

CHAPTER 2: THE HIV/AIDS EPIDEMIC IN SOUTH AFRICA

2.1. INTRODUCTION

A variety of problems co-occurring with the HIV/AIDS epidemic has been mentioned in chapter one. The following chapter endeavours to shed greater light on the course of the HIV/AIDS epidemic in South Africa, the policies devised to fight the disease and the effectiveness thereof. The progress of the disease has been particularly problematic and grievous in South Africa. As the following discussion will explain, South Africa is facing almost insurmountable problems in view of the rapid progress of the disease and the historical failure to combat HIV/AIDS.

2.2. DEFINITION OF CONCEPTS: EPIDEMIC VERSUS PANDEMIC

The Chambers Twentieth Century Dictionary defines the concept “pandemic” as follows: “*incident to a whole people, epidemic over a wide area*” (Macdonald, 1981:954). “Epidemic”, conversely, is defined as “*a disease that attacks great numbers in one place, at one time, and itself travels from place to place*” (Macdonald, 1981:439). It seems that an epidemic, even though it is thought to be capable of travelling through communities, is typified by local outbreaks of a disease, whereas a pandemic may be regarded as a disease that spreads globally. In the case of the HIV/AIDS crisis, both epidemic as well as pandemic characteristics may be noted. According to Hanass-Hancock (2009:35), “*HIV/AIDS has become a full-blown epidemic in South Africa*”. HIV/AIDS has many different faces, on the one hand it is a disease rapidly affecting and invading particular communities and ethnic groups (Roedlach, 2010:54; Alvarez, Jakhmola, Painter, Taillepierre, Romaguera, Herbst & Wolitski, 2009:7-8) and on the other hand it is also an illness travelling the globe and reaching “*pandemic proportions*” (CDC, 2006:841).

In the context of South Africa HIV/AIDS is referred to as an epidemic as the title of this chapter indicates. The term ‘epidemic’ has been chosen, seeing that this chapter refers to the localised outbreak of HIV/AIDS in South Africa, where it has travelled through communities and left behind trails of disaster to a greater or lesser extent. The term ‘epidemic’ is frequently found in the writings of authors on HIV/AIDS in South Africa (Nyabadza, Mukandavire & Hove-Musekwa, 2011:2091; Wand, Whitaker & Ramjee, 2011:28; Shisana, Simbayi & Human Sciences Research Council, 2002:1; Schneider & Stein, 2001:723; Van Harmelen, Wood, Lambrick, Rybicki, Williamson & Williamson, 1997:82; Jochelson, Mothibeli & Leger, 1991:157).

2.3. THE ORIGIN OF HIV/AIDS IN AFRICA

The AIDS virus seems to have come into existence for the first time in central Africa, where the *simian immunodeficiency viruses* (SIV's) closely related to the HIV-1M virus (the virus responsible for the HIV/AIDS epidemic) was found in monkeys and chimpanzees (Martin, 2010:222). It is generally believed that a human being became infected with an SIV whereafter it became contagious among humans (Martin, 2010:222). For the chimpanzee-to-human transmission of the virus various routes of transmission have been suggested (Martin, 2010:222). Regardless of the transmission route, the consequences are that millions of Africans are now infected with HIV/AIDS, as reported in the following paragraphs.

In the year 2008, 22 million Africans in sub-Saharan Africa compared to 30.1 to 36.1 million people globally were believed to be infected with HIV/AIDS (UNAIDS, 2008b). Southern Africa has been most fatally hit by the HIV/AIDS epidemic. According to UNAIDS, "*all of the top five HIV-affected countries are neighbours of South Africa*" (Baldauf, 2009). Sub-Saharan Africa, which houses only 10% of the global population, carries 60% of global infections with HIV/AIDS (Delobelle, Rawlinson, Ntuli, Malatsi, Decock & Depoorter, 2009:1062). The only African country that seems to have been capable of successfully reversing the HIV/AIDS epidemic is Uganda. With its strong emphasis on abstinence and faithfulness within marriage, Uganda has managed to decrease premarital sex among single males aged 15-24 years from 60% in 1989 to 23% in 1995 (Green, Halperin, Nantulya & Hogle, 2006:335; see also Hunt, 2010). Uganda successfully reversed the trend of the epidemic, and life expectancy in Uganda is now on the increase, instead of decreasing dramatically, as is the case in South Africa (Hunt, 2010). If South Africa had followed the same route as Uganda, we would not now be presented with the extremely sad and tragic picture marking the rampant progress of the disease.

2.4. THE BLEAK PICTURE OF HIV/AIDS IN SOUTH AFRICA

The following discussion will provide a more in-depth insight into how the HIV/AIDS epidemic progressed in South Africa, and provide explanations for the rampant spread of the disease in our country.

2.4.1. Early history of HIV/AIDS and AIDS policies in South Africa

A very tragic event for South Africa as a whole is that with the announcement of freedom in 1994, at the onset of a completely new era of democracy in South Africa, a certain enemy made itself felt more clearly (Leclerc-Madlala, 1997:367). This enemy was new in the sense that in the 1980's, the subject of HIV/AIDS did not receive much national attention (Nyabadza *et al.*,

2011:2091). General expectations of the new democratic government's ability to initiate an effective fight against HIV/AIDS were high (Schneider & Stein, 2001:723) but millions of South Africans were conquered and left defenceless against the attack. HIV/AIDS cast a very dark shadow on the new South Africa, and this sadly includes the AIDS policies followed by South Africa since the arrival of the disease. The policies devised by South Africa intended to fight HIV/AIDS could not reverse the rampant spread of the disease and today the country has the highest incidence of HIV/AIDS infections in the world (Pouris & Pouris, 2011:542; Auerbach, 2010; Hart, 2010:2; Keeton, 2010:803; Richter & Massawe, 2010:21). Tragically, South Africa's history of combat strategies against HIV/AIDS is characterised by a host of conflicts, political blunders, unscientific precepts and counterproductive policies (Chigwedere & Essex, 2010:237-244; Campbell, 2003:157-158; Schneider & Stein, 2001:723; Morris, 2000).

