AN INVESTIGATION INTO THE EFFECTIVENESS OF LEADERSHIP IN THE ADMINISTRATION OF HIV/AIDS

By

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PROMOTER: PROF. P F VENTER

DATE: OCTOBER 2004

Certificate of Compliance

To the External Examiner

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DECLARATION

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AN INVESTIGATION INTO THE EFFECTIVENESS OF LEADERSHIP IN THE ADMINISTRATION OF HIV/AIDS

submitted herewith for the Degree PhD (Business Management) at North-West University is my own work, that all the sources used or quoted have been indicated and acknowledged by means of complete references, and that this thesis was not previously submitted by me for a degree at any other university.

H J Botha

October 2004

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SUMMARY

The aim of the study is to analyse the role and the effectiveness of transformational leadership in the administration of HIV/AIDS in the African countries: Botswana, Uganda and South Africa.

The effect of HIV/AIDS in society is so enormous as no cure exists to curb the phenomenal growth of confirmed carriers in order to halt the death toll. The impact of HIV/AIDS on society and the economy is so large that containment programmes and other programmes that aim to mitigate the socio-economic impact of the epidemic require effective and transformational leadership at the most senior levels of government to address the problem comprehensively and successfully.

Transformational leadership is essential in achieving results through effective leadership when faced with values and behaviour that work against the achievement of expected results.

The effective administration of HIV/AIDS was studied in a predetermined period within South Africa, Botswana and Uganda. The period 1 May 1999 to 30 August 2004 was demarcated because it deals with policy from the start of the term of office of President Thabo Mbeki, as well as for comparison purposes. The period ends just after the XV International AIDS Conference in Bangkok, Thailand in July 2004.

Each of the three countries have been evaluated separately through the answers to a list of 14 questions, mostly derived from the address by the United Nations Secretary-General, Kofi Annan, to the XV International Conference on AIDS on 11 July 2004. Mr Annan based his comments on the document Declaration of Commitment on HIV/AIDS, that was accepted at the United Nations General Assembly, Special Session on HIV/AIDS, 27 June 2001.

The national prevalence rate of the infected number of people have stabilised in Botswana and are decreasing in Uganda. It was found that the leadership in Botswana and Uganda are effective in terms of delivering results. In South Africa, however, the

national prevalence rate of the infected number of people is increasing and the leadership has not been effective in terms of delivering results.

It was found that under the leadership of President Festus Mogae in Botswana, and in Uganda under President Yoweri Museveni, both countries were committedly and comprehensively addressing the HIV/AIDS phenomenon and have been successful with the transformation of society in effecting behaviour change. On the other hand, it was found that under the leadership of President Thabo Mbeki in South Africa, the government was not committedly and comprehensively addressing the HIV/AIDS phenomenon and was not concerned with the transformation of society to effect behaviour change.

OPSOMMING

Die doel van die studie is om die rol en die effektiwiteit van transformerende leierskap in die administrasie van HIV/VIGS in die Afrikalande Botswana, Uganda en Suid-Afrika te ontleed.

Die uitwerking van HIV/VIGS in die samelewing is geweldig groot omdat geen geneesmiddel bestaan om die fenomenale groei van bevestigde draers of die sterftetal te stuit nie. Die impak van HIV/VIGS op die samelewing en die ekonomie is so omvangryk dat beheermaatreëls en programme gemik op die versagting van die sosio-ekonomiese impak van die epidemie, effektiewe en transformerende leierskap op die hoogste, regeringsrange vereis om die probleem omvattend en suksesvol aan te spreek.

Transformerende leierskap is in essensie die behaal van resultate deur effektiewe leierskap wanneer dit gekonfronteer word met waardes en gedrag wat indruis teen die verkryging van verwagte resultate.

Die effektiewe administrasie van HIV/VIGS is in 'n afgebakende tydperk in Suid Afrika, Botswana en Uganda bestudeer. Die tydperk 1 Mei 1999 tot 30 Augustus 2004 is afgebaken omdat dit beleid insluit vanaf die aanvang van President Thabo Mbeki se termyn asook vir doeleindes van vergelyking. Hierdie tydperk eindig net na die XV Internationale VIGS Konferensie in Bangkok, Thailand in Julie 2004.

Elk van die drie lande is afsonderlik ge-evalueer aan die hand van antwoorde op 'n lys van 14 vrae, die meeste waarvan ontleen is aan die toespraak van die Verenigde Nasies Sekretaris-Generaal, Kofi Annan, voor die XV Internasionale Konferensie oor VIGS op 11 Julie 2004. Mnr Annan het sy kommentaar gegrond op die dokument "Declaration of Commitment on HIV/AIDS" wat op die Verenigde Nasies Algemene Vergadering se Spesiale Sessie oor HIV/VIGS, op 27 Junie 2004 aanvaar is.

Die heersende nasionale koers van infeksie van getalle mense het in Botswana gestabiliseer en het in Uganda gedaal. In Botswana en Uganda is bevind dat die leierskap effektief was wat betref die lewering van resultate. In Suid-Afrika

daarenteen styg die heersende nasionale koers van die aantal mense met infeksie en is bevind dat die leierskap nie effektief was wat betref die lewering van positiewe resultate nie.

Dit is bevind dat die leierskap in Botswana onder President Festus Mogae en in Uganda onder leiding van President Yoweri Museveni, die HIV/VIGS fenomeen toegewyd en omvattend aangespreek het en dat welslae behaal is met die transformering van die samelewing deurdat gedragsverandering meegebring is. Aan die anderhand is bevind dat die leierskap onder leiding van President Thabo Mbeki, Suid-Afrika nie die HIV/VIGS verskynsel toegewyd en omvattend aangespreek het nie en nie begaan was oor die transformering van die samelewing nie, dit is gedragsverandering is nie meegebring nie.

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CHAPTER 1

INTRODUCTION AND SCOPE OF THE STUDY

1.1 INTRODUCTION

The aim of the study is to analyse the role and the effectiveness of leadership in the administration of HIV/AIDS in the African countries: Botswana, Uganda and South Africa.

Leadership is a major aspect of politics, public administration, military strategy, for-profit and non-profit organisations, organisational behaviour, and industrial and organisational psychology. The theories of leadership will be carefully evaluated and applied in the context of the study.

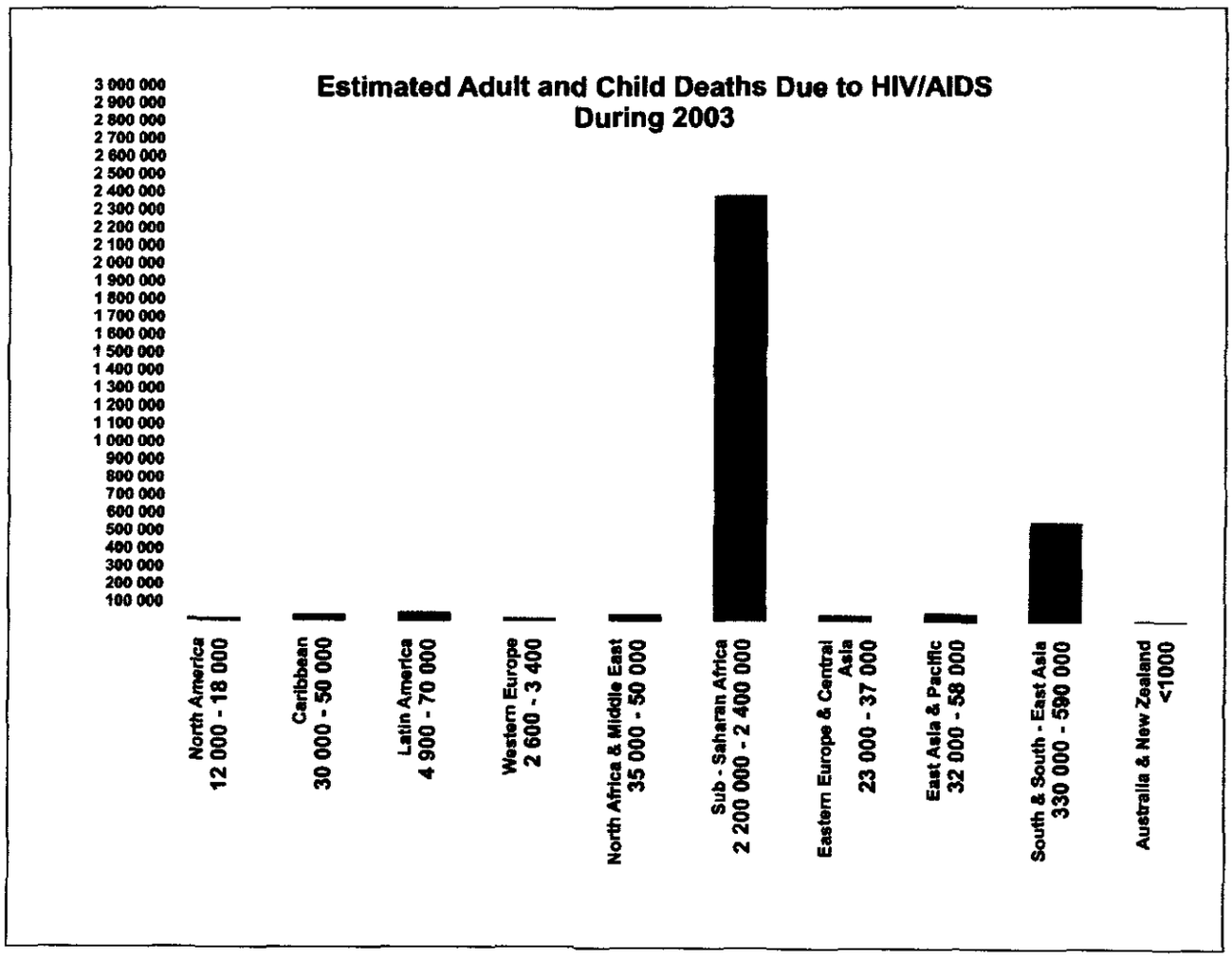
The increasing complexities, needs and constant change within society and the urge for higher levels of performance require effective leadership. Without effective leadership at all levels in private, public and non-profit organisations, it is nearly impossible to sustain effective administration, and to attain goals, and good governance. This also applies to socio-economic and health problems such as the HIV/AIDS epidemic (DuBrin, 2004).

According to international reports HIV/AIDS in sub-Saharan Africa, and specifically in the countries of South Africa and Botswana, have grown to crisis proportions, although senior government spokesmen in South Africa have disregarded its seriousness.

The impact of the HIV/AIDS epidemic globally is expressed in the most recent report released by the United Nations Joint Programme on HIV/AIDS (UNAIDS, 2003a) "Epidemic Update 2003". This report estimates the total number of deaths among adults and children in 2002-2003 at 2,5–3,5 million. The number of deaths are expressed in

figure 1.1 "Number of deaths among adults and children due to HIV/AIDS globally during 2003" below.

Figure 1.1 Number of deaths among adults and children due to HIV/AIDS globally during 2003



Source: Epidemic Update Report (UNAIDS, 2003a)

The extend of the HIV/AIDS phenomenon is expressed in the most recent statistics published by the World Bank (2003) report on the effect of HIV on the economy of South Africa.

- Estimated figure of people infected: 4,8 million
- Estimated figure of people in 1999: 250,000
- Estimated figure of orphans due to the virus: 420,000
- Percentage of people infected with the virus 2003: 11%
- Estimated percentage of people infected with the virus by 2010: 25%
- Estimated figure of orphans due to the virus by 2008: 1,6 million
- Estimate figure of deaths by 2015: 4,4 million

The above statistics are taken from the World Bank (2003) report "The long-run economic costs of AIDS: theory and an application to South Africa".

In South Africa, senior government spokesmen have belittled the impact of these figures. The Minister of Finance Trevor Manual condemned the World Bank report as most unhelpful saying the Bank's modules were a case of "garbage in and garbage out" (Wray, 2003).

The effect of HIV/AIDS on society is so enormous because no cure or vaccine exists to curb the phenomenal growth of confirmed carriers in order to halt the deathtoll. The impact of HIV/AIDS on society and the economy is so large that prevention programmes and programmes that aim to mitigate the socio-economic impact of the epidemic require effective leadership at the most senior levels of government to address the problem comprehensively and successfully by transforming social conduct.

1.2 LITERATURE REVIEW

A detailed study was made to identify the most important sources. These sources have been carefully studied, evaluated and compared to determine the true meanings and values of the relevant information of the sources.

The literature on the subject has also been reviewed. A study thereof provides a better insight into the research problem and the necessary background to guide the research.

Sources studied include theses and dissertations, books, periodicals, authoritative reports of eminent international and local institutions as well as official government publications. The reports and documents of these sources and institutions contain all the relevant and most up to date facts and statistics regarding HIV/AIDS, such as the total figure of infected individuals per country and strategies for managing the impact of the epidemic.

Apart from the information obtained from reports and textbooks, other sources have been consulted in order to obtain the information needed for this particular study. Sources such as journals, articles, magazines, newspapers and the Internet have been consulted. Statistics and other relevant information were also used in the study. Computer searches for relevant material were undertaken in the library of the North-West University, Vaal Triangle Campus and the University of Johannesburg, Aucklandpark Campus.

A few of the major sources of reference on leadership and HIV/AIDS are:

- Bass and Stogdill's Handbook of Leadership, which focuses on the concept of leadership (Bass, 1990). This handbook is a compilation of the most authoritative publications on leadership since the early 20th century. The author suggests that there are at least twelve different intepretations to the definition of leadership. Specifically, they identify the following: (i) Leadership as a focus of group processes; (ii) Leadership as personality and its effects; (iii) Leadership as an act or behaviour; (iv) Leadership as an instrument of goal achievement; (v) Leadership as an emerging effect of interaction; (vi) Leadership as differentiated role; (vii) Leadership as the initiation of structure; (viii) Leadership as the art of inducing compliance; (ix) Leadership as the exercise of influence; (x) Leadership as form of persuasion; (xi) Leadership as a power relationship and; (xii) Leadership as a combination of elements.

- Barnard (2002), The Functions of the Executive. This handbook was developed from a series of lectures at the Lowell Institute in Boston in November and December 1937 under the title "The functions of the executive". Barnard (2002) appears in virtually every bibliography on organisations and leadership.

- AIDS - the greatest leadership challenge: a paper delivered by the government of Uganda (2000e) at the Africa Development Forum in Addis Ababa, Ethiopia in December 2000.

- The policies on HIV/AIDS of the three African governments namely: the Botswana National Policy on HIV/AIDS (Botswana, 1993); the National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1–2005/6 (Uganda, 2000a); and the HIV/AIDS/STD Strategic Plan for South Africa 2000 (South Africa, 2000c).

- The "Declaration of Commitment on HIV/AIDS", set out at the United Nations General Assembly, Special Session on HIV/AIDS, 25-27 June 2001 (UN, 2001), is an important source that refers to the role of leadership. Publications of authoritative international institutions such as the United Nations Joint Programme on HIV/AIDS and its constituent agencies, i.e. World Health Organisation (WHO) and the World Bank were also utilised.

- Other important sources include publications and articles of the Harvard Business School Press and the Harvard Business School Review.

The Harvard Method of source referencing and acknowledgement was used. Footnotes will not appear on the bottom of each page; instead quotations and references are specified directly after the particular quotation of reference.

1.3 BACKGROUND TO THE STUDY

1.3.1 HIV/AIDS

To understand HIV/AIDS an introduction to the disease is required. AIDS stands for Acquired Immune Deficiency Syndrome. The Human Immunodeficiency Virus (HIV) infects cells of the immune system, mainly CD4 cells and macrophages, that are key elements of the cellular immune system, destroying or impairing their function in the process. Progressive HIV infection results in the progressive depletion of the immune system, leading to immune deficiency. The immune system is said to be deficient when it can no longer play its role of: fighting off infections, and keeping cancers and other diseases and viruses becoming life threatening. People with cellular immune deficiency are much more vulnerable to infections such as Pneumocystis carinii pneumonia, toxoplasmosis, systemic and oesophageal candidiasis, generalised herpes zoster, cryptococcal meningitis, and to cancers such as Kaposi's sarcoma. These diseases are very rare amongst people without immune deficiency. Some of these diseases, namely those that are strongly associated with severe immunodeficiency, are called "opportunistic" diseases, because they use the opportunity of a weakened immune system to develop and overrun the normal functioning of the body (UNAIDS, 2003c).

Immune deficiency can also be presented as a consequence of rare inherited diseases, and be acquired through cancer chemotherapy or immunosuppressive therapy in transplant recipients. However, HIV infection is the most common cause of acquired immune deficiency. The symptom complex associated with acquired deficiency of the cellular immune system is called "AIDS" (UNAIDS, 2003c).

Descriptive definitions on HIV and AIDS can now be formulated. HIV is a virus that attacks and destroys the body's immune or defence system against infections and diseases. AIDS is an immune deficiency meaning that the body's immune system is incapable of functioning as a protective barrier against disease.

The rapid spread of HIV/AIDS can be connected to the massive acceleration of communication, the speed with which consumer demands are marketed and being met globally, and the gross inequality that exists within and between societies (Barnett & Whiteside, 2002:4). Inequality and poverty is considered a cause for conflict and the irregular movement of whole populations that contribute toward the spread of the epidemic.

Visible symptoms of the disease only appear after many years, making it easier for people not to accept that HIV will eventually cause AIDS. Then again, the idea of re-examining the evidence regarding the causes of AIDS may provide hope that if a cause other than HIV is identified, a cure might more readily be found.

The Human Immunodeficiency Virus (HIV) has been decisively established as the cause of AIDS. Notwithstanding the evidence, a small, but vocal group continued to question the link between HIV and AIDS. Periodically, this results in media attention and generates some renewed public interest in their views. Most recently there has been controversy in the South African and international media over the South African government's announcement that it would convene an international panel to re-examine the scientific evidence surrounding AIDS. The re-examination process would include pouring over evidence regarding the cause and diagnosis of the disease, although there is more complete understanding of how HIV causes AIDS today than in the 1980's when the disease was diagnosed for the first time. The evidence that HIV causes AIDS is overwhelming. Numerous authoritative laboratory and clinical research, and epidemiological studies have proven this fact (UNAIDS, 2003c), therefore to spend time and valuable resources in re-examining the cause of the disease is wasteful and ignorant and lacks empathy for the people suffering from HIV/AIDS.

The disease is predominantly a sexually transmitted disease. Therefore it mostly causes illness and death among mature adults. The groups at greatest risk are those between 15 and 50 years of age, often referred to as "sexually active". These are the most productive people within a society. The seriousness of the disease is expressed in Barnet and

Whiteside (2002:4): "Despite millennia of epidemics, wars and famine, never before in history have death rates of this magnitude been seen among young adults of both sexes and from all walks of life". In these circumstances it is imperative that governments must be effective in their leadership and policies that the public be mobilised, that sufficient infrastructure be provided and strategies and programmes implemented that can deal with the HIV/AIDS epidemic.

The fight against HIV/AIDS also raises the matter of human rights and the right to access medical treatment. UNAIDS Executive Director, Dr Peter Piot, speaking at the 59th session of the United Nations Commission on Human Rights said the "... goal of realising human rights is fundamental to the global fight against AIDS" (UNAIDS, 2003d).

1.3.2 Leadership

According to Peter F. Drucker (in Hesselbein et al. 1996) there is no such thing as a specific "leadership personality", "leadership style" or "leadership traits". Drucker states that among the most effective leaders studied by him during the last four decades were all unique, however, they shared one quality: effectiveness. They were doers, not preachers.

Transformational leadership is essential in achieving results through effective leadership when faced with values and behaviour that work against the achievement of expected results (Morris, 2003:36).

A case in point is Annie Mulcahy who succeeded against all odds and expectations in turning the Xerox Corporation away from bankruptcy and making it profitable with the promise of a bright future with new products and services. Through her effective leadership she transformed the culture and modus operandi at Xerox to attain results that astonished the markets. "This story here is a minor miracle". Three years ago Xerox had US$ 17,1 billion in debt and US$ 154 million in cash. It was about to begin seven straight quarters of losses. The credit markets had slammed shut. Reorganisation of the sales

force and the billing centres led to wide spread confusion among staff and customers. In 2000 the stock fell from US$ 63,69 a share to US$ 4,43. The company lost 90% of its market capitalisation, and the best and brightest employees were leaving (Morris, 2003:36).

Mulcahy, 47, smart and energetic, had an excellent reputation but not the track record of a potential leader or a Chief Executive Officer (CEO). She had spent 16 of her 24 years at Xerox, in sales. Instead of an MBA, she held a degree in English and Journalism, and had not served on the Xerox board of directors. In May 2000, when the board replaced her predecessor and made her president and CEO nobody was more astonished than Mulcahy herself who was never groomed for a leadership position nor expected to be given the leadership role at Xerox. But she had other qualities, missing in so many leaders today: straight forwardness, strong work ethic, discipline, fierce loyalty, honesty and integrity, compassion, endurance, not afraid of bad news, and a willingness to work shoulder to shoulder with subordinates. These characteristics gave her credibility, effective leadership, which in turn gave her the ability to transform the values and behaviour of her organisation to achieve results (Morris, 2003:36).

Many schools of thought are convinced that effective leadership is required to meet the needs of the population, to formulate and implement processes, to meet the needs of followers, and to overcome organisational and policy challenges (DuBrin, 2004). The specific need of constituents or the type of organisation is not of consequence, be it public, private or non-profit institutions; leadership may be studied from them all (Hesselbein et al., 1996).

As the world has become increasingly complex and unreliable, the rigidity of public, private and non-profit organisations' hierarchies and rule-based systems have provided for more complex reporting structures that are often very fluid, therefore demanding a more flexible and effective leadership style to attain expected results. The single leadership model of today is no longer sufficient but only transformation through effective leadership can bring about real and long-term change of values and behaviour

that is required to achieve sustainable results. According to the circumstances and personalities involved, a typical senior official or executive in order to be effective may need to use any of the defined leadership styles in any one day: coercive, authoritarian, affiliative, participatory, a-pace-setting or coaching style (Dam, 2003:14).

Followers and stakeholders understand that leadership goes beyond the scope of most senior positions. As a consequence they require leaders with appropriate leadership skills to give rise to and positively influence other individuals and groups of people to transform the values of society in order to produce expected results that meet their needs (Burns, 2003).

Society does not require leaders who start out with the question: "What do I want?" Instead society requires leaders that ask: "What needs to be done?", and are intolerant when it comes to performance, standards, values and the achievement of expected results (Hesselbein et al., 1996).

1.3.3 The role of leadership in HIV/AIDS

The need for effective leadership in the administration of HIV/AIDS is paramount. The Executive Director of the United Nations World Food Programme, James Morris, stated that Southern Africa with the greatest level of HIV/AIDS in the world, had been hit with a destructive force that was causing ruin to people's lives and potentially fuelling wide spread social and economic collapse. Mr Morris said not only was HIV/AIDS "... killing millions of people prematurely, it is also wiping out the most productive members of society – farmers, teachers, health workers – leaving millions of orphans, widows, widowers and elderly". As a consequence, decades of development gains have been lost and efforts to reduce poverty and improve living standards have been undermined (Peta, 2003).

In comparison with this statement the South African government does not appear to have the same concern with the situation, for example in the teaching profession. According to

the Council of Education Ministers there was little to be worried about HIV/AIDS, as stated by Prof. Kader Asmal, the then Minister of Education (Sapa, 2003c).

On its own account the Gauteng Provincial Health Department admitted that bad leadership existed and therefore a weak policy on research into the prevalence of HIV/AIDS in the wealthiest province in Africa (Gauteng). The South African National Department of Health conducts an annual antenatal care (ANC) survey to monitor HIV and syphilis infections amongst women attending public antenatal services. It reflects HIV prevalence (accumulated infections amongst women attending ANC) and not just new HIV infections. This is a national survey and results thereof are the best available measure of HIV prevalence in South Africa and also demonstrate changes in infection over time. However, they do not provide a direct measure of HIV infection in the community at large (Gauteng, 2002:33).

Effective leadership that produce results by comprehensively addressing HIV/AIDS through the transformation of social conduct and the downstream socio-economic problems connected with the epidemic is required. People are dying. Children are being orphaned. The elderly are left without care. Severe poverty is worsening. HIV/AIDS marks exclusions that can be found not only across the gross geography of continents, but also in the more subtle geography of social networks and city blocks. It is noticed in the ebb and flow of global and local labour markets, where the quest for work and livelihoods may take on a sexual complexion. With the development of antiretroviral therapies (ARV's), the epidemic defines who is saved and who is left to die from the disease and its impacts. In its distribution across the continents and in relation to access to drugs and prevention programmes that can save lives, it is a global epidemic that defines the excluded of the world and requires effective leaders that are committed to the fight and are focussed on achieving success (Barnett & Whiteside, 2002:4).

It is worthwhile for leaders to become involved in the fight against HIV/AIDS. As more patients receive early medical care, the economic benefits of HIV/AIDS risk management programmes will surge. Not only are the HIV-positive patients, by definition, healthy and

productive, but the costs of caring for these people are significantly lower than the intensive drug treatment and overall patient care costs required by patients living with AIDS. It is estimated that around 90% of all employees living with HIV are still healthy in the asymptomatic, pre-AIDS stages. They must not be ignored if the risk of HIV/AIDS are to be managed effectively both medically and economically. Political leadership and governments need to recognise this fact in order to stop being ignorant toward the existence of HIV/AIDS and the effects of the epidemic and must start taking action to comprehensively address the epidemic, which is the real enemy (Jelley, 2003:8).

1.3.4 African comparisons

Valuable lessons can be learned from the leadership of Uganda in dealing with the HIV/AIDS epidemic. Uganda was the African continent's pioneer in human trials of an AIDS vaccine in 1999. Dr Seth Berkley stated in his address to the Ugandan parliament AIDS committee during the 2003 session that Uganda was not only the first country to test an AIDS vaccine, but also the leader in AIDS prevention in Africa (Keeton, 2003). Dr Berkley is president and chief executive of the International AIDS Vaccine Initiative (IAVI), a non-profit organisation. Uganda is one of the first countries to record a decrease in statistics of HIV/AIDS prevalence.

