

**The role of governments in the fight against HIV/AIDS
in Southern Africa: a case study of South Africa.**

By

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ABSTRACT

HIV/AIDS is a deadly disease that needs to be addressed with immediate effect before serious damage can occur. Because the government has a responsibility over the health of its citizens, everybody expects the government to take a lead in the fight against this epidemic and from the look of things the government's strategies are not making the desired impact on the epidemic. The author attempts to highlight that the South African government has not played a satisfactory role in the fight against this pandemic, which threatens to alter history to a degree not seen in the world. Antenatal data and recent mortality rate bear testimony to this argument. The researcher has used a mixture of informal and formal unstructured and semi-structured, open-ended interviews with students who come from different provinces and relevant government officials. Secondary sources were also used in this study. The impact of poverty on HIV/AIDS is clearly explained. The study recommends that the programmes on HIV/AIDS be reviewed immediately. The responses to the epidemic must take into account circumstances under which the majority of the population lives. Failure to tackle situations that worsen poverty will make HIV/AIDS even more severe.

Key words

HIV, AIDS, epidemic, pandemic, immune system, opportunistic infections, poverty.

DECLARATION

I declare that this research report is my own work. It is being submitted for the degree of **Magister Public Administrationis** at the University of the Western Cape.

I further testify that it has not been submitted for any other degree to this or any other university or institution of higher learning.

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Skhumbuzo Julius Mngomezulu



25 February 2005

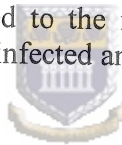
DEDICATION

I dedicate this Dissertation to my dearest mother, **Regina, N. Vilakazi** who has been a pillar of strength and a source of hope and inspiration from the cradle to the present. Without her love, attention, care and guidance I would never have come thus far –*Mphephethe binda ngibonga kakhulu ukwanda kwaliwa ngumthakathi.*

I also dedicate this Dissertation to my late father, E. M. Mngomezulu, who would have been proud of me today and to the memory of my aunt **Thembi Vilakazi** and my special little daughter **Thembokuhle Mngomezulu** (you will always be in my heart).

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Lastly, this work is dedicated to the millions of Africans (men, women and children) who until today are infected and affected by HIV/AIDS.



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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinics
AZT	Zidovudine
DOH	Department of Health
DNA	Deoxyribonucleic Acid
DRC	Democratic Republic of the Congo
HIV	Human Immune Virus
MCC	Medicines Control Council
MTCT	Mother-To-Child Transmission
NACP	National AIDS Coordinating Program
NGOs	Non-Governmental Organisations
PMTCT	Prevention of Mother-To-Child Transmission
PWV	Pretoria Witwatersrand Vereeniging
PVOs	Private Voluntary Organisation
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TAC	Treatment Action Campaign
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme

List of Tables and Graphs

Graphs

- A graph on antenatal data has been provided.
- A graph by the Western Cape Health Department, predicting the spread of HIV with intervention.

Tables

- This Mini-Thesis contains a table on global summary of HIV/AIDS epidemic December 2000
- It contains also a table on percentage of HIV/AIDS in Southern Africa
- A table on distribution of participants with regard to gender
- A table on participants age grouping
- A table on participants awareness about HIV/AIDS
- Lastly, distribution of participants by place of residence



CHAPTER ONE

1. INTRODUCTION: HIV/AIDS PROBLEM

“If an earthquake – or an epidemic like AIDS – is conceptualised as a natural disaster, an act of God, people in some cultures are less likely to expect or demand immediate government assistance than if it is seen as a massive social or public health crisis (in other cultures, the opposite might be true)” (Treichler, 1992: 87).

Cries about the spread of HIV/AIDS¹ in the world have become ubiquitous to the extent that their impact on society has been drastically reduced. Philips (2001) argues that in the realms of writing on AIDS in South Africa, both scholarly and popular there runs a strong sense that this is an unspeakable epidemic. It ‘defies description’; remarked a leading AIDS scholar (Crewe, 2000), while the South African chair of the AIDS 2000 Conference in Durban said he ‘could find no parallel in history for AIDS’. Unfortunately, HIV/AIDS is a reality one cannot shy away from because it continuously devours the population like an insane soldier shooting innocent civilians. Whether one lives in the developing or in the developed world, AIDS is a shocking illness. The changing structure of the population will have untold effects on the way societies organise and reproduce themselves (Crewe, 2001: 5). The African continent is already feeling the pinch. Africa cannot escape the AIDS epidemic; it has the highest HIV/AIDS infection rate in the world.

¹ Terms such HIV/AIDS and AIDS will be used interchangeably in this paper.

The HIV epidemic is one of the fastest growing diseases in Southern Africa and the region is seen as an epi-centre of the HIV/AIDS explosion. Reports from the UNAIDS (United Nations Programme on HIV/AIDS: 2001) place Southern Africa far higher than the rest of the world. Recent reports such as *Statistics South Africa and Medical Research Council* estimate that 10 million South Africans out of the population of approximately 40 million will die of HIV/AIDS during the next ten years (HIV/AIDS profile in the provinces of South Africa: 2002). This epidemic is so widespread that it will soon aggravate the already deteriorating socio-economic situation. In the long run, governments will have to look after a large number of orphans and very few people will be healthy enough to work in any sector. People who are mostly infected are those that are economically active. They die in their prime, and so one can easily predict that a few years from now the economic situation will be worse than it is at the moment. This kind of situation is undesirable in any country, let alone poor Southern African countries.

1.1. Problem statement

It is common knowledge that HIV/AIDS will have serious socio-economic consequences in developing countries such as South Africa. This mini-thesis discusses the magnitude of the HIV/AIDS problem with specific reference to possible strategies to combat it in the South African context. Moreover the paper seeks to argue that South African government's strategy against HIV/AIDS is ineffective.

The HIV/AIDS scourge will claim the lives of many more of the country's most highly trained and productive professional people. Equally serious will be the loss of thousands

of skilled and semi-skilled workers. Recruiting and training staff to replace all those lost through HIV/AIDS will be both a costly and time-consuming exercise. HIV/AIDS is, therefore, a real threat to the economic productivity and to the survival of many companies. It is also a threat to human existence not only in southern Africa, but also in many other countries in the developing world. HIV/AIDS in Southern Africa is so severe that it eclipses the often-used term 'crisis'. For example, in Botswana about 35.8% of the population is infected (UNAIDS Report, 2000). This pandemic is destined to alter history in Africa, and in fact the world to a degree not seen in humanity's past since the Black Death.²

The point being made is that HIV/AIDS is a deadly disease that needs to be addressed with immediate effect before the disease causes serious damage. Various governments in Southern Africa, including South Africa have not played a leading or satisfactory role particularly with regard to AIDS-prevention programmes and projects that could help contain and prevent the spread of this killer disease. Programmes put in place in various countries were not followed up to see if they are making any impact. In countries such as South Africa and Botswana, resources (both financial and human) are in place to fight this pandemic. Those governments that have taken a rearguard position in addressing this pandemic are already feeling the pinch.

In 2001 the South African government allowed provinces to start experimenting with Nevirapine to pregnant mothers who are HIV-positive. This drug was known long time

² The Black Death broke out in the 14th century. The plague spread across Asia, Europe and Great Britain with such virulence that the course of human history changed. Everybody believed the end of the world had come. The plague killed about 25 million people (R Horrox, 1996).

ago that it could make a huge difference in reducing the spread of HIV from mother-to-child. In Zimbabwe, the government supported the unpopular war in the Democratic Republic of the Congo (DRC) at the expense of the HIV/AIDS pandemic. In these countries the mortality rate is on the increase due to HIV/AIDS. Life expectancy has remarkably decreased in various countries in the region. If the above-mentioned governments want to make an impact in the world, HIV/AIDS has to be given first priority in the government's planning.

1.1.2. Guiding assumptions

- HIV/AIDS prevalence in South Africa is on the increase and the response is ineffective.
- Furthermore, the South African government has also failed its Constitutional obligation of providing basic health care to all its citizens.
- Though some efforts are being made, evidence suggests that the governments in the region are not doing enough to combat the disease. Accordingly, this study tracks the efforts made thus far to control the spread of HIV/AIDS with reference to South Africa, Zimbabwe, Botswana and Namibia.

1.1.3. Objectives of the study

- To assess HIV/AIDS prevalence in South Africa.
- To examine the effectiveness of government strategies against HIV/AIDS.
- To suggest ways in which governments could fight HIV/AIDS.

- To establish if governments like that of South Africa are doing enough to face AIDS head-on and, lastly,
- To contribute to the corpus of knowledge

1.1.4. Research Methodology

The study is based on the collection of both primary and secondary data. Primary data on HIV/AIDS information was gathered from the questionnaires that were administered. Secondary data on HIV/AIDS comes from documentary sources such as relevant books, journals, articles, official publications, newspaper clippings, reports and seminar papers. The information was utilized to present the facts and to substantiate the arguments.



Both the provincial and local government health and HIV/AIDS were interviewed. This study wanted to find out programmes in place to combat HIV/AIDS at both spheres of government. The strategies by the City of Cape Town as the delivery arm of the national government are highlighted. Local governments are 'closer' to communities. Interest groups such as Treatment Action Campaign (TAC), National Association for People Living with AIDS (NAPWA) and many more played a significant role were observed in validating the study. Interviews were utilised to back up recent events and arguments because of little documentary evidence for what is being described. Interviews are a useful way of gathering information. Questionnaires were also utilised to cross-refer information, because the researcher can misunderstand the person being interviewed. The questionnaire was designed mainly to gauge people's knowledge about HIV/AIDS.

The field site for the investigation is South Africa. The investigation was conducted during June 2003 at the University of the Western Cape. 100 Students from different provinces and other parts of the continent took part in the study. People from different provinces articulated their views about the fight against HIV/AIDS in South Africa. There was no special funding for this research therefore I personally distributed the questionnaires. Even though participants come from various provinces it is still hard to generalise. Students from another campus or university might have different ideas.

The research has been conducted amongst males and females between the age groups 15-25 and 26-40 years. These are two groups mostly affected by the epidemic. The age group 15-25 is the most at risk of contracting the killer virus, while 26-40 is the group dying out since being infected long time ago. The research was conducted on 100 students (both post-graduates and undergraduates across the racial line and interdisciplinary). The random sampling technique was used, i.e. selection meant every student registered at the University of the Western Cape stood exactly the same chance of being selected for the study. This is advantageous because it limits a biased sample.

An open-ended questionnaire was used as the gathering instrument, which contained 9 questions pertaining to the role of government in the fight against HIV/AIDS in South Africa (see Appendix 1). Open-ended questionnaires are used not to limit respondents more answers expected instead of Yes or No. Face-to-face interviews were opted for and the main reason was that face-to-face interviews allow flexibility in the questioning process and also allow the interviewer a chance to clarify terms that are unclear. The

subjects were informed about the nature of the research before the interviews were conducted. During the interview participants were asked to reflect on the questions contained in the questionnaire.

The question of knowledge is fundamental to the examination of the HIV/AIDS discourse. The questionnaire was used to establish if people knew anything about HIV/AIDS and for how long they have known about this killer disease. It also wanted to investigate if HIV is a serious problem in their areas (different provinces in South Africa) and if the government response is making an impact. The paper moves from a premise that governments should inform the general public about the epidemic. It is crucial that people get as much information on AIDS as possible to be alert. The questionnaire also investigated the sources of information about HIV/AIDS.



Condoms are part of prevention strategies in the fight against HIV/AIDS. The government should ensure that every sector of the population has access to condoms. Failure to which, HIV/AIDS will reach greater heights. The questionnaire wanted to find out if areas where the interviewees lived have condoms readily available at all times. The absence of vaccines makes the task of dealing with HIV/AIDS even harder. People should know that HIV/AIDS cannot be cured but it can be prevented.

The buzzword these days is poverty. It has been argued that poverty plays a certain role in the spread of HIV/AIDS. In fact, it worsens the predicament of HIV/AIDS many countries find themselves in. Do people see the relationship between poverty and

HIV/AIDS? This is the sort of question people should try to grapple with. Secondly, if poverty alleviation is essential in the fight against HIV/AIDS, is the government making any progress?

1.1.5. Significance of the study

HIV/AIDS is a widespread disease, which warrants everybody's (be it NGOs, government officials, students, researchers and health workers) attention and contribution. This study will form part of the existing literature on HIV/AIDS. The research will make an academic contribution to the understanding of HIV/AIDS as a deadly disease with specific reference to Southern Africa and South Africa in particular. If this paper is acceptable, it can be published; various countries in the region can have full access to it and better their policies or change their strategies when dealing with HIV/AIDS.

1.1.6. Limitations of the study

Because this is a case study, it is extremely hard for the researcher to generalise about Southern Africa. It cannot be denied that countries in the region have different backgrounds. What is important for South Africa might not be that significant for other countries. Cultural diversity in Southern Africa is one of the factors that make generalisation impossible. The vast cultural differences in Southern Africa serves as an obstacle, in other parts of the continent it is taboo to talk about sex and in other it is not. Secondly, the research was conducted over a short period of time due to financial constraints thus, it cannot be as comprehensive as it would have been had it been done

over a long period of time. Conducting a five-year study would have been ideal to produce a systematic and comprehensive contribution to the academic realm. Lastly, HIV/AIDS is not an event, but a process. At some point new drugs can be found and this paper would not be able to cover that. Apart from new drugs, HIV/AIDS is a topical issue, it is debated in every corner and other significant debates will be missed including government policy change may not be recorded.