When HIV/AIDS appeared in South Africa, it was predominantly found among (white) homosexual men (Nyabadza *et al.*, 2011:2092; Van Harmelen *et al.*, 1997:81,85; Jochelson *et al.*, 1991:161) as was the case in North America and Europe when the disease was in its initial stages (Jones, Fosbery, Taylor & Gregory, 2007:171). HIV/AIDS appeared for the first time in South Africa in 1982 when two AIDS deaths occurred in the Pretoria/Johannesburg area. The sufferers were male homosexuals (Leclerc-Madlala, 1997:363; Van Harmelen *et al.*, 1997:81-82; Jochelson *et al.*, 1991:161; Spracklen, Whittaker, Becker, Becker, Holmes & Potter, 1985:141). By August 1985, 18 cases of HIV/AIDS had been affirmed, the majority of which could be found among the homosexual population of South Africa (Spracklen *et al.*, 1985:141). By April 1990, the number of HIV/AIDS cases in South Africa had risen to 386 (Jochelson *et al.*, 1991:161). In spite of Spracklen *et al.* (1985:141) mentioning the infection of one black male with HIV/AIDS by 1985, Leclerc-Madlala (1997:364) states that not until 1987 were infections with HIV/AIDS recorded among the black population of South Africa. Furthermore, by 1992, new cases of HIV/AIDS among women more or less equalled new cases of HIV/AIDS among men, thereby establishing the heterosexual transmission route (Van Harmelen *et al.*, 1997:82) after it had been predominantly homosexual in nature in the beginning stages of HIV/AIDS in South Africa (Spracklen *et al.*, 1985:143). In the 1990's, a time of significant political transformation, HIV/AIDS established itself very well in South African society (Nyabadza *et al.*, 2011:2092).

In 1992, the National AIDS Convention of South Africa (NACOSA) was founded (Nyabadza *et al.*, 2011:2092; Evenson & Stokke, 2010:152). NACOSA set up a plan to attack HIV/AIDS in all domains. These domains included “*prevention, research, human rights, counselling and welfare*” (AVERT, 2011). Various departments such as political parties, trade unions, and non-

governmental organisations (NGO's) would also be included in the strategic plan to arrest the spread of HIV/AIDS (Evenson & Stokke, 2010:152). At the 1994-election, South Africans even hoped that the crisis faced by other African countries with regards to the HIV/AIDS epidemic would not hit South Africa. This hope was tragically disappointed in the years to come. The actions planned "*failed to materialise*" (Evenson & Stokke, 2010:152; Schneider & Stein, 2001:723). This is not surprising, given the facts that South Africa lacked decisive leadership where HIV/AIDS was concerned, and that civil society organisations (CSO's) were often excluded from state-induced action against HIV/AIDS (Evenson & Stokke, 2010:152). These early failures were the precursors of what later on characterised South Africa's problematic fight against the HIV/AIDS epidemic: the huge gap between policy making and policy implementation.

It seems that HIV/AIDS was not a very popular topic for policy-making in the new South Africa, as the newly established government preferred to focus on positive messages such as increased access to jobs, housing for the general population, the abolition of apartheid, traditional beliefs and the like (AVERT, 2011; Nyabadza *et al.*, 2011:2092). A further reason for failure might be the fact that the AIDS Programme Director was placed in the Ministry of Health instead of in the President's Office, causing the National AIDS Plan to be of decreased significance. The government of South Africa failed to address HIV/AIDS as an illness affecting multiple aspects of society, by allocating its management to the Health Department only, whereas it was crucial to involve all government departments so that the effects of HIV/AIDS on all sectors of society could be continuously addressed and assessed (Boutayeb, 2009).

By the middle of the 1990's, several initiatives against HIV/AIDS actually demonstrated and brought to the fore the ineffectiveness of strategies devised by the South African government to fight the epidemic (Schneider & Stein, 2001:723). The South African government's approach towards HIV/AIDS became characterised by the politicisation of the issue (Evenson & Stokke, 2010:152). A highly controversial example in the attempt to attract public attention to the HIV/AIDS epidemic was the musical screenplay "*Sarafina II*" (Mackintosh, 2009:14; Campbell, 2003:157) which was severely criticised for its irrelevancy and ineffectiveness. A little later a small number of researchers in Pretoria tested the antiretroviral medication "*Virodene*". They had to discontinue their trials when the Medicines Control Council (MCC) forbade them to continue (Paroske, 2009:155). The researchers regarded themselves as victims of the AIDS establishment and wanted support from the government (Mackintosh, 2009:14). Upon Dlamini-Zuma's (the then Minister of Health) invitation, the researchers tabled their results before the

cabinet, after which the ministers promised to support the Virodene research until the product would become recognised by the MCC (Mackintosh, 2009:14-15). In this way, South Africa's politicians opposed the MCC and the Medical Research Council (MRC) (Butler, 2005:594). These incidences of dismally failed attempts to fight HIV/AIDS had created the opportunity for critics to voice much criticism and hostility against South Africa's HIV/AIDS policies.

South Africa's fight for the implementation of anti-retroviral medication (ARV's) was greatly hindered by the proclamation of "*natural means*" such as garlic and beetroot against the lethal HIV/AIDS. This was further worsened by the fact that South Africa's previous Minister of Health, Dr Manto Shabala-Msimang, strongly supported the notion regarding the myth that natural means could be effective in the fight against HIV/AIDS (Hart, 2010:2). When the previous South African president, Thabo Mbeki went on to question a relationship between HIV and AIDS (as can be seen in the verbatim quotation below), an efficient, coherent battle against HIV/AIDS on a national level in South Africa, seemed to be lost:

"In 2000, the South African President Mbeki courted controversy by questioning the link between HIV and AIDS, seeking to bolster his claim with the research of an obscure and small group of 'dissident scientists' – in the face of the incredulity of most of the local and international scientific community.(...)President Mbeki and government colleagues repeatedly voiced their belief that the existence of HIV/AIDS was a fiction, perpetuated by international drug companies, who sought to make vast profits by peddling their toxic drugs in Africa.(...) It was also within this context that a German doctor was suspended from her job in a government hospital in Kimberley. In the furore that resulted after it, it was found that the hospital had breached government policy by prescribing a course of anti-AIDS drugs for a nine-month-old baby girl who had been gang-raped by a group of men who believed that having sex with a virgin would cure them of HIV/AIDS.(...) This has also been the context within which, for several years, the government refused to provide the relatively inexpensive drug nevirapine to HIV-positive pregnant women, despite research evidence that this would reduce the likelihood of their babies being born HIV positive. Leading South African scientists have estimated that about half of the 75 000 infants who were born with HIV infection in South Africa in the year 2000 alone could have been saved from HIV infection had they been given proper access to appropriate drug treatment" (Campbell, 2003:158).