Other countries in Africa are also achieving successes in AIDS prevention. Botswana is pulling itself back from the HIV/AIDS brink. The ambitious national programme instituted by the government of Botswana to combat AIDS with free antiretroviral drugs (ARV's) could serve as a model for other countries in sub-Saharan Africa. The provision of free medications or ARV's by the bold leadership of the Botswana government has inspired greater dreams and hopes in the hearts and minds of the country's citizens. The fact that antiretroviral therapies merely postpone the inevitable, provides hope that these patients can live long enough to raise their children and continue to be economically active; thereby mitigating the socio-economic effects due to the HIV/AIDS epidemic (Boroughs, 2003:7).

Contrary to the decisions of the leadership in Botswana and Uganda, the political leadership in South Africa, the SA Cabinet, again decided in 2003 to postpone a decision whether a national AIDS treatment plan with free access to antiretroviral drugs was necessary or viable for South Africa (Lackay, 2003:22).

The hesitance of the South African government to initiate a national rollout of ARV's must be viewed in relation to the costs of such a programme. The cost for one year of basic healthcare for an individual living with HIV/AIDS is two to three times more than the average gross domestic product of many countries in Africa (AIDS Action, 2003). Despite this, the costs associated with the provision of ARV's should not be perceived as a barrier to its provision by third world countries (Mullholland, 2003:15).

It should be viewed as criminal to prohibit infected people access to help that can be paid from international subsidies. In 2003 President G. W. Bush pledged US$ 15 billion, mostly new money for fighting HIV/AIDS in Southern Africa and the world. The funds were made available because the American people do not want Africans to die painfully and with catastrophic consequences for those that are left behind. Political leaders and their governments need to wake up and utilise these funds (Mullholland, 2003:15).

A list of 14 questions was compiled based on the comments made by the United Nations Secretary-General, Kofi Annan (2004), in his address to the XV International Conference on AIDS on 11 July 2004. The Secretary-General's comments were based on the "Declaration of Commitment on HIV/AIDS", accepted at the United Nations General Assembly, Special Session on HIV/AIDS, 25-27 June 2001 (UN, 2001). The questions were used by the author to evaluate and compare the government policies and leaders of Botswana, Uganda and South Africa in order to determine the results of their leadership; whether it contributed to an increase, stabilisation or decrease in the number of infected cases.

The results of the policies and leadership in the three African countries Botswana, Uganda and South Africa are compared in the concluding chapter.

1.3.5 Focus of the study

The socio-economic impact that HIV/AIDS will have over the next decade will be a test to the leadership skills of South Africa and many African countries, organisations and their people.

The problem area connected with the socio-economic impact due to HIV/AIDS was also a focus of the study.

This study focuses on the most senior leaders and the leadership they provide through policies for the administration of HIV/AIDS in Botswana, Uganda and South Africa. Government legislation and policies on the subject and other relevant literature concerning leadership and control of the epidemic will be investigated in order to determine what type of leadership is required for attaining results regarding the HIV/AIDS epidemic.

Policies were evaluated and analysed in order to determine whether particular policies driven by political leaders were effective or not. The research evaluated the issue of prevention and if government leadership and policies were effective in the handling and control of HIV/AIDS by addressing behavioural change.

The focus of this study is to determine the impact that transformational leadership and the lack of effective leadership have on the administration of HIV/AIDS in dealing effectively and comprehensively with the epidemic in Botswana, Uganda and South Africa.

1.4 RESEARCH PROBLEMS

The following problem areas in the thesis were addressed.

- The announcements of government policy by official government spokesmen in South Africa left the impression that their understanding of the HIV/AIDS pandemic was that it is of lessor consequence than the authoritative pronouncements by experts in South Africa and abroad indicated it to be.

- To understand the South African situation a comparison of its leadership with that of two other African countries namely, Botswana and Uganda was made.

- Policy on HIV/AIDS in Uganda was published in the National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1–2005/6 and various revised and improved plans issued by the Uganda AIDS Commission (UAC). Policy in Botswana was published in the Botswana National Policy on HIV/AIDS of 1993. Policy on HIV/AIDS in South Africa was published in the White Paper on the transformation of the health system in South Africa; in the HIV/AIDS/STD strategic plan for South Africa 2000-2005; and in Managing the impact of HIV/AIDS in SADC. An analysis and comparison of the implementation of these policies were necessary to determine in what way government implemented its policies and whether the emphasis was on prevention. A further issue concerns the commitment of political leaders, particularly to affect behavioural change.

- Another area of this study is the comparison of the actions and pronouncements of the leaders of the three African countries as well as a comparison with the authoritative reports of the United Nations Joint Programme on AIDS (UNAIDS), and the World Bank. These reports contain data on the epidemic and discuss the requirements for good governance, effective policy and committed leadership as demonstrated in the administration of HIV/AIDS.

- The effectiveness of the leadership and policies can only be measured in terms of their overall results in containing or reducing the growing number of infected persons nationally and whether the leadership has created facilities for prevention and treatment in dealing with the problem successfully. The statistics on infected persons in Botswana, Uganda and South Africa are contained in their national prevalence rates of HIV/AIDS as released and published by each government and UNAIDS. These figures needed to be analysed and tabulated in order to compare and evaluate the countries.

- The sources are reports, by the South African government, research institutions and non-governmental organisations as well as reports by the United Nations, the World Bank and the governments of Botswana and Uganda. These sources were analysed and compared to come to a better understanding of the performance of each country's leadership.

1.5 PURPOSE OF THE STUDY

The purpose is to evaluate South Africa's leadership and policies on the HIV/AIDS crisis as compared to other countries in Africa. For this purpose, two other African countries were selected, namely Botswana and Uganda.

The reason they were selected is their difference. Botswana's population of approximately 1,6 million is much smaller than Uganda with a population of approximately 23 million. One is north of the equator and the other close to the tropic of Capricorn. See figure 1.2 "Map of Africa".

The purpose of the study is to investigate the effectiveness of leadership in each country in achieving improvement in combating HIV/AIDS through the transformation of

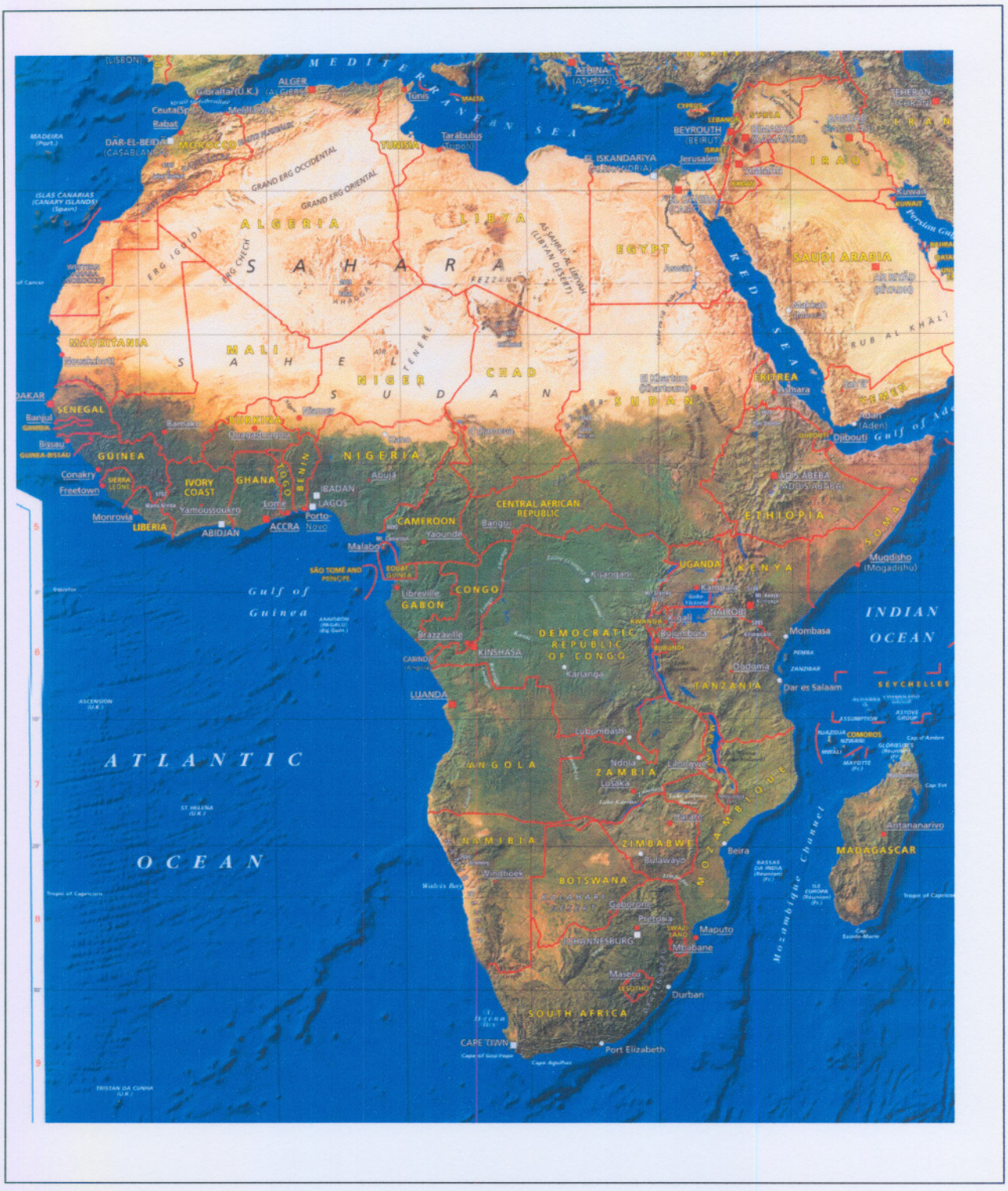
society. In this regard the leadership demonstrated by the most senior government leaders, the presidents and their cabinet members was studied.

The leaders' announcements on policy and the HIV/AIDS epidemic were analysed and evaluated to determine whether they recognised and addressed the HIV/AIDS problem correctly and to its full extent and whether they intended a cultural shift (change of behaviour) in society.

From the findings of the comparative study and the analysis of policies and the role of leadership it was possible to establish to what extent the South African leaders have been successful or not in dealing with the HIV/AIDS epidemic.

Figure 1.2 follows on the next page.

Figure 1.2 Map of Africa



Source: Atlas of the World (Readers Digest, 1990)

1.6 OBJECTIVES OF THE STUDY

1.6.1 Primary objectives

The primary objectives of the study are to investigate the effectiveness of leadership in the administration of HIV/AIDS.

- Is leadership actually effective in terms of delivering results? Are the national prevalence rates of the infected number of people increasing or decreasing?

- Is leadership addressing the HIV/AIDS phenomenon in such a manner that it deals positively and comprehensively with the transformation of society?

1.6.2 Secondary objectives

The attainment of the following secondary objectives is important to support the achievement of the primary objectives.

- To come to an understanding of the socio-economic responsibilities of leaders due to the HIV/AIDS epidemic.

- To investigate policies and leadership relating to HIV/AIDS in Botswana, Uganda and South Africa in order to compare the differences in leadership and the degree of effectiveness thereof.

- To ascertain whether leadership has been clear and unambiguous in its role and pronouncements of the HIV/AIDS pandemic.

1.6.3 Hypotheses

The research problem was translated into hypotheses. Hypotheses assist the researcher in providing answers to the research problem.

In this study two hypotheses have been formulated.

- **The null hypothesis (Ho):** Effective leadership is demonstrated in the successful administration of HIV/AIDS through the transformation of social conduct.

- **The alternative hypothesis (Ha):** Effective leadership is lacking in the administration of HIV/AIDS as seen in the unsuccessful transformation of social conduct.

1.7 RESEARCH METHOD

This research is based on the investigation of HIV/AIDS, leadership and policy, and a comparative study of the role of the leaders and their policies concerning HIV/AIDS in the three African countries Botswana, Uganda and South Africa.

This study differs from the case study approach in a workplace environment. In this study the issue is analyses on a national level and it focuses on the role of national leaders namely the President and his Cabinet. It proved unrealistic to place the President in a position where he had to answer a questionnaire on his own policies.

Research by questionnaire and interviews was found to be problematic as an in depth study covering a period of four to five years was done and the results from numerous research reports provided the necessary data.

Empirical research was not undertaken to compile statistical data as local and international reports were extremely comprehensive and detailed. The numerous reports from authoritative institutions in South Africa and from the World Bank and United Nations were found sufficient in providing current data on the subject. These figures were tabulated and intepreted.

Structured interviews were done with a select number of respondents to test the validity of the questions and answers in evaluating each of the three African country's leadership.

1.7.1 Databases

The following databases were consulted to ascertain the availability of study material for the purposes of this research:

(i) Catalogue of theses and dissertations of South African universities;
(ii) Catalogue of books: Ferdinand Postma Library (NWU Vaal Triangle campus);
(iii) Catalogue of books: University of Johannesburg Library (Aucklandpark campus)
(iv) NRF: Nexus;
(v) Index to South African Periodicals (ISAP);
(vi) Amazon Inc. database: www.amazon.com;
(vii) Harvard Business Review Online: www.hbrweb.org; and
(viii) United Nations and World Bank databases of reports and publications.

1.7.2 Procedure

A comparative study of the leaders' pronouncements on policy on HIV/AIDS and of the policy and it's implementation in the three African countries Botswana, Uganda and South Africa provides the research data which justifies the research findings of this study.

The following procedure was followed.

- A literature study was done to determine the origin, epidemiology and socio-economic impact of the HIV/AIDS epidemic, as well as the role of leadership and relevant policy. The latests figures were tabulated and discussed, namely the prevalence rate in each of the three African countries according to the groups: adults and children combined, adults (15-49 years of age), women (15-49 years of age) and children (0-14 years of age).

- A list of 14 questions was formulated to evaluate and compare the government policies and leadership in Botswana, Uganda and South Africa in order to determine the results of their leadership; whether it contributed to an increase, stabilisation or decrease in the number of infections. The comments by the Secretary-General of the United Nations, Kofi Annan, on political leaders' commitment and transformation of society are addressed.

- The answers to the list of questions on the three African countries were used in drawing a comparison of the leaders in Botswana, Uganda and South Africa

- Structured interviews were conducted with a select number of repondents to determine the validity of the questions and evaluations of the leadership of the three African countries.

- All data and theories were analysed objectively and analytically.

1.8 DEMARCATIONS AND LIMITATIONS OF THE STUDY

Different theories on leadership exist. The true nature of leadership is difficult to define. Leadership as a phenomenon is to be distinguished from management in the sense that management could be described as more formal and scientific. Management relies on such skills as planning, budgeting and controlling. Leadership is described as an art and a

personality trait. It is having a vision of what the organisation can become and how the needs of followers and stakeholders can be met (Kotter, 1990; DuBrin, 2004). The focus is on effective leadership and its results through transformation of behavioural conduct.

In this study transformational leadership is regarded essential in achieving results because a drastic improvement in the HIV/AIDS prevalence rate can only be realised through behavioural change in society.

The effective administration of HIV/AIDS was studied in a predetermined period in South Africa, Botswana and Uganda. The period 1 May 1999 to 30 August 2004 was demarcated to cover policy from the start of President Thabo Mbeki's term of office, and for comparison purposes. The period ends just after the XV International AIDS Conference in Bangkok, Thailand in July 2004.

The focus of the research has been on official policy documents, reports, statistics and publications, as well as statements by the leaders themselves that reflect their viewpoints and how they handled the problem of HIV/AIDS.

A clarification of the term administration in the context of this study is required. The term administration in this study refers to the handling of HIV/AIDS at the most senior level of government and is not to be construed as a concept of governance at an institutional level such as departments of the public service or a hospital.

1.9 OUTLINE OF THE STUDY

The research study consists of eight chapters. The content is summarised as follows.

Chapter 1: Introduction and scope of the study

Chapter 1 comprises the introductory section of the study and a review of relevant literature. The importance and the purpose of the study are clearly stated. The objectives of the study are formulated to focus the research on attaining the goals. Reference is made to the procedure to be followed in conducting the research and to certain limitations that may have an influence on the outcome of this particular study.

Chapter 2: Background on the HIV/AIDS phenomenon

The impact of globalisation on diseases is explained in order to assist with the explanation of the origin, recognition and epidemiology of HIV/AIDS, and to form a foundation to understand the impact of the epidemic.

Chapter 3: The socio-economic impact due to HIV/AIDS

In this chapter the socio-economic impact due to the HIV/AIDS epidemic is investigated with specific emphasis on the social groups structure: households and communities, women, the elderly and orphans. It also serves as identification of the fields in which leadership has to formulate policy and make decisions.

Chapter 4: Leadership

A survey of the history, meaning, importance and the theory of transformational leadership is undertaken in order to define effective leadership that produces results. Leadership and management are investigated as separate concepts to distinguish the difference in nature in order to describe leadership more clearly.

Chapter 5: An investigation of policies and leadership relating to HIV/AIDS in Botswana

The government policies and the leadership of President Festus Mogae are investigated. The conclusion contains the final figures (at end 2003) of HIV-infections, to determine the results of leadership; whether it contributed to an increase, stabilisation or decrease in the number of infected cases. A summary is made on the comments in Kofi Annan's address to the XV International Conference on AIDS, 11 July 2004. The United Nations Secretary-General's comments are based on the "Declaration of Commitment on HIV/AIDS", accepted at the United Nations General Assembly, Special Session on HIV/AIDS, 25-27 June 2001.

Chapter 6: An investigation of policies and leadership relating to HIV/AIDS in Uganda

The government policies and leadership of the Ugandan president fall within the period of office of President Yoweri Museveni. The conclusion is an update of the final figures (at end 2003) of HIV-infections, to determine the results of leadership; whether it contributed to an increase, stabilisation or decrease in the number of infected cases. A summary is made based on the comments made in Kofi Annan's address to the XV International Conference on AIDS, 11 July 2004. The United Nations Secretary-General's comments are based on the "Declaration of Commitment on HIV/AIDS", accepted at the United Nations General Assembly, Special Session on HIV/AIDS, 25-27 June 2001.

Chapter 7: An investigation of policies and leadership relating to HIV/AIDS in South Africa

The government policies and leadership of the South African president under investigation fall within the period of office of President Thabo Mbeki. The conclusion is an update of the final figures (at end 2003) of HIV-infections to determine the results of

leadership; whether it contributed to an increase, stabilisation or decrease in the number of infected cases. A summary is made based on the comments made in Kofi Annan's address to the XV International Conference on AIDS, 11 July 2004. The Secretary-General's comments are based on the "Declaration of Commitment on HIV/AIDS", accepted at the United Nations General Assembly, Special Session on HIV/AIDS, 25-27 June 2001 (UN, 2001).

Chapter 8: Conclusion

The conclusion is based on the role of leadership in terms of the results and specifically addressing the socio-economic impact and behaviour change to halt the epidemic and decrease the number of new HIV-infections. In this chapter the attainment of the objectives of the research are discussed. The answers to the list of questions taken from the summaries at the end of each chapter on the three African countries, are utilised in drawing a comparison of the leadership in the three countries, namely Botswana, Uganda and South Africa. Reference is also made to specific limitations as well as opportunities for further research.

1.10 ABBREVIATIONS

Abbreviations consist of ordinary contractions, letter groups and acronyms. Abbreviations used in this study are presented in alphabetical order and include the following.

ABC	HIV/AIDS Prevention Policy: A – abstain; B – be faithful; C – use condoms
ACP	AIDS Control Progamme
AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress

ANC	Antenatal Care
ARV	Antiretoriviral Therapies
AU	Africa Union
CBO	Community Based Organisation
CEO	Chief Executive Officer
CG11	Eleven Core Group of Members
CHAI	Community HIV/AIDS Initiative
COED	Concise Oxford English Dictionary
COMESA	Common Market for Eastern and Southern Africa
DOH	Department of Health
DPSM	Directorate of Public Service Management
DRC	Democratic Republic of Congo
EAC	East African Community
EI	Education International
FAO	Food and Agricultural Organisation
FBO	Faith Based Organisation
GDP	Gross Domestic Product
GLIA	Great Lakes Initiative on AIDS
GNP	Gross National Product
GPA	Global Programme on HIV/AIDS
GRID	Gay-Related Immune Deficiency Syndrome
GRIP	Greater Nelspruit Rape Intervention Project
HAART	Highly Active Antiretroviral Therapy

HIV	Human Immunodeficiency Virus
HRW	Human Rights Watch
HSRC	Human Sciences Research Council
HST	Health Systems Trust
IAVI	International AIDS Vaccine Initiative
IEC	Information, Education and Communications
IGADD	Inter-Governmental Authority on Drought and Development
ILO	International Labour Organisation
IODSA	Institute for Directors of Southern Africa
ISS	Institute of Security Studies
KAPB	Knowledge, Attitude and Practices Behaviour interventions
LC	Local Council
MACA	Multisectoral Approach to the Control of AIDS
MASA	National Antiretroviral Programme
MBA	Master of Business Administration
MCC	Medicines Control Council
MEC	Member of Executive Council
MOH	Ministry of Health
MRC	Medical Research Council
MTCT	Mother-to-child Transmission
MTP	Medium Term Plan for the Prevention and Control of HIV/AIDS
NAC	National AIDS Commission
NACA	National AIDS Coordinating Agency

NACOSA	National AIDS Co-ordinating Committee of South Africa
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organisation
NWU	North-West University
NRM	National Resitance Movement
OECD	Organisation for Economic Cooperation and Development
PEAP	Poverty Eradication Action Plan
PEP	Postexposure Prophylaxis
PHA	People Having AIDS
PHCD	Primary Health Care Department
PLWA	People/Persons Living With AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PRB	Population Reference Bureau
PTA	Kagera Basin Authority Preferential Trade Authority
R&D	Research and Development
RHRU	Reproductive Health Research Unit
SA	South Africa
SABCOHA	South African Business Coalition on HIV/AIDS
SABS	South African Bureau of Standards
SACLA	South African Church Leadership Assembly
SADC	Southern Africa Development Community
SADTU	South African Democratic Teachers Union
SAMJ	South African Medical Journal

SANAC	South African National AIDS Council
SANDF	South African National Defence Force
SAPS	South African Police Service
SME	Small and Medium Enterprises
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TASO	Treatment AIDS Organisation
TB	Tuberculosis
UAC	Uganda AIDS Commission
UASA	United Association of South Africa (trade union)
UN	United Nations
UNAFREC	United Nations Africa Recovery
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNU	United Nations University
US	United States of America
USAID	United States Agency for International Development
USCDC	United Stated Centre for Disease Control

VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WFP	World Food Programme

1.11 SYMBOLS

Symbols used within this thesis include the following.

,	comma
+	positive
-	negative
>	larger than
<	smaller than
$	Dollars
R	Rands

1.12 GENERAL

- Appendixes are attached to the back of this thesis.
- The Harvard method for source references was used.
- If reference has been made only to the year of publication, emphasis has been placed on the general impression or impressions of the author(s).
- Where no sources are mentioned it refers to own research.
- In this thesis figures and tables have been placed on the relevant pages.
- The questionnaire is provided as an appendix at the back of the thesis.

CHAPTER 2

BACKGROUND TO THE HIV/AIDS PHENOMENON

2.1 INTRODUCTION

The primary aim of this chapter is to do a background study of the HIV/AIDS phenomenon to bring greater understanding of the problem, and to create a foundation for an explanation of the socio-economic impact caused by the epidemic, discussed in chapter 3. Chapter 2 also provides a factual framework to analyse the role of leaders confronted by these issues.

In order to draw a comparison of the HIV/AIDS epidemic in the three African countries of Botswana, Uganda and South Africa, a background of the HIV/AIDS epidemic worldwide is of value to comprehend the impact of the epidemic. It is important to understand how and where the virus originated and why it spread so rapidly throughout the world with no consideration for race, sex, creed or income group and with no geographic boundaries specific to the virus. The United Nations has recognised the global importance and possible economic and social impact that HIV/AIDS may have and therefore assigned the HIV/AIDS epidemic the first permanent management function dedicated to one epidemic within the organisation namely, the Joint United Nations Programme on HIV/AIDS (UNAIDS).

The following section provides a background to, and explains the impact of globalisation on diseases.

2.2 INTRODUCTION TO DISEASES

Communicable diseases have been the primary cause for past epidemics and pandemics globally.

The practical impact of a communicable disease can be described under four headings: (i) Sporadic. This applies to a single episode of infection either in an individual or a small group like a family, as with yellow fever. It is a potential source of an epidemic. (ii) Endemic. This indicates that the infection is continuously present in a specific geographical location, because the population has been exposed to this agent from birth onwards. A natural balance exists between the organism and the host such as malaria. (iii) Epidemic. This implies the occurrence of a group of illnesses or an outbreak of similar nature which is in excess of the normal expectancy for that population group and which is derived from a common source. (iv) Pandemic. This describes epidemics of worldwide proportions, such as influenza in 1918 and HIV/AIDS today (Cook, 1988:2).

Diseases played an important role in human history because there were few defences against them. The spread of disease and the medicalisation of the world have sprung from global trade. Medicalisation as described in Watts (1997:xiii) was lay people's acceptance of medical doctors as their first line of defence against illnesses and disease, as opposed to their earlier acceptance of family remedies and advice from passing travellers. Europe's first move towards establishing global trade was undertaken by the Portuguese and Spanish in the fifteenth century.

