showed me the end of the video. SHOULD CHILDREN GET AIDS? it read in large black-and-white letters. ARE WE NOT RESPONSIBLE FOR THIS?

The big question is, What can be done to halt this epidemic? Experts agree that considerable resources must be devoted not only to drugs and to treatment but also to raising awareness. "Preventing new infections is the only truly effective way to stem the emerging epidemic in India," says Auerbach of amfAR. "HIV prevention, including educational interventions and male and female condom distribution, must be a priority."

The Bill & Melinda Gates Foundation has committed \$200 million to HIV prevention in India. But with the rapidly rising rate of infection, India also has to improve its health-care structure, produce low-cost drugs, and train doctors. In a country that

spends \$10 per capita per year on health care—and less than 6 cents per person on AIDS research—that's asking a lot. Also, as Vijayshankar points out, certain sectors of the population are extremely hard to reach: for example, HIV-positive women from the slums. One afternoon, I accompanied Geeta, the midwife at YRG, on a home visit to one of her patients, a nineteen-year-old woman called Raj, who had given birth nine days before. Raj was raped when she was thirteen by her brother-in-law, who

infected her with HIV. Despite that, she married a man who did not have the disease, and she got pregnant, delivering by Caesarean section. During labor she—and later the infant—was given Nevirapine to reduce the risk of transmission.

Geeta was concerned that Raj's neighbors—who don't know she is infected with HIV—would grow suspicious if foreigners visited her, so she gave us stethoscopes, and we pretended to be doctors. Raj lived on a squalid street, and her home lay over an open sewer and up four flights of narrow stairs. She and her husband, who sometimes worked as a street cleaner, lived in a small, stifling-hot room with one little window near the roof.

Raj lay on a mattress on the concrete floor, with her baby, who was still unnamed, covered in a pink towel. There was a small gas stove in the room, some clothes and bedding piled on open shelves, and a plastic bag of used baby clothes, which Raj proudly showed off. There was also a baby bottle and a tin of formula, on which MOTHER'S MILK IS BEST was written in Hindi.

Raj had been firmly told not to breast-feed. But formula costs a lot, and her neighbors keep asking her why she is not feeding her baby herself. As Geeta snaps on rubber gloves to remove Raj's stitches, the young woman wonders out loud how the couple will get by, feeding their daughter. "We'll manage," she finally says. Her daughter can't be tested to see if she has HIV until she is eighteen months old, and Raj is hoping that she has not passed on the disease. "She's so tiny," she keeps saying, stroking the baby's cheek, "so little." (continued on page 379)

"Most people won't come to be tested, even if the test is free and anonymous. They just can't accept what happens. To an Indian in the slums, HIV means you are immoral"

ocean, gone from sight, but still there. And that's how I feel about my parents' story now—it lies many years under the surface of the present, lost in the murky depths of family folklore, looming somewhere in the darkness. □

HOPE WANTED

(continued from page 347)

But Raj, who has accepted her disease and has acted responsibly giving birth, is a rare exception. Sethu Lakshmi had told me that the biggest obstacle for workers in the slums is denial. "Most of them won't come to be tested, even if the test is free and anonymous," she says. "They just can't accept what happens. To an Indian in the slums, HIV means you are immoral. And that you will die."

Another section of the population that is essential to reach is the truckers, who are believed to be the main transmitters, along with sex workers, of the virus. Most of us live in countries where much of our freight is delivered by air or rail, but in India, truck routes are the lifeline of the country. Until you've seen an Indian truck stop, it is difficult to understand what a huge part of the culture this is: There are an estimated five million truck drivers who race up and down the subcontinent, serving every kind of industry. And the HIV virus also runs up and down these truck routes as truckers and sex workers spread the virus north to south, east to west.

One night, as a gentle rain slicks the road, I drive to Red Hills, a truck stop an hour outside of Chennai on the Kolkata highway. The Gates Foundation recently gave millions to a trucking-education project dubbed Healthy Highways, and a social worker takes me to a kind of flophouse where the men rest between road trips. The place reeks of curry and unwashed flesh, and men lie on the floor, sleeping, playing cards, and watching Hindi DVDs.

We climb up an unlit staircase until we reach a small room at the top. It's an office with logbooks from counseling sessions and cartoons of men putting on condoms. "A lot of the men don't know how to use them," the embarrassed social worker says. "We have to tell them that the penis must be erect." He also says that a prostitute takes the risk of losing a customer if the man refuses to use one. There is always another sex worker he can go to who won't insist, he tells me.