Ironically, South Africa thus passed through a period of AIDS denialism in the midst of the devastating and debilitating HIV/AIDS crisis. On March 26 in the year 2000, the then president

Thabo Mbeki announced his determination to “*continue to question conventional wisdom on the relation between HIV and AIDS*” (Baleta, 2000:1167). Mbeki refuted the widely accepted and Western-scientific notion that HIV causes AIDS, and his denial of a connection between HIV and AIDS meant a prohibition of the distribution of ARV’s to the poor of South Africa during that period of time (Paroske, 2009:148). Mbeki never refuted his stance on AIDS denialism, not even during the 13th International AIDS Conference in Durban in July 2000 (Marcus, 2000:730). This International AIDS Conference was termed the ‘*most important*’ of conferences so far (Marcus, 2000:730). The participants of the conference reacted to Mbeki’s AIDS denialism and its consequences by signing the “*Durban Declaration*” which scientifically confirms the link between HIV and AIDS through references to relevant literature. More than 5000 international scientists worthy of mention signed the “*Durban Declaration*” (Marcus, 2000:731).

Mbeki had been in contact with David Rasnick (a US AIDS dissident) of the University of California, Berkeley who, in cooperation with his colleagues, was of the opinion that “*long-term consumption of recreational drugs and of anti-HIV drugs causes AIDS*” (Baleta, 2000:1167). Mbeki’s part in the spread of the HIV/AIDS epidemic has been described as “*tantamount to Holocaust denial because its implications are so serious*” (Baleta, 2000:1167). It seems that Mbeki played a significant role in an ongoing debate within the Department of Health. This controversy was caused by the refusal of South Africa’s government to provide *zidovudine* (AZT) to pregnant women for the prevention of vertical HIV/AIDS transmission to babies (Baleta, 2000:1167). This refusal was a questionable measure in the light of the fact that mother-to-child transmission is an important infection route for HIV/AIDS (Sartorius, Kahn, Vounatsou, Collinson & Tollman, 2010). While Malegapuru Makgoba, the South African president of the Medical Research Council called Mbeki’s attempts at AIDS denialism a “*national scandal*”, Mbeki continued to assert that he was serious in his fight against HIV/AIDS (Baleta, 2000:1167).

Headings such as “*Prospects of success after the repeated failure of previous AIDS policy?*” (Wouters, Van Rensburg & Meulemans, 2010:171) cast a very doubtful picture on South Africa’s handling of the rampant progression of HIV/AIDS. Even more condemning is the fact that South Africa’s AIDS policy is viewed as fruitless, not only domestically, but also internationally (Wouters *et al.*, 2010:172) It becomes clear that the failure of the fight against HIV/AIDS up to the present moment has been due to ineffective approaches and a gap between policy making and policy implementation (Wouters *et al.*, 2010:172).

Schneider and Stein (2001:724) make it clear that financially, South Africa is far better equipped to develop coherent strategies against the HIV/AIDS epidemic than most of its African neighbours. When considering national income, South Africa can rather be compared to certain Latin American and Asian countries (Schneider & Stein, 2001:724). The example of Brazil, which is also a developing country, evidently contrasts with South Africa. *“Brazil was the first country to provide unrestricted cost-free access to antiretroviral medicines for AIDS treatment”* (Antunes, Waldman & Borrell, 2005:588). This was probably done as a result of decisive national leadership (Campbell, 2003:158). Already in the mid-1990’s Brazil began to make ARVs available to the AIDS-suffering public (Antunes *et al.*, 2005:588-590). South Africa was even put to shame by some of its poorer Southern African neighbours such as Botswana, that put a considerable effort into providing ARVs to its population before South Africa did so. In 2004, years after evidence of antiretroviral effectiveness was conclusive, the South African government was still in the process of deciding on a plan to make ARVs available. At that point in time HIV/AIDS had already spread beyond control in South Africa (Nyabadza *et al.*, 2011:2092). Before 2003/2004, South Africa’s health care system did not provide the public with ARVs (Keeton, 2010:803, see also Nyabadza *et al.*, 2011:2092). At the end of the year 2007, a mere 28% of people in need of treatment actually had access to it (Nyabadza *et al.*, 2011:2092). By 2010, South Africa was still considered to be *“moving towards the implementation of treatment for HIV/AIDS”* (Evenson & Stokke, 2010:151).

It seems that the government’s inaction against HIV/AIDS has forced South African citizens to resort to other initiatives in search of protection from and treatment of the disease. An example of such a social initiative is the *Treatment Action Campaign* (TAC) founded by Zackie Achmat in 1998, who is HIV positive himself (Nyabadza *et al.*, 2011:2092; MacGregor, 2009:85). According to MacGregor (2009:85), the TAC *“has mounted successful legal challenges not only against the South African Department of Health but also against the patent laws protecting multinational drug companies”*. It was also TAC that managed to *“secure an injunction”* in order to force the South African government to provide antiretroviral treatment (MacGregor, 2009:85). During a presentation at an academic conference in 2004, Zachie Achmat complained, however, about the slow rate at which ARVs were being provided to the suffering population.

It seems as if South Africa has gradually started to realise the frightening extent of the massive crisis confronting the country. This becomes evident from the following statement by Chipkin, chief research specialist at the Human Sciences Research Council: *“I think it’s beginning to dawn on South Africa as a whole that the scale of the situation is so alarming, it’s difficult to*

imagine how we are going to deal with it” (Baldauf, 2009). Chipkin predicted that by 2015, a third (32%) of South African children will be orphaned due to HIV/AIDS (see also Freeman & Nkomo, 2006:302). He also emphasised that the South African family is facing a fundamental crisis (Baldauf, 2009).

2.4.2. South African HIV/AIDS statistics

On a more practical level, what were the results of the failed HIV/AIDS policies and the ineffectiveness of South Africa’s government to fight the disease? Wouters *et al.* (2010:171) call the story of HIV/AIDS in South Africa “*one of the lost opportunities*”. Since 1983, when the early HIV/AIDS cases were discovered in South Africa, numbers of people infected with HIV/AIDS have risen dramatically. Circumspection is necessary when dealing with HIV/AIDS statistics in South Africa. Statistics may vary since they only display information gathered among a sample of the population, and important aspects from large segments of the South African population may go undetected. An example of these segments are the South African people living in remote and rural areas, where lack of infrastructure makes it unlikely for those people to be reached by researchers. However, most sources cited in the present literature review are academic in nature or made available by credible organisations such as UNAIDS, and may therefore give reasonable indications with regards to the direction the HIV/AIDS epidemic is taking in South Africa.