DEFINITION OF MAJOR TERMS

AIDS

Acquired Immune Deficiency Syndrome—A syndrome (collection of diseases) that results from infection with HIV.

Epidemic

A disease, usually infectious, that spreads quickly through a population



HIV

Human immunodeficiency Syndrome virus—the name of the virus, which undermines the immune system and leads to AIDS.

Immune system

A complex system of cells and cell substances that protects the body from infection and disease.

Opportunistic infections

Infections that occur because a person's immune system is so weak that it cannot fight off the infections.

Pandemic

An epidemic occurring simultaneously in many countries.

Prevalence of HIV

The number of people with HIV at a point in time often expressed as a percentage of the total population.

Poverty

It is the inability to attain minimal standard of living, measured in terms of basic consumption needs or the income required satisfying them.



CHAPTER TWO

2. THEORETICAL CONCEPTUAL FRAMEWORK

Very rapid and significant medical advances have been amongst the cornerstones of human development in the 20th century. Admittedly advances have not benefited all mankind; but they have been made and there is no doubt that much misery has been eradicated consequently. Most of the great scourges of the past—amongst them smallpox, tuberculosis and many more hold few terrors today, at least for people of the industrialized nations. And even the old-aged mystery of cancer is at last beginning to yield up to its secrets.


HIV/AIDS is profoundly disturbing for many people (medical practitioners and the general public) because it is a relatively new disease that invariably kills, and because there is no vaccine for it and no cure. Adding to the state of fear that HIV/AIDS already provokes is the fact that the doctors and scientists, in whom we have hitherto placed so much trust, appear to be every bit bamboozled about the link between HIV and AIDS. The section intends to highlight different HIV/AIDS theories. There are two significant groups in the HIV/AIDS realm i.e. conventional theorists and dissidents.

2.1. Conventional Theorists (HIV causes AIDS)

HIV/AIDS is a multiple disease caused by a particular kind of virus that works in two main ways. The contestations around the HI virus will be discussed in detail in the chapter. There have been massive consternation among scientist, doctors and many others

treat AIDS patients or who work with AIDS in other ways. There is a widespread anxiety that denying or doubting the cause of AIDS will cost countless lives if blood screening, use of condoms, and methods to prevent mother-to-child transmission of the virus are not implemented.

Over 5000 people, including Nobel prizewinners, directors of leading research institutions, scientists and medical societies, signed a Declaration. The declaration acknowledges the link between HIV and AIDS. Furthermore thousands of individual doctors and scientists have signed, including many from countries bearing the greatest burden of the epidemic.

Years after the discovery of the  human immunodeficiency virus (HIV) medical practitioners, academics, civil society and interested groups gathered in Durban to attend the International AIDS conference in 2000. Like many other diseases, AIDS is spread by infection that causes illness and death especially in underprivileged and impoverished communities. HIV-I infects T lymphocytes, white blood cells that have a central role in the immune response (www.unaids.org accessed 18 June 2003). HIV-1 is a retrovirus closely related to a simian immunodeficiency virus (SIV) that infects chimpanzees

Conventional theorists argue that the evidence that AIDS is caused by HIV is not only crystal clear but meets the highest standards of science. The data fulfill exactly the same criteria as for other viral diseases, such as polio measles and smallpox: (www.unaidsa.org accessed 20 June 2003)

- Patients with acquired immunodeficiency syndrome, regardless of where they live, are infected with HIV
- If not treated, most people with HIV infection show signs of AIDS within 5-10 years. HIV is identified in blood by detecting antibodies, gene sequence or viral isolation. These tests are as reliable as any used for detecting other virus infections
- People who receive HIV-contaminated blood or blood products AIDS, whereas those who receive untainted or screened do not.
- Most children who develop AIDS are born to HIV-infected mothers. The higher the viral load in the mother, the greater the risk of the child becoming infected.
- In the laboratory, HIV infects the exact type of white blood cells (CD4 lymphocytes) that becomes depleted in people with AIDS.
- Drugs that block HIV replication in the test tube also reduce virus load in people and delay progression to AIDS. Where available, treatment has reduced AIDS mortality by more than 80%.

The data above clearly show the scientific link between HIV and AIDS. HIV develops to AIDS and people infected by it die ultimately.

2.1.2 Dissident's Views (Duesberg's Theory)

Other scientists such as Duesberg do not subscribe to the notion that there is a link between HIV/AIDS. Duesberg's theory argues that HIV is a harmless retrovirus that may serve as a marker for people in AIDS high-risk groups. AIDS is not a contagious syndrome caused by one conventional virus or microbe. Duesberg further argues that

HIV/AIDS is caused by malnutrition, parasitic infection and poor sanitation. “There is no scientific evidence for the correlation between HIV and African AIDS, only guesses.” (“Peter Duesberg on AIDS” website, <http://www.duesberg.org> accessed 20 June 2003).

The South African government has allowed debate over the cause of HIV/AIDS even though government policies and programmes indicate that the government believes that HIV/AIDS causes AIDS. To complicate matters worse South African government signed the Declaration at the AIDS Conference in Durban confirming that HIV causes AIDS.



CHAPTER THREE

3. THE HIV/AIDS PROBLEM: SOME INSIGHTS FROM THE EXISTING LITERATURE

In a short space of less than a decade, AIDS has swept around the world as a massive tidal wave of misery and death. The epidemic is currently at its peak in Southern Africa and AIDS will probably decline only after 2010, because the majority of people who are HIV-positive now will be dying in numbers and others might learn from this. The challenge for countries still in the expanding phase of the epidemic is to make the peak as low as possible; and the challenge facing all countries is to bring the incidence of new infections down as quickly as possible (Bradshaw, Johnson, Schneider, Bourne & Dorrington, 2002: 2).



The South African government has extensively engaged in AIDS education and awareness programmes as means or attempts to prevent the spread of the disease. Some of the methods used in teaching people about AIDS do not suit the lifestyles of the people. Governments have not come up with appropriate ways of teaching or conveying the message of preventing the spread of the killer-disease to the people. Statistics South Africa (1996) observes that education and awareness can and does make a difference in preventing the spread of sexually transmitted diseases. AIDS education and awareness campaigns in South Africa have not enjoyed much success, as the epidemic is still on the increase.

There is currently little debate about the destructive nature of the AIDS epidemic. Existing literature shows that AIDS is indeed a global problem. Attesting to this view, Kofi Annan maintains “AIDS is not an African problem alone, AIDS is a global problem”(Washington Post, 07 July 2001). Available statistics indicate that not all continents, regions, and countries are affected in the same manner. The African continent for example appears to be the most affected. Within the African continent, the case of Southern Africa seems to be worse. It is argued that HIV-positive patients occupy up to 80 per cent of hospital beds in Zambia and Zimbabwe (Pudifin, 1995: 3).

Two decades ago the terms HIV and AIDS would not have been found in any medical dictionary, and would certainly have caused blank looks on the faces of health authorities. Today the epidemic is one of the most serious problems facing many countries in the world. Although the disease has to be seen in context, given that there are many health and other problems facing many countries, there are a number of characteristics that make it unique (Loewenson & Whiteside, 1997: 13). HIV/AIDS in particular it is far more a health problem.

3.1. The Origins of HIV/AIDS

This section tries to identify the origins of the HIV/AIDS pandemic. If the origin can be traced undoubtedly proper intervention can be made. HIV/AIDS is a fairly new epidemic and its origins have not been positively identified. “This disease or more correctly the syndrome has taken on a character of malicious intent with its own destructive technology, becoming in the minds of some observers a ‘killer disease’, a

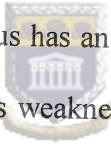
slow plague, and a misery seeking missile” (Webb, 1998:1). Doctors began to observe clusters of diseases, which previously had been extremely rare. HIV/AIDS is a disease that is a league of its own. “These included a type of pneumonia spread by birds (*pneumocystis carinii*) and a cancer called karposi’s sarcoma” (Whiteside & Sunter: 2000: 1). Not long after this observation health workers began to notice a new disease characterised by diarrhoea and severe weight loss. Today HIV/AIDS is one of the leading causes of death for people in a number of countries in Sub-Saharan Africa.

The first public documentation of the phenomenon was contained in the Morbidity and Mortality Weekly Report (MMWR), a widely circulated report on infectious diseases and deaths in the USA. The report recorded five cases of *pneumocystis carinii*. Later, the MMWR reported a clustering of cases of both diseases that were mainly centred on New York, which rose rapidly and scientists realised that they were dealing with a new phenomenon.

This phenomenon was initially seen among homosexual men in the United States who had adopted a promiscuous life-style. Soon, however, there was evidence of cases among *heamophiliacs*. The disease came to be called the Acquired Immunodeficiency Syndrome, shortened to the acronym AIDS.

- The ‘A’ stands for Acquired. Orr (2000) holds that it is obtained from some outside source. This means that the virus is not spread through casual or inadvertent contact like flu or chickenpox. In order to be infected, a person has to do something (or have something done to them), which exposes them to the virus.

- 'I' and 'D' stand for Immunodeficiency. The virus attacks a person's immune system and makes it less capable of fighting other infections. Thus, the immune system becomes deficient or unable to fight illness.
- "S" is for Syndrome. AIDS is not just one disease but it presents itself as a number of diseases that come about as the immune system fails to cope.

Once the syndrome had been identified, an outbreak of scientific and epidemiological activity followed. In order to exist, the virus has to enter a cell and insert itself into the cell's DNA to reproduce itself. Even today tests detect the antibodies to the virus rather than the virus itself. Whiteside & Sunter (2000) argue that these might be compared to footprints on a sandy beach because they show that a person has been there even though the person cannot be seen. This HI virus  has an extra-ordinary ability to hide meaning it cannot be detected easily. HIV causes weakness of the body. AIDS is any illness that arises out of the weakness. Any illness including Tuberculosis, Cancer, Pneumonia, and great weight loss due to constantly upset stomach that enters when the body is very weak.

Two types of HIV have been identified, namely HIV-1 and HIV-2. The second immunodeficiency virus labelled HIV-2 was discovered in West Africa. Hiv-1 is far more geographically extensive than HIV-2, which is mostly confined to West Africa. "The clinical manifestations of AIDS are similar for the two strains, although the onset of immune deficiency appears to be slower with HIV-2" (Webb: 1998: 5). Nonetheless, the viruses are both transmitted in the same ways, which involve the mixing of body fluids.

3.1.1. A Global and African Overview

The epidemic is spreading around the world, moving into communities not yet affected and strengthening its grip on areas where HIV/AIDS is already the leading cause of death. This section shows how different continents, regions are affected by the epidemic. Estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) tracks the epidemic in time and in different parts of the world. HIV/AIDS is not an African problem but a global problem.

TABLE 1

Global summary of the HIV/AIDS epidemic: December 2000

People newly infected with HIV in 2000:	Total 5.3 million
Adults 4.7 million	
Women 2.2 million	
Children <15 years 600 000	
Number of people living with HIV/AIDS	Total 36.1 million
Adults 34.7 million	
Women 16.4 million	
Children < 15 years 1.4 million	
AIDS deaths in 2000:	Total 3 million
Adults 2.5 million	
Women 1.3 million	
Children < 15 years 500 000	
Total number of deaths (since the beginning of the epidemic)	Total 21.8 million
Adults 17.5 million	

Women 9 million

Children < 15 years 4.3 million

Source: *UNAIDS Report (December 2000)*.

In sub Sahara-Africa an estimated 3.8 million adults and children became infected with HIV during the year 2000, bringing the total number of people living with HIV/AIDS at year's end to 25.3 million (UNAIDS Report: 2000). Over the same period, millions of Africans infected in earlier years began experiencing ill health, and 2.4 million people at a more advanced stage of infection died of HIV-related illness. The region thus continues to face a triple challenge of colossal proportions:



- Bringing health care, support and solidarity to a growing population of people with HIV-related illness
- Reducing the annual toll of new infections by enabling individuals to protect themselves and others.
- Coping with the cumulative impact of over 17 million AIDS deaths on orphans and other survivors, on communities, and on national development.

3.1.2 HIV/AIDS in South Africa

The first case of AIDS in South Africa was reported in 1982 in a white homosexual man who contracted the virus while in California. The spread of HIV among white homosexuals concentrated in the PWV area (Pretoria-Witwatersrand-Vereeniging, now

known as Gauteng). In the 1980s AIDS deaths were predominantly amongst white male homosexuals (Webb: 1998). There was a turn around in the transmission of AIDS from the homosexual to heterosexual community. By the time this first outbreak peaked in sub-Saharan Africa, South Africa faced a new heterosexually transmitted epidemic predominantly affecting black African communities.

The prevalence of HIV is measured in the annual antenatal HIV surveillance surveys conducted at the state clinics. When the survey began in 1990 the prevalence rate was 0.7 percent of pregnant women tested positive. By 1999 the prevalence had risen to 22.4 percent, and 4.2 million South Africans 19.9 percent of the adult population were infected according to a report released in June of 2000 by the Joint United Nations Programme on HIV/AIDS (UNAIDS).



A number of people including medical practitioners, academics, health professionals ask themselves why South Africa has not managed to turn the epidemic around. A long time ago HIV/AIDS was seen to threaten the existence of mankind. The disease was left till too late; in its early stages little or nothing was done to mitigate its spread. The fact that AIDS began under the old order and burgeoned under the new has immensely complicated attempts to deal with it. It is worth examining the responses to the epidemic during the apartheid era as they go some way toward explaining the problems of today.