Portuguese sailors rounded the Cape of Good Hope and crossed the Arabian Sea to establish a fortified trading base at Goa, on the West Coast of India. From Goa they crossed the Bay of Bengal and established a network of connections in Malacca (Malaya), Macao (China), Nagasaki (Japan) and in Manila (Philippines) and to the New World (the Americas): Portugal conquered Brazil and the Spaniards conquered Mexico and the rest of South America. Hence, by 1550 the Portuguese and Spanish were unique among the nations of Europe in having controlled a commercial empire that extended

across the globe. This was followed in the next 200 years by the Dutch, French and English and was the beginnings of mass consumerism and global trade. The European drivers of global trade and consumerism ensured that the processes required for the sustainability thereof such as raw materials, labour and credit, kept turning over and brought under its influence more and more of the world's people. A direct consequence of trade and consumerism is globalisation: wherein all nations of the planet are free to trade their goods and receive payment therefore with any nation in need of trade or goods (Fritze, 2002).

Among the unintended consequences of global trade and consumerism was the creation of disease networks along side the trade networks such as those established by the Portuguese. Before the fateful crossing of the Atlantic in 1492 by the Spanish expedition led by Christopher Columbus, none of the epidemic diseases such as the bubonic plaque, leprosy, smallpox or cholera existed in the New World (Watts, 1997:xiv).

The bubonic plaque (also referred to as the Black Death) with its roots in Central Asia, spread from the Mediterranean ports of southern Europe in 1347 and changed the course of European, and that of world history. During the period 1347 to 1351, the outbreak of the Black Death in Europe, mortality varied between 12,5-33% of the total population. It is estimated that some 24 million Europeans died - three out of every 10 people (Watts, 1997:1). Some historians argued that the consequent labour scarcity led to technical, social and religious innovation, and ultimately to the creation of capitalism.

Today, most historians accept the plaque's role in destroying feudal barriers to economic growth, and creating an instant demand for labour, which had to be satisfied from a drastically reduced workforce. In effect, the fourteenth century bubonic plaque intensified the action of powerful structural forces, which were turning Europe toward modernity (McGrew, 1985:40).

While Europe was affected by epidemics, they also devastated other regions of the world. From the middle of the last millennium contact between Europe, the Americas, Australia

and parts of Africa proved disastrous for indigenous populations whom due to their distance had no previous occasion or need to develop immunities against European diseases. Lacking defences against common European diseases such as smallpox, typhus, measles and influenza, these indigenous populations fell ill faster and diseases became more virulent. Diseases spread with great ease and the mortality rate was very high. The result of this was massive depopulation. Whole people were carried off while other groups were so seriously depleted as to have been written out of history (Watts, 1997).

Documentation of this process begins with Columbus's landfall on the Caribbean Island of Hispaniola. In 1492 at the time of his arrival, the Taino people counted at least a million. A disease liken to smallpox appeared in 1519 and by 1550 the Tiano were extinct (Watts, 1997:88). This pattern of devastation was repeated throughout the Caribbean islands. The Aztec and Inca kingdoms of mainland South and Central America were to be affected next. The troops of the Spanish conquistador Hernan Cortes brought smallpox. It is estimated that the population of Mexico fell from 25,2 million in 1518 to 1,1 million in 1605. Similarly affected were the Inca to the south and Native American populations to the north. In the north, Spanish explorers encountered a vibrant culture with towns and temples in the Mississippi valley. By the early 1700's these vanished along with most of the indigenous people.

Numerous authors have chartered the role of disease in human history. The perspectives of Diamond (1999) and Watts (1997) are both that diseases must be seen as part of a broader geographical determinism such as the pursuit of global trade.

By the end of the nineteenth century the principles of disease transmission were generally accepted in Europe. The first well-known public health intervention started in 1854 when Dr John Snow tracked the source of an outbreak of cholera in London to a water pump in Broad Street. Closing the public pump brought the outbreak under control. However, it was not until 1883 that Robert Koch identified the cholera bacillus. The first identified "germs" or disease-causing organism were the bacilli of anthrax and tuberculosis discovered by Louis Pasteur in the 1870's. In the second half of the nineteenth century a

flurry of activity often associated with expansion of European interests led to the identification of more "germs" and linked them with specific diseases (Watts, 1997). As a result scientifically based public health interventions began.

Among these was the Yellow Fever Commission funded by the United States of America, which in 1900 identified the mosquito as the vector of disease transmission. In Havana, Cuba anti-mosquito measures reduced the number of cases from 1,400 in 1900 to zero in 1902. Other public health interventions were also being developed and mostly gave the impression of being successful (Watts, 1997).

Medical advances lead to the development of vaccines initially for polio, and by the 1960's for most other major childhood illnesses. Global smallpox vaccination resulted in eradication of the virus and the last naturally acquired case of the disease was reported in Somalia in October 1977 (Watts, 1997:120). By the mid-twentieth century, drug and vaccine development suggested to many that the world might be entering a period when the battle against infectious diseases could be won. The next challenge was viral diseases.

Prior to the emergence of HIV/AIDS, the last global epidemic had been influenza in 1918-1919: this played out so long ago and during a time when there was little organisational specific memory of global epidemics. During this period the healthy world also had little memory of killer epidemics. Poliomyelitis ceased to be a major concern with the introduction of a vaccine in 1955. Between 1946-1955 on average of 32,890 cases per year and 1,742 deaths were reported in the United States. After the introduction of vaccination the number of cases fell to 5,749 and deaths to 268. In the rich world preventable diseases are generally prevented. Most people have clean water, heat, acceptable housing, nutritious diets and access to health care. The diseases that kill the rich are diseases of affluence such as heart disease. Outside the industrialised world there have been major successes in immunisation against childhood diseases, although a large number of children are still not reached and subsequently die (Barnett & Whiteside, 2002:26).

Where epidemics do emerge, scientific and medical responses are mobilised and emergencies are contained. However, all is not well. Public health systems are under-funded: politically they attract few votes, and in certain parts of the world they are close to collapse. Currently, there is only a mere hint of any system of good public health.

In the United States of America it is estimated that 40,000,000 people from a population of 260,000,000 live without health care protection (2000 and 2004 Presidential Campaign issue). In South Africa the provincial hospitals in the province of Gauteng are in such financial crises that they are only allowed to provide emergency services to patients (Pretorius, 2003:3). According to a report issued by the regional commission of the World Health Organisation (WHO) hospitals in Africa are not meeting the needs of the continent's people and are deteriorating with regard to the scope and quality of health care they provide. The report also states that hospitals lack equipment, drugs and consumables and in addition, negative attitudes, unprofessional behaviour and a high turnover of practitioners have compromised the provision of services. The availability of health workers such as physicians ranges from 4-56 per 100,000 of the population and with beds, medical equipment and vehicles often in disrepair. Among the findings in the report are that current "... funding from government is far below the real needs of hospitals, and is exacerbated by unreliable government spending". This has led to the provision of care far below expected standards, resulting in patient dissatisfaction, increasing mortality rates, hospital-acquired infections, unacceptable training standards of incumbents and underdeveloped information systems and research (Sapa, 2003a:6).

Health is not only about confronting individual diseases. A general condition of comfort and good health form part of general social and economic conditions. The 1990's have seen the recognition of many emerging (arising as an effect of complex causes) diseases such as Ebola, Lassa and Marburg fever. More serious are multi-drug resistant (unsuccessful in being constrained) TB, Tuberculosis and antibiotic resistant bacteria.

HIV/AIDS has become apparent because of - and broke out from this milieu. It is the first global epidemic in 60 years and will not be the last. Based on past experience, many

hoped that the solutions would be in quick technical corrections with drugs or possible vaccines. But there has been no medical-scientific solution to date of publication of this thesis. With the exception of its first manifestations in developed countries, this disease is linked to poverty and inequality and the ways that globalisation made these more visible and worse. According to Barnett and Whiteside (2002), the consequences of HIV/AIDS will be felt for many decades, and its origins lie far back in time and deep within the structures of social, economic and cultural life. The epidemic is not just about medicine or even public health. HIV/AIDS is a disease that is altering the history of mankind.

Because of its scale and the international and local concern it evokes, we are confronted with volumes of information that may be overwhelming. Thus, in the last part of chapter 2, the most recent data on HIV/AIDS will be discussed. In the next sections, the origins of HIV/AIDS, how the disease is transmitted and it's particular characteristics, will be discussed.

2.3 THE RECOGNITION OF AIDS AND HIV

On 5 June 1981, the syndrome was first recognised and can be considered as the date an epidemic or rather a pandemic officially begun. June 5, 1981 provides a useful date for the classification of a Year Zero or the medical equivalent of Anno Domini 1. All reported cases that follow Anno Domini 1 can be viewed as part of the recognised worldwide spread of AIDS. Cases prior to Anno Domini 1, that have been classified as caused by AIDS, can be said to have occurred before the epidemic. Andre Nahmias, professor of epidemiology and immunology at Emory University in Atlanta, USA, was the first scientist to have claimed that he had unearthed a positive sample of HIV dated from 1959: from an unidentified African male from Leopoldville in the Congo. This sample was referred to as L70 and was initially taken from a donor in the Congo and frozen for future medical reference (Hooper, 2000:129). The significance of this classification prior to Anno Domini 1 provides scientific proof that HIV/AIDS was in a

state of endemic existence decades before the disease was officially recognised and had become a pandemic.

Doctors in the United States started to detect clusters of very scarce diseases in 1979 and 1980. These included a rare cancer type called KS for Kaposi's Sarcoma and PCP, a rare pneumonia caused by Pneomocystic carinii (a microorganism to which most people have been exposed, but which causes disease in very few people). These people include those with congenital immunodeficieny, and people whose immune systems have been ruined by cancers and leukemias, or intentionally inhibited by the administering of radiotherapy or immunosuppressive drugs during cancer treatments or transplant cases (to ensure that the body accepts the donor parts). None of these aforementioned factors was relevant in any of the first reported cases.

The first record of the phenomenon made public was contained in the well-circulated Morbidity and Mortality Weekly Report (MMWR) of 5 June 1981, published in Atlanta, USA by the Centre for Disease Control (USCDC, 1981). The report contained five cases of PCP, Pheomocystic carinii, and on 3 July reported a clustering of cases of KS, Kaposi's Sarcoma, in New York, USA. Thereafter, the number of cases of both diseases rose at great speed in a short space of time, which was concentrated mainly in and around New York and San Francisco. This assisted scientists to come to the realisation that they were dealing with a new phenomenon. Homosexual men were amongst the first cases and as a result the disease was initially called the Gay-Related Immune Deficiency Syndrome (GRID). Subsequently, cases among other groups followed. Epidemiologists recorded cases among injecting drug users and soon thereafter the syndrome was also identified among haemophiliacs and recipients of blood products, and infants born to mothers who used drugs. This proved that the then unknown causative agent of GRID could be acquired by both sexes, parentally (via the bloodstream) and also transferred perinatally (from mother-to-child). The disease was renamed Acquired Immune Deficiency Syndrome, and deduced to the acronym AIDS (Barnett & Whiteside, 2002).

AIDS: "A" means Acquired and that the virus is not spread through casual contact like flu or chickenpox. To become infected an individual has to have something done or do something to another individual which exposes him or her to the virus; "I" and "D" stand for Immunodeficiency. The virus takes destructive action against an individual's immune system and alters the ability of the immune system to become less able to fight off infections and, ultimately becomes deficient; the "S" is for Syndrome. AIDS is not one disease but occurs and makes itself available for a range of other diseases to take root as the immune system fails. For this reason it is regarded as a syndrome.

The illness was simultaneously recognised in a number of locations outside the United States. In Zambia, Dr Anne Bayley, Professor of Surgery at the University Teaching Hospital in Lusaka, reported a significant rise in the number of Kaposi's Sarcoma (KS), tuberculosis and esophageal candidiasis cases as well as enteropathic conditions such as severe loss of weight. According to Hooper (2000) reports of a significant wave of deaths in the south of Uganda began to reach the Ministry of Health in 1982. The ministry investigated this new disease in the Lake Victoria fishing village of Kansensero and concluded that it was AIDS. Furthermore, similar documented cases gave recognition of the disease in Tanzania, Rwanda and Congo. Evidence of this is from the case of a thirty-four-year old airline secretary from Congo who had flown to Belgium in August 1977 in order to bring her three-month old daughter, who had been suffering from oral candidiasis from birth, to a Belgian hospital. As it turned out, the daughter was readily cured and was later declared HIV-negative. Within a week the mother herself fell sick with fever, fatigue, headache and sinusitis. During the next five months, she baffled her Belgian doctors by developing a staggering range of opportunistic infections, including polyarthralgia, weight loss, oral candidiasis, genital and perianal herpes, generilised cryptococcosis, severe diarrhea, plus four different bacterial infections. Eventually at her own insistence she flew back to Kinshasa, where she died in February 1978. Of course many hundreds of African doctors were well aware that a new disease was killing their patients. However, these frontline health care workers do not write for learned journals such as the Lancet or Science and Nature, so most of the cases and the disease remained unreported (Hooper, 2000).

Outside Africa AIDS cases were identified in all Western countries and in Australia, New Zealand and some Latin American countries, most notably Brazil and Mexico. In retrospect it would appear that Denmark was among the first European countries to experience the syndrome. The symptoms were first diagnosed in a thirty-seven-year old agricultural engineer who died of PCP and arthralgia in September 1980. A forty-nine-year old man who died in the fall of 1981 from PCP was the first known fatality in Britain. However, the European country that provides the earliest evidence of AIDS among gay men is Germany with two reported cases in January of 1979. The first case was of a twenty-one-year old soldier who died of an unusual mycobacterium, M. fortuitum, due to immune deficiency that was not congenital. The second case was of a fifty-two-year old concert violinist who died of multiple-site Kaposi's Sarcoma (KS) and other opportunistic infections including meningitis and Molluscum contagiosum. From 1981 global recognition was given to the syndrome. Clinicians and other medical staff knew by that time what to look for and that it could be given a name. Immediately the question arose where was AIDS first seen: by whom and what it meant. What it meant and how it was represented in the press and the popular consciousness was of the greatest significance for people affected by a disease linking sex, sexuality, death, ethnicity and status (Hooper, 2000).

In this regard, Farmer (1992), stated that it inevitably became a vehicle for stigma. This statement is supported in Hooper (2000:8), who states, one of the greatest "... tragedies of this new and horrible condition is that it all too swiftly brings out the stentorian language of blame and accusation, especially among those who, by their own lights should know better. It became quite quickly clear that GRID is not just a gay disease, and that gay men were merely the unfortunate group among whom the agent first became widely disseminated in the West". Also, Barnett and Whiteside (2002:66) states, that HIV/AIDS "... mixes sex, death, fear and disease in ways that can be interpreted to suit the prejudices and agendas of those controlling particular historical narratives in any specific time or place. Fear of infection all to easily translates into fear of the infected. The disease has been used to stigmatise various out-groups. 'Gay plaque', women sex-

workers, foreigners, 'those people living across the lake', 'those people who are black/Haitian/white/rich', 'non-Han Chinese' and so on. People have used these labels, and many more, to identify those who are to be stigmatised".

Once the new syndrome had been identified, the pace of scientific and epidemiological activity to identify the cause of the disease increased. In 1983 a team lead by French scientist Luc Montagnier from the Pasteur Institute in Paris, France identified the virus, causative agent of AIDS, we now know as HIV-1: Human Immunodeficiency Virus. In 1985, a second Human Immunodeficiency Virus, HIV-2, was identified. This is more difficult to transmit and is slower acting and less virulent than HIV-1. Initially HIV-2 was found in West Africa with the greatest number of infections outside this area in Angola, Mozambique, France and Portugal. In Southern Africa the dominant strain is HIV-1 and, henceforth in this thesis, referred to as HIV (Hooper, 2000).

A virus has been defined by Oldstone (1998:8) as a "... piece of nucleic acid surrounded by bad news". These are genetic materials covered with a coat of protein molecules. They do not have cell walls, are parasitic, and can only replicate by entering host cells. The genetic materials of viruses are commonly known as DNA, or less frequently RNA. Viruses have few genes compared with other organisms: HIV has fewer than 10 genes as does Ebola and measles; smallpox has between 200 and 400 genes. According to Oldstone (1998:9), the smallest bacteria consist of between 5,000 and 10,000 genes. A human has between 30,000 and 80,000 genes (Ridley, 2000:5 in Barnett & Whiteside, 2002:29).

HIV belongs to the family of viruses known as retroviruses, scientifically called Retroviridae. The first retroviruses were only identified in the 1970's. All members of this family have the ability to produce latent infections. HIV is in a virus group called the lentiviruses. These develop over a long period, producing diseases, many of which negatively affect the immune system and/ or the brain (Schoub, 1999). These viruses have a unique enzyme, the reverse transcriptase. Outside the cells they infect, they consist of two strands of RNA. Once they infect cells they make DNA copies of their own RNA

and are able to reproduce. It is this feature as well as the ability of the virus to mutate rapidly which makes it hard to develop pharmaceutical responses.

People are said to be HIV-positive when the HIV antibodies are detected in their blood. In most settings, however, the capability to carry out such sophisticated tests does not exist. So AIDS is defined clinically, i.e. by examining the patient and making an assessment of his or her condition. There are a number of opportunistic infections that take particular advantage of a depleted immune system: some of these are fairly unique to HIV infection such as Tuberculosis (TB) and Pneumonia. Complicating matters further, the new advanced drug therapies make it possible for people to move back from a state of AIDS, when they are very sick, to being HIV positive and able to lead fairly normal lives again (Hooper, 2000; Barnett & Whiteside, 2002). Ms Ntsepe is an example of this.

For Ms Kgalalelo Ntsepe the drugs are working and have allowed her to regain her immunity, put on weight and live a normal life. Ms Ntsepe said that she began treatment in August 2001, "... which was the first time I tested positive." At the time Ms Ntsepe tested, she was confined to bed. She entered the antiretroviral therapy (ARV) programme in Botswana, and now she is a living testimony to other people that participating in the ARV programme is worthwhile (Sapa-IPS, 2003a:7).

2.4 HOW HIV WORKS

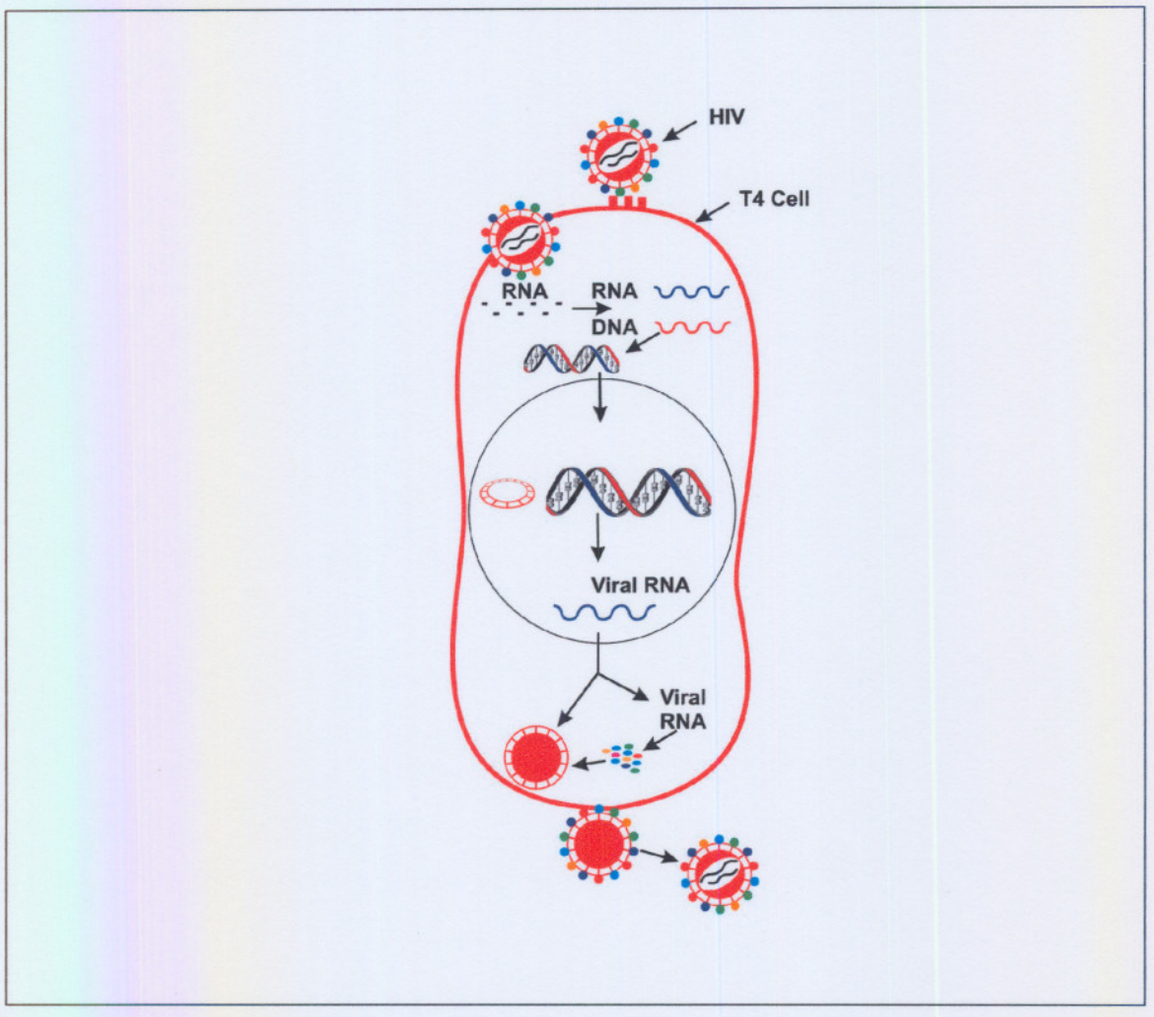
For infection to occur, the virus has to enter the body and attach itself to the host cell. HIV attacks a particular set of cells in the human immune system known as CD4 cells. There are two main types of CD4 cells. The first type is the CD4 positive T-cells that organise the body's overall immune response to foreign bodies and infections. These T helper cells are the prime target of HIV. For a person to become infected, virus particles must enter the body and attach themselves to the CD4 cells. HIV also attacks immune cells called macrophages. Macrophages engulf foreign invaders and ensure that the

body's immune system will recognise them in the future (Whiteside & Sunter, 2000; Barnett & Whiteside, 2002).

Once the virus has penetrated the wall of the CD4 cell it is safe from the immune system because it copies the cell's DNA and therefore the virus cannot be identified and be destroyed by the body's defence mechanisms. Virus particles lurk in the cells until their replication is triggered. Once this happens they make new virus particles that bud from the surface of the host cell in vast numbers, destroying that cell as they do so. These viruses then infect more CD4 cells (Whiteside & Sunter, 2000; Barnett & Whiteside, 2002). See figure 2.1 "The virus in action" for an illustration of how the virus works.

Figure 2.1 follows on the next page.

Figure 2.1 The virus in action



Source: Whiteside and Sunter (2000:7)

When a person is infected, a battle commences between the virus and the immune system. There is an initial burst of activity during which many cells are infected, but the immune system fights back, manufacturing immense numbers of antibodies. This period is marked by an unseen and unfelt war in a person's body. The viral load is high, the immune system is taking a knock, and the person's HIV status cannot be detected using standard tests. This is commonly called "the window period" and lasts from several weeks to several months. At this stage a person is highly infectious, as his or her viral load (the number of viral particles they are carrying) is considerable. This fact is of

epidemiological importance. The more people there are in the early stage of infection, the greater the chance of effective transmission between people (Barnett & Whiteside, 2002:30).

Imagine the damage that can be done in the space of a few days or weeks when HIV is introduced into an unknowing, highly sexed population that, unlike the more conservative segments of society, is not inhibited about sharing partners. To be more precise, people who are having sex with as many partners as possible. Three examples of persons in this category are: (i) military gangs making use of their official status to loot, rape, and murder, furthermore victorious soldiers and relieved civilians celebrating the toppling of a repressive dictator; (ii) wealthy smugglers and the prostitutes who are willing to share their unhealthy habitats for a fee; and (iii) gay men in their bathhouses (Hooper, 2000:50).