HIV/AIDS is mainly spread in South Africa by way of heterosexual activity (Reddy, 2010:88; Van Donk, 2002:1). In the year 1990, it was estimated that 0.7% of pregnant women were infected with HIV/AIDS in South Africa, compared to an estimated increase in prevalence of 30.2% in 2005 (Nyabadza *et al.*, 2011:2091). At present an estimated total of 5.7 million out of a population of 48.6 million people are living with HIV/AIDS in South Africa (AVERT, 2011; United States Department of State, 2011; Auerbach, 2010; UNAIDS, 2008a:4).

In the light of the epidemic number of infections, certain high risk areas and population groups particularly impacted by HIV/AIDS can be identified. In certain regions of KwaZulu-Natal, for example, one of South Africa’s provinces most fatally hit by the disease, it is estimated that half of the population may be infected with HIV/AIDS (Dente, 2009). Adding to the HIV/AIDS crisis are epidemic outbreaks of Tuberculosis (TB) and even severe and feared drug-resistant TB. Rural Tugela Ferry in KwaZulu-Natal was hit by such an epidemic outbreak in 2006 (Dente, 2009).

Provinces with particularly high infection rates are KwaZulu-Natal and Mpumalanga. Among the general population, KwaZulu-Natal, displays an infection rate of 15.8%, closely followed by Mpumalanga with 15.4% (Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-van-Wyk, Mbelle, Van Zyl, Parker, Zungu, Pezi & SABSSM Implementation Team, 2009:xvi). The Western Cape with a 3.8% infection rate is one of the least affected provinces, similar to the Northern Cape with 5.9% (Shisana *et al.*, 2009:xvi).

Certain groups also display heightened infection rates. Among these are pregnant women, sex workers, homosexuals, patients with sexually transmitted infections (STIs) Tuberculosis patients and truck drivers (UNAIDS, 2008a:7-8). In 2008, almost 30% of pregnant women in South Africa were believed to be infected with HIV/AIDS (UNAIDS, 2010:20; Anon, 2009a; see also UNAIDS, 2008a:7). According to UNAIDS (2010:23) South African research has disregarded high risk groups, to a great extent, and thus only limited data is available on other high risk groups. UNAIDS (2008a:7) also indicates that in 2004, HIV/AIDS infection rates among sex workers in South Africa were up to almost 70%. Among the general population, the young adults are most heavily affected by the disease: One out of three women aged 25-29 and one out of four men aged 30-34 are infected with HIV/AIDS in South Africa (UNAIDS, 2010:11). In the age group 15-49 years of age, more than 15% (just over 18% according to the US Department of State, 2011) of the South African population is infected with HIV/AIDS (UNAIDS, 2010:20). There is also an apparent discrepancy in infection rates between the male and female population: out of 5.7 million infected people, 3.2 million are female and 2.5 million are male (UNAIDS, 2008a:4).

In 2007, about 280 000 children were estimated to be infected with HIV/AIDS in South Africa (UNAIDS, 2008a:4). Whereas in recent years the world has seen great decreases in child mortality, South Africa's rate of infant mortality showed a different tendency. With an infant mortality rate of 49 deaths per 1000 children in 1990, and 46 deaths per 1000 children in 2007, one can hardly speak of a diminution in child mortality (Sartorius *et al.*, 2010). No doubt this tragic reality can mainly be contributed to the HIV/AIDS epidemic, because a notable 50% of children who are prenatally infected with HIV/AIDS pass away before reaching the age of two years (Li, Jaspan, O'Brien, Rabie, Cotton & Natrass, 2010:751).

One of the factors that clearly illustrates the tragic progression of the HIV/AIDS epidemic in South Africa is the rise in the country's mortality rates (Taylor & Kvalsvig, 2008:61). In 1997, 316,559 people passed away in South Africa, compared to the 607,184 citizens in 2006 (AVERT,

2011). This means the registered yearly deaths rose by 91% from 1997 to 2006. Among the age group 25-49 years the rise in deaths was an appalling 170% during the same time period (AVERT, 2011) and 49% of deaths among young adults in 2006 can be contrasted with 29% of deaths in the same age group in 1997 (AVERT, 2011). These figures may serve to indicate that AIDS is a foremost driving factor in the rise of death rates in South Africa (AVERT, 2011).

Closely linked to the general mortality rates in South Africa is the rise in HIV/AIDS related deaths. The number of people who have died of HIV/AIDS in South Africa has increased dramatically over the past years. The number of HIV/AIDS deaths has risen from an approximate zero in the year 1990 to an estimated 350 000 in the year 2007 (UNAIDS, 2008a:5). This number is likely to increase. Connected with HIV/AIDS deaths are the steadily increasing number of AIDS orphans. The number of AIDS orphans in South Africa (children who have lost either a father or a mother or both parents to HIV/AIDS) has increased dramatically from 400 000 AIDS orphans in 2001 to 1.4 million AIDS orphans in 2007 (UNAIDS, 2008a:6).

2.4.3. The impact of HIV/AIDS on the health care sector

Almost 50% of all inpatients in public hospitals in South Africa are HIV positive (Delobelle *et al.*, 2009:1062). This leads to a large number of patients in need of treatment with antiretroviral medication. Staff in the health care sector have been heavily affected by the HIV/AIDS epidemic. More specifically, health care workers fall increasingly ill, have to battle with difficult working conditions and resort to absenteeism. The conditions are worsened by a low morale, insufficient personnel, and underpaid health care workers (Delobelle *et al.*, 2009:1062). Developing countries often experience a lack of knowledge among health care workers with regards to HIV/AIDS transmission and prevention measures (Delobelle *et al.*, 2009:1062). South Africa is not excluded from these uncertainties making working life stressful for nurses and reducing the quality of care provided by the health care sector. This is undesirable since health care workers' attitudes towards patients, especially those infected with HIV/AIDS, can also be affected.