3.1.3 HIV/AIDS in apartheid South Africa

Of all the countries in the Southern African region, the response of apartheid South Africa to the epidemic has been the one most characterised by denial, ministerial wrangling, the misallocation of resources, and has been muted throughout by those either resisting or pushing for political transformation (Webb, 1998: 73). The apartheid administration was ill-prepared to handle the new challenge.

Furthermore, a number of posters produced were culturally illiterate, featuring white characters with the faces coloured in, and only rarely in appropriate language. Van der Vliet (2001) holds that the media campaign directed at black audiences was different from that designed for white audiences. For example programmes designed for black audiences emphasised the debilitation and death arising from AIDS in a drastic way, while for whites in contrast, the campaign was soft, with an emphasis on long-term love that should override short-sighted unsafe sexual practices. AIDS meant death to black people, but close companionship to white people.

3.1.4. The nature of HIV/AIDS in Southern Africa

Jackson (1999) argues, the Southern African region is the hardest hit by HIV/AIDS. The statistics show the extent of the epidemic in a number of countries in the region. HIV prevalence in Southern Africa is as follows:

Table 2

Country	Percentage
Angola	19,5%
Zambia	19,9%
Malawi	16%
Namibia	19, 5%
Botswana	35.8%
Zimbabwe	25, 1%
Mozambique	13, 2
Swaziland	25, 3%
Lesotho	23.6%
South Africa	19.9%

Source: UN Africa Recovery, June 2001



3.1.5 The response of Southern Africa to HIV/AIDS

Obviously the response to the spread of HIV/AIDS in the region has been unimpressive. Initially, there was a disbelief that the epidemic was occurring or, indeed, would occur. The disease was seen as belonging to the Western world or to homosexuals and people with 'deviant' lifestyles. Countries like Zimbabwe went to the extent of hiding statistics on HIV/AIDS. They did not want to hear anything about HIV/AIDS, let alone about HIV/AIDS in their own country. It took them a long time to respond and accept that HIV/AIDS was present and killing people. Different governments discouraged the discussion of the problem and, in some cases, refused to allow statistics to be published or recorded (Whiteside, 1994: 246).

Where AIDS was seen as a problem, it was – and still is largely – regarded as a medical problem to be dealt with by the Ministry of Health. This perception governed the early response to the epidemic. Initially the response to HIV/AIDS in the region did not match the severity of the disease. African governments, after failing to address problems at the outset of the epidemic, are now faced with even greater difficulties than might otherwise have been the case (Fredland, 1998: 549). The African health situation may have been different had there been an aggressive response when the epidemic first became apparent. The Joint United Nations Programme on AIDS (UNAIDS) has persistently called for national AIDS programmes to be publicly supported at the highest political level (Piot: 2002). Instead there has often been a stance of denial or, alternatively, official acknowledgement of the need for an AIDS policy coupled with a persistent failure to accept the depth of the crisis or urgency of the situation, much less to follow through on construction of a comprehensive policy. It seems as if, having officially conceded the presence of AIDS, governments then go about their business—fighting wars, co-opting or undermining opposition elements, issuing statements about development initiatives—all with a nary whisper about the impact of AIDS on all aspects of social and economic affairs.

The role of governments in AIDS-prevention projects has not been covered sufficiently; the gaps that were left by other researchers should be filled. Many researchers do not address specifically the role of government in the fight against HIV/AIDS. Relatively there has been very little information on the role of government in as far as curbing the killer-disease is concerned. The limited information allows researchers to explore other

avenues left behind, not covered or not highlighted. The governments in the region have been slow in recognising the seriousness of the epidemic. As indicated earlier, some governments went to the extent of hiding statistics with a fear of losing investors and tourists. Fredland (1998) argues, some combination of fear and denial must explain the situation in the 1980s of a Zimbabwean Minister of Health ordering physicians not to report AIDS as a cause of death. This pervasive reaction became an invitation to the spread of the virus that was already present.

3.2. Zimbabwe

Zimbabwe used to be a powerhouse in Southern Africa not only politically but also economically. It is interesting to uncover the way in which HIV/AIDS is handled. With an adult prevalence rate of 25 per cent, Zimbabwe is among countries hardest hit by HIV/AIDS in sub-Saharan Africa. At the end of 1999, 1.4 million adults were living with the disease and approximately 2, 000 people were acquiring HIV infections everyday. As a result of HIV/AIDS, the crude death rate in Zimbabwe will be more than 200 per cent higher in 2005 than it was 1990. Zimbabwean life expectancy is predicted to decline to 35 years by 2010, compared with 66 years in 1997. The population is expected to grow slowly because of HIV/AIDS; by 2015 it will be 19 per cent smaller than it is today.

3.2.2. The Zimbabwean national response

Soon after the first cases of HIV/AIDS were identified, the Zimbabwean national government established the National AIDS Coordination Program (NACP), housed in the Ministry of Health, to coordinate national prevention efforts and donor-supported activities. The NACP intended to tackle the disease in the following manner:

- Preventing transmission of HIV and other STIs through information, education and communication, counseling and promotion of condom use
- Providing health care, counseling and social services for the people living with HIV/AIDS and their families
- Reducing the impact of HIV/AIDS on labour supply and public expenditures.

However, the national effort lacked commitment from senior officials (HSRC: 2002). Most activities were actually carried out by private voluntary organisations (PVOs) and non-governmental organisations. The major constraints to HIV/AIDS control in Zimbabwe include:

- The lack of government leadership and commitment in responding to the epidemic
- The NACP's reliance on donor funding. NACP staff is almost entirely donor supported.



Clearly much depends on visible commitment from the country's leadership. Public endorsements and supportive action by national and community leaders will heighten awareness of the threat posed by the epidemic, and promote multi-sectoral response to HIV/AIDS at all levels of society.

3.2.1. Namibia

The importance of monitoring progress of countries in Southern Africa can never be over-emphasised. Countries are tackling the scourge differently. Namibia has been experiencing a steadily worsening epidemic since the 1990s. It is experiencing an

explosive increase in HIV infection similar to other countries in Southern Africa. Namibia has a population of 1.6 million. With an adult prevalence of more than 20 per cent, Namibia is among the worst HIV/AIDS affected countries in Africa. An estimated 150, 000 to 180, 000 Namibians are living with HIV. With current trends, this figure is expected to rise to 400, 000 shortly.

The prevalence among women in Windhoek—a major urban area and the capital of Namibia---increased from 4 per cent in 1991 to 30 per cent in 2000. In rural areas, the HIV prevalence rate was 15 per cent in 1998 and increased to 34 per cent in infection rate. If HIV/AIDS continues to spread at its current rate, direct costs to the health system will increase. The epidemic also presents a real challenge for a newly independent country with a fragile economy and scarce human resources.



3.2.2. The Namibian national response

In 1999 the Namibian government launched an expanded National AIDS Coordination Programme which focused on condom promotion, prevention and epidemiological surveillance. The National AIDS Coordination Programme is the key to the expansion of the national response. The recent proposals have been advanced to make AIDS a 'notifiable' disease. Doctors would be required to notify those closest to the patient about his or her status, and relatives and partners would be given counselling after notification. The government believes this would destigmatise AIDS and thus more effectively combat the epidemic. Like Zimbabwe, donors carry the large part of the burden in the fight against HIV/AIDS in Namibia.

It was also believed that notification would assist in gathering HIV/AIDS data. While few would disagree that there is a need for good information on the epidemiology of HIV/AIDS, it is widely believed that notification will not provide this data. Namibia is not unique in Africa with regard to the underreporting of AIDS. Several African countries have attempted to make AIDS a notifiable disease, but did not yield the desired results. The World Health Organisation (WHO) revises the reported cases upwards by a factor of almost 10. Notification data can also not provide the true picture of the epidemic.

It has been suggested that the Department of Health of Namibia could use AIDS notification as a tool to improve the whole system. This might be true, even though the data would still not be useful for surveillance purposes. In order to determine the incidence of AIDS, all patients with one of the many indicator diseases would need to be tested for HIV, which would be very expensive and probably not feasible. Not all health care facilities do HIV testing.

If people are forced to disclose their status or their status is disclosed in one way or the other, the probability that people would not visit clinics when they are sick is high. This again would hide the extent of the epidemic in Namibia. Notification of AIDS is not recommended as a mechanism to improve surveillance in many countries. Furthermore, AIDS notification does present a problem regarding confidentiality. Where does a doctor draw a line between what is acceptable by different boards of medicine that emphasise confidentiality and the requirements of the state.

Both Namibia and Zimbabwe have never prioritised HIV/AIDS. Their involvement in the war in the Democratic Republic of the Congo attests to that. The prioritisation in both Namibia and Zimbabwe has not been on AIDS. "The Zimbabwean government admits it is spending more than 70 times the budget of the AIDS programme on its unpopular military intervention in the Democratic Republic of the Congo, though independent observers estimate the war costs more than that" Whiteside, 1999: 2). Large sums of money are spent everyday at the expense of HIV/AIDS. One might argue that they do not take the health of their citizens seriously.

3.2.3. Botswana

Botswana is regarded as Africa's model of good governance. It boasts a growing economy and stable political environment. It is another country worth looking in terms of its response to HIV/AIDS. It has a population of 1 330 000 (1991) and one of the fastest growing economies in the world (Barnett & Whiteside: 1996). It has been hailed as one of the economic success stories in Africa. Shortly after it became independent of British rule in 1966, diamonds were discovered in one of the richest mines ever found. Revenues from the booming diamond fields changed the capital of Gaborone from a sleepy village into the bustling capital of a rich nation. Yet this appearance of a progressive society belies the impact of the HIV/AIDS epidemic, whose effects permeate every aspect of life in Botswana. Longevity has decreased dramatically, dropping from 60 to fewer than 45 years over the course of a single decade.

Botswana is located at the centre of Southern Africa with a population of 1.4 million. It now ranks as number one of the four hardest hit by the HIV pandemic. An estimated 36

per cent of adults (15-49 years old) are HIV positive as of 2000 (UNAIDS, 1999). The number of deaths due to HIV-related illnesses will increase remarkably in the near future. In this small-populated country, AIDS directly or indirectly affects almost every family.

3.3. 4. The Botswana national response

Like all Southern African countries, it took Botswana quite long time to accept that HIV/AIDS exists especially the churches. In the face of this catastrophe, the Botswana government was committed to the most ambitious combination programmes on the continent. Although Botswana has been late in seriously responding to the disaster that is slowly taking grip of the country, President Festus Mogae started concrete and firm action.



The Botswana government's programme against HIV/AIDS is based on a multi-sectoral approach, drawing in non-governmental organizations, government departments, churches and the private sector. Furthermore, Mogae has committed his government to supplying free anti-retroviral drugs to all HIV-positive people who attend government clinics (Sunday Independent, June 24 2001: 5). The motive behind this offer is to see more people coming forward to be tested. This is a significant move never made before by any country in Southern Africa.

Rapid assessments are made to determine the needs of hospitals and clinics, while funding is being made available to upgrade and build new laboratories around the country. Companies such as Botswana Telecommunications and the mining company

Debswana have developed intervention strategies. Debswana will begin distributing anti-retrovirals to its HIV-positive employees.

The Minister of Health, Joy Phumaphi, who had herself tested publicly for HIV with her husband, is mindful of the need to implement the anti-retroviral programme carefully, because of drug resistance that can arise from non-compliance with treatment regimens. The political will in Botswana is excellent and half of the battle won. Evidence of the trickle-down effect of the government's commitment to fighting AIDS can be seen in all parts of the country. Every district has set up a multi-sectoral AIDS committee, and ordinary citizens have started projects for people living with AIDS and orphans. If the Botswana model is successful, it will provide momentum and encouragement to all of the afflicted countries in Southern Africa and beyond. At the moment it is too early to tell (statistically) if the attempts are making a positive impact.

The response to HIV/AIDS is not harmonised, some countries are not bothered at all while others seem to take a different path. Some countries are doing little; some exhaust all avenues possible in the fight against the epidemic. The entire Southern African region is devastated by the epidemic, one would expect some sought of consistency. HIV/AIDS does not only pose problems to individual countries but also to the region at large.

CHAPTER FOUR

4. KNOWLEDGE AND RESPONSE TO HIV/AIDS

This chapter is a report on the students' knowledge and understanding with regard to HIV/AIDS. The rationale for questions asked was to establish what the students feel the government's role should be in addressing the AIDS issue in South Africa. The participants come from different sectors of the country. Information about participants is provided such as gender, age and origin.

Table 3: Distribution of participants with regard to gender

Gender	N
Female	45
Male	55
Total	100



The study was conducted on the afore-mentioned students, it was not planned to have this sort of breakdown.

Table 4: Age grouping

Age	N
15-25	95
26-40	5
Total	100

The fact that these groups were evenly split does not mean that the respondents were asked how old they were before they were given the questionnaire. It was just sheer coincidence.

Table 5: HIV/AIDS awareness

Age	N
15-25	95
26-40	5
Total	100

All age groups are quite aware of HIV/AIDS and the threat it poses to the nation.

Table 6: Distribution of the participants by provinces

Provinces	N
Eastern Cape	19
Gauteng	16
Free State	4
KwaZulu-Natal	12
Limpopo	7
Mpumalanga	13
Northern Cape	1
W Cape	28
Total	100



Table 6: Distribution by place of residence

Place	N
Urban	28
Rural	72
Total	100

The split of respondents is not even, people from urban; especially people coming from townships were the most interviewed. This, too, was not preplanned. The UWC students were asked the following questions mainly to understand their views on the fight of the government against HIV/AIDS in South Africa.