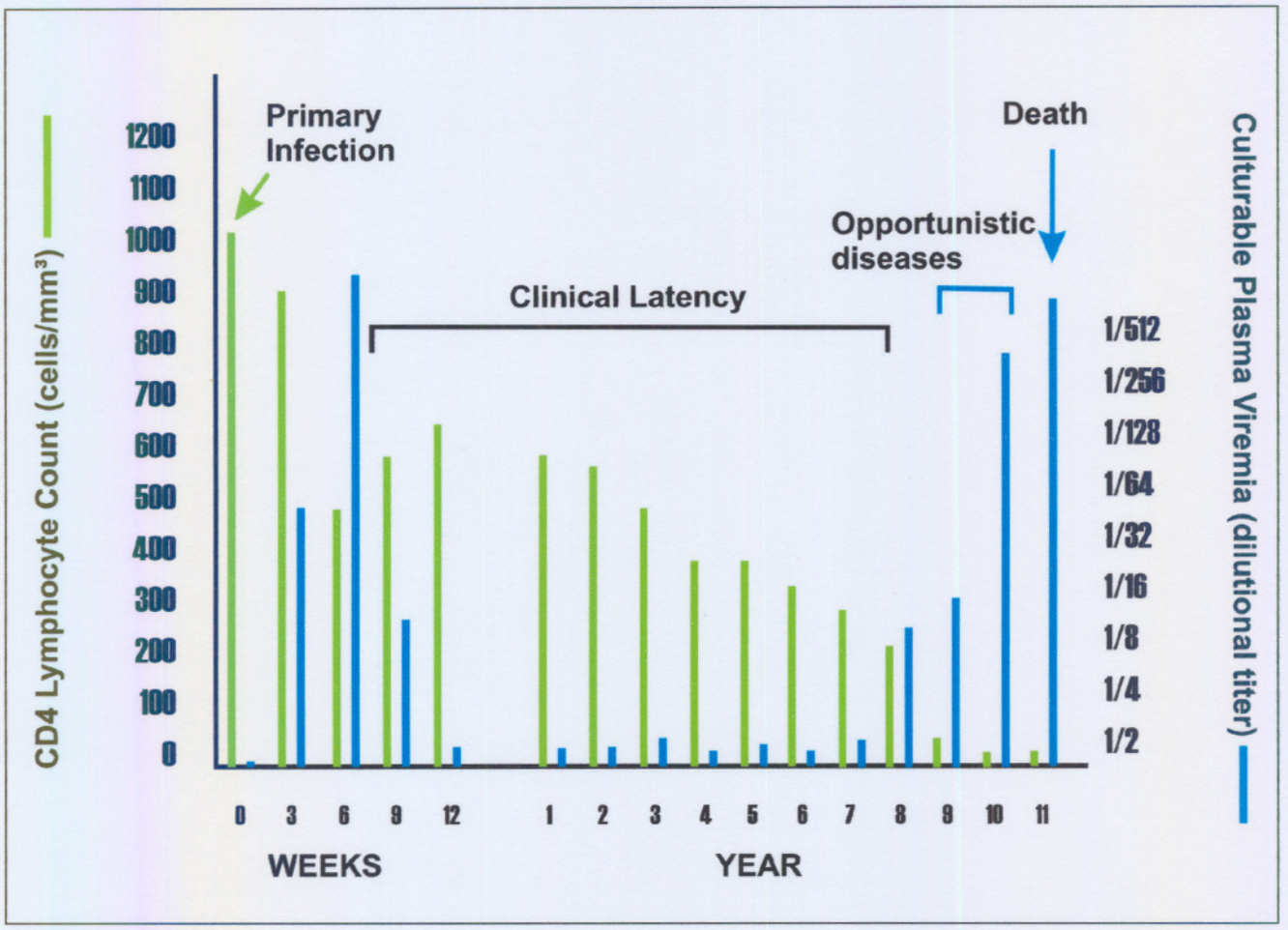
War, rape and AIDS are a deadly trio. In Africa the cycle of war is spreading HIV. A steady stream of reports are being received in the Democratic Republic of Congo (DRC) from hospitals, church health clinics and traditional healers that great numbers of women have been raped by fighters. Health workers state that about half of the women who go to hospitals for treatment are HIV-positive. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Kinshasa and the Ministry of Health about 5% of the population was infected with HIV before the outbreak of the war. It is now estimated to be 20% of the population. In Liberia, less than 1% of the population suffered from HIV before war broke out in 1989. In 1999 about 8% of the population was infected and in 2003 the United States Agency for International Development (USAID) estimated that figure to be 16%. UNAIDS stated that HIV infection in the Angolan military ranges between 40% and 60% versus the general population figure of 3%. Furthermore, it is estimated that in Zimbabwe, 50% of the military is HIV-positive and 25% of the general population. UNAIDS maintained that the war in the DRC has been particularly conducive to the spread of AIDS where fighters from five neighbouring armies brought rising rates of HIV infections along with their weapons (Wax, 2003b:11).

An infected person will usually experience an episode of illness at the end of the window period, but this will often resemble flu and will not be seen as a marker for HIV. A good example of the marker is in the aforementioned case in Hooper (2000) of the twenty-one-year old German soldier who died in January 1979. The soldier first fell ill in October 1977 with ill-defined pains in his abdomen and unexplained weight loss. The window period is followed by the long incubation stage. During the incubation phase, the viruses and the cells that they attacked are reproducing rapidly and are being destroyed as quickly by each other. Up to 5% of the body's CD4 cells, approximately 2,000 million cells may be destroyed each day by the billions of virus particles (Schoub, 1999). Eventually, the virus is able to destroy the immune cells faster than they can be replaced. As infection progresses, the number will fall. When the CD4 cell count falls below 200, opportunistic infections begin to occur and a person is then said to have AIDS. Infections will increase in frequency, severity and duration until the person dies. See figure 2.2 "Viral load and CD4 cell counts over time" for an illustration of this process. These opportunistic infections cause the syndrome referred to as AIDS.

The time span between infection and illness is critical in planning for the social and economic impacts due to the epidemic. Time from infection to illness and from illness to death appears to be linked to the disease environment and the availability of health care.

Figure 2.2 follows on the next page.

Figure 2.2 **Viral load and CD4 cell counts over time**



Source: Whiteside and Sunter (2000:9)

The period from HIV infection to illness and death is thus crucial. It was generally believed that, in the industrialised world, people lived on average 10 years before they began to fall ill. Without treatment of antiretroviral drugs, the normal period from the onset of AIDS to death was thought to be between 12-24 months. The incubation period in the developing world was thought to be between 6-8 years: much shorter than in the industrialised world. This was based on the assumption that people in the poor world had more challenges to their immune systems, poorer nutrition, and less access to health care. It seemed that they would progress to symptomatic AIDS faster.

The period from onset of symptoms to death is shorter in poor countries. In this regard, Hooper (2000:50) stated that studies "... conducted in Uganda and Kenya indicate that the average time of progression from initial to full blown AIDS tends to be much briefer in Africa than in the United States. Less than four years as compared to just fewer than 10, as does the time between the first development of AIDS symptoms and death. This is perhaps because the overall burden of pathogens in tropical Africa is greater than in temperate climates". This view is also supported by French et al., (1999) in Barnett & Whiteside, (2002:33), who argues that patients do not receive early and appropriate treatment which is a daily issue in poor regions where resources are scarce. Another study found that the time from HIV illness to death is shorter for untreated patients in Uganda than in the rich world, and the spectrum of HIV/AIDS related diseases is different. However, the period from infection to illness did not seem to vary.

This suggests that tropical diseases and infections such as TB or sexually transmitted infections do not hasten the progression of HIV to AIDS in Uganda (French et al., 1999: 509 in Barnett & Whiteside, 2002:33). However, of six African studies reported in 1996, four suggested progression rates similar to those in the industrial world, and two found shorter periods. Thus: it can be reasoned that a small amount of knowledge is to date available regarding the rate of progression in African patients from HIV to AIDS where the prognosis appears to be considerably worse than among homosexual men in Western countries. Furthermore, that more research is justified to determine the exact progression rates in developing countries versus the industrialised countries viz a vie the effect infectious diseases such as TB and sexually transmitted infections have. This deduction is supported in both Schoub (1999) and Barnett and Whiteside (2002).

The differences between the poor and rich worlds also apply to the rich and poor worldwide, and come down to the following: people who are able to eat enough nutritious food, who lead stress-free lives and who are not exposed to multiple infections will stay healthy and live longer. This is true generally and does not apply just to those who are HIV infected.

Severe under-nutrition impairs immune functions and thus reduces resistance to infections. Nutritional disorders are common among people living with HIV infection in sub-Saharan Africa. Early in the HIV epidemic, malnutrition in the form of "slim disease" was described among adult populations in Uganda, as is testified in Hooper (2000). The prevalence of wasting or "slim disease" was reported to be 40,3% in adult AIDS patients in Burundi and 44% in HIV-seropositive subjects in an autopsy study in Cote d'Ivoire (Essex et al., 2002:419).

The World Health Organisation (WHO) has collaborated with the Food and Agriculture Organisation (FAO) to formulate a manual on nutrition for people living with HIV/AIDS. The manual indicates that good nutrition cannot cure AIDS or prevent HIV infection, but it can help to maintain and improve the nutritional status of a person with HIV/AIDS and delay progression from HIV to AIDS related diseases. It can therefore improve the quality of life of people living with HIV/AIDS. The FAO, UNAIDS, the World Food Programme (WFP) and WHO are United Nations agencies and international organisations that have highlighted good nutrition as part of a comprehensive response to HIV and AIDS. However, HIV infection throws inequality into even starker relief. In this regard, the World Bank (2000b) report states that extreme "... poverty deprives people of almost all means of managing risk themselves". For the poor, HIV is more likely to be a death sentence than for those who can care for themselves and afford treatment. In Africa more than 290 million people survive on less than one US$ per day (Guest, 2004).

The implications of HIV/AIDS on poverty are well described by South African High Court Judge Edwin Cameron. Judge Cameron disclosed his HIV-positive status during 1999. This revelation forced the South African nation to look at HIV and AIDS in a fresh manner. To celebrate World AIDS Day in 1999, Cameron and other HIV-positive South Africans discussed their personal choice to publicly reveal their status in interviews with the press. Diagnosed with HIV in the early 1980's, Judge Edwin Cameron said he considered disclosing his status in 1997. Unlike many South Africans, Cameron could depend on the support of friends and family, and had little to fear from disclosing his status. He is also protected by his position as a Constitutional Court judge and has access

to drugs and medical care that allow him to remain healthy. Most HIV-positive South Africans do not have these luxuries. Judge Cameron stated that: "Before my statement I felt apprehensive. I think the fact that one is living with a deadly virus is an intensely personal fact. To make a statement about something that could still claim your life is a very precarious thing to do". He continued by stating that there exists "... a great deal of prejudice around and I feared that there would be a negative response. I was apprehensive, but deep within myself I knew that it was the right thing to do" (Cameron, 1999).

Judge Edwin Cameron made the following statement at the XIII International Conference on AIDS: "My presence here embodies the injustices of AIDS in Africa. Amidst the poverty of Africa, I stand before you because I am able to purchase health and vigour. I am here because I can afford to pay for life itself" (Cameron, 2000).

2.5 DETECTING HIV AND AIDS

HIV was difficult to detect because it is a retrovirus, hiding itself in the body's immune system. The first tests detected the antibodies to the virus rather than the virus itself. These might be compared to footprints on a sandy beach: they show a person has been there even though that person cannot be seen. Antibodies show that a person has been and in the case of HIV, is infected. Even today, most screening and diagnostic tests have a high degree of sensitivity. This means that the tests do not miss positive results – if the person is infected the tests will show this and specificity which means that they do not miss negative results. If the person is not infected the tests will not suggest that they are. The most advanced tests have reduced the window period to about three weeks. People are said to be HIV positive when the HIV antibodies are detected in their blood (Barnett & Whiteside, 2002:34).

It is more difficult to define AIDS. In areas where CD4 counts and viral loads can be measured, people are regarded as having AIDS when their CD4 count falls below 200

(Barnett & Whiteside, 2002:34). But in poorer countries where tests are unavailable the problem associated with the spreading of the disease is compounded and a patient is thus said to have AIDS by diagnosing the opportunistic infections associated with the disease. By the time women fall ill with AIDS, they have unknowingly transmitted the disease to their husbands and babies. Ms Bisimwa Gaspard, a nurse at a fetid military hospital in Bukavu, Democratic Republic of Congo, said: "We know it's spreading. To be very honest, it's very much out of control now. What can we do? We don't even have AIDS tests". A patient is thus diagnosed to be HIV-positive due to the opportunistic infections that become untreatable (Wax, 2003b).

2.6 THE ORIGIN OF HIV

Professor Andre Nahmias testifies in Hooper (2000:130) of the importance in identifying the origin of the Human Immunodeficiency Virus and how old the virus is in humans. Prof. Nahmias said this could "... only improve scientific understanding of whether HIV would eventually become attenuated – how long it would take before people could develop resistance to it". Nahmias estimates that without medical intervention it would take 40 generations or 800-1,000 years, before humans were able to co-exit with HIV. From an evolutionary viewpoint it is convincing to reason that: when a virus enters a new host population there is likely to be a wide range of responses to the pathogen, from rapid progression to disease to very slow progression or no disease at all. It is also reasonable to believe that only after some time has passed the host and the pathogen will establish a more stable relationship. Thus it might be that the Rakai-Kagera region in Uganda and the other early epicentres of AIDS including New York, USA, and Port-au-Prince in Haiti are experiencing an especially rapid burst of deaths shortly after HIV entered those communities. In Essex et al., (2002:113), the importance for further research into the role of viral characteristics in the evolutionary chain, is also stressed. The AIDS epidemic attributed to HIV-1 is much more significant when compared to that attributed to HIV-2, despite the fact that both viruses share common modes of entry into humans.

Contrary to the belief that it is important to ascertain the origin of the virus, most clinicians and scientists manage to have a strange reply to questions regarding the origin of the epidemic. "I have not got time to worry about that, I am too busy worrying about where this thing is going, I am too busy trying to save lives to bother about archaeology" (Hooper, 2000:10). This belief, that the search and debate about the origin is of no real value, is also supported in Barnett and Whiteside (2002:38) and earlier in Whiteside and Sunter (2000:7): "When all is said and done, debate about the exact origin of the epidemic is academic. What matters is that the virus has reached mankind and is spreading fast". Furthermore, Professor W. D. Hamilton wrote that the research of Louis Pascal in New York, USA, was forcibly published in Australia as well as the investigations of science journalist Tom Curtis in a popular magazine, the Rolling Stone. The medical fraternity would rather have these articles published on the sidelines than in recognised journals in the United States in order to avoid any follow-up debate. Another aspect of this phenomenon is denial, of which numerous cases are recorded. According to Whiteside and Sunter (2000:3) the link between HIV and AIDS has been questioned in South Africa even though there is no such debate among the majority of scientists. Furthermore, the myth is believed that no evidence exists that HIV is a virus but that it is due to factors of poor living conditions, malnutrition, trauma and stress although the majority of virologists believe the hypothesis about HIV is correct. Newspapers in some African countries now openly acknowledge that for some time AIDS was considered a topic to keep quiet about. "A few years ago there was an unwritten rule not to discuss the presence of AIDS in Zambia", The Times of Zambia, August 1987. "Nigeria has tried its best to wish it away", the Newswatch, March 1987 (Panos Institute, 1986:14).

This is questionable behaviour because establishing how diseases started, where and when, usually is the first step toward understanding how to stop diseases in their tracks. Take the classic example of John Snow in 1854. His innovative development of new epidemiological research methods led to the identification of the origin of the cholera outbreak in London, which caused hundreds of deaths in days. The subsequent closure of the water pump in Broad Street by removing the handle of the pump immediately terminated the epidemic (Watts, 1997:198).

It is important to note that the spread of diseases from animals to humans is not unique to HIV. We know that human diseases also spread to animals but because animals do not have access to science and the media it mostly goes unnoticed. The influenza virus evolved in waterfowl. Virologists described these birds as "reservoirs" of infection. They carry nearly all known types of influenza, with no effects of illness, and spread them to the rest of the animal kingdom through their faeces. Hence, many kinds of animals such as horses, ferrets, seals, pigs as well as human beings can get the flu like symptoms. However, viruses can only infect and take over a cell if it has a proper "receptor". Human cells do not have a receptor enabling them to contract avian flu directly. For human infection to occur another species must act as an intermediary. It can play this role by having a receptor for avian flu and humans in turn having a receptor for its flu. The pig is one such species. The process can be as simple as a flu-contaminated duck dropping its faeces into the dirt in which a pig then rolls. The pig is then infected and passes the virus on to a farmer through physical contact or by sneezing in a close proximity to the farmer. It can also be more complex. It is possible for a pig to be infected with one kind of flu, say human flu, only to contract another avian flu. The pig then has two types of flu simultaneously. When the pig re-infects the human, it passes on a pig-bird-human influenza. For example, the Hong Kong Flu held seven genes from a human virus and one gene from a duck virus: these met inside a pig, producing a new hybrid (Barnett and Whiteside 2002:35).

Another good example is the Severe Acute Respiratory Syndrome (SARS) virus that killed more than 900 people during the first outbreak of the flu-like disease in Asia and Canada during 2003. Dr Gleeson, a senior Australian veterinarian from the Commonwealth Scientific and Industrial Research Organisation, said that from preliminary laboratory testing a number of animal species is under investigation as a possible source for the virus, including the palm civet, raccoon dog, a species of fruit bat and a species of snake in China. The original source of the virus is still unknown, as it is possible that these animals were exposed to the virus in the animal markets. Identifying

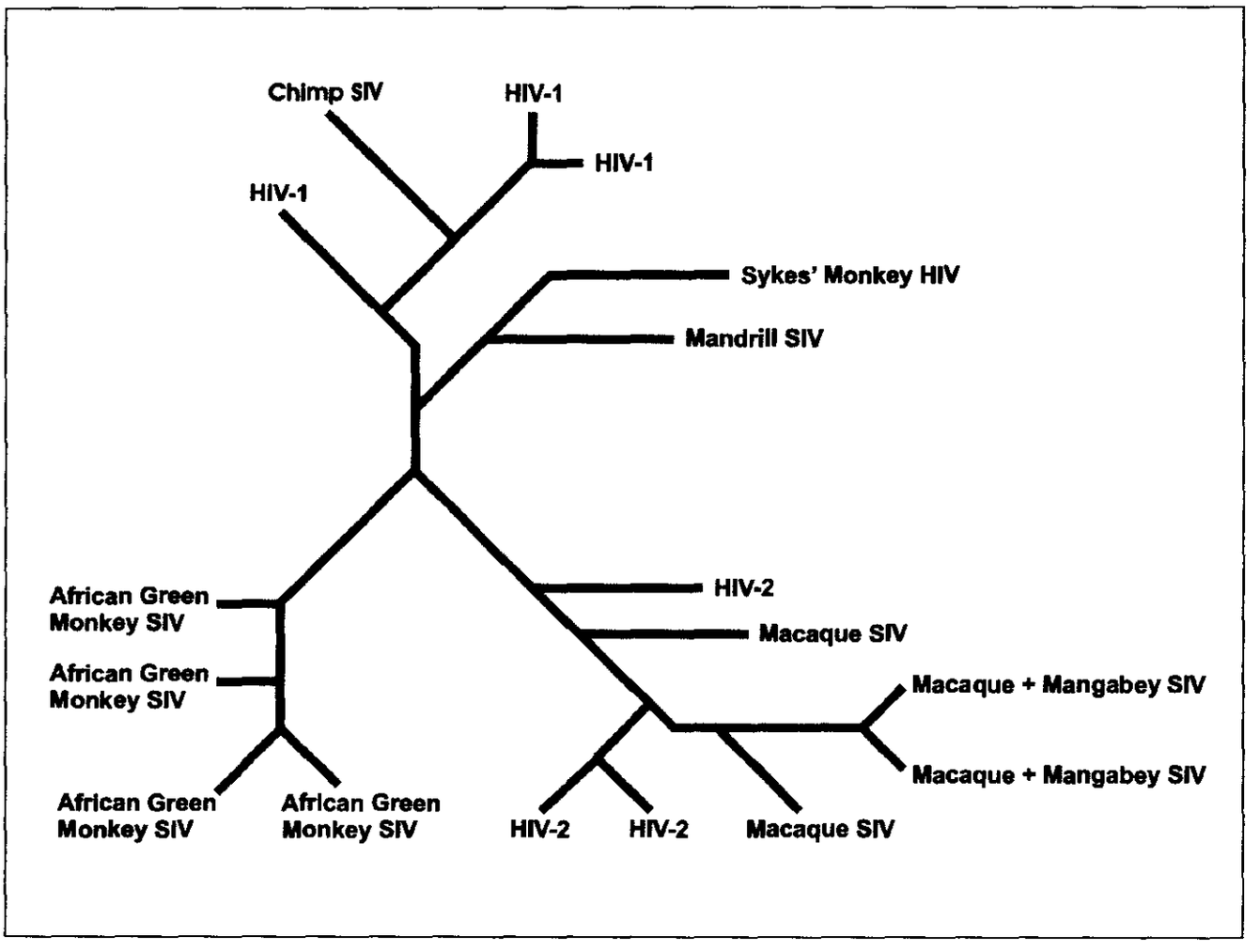
an animal reservoir is of great importance for future prevention measures in China or elsewhere (FAO, 2003).

It is not just different viruses that can combine to create new and possibly more deadly diseases in the host. Viruses, and indeed all diseases, also replicate themselves within the host. This gives rise to variants of the virus within one person. These may in turn recombine to create new variants, some of which may be more virulent or drug resistant as has been discussed in this chapter.

HIV derives from a virus that crossed the species barrier into humans. It is closely related to a number of Simian (monkey) Immunodeficiency Viruses (SIV's) found in Africa. The evolution of the virus is traced through a "family tree". See figure 2.3 "The HIV family tree" for an illustration of the tree. This differs from the more familiar family tree because in order to read it one has to start near the middle. In this case, the proximity of the different types of viruses is an indication of how closely they are related. HIV-1 is clearly related to chimpanzee SIV and HIV-2 to sooty mangabeys SIV (Van Rensburg, 2000:267).

Figure 2.3 follows on the next page.

Figure 2.3 The HIV family tree



Source: Wills (1996)

According to Van Rensburg (2000:268), humans are not the natural hosts of either HIV-1 or HIV-2. We know that at some point the HIV virus entered the blood of humans and then spread from person to person. In West Africa the less virulent HIV-2 spread from macaque monkeys. HIV-1 spread from chimpanzees into humans in Central Africa. Four lines of evidence have been used to substantiate the zoonotic origin of HIV (Van Rensburg 2000:268):

(i) similarities in organisation of the viral genome;

(ii) phylogenic relatedness of a particular HIV strain to that of SIV in the natural host;
(iii) geographical coincidence between the SIV and particular HIV strains; and
(iv) plausible routes of transmission.

Zoonotic diseases can be defined as those diseases and infections of which the causative agent or agents is naturally transmitted between other vertebrates and man. Domestic pets are a significant source of disease. Although more than 100 zoonotic diseases can be acquired from pets, only about 10-20 occur in the United Kingdom. Of the viral zoonoses: rabies undoubtedly causes the most severe disease; this is transmitted not only by dog bites but a whole range of mammals. Herpes simiae is transmitted by bites from macaques, which are mostly asymptomatic (Cook, 1988:9).

Although it has now been established that HIV is a zoonosis and the species from which the virus originally came has apparently been identified, the question as to how HIV entered the human population remains open (Van Rensburg, 2000:268).

It is known that HIV is not an easily transmitted disease. It is carried in body fluids, with the highest concentration in blood, semen and vaginal secretions. For transmission to occur it had to enter the human body and reach the cells that can become infected. It thus had to penetrate the skin or mucosal barriers.

There are seven widely known hypotheses as to how this might have happened. These will be briefly discussed.

(i) Bush meat. It is not hard to imagine a hunter killing or someone butchering an infected monkey and in the process contaminating a cut on his hand with the monkey's blood. Carcasses of chimpanzees, gorillas, monkeys and almost any indigenous animal can be found in African marketplaces. In this case the transfer of the virus from an animal into a human may have happened on a number of previous occasions. However, because on those occasions an infected person did not in turn infect more than one other person, the potential epidemic petered out (Van Rensburg, 2000).

(ii) Contaminated vaccine. Hooper (2000) suggests that experimental polio vaccination campaigns in Central Africa in the 1950's, using vaccine cultivated on the kidneys of chimpanzees, may have provided the opportunity for the virus to cross the species barrier. In this process of mass vaccination campaigns, millions of people could have been infected in a short period of time. Seen against the backdrop of these people becoming more mobile due to the development of their economies (trade networks) and together with the social turmoil and destruction caused by war (the liberation of Uganda by Tanzania during 1978-1979) could have started the pandemic of HIV/AIDS.

(iii) Contaminated needles. The use and re-use of contaminated needles may have contributed to the spread of HIV/AIDS in many African countries. During the French campaign in 1916 to treat sleeping sickness in Central Africa and arm-to-arm smallpox vaccination the re-use of needles was common practice (Van Rensburg, 2000:268). This theory is supported by research released during 2003.

Researchers dropped a bombshell on Africa with regard to the unrestrained spread of HIV/AIDS. The epidemic might not have been fuelled mainly by sexual transmission of the HIV virus, but by unsafe medical injections and blood transfusions, a team of international researchers stated in London, United Kingdom on 20 February 2003.

These findings contradict widely held views about how the virus that causes AIDS spread through Africa, and could have implications for public health measures to fight the disease. Most scientists believe heterosexual sex spreads HIV in up to 90% of adult cases in sub-Saharan Africa, home to 30,000,000 of the 42,000,000 people living with the disease. But a team of eight experts from three countries who reviewed data on HIV infection in Africa estimates that approximately 33,3% of adult cases is sexually transmitted. They stated health care practices, especially contaminated medical injections, are major causes of the unrestricted spread of the disease. "The idea that sex explains 90% of African HIV just does not fit the fact", said David Gisselquist, a Pennsylvania-

based independent consultant and member of the research team. Gisselquist added that they "... need to take a look at the alternate explanations, in particular healthcare transmissions which seems to fit a lot of facts" (Reaney, 2003).

The findings, reported in the International Journal of STD's & AIDS which is a peer-reviewed journal published by the British Royal Society of Medicine, is not accepted by all scientists. Dr Chris Ouma, head of health programmes at the charity ActionAid Kenya, said the idea "... that dirty needles or blood transfusions are the main route for HIV transmission in Africa today, flies in the face of experience on the ground". Dr Ouma added that in Kenya "... medical procedures have largely been made safe but still HIV infections continue to rise". However, Dr George Schmid, of the department of HIV and AIDS at the World Health Organisation (WHO) in Geneva, said it is "... plausible that unsafe medical injections can cause some HIV cases. I think the question is what proportion". Dr Schmid added that he is aware of and concerned about the situation, and does want to work with Gisselquist and others to try and resolve the issues (Reaney, 2003).

In three reviews in the International Journal, HIV specialists including Gisselquist, Francois Vachon of the University of Paris in France, Devon Brewer of the University of Seattle in Washington and others, stated the AIDS epidemic in Africa has not followed the normal pattern of sexually transmitted diseases (STD's). In the 1990's in Zimbabwe, overall STD's decreased by 25% but HIV infections rose by 12% a year despite the increased use of condoms in high-risk groups. The team argued that the virus is more easily transmitted through unsafe injections and tainted blood transfusions than through heterosexual sex. They also said surveys have shown sexual activity in Africa is much the same as in North America and Europe where the HIV and AIDS infection rates are much lower. Studies have also identified HIV positive babies whose mothers are not infected, which the researchers said suggests unsafe injections could be a factor (Reany, 2003).

In this regard, Gisselquist said every year "... there are 100's of millions of unsafe injections in Africa where needles have been used on someone and re-used without

sterilisation". He said a growing "... body of evidence points to unsafe injections and other medical exposures to contaminated blood" as an explanation for the spread of the epidemic (Reaney, 2003).