2.4.4. South Africa as the precursor of the HIV/AIDS epidemic

On a global scale, South Africa has been hardest hit by the AIDS virus (Anon, 2010). As mentioned previously, it is estimated that over a tenth of South Africa's general population could be infected with HIV/AIDS (Delobelle *et al.*, 2009:1062). This includes an estimated 5.5 million people (Baldauf & Freeman, 2010). Dageid and Duckert (2008:182) even place the number of people infected with HIV/AIDS in South Africa at more than 6 million. The resulting high

number of orphans South Africa has to deal with is highly problematic. With an estimated 1.4 million South African AIDS orphans from 2007 onward (Baldauf & Freeman, 2010), South Africa has the largest number of AIDS orphans in the world in proportion to the country's population (Baldauf & Freeman, 2010). Of the 1.4 million or more orphans in South Africa, 11% are also thought to be HIV positive (Baldauf & Freeman, 2010).

2.5. THE EFFECT OF HIV/AIDS ON SOUTH AFRICAN FAMILIES

The devastating progression of HIV/AIDS in South Africa has been made clear. The following section will explain how the disease has taken its toll on South Africa's families.

2.5.1. Premature parental deaths

As previously alluded to, adults in the age group 25-49 years of age are the group most affected by the HIV/AIDS epidemic. Premature deaths in South Africa have risen from 39% a decade ago to a frightening 75% in 2010 (AVERT, 2011). In his book *"Unimagined communities: Sex, Networks, and AIDS in Uganda and South Africa"*, Thornton (2008) compares the fundamentally different tendencies with regard to infection with HIV/AIDS in South Africa and Uganda. Thornton points out the paradox that life expectancy is higher in Uganda (one of Africa's poorest countries) than in the richest nation of the continent, South Africa. In 2006 the life expectancy for the average South African was 51 years of age according to World Health Statistics (UNAIDS, 2008a:19).

It is not exceptional anymore for a child in South Africa to lose one or both of his parents to HIV/AIDS. Schatz, Madhavan and Williams (2011:598) state that households headed by women, among other factors, are increasing because of HIV/AIDS-related mortality. With the low life expectancy mentioned already a situation is developing where not only children below the age of 18 may lose their parents, but even beyond this age, young adults may lack the much-needed social, emotional and material support usually received from parents as they are transitioning into adulthood.

According to Schatz *et al.* (2011:599), literature on the effects of HIV/AIDS on households is increasing. Schatz *et al.* (2011:599) relate: *"Most studies suggest that AIDS drastically alters household organisation and challenges households' capacity to cope with the disease. These drastic effects are partly due to the considerable economic and emotional shocks to households and broader social networks brought on by AIDS. African households function as the primary locus of care for the sick and for the AIDS orphans. There is little doubt that these households*

face enormous strain from costs related to illness, funerals, and care for orphaned children.” Baldauf and Freeman (2010) put the number of children orphaned by HIV/AIDS in South Africa specifically at 1.4 million in 2007.

2.5.2. Caregivers of children orphaned by AIDS

Related to the large incidence of premature parental deaths in South Africa, the question immediately arises, “Who will take care of the great number of AIDS orphans?”. According to Freeman and Nkomo (2006:302), it is generally expected that the extended family members will take care of AIDS orphans. However, the resources of extended families with regard to orphan care are being considerably stretched so that relatives cannot be regarded as limitless sources of help (Freeman & Nkomo, 2006:302). In sub-Saharan Africa, the extended family system is facing a crisis in being expected to care for the growing number of AIDS orphans (Lalthapersad-Pillay, 2008; Schatz, 2007; Ssenigozi, 2007).

Freeman and Nkomo (2006:302) make it clear that relatives will need additional support if they are to take in orphans, or else the extended family may no longer be an expected source of help. Also, the stigma surrounding HIV/AIDS may influence relatives’ willingness to harbour children (Freeman & Nkomo, 2006:302). There are definitely cases where alternative ways of caring for AIDS orphans will have to be found, especially in the light of the fact that 12% of caregivers questioned in Freeman and Nkomo’s study (2006:302) could not indicate who would possibly take care of their children.

In the context of sub-Saharan Africa, and more specifically in South Africa, the care giving role of elderly people is becoming more and more significant (Ogunmefun, Gilbert & Schatz, 2011; Lombard & Kruger, 2009; Lalthapersad-Pillay, 2008). A situation is developing where the older generation has to take care of their own sick adult children and at the same time care for their grandchildren (Schatz, 2007:147) who have significant physical, social and emotional needs (Lalthapersad-Pillay, 2008:148). Not only do these circumstances drain elderly people’s resources – financially, emotionally and physically – they also display a complete reversal of the traditional role of the elderly. Instead of the older generation being the generation in need of care, they become the very ones who are expected to take care of their own children and grandchildren!

Schatz’s (2007:152) study on South African grandmothers taking care of their own grandchildren, showed that the elderly often act as “*surrogate mothers*”, completely taking over

the parenting role, providing grandchildren with everything they need from schooling to clothing and other kinds of care giving required. Schatz (2007:152) also found a general tendency among prime-aged mothers to leave their children in their mother's care, especially children born out of wedlock. Sick adults, especially those suffering from HIV/AIDS, are often taken back to their mother's home once they need to be cared for (Schatz, 2007:152) as South Africa's health care system is immensely strained by the rising number of HIV/AIDS patients and state health care institutions cannot keep HIV/AIDS patients hospitalised limitlessly.

Taking care of their own dying children and at the same time taking responsibility for the upbringing of their orphaned grandchildren, elderly women in South Africa and other sub-Saharan countries are performing a phenomenal task. Their capabilities, however, are often being stretched beyond limits and, as research findings indicate, they struggle to cope with this enormous responsibility being placed on their shoulders (Schatz, 2007:153). Again, the great need for financial, emotional, social and other types of support to elderly caregivers cannot be overlooked.

2.5.3. The development of child-headed households

Another awful reality caused by HIV/AIDS related parental deaths in South Africa, is the breakup of traditional nuclear family units. Because of this phenomenon a new type of family has evolved, namely child-headed households. Meintjes, Hall, Marera and Boule (2010:40) assert that only a small number of AIDS orphans are residing in child-headed households and that most children living in child-headed households in South Africa still have a living parent somewhere. Meintjes *et al.* (2010:46) also report that their study did not provide evidence in support of the notion that child-headed households are rapidly increasing at present. Even though Meintjes *et al.* (2010:46-47) do not deny that the HIV/AIDS epidemic is causing the development of child-headed households, they argue that the causal factors behind children living by themselves are more complex than assumed. Nevertheless, child-headed households do exist in South Africa and the government and society at large have an immediate responsibility to support and assist these children (Mogotlane, Chauke, Van Rensburg, Human & Kganakga, 2010:24).