1. What do you know about HIV/AIDS
2. For how long have you known about HIV/AIDS
3. Is HIV/AIDS a serious problem in your area? Please explain
4. What area is it (rural or urban)?
5. Where did you hear about HIV/AIDS
6. Are condoms readily available in your area?
7. Do you know how HIV/AIDS can be cured?
8. Do you see any relationship between HIV/AIDS, if yes what do you think the government should do to break the cycle of vulnerability?
9. Do you think the government is really committed or doing enough to fight HIV/AIDS?

4.1. Summary of the findings

4.1.1. What do you know about HIV/AIDS?

When AIDS emerged from the shadows two decades ago (early 1980s), a many people predicted how the epidemic would evolve, and fewer still could suggest with any certainty the best ways of combating it. Now at the beginning of the new millennium, we

are past the stage of conjecture. We know from experience that AIDS can devastate whole regions, knock off national development and widen the gulf between the rich and poor countries. Awareness is an important part of the prevention process. All 100 people interviewed know or understand what HIV/AIDS is. The respondents know about the destructiveness of the disease and the threat it poses to the population at large. To sum it all one respondent held:

“ HIV/AIDS is a sexually or intravenously transmitted, terminal disease that has reached epidemic proportions in parts of the world, including South Africa. This disease has killed a number of young people in many countries”.

The above quote clearly indicates that the respondents are well aware that HIV/AIDS is a deadly disease. So is the general population. About 90% of the South Africa population is quite aware of HIV/AIDS (Lovelife, 2000). But awareness alone is not enough for people to change behaviour. This illustrates that HIV/AIDS awareness alone is not necessarily a guarantee that people will change their behaviour. In this instance, the government cannot claim success; awareness has not yielded desired results. The continuing increase in infection rates suggests that this effort has been limited or perhaps ineffective on a broad scale. The government cannot rest on their laurels and say everything is fine because most people know about the disease.

4.1.2. For how long have you known about the HIV/AIDS?

As mentioned earlier HIV/AIDS was firstly noticed in South Africa in the early 1980s, but 88% of the respondents have come to know about it in the 1990s, 8 years ago to be

specific. Most respondents come from rural areas where information filters through last. Rural students are not as exposed as students from urban areas. Unfortunately, it is still the reality in South Africa. Only 12% of the respondents knew about HIV/AIDS 13 years ago. They knew about HIV/AIDS long time ago because they are a bit older; fall in the 25-40 age group. Two respondents came to know about HIV/AIDS in 1996. Given the destructive nature of the disease, one would expect respondents to learn about the disease at a very early age. HIV/AIDS should have been part of the Life Skills programme taught early in school.

4.1.3. Is HIV/AIDS a serious problem in your area? Please explain

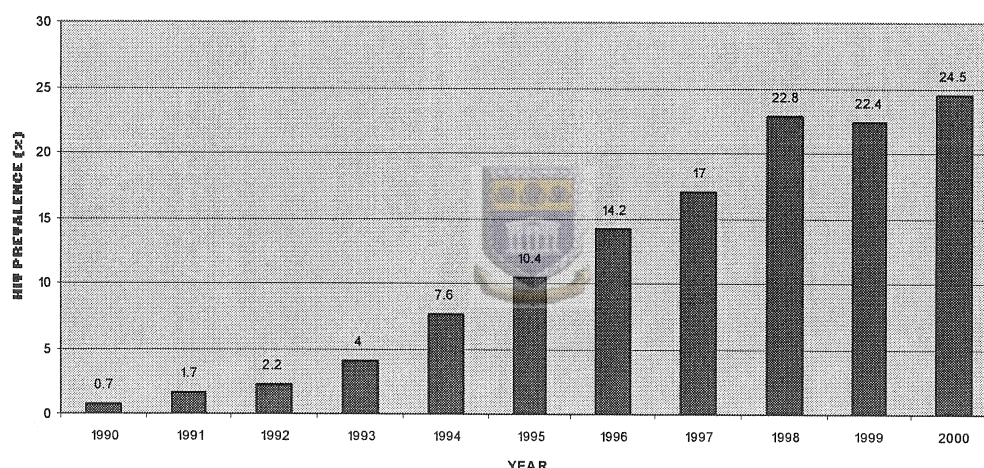
The report on the mortality rate (Dorrington, 2001) in South Africa tells us that deaths are on the increase as a result of HIV/AIDS. The number of people dying has increased dramatically over the past ten years. Apart from the antenatal data from pregnant women, the mortality rate in South Africa has taken another turn. “The pattern of mortality from natural causes in South Africa has shifted from the old to the young over the last decade particularly for young women-this is unique phenomenon in biology” (Dorrington et al, 2001). The respondents attest to this view. People cannot even say with any certainty that HIV/AIDS is on the increase in their respective areas but the number of deaths is increasing at a frightening rate. 99% of the respondents do not know but think HIV/AIDS is on the increase in the areas due to increase in death and mostly it is the youth dying. One (1%) respondent answered the question whether HIV/AIDS is on the increase in his area as follows:

“I really do not know anybody who died of HIV/AIDS because people do not talk about HIV/AIDS as a result of stigma

attached. It is not for families to say out publicly that their member of the family died because of AIDS. What I know is that people are no longer dying in a normal way and it mostly youth who are dying now”

Maybe one can pick up something from the above quotation. HIV/AIDS affects us all and mostly the youth and the more sexually active people. These people tend to fall victims to the epidemic. There is consensus that there is something killing people out there.

National HIV Prevalence trends among ANC attendees in South Africa: 1990-2000



Source (*Department of Health, 2000*)

Right now South Africa is experiencing an HIV/AIDS epidemic of catastrophic dimensions. The antenatal data from the antenatal clinics (ANC) conducted by the Department of Health demonstrates that HIV/AIDS among pregnant women continues to increase. This can be generalised to the population at large. Women get pregnant after sexual intercourse with men and if a woman tests HIV-positive the chances that the

partner is also infected are high. Currently approximately 4.2 million South Africans are living with HIV/AIDS. It was estimated that in 1998 over 1, 600 people were infected with HIV each day--- this translates to more than 550, 000 people infected each year (Department of Health, 2000: 5). So HIV/AIDS does not necessarily increase only among pregnant women but also among other sections of the population. The only problem is that there is no recorded data like the antenatal survey conducted in clinics. It is estimated that by 2005, there will be 6 million South Africans infected with HIV and almost 1 million orphans under the age of 15 whose mothers will have died of AIDS (Lovell, 2001: 12).

4.1.4 What area is it (urban or rural)?

It is important to find out where respondents come from. All respondents were based at the University of the Western Cape, but interestingly 72% of them are from other provinces. The bulk of the students at the University of the Western Cape come from the Eastern Cape which is a poor, rural province. Only a section 28% of respondents is from them urban areas. It is important to gather this kind of biographical information of the respondents. One can easily pick if the government is concentrating in one section of the country at the expense of the other.

4.1.5 Where did you hear about HIV/AIDS?

Information, education and communication typically forms part of the HIV prevention activities, and in South Africa they have been crucial in raising awareness about HIV/AIDS. While South Africa has been criticized left, right and centre for the slowness of the response to the epidemic, a high level of mass media have publicised HIV/AIDS.

81% respondents gained the information about HIV/AIDS at high school and the other 17% respondents from the media (radio, TV and magazines). The most worrying aspect to note is that 2% gained the information from friends.

Various newspapers write adverts, cartoons and stories on HIV/AIDS almost everyday. Almost every newspaper contains an article on HIV/AIDS. Furthermore, government prints and publishes little booklets on HIV/AIDS in all eleven languages. More recently Lovelife a national youth sexual initiative has started a mass media campaign using billboards, newspaper advertisements, radio and other outlets to address sexual health issues as well as underlying causes of HIV/AIDS, including gender issues and sexual coercion.



Another source of information about HIV/AIDS has been the teachers at schools. Through the recently introduced life skills programme, HIV/AIDS is part of the curriculum at schools. Thousands of young people are infected with the HIV/AIDS virus during adolescence. A number of school kids engage in behaviours that could lead to the HIV/AIDS infection or transmission. Most tend to engage in risky behaviours unknowingly e.g. drug use or engage in sexual activity. Schools are strategically positioned to provide education on HIV/AIDS prevention. More than 80% of the nation's children attend school for a maximum of 6 to 12 years (Wilderman, 2001: 2). Quite clearly teachers spend more time with young people. This approach is endorsed by the *National Education Policy Act* (Act 27 of 1996), which states that a continuing HIV/AIDS education must be implemented at all schools and institutions for learners, students, educators and staff members. The goal of the policy is to implement an

HIV/AIDS programme that will assist the youth to acquire knowledge, develop skills and establish standards that will enable them to make responsible choices and grow up healthy.

AIDS education through mass media will have an impact in a locale or environment that has well-established links with media institutions such as newspapers, television and advertising space. Rural populations have less access or no access at all to newspapers than the urban population, who would have more complex and full accessibility to various information sources. Literacy is bound to impact on prevention strategies. Illiterate people cannot access some of the information. Available statistics reveal that more than 4 million South Africans have never set a foot in school or do not have any kind of education (Burger, 1999: 336). The majority of these are people 20 years or older. This is a group not to be missed by HIV/AIDS strategies. The onus of spreading the gospel about HIV/AIDS was left on the teachers who were poorly equipped at the time. Most people who were not at schools missed out on the information. Even if they gained some information, it was from friends and community members. In the case of HIV/AIDS firsthand information is more important in determining behaviour than secondhand information.

4.1.6. Are condoms available in your area?

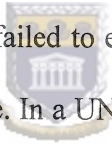
Condom distribution forms an important component of any HIV prevention programme. Snyman (1993) holds that behind this activity lies the conviction that the condom must play a central part in the control of AIDS in Africa. At present condoms are the only

barrier method known to the transmission of HIV during penetrative sexual intercourse with an infected partner. Reports from Thailand indicate that condoms can significantly reduce the incidence of HIV. The Department of Health each and every year tries to increase the distribution of condoms. The distribution of condoms has increased from 20 million in 1991 to over 170 million in 1997 (DOH, 1999). Less than half of the respondents 42% agreed that condoms are readily available in their areas. This is mainly because most of these areas have health care centres or clinics. 58% respondents deny the availability of condoms in their areas. Condoms are only available when the mobile clinic arrives. Mobile clinics come once a month and they are thought to be bringing service to women. Men are very scared to go and ask for condoms in these mobile clinics.

In rural areas people wait impatiently for a mobile clinic to arrive. Even when the mobile arrives, only a few condoms per person are available. Practically rural areas do not have enough access to condoms, which is essential in the fight against HIV/AIDS. If a person takes 10 condoms per month, would that be enough to last the person the whole month? One can read between the lines that people in rural areas end up engaging in risky sexual behaviours, like sleeping with somebody without a condom because they have run out of condoms. In urban areas the story is different. One respondent argues,

“Condoms are available in our clinic, but we are scared to take them. We are worried that we might be seen as people who like sex, because nurses come from our area. It is extremely difficult if not impossible for many of us to take them”.

The increase in condom distribution again does not necessarily mean there will be a decrease in HIV/AIDS. The problems explored (availability and unavailability) here are minor. The use of condoms requires the co-operation of both partners: a man can choose whether or not to wear a condom; a woman has to ask a man to use this protection. If men and women enter sexual encounters as unequal partners, the basis for this co-operation is tenuous. Thus availability of condoms does not address the question whether people use the condoms or not. In South Africa there has to be widespread appreciation of the need to use condoms to protect the spread of HIV/AIDS. This huge gap between knowledge and practice has to be bridged.

More importantly the government has failed to ensure that various stakeholders speak in one voice when it comes to condom use.  In a UN AIDS conference (July 2001) the South African Catholic Bishops have questioned the ethics of using condoms to prevent the spread of HIV/AIDS (Sunday Times, 28 August 2001). The church has quite a large number of followers and if the followers decide to go the route preached by the bishops, this country is likely to see HIV/AIDS figures skyrocketing. The HIV/AIDS pandemic with all its ramifications calls everybody to urgently address the issues of social, economic, racial and gender injustice, which make our country so vulnerable to the spread of the virus. South Africa is at a critical stage of the epidemic (fastest growing) and it cannot afford to send mixed signals to the population to open another debate on the efficacy around the use of condoms.

It is critical that condoms are made widely available not only in health institutions, like local clinics. Places like schools, beer halls and restaurants etc should have them. The importance of making condoms available in as many places as possible cannot be over-emphasised. Condoms are the only remedies available to prevent a person from acquiring AIDS. Even so, it is also necessary to address structural issues such as the relationship between HIV/AIDS and poverty as suggested in the ensuing sections.

4.1.7. Do you know how HIV/AIDS can be cured?

At the moment there is no cure for HIV/AIDS and this needs to be articulated unambiguously to all sectors of the population. Most respondents 95% believe that there is no cure for AIDS. They respondents argue that the prevention is better cure attitude should be preached. They believe only using condoms can prevent the spread of HIV/AIDS. While 4% of the respondents are unsure about the cure even though a traditional healer in their area has helped a lot of people whose believed to be suffering from AIDS. Another respondent argued that she knows somebody suffering from the disease who went to England and returned better. The respondent strongly believes that the medication in the United Kingdom is far better what we have here.

4.1.8. Do you see any relationship between poverty and HIV/AIDS, if yes what do you think the government should do to break the cycle of vulnerability?