(iv) Ritual behaviour. It has been suggested that the use of monkey blood in certain rituals and the acts of bestiality might have caused transmission. These hypotheses reflect a high degree of ethnographic ignorance and blame. As no one has described these rituals or given any examples as to where they take place, it cannot be taken seriously (Van Rensburg, 2000).

(v) Conspiracy theories. Some people have suggested that either the CIA in America or the KGB in the former Soviet Union invented HIV to eliminate each other. These theories do not make much sense as it would take generations before the virus could take hold (due to the long incubation period it has to go through) and effect continental wide economic and social damage. In 1986 the former East German scientists Jakob and Lilli Segal circulated a memorandum to the delegates of the Non-Aligned Movement meeting held in Harare, Zimbabwe, in which they elaborated as follows. HIV was in reality genetically engineered and that it was released among prisoners who had become practising homosexuals during their incarceration and that upon their release, it spread to the gay community in New York, America, and from there onwards (Hooper, 2000:153).

(vi) Religious groups. It has been suggested that HIV is a virus inflicted on mankind as punishment for the wicked when in reality HIV is like any other virus except that it attacks the immune system itself. This hypothesis is hard to explain when applied to groups such as new-born babies, haemophiliacs, recipients of blood products and the monogamous partners of men, who in turn have multiple partners, all of whom are most undeserving victims. This hypothesis is based on religion rather than scientific reasoning (Hooper, 2000).

(vii) Colonial influences. Finally, the arguments above may explain how the virus crossed into humankind but they do not explain its rapid spread. The most probable theory has its beginnings with the colonisation of Africa by European empires about 150 years ago. The colonisers had a disruptive influence on the social, political and ecological structures of the continent. Many thousand of workers were forced to work as miners, housemaids, and in various civil engineering projects. Truck and railway routes were put in place while complete forests where cut down and people were forced away from subsistence rural farming communities towards urban centres. Here large squatter areas arose. There could have been a small group or groups of infected persons among isolated peoples for many years in some parts of Africa. But what was different about the crossing of the species barrier in the 1930's and the subsequent pattern of the epidemic was the chaotic environment into which the virus was introduced. Thus, previously isolated people moved to newly expanding cities. It is estimated that the population of Kinshasa, Congo increased 10 times between 1905 and 1940 and again between 1940 and 1961 (Hooper, 2000).

The state of great disturbance and uncertainty associated with forced resettlement and low cost labour, disrupted traditional sexual practices and networks. Labour camps and hostels were created where thousands of men stayed. This encouraged prostitution as men lived apart from their families for long stretches of time (Van Rensburg, 2000:268). The same applied in turn to the women and children who were left alone at home for extended periods of time.

AIDS stalks poor children living in urban areas. According to UN-Habitat Africa the spread of HIV/AIDS among children is more pronounced in Africa's informal settlements than in its more affluent suburbs. Mr Alione Badiane, the regional director, states that poor families were often forced to live in cramped and squalid conditions, increasing the chances of rape. In this regard, Mr Badiane said the "... impact of HIV in these settlements is higher than in any other place. Young girls are often left alone at home while parents go to work, and these girls become victims of violent crimes". Director Badiane continued by highlighting that these children could not attend school

Even though HIV has been isolated from saliva and tears, there is no evidence that these fluids can transmit the virus. Similarly, there is no proof that HIV is transmitted by casual contact such as touching hands or coughing (UN & WHO, 1990:26). Table 2.1 "Probability of HIV-1 infection per exposure" describes the probability rates for infection of HIV per mode of transmission.

Table 2.1 Probability of HIV-1 infection per exposure

MODE OF TRANSMISSION	INFECTIONS PER 1,000 EXPOSURES
Female-to-male, unprotected vaginal sex	0,33-1
Male-to-female, unprotected vaginal sex	1-2
Male-to-male, unprotected anal sex	5-30
Needle stick	3
Mother-to-child transmission	130-480
Exposure to contaminated blood products	900-1,000

Source: World Bank (1999:59)

2.7.1 Sexual transmission

The greatest number of HIV infections is the result of sexual transmission. Initially most cases were discovered among homosexual men because the virus was first identified in

this group in the United States of America. Additionally, the chances of infection are higher during unprotected anal intercourse than unprotected vaginal sex. There exists a small chance that HIV can be transmitted through oral sex, especially if a person has abrasions in the mouth or gum disease such as gingivitis. The presence of sexually transmitted diseases (STD's), particularly those involving genital ulcers such as chancroid and syphillis or discharges, and having a number of sexual partners, will greatly increase the odds of HIV infection (UN & WHO, 1990:28). The existence of a STD means that there is more chance of broken skin or membranes allowing the virus to enter the body. Furthermore, the very same cells that the virus is seeking to infect will be concentrated at the site of the STD because these cells are fighting infections (Whiteside & Sunter, 2000:10).

Even though the lack of case notification and national surveillance systems in most developing countries precludes making precise estimates of STD prevalence and incidence, results from numerous epidemiologic studies prove that STD's are a major public health problem in the third world. The World Health Organisation (WHO) estimated in 1995 that more than 333 million new cases of syphilis, gonorrhoea, chlamydia and trichomoniasis occur worldwide each year of which the developing world share a disproportionate number of cases. The estimated annual incidence rates are highest in sub-Saharan Africa, where they range from 12-120 per 1,000 adults aged 15-49 years of age (Essex et al., 2002:232).

2.7.1.1 War and rape

Warring groups in Sudan, the Democratic Republic of Congo and Uganda have raped thousands of women and girls during 2003-2004, putting them in dire danger of contracting AIDS. "Immediate steps can and must be taken by governments and civil societies to stop these attacks on women and girls which increase their vulnerability to HIV", Women's Equity in Access to Care and Treatment (WEACT) said at the XV International AIDS conference in Bangkok, Thailand (Ee Lyn, 2004:6).

According to WEACT there exist an "... immediate need for protection from further rape and sexual torture, access to emergency medical services, including post-exposure prophylactic antiretrovirals, rape counselling as well as food and shelter". Releasing its case studies on various African nations, the organisation said systematic rape by warring groups would seriously exacerbate the AIDS pandemic already destroying the region. In this regard, WEACT executive director, Anne-Christine d'Adesky, said rape is an "...engine of HIV infection" (Ee Lyn, 2004:6).

More than 25 million people live with HIV/AIDS in Africa, 33% of the world total. Rape was widespread in Rwanda when the country was embroiled in genocide in 1994. Of the about 250,000 rape survivors, approximately 67% were living with HIV. According to d'Adesky, this number is expected to rise as more women came forward for testing. However, while systematic rape in Rwanda seemed to have stopped, the same could not be said for the Democratic Republic of Congo (DRC), northern Uganda and Greater Darfur in Sudan. The most recent human rights cases cite girls as young as 3 years old raped in the DRC (Ee Lyn, 2004:6).

Beatrice Were, a Ugandan activist, said people talked about "... medicines, abstinence, the Global Fund at the XV International AIDS Conference, but when we are talking about women and children in conflict, these things mean nothing. She added: "Can you imagine the trauma of a woman who not only gets raped, but who contracts HIV because of that? She has to live with two stigmas - being raped and being HIV- positive" (Ee Lyn, 2004:6).

2.7.2 Mother-to-child transmission

Mother-to-child transmission (MTCT) is after sexual transmission the most important cause of HIV infection. A child can be infected with HIV prenatal, at the time of delivery, or postnatal, through breast-feeding. The most common mode of transmission is

infection at delivery. In Essex et al., (2002:251) it is reported that of all HIV infected children worldwide, 87% are estimated to live in Africa.

According to Whiteside and Sunter (2000:13) the role of breastfeeding is an important issue which deserves to be better clarified. The perplexities are described as follows: on the one hand, formula feeding reduces the risk of MTCT; on the other hand, it increases the risk of children dying of other causes, particularly when they live in poverty. Breast-feeding has been promoted in developing countries for many years as part of child health and survival strategies. There are many problems with formula feeding, including the cost and continuous availability of the product, access to clean water, the means and fuel to boil the water and prepare the feed, and knowledge of how to mix the feed. According to Essex et al., (2002:258) the formula approach also means that women may suffer social stigma and even social isolation which can be life threatening because of their communal interdependence; if they are observed using replacement feed. Recent work suggests that the key to reducing risk is consistency in either breast-feeding or formula feeding an infant. Mixing the two is the most risky approach. Chinnock (1996:15) in Barnett and Whiteside (2002:39) explain this difficulty by saying a baby "... who is fed both breast-milk of an HIV-positive mother and poorly made-up formula feeds is getting the worst of both worlds". The high rates of HIV infection, especially among adolescent African women, assure the continuation of the paediatric HIV epidemic in Africa until Afro-centric strategies to prevent mother-to-child transmission of HIV are developed and effectively implemented.

The design and evaluation of appropriate and effective strategies to prevent Mother-to-child transmission (MTCT) of HIV in Africa requires an understanding of both African and global information on transmission and the risk factors involved. More development and long-term support of a vigorous, active, and sustainable research infrastructure that focuses on African health issues is also needed (Essex et al., 2002:259). One answer to reduce MTCT lie in the use of antiretroviral drugs. These drugs decrease the viral load and inhibit viral reproduction in the infant, thus decreasing the risk of MTCT.

2.7.3 Infection through blood and blood products

Use of contaminated blood or blood products are the most effective ways of transmitting the virus as it introduces the virus directly into the bloodstream. This is the main reason why so many haemophiliacs were infected in the early years of the epidemic: they received unchecked blood products. It also accounts for early infections among recipients of blood transfusions. Fortunately, in most countries, the risks of transmission through this route are now minimal. Blood banks seek to discourage those who might be infected from donating blood, and technology is available to test all donations. However, because of the window period when people are infected but the antibodies are not detectable, the risk of infection cannot be entirely eliminated (Whiteside & Sunter, 2000:13). The problem is greatest where donors sell blood, this was the driving force of the epidemic in a number of Asian countries. Blood products that are known to transmit infection are whole blood, blood cellular components, plasma and clotting agents (UN & WHO, 1990:29)

Preventing infection through blood transfusion depends on checking all donations and discouraging potentially infected donors from donating their blood. Occupational exposure can be reduced through adopting universally accepted precautions regarding safety and sterility. In the event that a health care worker is exposed, immediate treatment with antiretroviral therapy can greatly reduce the risk of infection. In the case of injecting drug users, simple procedures such as the use of sterilised needles and needle exchange programmes have been very successful (Whiteside & Sunter, 2000:17).

2.7.4 Intravenous drug users

According to Whiteside and Sunter (2000:14), drug users "... who share needles are at high risk of infection. If the equipment or drugs are contaminated, the virus will be introduced directly into the body". This has driven the epidemic in Eastern Europe, the former Soviet Union and parts of Asia. Since the practice of intravenous drug use is

virtually absent in Africa, its importance in the dynamics of HIV transmission is not of great concern in sub-Saharan Africa yet (UN & WHO, 1990:29).

2.7.5 Other modes of transmission

Possibilities do exist that HIV may be passed on in other ways. Medical or other instruments that are contaminated can transmit the virus. Examples include dental equipment, syringes and tattoo needles. Sterilisation procedures should ensure that this does not happen. Accidents through needlestick injury or during surgery are a concern for medical staff. Standard precautions such as the use of gloves and sterilising of equipment, will protect doctors and nurses against HIV transmission from patients, and vice versa (Whiteside & Sunter, 2000:16).

Similar findings that correspond with all of the above modes of transmission are reported in the World Bank (1999:17) report "Confronting AIDS: Public priorities in a global epidemic".

2.8 RESPONSE TO THE DISEASE

First prize with any disease is most certainly the ability to prevent it. If prevention programmes had been successful, there would be no news of the impact HIV/AIDS had, to write about other than the fact that it exists. Unfortunately prevention programmes is the only response available to halt the disease.

2.8.1 Prevention

The cornerstone of successful prevention policies ensure that people are not exposed to the disease or, if they are, that they are not susceptible to infection.

The impact of HIV on Africa has been highly destructive, due to sexual practices and behaviour. The large number of people currently infected with HIV means that its impact will inevitably worsen in coming decades. However, the lessons learned from the successful responses to this disease, which have resulted in reductions in HIV prevalence in Uganda, demonstrate that it is possible to reduce the spread of the epidemic and to mitigate its impact. To achieve this requires comprehensive responses from responsible government leaders that take account not only of the different phases of the epidemic but the complex social, population, and biologic dynamics that determine the course of the epidemic (Essex et al., 2002: 211).

2.8.2 Preventing sexual transmission

Intercourse is on the whole the cause of most of the transmission; therefore prevention strategies addressing this mode are most important.

One of the first responses to the epidemic was to call for the isolation of HIV infected people. This is an impractical, oppressive and discriminatory way of addressing the epidemic, even though it can be highly successful. During the 1980's in Cuba the authorities tested the entire population, cutting off those found to be HIV-positive by placing them in sanatoriums. This action has contributed to Cuba's low level of HIV infection and the virus not reaching pandemic proportions. At the end of 1997, it was estimated that there were only 1,400 infected Cubans (UNAIDS, Pan American Health Organisation & WHO, 1998). However, for this approach to work, a high degree of governmental control is necessary. People entering the country that might be infected and/or spread the disease have to be tested, and there has to be strict border control. In addition, there needs to be a programme of regular testing. This has not been an option for most countries and certainly not for poorer democratic countries. Apart from the expense and difficulty of implementing such a programme, some argue that it constitutes a violation of human rights (Whiteside & Sunter, 2000:18).

The scientific evidence of the role of STD's in contributing to sexual transmission of HIV supports the reasoning for the control of STD as a strategy to reduce further expansion of the epidemic in Africa (Essex et al., 2002:245). In the prevention of sexual transmission a limited but potentially effective range of interventions is distinguished. The first set of interventions is "biomedical"; it aims to reduce sexual transmission of the virus. Good sexual health is of the utmost importance. This means that STD's should be treated immediately, and the availability of STD treatment in the developed world has probably played a decisive role in controlling HIV. Sexual practices that increase risk can be discouraged or made safer: a Southern Africa example is "dry sex" where a woman may use a drying agent in her vagina to increase friction during sex. This exercise increases the risk of tears and abrasions, and can therefore facilitate the entry of the virus. The Filipino practice of inserting small metal balls into the penis, also in the belief it will increase pleasure, can create a gateway for infection (Barnett & Whiteside, 2002:41). In Essex at al., (2002: 245) the aspect of genital hygienic practices in women and their male partners may also be important risk factors to consider and therefore it justifies more research to define the contribution of these practices in facilitating transmission.

The most effective intervention seeks to prevent exposure to HIV by altering sexual behaviour: these are the Knowledge, Attitude and Practices Behaviour (KAPB) interventions. First, people need to gain the knowledge, then they need to change their attitudes and finally change their practices and behaviour. People are encouraged to keep to one partner, to delay first sexual intercourse, and to use condoms if they have more than one partner. This is the policy of ABC: A – abstain; B – be faithful (behaviour change); C – to use a condom if necessary (Barnett & Whiteside, 2002:42).

The effects of behavioural change on HIV prevalence are best demonstrated amongst the younger population groups. In Zambia, for example, HIV prevalence for women under 20 attending antenatal clinics in Lusaka declined from 27% in 1993 to 17% by 1998 and outside major urban areas the rate has declined from 14% in 1994 to 6% in 1999 (Essex et al., 2002). In Uganda the policy of ABC assisted in the overall change of the epidemic where the HIV prevalence in pregnant women has fallen for eight consecutive years,

from a high of 29,5% in 1992 to 11,25% in 2000. The policy of ABC was propagated country wide right down to village level (Essex et al., 2002).

The most available biomedical intervention is the use of condoms. These provide a barrier to the virus and, if properly used, are effective. Both male and female condoms are available, but female condoms are more expensive and more difficult to use. Therefore, a description of "how do condoms work and how does it protect people against HIV" is required.

HIV can be hindered from going from person to person when good quality condoms are used constantly. A condom is a thin rubber (latex) sheath that fits over an erect penis and it collects the discharged semen. The virus cannot pass through the latex. If condoms are used properly, consistently, and are approved by a credible standards body like the South African Bureau of Standards (SABS), it provides close to 100% protection. A condom acts as a tough extra skin, and the virus or any other sexually transmitted diseases cannot penetrate it. Millions of people all over the world choose to use condoms. They choose them to serve three purposes: (i) for family planning, so they can enjoy sex but prevent pregnancy; (ii) to enjoy sex, confident that they are protecting themselves and their partner from STD's; and (iii) to make the enjoyment of sex last longer (BBC World Service, 2003).

2.8.3 Treatment

Diseases caused by viruses can be relatively harmless, like the common cold, or deadly like smallpox. Twenty-three years after the first diagnosis in the United States, there is still no cure for AIDS. But treatment is improving, and consists mainly of fighting symptoms of the opportunistic infections that take advantage of the patient's damaged immune system such as pneumonia, fungal infection, tuberculosis, cancer and diarrhoea.

Tuberculosis (TB) is one disease of particular public health concern that has been greatly affected by HIV infection in Africa. Incidence of TB has risen sharply wherever HIV has

become endemic. Data from Burundi, the Central African Republic, Tanzania and Zambia show that the prevalence of TB has at least doubled in recent years. This has to be seen against a general background of high TB infection in Southern Africa. The annual incidence here in 1998 was 254 per 100,000 people, whilst in Europe it is 19; in China, 113; and in India, 187. Immunodeficiency induced by HIV is thought to lead to reactivation of latent infection with Mycobacterium tuberculosis and may be the force behind the resurgence of TB. Reported HIV seroprevalence rates among TB patients in Africa now range from between 12% and 55%, with most studies finding rates between 30% and 50%. The incidence of TB among people with HIV has been estimated at 4% per year, which is 30 to 40 times higher than that in HIV-negative people. TB control is hampered among HIV-positive patients, which is primarily attributed to the overwhelming effects that opportunistic infections have (Essex et al., 2002:211). But when the treatment of opportunistic infections stops, the same or a different infection eventually returns. A substance that destroys the virus without poisoning the patient would be the ideal drug treating AIDS, but even this would not be a cure if HIV had already destroyed part of an individual's immune system. In this case, curing the patient would require repairing the damage and restoring the immune system functioning as normal.

Enormous resources have gone into the search for a cure and a vaccine. Neither has yet been developed. However, there have been major advances in clinical treatment. Developments in treatment have resulted in declining mortality rates from HIV. There are three stages in the treatment of HIV positive people. The first is when they are infected, but CD4 cell counts are high. At this point, the emphasis is on living positively; staying healthy, eating healthy foods, exercising regularly and so on. The second stage is when the CD4 cell count begins to drop. At this stage, prophylactic treatment to prevent TB and other common infections commences. The third stage is the use of antiretroviral drugs to fight HIV directly and this can be introduced when the CD4 cell count drops below 350 (Whiteside & Sunter, 2000:21).

Two reasons exist why there are no antiretroviral drugs that permanently rid the body of HIV: (i) because HIV hides in the cells of the body it infects. To kill it, a drug will also probably kill these cells and in the process damage the patient's immune system even more; (ii) the virus can infect brain cells, where most antiretroviral drugs cannot follow, because they are filtered out by the blood-brain barrier. It is extremely difficult to design a drug that will enter the brain and kill the HIV without damaging the brain itself (Panos Institute, 1986:20).

A number of studies of the use of antiretroviral drugs have shown that the chance of mother-to-child transmission (MTCT) can be greatly reduced at a relatively low cost and using fairly simple treatment regimes such as Retrovir. These drugs have all shown real potential in having the ability to interfere with or halt MTCT. The most promising one is Retrovir, which can penetrate the blood-brain barrier, and it was formerly known as azidothymidine (AZT) (Cook, 1988:191). AZT has been around since the 1960's, when it was developed to combat cancer and is made from thymidine, a substance extracted from the sperm of herring and salmon (Panos Institute, 1986:21).

Antiretroviral drugs slow the production of HIV and give an infected person's body a chance to build up the CD4 cell count. As previously stated, the CD4 is a cell that fights infections and HIV targets this cell. Healthy children have up to 1,500 CD4 cells and adults about 1,000. In HIV-positive people, a low CD4 count for children are less than 500 and 250 for adults. A CD4 test measures the amount of these cells in the blood. The strength of the immune system is a good predictor of how the body will fight infections. As soon as a person is diagnosed with HIV, they are not automatically put on a course of medication. Depending on their CD4 count, it could be years before they need antiretroviral therapy. When an infected person's health begins to wane, medication is prescribed (Centre for AIDS Development Research Evaluation, 2003).

With the development of effective antiretroviral therapies, infected people can expect to live a fairly good life for longer even though they remain infected. However, recent evidence suggests that viral resistance to these drugs is growing. One in ten people who

test positive for HIV in Europe are infected with a mutation of the virus that is resistant to antiretroviral drugs. Europe's levels of resistance are thus equal to those in the United States. Joep Lange, Director of the International Antiviral Therapy Evaluation Centre in Amsterdam, Holland, is recorded as saying that this now limits the number of drugs available to treat patients from the beginning stages of infection. Dr Peter Mugyenyi, Director of the Joint Clinical Research Centre in Kampala, Uganda, indicated that the Centre in Kampala has detected less than 50 out of 10,000 patients in Uganda with drug-resistant HIV strains, but predicted the number will increase as more and more people gain access to the drugs. Resistance develops faster when patients take the wrong doses or swallow the pills irregularly, giving the virus an opportunity to survive and mutate (Wendo & Agencies 2003:34). If this phenomenon continues it's unusual trend, then the threat from the epidemic is as great in the future as it is in the present, unless an effort is made to transform social conduct through behaviour change. This change in behaviour is referred to as the policy of ABC: abstinence, remaining faithfull to one partner (behaviour change), and to use condoms when necessary (Barnett & Whiteside, 2002).

Together with the development and use of antiretroviral drug therapies three new and harmful matters arise to be overcome. Firstly, the HIV virus mutates. There are over 120 sections in the structures of the virus which can mutate. According to Schoub (1999), with hundreds of millions of virus particles being produced daily, it is not difficult to see how readily mutations occur which give rise to a wide range of biological variants even within the same individual. This causes drug resistance and the virus's inability to be constrained. Secondly, as Africa becomes the biggest consumer of antiretroviral drugs, since the continent has the largest number of people with HIV, therefore resistance will inevitably increase as the drugs become widely used, and public leaders will have to plan ahead to deal with resistance with limited resources. Thirdly, if people start to perceive AIDS as a simple, chronic and manageable condition they may be less inclined to readily take precautions against becoming infected.

Since the first antiretroviral drugs were developed, many new generations of drugs have become available. At the moment antiretroviral drugs may be used in single therapies

(just one drug), double therapies (a combination of two drugs) or triple therapies (three drugs). Single drug therapy is not used much because it causes relatively swift mutation of the virus into drug resistant strains. Dual therapy is cheaper than triple therapy, but the antiviral effect is less immediate as the viral load falls slowly and the viral control may be of a limited duration. Highly Active Antiretroviral Therapy (HAART) is any antiretroviral regimen capable of suppressing HIV for many months and perhaps years in a significant number of individuals. Such is the case with triple therapy. It usually involves the use of two reverse transcriptase inhibitors and one protease inhibitor. Although not a cure, such treatments are effective in rapidly reducing the viral load to undetectable levels, thereby prolonging survival (Barnett & Whiteside, 2002: 42).

Timing the introduction of a HAART regimen is of great importance. Early treatment prevents damage to the body caused by high and prolonged viral loads – but it does use up the big guns sooner, which can decrease subsequent options if resistance builds up. Thus it is preferred to step up the treatment gradually commencing with a single drug therapy.

Cost is also a factor (Sunter and Whiteside, 2000:22). The cost of anti-retroviral AIDS treatment in the Western world ranges between US$ 10,000-20,000 per patient per year, although it can go much higher. Effective treatment of HIV/AIDS involves more than merely prescribing drugs: patients need regular consultations testing for viral load and CD4 cell counts and, if treatment fails, testing for drug resistance. All this adds to the costs. The cheapest price on offer for the most advanced triple therapy at the beginning of 2001 was from drug company Cipla Ltd of Bombay who offered to sell drugs for US$ 600 per patient per year to the South African government and US$ 350 to Non Governmental Organisations (NGOs). The difference in cost may be based on whether the cost of observing patents is included or not. This is illustrated by comparing the costs of Flucanzole (used to treat AIDS-related meningitis) in Thailand (which does observe patents), where it costs US$ 18. One study determined that for treatments to be affordable, HAART would need to be available at a monthly cost per person of US$ 10 for Zambia, US$ 20 for Botswana and US$ 45 for Mozambique. These figures assumed

that it would be reasonable to spend 15% of the total health budget to treat 25% of the HIV positive population (Barnett & Whiteside, 2002:44).

In most of the poor countries drugs are not available to treat opportunistic infections or are too expensive. This is not even taking into consideration the cost of antiretroviral drugs. Thus, for the majority of AIDS sufferers all these treatments are out of reach. Furthermore, most countries do not have the infrastructure to deliver the therapies, therefore the primary focus has to be on prevention and the transformation of social conduct through behavioural change (abstinance and faithfullness).

In addition, patient adherence to timetables is a real problem. Barnett and Whiteside (2002:44) describe it as follows: triple drug therapies involve taking 18 pills a day in a particular sequence. The strict adherence to prescribed anti-HIV drug regimens are of critical importance for success in the long run. Missing a single dosage of medication may allow drug concentration in blood and tissues to drop below that needed for full HIV suppression. This decrease allows HIV replication to occur in the optimum environment for selection of drug resistant mutant strains.

2.8.4 Vaccines

Even though HIV prevention strategies can reduce the spread of the virus, and treatment with HAART can prolong the lives of the infected individuals, only a safe, effective and widely available preventive vaccine holds any realistic assurance of restraining the AIDS epidemic in Africa. This can be ascribed to two observations: (i) most prevention programmes are test projects or introductory of nature that mostly reach less than 5% of the eligible population groups; and (ii) none of the effective strategies for preventing, treatment and mitigating the consequences of HIV infection have been fully implemented in any African country. Thus the potential impact of these interventions for preventing infections at the population level is still not quantifiable (Essex et al., 2002:584).