2.5.4. The impact on the development of AIDS orphans

The negative impact of the HIV/AIDS epidemic on AIDS orphans is grave and alarming. According to Hearle and Ruwanpura (2009:423), the HIV/AIDS crisis is responsible for a large number of children who are socially maladapted, uneducated, malnourished and vulnerable in

general. Furthermore, children orphaned through HIV/AIDS may undergo a significant degree of stigmatisation and subsequent bullying. Cluver, Bowes and Gardner (2010:793) identify bullying as an “*independent and important risk factor in child psychological distress in South Africa*”. The sad fact is that AIDS orphans, who may have pre-existing psychological disorders, are at an increased risk to experience bullying (Cluver *et al.*, 2010:794). The bullying itself is a distressful experience and adds to the psychological problems a child may already experience (Cluver *et al.*, 2010:794).

According to Cluver, Fincham and Seedat (2009:106), children orphaned by HIV/AIDS are also at particular risk for developing post-traumatic stress. Effective reduction of the effects of exposure to trauma in children orphaned by HIV/AIDS depends very much on the degree of social support that can be provided. Research supports the notion that the presence of a supportive caregiver lessens the disastrous effects of experienced trauma (Cluver *et al.*, 2009:106). In the light of the ever increasing number of AIDS orphans, it will be vital to identify environmental factors that may augment the effects of trauma exposure. Bronfenbrenner’s ecosystemic model (Donald, Lazarus & Lolwana, 2006:41) may assist in identifying and consequently, better controlling, contextual factors which may negatively affect AIDS orphans. It should also be kept in mind that negative, or potentially harmful factors cannot always be immediately removed. Negative factors in certain spheres may also be compensated for, by enabling aspects in other spheres (Cluver *et al.*, 2009:107). It is very important to consider AIDS orphans against the totality of their environment since this will enable us to gain an in-depth understanding of the various aspects impacting on their development.

Lastly, a very obvious and perhaps most immediate need of AIDS orphans in a third world context, is the physical need. It has been mentioned earlier that the resources of the extended family system are strained in this regard. Providing AIDS orphans with financial aid, however, has to be done with utmost care because identifying AIDS orphans as those in need may increase stigmatisation (Hearle & Ruwanpura, 2009:432).

2.6. THE EFFECT OF HIV/AIDS ON THE SOUTH AFRICAN ECONOMY

Kauffman and Weerapana (2006:349) describe HIV/AIDS as “*perhaps the most significant macroeconomic problem*” facing sub-Saharan countries. Concurring with Kauffman and Weerapana’s view, Bowen, Cattell, Edwards and Marks (2010:997), refer to HIV/AIDS as “*a substantial long-term threat to economic development in South Africa*”. Kotzé and McDonald (2010:60) likewise believe HIV/AIDS will prove very detrimental to socio-economic

development in South Africa. South Africa plays a leading economic role in sub-Saharan Africa; the survival of the South African economy is of interest not only to the country itself, but also to the rest of Africa (Kauffman & Weerapana, 2006:349-350).

2.6.1. The impact of HIV/AIDS on the South African labour force

Because so many young people in South Africa are affected by HIV/AIDS, the epidemic is robbing South Africa of its workforce. Kauffman and Weerapana (2006:350) state that in particular, the adult male population who works in the mining and manufacturing industry, is affected. Next to the mining and transport industry, Bowen *et al.* (2010:997) add the construction industry as a branch of the labour market that is endangered. It follows that the financial health of the South African economy is at stake (Kauffman & Weerapana, 2006:350).

Companies are affected in the following ways by HIV/AIDS: lower productivity due to the lower job performance and absenteeism of infected workers, unoccupied positions due to illness and death, costs involved in filling such positions, lowered productivity of newly appointed workers and the like (Dickinson, 2004:629).

Other issues that arise within firms due to HIV/AIDS may concern social and ethical issues that relate to confidentiality, discrimination and stigmatisation as well as detrimental interpersonal communication (Aventin & Huard, 1999:363). A further point of concern is that in general, migrant workers are perceived as being at a heightened risk for contracting HIV/AIDS by having multiple sexual partners when they live away from their spouses (Muchoki, 2011:250-251). This situation does not only put migrant workers' health at risk, but also that of spouses and children who may become infected upon the father's return.

2.6.2. Corporate HIV/AIDS policies

In his article "*Corporate South Africa's response to HIV/AIDS: why so slow?*", Dickinson (2004:627) elaborately tackles the question of why the South African corporate sector has been so slow at responding with policies to address the mounting HIV/AIDS crisis. Dickinson refers to the government's delayed decision to take charge of fighting the disease in 2002 (Dickinson, 2004:627). As a result, large companies began to declare that they would carry the costs of Antiretroviral Medication for their employees (Dickinson, 2004:627). In 2005, Venter (2005:1215) stated that the number of companies supplying their employees with antiretroviral drugs, was rising. The government's slow response to HIV/AIDS seems to have prompted South

African companies to take more responsibility for their workers than has been the case in the past.

2.7. YOUNG PEOPLE AND HIV/AIDS

Young people are the future of South Africa, the hope of our generation. Yet, as the following paragraphs will show, HIV/AIDS has singled out the young people as one of its prime targets.

2.7.1. The prevalence of HIV/AIDS among South African youth

The World Bank singled out youths aged 15-24 years as a particular high risk group when it comes to infection with HIV/AIDS (Buthelezi, Mitchell, Moletsane, De Lange, Taylor & Stuart, 2007:446). The Sixteenth International AIDS conference held in 2006, made unmistakably clear that more than 50% of new infections with HIV/AIDS concern young people in the age group 15-24 years (Buthelezi *et al.*, 2007:446). As the following paragraphs will show, South Africa concurs with the global trend as far as HIV/AIDS infections among young people are concerned.