HIV/AIDS began to surface in the global consciousness and medical doctors and social scientists started an aggressive campaign to combat it. Their strategy of increasing

preventative knowledge was widely viewed as the best weapon readily available in a limited arsenal. Evian (1995) argues AIDS is essentially a disease governed by and intertwined in the relationships between people, which in turn is influenced by many social and economic factors. Despite the campaigns and strategies HIV/AIDS is still on the increase in many countries. Although HIV/AIDS awareness is fairly common among people, that awareness has not generally been reflected in a reduction of HIV cases. All respondents see the link between HIV/AIDS and poverty and poverty puts poor people at risk of contracting the virus.

If awareness programmes do not reduce the rate of infection, the question that must be answered is: what other factors apart from ignorance about HIV are contributing to the high rates of infection in South Africa. In answering this question global health experts have shifted from traditional the behaviourist model and have sought to find solutions within socio-economics. It can be argued that poverty has created an atmosphere conducive to the spread of HIV. The past, present, and future forces, influences and stresses on community and family life in South Africa have and will continue to determine the ultimate size and impact of the epidemic.

Dossier (1992) argues that with certain exceptions, the overriding reason for the rapid spread of poverty has been the high correlation that exists between poverty and vulnerability to the virus; a correlation that has led to high rates of infection in the most economically deprived populations. HIV/AIDS disproportionately affects the poor and the disadvantaged. The same is true for South Africa. The most affected or infected sections of the population are the black people struggling to make ends meet. While it is

not a disease of poverty in itself, as HIV/AIDS is a considerable problem among qualified professional groups, poverty increases susceptibility to the disease. The ability to make informed choices and to act on awareness and educational input is also a function of an individual's economic and social empowerment and status.

HIV/AIDS continues to cut into the fabric of African households and societies. It is not uncommon to hear that a quarter to a third of the adult population in several African countries is infected. Against this reality of a rapidly spreading epidemic, some two decades of prevention interventions have met with but limited success. Whatever successes there might be are not taken lightly or dismissed. The reason for those successes, however, are not well understood and thus not readily applicable elsewhere. To date, prevention efforts have focused on increasing individual awareness about risks of transmission and promoting individual risk education through a variety of means. Far less attention has been given to either understanding or designing programmes in light of the social and economic context in which individuals live.

Poverty is a key factor that leads to behaviours that expose people to the risk of contracting HIV/AIDS. The United Nations Development Programme (UNDP), for example, argues that poverty aggravates other factors that heighten the susceptibility of women. Lack of control (by poor women) over the circumstances in which the intercourse occurs may increase the frequency of intercourse and the lower age at which sexual activity begins. All respondents understand the role played by poverty in the spread of HIV/AIDS. The general argument among respondents has been that poverty is

contributing heavily towards the high rate of HIV in this country, because females who are poor are forced by circumstances to sleep with any person without condoms for money. Women are forced into prostitution and in the process end up getting infected. One respondent saw poverty and HIV/AIDS from a different angle; she looks at already infected people and the role played by poverty. She argues,

“AIDS medication is expensive in South Africa, and many people are poor—they cannot afford the cost of medication, or to improve diet and other conditions of living. This worsens their susceptibility”.

If a prostitute contracts HIV/AIDS, the medication is out reach for many of the many of them. Once they get sick, they would die very quickly because they do not enough money to buy the drugs that lengthens the life of an HIV-positive person.

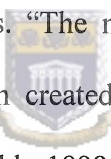
Poverty makes it difficult for people to refuse sex if a client refuses to use a condom (Campbell & Williams, 2001: 138). Furthermore, poor women tend to be ill informed on health matters and have little power to protect themselves from infected husbands. Prostitution is widely implicated in the spread of STDs and HIV/AIDS. In South Africa, as in most countries, prostitution is illegal. Policies towards prostitution have reflected two major concerns: the moral agenda, which holds that prostitution sanctions promiscuity and promotes indecent sex and health consideration, especially the spread of sexually transmitted diseases. Posel (1993) argues that prostitution serves as a means of survival for women with no skills and no other realistic alternative, and is a more lucrative option than formal employment. Economic dependence and the desire to have

children are among other reasons why many women continue to have unprotected sex with their husbands or partners, they know have another partner. Competition for paying clients undermines the prospect for a unified response to men who refuse to use condoms. “The principal course of prostitution is undeniably poverty, compounded by a combination of factors such as poor education (and education opportunities), and a family background characterised by neglect and poor socialization” (Webb, 1998: 143). In reality, a complex interaction of factors would lead a woman into sexual activity for material or economic gain.

Poor communities tend to have less access to health care and therefore diseases especially STDs are not properly healed. Apart from the exorbitant fees for treatment, facilities to treat people are not available. The respondents bear testimony to this view; rural areas, which are considered to be the poorest in the country, do not have clinics; instead a mobile clinic comes once a month. If there are no clinics in some places, the chances of fighting ordinary diseases are slim, let alone HIV/AIDS.

Poor people normally have less education and therefore are more likely to be illiterate, which limits their access to information about HIV/AIDS. Illiteracy is compounded by lack of access to a radio or television set. Again those with little knowledge or no education tend to start their sexual life without any knowledge of the means of preventing HIV/AIDS or other STDs or pregnancy for that matter. All these impact negatively on HIV/AIDS.

In a nutshell, poverty affects attitudes to risk-taking. For people struggling to meet their immediate needs for food and shelter, avoiding a disease which might not materialise for years can be low on their list of priorities. There is a feeling that life is already too hard. There are priorities like getting the next meal, which press on people much more than AIDS. They (poor people) first want to secure food and shelter. Furthermore, alcohol, drugs and sex are sometimes the only means to escape from their harsh existence. Once HIV/AIDS enters the vicious circle of poverty, it intensifies dramatically.

Poverty makes people increasingly vulnerable to AIDS by increasing migrant labour, family break up, homelessness and overcrowding. Men normally go to look for work in urban areas without their wives or partners. This places them (men) at greater risk of having multiple casual sexual partners.  "The migrant labour system is a relic of the colonial era in southern Africa, which created a large scale demographic imbalance within both urban and rural areas" (Webb, 1998: 89). Women, deep-rooted in patrilineal social structures, have had minimal role in the urban setting where men considerably outnumber them, and within the job market. In the rural areas of developing countries, permanent and seasonal migration to urban and industrial centres is on the increase. Most rural areas are unable to generate jobs. This leads to disruption to social and family patterns and have negative implications for HIV/AIDS.

The epidemiological relationship between migration and HIV is well established. A study in Senegal found that **27 per cent** of the men who had previously travelled to other African countries were infected with HIV. In neighbouring villages where men had not migrated, less than **1 per cent** of people were HIV-positive. High HIV prevalence rates in

areas of high out-migration have been documented in Senegal, Mexico and Ecuador. The risks of HIV/AIDS associated with migration are well known to both men and women. For example, women in rural Tanzania told researchers that they lived in fear of their husbands coming home for Christmas since they thought they would be 'bringing AIDS' (www.unrisd.org).


Migrant labour is an important facilitator in the epidemic. Its importance, in terms of the epidemiology of HIV/AIDS, is that the virus is purported to spread from core groups (migrant and prostitutes) to the background population (wives, girlfriends and rural sexual networks). Rapid urbanisation is associated with increased poverty and with high levels of HIV/AIDS. The movement of individuals from low to high prevalence areas and from poor to richer areas, and the breakdown in social structure facilitates the spread of the epidemic. Poverty not only creates conditions which facilitate the spread of HIV/AIDS, but also prevent an effective response to the epidemic. The lesser the money available to provide support measures to limit the spread of HIV, the greater the likely impact of the epidemic.

If the government is to contain this epidemic and cushion its impact, there is a need to expand the response considerably --- not by doing more of the same but by expanding the best, so as to ensure that HIV/AIDS is not just on the health agenda but that it is firmly placed on the development agenda as well. The expanded response should involve a multi-pronged approach: reducing individual risk and lowering vulnerability to HIV. Few people could dispute the link between HIV/AIDS and poverty. Inability to tackle poverty means the battle against HIV/AIDS is unlikely to be won. As long as people are still

compelled by circumstances, no amount of words can change their behaviour. In fact, poverty alleviation should be part of the fight against HIV/AIDS.

4.1.9. Impression of people of government's commitment to AIDS


The general impression of the respondents about the government's commitment in the fight against HIV/AIDS varies. But most respondents feel that the government has dismally failed in its obligation to fight diseases to create a healthy nation. The main argument against the government has been the inability to take a crucial stance on drugs proven to save lives, especially, saving the lives of millions of unborn babies.



“The government has failed to take a bold stance on pharmaceutical companies. Some antiretroviral drugs (AZT and Nevirapine) have shown beyond any reasonable doubt to prevent the transmission of HIV from mother to her unborn child”.

The use of antiretroviral treatment during pregnancy has resulted in a dramatic reduction of HIV/AIDS in the United States of America and Europe. Transmission rates in Los Angeles have dropped from 30% to 10% and in North Carolina from 21% to 8.5% (McIntyre et al, 2000: 3). This course of therapy was accepted as standard care in the developed countries like the USA and Europe.

The government has been very skeptical to allow mother-to-child programmes to go ahead citing high costs and toxicity as the main reasons (Nattrass & Skordis, 2001). The issue of mother-to-child transmission has become politicised in this country, with accusations and counter-accusations from all sides (government and Treatment Action Campaign). This has resulted in the government being taken to court by the TAC for failing to provide pregnant women with the drugs. The TAC accuses the government of child murder, while the President (Thabo Mbeki) and the current Minister of Health (Dr Manto Shabalala-Msimang) claim concern about the safety of the drugs and make sweeping statements about black people used as guinea pigs. Amid all the political noise, scientific findings seem to be forgotten.

It took 16 months for the Medicines Control Council (MCC) to register the life-saving anti-HIV retroviral drug (Nevirapine).  Saving its own skin, the MCC accused the government of blocking its registration for such a long time. The drug was finally registered in South Africa in December 1999. In the country with the highest number of people infected with HIV, it is unacceptable when the drugs that have been demonstrated to be effective are delayed. The delaying tactics kept the drug out of the market for a long time even though the demand for a response was increasing. While it is true that drugs alone will not solve the problem, it is equally clear that not enough is being done to stem the tide of new infections.

The government is arguing that it is taking a cautious approach to the antiretroviral and Nevirapine, making it only available at the 18 research sites scattered throughout the country. The Medicines Control Council has just decided to deregister Nevirapine (*Mail*

& *Guardian* 8-14 August 2003). The argument put forward against the use of Nevirapine, it causes more harm than healing. The government's own statistics suggest that 70, 000 children are born with HIV every year. If you take a medicine like Nevirapine, one can cut that number of new births with HIV by at least 20, 000. It is very expensive to keep a baby who is HIV-positive than a healthy one. HIV-positive babies are likely to come in and out of hospital (Mngomezulu, 2001³). The state's decision not to provide drugs to every pregnant woman is unreasonable and irrational. It could cause thousands of unnecessary deaths of children.

4.2 Government's AIDS policy and tertiary institutions

The increase in HIV infection rate among tertiary students has compelled institutions of higher learning to act. Currently there is no policy from the government (both national and provincial) stipulating steps to undertaken. One would expect the Department of Health and Education to outline the framework or guidelines to combat HIV/AIDS at various campuses around the country. United States AID (USAID) has decided to play a leading role in assisting historically disadvantaged universities through Tertiary Education Linkages Project (TELP) (www.sn.apc.org/usaaid accessed 15 February 2005) This project seeks to increase awareness of HIV/AIDS issues through integration into the curricula, teaching and learning.

³ S.J. Mngomezulu presented an unpublished paper on the fight against HIV/AIDS in the Western Cape: an evaluation of the MTCT programme in Khayelitsha at the School of Government on the 03 November 2001.

Again the government does not prioritise HIV/AIDS in the planning. Very few would disagree that HIV/AIDS would wipe out the future leaders of the country. Setting out a framework would go a long way in assisting in terms of providing direction. It could secure the future of the next generations.



CHAPTER FIVE

5. COMBATING HIV/AIDS: LOCAL AND GLOBAL EXPERIENCES

It must be remembered that Southern Africa is not the only region to experience the HIV/AIDS epidemic. In developing countries such as Cuba, Senegal, Thailand, Uganda efforts and the Western Cape in South Africa have also been made to address this pandemic. Useful lessons can be derived from their experiences for Southern Africa. In the next chapter the focus is the lessons from other developing countries.

5.1. Inside South Africa

5.1. 1. Specific successful programme in the Western Cape Province

The current plan (Strategic AIDS Plan 2000-2005 and the Western Cape AIDS Plan 2001) indicates that the Western Cape continues to enjoy lower prevalence rates than any other province. Firstly, this can be partly attributed to the good and sound health system that has been put in place during the apartheid years. This has come about as a result of the programmes being implemented by the provincial government. Secondly, another part of the success comes from the programmes put in place by the provincial government.

The Western Cape province is largely urban (70% of the area is urban) unlike other rural provinces like the Eastern Cape or Limpopo Province⁴. In most areas, the infrastructure already exists e.g. clinics or hospitals. This means people can go to the clinic when they have STDs, which if untreated may lead to AIDS. People can also receive condoms at

⁴ Limpopo Province was previously known as Northern Province.

clinics or hospitals unlike other places where they are not available at all. Furthermore, poverty levels are less severe in the Western Cape than in other provinces like the Eastern Cape. People from the Eastern Cape continue to flock to the Western Cape for greener pastures. Education levels are higher in urban settings than rural areas.