We next walk down a muddy alley to a small stall selling sweets, magazines, and toiletries. There is a packet of condoms, costing one rupee—about 2 cents. A prostitute charges around 50 rupees—\$1. Has anyone bought condoms today? I ask the man behind the counter. He flushes and shakes his head.

Many of the men at the flophouse will probably go out to the highway and spend time with a sex worker before getting back on the road. Some of them will have heard of AIDS; some may not. Because many of the truckers won't take the responsibility, it is often up to the women to practice safe sex.

For the two million sex workers, this means a total reeducation. Many are concerned about losing business, but others now realize that it is a matter of life—their own life—or death. In Kolkata, for instance, the Sonagachi Project is led by sex workers to pass information about the infection and ways to access care. The women discuss power relations and negotiating techniques to encourage clients to use condoms. The group sessions sometimes include regular clients.

But what about the ones who already have the disease? They are the modern-day equivalent of the untouchables. I drive out to Pallavaram, on the outskirts of Chennai, to a bungalow housing a dozen HIV-positive former sex workers. It is run by Zonta Resource Centre, which was founded in 1990 by three Chennai women as a refuge for women who had no other place to go. One of the founders is a gynecologist who introduces herself as "Dr. Mrs. Ida Lobo." Born in Zanzibar, then part of British East Africa, in 1927, she speaks in a clipped British accent reminiscent of the days of the Raj. On the trip to see the "children," as she calls them, she tells me about how difficult it was growing up in those days as a woman, struggling to get educated. Widowed at the age of 47, she raised her five children alone. She now devotes herself to caring for these women and speaks about the faults of the government caring for AIDS sufferers with a passion and anger I have not yet heard. When we arrive, the women rush forward with great excitement. "Children! Say your prayers!" Lobo says bossily, sitting down like a pasha in front of them. The women are originally from (continued on page 380)



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Chennai but were taken by pimps when they were ten and eleven years old to Mumbai. When they were discovered to have HIV, they were discarded both by the pimps and by their own families.

"So we gave them a place where they could live peacefully and eat nutritious food and feel safe," Lobo says. The "children" come forward and show their "medical boxes"—plastic cases full of brightly colored pills and Ayurvedic powders. Lobo explains each of their individual problems: One is deaf-mute; one is nearly blind; one ate a forbidden curry and had to be rushed to the hospital ("We almost lost her; their stomachs just can't take spicy food"); another died the week before. Most of the women have TB, jaundice, and constant diarrhea. I ask Lobo how long most have; she tells me in extremely lucky cases ten or fifteen years, maximum.

As the women scurry around, excited to have a visitor from the outside world, Lobo suddenly breaks into a contralto, a song from her childhood: "Bless this House. O Lord we pray. / Make it safe, by night and day. / Bless these walls, so firm and stout, / Keeping want and trouble out."

I think the irony of "Bless This House" is lost on the "children" who sit gaping at her and me. They remind me of teenagers in a girls' boarding school. I ask if they miss men or just a normal life where they can live and work freely.

"They do," says Lobo cheerfully. "Sometimes they climb a wall. Then we find them by the highway starving. No one wants them. They end up coming back." When we leave, Raymond, Lobo's son, who drove us to the home, gives me some of the embroidered hankies that the girls made as a gift.

"It's something they do to pass the time," he says. "Because they know they are going to pass away. They all know it."

Dr. Solomon knew she wanted to become a doctor when she was four years old and was given a vaccination for smallpox. "I asked my father what it was, and he showed me pictures of what smallpox could do without that vaccine," she says. "I decided then and there I wanted to give injections. That was my dream." But one Sunday morning, I meet her at her spacious home for tea and ask her if the weight of her task ever feels unbearable. In India, it is estimated that two adults become infected with

HIV every minute. How can she possibly fight a statistic like that? The doctor is usually an optimistic person—she often talks of drug trials and therapeutic vaccines that bring down the viral load to an undetectable level—but at this moment, she sighs. She's wearing a gold-and-white sari that catches the light, and as we talk she's trying to calm her hyperactive two-and-a-half-year old golden retriever, Lara. "I tell Lara everything, all the sad stories," she says. She begins to tell a few of them: about babies being left on the doorstep of her clinic; about suicides and rapes, and women being turned out on the street. But she also tells me about AIDS babies' being adopted and brought to America, and sex education in schools growing, and young people being much more aware than when she herself first stood before them and talked about condoms and AIDS.

We walk to her small garden, with a lily pond filled with dark-green water; I ask her if she ever feels like giving up. She says no, but there are days that are harder than most. "When it comes to individuals, you feel hopeless," she says. "Poverty. They don't have food—how can we give them drugs?"