Infection rates of HIV/AIDS among South African young people are high (Li *et al.* 2010:751). No doubt high infection rates stand in direct relation to the fact that in South Africa, many young people are becoming sexually active at an early stage in their lives, beginning at the age of 14 years or younger (Pettifor, O'Brien, MacPhail, Miller & Rees, 2009:84). UNAIDS (2008a:14) stated that around 5% of males and 12% of females have had sex before the age of 15. According to MacPhail, Pettifor, Moyo and Rees (2009:456), 10.2% of youths from 15-24 years of age are infected with HIV/AIDS in South Africa. This number seems to be realistic, as a year earlier, the prevalence of HIV/AIDS of the same age group was at more or less 8% (UNAIDS, 2008a:5). Young people and adolescents in South Africa represent an important proportion of the population infected with HIV/AIDS. Fifty percent of the people currently living with HIV/AIDS, became infected before the age of 25 years (Bhana & Pattman, 2011:962). When developing ways of assisting HIV/AIDS infected young people and adolescents, not only the adolescents infected through sexual activity should be targeted, but also that part of the child population growing up with HIV/AIDS (Li *et al.*, 2010:751). The challenges with regard to HIV/AIDS and young people are innumerable and the fact that so many young people are now confronted with this deadly disease remains a tragic reality.

As mentioned beforehand, a large number of young people in South Africa engage in premarital sex. This leads to a larger incidence of HIV/AIDS infected young people. Another fact that should not be forgotten, is that infection with HIV/AIDS, regardless of how the youth views

his/her infection, may mean the loss of the dream of a happy family and a marital relationship for the rest of their lives. Francis (2010:317) and Rau, Coetzee and Vice (2010:81) identified alcohol consumption as a factor which promotes sexual practices and consequently the transmission of HIV/AIDS amongst young people. Francis (2010:315) mentioned the role that the media play in bombarding young people with messages of “*more sex, earlier sex and peer pressure*”. These images are shaping young people’s views of their own sexuality as they grow up (Francis, 2010:315). The situation among young people is desperate. Already in 1997, young people who thought themselves infected with HIV/AIDS stated repeatedly that they would purposefully try to spread the virus to as many other young people as possible so that they would not have to die alone (Leclerc-Madlala, 1997:369). Here are a few quotes made by young people expressing their motivation for spreading the virus:

“If I have HIV I can just go out and spread it to 100 people so we all go together. Why should they be left behind having fun when I must die.” (20 year old male)

“At least I know my boyfriends won’t be enjoying themselves when I’m gone. I can feel good about that. We’ll be sick together and we’ll die together.” (21 year old female)
(Leclerc-Madlala, 1997:369).

Parents may be unaccustomed to talking to their children about sex with the same openness with which the media presents it. Francis (2010:316) in his article on sex education emphasises the mediating role of schools in shaping learners’ attitudes in order to protect them from infection with HIV/AIDS. Nevertheless, sex education will have to be very carefully planned and based on research demonstrating positive outcomes of past sex education endeavours, in view of the fact that increased knowledge does not necessarily lessen sexual risk-taking, and may even increase risky sexual behaviours (Tenkorang, Maticka-Tyndale & Rajulton, 2011:532).

It may not be left unsaid that it is becoming increasingly difficult to assist young people to control their sexual behaviour in a society where choices leading to reduced infection with HIV/AIDS are not encouraged by young people’s peers or wider societal values (Rau *et al.*, 2010:87; CADRE, 2010:6). Young people thus represent a very vulnerable group of potential HIV/AIDS victims who are increasingly exposed to pornography, media influences and sexual pressure.

2.7.2. AIDS awareness among young people in South Africa

A national survey conducted in South Africa in 2003 yielded conclusive evidence with regard to HIV/AIDS infection among South African young people aged 15-24 years (MacPhail *et al.*, 2009:456). Several aspects are indeed noteworthy. In spite of high HIV/AIDS infection rates among South African youth, many young people are not familiar with their HIV status (MacPhail *et al.*, 2009:456). Knowledge of their HIV/AIDS status is also clearly higher among young females of 20-24 years of age, youth living in cities, those having finished high school, females who have fallen pregnant, males having caused pregnancy, and males of races other than black (MacPhail *et al.*, 2009:458). Other significant factors that influence knowledge of a person's HIV/AIDS status are conversing with parents about the topic, taking part in a love life campaign, and paying a visit to a clinic (MacPhail *et al.*, 2009:456). Youth with less access to medical health care facilities are more ignorant of their HIV/AIDS status and therefore more vulnerable.

In a qualitative study performed among university students in the Eastern Cape, Rau *et al.* (2010) assessed students' perceptions of HIV/AIDS infection in South African society. Rau *et al.* (2010:81-82) noted that students' ideas of risks pertaining to HIV/AIDS were based more on the immediate risks that HIV/AIDS posed for them than on longer term future risks. Social relationships and peer pressure were identified as factors that greatly impact young people's perceptions of HIV/AIDS and associated risks (Rau *et al.*, 2010:82). On the whole, students justified their risky behaviour in terms of the freedom they had attained "*at last*" in order to experiment with the joys of adult life (Rau *et al.*, 2010:82). Rau *et al.* (2010:96) concluded that young people or students "*only believe themselves as much at risk as they believe their peers to be*", and that they feel pretty safe within the social '*bubble*' their small university town offers them. This shows that cultural, traditional and environmental aspects may be just as important in the spread of HIV/AIDS among South African young people as perceptions and cognitions of individuals (Tenkorang *et al.*, 2011:525). Intervention programmes that are to increase HIV/AIDS awareness and challenge existing behaviour patterns will therefore have to focus on agency factors as well as structural aspects (Tenkorang *et al.*, 2011:525).

2.7.3. Reasons why South African youth refrain from HIV/AIDS testing

Interestingly, and maybe surprisingly, 60% of the South African youth desire to know their HIV/AIDS status (Pettifor, Rees, Steffenson, Hlongwa-Madikizela, MacPhail & Vermaak, 2004). One should therefore rightly look for reasons why they refrain from HIV/AIDS testing. MacPhail *et al.* (2009:461) state that young people may be reluctant to go for testing due to "*lack of perceived vulnerability, beliefs that testing is unnecessary while still healthy, negative beliefs*

about health care systems, fear of an HIV-positive diagnosis and testing costs” (see also Horizons, 2001). Thus it appears that the fear of social consequences, the assumption that testing is only required once symptoms become obvious, and negative attitudes displayed by health care workers are reasons why South African youngsters do not to go for testing. The fact that the fear of social stigmatisation may play a decisive role in decisions to go for testing procedures or not, strongly emphasizes the need for HIV/AIDS education, not only among young people, but also in most communities in South Africa as a whole.