5.1.2. Mother-to-child transmission programme

HIV infection is currently a very serious public health problem globally (Ndiaye, 2000: 59). In South Africa, despite the government's attempts to respond to AIDS challenges, the infection rate has increased significantly. This increase or proliferation in infection rate undoubtedly calls for a renewed commitment from the government. HIV prevention efforts are central to slowing the rapid spread of HIV/AIDS and reducing the rate of new infections. Prevention efforts should not only be about raising awareness and distributing condoms. Kumaranayake & Watts (2001) hold that key prevention should include the provision of education and condoms (both male and female), strengthening treatment sexually transmitted (STD), prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT) ensuring the safety of blood transfusion systems, and interventions targeted at vulnerable groups to HIV infection. This is, indeed, a legitimate call, which forces the government to cast the net wide open in its attempts to win the AIDS battle. The problem of finding a quick solution to HIV/AIDS is compounded by the fact that there are more than one ways in which the deadly disease can be transmitted from one person to the other. These include the following:

- By having unprotected sex with an infected person
- Through contact with infected blood
- From an infected mother to her unborn or newborn baby

Without medical intervention the virus will infect approximately a third of children born to HIV positive mothers (Harber, 1999). Most of these children will develop AIDS and die within few years after they have been born. The use of antiretroviral treatment during pregnancy has resulted in a dramatic reduction in the United States of America and in Europe. Transmission rates in Los Angeles have dropped from 30% to 10% and in North Carolina from 21% to 8.5% (McIntyre & Gray, 2000: 30).

5.1.3. AZT treatment

The first major breakthrough in the protection of mother-to-child transmission came with the results in 1994. AZT given to the pregnant mother orally after *14 weeks* of pregnancy showed a considerable reduction of MTCT of HIV. The use of long-course of AZT in pregnancy is recommended as the standard care for Europe and USA and some developing countries like Brazil and Thailand. Women who received AZT from the perinatal period had a low transmission rate than women who did not take part in the programme at all.

5.1.4. Nevirapine treatment

The high cost of long course regimens prompted research into shorter-drug regimens in pregnancy that would be more feasible in resource poor settings. The pregnant women got Nevirapine at the beginning of labour and then the baby was given the same tablet after birth. All women were advised not to breastfeed and were provided with milk formula.

5.1.5. Elective Caesarean Section

If the elective caesarean section is used during delivery, the risk of transmission of HIV/AIDS can be reduced by half (50%). In the resource-rich settings, elective caesarean section is becoming a routine part of care for HIV-positive women. Again in Europe and North American, elective caesarean section has tremendously reduced the risk of mother-to-child transmission (McIntyre & Gray, 2000). However, the situation is very different in many parts of sub-Saharan Africa. In resource-poor settings, the risks of serious complications after a caesarean delivery may outweigh the potential benefits. This is particularly true for HIV-positive women who are more vulnerable to other infections and whose wounds may be slow to heal. Elective caesarean section is not popular both in Africa and South Africa. Given the difficulties mentioned above elective caesarean section is not an option. The Western Cape government stuck to the use antiretroviral drugs as a way of reducing the spread of HIV/AIDS from mother to the unborn or newborn baby.

Regardless of the favourable conditions, the Western Cape did not rest on their laurels; various programmes were put in place to ensure that HIV/AIDS does not get out of control. The Western Cape has always been above the rest of the provinces in the fight against HIV/AIDS. It was the first province to start an AZT drug pilot project in Khayelitsha in January 1999 (Mngomezulu, 2001). It recognised that the fight against HIV/AIDS should take a multi-faceted approach. The pilot project in Khayelitsha went ahead against the wishes of the national government. The national government argued that the AZT drug was toxic and too expensive for the public service. Secondly, the

national government felt the Western Cape provincial government was using black women as 'guinea pigs'. Thirdly, the Minister of Health, Dr Manto Shabalala-Msimang, did not see the drugs as a solution to the pandemic. This is appropriate as the solution involves more than the provision of drugs, but the drugs are part of the solution. From January 1999 to March 2001, 18, 788 pregnant women attended the Khayelitsha pilot project. 13, 945 (74%) accepted voluntary counseling and testing (VCT), meaning accepted to be tested for HIV. From the number that accepted to be tested 2, 674 (19.2%) were found to be HIV-positive (Abdullah, 2001). The good news was that 11, 271 were found to be HIV-negative.

The number of people accepting voluntary counseling and testing is very high. With respect to transmission, whether people test negative or positive is immaterial; what matters is that these people know their status. The general understanding is that if people know their status, the chances of them behaving responsibly are greater. The testing of people for HIV enables the Department of Health and policy makers to have a picture of the extent of the problem. If pregnant women tested positive, AZT was given to them until they went into labour.

The MTCT programme in Khayelitsha was a success. To a large extent, one can argue that the 18 national sites came about as a result of the success witnessed in Khayelitsha. The results from the Khayelitsha site managed to convince the national government beyond any doubt that the MTCT programme is worthy to be undertaken countrywide. About 90% of the babies born by HIV-positive mothers were saved from contracting HIV (HIV/AIDS Update: 2001). The Western Cape is determined to reduce mother-to-child

transmission by opening more sites. A large section of the population is now able to access the programme with relative ease than it was the case before.

- Khayelitsha started in January 1999
- Gugulethu started in January 2001 administering Nevirapine
- Vanguard and Paarl started in May 2001 administering Nevirapine
- George and Worcester started in June 2001 administering Nevirapine

The report from the Provincial government is that all sites up to so far are doing extremely well, offering the crucial service to HIV positive pregnant women. The Western Cape provincial government is leading from the front.

5.1.6. Treatment Partnership Programme

Prevention and treatment of opportunistic infections is one of the core health programmes in the Western Cape. Pfizer Pharmaceutical Company has donated free diflucan (Fluconazole) for treating HIV/AIDS patients in the public sector who develop *cryptococcal meningitis* and or *oesophagal candidiatis* (Naledi, 2000). The Diflucan Partnership Programme is a partnership between the Western Cape Department of Health and Pfizer (Pharmaceutical company). The Director of the Treatment Action Campaign, Zackie Achmat threatened to import fluconazole from Thailand to treat HIV/AIDS patients. This exerted some pressure on pharmaceutical companies to make a donation.

The Fluconazole drug is available at selected public health facilities and there is movement to expand it even further. Health workers were trained to be familiar with both clinical and regulatory aspects of the drug. Diflucan is a **schedule 4** drug, meaning it can

be dispensed like Panados or Dispirin but for monitoring purposes, the drug would be dispensed as a **schedule 6** drug. Schedule 6 means

- Only the doctor can prescribe the drug.
- The doctor must specify the indication for the drug on the prescription chart when prescribing.
- The pharmacist dispensing the drug must keep a register specifying amongst others, the name of the patient, amount dispensed and the indication for the drug.

HIV-positive people with throat problems can now get the medication free of charge. This elongates their lives and thus contributes to the economy. Their conditions improve and people continue to work. HIV/AIDS has become a chronic disease; people can live with it for years without getting sick. In this way the Diflucan Partnership attempts to maintain the good work.



5.1.7. Community mobilisation

There has been recognition of the multi-sectoral approaches in the would-be assuaging, actually extremely challenging calls for a partnership; an encouraging but rather vague formulation of a hugely complex set of needs and approaches. The necessity of establishing partnerships has been broadly acknowledged. Peter Piot, Executive Director of UNAIDS, put the case very clearly in May 2000 “Partnerships are not an optional extra, but the foundation of taking forward effective work against the epidemic”⁵. As a result Government AIDS Action Plan (GAAP) was formed. The main objective of the Government AIDS Action Plan is to expand sectoral involvement in HIV/AIDS and build capacity of partners. These sectors include youth, women, faith-based organisations and

⁵ Peter Piot speaking at Programme Coordinating Board, Ninth Meeting, Geneva, 25-26 May 2000.

traditional healers. The process of bringing together relevant stakeholders will increase public awareness.

5.1.8. Multi-sectoral response

- HIV/AIDS is not just a responsibility of the Ministry of Health, and the no sector can tackle HIV/AIDS alone. An effective response requires the involvement of all government ministries, with each ministry taking responsibility for some aspects of the response using their own response.
- It requires involvement of all sectors outside government, including business, civil society organisations, communities, people living with HIV/AIDS and those affected by the epidemic. Each sector consider how it is affected by the HIV/AIDS epidemic, and develop sectoral plans of action that accord with National Strategic Plan

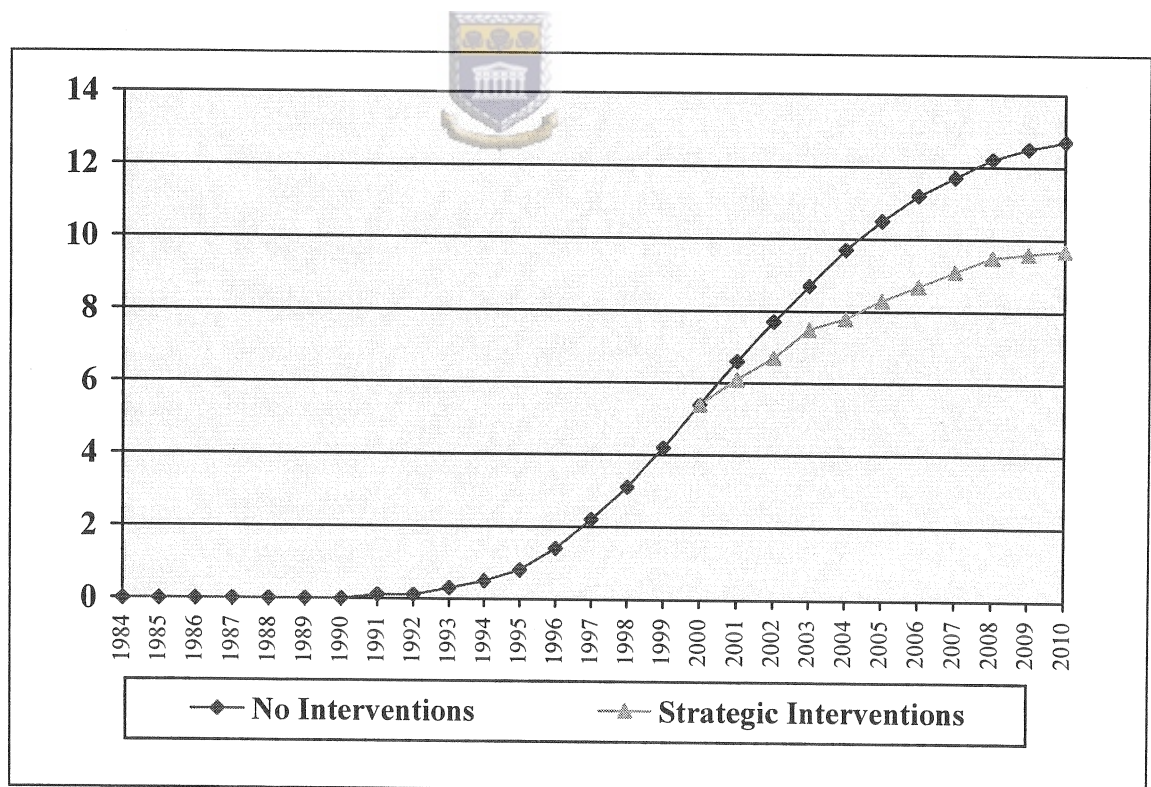


Any structure that attempts to bring different sectors together in the fight for common course deserves acknowledgement. If this idea (partnership) can be realised, this can be the most comprehensive approach ever taken by bringing every member of the society on board. If this plan can succeed it can be easier to fight HIV/AIDS because one plans with the people who are at the receiving end. Every sector will cry in one voice. Tensions can be reduced easily between different sectors. The settlement of disputes peacefully can have a positive spin off on HIV/AIDS and its spread can be curtailed.

5.1.9. Life-skills programme

The provision of drugs was not only the major programme undertaken; the life-skills programme in conjunction with the Department of Education was designed. Most new HIV infections occur between the ages of 15 and 20 years. The best hope of curtailing the epidemic is in the fact that approximately 45% of all South Africans are under 20 years (Department of Education, 2001). Reductions in the rate of HIV infection among teenagers would lead to a substantial slowing of the epidemic over a period of 5 years or so. The appropriate time to make an impact on adolescent sexual behaviour is prior to sexual activity. The key is to teach young people about sex and sexuality.

5.1.10. Effects of Strategic Prevention Programmes



Source: F. Abdullah (7 September 2001)

The Western Cape Department of Health believes that with the above-mentioned interventions it could reduce the spread of HIV/AIDS from 12% to less than 10% by 2010. The strategies undertaken look to be on course to achieve this goal. The Western Cape Province is one best example in South Africa and is a success story. The main argument about the introduction of life-skills education is that it should be introduced early from primary school in order to reach learners before they are sexually active and even before they establish unhealthy behaviour.

Many young people cannot talk about AIDS either at home or in the community. Nor can they talk about the risk behaviours that can lead to HIV infection. Young people are reluctant to talk to doctors or nurses, either out of embarrassment or because they are worried that confidentiality will not be respected. They may feel equally uncomfortable talking to their parents, and their parents in turn may also be embarrassed or lack confidence to discuss the subject with their children. The now Minister of Education of Education (Prof Kader Asmal) started his tenure by launching a thorough investigation into the state of education and training in South Africa. The Tirisano document states that the fight against HIV/AIDS is the priority that underlies all other educational priorities.

The Western was the first province once again to take advantage of good ideas from the national government. The Tirisano document provides such a specific guide on how to contribute to the lessening of HIV/AIDS. The Provincial Inter-departmental committee (PIDAC) meets every Wednesday to discuss progress made. It's a sort of report back to other departments. All key departments (Health, Education, Social Development and

Sports and Recreation) convene to discuss what each department has made to alleviate HIV/AIDS.