During my time in Chennai, I saw many people and places that brought back the horror and shame of AIDS in India. But there was one woman in particular who struck me because she seemed to be an Indian Everywoman. She had a job she loved, she was a mother, she was middle-class and worried about her weight, her children, and her complexion. The only difference between her and me is that she is HIV-positive—she caught the virus from her husband—and that she knows that some time in the near future, she will die.

Latha is 28, with skin the color of coffee and long, thick eyelashes. She's educated; from a wealthy family. She was a nineteen-year-old virgin when she married a man from a similar background to hers. He was her first and only partner, and he gave her HIV. We meet at her office, and she asks me not to mention where she works and to please change her name. After she fetches us ice water, she returns to the room and locks the door. She sits very close to me and speaks in a barely audible whisper. "If people knew I had HIV, I would be discriminated against," she says. "It's still shameful."

She tells me about when she discov-

ered her husband had AIDS and how she begged him to use a condom to protect her. He refused. She tells me how he continued going to prostitutes after their marriage and how painful it was for her and how ashamed she felt when he laughingly told relatives, "She doesn't like sex, so I have to go to sex workers."

She has a daughter who is "thankfully, negative," whom she adores. But Latha is aware—even though her CD4 (immune-cell) count is now above average—that she probably has a limited time on Earth to spend with her. Still, she wants the time she has left to be better. One day, she gathered courage and left her husband. Her own family took her back, which is rare. When her husband died, she said, she did not feel sadness, only relief. This spring, she married again. Her new husband is also HIV-positive, and they were introduced by friends. It may sound like a macabre sitcom, but in a culture that still relies on matchmaking, it was a perfect solution. Latha says her new husband caught his HIV from his wife, who died last year. Although he would love to have a child, both of them feel too responsible to risk transmitting the disease to an infant. Latha's daughter is still young, and she does not know what her father died from, or what her mother's sickness is. Latha is not sure how she will tell her or when. But she is adamant that she will tell her one thing, and this one thing is a small link on a ladder to preventing AIDS. "When it comes time for her to get married," Latha says, "I am going to tell her to marry a man that she loves." She drops her voice and smiles slightly for the first time. "And when she is a little older, I am going to tell her about condoms."

Latha was a small ray of light in a dismal landscape. But, a few weeks after I left India, more darkness: Word came through from the CHES orphanage that Dilli Babu had breathed "his last breath." His closest surviving relative, a maternal uncle, refused to claim his AIDS-ravaged body.

"Please do pray for him," wrote Dr. Manorama, "that his soul rests in peace along with his mother and father." □

SUPREME COURT

(continued from page 350)

his line of colognes and men's toiletries, a concession to fame.

Meanwhile, the recognition back home rolls in. Last year he was named the Swiss Person of the Year, about which he is typically modest. "I mean, this is not something too difficult to do," he says. "We have only seven million people."

Roger's levelheadedness extends to his activities off the court. He has put some of his own millions into a group called Imbewu, a nonprofit group in New Brighton, South Africa, that helps feed and educate young people in an area where the unemployment rate is nearly 80 percent. "And I hope this will stay with me a long time, because this will go beyond my tennis career, obviously," he says. Imagine being 23; imagine having yet to hone your obviously extraterrestrial skills; imagine having possibly your best tennis years ahead of you and thinking about what goes on after your career.

By the end of the morning, he's so vacationed, so relaxed, that he even begins fielding a few questions about tennis—which is a good thing if you happen to be learning how to play in order to maybe someday win a game against your wife.

The Beverly Hills Hotel has a tennis court, and after a while, you persuade Roger to show you a couple of pointers. So there you are with the world's best tennis player, and you are ready to demonstrate your moves.

"Show me your forehand," he says graciously. You begin to swing, ungracefully.

"You're coming too . . . under," Roger says, putting it mildly. You understand this. You appreciate it, as a criticism, and you want to ask more about it, but then the waiter brings out a cordless phone.

Roger speaks to the caller. "Ja."

Mirka eavesdrops. "Oh, that's Arthur Cohn," she says, speaking of the Swiss-born filmmaker, producer of *Central Station*. "He is an old friend." Apparently Cohn has been setting up meetings for Roger all week. Roger is still chatting, pacing excitedly. He has forgotten tennis again, happily.

Mirka is translating, and as a result, suddenly they are ready to leave.

"Well, we have to go see Kirk Douglas today," she says.

And they are off for another Los Angeles celebrity match, with maybe some shopping on the side. □



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