2.8. TREATMENT OF HIV/AIDS IN SOUTH AFRICA

With the slow progression of effective policies addressing the HIV/AIDS crisis in South Africa, the treatment of HIV/AIDS through retroviral medication was launched at a stage when the disease had already penetrated large parts of the South African population. Treatment, however, is very important as it may significantly improve the quality of life of infected people. The following paragraphs address the importance of HIV/AIDS treatment.

2.8.1. The necessity of voluntary counselling and testing

There is great need for voluntary counselling and testing (VCT) which South African health care facilities endeavour to make available. VCT enables informed decision-making with regard to sexual behaviour and lifestyle choices (MacPhail *et al.*, 2009:456) and should therefore be promoted among young South Africans, especially among rural youth. Positive findings of a study carried out in three countries support the success of VCT. The incidence of unprotected sex with non-primary sexual partners lessened amongst those who had undergone the testing and counselling procedure (MacPhail *et al.*, 2009:456). VCT also seems to be more successful among youngsters testing HIV-positive than among their negative counterparts. VCT may ease the process of gaining access to Antiretroviral Medication (ARVs). Beginning on time with Antiretroviral therapy is important since this leads to fewer demands on clinical resources (MacPhail *et al.*, 2009:456). Increasing VCT opportunities also means that systems have to be in place which make this service accessible. Increased knowledge of HIV/AIDS and its connection with sexual behaviour are basic factors which will encourage the youth to use VCT more frequently and responsibly (MacPhail *et al.*, 2009:457).

2.8.2. Access to antiretroviral medication

According to the South African government, relatively few people in South Africa can obtain Antiretroviral medication (ARVs) due to the expense thereof (Nattrass, 2004). Delobelle *et al.* (2009:1062), state that the public healthcare sector in South Africa only began with the

distribution of ARVs in 2004 (see also Dugger, 2010). Well-timed ARV intervention is imperative and crucial if the quality of life of millions of South Africans infected with HIV/AIDS is to be markedly improved (Steyn, Schneider, Engelbrecht, Janse van Rensburg-Bonthuyzen, Jacobs & van Rensburg, 2009:1). In 2007, 362 sites in South Africa were reported to provide antiretroviral therapy (UNAIDS, 2008a:11). According to UNAIDS (2008a:13), antiretroviral therapy in 2007, was estimated to be 28% among infected men and women in South Africa. Based on UNAIDS and the World Health Organisation (WHO) findings, where an estimated number of 460 000 people were receiving antiretroviral therapy in South Africa in 2007, 1.7 million people were still in need of ARVs at the time (UNAIDS, 2008a:11). According to the National Strategic Plan (NSP), representing a multi-sectoral approach towards the epidemic, support is to be granted to 80% of people infected with HIV/AIDS in South Africa by 2011 (AVERT, 2011). In the light of past failures of HIV/AIDS policies in South Africa, it is questionable whether this goal is realistic since the number of HIV/AIDS infections increases rapidly every year. In the year 2006 alone half a million citizens became infected with HIV/AIDS in South Africa (Delobelle *et al.*, 2009:1062).

2.9. POVERTY AND HIV/AIDS IN SOUTH AFRICA

Almost half (43%) of the South African population lives below the poverty line (Baldauf & Freeman, 2010). According to Hart (2010:2), the previous South African president, Mbeki, blamed poverty for the escalating HIV/AIDS crisis. In this context, it may be mentioned that informal settlements in South Africa display double the number of HIV/AIDS infections than is the case in both rural and urban areas (Hunter, 2010:26, see also Shisana *at al.*, 2002:59). This does not necessarily mean that a positive relationship between HIV/AIDS and poverty has been established beyond all doubt. Data in support of a negative relationship between HIV/AIDS and poverty (Shisana, Rice, Zungu & Zuma, 2010:40) can also be found. The example of Uganda, which focused on abstinence and faithfulness within marriage (Blum, 2004:430) and progressed successfully in its fight against HIV/AIDS (in spite of being a much poorer country than South Africa) can serve as an example.

MacGregor (2009:86) presents us with two views on the relationship between poverty and HIV/AIDS. The one extreme, where poverty is seen as the causative agent of HIV/AIDS contrasted to the other view, where the virus occupies a central place with poor social conditions possibly exacerbating conditions of vulnerability to the disease. The latter statement may imply that people growing up in poverty may be exposed to conditions which increase the risk of being exposed to sexually risky lifestyle choices. It appears that a complex set of variables affect risk-

taking sexual behaviour and that the latter cannot be oversimplified in terms of “poverty is the cause of HIV/AIDS”.

The introduction makes it clear that a complex relationship exists between HIV/AIDS and poverty. A distinction can be made between individual and community-level poverty (Tenkorang *et al.*, 2011:526). According to Tenkorang *et al.* (2011:526) the effect of community-level poverty on risky sexual behaviours is an under-researched topic, which has in the near past been put into use in an effort to understand the rising numbers of HIV/AIDS infections in rural and urban African communities better.

In the following chapter the researcher will attempt to explain how poverty can negatively affect a range of developmental outcomes. Felner (2006:125) is quoted to have said that poverty is one of the great risk factors to youngsters. One factor that correlates with poverty persistently, is teenage pregnancy (Felner, 2006:125). This may point to higher sexual activity or less precautionary measures among poor people. Based on Hunter’s findings (2007) Tenkorang *et al.* (2011:527) conducted a study on sexual risk-taking behaviour among young people in Cape Town. Since HIV rates “*are twice the national average in South Africa’s urban informal settlements*” (Tenkorang *et al.*, 2011:527) the assumption was that people living under conditions of poverty engage more in sexual risk-taking practices than people who are more affluent. The fact that poor communities have limited access to adequate health care facilities, which leads to subsequent poorer health outcomes, should also be borne in mind (Khan, Hotchkiss, Berruti & Hutchinson, 2006).

2.10. CONCLUSION

In this chapter, an overview of the HIV/AIDS epidemic in South Africa has been given. It is clear that in view of the various sectors of society which are threatened by the epidemic a future-directed and co-ordinated effort to fight the disease on all levels of society, is inevitable. Whether we will be successful in fighting HIV/AIDS and providing the most vulnerable people of our society with much-needed aid and support, depends on the willingness of the different parties involved to sacrifice self-interest for the purpose of saving a dying population.