5.2. City Of Cape Town

The new city Cape Town has taken over the responsibility for the delivery of services throughout the metropole. The city of Cape Town has a responsibility just over 2 million residents. Moreover the city employs about 28,000 staff (Van der Watt Presentation: 1999). Apart from the fact the local government is the delivery arm of the national government, the city of Cape Town has every reason to tackle HIV/AIDS both internally (among its employees) and externally (communities). Local governments are more closer to the people hence they carry such huge responsibilities or turning communities around. The city is divided into 11 districts with a hope of making service delivery not only easier but also manageable.



1. Athlone
2. Blaauberg
3. Central
4. Helderberg
5. Khayelitsha
6. Mitchell's Plain
7. Nyanga
8. Oosternberg
9. South Peninsula
10. Tygerberg East
11. Tygerberg West

The city of Cape Town drew up its own HIV/AIDS strategy termed HIV/AIDS Multi-sectoral strategy. Priority areas of the strategy:

- Prevention
- Treatment, care and support

5.2.1 Prevention

The city gets its revenue from the residents. If the city needs to be sustainable, the prevention of this killer disease needs to be high on its agenda. The city has been involved in a number of awareness campaigns, education and training. Booklets and pamphlets on HIV/AIDS in all three languages (English, Afrikaans and Xhosa) mostly used in Cape Town have been published. These are the programmes that are supposed to play a huge role in limiting the spread of the disease. Secondly, the voluntary counseling and training programme has been widely publicised. Limiting the infection rate. Every month more than 10 000 people undergo voluntary counseling and testing in the city of Cape Town (Naidoo & Allen: 2003.1).

5.2.2. Treatment, care and support

Tuberculosis is one of the opportunistic infections affecting and the biggest killer of people living with HIV/AIDS. The city has launched a TB/HIVAIDS programme. All patients diagnosed with TB will be given treatment. It is expected that this year alone 24 000 people will be treated for TB in Cape Town (Naidoo & Allen: 2003). Despite the growing numbers of TB patients each year the cure rate has been steadily improving. During 2002 the cure rate improved to 75% of new smear positive TB patients (Toms:

2003). All employees of the city of Cape Town suffering from HIV/AIDS will be given all the support they need.

The city of Cape Town also works closely with various NGOs like AIDS link. AIDS link is dedicated to supporting people facing the progression of AIDS. In most cases NGOs are better placed to attend to the needs of the communities. Furthermore, AIDS link provides people living with HIV/AIDS with:

- Health care
- Food and clothing
- Counseling
- Income generating opportunities
- Financial and legal aid



A number of monitoring structures have been set up both at district and sub-district level to monitor if the programmes achieving the desired outcomes. Different directorates are part of this strategy. All departments (directorates) are affected equally by HIV/AIDS hence they are pulling their weight for the same course.

The strategy fails though fails to recognise the role played by other spheres of government e.g. provincial government. There is no working relationship between the provincial HIV/AIDS Unit and city of Cape Town's unit. If the two units were to work together the workload would be simpler and more comprehensive. It is unimaginable that the two spheres of government are working hand in glove in tackling this huge epidemic

that threatens to wipe out communities. Secondly, the city's strategy says nothing about the transmission of HIV/AIDS from the parent to the child. It is an important aspect in the fight against AIDS that should not be overlooked. The strategy is silent about the 10,000 people who go through the voluntary and counseling process. The treatment plan needs to be expanded to the general public not only to people working for the city of Cape Town.

The city of Cape Town has decided to put emphasis on few measures to ensure that the infection rate is under control. The strategy is no way comprehensive, but maybe concentrating on what is achievable than trying to swallow more than one can chew can be detrimental. It looks like the city of Cape Town is doing well on what it has decided to focus on. The city needs to be sustainable hence it is putting measures to fight HIV/AIDS.



5.3. Inside Africa

5.3. 1. Uganda

The cases of Slim disease were reported in 1982. The Slim disease was later confirmed as AIDS in 1984 (Mwaura, 1998). A total of 1.9 million cumulative HIV infections have been reported since the start of the epidemic. Of these, 1.4 million are living with HIV. About 500,000 have died of AIDS in Uganda (www.aidsuganda.org). According to UNAIDS, Uganda was among the first hardest hit countries by the HIV/AIDS epidemic, but it has come up with measures and responses that have not only stemmed the rise of the epidemic, but are also beginning to show reduction in its spread among some groups in the country. Taking stock of the national response for the last two decades, it has been

observed that the country has moved from being the 'epicentre' of the epidemic to a 'success story' (www.aidsuganda.org). This is inspite of the limited resources. Uganda has recorded declining rates of HIV infection since 1993 (Kirungi, 2001: 26).

The examples of the response of Uganda may be instructive in showing how HIV/AIDS can be brought under control. The country is fortunate to have strong political recognition of the problem that was posed by the epidemic early on. The Minister of Health went to the streets dispensing condoms. Members of NGOs and government went to the villages encouraging people to come for HIV testing. The government has created a supportive environment for community responses to the epidemic through fostering a climate of destigmatisation, which has enabled several role models and key figures to publicly disclose their HIV status. Government policies that openly address the problems associated with the disease have advantages. Interconnected and comprehensive approaches can be developed to strengthen connections (Fredland, 1998: 52).

5.3.2. Senegal

Senegal has many of the hallmark conditions of African nations that have been ravaged by AIDS: low income, high illiteracy rate and some traditional customs that can spread the AIDS virus (Ministry of Health: 2000). Yet the West African nation has found ways to stave off the HIV scourge. Senegal has one of the lowest prevalence rates in Sub-Saharan Africa. Senegal has had considerable success thus far controlling the spread of HIV. "Since its first confirmed in 1986, the prevalence rate of HIV infections among adults has been kept at between 1.77 and 1.74 per cent" (Lom, 2001: 24).

The reasons for this success against the spread of the virus lie in Senegal's early response to the disease, vigorous preventative action, care of AIDS patients and the mobilisation of people at all levels (religious and cultural influences as well as government programs). Even though the government spends barely one dollar per person each year in public health, this former French colony has achieved a lot. Senegal's long experience with democracy and its freedom of press also made it possible to openly discuss the problem and easily gained information about the disease, by letting people take the initiative in their own programmes and making sure that programmes are acceptable by everyone.

Sex work was regulated in Senegal in the 1960s, resulting in a sexually transmitted infection (STI⁶) control programme for sex workers and clients, and a high rate of condom use among sex workers. Perhaps most importantly, they targeted the commercial sex trade, traditionally the epicentre of an HIV outbreak. In a program that was started way back in 1969 to control sexually transmitted diseases, all sex workers and prostitutes were required to go to clinics for regular check-ups. Many registered and came in for monthly check-ups at different clinics. Senegal also has a long tradition of thousands of experienced associations/movements and community organizations working in the health field.

Furthermore, Senegal was also among the first countries in Africa to take advantage of the new opportunities to gain access to antiretroviral medicines, to care for those who have become infected. According to Lom (2001) the average cost of basic medicines for

⁶ Again STIs and STD will be used interchangeably in this paper.

treating AIDS-related diseases has been reduced by 90 per cent. President Abdoulaye Wade has committed the government to doubling the amount needed for anti-retrovirals.

5.4 Outside Africa

5.4.1. Cuba

Since the beginning of the epidemic in the Western Hemisphere, Cuba's approach to HIV/AIDS has been different from the rest of the world. Cuba is notorious for its draconian treatment of people infected with the HIV virus. The government has rounded up everyone infected with the human immunodeficiency syndrome virus and locked them in sanitariums until they developed AIDS and died. HIV-positive people live in communities separate from the rest of the population. A combination of widespread HIV testing and a policy of isolating many AIDS patients in special sanatoria have helped to slow the spread of HIV in communist-led Cuba.



The HIV problem has been integrated into the comprehensive nationalised health care system. Cuba's policies towards HIV have been consistent with its policies towards other diseases and epidemics (Holtz, 1997: 1). In a nutshell, Cuba treated the introduction of HIV into the country as a public health emergency. They have been rewarded with one of the lowest prevalence rates of HIV infection in the world.

The recent information and statistics provided by the Ministry of Health on HIV/AIDS indicate clearly that the programmes are yielding the results. As of mid 1997, there are 1,678 known cases of HIV infection (infection rate approximately 0.02%), with 609

persons carrying the diagnosis of AIDS. Only nine cases of infection have resulted from transmission through blood products, five cases of HIV infection are known in children.⁷ The most controversial aspect about the Cuban national HIV/AIDS programme is the use of sanitariums for people with HIV. HIV was treated like any contagious, infectious disease employing traditional health measures. It was a health problem/public problem with human rights dimensions, rather than a social problem with health repercussions. Quarantine was the initial reaction to a public health threat whose scope was unknown, which led to the semi-isolation of infected patients. The goal was to reduce the risk of transmission through case finding, isolation, medical treatment and education. Things changed in 1993 when patients were allowed to choose whether to stay at home or go to sanitariums. In Cuba, access to medical care is a right available to all persons with HIV.



Cuba has tackled HIV/AIDS differently from the rest of the world. This country has sacrificed human rights for the sake of the health of its nation. This is not the most viable option of tackling HIV/AIDS and many countries are not following the Cuban example. Cuba is a small country with a small population size. It also has a high number of doctors. The system of government in Cuba is different from other countries. People in an authoritarian country are more likely to obey the government than in a democratic country. The international community, especially the United States of America does not care about what happens in Cuba, consequently little noise is made about the violation of human rights in Cuba. It would have been in a different case in democratic countries like South Africa, Zimbabwe or Namibia.

⁷ This information was accessed from www.cubasolidarity.netcubahol2.html

5.4.2. Thailand

Thailand's AIDS epidemic is one of the most extensively documented of any developing world. Thailand has made substantial progress in the fight against HIV/AIDS because of strategies and policies for prevention that were initially based on research and evaluation and then received the necessary level of commitment to implementation and financing (www.utoxia-asia.com accessed 23 June 2003). Sexual behaviours have changed significantly, with condom use on the increase and visits to sex workers decreasing. The spread of HIV/AIDS has been slowed dramatically. A major factor in the spread of the disease in Thailand has been a thriving sex industry and sexual attitude that condone male patronage of prostitutes.

There are very few developing countries in the world where public policy has been effective in preventing the spread of HIV on a national scale, but Thailand is an exception. A massive programme to control HIV has reduced visits to commercial sex workers by half, raised condom usage, decreased STDs dramatically, and achieved substantial reduction in new infections.

AIDS was discovered in Thailand around 1984, but the initial response was limited. The prevailing view was that this was an epidemic brought from abroad that would be confined to a few individuals in high-risk groups, like gay men and injecting drug users, and would not spread more widely. This view was challenged in the first major wave of the epidemic HIV infection exploded to 40% especially among drug users and sex workers in a single year (Renaud & Hess, 2000).

The government of Thailand acted decisively, launching a nationwide campaign to reduce HIV transmission. The key elements of the programme were a massive public information campaign launched through the media, and NGOs. A programme to promote universal and consistent condom use in commercial sex was introduced. Fewer men visited prostitutes and condom use rose sharply and infection rates dropped by half (World Bank report: 2000).

The government also ensured that people with HIV/AIDS have access to cost-effective prevention measures and treatment of opportunistic infections. People with HIV/AIDS can fall seriously ill and die from curable infections that people with normal immune systems can resist. Ensuring access by people with HIV/AIDS to prevention and treatment of the major opportunistic infections, like tuberculosis was cost-effective and inexpensive.



CHAPERT SIX

6. TOWARDS HIV/AIDS PREVENTION: CONCLUSIONS AND RECOMMENDATIONS

This chapter provides a summary of the obstacles to the fight against HIV/AIDS. It is customary to conclude an investigation with a summary in which all loose ends are brought together and possible hypothesis tested. There is a general consensus amongst scholars that HIV/AIDS will have a negative impact on the economies of various countries not only in Southern Africa but also in the world at large and that there is a need to limit the spread of this pandemic. The research has proved that what is being done currently in South Africa is not enough to curtail the spread of the epidemic.



In chapter 2 the HIV/AIDS theorists is discussed. Since the outbreak of the epidemic academics, scientists and medical practitioners have never spoken in one voice. The link between HIV and AIDS has been subject of controversy. This chapter tries to show the arguments around the link of HIV and AIDS.

In chapter 3 the nature of the epidemic in the world is highlighted. The epidemic did not sneak in South Africa unnoticed. This chapter traces the origin of HIV in the 1980s from the gay community and follows it up until it became a heterosexual problem. The extent of the epidemic in various countries is well illustrated. This chapter shows the nature of HIV/AIDS both in Southern and South Africa. Furthermore the national responses of Zimbabwe, Namibia and Botswana have been highlighted. The little efforts taken by the apartheid government did not make any impact, as the government at the time lacked

credibility from black people. This chapter indicates that HIV/AIDS in South Africa is on the increase. The antenatal data and mortality statistics attest to this. There has been an increase in HIV/AIDS in pregnant women attending clinics. The same applies to the population at large. The hospitals are having more patients than ever before. The mortality rate has increased remarkably and this has to be attributed to AIDS.

In chapter 4, in-depth information on the programmes of HIV/AIDS has been discussed. In general, people are aware of HIV/AIDS but this does not result in the reduction of the spread of the epidemic. The government cannot claim success; awareness is not the magic bullet. The shortcomings of the education programme are clearly depicted. The limited impact made by condom distribution is also shown. Then lastly, the chapter shows the link between HIV/AIDS and poverty. The inability to fight poverty in this country has a negative impact in the fight against HIV/AIDS. The two are linked in a fundamental way.