Intensive research is being carried out to develop a vaccine, so far with limited success. More than 15 years have passed since the first efforts, but as yet a vaccine remains elusive. Unfortunately the amount of money spent on researching AIDS vaccines is small, between 300 and 600 million dollars a year and mostly on strains of the virus found in Western Europe and the United States of America (Barnett & Whiteside, 2002:45).

Scientists from the University of Stellenbosch have found in 12% of 360 HIV samples analysed non-C strains of the virus that are most commonly found in South Africa. This has huge implications for the development of AIDS vaccines, because scientists do not know whether a vaccine based on one strain of the virus will be effective against other strains as well. It could mean that they would have to develop a vaccine based on a combination of various strains of HIV (Altenroxel, 2003b:3). These findings could complicate the research process further, by extending the duration and increasing the funding requirements thereof. Therefore, it should be a priority for the public sector to become involved in the vaccine research: since market failure prevents private industry from carrying the financial costs in developing and delivery of an AIDS vaccine alone.

Market failure can be attributed to various factors. One such example is the third worlds inability to purchase and distribute a vaccine at prices that will ensure a good return on investment for the pharmaceutical firms.

The ideal characteristics of an HIV vaccine for use in Africa is described in Essex et al., (2002:586) as follows: (i) to provide protection and be able to stimulate the production of a hard-wearing, functional, protective immune response against all HIV subtypes to which a person might be exposed to, and from all modes of transmission; (ii) must be safe over both the short and long term. The vaccine should be safe for use without prior testing for HIV infection and be safe for use by pregnant girls; (iii) have a long shelf life, demonstrate heat and cold resistance, be simple to administer (preferably orally) and provide long lasting protection with a minimum number of doses (preferably one); (iv) health care professionals should be provided with a marker that enables seroconversion

due to vaccination and seroconversion due to infection to be distinguished rapidly, and easily; (v) the price should be affordable to provide for wide distribution particularly the poorest individuals and; (vi) finally, provide for mass manufacturing and ideally packaged in ready to open and administer formats.

So far we have described the disease and how it works in the body of an individual person. Disease is of social and economic significance. It causes groups of people to become infected, fall ill and die. Here is where HIV/AIDS is unique. The disease is primarily sexually transmitted, therefore it affects prime-age adults, is fatal and it is widespread. It is unusual for this group of prime-age adults (mostly 20-40 year-olds) to be the target of any disease (World Bank, 1999:14). This is why it has profound social and economic consequences. To understand the complete phenomena of this disease, before describing the socio-economic responsibilities and the effectiveness of the leaders and their policies, a thorough understanding is required about the epidemiology of HIV/AIDS and epidemiology in general.

2.9 EPIDEMIOLOGY

Cook (1988:2) defines epidemiology to be the "... study of frequency, distribution and cause of diseases in a population, taking into account factors in the physical and social environment". In Katzenellenbogen et al., (1997) epidemiology is describes as the study of the distribution and determinants of health-related conditions and events in populations, and the application of this study to the control of health problems. Epidemiology examines patterns of disease in aggregate and describes the social and geographical distribution and dynamics of disease.

According to Barnett and Whiteside (2002: 46), there are four reasons why it is not easy to comprehend the epidemiology of HIV/AIDS, they are as follows.

(i) People do not distinguish between HIV and AIDS, therefore the data can be confusing. In many countries as in South Africa it is not compulsory to test for HIV;

and if AIDS was the cause of death, medical professionals rather pronounce it as caused by or due to the opportunistic infection the deceased patient suffered from.

(ii) The data quality is not consistent.

(iii) Data are constructed according to a range of implicit or explicit assumptions.

(iv) Data may be interpreted according to biases which people have which is dependent upon the discipline such as the preference of political or donor bodies.

Data is fundamental in the formulation of effective prevention interventions because it describes where the epidemic is located, how and where it might spread too. Furthermore, to be able to consider the potential social and economic impact of an HIV/AIDS epidemic, we need to know the numbers of people who are infected with the virus, and who and where these infected people are. Predictions can then be made as to how many people will fall ill and die and when this will happen. For example, a ministry of security needs to know what effects the epidemic will have on the availability and training needs of police officers.

Most countries in sub-Saharan African, such as South Africa and Botswana have conducted regular studies for HIV prevalence at antenatal clinics since the 1990's. Antenatal clinic attendees provide a good sample because they are sexually active and they are adults. A major advantage of antenatal clinics, is that blood is routinely taken from women attending these clinics, so a number of standard tests and surveys can be completed, and can be easily repeated. Furthermore, because the data is supplied by the countries themselves it can be stated that: the data used for HIV prevalence from these countries for studies are reliable to a high probability and can be matched to new data, taken on the same basis, annually for further usage (UNAIDS, 2002b).

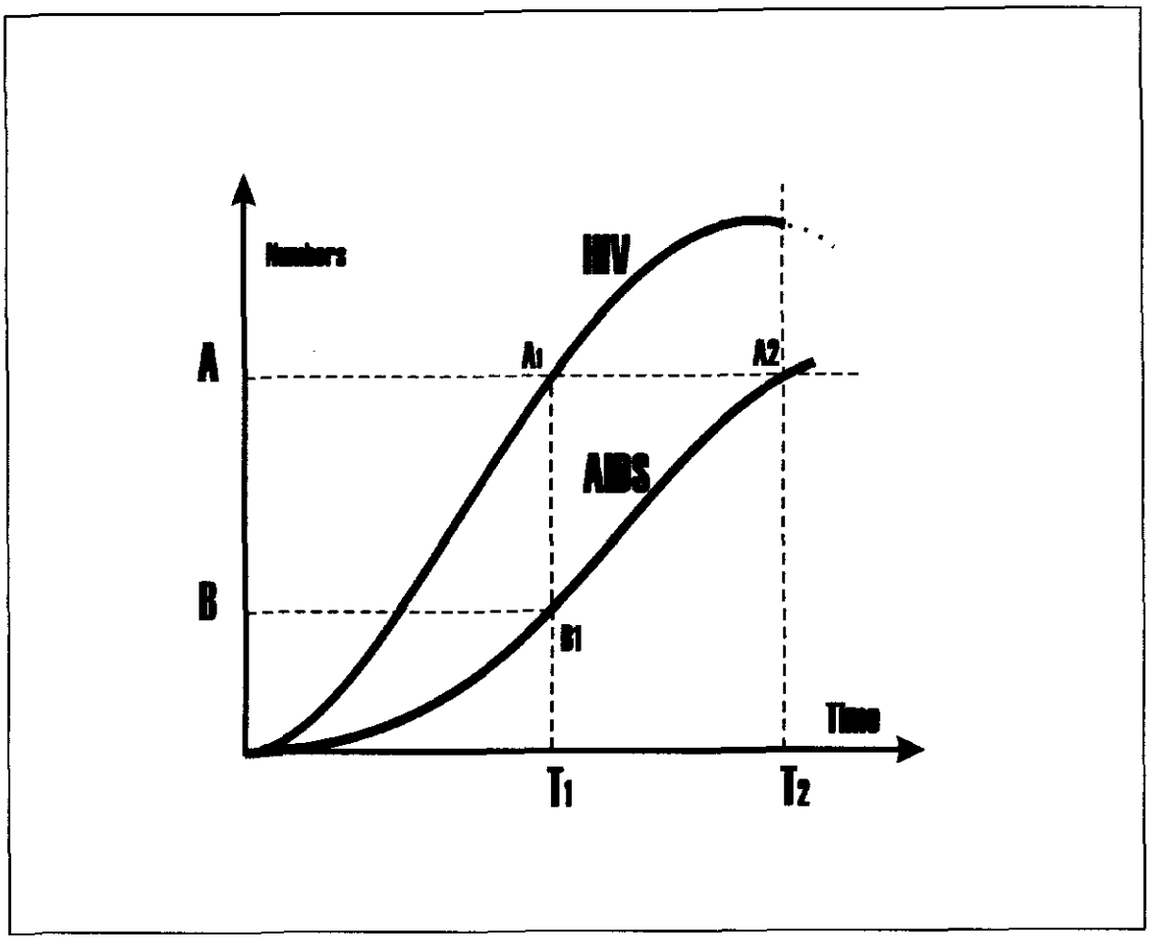
2.9.1 Epidemic curves

The epidemic curve is a key concept. HIV, as with any disease, will spread through a susceptible population infecting some and missing others. Epidemics follow an "S" curve, as shown in figure 2.4 "The two epidemic curves", it starts slowly and gradually.

At a certain stage, a critical mass of infected people is reached and the growth of new infections accelerates. The epidemic then spreads through the population until many of those who are susceptible to infection have been infected. Some people are passed over and do not become infected because, even though they are susceptible, they never come into contact with an infectious person. Due to globalisation there exist few instances of isolated communities such as is the case mentioned earlier in this chapter on Cuba. Therefore, epidemics can quickly spread worldwide. The large and rising count of the global population also means that many more people will become infected. In the final phase of an epidemic, where the "S" curve flattens off at the top and turns down, people are either getting better or deaths outnumber new cases so that the total number alive and infected passes its peak and begins to decline. With most diseases the curve will decline rapidly. This is where HIV and AIDS are different (Whiteside & Sunter, 2000).

Figure 2.4 follows on the next page.

Figure 2.4 The two epidemic curves



Source: Whiteside and Sunter (2000:27)

HIV/AIDS is different from other diseases because there are two curves utilised in describing it, as illustrated in figure 2.4 above. In most other diseases, infection is followed by illness within a few days or at most weeks. In the case of HIV the infection curve precedes the AIDS curve by between five and eight years. This reflects the long incubation period between infection and the onset of illness. This is why HIV/AIDS is in some ways such a lethal epidemic compared to for example Ebola fever. In the latter case victims of the disease quickly and visibly fall ill, putting the general population and public health professionals on their guard quickly. The community can therefore take

precautions to stop the spread and the infected individuals can be quickly quarantined, reducing their infective potential different (Whiteside & Sunter, 2000).

HIV infection affects a population giving little sign of its presence. It is only later, when substantial numbers are infected, that AIDS deaths begin to rise. People have no ability to leave the infected group by getting better or cured because there is no cure. They depart by dying of AIDS or other causes due to opportunistic infections. Ironically, the effect of life-prolonging antiretroviral drugs, can assists in the increase of the number of infected people (Barnett & Whiteside, 2002).

See figure 2.4. The vertical axis represents numbers of infections or cases of illness and the horizontal represents axis time. At time T1, when the level of HIV is at A1, the number of AIDS cases will be markedly lower at B1. AIDS cases will only reach A2 (that is, the same level as A1) at time T2. By that time years will have passed and the numbers of people who are infected with HIV will have risen even higher. Figure 2.4 also shows that wile prevention efforts may aim to lower the number of new infections, the truth is that without affordable and effective treatment, AIDS case numbers and deaths will continue to increase after the HIV wave has been turned. Beyond the point T2, the lines are dotted. This is due to a lack of knowledge as to precisely how either the HIV or the AIDS curves will continue (Whiteside & Sunter, 2000).

2.9.2 Incidence and prevalence of HIV

Incidence is described as the number of new infections that occur over a specified period of time. Incidence is the rate of the number of infections per specified unit of population in a given time frame. Rates can be per 1,000; per 10,000; or per 1,000,000 for a rare disease. The time may be expressed per annum, but in the case of more rapidly moving infections it may be expressed per days or per weeks. Prevalence is described as the absolute number of infected people in a population at a given point in time; it can be seen as a still photograph of current infections. The prevalence rate is the percentage of the population that exhibits the disease at a particular time or averaged over a period of time.

A numerical example and an illustration are given in table 2.2 "Incidence and prevalence" below and actual figures are expressed in figure 2.5 "Number of adults and children estimated to be living with HIV/AIDS, end 2003" respectively.

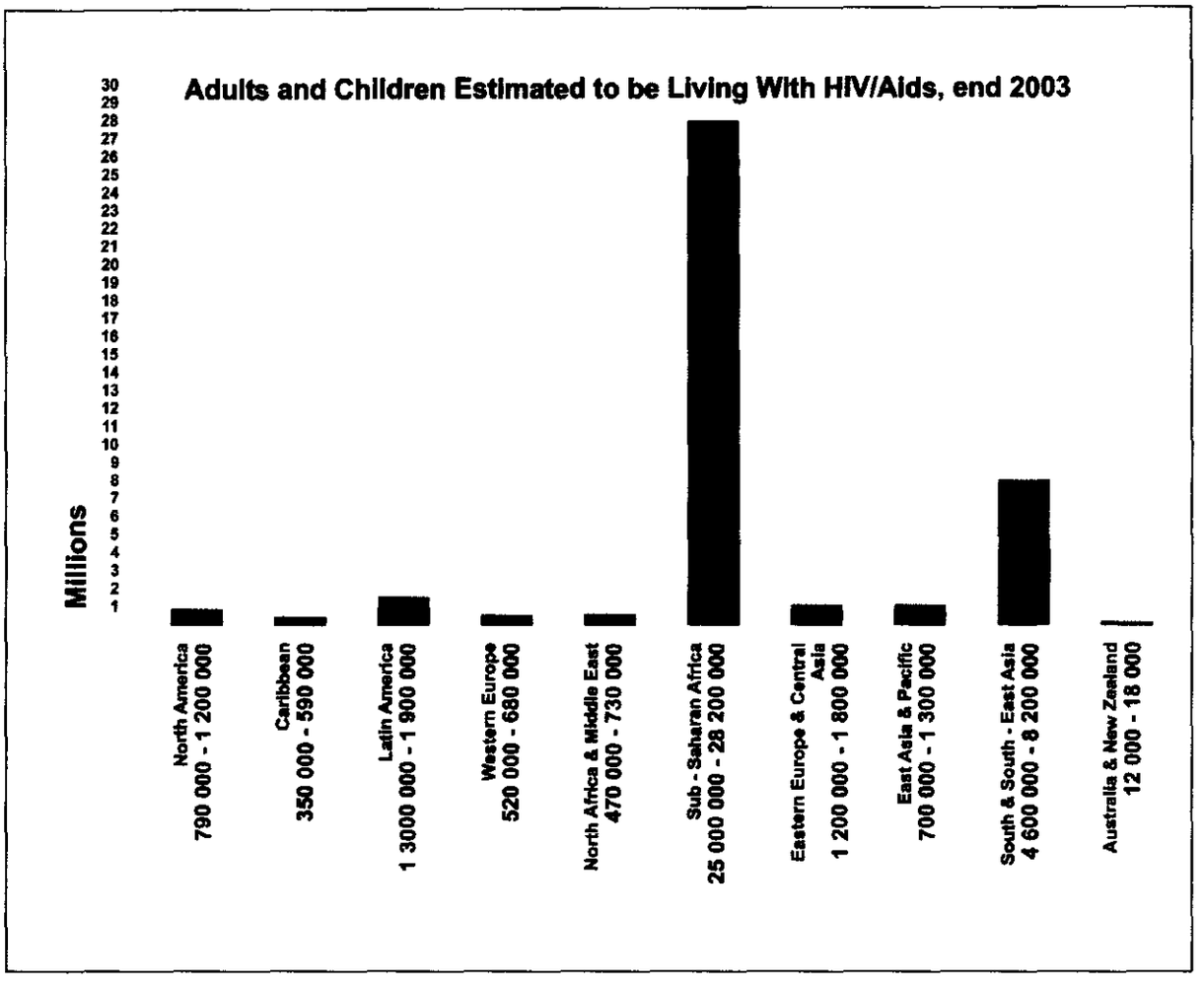
Table 2.2 Incidence and prevalence

Year	Population	Incidence (actual)	Incidence rate per 1,000	Prevalence	Prevalence rate (%)
1	9,750	0	0	0	0
2	10,000	50	5	50	0,5
3	10,500	50	4,7	100	1,0
4	11,000	150	13,6	250	2,3
5	12,000	750	62,5	1,000	8,3

Source: Whiteside and Sunter (2000:28)

Figure 2.5 follows on the next page.

Figure 2.5 Number of adults and children estimated to be living with HIV/AIDS, end 2003



Source: Epidemic Update Report (UNAIDS, 2003a)

Data on incidence and prevalence are key statistics for tracking the course of the HIV epidemic. In HIV: prevalence rates are given as a percentage of specific groups of the population. Commonly used groups are antenatal clinic attendees, adults aged between 15-65, blood donors, men with STD's, or the "at risk" population, usually taken to mean the 15-49 year-olds who are sexually active. Annual incidence is calculated by subtracting the previous year's prevalence from that of the current year. Because we do not know when people were actually infected – we only know the date on which their

serostatus is ascertained – the date (incidence) which would be most helpful in measuring the impact of prevention efforts are simply not available. Moreover, high incidence may occur even when prevalence has levelled off, because those dying are being replaced by new infections (Whiteside & Sunter, 2000:29).

The HIV curve tells us the area where the epidemic affects and has affected the population. Projections indicate where it might go. HIV is not on its own important for understanding the social and economic impact of the epidemic. What is important is the AIDS curve. See figure 2.4. If we are to consider impact we need to have an idea of the size of the potential AIDS epidemic which will hit a particular society. How bad is the epidemic? How many people are infected and will die? How serious and global a crisis is it? These are all questions that are seldom posed in a precise manner.

Currently we have to use prevalence data to track how the epidemic is spreading through a population, comparing one year with another. The aim of control and prevention measures is to reduce both prevalence and incidence. To achieve this the number of new infections produced by each existing infection must be reduced.

In Essex et al., (2002:282) the importance is stressed of appropriate HIV and AIDS surveillance and that it provides information that allows researchers to determine the extent of the epidemic and to track changes or trends in the epidemic over time. The information provided by a functioning surveillance system is essential for leadership in developing strategies to respond to the HIV epidemic and can be useful in planning for and providing health and social services. HIV epidemics are classified in three stages together with appropriate surveillance systems accordingly: (i) Low level. HIV prevalence has not consistently exceeded 5% in any defined sub-population grouping whose behaviour places them at high risk. These groups include injection drug users, commercial sex workers and men who have sex with men. At this level of the epidemic, HIV surveillance should be carried out in the groups at highest risk in the country; (ii) Concentrated. HIV prevalence is consistently over 5% in at least one defined sub-population group at high risk, but prevalence remains below 1% in the general adult

population ages 15-49 in urban areas. At this level of the epidemic, surveillance of the general population in urban areas should begin; and (iii) Generalised. HIV prevalence reaches 1% of the general adult population ages 15-49 in urban areas. At this level, surveillance of the general population in rural areas should begin in addition to the continued surveillance of the general population in urban settings and at least one high-risk group.

2.9.3 AIDS epidemic report, July 2004

See table 2.3 "HIV and AIDS estimates, end 2003", for the state of the epidemic in sub-Saharan Africa and globally. Sub-Saharan Africa is the world's worst affected region, with 25,000,000 people estimated to be living with HIV/AIDS, this constitutes 66,13% of the total estimated 37,800,000 people living with HIV/AIDS worldwide. Also, Table 2.3 provides data for adults and children combined, adults (15-49), women (15-49), and children (0-14) at end 2003, and a comparison of these figures as reported at end 2001. The data in table 2.3 is taken from the UNAIDS "Report on the global AIDS epidemic", July 2004.

Table 2.3 follows on the next page.

Table 2.3 HIV and AIDS estimates and data, end 2003

Estimated number of people living with HIV

Country	Adults and Children end 2003 *Estimate*	Adults and Children end 2001 *Estimate*	Adults (15-49) end 2003 *Estimate*	Adults (15-49) end 2001 *Estimate*	Adult (15-49) rate (%) end 2003 *Estimate*	Adult (15-49) rate (%) end 2001 *Estimate*	Women (15-49) end 2003 *Estimate*	Women (15-49) end 2001 *Estimate*	Children (0-14) end 2003 *Estimate*	Children (0-14) end 2001 *Estimate*
Global Total	37,800,000	34,900,000	35,700,000	32,900,000	1.1	1.0	17,000,000	15,700,000	2,100,000	2,000,000
Sub-Saharar	25,000,000	23,800,000	23,100,000	22,000,000	7.5	7.6	13,100,000	12,500,000	1,900,000	1,800,000

Source: Report on the global AIDS Epidemic (UNAIDS, 2004)

Global: figures for adults and children combined

See table 2.3. Globally, the HIV prevalence rate for adults and children combined, has increased from 34,900,000 at end 2001 to 37,800,000 at end 2003: an 8,31% increase in the number of infected people.

Global: figures for adults (15-49 years of age)

See table 2.3. The total number of adults (15-49 years of age), has increased from 32,900,000 at end 2001 to 35,700,000 at end 2003: an 8,51% increase in the number of adults infected with HIV.

Global: figures for women (15-49 years of age)

See table 2.3. The total number of women (15-49 years of age), has increased from 15,700,000 at end 2001 to 17,000,000 at end 2003: an 8,28% increase in the number of women infected with HIV.

Global: figures for children (0-14) years of age

See table 2.3. An increase can be noticed amongst children (ages 0-14) from 2,000,000 at end 2001, to 2,100,000 at end 2003: a 5% increase in the number of children infected with HIV.

Sub-Saharan Africa: figures for adults and children combined

See table 2.3. In sub-Saharan Africa the HIV prevalence rate for adults and children combined, has increased from 23,800,000 at end 2001 to 25,000,000 at end 2003: a 5,04% increase in the number of people infected.

Sub-Saharan Africa: figures for adults (15-49 years of age)

See table 2.3. The total number of adults (15-49 years of age) has increased from 22,000,000 at end 2001 to 23,100,000 at end 2003: a 5% increase in the number of adults infected with HIV.

Sub-Saharan Africa: figures for women (15-49 years of age)

See table 2.3. The total number of women (15-49 years of age) has increased from 12,500,000 at end 2001 to 13,100,000 at end 2003: a 4,8% increase in the number of women infected with HIV.

Sub-Saharan Africa: figures for children (0-14 years of age)

See table 2.3. An increase is also noticed amongst children (ages 0-14) from 1,800,000 at end 2001, to 1,900,000 at end 2003: a 5,56% increase in the number of children infected with HIV.

2.9.4 Demographic indicators due to the HIV/AIDS epidemic

In this section, population growth rates, life expectency figures and mortality rates (with and without the impact due to HIV/AIDS) will be presented as well as the discussion thereof.

AIDS increases mortality rates many times over among people aged 15-49 years. Normally, non-AIDS mortality rates for this age group are among the lowest of all age groups within a population.

New HIV infections among adults are concentrated among those in their late teens to about 30-35 years of age. These are ages of peak sexual activity. See section 2.5 "Detecting HIV and AIDS". Because of the 10 year average incubation period between

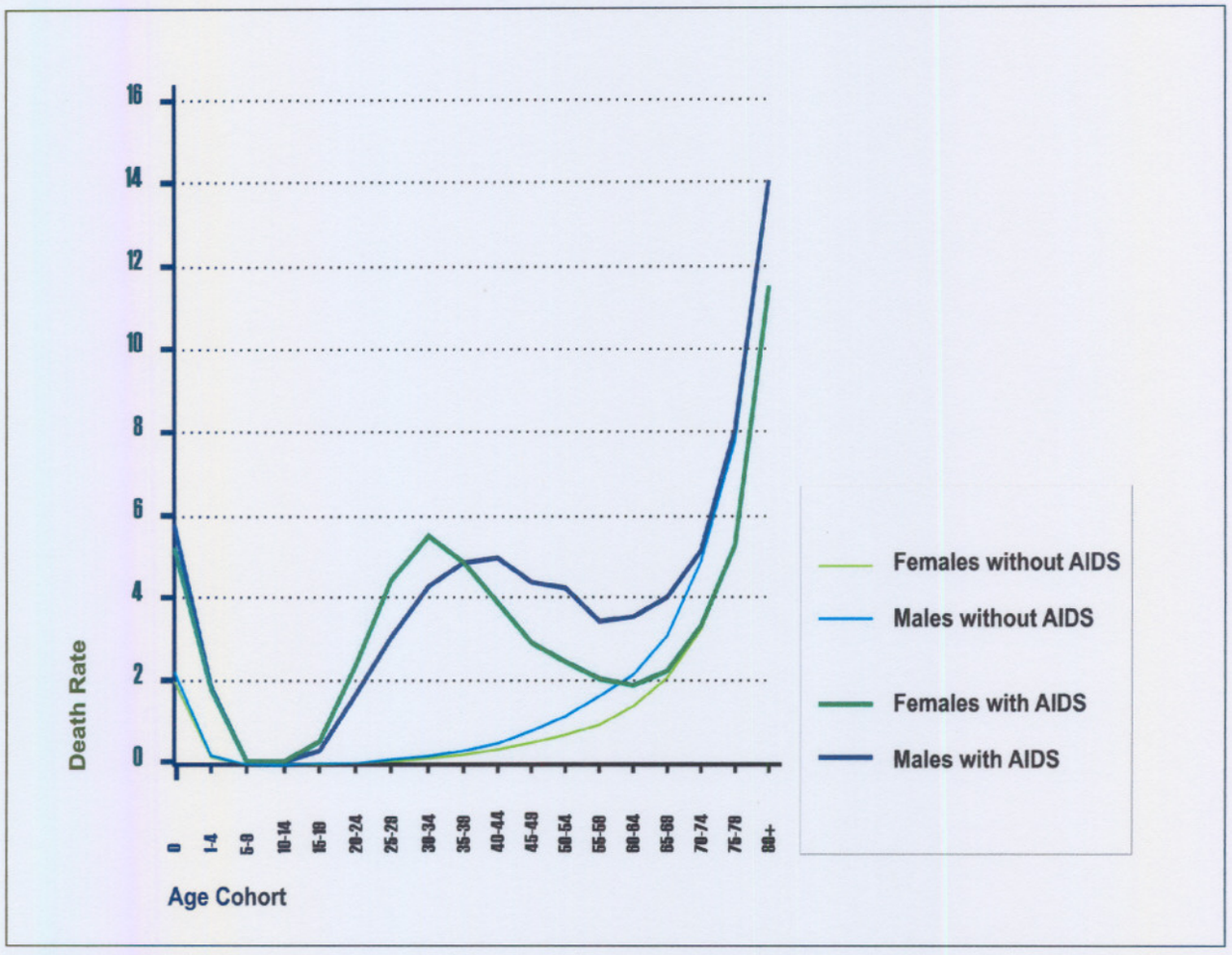
HIV infection and the onset of AIDS, and about a one-year survival period after acquiring AIDS, deaths from AIDS now occur in older age groups and tend to occur most often in the 20-45 year age range. Normally, non-AIDS mortality rates for this particular age group are among the lowest of all age groups (Essex et al., 2002:288).