The study discovered that education is likely to make little impact on the spread of the epidemic because not everybody in this country goes to school. Most people come to know about HIV/AIDS at school and quite a substantial number of South Africans have not set foot on school premises. There has to be a way of reaching those people who are not at a school-going age especially those from rural areas who do not have access to radios or television.

The study also discovered that condom distribution; a crucial part of the fight against HIV/AIDS does not reach all sectors of the population. There are areas where condoms are unknown, let alone being used. Some people do not have any access to condoms, which tarnishes attempts to fight this epidemic from all possible angles. The unavailability of condoms means people will engage in risky sexual activities not that they want to but because of prevailing circumstances.

The relationship between poverty and HIV/AIDS has been also explored. Poverty and HIV/AIDS are inextricably linked. Firstly, poor people have less access to health and educational facilities. They tend to receive information very late as compared to other sections of the population. They do not have access to clinics. This has negative consequences for HIV/AIDS. Furthermore poor people are more likely to engage in risky behaviours than affluent ones. Preventing HIV/AIDS is not a priority to them other than getting the next meal.

Lastly, the unavailability of drugs to the wider population has not been taken seriously. The spread of HIV/AIDS from the mother-to-child continues unhindered. Drugs like, AZT and Nevirapine have proven to minimise the spread of the virus from mother-to-child and this country has not taken advantage of that. The success in many countries came about because of a multi-pronged approach. Uganda, a success story in Africa used drugs to limit the spread of the virus from mother-to-child. The predictions from UNAIDS indicate that 7 to 10 million South Africans will die from AIDS in the next ten

years. However, the predictions suggest that even at this late stage of the epidemic the impact can be reversed by interventions such as providing affordable antiretroviral drugs.

Chapter 5 looks at the successes achieved outside Africa, inside Africa and indeed inside South Africa. These successes indicate that AIDS is not invincible as many would think. Other countries have managed to turn the epidemic around. This chapter points out what has worked in various countries and provinces. Cuba, Uganda, Senegal, Thailand and the Western Province are success stories. All these case studies provide interesting scenarios for South Africa. The role played by the City of Cape Town as the delivery arm of the national government is also explored. The City of Cape Town 's HIV/AIDS is in no way comprehensive, but maybe concentrating on what is achievable is the way to go. The way the went about addressing AIDS is informative. The trend has been set other countries have to follow. Different countries have to shape their response to suit their population. All the countries that stemmed the tide against HIV/AIDS went about it differently.

In 1994, when blacks in this country voted for the first time, about 10 per cent of the adult population in Hlabisa⁸ was infected with HIV (Department of Health: 1999). Today, the figure stands at about 35 per cent, one of the highest rates in a nation that has many infected people (*The New York Times*, 25 November 2001). Blinded by shame and denial, distracted by the enormous challenge of addressing racial inequities, black leaders have mostly closed their eyes to AIDS. The time to change the way things are done is now.

⁸ Hlabisa is one of the severely affected areas in KwaZulu-Natal.

6.1. Recommendations

The researcher recommends an education strategy, which should take into account differences between people and societies. Not everybody goes to school and strategies should not focus on school-going people only because everybody is at risk including those who are unemployed and uneducated. The HIV/AIDS battle cannot be won by strategies that do not take into account the differences of communities or societies. The economic disparity between races and classes in South Africa means the strategy will not work for everyone. The poor will not access the services like the affluent and this has to be taken into account.

Condom distribution has to be extended to other areas especially rural areas. It remains the responsibility of health officials to see to it that condoms are available at all times particularly in areas where they are needed most (rural areas). There has to be a way of encouraging people not only to take condoms but also to use them. The government should ensure that people buy into their strategy. Condoms are part of the limited arsenals countries have to fight AIDS. The provision of condoms has to go beyond health facilities. They should also be available in places like beerhalls, shebeens, nightclubs, churches etc.

As poverty and HIV/AIDS go hand in hand approaches to deal with AIDS should take poverty into account. How can the lives of poor people be improved? All strategies (education and condom distribution) will come to nothing if people are still poor and have little choice over what to do and what not. Unless people's lives are changed

dramatically the battle against HIV/AIDS is likely to be lost. Some sections of the society have to be empowered to be able to make responsible and informed decisions about their lives. Far less attention has been given to either understanding or designing prevention programmes in light of the social and economic context in which individuals live. It is commonplace for HIV/AIDS programme managers to acknowledge poverty as a causative factor, but to then say that poverty is beyond the scope of their programmes.

Instead, top-down analyses and decisions about prevention have shaped public health responses. While the urgency spawned by an epidemic often requires quick decisions and implementation, and while the HIV/AIDS epidemic is of urgent concern in many countries and to many social groups, HIV/AIDS is now too pervasive and too deeply embedded in society to be managed through top-down public health approaches alone. Placing the epidemic within a context of a set of development issues and drawing upon the resources and experiences of local initiatives might at first appear a step back from the urgency demanded by the epidemic; in fact it is the only effective response.

The government has to fight the spread of HIV/AIDS from all angles and this includes the regulation of prostitution. The Minister of Justice and Constitutional Development, Penuell Maduna says if prostitution is legalised South Africa would be “the worst of all possible worlds” (*Mail & Guardian*: 8-14 March 2002). We cannot close our eyes as if prostitution does not exist. This would result in an inability to prevent the spread of HIV/AIDS. Prostitutes are both transmitters and victims of the epidemic (*Mail & Guardian*: 8-14 March 2002). In considering policy alternatives to reduce the spread of

HIV, the possibility of legalising brothels to contain prostitution, together with regular medical examinations of prostitutes is recommended. Legalising prostitution will not guarantee that the safety regulation is not violated. It will, however, afford the prostitute more control over sexual exchange. It would offer more space for AIDS-prevention programmes to target both prostitutes and their clients on the high-risk nature of commercial sex.

The availability of life-saving drugs will play a crucial role in the managing of HIV/AIDS. If the drugs can be given to pregnant women, an undesirable situation can be avoided. Saving babies is not only morally correct but it is also an economically viable option. Public hospitals can be saved from collapsing. HIV/AIDS threatens the hospitals to a degree not seen before, where a critically ill patient will be kicked out by another critically ill patient. Once hospitals reach that stage, the overall functioning of hospitals will be at risk. They would not be able to render other services because HIV/AIDS will be the only disease to tackle. In fact most patients will also be suffering from other curable diseases. The present government have resources and funding to tackle the epidemic. Money in government departments or sectors is not a problem. It can be moved from one department to the other. Some departments have been unable to spend large sums of the budget allocated to them. Why keep that money while people are dying?

On the contrary there should be laws dealing with HIV-positive individuals. The fight against AIDS should be a comprehensive approach. In many countries there are no laws dealing with HIV-positive individuals. People who know their status can infect others at

will. The government should put a stop to this by putting tough laws. There is no way HIV-positive individuals can be allowed to disrupt 'progress' made in some areas. Everybody is aware that one of the roles of government is to pass laws. It is not debatable whose jurisdiction it is to ensure the safety of the citizen from any forms of threat. The law regarding HIV positive individuals may be contentious but it is absolutely necessary. The law should not force people to disclose their status, but once their status people should act responsibly.

The government has a responsibility to ensure that all stakeholders are brought together to agree on a common vision from traditional leaders, NGOs to church leaders. The ideas need to be the same; if one says HIV/AIDS has no cure, the other one must not say the opposite. It does not give the public any sense of hope and confuses them. The war over the efficacy of condoms has demonstrated how destructive public disagreement between powerful figures can be. The ordinary were torn in between as to whom to trust. Surely, the aim is not to confuse people but to help them avoid this deadly disease at all cost even if it means overlooking some religious and cultural aspects.

In a nutshell, a cost-effective response to HIV/AIDS should be built on a small core of objectives in terms achievable objectives and measurable outcomes. Governments should address four areas--- overall coordination, prevention, care and mitigation. It should also monitor national programmes and provide public goods, ensure behaviours, and ensure universal access to treatment for opportunistic infections and integrate AIDS into poverty

alleviation strategies. Their position warrants a serious consideration given the urgency of the emergency posed by AIDS.

HIV/AIDS is an infectious disease but with commitment, clear political leadership and good programmes it can be beaten. It is important to translate political commitment into strong national and provincial AIDS programmes. Uganda is Africa's success story; it emerged victorious against all odds. It managed to turn the epidemic around with very limited resources at their disposal. Speaking at the Abuja Conference on HIV/AIDS in April 2000, United Nations secretary-general Kofi Annan spoke of leaders' duty to "inform, inspire and mobilise" their people through an awareness campaign such as the world has never seen. Leaders showed that HIV/AIDS was their main concern and there should be no difference in South Africa. In fact there will never be enough money to do whatever one feels like doing. We know what works and we know what to. The United Nations has reiterated the importance of strong political leadership. It has worked in other countries and there is nothing wrong in doing the same even here in South Africa.

Uganda turned the epidemic around mainly because of strong political leadership. Uganda is a relatively poor country in comparison to South Africa; there is no reason why one should not believe it would work in South Africa. This country is in a better position than Uganda who mostly relied on behaviour change. The importance of learning from what has worked cannot be over-emphasised. It is clear that South Africa is facing a catastrophic epidemic. The window of opportunity to prevent a large-scale epidemic has passed. The country now has to contend with the social and economic

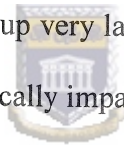
effects of large numbers of HIV infected and affected people. The control of this epidemic will only be achieved through sustained action in a well-managed programme that is based on interventions that have been shown to work and in a programme in which all South Africans can participate.

Southern Africa is currently at the epicentre of the HIV/AIDS epidemic. It is estimated that approximately 70 per cent of people living with HIV live in Sub-Saharan Africa. In Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe, large sections of the adult population are infected with HIV. Prevalence is especially high in cross-border areas with high mobility among truck drivers, migrant workers and commercial sex workers. All the countries in the region have a similar problem of HIV/AIDS. A Regional HIV/AIDS programme for Southern Africa should be launched. The primary aim of the programme would be to target high transmission areas at cross border sites with appropriate interventions.

The regional programme should have four main areas of focus:

- Cross border sites activities targeting mostly truck drivers, commercial sex workers and many more. Activities should include behaviour change, condom marketing and the management of sexually transmitted diseases.
- Regional policy improvement, including such activities as developing policy recommendations and promoting leadership for HIV/AIDS programmes.
- Networking and information sharing to stimulate interaction among and between countries and share best practices.

Southern Africa should move towards regional integration. A regionally integrated approach to regional problems will not only create economies of scale but also create a formidable negotiating block. For example, regarding the quest for access to antiretroviral therapy, the best option for Southern Africa is to present a united front in negotiations with both patent and generic manufacturers. The unifying objective is that Southern Africa should leave no stone unturned in the fight against HIV/AIDS. These unique Southern African challenges require unique Southern African remedial strategies. No partner can do for Southern Africa what it must do for itself. Partners should complement, not, direct or lead AIDS remedial efforts in Southern Africa. Graca Machel⁹ says that governments in the Southern African Development Community must wake up and speed up their efforts to deal with HIV/AIDS (*Cape Times*, 10 April 2002). The governments in the region are waking up very late and the worst is still to come. The number of deaths will increase dramatically impacting negatively on the economies.



President Thabo Mbeki has declared the 21st century an African century and says South Africa will help fuel the renaissance. Most Western leaders agree that if any country can make a good progress on this continent's elusive promise, it will be South Africa, with its stable government and sizeable economy. It remains to be seen if indeed South Africa will live up to the expectation.

HIV/AIDS in Southern Africa is a major challenge to the region's survival. The international community is mobilising to stop AIDS in Africa, especially Southern Africa. However, Southern African governments and their people are the first line of

⁹ Graca Machel, a leading human rights activist and wife of former president Nelson Mandela.

defence. The New Partnership for Africa's Development (NEPAD) has shown Africa's resolve. The vision of seeing Southern Africa as a strong economic block in Africa and the to world at large will not be realised. Initially the disease will hit few families, firms and communities. Furthermore, micro-effects of the epidemic will accumulate to form the macro-effects. Once enough families have been infected, production will decline and health services will begin to falter under increased patient load. What is needed is action. To act, Southern Africa should rethink current strategies with a view of implementing an aggressive proactive, dynamic and resourceful response to HIV/AIDS.



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Appendix A

**University of the Western Cape
School of Government**

This questionnaire will be confidential

Please fill in this questionnaire as honest as possible

HIV/AIDS in South Africa

Name.....

Gender.....

Occupation.....

Age

15-25	26-40	Other
-------	-------	-------

1. What do you know about HIV/AIDS?



.....

.....

.....

2. For how long have you known about HIV/AIDS?

.....

.....

3. Is HIV/AIDS a serious problem in your area? Please explain

.....

.....

.....

4.What area is it (Rural or Urban)?

.....

5.Where did you hear about HIV/AIDS?

.....

.....

.....

6.Are condoms readily available in your area?

.....

.....

.....



7.Do you know how HIV/AIDS can be cured?

.....

.....

.....

8.Do you see any relationship between poverty and HIV/AIDS, if yes what do you think the government should do to break the cycle of vulnerability?

.....

.....

.....

.....

.....
9. Do you think the government is really committed or doing enough to fight HIV/AIDS,
why do you say so?

.....
.....
.....
.....
.....