Cohort studies in Uganda have reported high levels of mortality due to AIDS in those age groups that generally should have low levels of mortality. In Masaka, Uganda, where 8% of adults aged 13 years or older are HIV-positive, 89% of deaths of people between the ages of 25 and 34 were due to AIDS in 1989-1990. In Rakai District, where 21% was HIV-positive, 87% of deaths between the ages of 20 and 39 were due to AIDS in 1990-1991 (Essex et al., 2002).

The Unites States Bureau for the Census (2000) provided figures to illustrate the comparison for death rates of South Africans living with and without AIDS by the year 2020. See figure 2.6 "Projected death rates among males and females, with and without AIDS, South Africa 2020".

Figure 2.6 follows on the next page.

Figure 2.6 **Projected death rates among males and females, with and without AIDS, South Africa 2020**



Source: Global Population Profile (United States Bureau of the Census, 2000)

From figure 2.6 above it is clear that mortality patterns are driven by HIV prevalence patterns. The most significant impact will be in the drop in projected life expectancies due to the increases in mortality rates among young adults. In South Africa, by 2020, mortality for adults aged 20-45 will be much higher than it would have been without AIDS. Mortality for women will peak between the ages of 30 and 34, earlier than the peak for men, which is between the ages of 40 and 44.

Table 2.4 "Adult prevalence of HIV/AIDS, state of the epidemic by country" contain information regarding the HIV prevalence rate for Botswana, South Africa and Uganda as released in the "Report on the global AIDS epidemic" by UNAIDS (2000a; 2004) released during June 2000, and 2004 respectively.

Table 2.4 Adult prevalence of HIV/AIDS, state of the epidemic by country

Country	**Year**	**Adults living with HIV/AIDS (ages 15-49)**	**Adult Rate (%)**	**State of epidemic**
Botswana	2000 2001 2003	280,000 330,000 330,000	35,8 38,0 37,3	Generalised Generalised Generalised
South Africa	2000 2001 2003	4,100,000 4,800,000 5,100,000	19,94 20,9 21,5	Generalised Generalised Generalised
Uganda	2000 2001 2003	770,000 520,000 450,000	8,3 5,1 4,1	Generalised Generalised Generalised

Source: Report on the global HIV/AIDS epidemic (UNAIDS, 2000a; 2004)

Table 2.5 "Demographic Indicators With and Without AIDS in Botswana, Uganda and South Africa: 2000" and table 2.6 "Demographic Indicators With and Without AIDS in Botswana, Uganda and South Africa: 2010" contain information regarding population growth rates, life expectancy and mortality rates due to HIV/AIDS for the populations of Botswana, Uganda and South Africa for 2000 and 2010 respectively. This information is provided by the United States Bureau for the Census (2001).

Tables 2.5 and 2.6 follows on the next page.

Table 2.5 Demographic Indicators With and Without AIDS Botswana, Uganda and South Africa: 2000

Country	Column A Growth rate (%)			Column B Life expectancy			Column C Crude death rate (per 1,000 population)		
	With AIDS	Without AIDS	Net AIDS	With AIDS	Without AIDS	Net AIDS	With AIDS	Without AIDS	Net AIDS
Botswana	0,8	2,5	1,8	39,3	70,5	31,2	22,8	5,4	17,4
South Africa	0,5	1,2	0,7	51,1	65,7	14,6	14,7	7,4	7,3
Uganda	2,7	3,4	0,7	42,9	54,2	11,2	18,4	12,3	6,2

Source: International database and unpublished tables (United States Bureau for the Census, 2001)

Table 2.6 Demographic Indicators With and Without AIDS in Botswana, Uganda and South Africa: 2010

Country	Column A Growth rate (%)			Column B Life expectancy			Column C Crude death rate (per 1,000 population)		
	With AIDS	Without AIDS	Net AIDS	With AIDS	Without AIDS	Net AIDS	With AIDS	Without AIDS	Net AIDS
Botswana	-1,3	2,0	3,3	29,0	73,2	44,2	36,0	4,5	31,5
South Africa	-1,3	1,0	2,3	35,5	68,3	32,8	30,3	7,1	23,2
Uganda	3,0	3,5	0,5	46,6	58,2	11,6	15,1	9,5	5,6

Source: International database and unpublished tables (United States Bureau for the Census, 2001)

See column A table 2.6. The first time the United States Bureau for the Census estimated negative population growth due to AIDS in any country was for Botswana and South Africa. Previously, experts in the field of HIV/AIDS did not expect HIV prevalence rates to reach such high national levels in any country. See table 2.4 "Adult prevalence of HIV/AIDS, state of the epidemic by country". But, by the year 2000 adult HIV prevalence had reached unexpectedly high levels for each of the three African countries: Botswana, 35,80%; South Africa, 19,94% and; Uganda, 8,30%.

See column A tables 2.5 and 2.6. It is projected that Botswana and South Africa will begin to experience negative population growth rates from 2003. See table 2.4. According to Essex et al., (2002:289) the negative growth rates are directly attributed to the high levels of HIV prevalence coupled with low fertility rates in both Botswana and South Africa. The population growth rates in the aforementioned two countries will during 2003 begin to range from –0,1% to –0,3% instead of +1,1% to +2,3%. By 2010 this negative growth is expected to continue. The population growth rate for the three African countries is projected to be as follows by 2010: Botswana, -1,3%; South Africa, -1,3% and; Uganda, +3,0%. Without AIDS, growth rates in 2010 has been projected to be as follows: Botswana, +2,0%; South Africa, +1,0% and; Uganda, +3,5%.

See column B tables 2.5 and 2.6. AIDS mortality is resulting in falling life expectancies. Already, life expectancies in many countries in sub-Saharan Africa have dropped from the number of years they would have been without the HIV/AIDS epidemic. The current life expectancy "With AIDS" is estimated to be as follows (in years): Botswana, 39,3; South Africa, 51,1 and; Uganda, 42,9. "Without AIDS" the combined average life expectancy rate for the three African countries in the year 2000 was projected at 63,5 years, this is markedly higher than "With AIDS".

In 2010, many countries will see life expectancies fall to approximately 30 years of age, a figure not seen since the beginning of the 20th century. By 2010, Botswana and South Africa could have anticipated life expectancy "Without AIDS" to reach an average 70,75 years of age. But both countries will see "Net" life expectancy reduced by a combined

average of 15,6 years to the rate of 44,2 years in Botswana and 32,8 years in South Africa respectively. This is in stark contrast to that expected for Uganda: by 2010 the life expectancy "Without AIDS" is anticipated to have reached 58,2 years, 4 years more than in 2000.

See column C tables 2.5 and 2.6. The most direct impact due to AIDS is an increase in the number of deaths in the populations affected. AIDS has already affected crude death rates: the number of people dying per 1,000 in the population. Both South Africa and Botswana have estimated adult HIV prevalence of approximately 20% or greater. In Uganda adult HIV prevalence is below 10%.

As a result of these long-term, high levels of HIV infection, estimated crude death rates including AIDS mortality rates in Eastern and Southern Africa are greater by 50% to 400% compared to what they would have been without AIDS. For example, in Botswana where adult HIV prevalence was estimated to be 35,80% (see table 2.4), crude death rates are estimated to be four times the level they would have been without AIDS (see column C table 2.4). In South Africa, where adult HIV prevalence was estimated to be 19,94% (see table 2.4), crude death rates are double due to AIDS (see column C table 2.4).

In many sub-Saharan African countries, crude death rates will be even higher in 2010 than in 2000, even though mortality due to non-AIDS causes will continue to decline. In South Africa, crude death rates will increase from 14,7 to 30,3 per 1,000 population. In all three of the countries, crude death rates would have been 4,5, 7,1 and 9,5 for Botswana, South Africa and Uganda respectively without AIDS.

With the exception of South Africa and Botswana populations in most sub-Saharan African countries will continue to increase despite the high levels of mortality albeit at a slower pace. Despite the possibility that current HIV/AIDS control strategies could result in lower HIV incidence and prevalence in the future, the populations of Botswana and South Africa will take a long time to rebound from the impact due to current levels of HIV prevalence and AIDS mortality.

2.10 CONLUSION

The discussion of the various aspects and elements of the HIV/AIDS phenomenon in the form of the background study was done from the works of authoritative authors and reports, to serve as a foundation to study the impact of HIV/AIDS in the next chapter. This also serves as the factual framework to analyse the operations of leaders confronted by the epidemic.

Chapter 3, that follows, will focus on the specific socio-economic impacts of the epidemic.

CHAPTER 3

THE SOCIO-ECONOMIC IMPACT DUE TO HIV/AIDS

3.1 INTRODUCTION

The primary aim of this chapter is to investigate the socio-economic impact due to the HIV/AIDS epidemic with specific emphasis on the social group structures: individuals, households and communities, women, the elderly and orphans.

A second aim is to analyse figures and statistics regarding the impact due to HIV/AIDS on the social groups: women, households, the elderly and orphans in order to fully comprehend the extent of the impact of the pandemic.

It is important to firstly give a background to the impact that epidemics have and specifically how the impact of AIDS is manifested before the impact on specific socio-economic groupings can be discussed.

3.2 BACKGROUND TO EPIDEMIC IMPACTS

Certain human catastrophes start with unmistakable fury: natural disasters like earthquakes, hurricanes, and volcano eruptions, military disasters like the murder and expulsion of civilians in Rwanda, and biologic disasters like the rapid spread of the Ebola virus in Africa. Other disasters begin slowly and subtly: their full impact hidden until they seem too large and difficult to be controled. This has been and is currently the case with the HIV/AIDS epidemic (Essex et al., 2002).

Epidemics have clearly noticeable effects therefore it alters the course of history. Epidemics end the lives of some, incapacitate others and reduce the capabilities of the

survivors who have to divert their energy, time and resources into care. Ultimately, sufficient numbers of deaths and illnesses cause a society to take a path other than that which it would previously have followed. This change in direction is referred to as impact. See chapter 2, section 2.2 "Introduction to diseases". The Americas (New World) would have had a different population structure, culture, economy and political system had more than 90% of the indigenous populations not been wiped out by bacteria causing diseases that originated in Europe (Watts, 1997). As a potential further impact, one could argue that the political and economic landscape of the Western Hemisphere could have been much different today.

In the following section we discuss the socio-economic impact due to HIV/AIDS as it affects the various levels and aspects of society at large before the individual groupings, women, the elderly and orphans, are discussed.

Epidemics and their impact do not take place in isolation. Therefore, stakeholders cannot afford issues to be dealt with on a piece-by-piece basis nor can ineffective leadership be afforded that are incapable of solving important and complex matters, such as HIV/AIDS. Leaders cannot deal with these types of events in isolation from one another. These complex matters, like epidemics, need to be related to other events, such as with changes in the values of society or the inability of an economy to outgrow poverty, in an effort to deal with it comprehensively. Therefore, interlocked multiple long-wave events must be on the agenda of every leader, politician and policy maker.

The HIV epidemic increases morbidity (sickness) and mortality (death) in populations in exactly those age groups where normal levels of morbidity and mortality are low. See chapter 2, section 2.9.3 "Current estimates and projections for the HIV/AIDS epidemic".

It is from unusual events such as this that other impacts flow. These impacts may be felt as an immediate and severe shock or they may be more complex, causing gradual and long-term changes in social and economic structures. Illness and death due to AIDS may threaten to obliterate communities and perhaps whole societies. In large populations the

shock can, to a certain degree, be absorbed. Impact occurs at three levels: (i) the household; (ii) the community; and (iii) the nation as a whole. Wealthy households and communities will be better able to cope than poor ones, and the same applies for rich and poor countries (Barnett & Whiteside, 2002).

See chapter 2, figure 2.3 "Two epidemic curves". The curve of HIV infection is followed by the curve of AIDS (illness and death) which in turn effects a third curve: impact. For example, orphaned female children have a higher likelihood of infection, or if they are withdrawn from school it is known that their children will suffer from higher mortality rates as female education is directly correlated with infant and child mortality rates. Thus: AIDS impacts over three generations.

See chapter 2 "The recognition of AIDS and HIV". The HIV/AIDS epidemic is only 23 years old. See chapter 2, figure 2.3 "Country specific HIV and AIDS estimates and data, at end 2003". In most of the poorest countries on earth, especially in sub-Saharan Africa, the number of people infected, continues to rise. This means that the HIV epidemic curve has not peaked yet and neither has the impact curve. Probably the most notable exceptions are Thailand and Uganda, and even here the curve for impact is still rising as the sum of all infections of past years evolve into illnesses and deaths and then socio-economic impact.

See table 3.1 "Understanding impact due to HIV/AIDS by level, time and degree". The worst impacts will be felt in households and clusters of households. It is here that monetary and emotional costs of the disease have to be borne. This is where social reproduction occurs at its deepest level: in the stories told by parents and grandparents to their children, in the giving and receiving of affection, in the taking and relinquishing of responsibility. It is also here that the state and large multilateral agencies have most difficulty responding because the scale is too small and the variability in circumstance too great to be covered by large programmes. The great danger is that it is here where it is most needed and where the very long-term costs are stacking up, that responding to the impact will become impossible because there is no way of dealing with small-scale and

large variability in a great number of households. This area has become a major leadership and policy challenge for society (Barnett & Whiteside, 2002:193).

Table 3.1 follows on the next page.

Table 3.1 **Understanding impact due to HIV/AIDS by level, time and degree**

Level of impact	Time of impact	Degree of impact	Does evidence exist that this actually is the case?
Individual	Early	Always severe and varies by gender and age	Yes. Death and illness
Family	Early	Severe emotional, variable financial depending on socio-economic status, gender, ethnicity and other social variables	Yes. Particularly orphans and the elderly are affected
Community	Early, middle and late	Variable: dependent on scale, and resource base of community but likely to be long term and profound but not necessarily easy to see	Yes. Orphans, the elderly and local service provision are affected.
Institution/ place of work	Middle and late	Variable: dependent on the nature or activities of the organisation or type of production or labour mix	Yes.
Sector	Late	Variable: dependent on location, production and use of labour	Yes. Some evidence but limited.
Nation	Late	Probably slight economic, other might be greater. Variable: tax base erosion	No. Only economic models.

Source: Barnett and Whiteside (2002:162)

Fieldwork uncovered the following case study of a grandmother in Lusaka, Zambia (Guest, 2001:17). This case assists in describing the impact due to HIV/AIDS by level, time and degree as set out in table 3.1.

Case study 1

Five of old Mary Banda's eight children have died. Once a year, for five years running, she buried one of her children. The lines on her face deepened with each burial. She had always thought that, by raising eight children, she had insured herself against hardship in old age. She was wrong. By 2000, she had inherited the task of rearing eight of her grand children. Mrs Banda has become one of Zambia's "elderly orphaned". She has a throng of new dependants, due to AIDS deaths, and no income (Guest, 2001:17).

Zambia, a landlocked country situated in Central Africa is arid and sparsely populated. Most of its 10,000,000 people are extremely poor. Perhaps three-quarters of them survive on less than one US$ a day and nearly half the children are stunted from malnutrition. The state cannot afford to provide its citizens with a safety net. The government has little money, so no pensions or child support grants are paid to those too poor to feed and clothe themselves (Guest, 2001:17).

The United States Agency for International Development (USAID) estimated that in 1990, 9% of children under 15 had lost their mother or both parents, and that AIDS bereaved approximately 61% of them. By 2000, 12% had lost their mother or both parents, 76% of the losses are to AIDS. If paternal deaths are added into the equation, nearly one third of all children in Zambia may be affected (Guest, 2001:17).

Most children who have lost both parents are taken in by their extended family, usually by someone who is elderly, female and widowed. Research by the United Nations Children's Fund (UNICEF) revealed that nearly 40% of all orphans are cared for by

grandparents (usually grandmothers) and another 30% are looked after by uncles or aunts (usually the mother's sister) (Guest, 2001:17).

In countries like Zambia, where 20% of the adult population are HIV-positive, grandmothers often find themselves grieving for more than one child and looking after several orphans. The orphans range in age from six to 20. In Zambia the surviving family of someone who has died of AIDS will not be shunned as might be the case in some other countries. This is mostly due to the disease being so common that most of the social stigma associated with the disease has been overcome (Guest, 2001:17).

According to the Non-governmental Organisation (NGO) Children in Distress, which assists widows, grandmothers and orphans, far fewer widowers need food parcels or emotional support because they tend to remarry quickly and can generally rely on the support of their mothers and sisters. Widows, however, find it almost impossible to find another husband. Therefore John Munsanje, head of an NGO in Zambia said when a family is "... struggling, the wider community should pitch in and help. The best way for outsiders to help is through organisations based in the community" (Guest, 2001:17).

For orphans the good thing about living with a grandmother is that she will usually love them unconditionally and will treat them all equally. The downside is that the material deprivation of both the orphans and their grandmother often worsens. Discipline can also become an issue in this type of household (Guest, 2001:17).

Most grannies are bad at disciplining children. You rarely get fierce grandmothers. They all want to be nice. Mrs Banda worries about her grandchildren getting into trouble, but she believes that she has found a method to keep an eye on them by insisting they come home for one meal a day. She admits that it is difficult "... dealing with grown-up children. Usually Zambian people would whip their kids if they do something naughty, but I do not, because they might think, O God, somebody is whipping me because I do not have parents". So even if they do something wrong, she just talks and plays with

them. Unfortunately she can not enforce the rules because she does not have the energy (Guest, 2001:17).

Zambia's Public Welfare Assistance System is meant to provide a safety net for the destitute amongst the unemployed, old, orphaned and disabled. It does not. Even without the epidemic, many elderly Zambians struggle (Guest, 2001:17).

AIDS is also accelerating the breakdown of the traditional African family. Rapid urbanisation has weakened family ties. Young adults often live far from the villages where their parents remain alone, poor and destitute. City life is more individualistic than village life. Many modern urbanites feel less duty-bound to support their parents than rural traditions would require and rising divorce rates splinter families still further (Guest, 2001:17).

Now that a background to epidemic impacts has been described the socio-economic impact due to HIV/AIDS regarding individuals, households and communities, will be discussed.

3.3 HIV/AIDS IMPACT: INDIVIDUALS, HOUSEHOLDS AND COMMUNITIES

See chapter 2, tables 2.5 and 2.6, columns B and C. The hundreds and thousands of individual deaths in sub-Saharan Africa are due to the changes in mortality and life expectancy. Impact due to individual ill health and death depends on who the individuals are, their place in society and the resources they, their families, communities and society have available at their disposal.

This section examines the impact of AIDS at the individual, family and community levels. As indicated in section 3.2 this is where the impact due to HIV/AIDS is felt first

and worst. But it is also here, beyond the obvious clinical and medical consequences, where the impact is the most difficult to measure.

3.3.1 Impact due to HIV/AIDS on the individual

In the absence of treatment, infected individuals can expect to experience periods of illness that increase in frequency, severity and duration. See chapter 2, figure 2.2 "Viral load and CD4 cell counts over time". As the CD4 cell counts decline, so does the state of an individuals health. Thus: individuals who are infected are always confronted with an impact on their health. In most cases they also face an impact on the resources they have at their disposal. The resources of an individual may not be affected if the individual is fortunate enough to live in a society where care is provided free by the state or if they are able to afford insured medical benefits. Unfortunately, this is currently not the case in many sub-Saharan countries. The situation for individuals is that: as with their chance of being infected, the impact of the disease will depend on their circumstances and the resources they can direct (Barnett & Whiteside, 2002: 183).

In Guest (2001:xi) the cost of the HIV/AIDS impact on an individual's health is described as follows: "On the world's poorest and most AIDS-ravaged continent (Africa), AIDS drugs are extremely expensive". The pills that are received free in the United Kingdom, cost about US$ 10,000 a year. Providing them at this rate for free in an African country would probably cost more than the entire national income of most African states, leaving nothing over for food, clothing or education in a national budget.

3.3.2 Impact due to HIV/AIDS on households

In describing a household the following stages can be identified: formation, when people come together to reproduce; maturity, as they have children and raise them; and dissolution, as children leave home and the parents grow too old to work and pen-ultimately die. There exists many cultural variations to the aforementioned description such as, adult children may remain in a household and be joined by their spouses, three

generations may live in one household, or siblings may form joint households with their spouse's children. But essentially the three stages mentioned above are what households consist of.

Due to HIV being sexually transmitted, it clusters in households. In AIDS afflicted households the impact of the epidemic is felt directly. A member is either ill or has died from the disease and therefore resources have to be reallocated in order to deal with the problem (Barnett & Blaikie, 1992:86). The impact of illness and death in households depend on four scenarios (Barnett & Whiteside, 2002:186): (i) the number of individual members that become infected in the household. This is where clustering becomes relevant; (ii) the characteristics of the deceased individuals: age, gender, income and cause of death; (iii) the community's attitude towards helping needy households together with the general availability of resources in that community (their standard of living); and (iv) the broader resources availability for assistance to households from the local authorities, the national government or from non-governmental organisations (NGO's).

Only a small number of studies of the impact of HIV/AIDS on households exist. But what is common to all the studies are the unbearable situations faced by household impacted by HIV/AIDS. One survey-based study was undertaken in the Kagera region, Tanzania, during the late 1980's and early 1990's co-sponsored by the World Bank. Barnett and Whiteside (2002:186) highlighted three important findings of the survey that are associated with impacted households:

(i) The measurement of impact on households during illness is difficult;

(ii) Recordings of illness can range from not feeling very well to complete inability to function; and

(iii) That it is difficult to unravel these subtleties with survey methods because firstly, even in the worst affected areas adult illness and death is comparatively rare. Secondly, the unit of measurement, the household, means that those that dissolve or disappear are lost to research. Thirdly, surveys of households will not receive data on complex relations between clusters of households and fourthly, the epidemic and the impact thereof are still evolving in most countries.

It is now quite obvious that death changes the nature of households. The loss of one member reduces its size (Barnett & Blaikie, 1992: 90). However evidence from a number of studies suggest that in practice the change that might occur in households is difficult to predict. In Rakai, Uganda, the mean household size fell from 6,4 to 4,7 (Menon et al, 1998 in Barnett & Whiteside, 2002:187). In contrast, in Kagera, Tanzania, a death added at least one member when a previously absent member or non-member joined, thus the average size declined by less than 1 from 6.0 to 5.7, despite that individual deaths are recorded. The death of adults may therefore also cause the dissolution of households.

In Manicaland, Zimbabwe, it was found that about 40% of the 215 sample households in a survey had taken in orphans. Mutangadura (2000:11) states that "65% of households where the deceased adult female used to live before her death were reported to be no longer in existence in both the urban and rural sites". This supports the argument that often the worst impact is invisible because it is among those who are not counted.

Fieldwork in Uganda in 1989 found the following tragic case that exemplifies the impact due to HIV/AIDS on households: a remnant household that was on the verge of disappearance was recorded (Barnett & Blaikie, 1992:98).

Case study 2

The man lived alone in a bare hut, sleeping on the floor. He possessed little beyond a blanket and the pot in which he was cooking a meagre meal. The man was said to be 45 years old but looked considerably older. He was quite clearly demented and could not be interviewed. Information was obtained from others that lived in the area. A few years ago, this had been a substantial household with a reasonable farm. The man's wife and eight of his teenage and adult children had died of AIDS within the last few years. He had no relatives left in the village, and supported himself by cultivating and selling some of his bananas. Onlookers said euphemistically that he "... is not expected to marry again". This case illustrates how, in extremes, the costs of nursing AIDS patients combined with

disappearance of the family led to a state of utter poverty where life was barely sustained. Non existent government and communal support systems could not cope, therefore this man was destitute and isolated (Barnett & Blaikie, 1992:98).

AIDS-affected households face the likelihood that they will have to cope with more than one death, because the disease clusters. They also have to deal with a long and debilitating illness that is costly in its use of resources in terms of both finances and time, and which pen-ultimately will end in death. In addition, the epidemic has a wider effect that weakens the ability of the community to lend support.

Due to their interdependence, deaths in individual households have implications for other households. Coping mechanisms become increasingly weakened as more households in a community are affected and communal support networks are less able to manage (Rugalema, 1999 in Barnett and Whiteside 2002:188). Affected households will have no choice other than to try and adapt to their changed circumstances. One way in which they do this is by changing their composition. Three key points can be mentioned to this effect.

(i) Societies where extended households are the rule or where clusters of households operate together to pursue a common livelihood strategy may become more resilient in the face of adult death.
(ii) Sending children to stay with relatives implies that the effect of the adult death will be felt beyond the forwarding family. Whoever takes responsibility for the care of the children can expect to spend more resources than is usual.
(iii) Orphans need care, either in other families or through some form of public support.

New forms of household are developing as a response to the impact of HIV/AIDS. Hunter (2000:195) identifies the following examples hereof.

(i) Grandparent-headed households, elderly household heads with young children.
(ii) Large households with unrelated fostered or orphaned children attached thereto.
(iii) Child-headed households.
(iv) Single-parent, mother-or father-headed households.

(v) Cluster foster care wherein a group of children is cared for formally or informally by neighbouring adult households.

(vi) Children in subservient, exploited or abusive fostering relationships;

(vii) Itinerant, displaced or homeless children.

(viii) Neglected and displaced children form part of groups or gangs.

Fieldwork recorded the following case of an aunt in Kampala, Uganda that illustrates the creation of new forms of household as a response to the impact of HIV/AIDS (Guest, 2001:28).

Case study 3

When Susan Nagawa died of AIDS someone had to look after her children. Her sister, Sophia Mukasa-Monico, already had two of her own, but she knew her duty. She returned to Uganda, together with her two children, from Italy where she had been living for over a decade, in order to adopt her orphaned teenage niece and nephew, Sharrot and Sandy. That was in 1990. Since then her home in the capital, Kampala, has filled up. With Sharrot and Sandy came another six teenagers, the orphans of Susan's co-wives (Guest, 2001:28).

In Uganda, people talk about the disease openly because every extended family has now lost someone to the disease. By 2000, there were nearly two million AIDS orphans. Ugandans are now having 10 children per family, which includes children from different families. This has become common practice in the East African country. "But it is hard work and expensive", says Mrs Mukasa-Monica (Guest, 2001:28).

Social welfare is facing such an acute situation in Uganda with orphans due to the impact of the HIV/AIDS epidemic that a non-governmental organisation named TASO, have stepped in. TASO recorded the names of 200,000 children on their books to be administered with only 259 staff members at seven branches nationally (Guest, 2001:28).

Mrs Mukasa-Monica is of the opinion that most Ugandans are being tested for HIV because the society is getting used to the disease. She says that everyone "... knows people who are not immoral, but are still infected, like my sister, who was one of the most faithful wives, but she still got infected". Most AIDS orphans would say the same about their mothers (Guest, 2001:28).

Things definitely improved when the political leadership came out in 1986 and stated: "Hey, we have a problem here. We have HIV." As Uganda's AIDS epidemic matures, a child who lives with two parents is now the exception. The need for people like Mrs Mukasa-Monica, prepared to provide love and shelter to children besides her own grows daily more severe. For Sophia it has entailed considerable sacrifices (Guest, 2001:28).

Income, consumption and expenditure patterns of affected households change. An adult illness or death reduces household income. Less labour is available, not only because the affected individual can not work but also because time is diverted to care for the sick (Barnett & Blaikie, 1992; Barnett & Whiteside, 2002).

Illness increases expenditure on medical care, food, washing materials, and so on. The experience has been that anecdotal evidence often shows they do not cope, or that the term coping may refer to be another way of describing a state of desperate poverty, social exclusion and marginalisation (Barnett & Blaikie, 1992; Barnett & Whiteside, 2002).

A five-year retrospective study of 232 urban and 101 rural AIDS-affected families in Zambia found that one "... of the striking features of the economic impact of AIDS in affected families in Zambia is the rapid transition to relative poverty" (Namposya-Serpell, 2000 in Barnett & Whiteside, 2002:189). This was particularly marked where a father died. Monthly disposable income of more than two-thirds of the families in this study fell by more than 80%. Thus: death is expensive. Some households cope by the sale of assets. In Zimbabwe, 24% of households said they had sold assets to cope with the death of an adult woman, with "... the main assets sold being cattle, goats, furniture, clothes, televisions, poultry and wardrobes" (Mutangadura, 2000:15).

For the survival of rural and poor urban households, it is crucial that they retain the productive assets necessary for them to recover and rebuild. A household can sell a radio and survive: the sale of cattle indicates a phase change in their lives and in their ability to maintain and reproduce themselves. Indeed, it may be taken as a clear indication of failure to cope. Two points should be noted. Firstly, people who are driven to sell the clothes of the dead or their own clothes can hardly be said to be coping: these are the actions of the desperately impoverished. Secondly, following from this, we have to be aware that the very notion of "coping" is deeply ideological and may smack of the wealthy telling the poor how to manage their concerns (Rugalema, 2000 in Barnett & Whiteside, 2002).

As discussed in the above sections HIV/AIDS causes the loss of household income. HIV/AIDS poses a threat to the economic organisation of a household, particularly to income-earning households. Women from income earning households who utilise health services represent an important segment since they carry the burden of the risk of HIV transmission and are responsible for the health of children and other family members. As the disease spreads among the economically active population, illness and ultimately death will result in changes in income in these households, while non-income-earning households may continue to receive pensions, grants or remittances irrespective of illness.

In the same way that individuals make up households, households make up communities and communities make up nations. The impact of the HIV/AIDS epidemic on communities is neglected, yet increasingly agencies and governments see them as being the answer to both prevention and impact strategies. There are no quantified studies of the impact of AIDS on communities. Thus: looking to communities as a resource in either prevention or impact mitigation relies on hope that communities are cohesive, interactive and mutually supportive entities. The utopian view is that people live in harmony with each other and adversity leads to increased cohesiveness and mutual aid and support. Communities may develop or divide around specific issues. Ugandan

communities have often united in the face of HIV/AIDS. In contrast in the KwaZulu-Natal province in South Africa, neighbours murdered Gugu Dlamini in 1999 for revealing her HIV positive status. They argued that she had brought shame on the community (Barnett & Whiteside, 2002). Furthermore, age and gender as the foundation for status is being replaced by individual achievement and with emphasis on youth, education and materialism in many African families. There is often a change in the positions of authority of husband and wife. The traditional extended family is gradually being replaced by a variety of family types, for example, the multigenerational family where the grandmother lives with her daughter and her daughter's children. Most elderly people at present have little or no education, but this can change as those who had education grow old (Eales, 1980:19), if they do not become infected with HIV and die because of AIDS.

While communities inevitably have some role to play, they cannot be seen as the ultimate solution to ending the epidemic. Rich communities may cope while poor communities may not be communities at all because they lack the resources to organise themselves effectively.

Despite this the burden of coping with impact is shifting on to communities. Again the reasons are varied: (i) the scale of the problem is such that governments recognise they have neither the financial nor the human resources to deal with the impact; and (ii) communities will manage whatever this means, and so to argue that they are being given the task of doing so is to legitimise what is happening in any event (Barnett & Whiteside, 2002).

Also, communities are seen as critical for successful prevention of the epidemic mainly because of two reasons: (i) prevention efforts have by and large focused on biomedical and scientific interventions, and it has been apparent that these do not work if the social, economic and community environment is not supportive; and (ii) in settings where prevention has worked, for example in Uganda, community responses have been

exceptional. These include openness and willingness to talk about the disease and to give support to those who are infected.

The socio-economic impact due to HIV/AIDS will be now discussed in the social category: women.

3.4 HIV/AIDS IMPACT: WOMEN

Since the beginning of the HIV/AIDS epidemic, it was observed that the disease does not affect all groups and communities equally. Instead, the impact is mediated by the structural inequalities inherent in societies worldwide. One consequence hereof is that the epidemic impacts more severely upon those who lack power or access to health care and other resources. Globally, women constitute one such disadvantaged group (Sherr et al., 1996:viii).

See chapter 2, table 2.3 "Table of country specific HIV and AIDS estimates and data, end 2003". Uniquely, sub-Saharan Africa is the only region in the world where more women than their male counterparts are infected with HIV. At end 2001, the total number of women (ages 15-49) estimated to be infected with HIV was 12,500,000 out of a total infected adult population (ages 15-49) of 22,000,000: or 56,82% were women. At end 2003, with an increased figure of total HIV infections, the total number of women (ages 15-49) estimated to be infected with HIV is 13,100,000 out of a total infected adult population (ages 15-49) of 23,100,000: or 56.71% were women.

Women suffer both emotionally and financially as their ability to provide for their families is affected by the death of a partner or personal fragility. This occurs at the very time that their needs increase for childcare, medication, hospitalisation, transport and the desire to live life to the full (Sherr et al., 1996:34).

The infection in women often places them at increased risk of rejection, loss of security, stigma, and violence. According to the UNAIDS (2003a) report AIDS is the leading cause of death for women aged 19-40, and infant mortality rates have increased as a result of mother-to-child transmission.

The physical factors responsible for this differential in transmission efficiency are the large mucosal surface area in women exposed to the virus, and the greater viral concentration in semen compared with vaginal secretions.

Sexual and economic subordination increase women's vulnerability to HIV infection. According to Essex et al., (2002:655) the six cultural and socio-economic gender-bound factors that increases the vulnerability of women to HIV infection and AIDS are the following.

(i) African women's relative lack of power over their bodies and their sexual lives. This situation is further reinforced by social and economic inequality and it makes women even more vulnerable to HIV infection and the consequences of the epidemic.
(ii) Social and economic inequality.
(iii) Traditional gender roles and attitudes toward fertility.
(iv) Lack of access to information about sexual and reproductive health.
(v) Traditional practices and beliefs about HIV and AIDS.
(vi) Gender based violence.
(vii) Limited political will and commitment exist to change the conditions between men and women.

In an effort to provide leadership and political will to bring about change in the situation of women as described above, the South African Deputy President, Jacob Zuma, stated in an address tilted "Restore morality to halt violence and abuse", that all South Africans should assist with the restoration of morality in their families and communities. He said that violence against women and children was mostly perpetrated by relatives or people known to them and, "It is only when families and relatives start exposing these practices, some of which go largely unreported, that we can minimise the violence and abuse".

Quoting the Medical Research Council (MRC) in South Africa, the Women's Health Project stated that 54,000 cases of rape were reported to the South African Police Services (SAPS) annually. The organisation questioned why it is that South Africa has some of the most desirable laws in the world but that the laws were seemingly unable to protect South African women and children (Sapa, 2003b:4).

The legal systems and cultural norms of many African countries reinforce gender inequality by giving men control over productive resources such as land, through, for example, marriage customs that subordinate wives to their husbands, and inheritance customs that make males the principal beneficiaries of family property. For example, in Botswana a woman married in community of property cannot access credit without her husband's permission. In other areas, young women face discrimination in employment and in economic opportunities in virtually every African society, resulting in a feminisation of poverty, and therefore perpetuating the economic subordination of women to men. These inequitable conditions impede women's ability to control income and property. Economic dependence on men further limits the sexual negotiating power of women thus making it difficult for them to refuse unsafe sex even when they know that their male partners are involved in risky sexual behaviours that could predispose them to HIV infection (Essex et al., 2002:657).

Women are more vulnerable and are most harshly impacted because of their inequitable status, roles, and limited rights in society (Essex et al., 2002: 655). AIDS is most prevalent among socially marginalised women who not only have a limited voice, but may also be intimidated and concerned to protect their children from stigma (Prebble and Foumbi, 1991 in Sherr et al., 1996).

Studies of women in Africa may reflect broader cultural as well as gender issues. According to De Bruyn (1992), it is reported in Uganda that women with HIV may be abandoned by their partners and may be left with no means to support themselves or their children.

Prevention programmes have traditionally neglected the role that heterosexual African men play in the transmission of HIV. Until recently, men have been treated as if they were unable to be seen as part of the solution to the HIV epidemic. Despite it being obvious that their patterns of socialisation and consequent behaviours often determine when, how, and to whom the virus is transmitted (Essex et al., 2002:655). In this regard, it is also reported that condom use is solely depended on male willingness (Sherr et al., 1996:35).

Most parents are absent in the sexual education of their children, highlighting another cultural issue. Research on intergenerational communication has shown that fathers and mothers are constrained by a culture that forbids them to talk to their sons and daughters about sex. While a few mothers do give their daughters instructions on menstruation and personal hygiene, most of them feel unable to discuss any topic related to sex. Girls, in turn, feel embarrassed about discussing these matters with their mothers and rely on friends or older sisters for information. Boys receive even less instruction on how to make responsible sexual decisions. Thus: boys and girls lack access to sexual and reproductive health information in a social context in which the majority of adult women face male control over sexual information and decision-making (Essex et al., 2002:657).

Cultural beliefs and practices relating to HIV/AIDS also play an important role. Public health campaigns have generally created high levels of awareness and concern about HIV and AIDS among Africans. However, the major problem in most countries is still the translation of this concern into responsible sexual behaviour. This gap between awareness and action results partly from cultural beliefs and myths. African youth grow up hearing about HIV/AIDS from older adults who share stories and myths that may render all prevention messages useless. This misinformation may lead youth to adopt behaviours with the belief that death is predetermined and therefore inevitable despite whatever actions they may take. For example, a young person who believes that HIV can be transmitted by mosquitoes is likely to see no point in abstaining from sex or using a condom. Some traditional doctors also claim that they can cure AIDS and cite stories of how their clients were healed and went on to live an AIDS-free life.

According to Essex et al., (2002) beliefs about HIV transmission and AIDS are also rooted in cultural perceptions of disease being a result of witchcraft or the breaking of social norms and taboos. It has been reported in Botswana that many older people believe that AIDS is not a new disease, but an epidemic resulting from non-compliance with the sexual taboos relating to widowhood, or "boswagadi". Boswagadi is a state of widowhood whereby one whose spouse has died must undergo ritual cleansing and observe several taboos. The major one being sexual abstinence for a period of one year. It is believed that failure to partake in the rituals and abstain from sex can result in disease and ultimately, the death of the widower or widow, or any person who has sex with him or her.

Women are not always equal partners in sexual relations and safety efforts are limited by negotiation skills, lack of dialogue, coercion, fear or dependency (Sherr et al., 1996:33).

This supposition is supported in (Essex et al., 2002:658) which states: "Gender-based violence is a major violation of human rights and a constraint to national development in Africa. Violence against women is deeply rooted in stereotypical gender beliefs and roles. Physical violence, the threat of violence, and fear of abandonment act as significant barriers for women who want to negotiate the use of a condom, discuss fidelity with their partners, or leave relationships that they perceive to be risky".

A study undertaken by the New York based Human Rights Watch (HRW) in Uganda found that domestic violence against women contribute to the spread of HIV/AIDS.

In the report released by HRW it is stated that women are forced by their infected husbands to have unprotected sex, and also fear testing, counselling or treatment due to the possibility of public scorn. Head of the Ugandan Health Ministry AIDS control programme, Dr Elizabeth Madra, disputes the claim that domestic violence plays a major role in spreading HIV/AIDS despite the fact that women in sub-Saharan Africa outnumber men with infections, by between 6%-8% (see chapter 2, table 2.3). The HRW

report states that women are left "... powerless to protect themselves from infection and are not able to access HIV/AIDS services because their husbands physically attack or threaten and intimidate them, and do so with impunity". Attorney Jackie Asiimwe said that the desperate situation Ugandan women found themselves in was being perpetuated due to marital rape not being an offence in Uganda and therefore women had no legal defence against sexual abuse (Sapa-AP, 2003b:4).

In most African countries women continue to experience beating, rape, abuse and socio-economic inequality, indicating that the home environment may not necessarily be as safe for many women and girls as is often assumed. It is required of leadership to provide political will for the cause of women and to make women part of HIV/AIDS prevention and impact mitigating strategies (Sherr at al., 1996).

The socio-economic impact due to HIV/AIDS will be discussed in the social category: the elderly.

3.5 HIV/AIDS IMPACT: THE ELDERLY

3.5.1 Ageing population

Population ageing is now a global phenomenon and is set to accelerate over the coming decades (Eekelaar and Pearl, 1989:4). This supposition is supported in Velkoff and Lawson (1998) who also states that the proportion of older people to younger people is changing. In the past, high mortality and fertility meant the proportion of the population reaching old age was relatively small. In this regard Kinsella and Ferreira (1997) also maintains that people are living longer. They attribute this to improvements in average life expectancy that are achieved primarily because infants survive the initial high-risk years of life in poor countries, whereas in rich countries this is achieved primarily through declines in mortality in the older age groups.

See table 3.2 "Proportions and numbers over age 65, past, present and future estimates". Since 1980 the majority of older people have been living in the developing countries. Myers, Binstock and Shana (UN, 1984) estimates that by 2020 there will be 300 million more older people living in developing countries than developed countries. Estimates also indicate that by 2020 there will be 357 million more elderly people worldwide than in 2000. This increase in the number of older people is not only based on more people living into old age but also that the older population is itself ageing further.

Table 3.2 Proportions and numbers of people over age 65, past, present and future estimates

	1980's	**2000's**	**2020's**
World	5,8% 259 million	6,6% 403 million	9,3% 760 million
Developed Countries	1,3% 128 million	13,0% 166 million	16,7% 230 million
Developing Countries	4,0% 132 million	4,9% 237 million	7,8% 530 million

Source: United Nations Yearbook (United Nations, 1984)

3.5.2 Problems associated with older people

In contrast to children who are orphaned or otherwise at risk, older people are less appealing to donors or governments in poor countries. In Barnett and Whiteside (2002:212) it is maintained that there exist prejudice against older people and that rapid social change and "development" often place them in positions of severe disadvantage. For example, the migration of young adults from rural to urban areas means that old people's adult children will not be around to look after them. The HIV/AIDS epidemic magnifies all of these problems and older women face even more difficulties than older men do. Rural old women are among the most adversely affected in any population.

The African population is finding that their traditional life is very much affected by the demands of an urbanising society. Consequently, this is having a profound effect on the family. Not only is the role of the aged person within the community changing, but also more families are finding it difficult to care adequately for their aged members (Eales, 1980:16).

The main problem confronting the elderly in a society affected by HIV/AIDS is poverty and an inevitable second problem is grief (Williams, 1998:245). Their failing powers make it more difficult for them to work on a farm or earn a living in some other manner. They become increasingly dependent physically and financially in all societies, and once again "the extended family" and its strengths can turn out to be more myth than reality. Poverty and frailty are made worse by the loss of adult children in two respects: (i) the loss of financial and other support that older people could have expected and might have received; and (ii) the unexpected burden of orphaned grandchildren who come to live with them.

There is an almost inverse correlation between the strength of belief in the effectiveness of support and caring functions of the African extended family, on the one hand, and a solid data and observational base on the other. Little is known objectively about the functioning of the African extended family with regard to welfare. Most work in this field

elderly in rural Africa. In this regard a case study undertaken by the UNU in Zimbabwe in 1987 found the following: (i) growing economic differentiation and pauperisation; (ii) very rudimentary welfare services with indifferent field staff; (iii) stronger informal support systems available to poorer elderly; and (iv) some elderly being more vulnerable

and insecure in terms of the limited provisions of the social security system (Hampson, in Eekelaar & Pearl, 1989:201).

3.5.2.1 Economic differentiation

In a small survey of 300 elderly in some 245 households from three districts of Zimbabwe, 54% of the sample households had no cattle. Those without cattle have to hire draught power from those who have, usually at high rates equivalent to at least the cost of tractor hire, but less efficient than tractor power because available draught beasts are undernourished at the beginning of the ploughing season when their efficiency is needed most. Lack of livestock also means that the households lack their own form of transport for agricultural, building and household activities like the carrying of firewood are all severely restricted and done by hand. Households without cattle also suffer from an absence of available manure, and any fertiliser used has to be bought and transported at very high cost (Hampson 1985 in Eekelaar and Pearl, 1989).

3.5.2.2 Welfare services

The main form of formal support at the time of the UNU study in 1987 was that of drought relief. Unfortunately the study showed that the delivery of services was very uneven, poorly organised, and discriminatory. It was uneven, because parts of the areas were very remote and almost inaccessible by vehicle, and in these areas small communities received no drought relief. The system was poorly organised because the maize meal was delivered at irregular intervals. Because there was only a standard amount of maize meal given, the recipients from big families suffered whilst others from small families had more than their needs (Hampson, in Eekelaar & Pearl, 1989:201).

3.5.2.3 Informal support

The devastating effects of drought in sub-Saharan Africa have focused attention on indigenous coping mechanisms and responses such as systems of exchange and social

organisation that can be mobilised in the face of drought in the region. The relational and kinship networks often cross over ecological, cultural and socio-economic boundaries, and transfer flows of goods, livestock, food and even labour in the form of children can be a source of support in time of crisis. The UNU study shows evidence that although the classic forms of indigenous support through labour are no longer common, nevertheless certain variations are used in times of crisis. Thus, in an emergency these systems can be reactivated. The support provided by the family is the most central type of informal support system available to the elderly in Africa, and principally the family means children (Hampson, in Eekelaar & Pearl, 1989).

Most societies are patrilineal and sons and daughters would grow up in the extended family that includes grandparents, parents, brothers, sisters, uncles and their children. As the extended family grows unwieldy and as the head of the family passes away, younger brothers of the deceased could move away to form their own family unit. However, when a man dies, his responsibilities for the family were taken over by a surviving brother or cousin, and this brother would look after the widow in old age, and would be known as "baba" or father to his deceased brother's children. The deceased's eldest brother would not only take over the property of the deceased, but could acquire marital rights over the widow if she was in agreement, otherwise the widow could return to her own family. All younger members of the extended family would thus honour their elderly relatives, and would be expected to visit them frequently, and invite their help and assistance on matters that arose from day to day (Hampson, in Eekelaar & Pearl, 1989).

The relationship between elderly parents and their children is strengthened by the very common practice of young boys and girls staying with their grandparents for an extended period of time (Hampson, in Eekelaar & Pearl, 1989).

3.5.2.4 Vulnerable groups

The United Nations University (UNU) data indicates, as is supported from other studies, that the following four groups are under served by formal support systems, and that the

informal support systems cannot meet even their basic needs: (i) elderly on their own with no children nearby; (ii) elderly widows who have elected to return to their "home" area; (iii) elderly farmers who have neither livestock nor agricultural implements; and (iv) elderly who suffer from serious emotional and psychosomatic illness but who lack an emotional support network.

The current formal systems of support and welfare provided by government such as drought relief and public assistance do not meet the needs of the elderly. A number of reasons account for this dismal state of affairs: (i) programmes are not targeted specifically at the elderly, and hence lack the concern that could alert responsive programme structures to the existence of unmet needs; (ii) programmes are underfunded for example, the public assistance programme has around a Zimbabwe Dollars 300 000 monthly expenditure for approximately 29,000 recipients and desperately needs manpower and training; and (iii) political and other considerations unfortunately hampers the work of welfare (Hampson, in Eekelaar & Pearl, 1989:201).

3.5.3 Old age and poverty

A detailed study of older people in Buganda (Williams, 1998) describes the conditions which the elderly endure in a rural society in Africa. They have poor housing and are often unable to repair what they have. Poor housing means poor security and loss of food and other valuable items to insects, animals and theft. Preparing and cooking food also present unique challenges. Within their homes, poor old people may not have sufficient bedding to stay warm at night. One respondent told Williams (1998:140) "I sleep on a bark cloth on the ground and I cover myself with my dress". Old people living alone also face considerable difficulties obtaining water for washing, cooking and drinking.

Failing adequate water supply, the results for the elderly may include thirst and hunger. Furthermore, with no water to cook and wash dirty clothes, a lack of personal hygiene and intestinal worms associated with poor sanitary conditions transpire (Williams, 1998:143). Another constraint is wood for fuel. This is a very labour intensive and

demanding task and old people often find it hard to obtain enough. The result of this combined with the failing ability to produce food from the farm or to purchase it, is inadequate diet. The impoverished and desperate situations of the elderly in sub-Saharan Africa are also mentioned in Guest (2001).

The elderly in sub-Saharan Africa are not alone in being left on their own to fend for themselves, forgotten or ignored. This is also the case in France, where nearly 10,000 elderly have died due to heat exhaustion during the summer of 2003. Now the French nation also has to confront their inaction and neglect of the aged (Crumley, 2003:42).

3.5.4 Elder people and orphans

Williams (1998:230) suggests that old "... people are affected by the epidemic more through the fulfilment of their parental obligations than the loss of their children's support". First of all they care for their children who are sick, then they put them to rest and finally, they care for their grandchildren. In Uganda as long ago as the late 1980's, aged grandparents had increasingly assumed responsibilities for rearing orphans. Lack of energy to work in the fields meant that the range of food available to them and their dependents became smaller and their nutritional status became worse. The implications of this situation are well summarised by a teacher, who said their school has "... over 80 orphans and you can tell those from grandparent homes. Their noses are always running and their uniforms are often not clean, ironed or repaired" (Barnett & Whiteside, 2002:219).

The socio-economic impact due to HIV/AIDS will be now discussed in the social category: orphans.

3.6 HIV/AIDS IMPACT: ORPHANS

Case study 4

Beauty Bala has taken six AIDS orphans into her home since 1998. Ms Bala found them living alone on the dusty streets of Rondebult, a poor township in South Africa. Ms Bala elaborated on her situation: "I only get a grant for one child and I am struggling. I have a food garden and that helps us but it is tough to live". Child-rights activist, Graca Machel, said orphans are "streamed into poverty" and faced the trauma of watching their parents die slowly and having to face the stigma of being children of AIDS (Russouw, 2003a:4). According to the United Nations Children's Fund (UNICEF, 2003) report, released in November 2003, the prevalence of orphans is increasing at an alarming rate in Africa and their situation has become desperate.

3.6.1 Orphan prevalence is increasing dramatically

Estimates of 26 African countries suggest that the number of children losing a father (paternal orphans) or a mother (maternal orphans) from any cause will more than double between 1990 and 2010. By 2010 15% of children in these 26 African countries will have lost one or both parents, with the greatest changes expected in Botswana (with 37% of children orphaned) and South Africa (with 32% of children orphaned). See chapter 2 and section 3.1 in this chapter. Even if rates of new HIV infections in adults were to fall in the next few years, the long incubation period of the virus means parental mortality rates would not level out until 2020. Thus: the percentage of orphans is expected to remain unusually high throughout the first half of the 21st century (Essex et al., 2002:665).

In the report "Africa's orphaned generation" released by the United Nations Children's Fund (UNICEF, 2003) in November 2003, it is predicted that by 2010 one in five children in Zimbabwe, Botswana, Lesotho and Swaziland will be orphaned due to HIV/AIDS. The UNICEF report states "As staggering as the numbers already are, the orphan crisis is just starting to unfold. As today's young adults die in growing numbers,

they will leave growing numbers of orphaned children. They are more likely to be poorer, suffer damage to their cognitive and emotional development and to be subjected to the worst forms of child labour". In this regard, Ms Carol Bellamy, Executive Director of UNICEF, said it is of crucial importance to ensure children were kept in school and that HIV-positive parents have access to life saving drugs "... so they can live longer" and raise their children (Russouw, 2003a:4).

3.6.2 Current figures and estimates of orphans

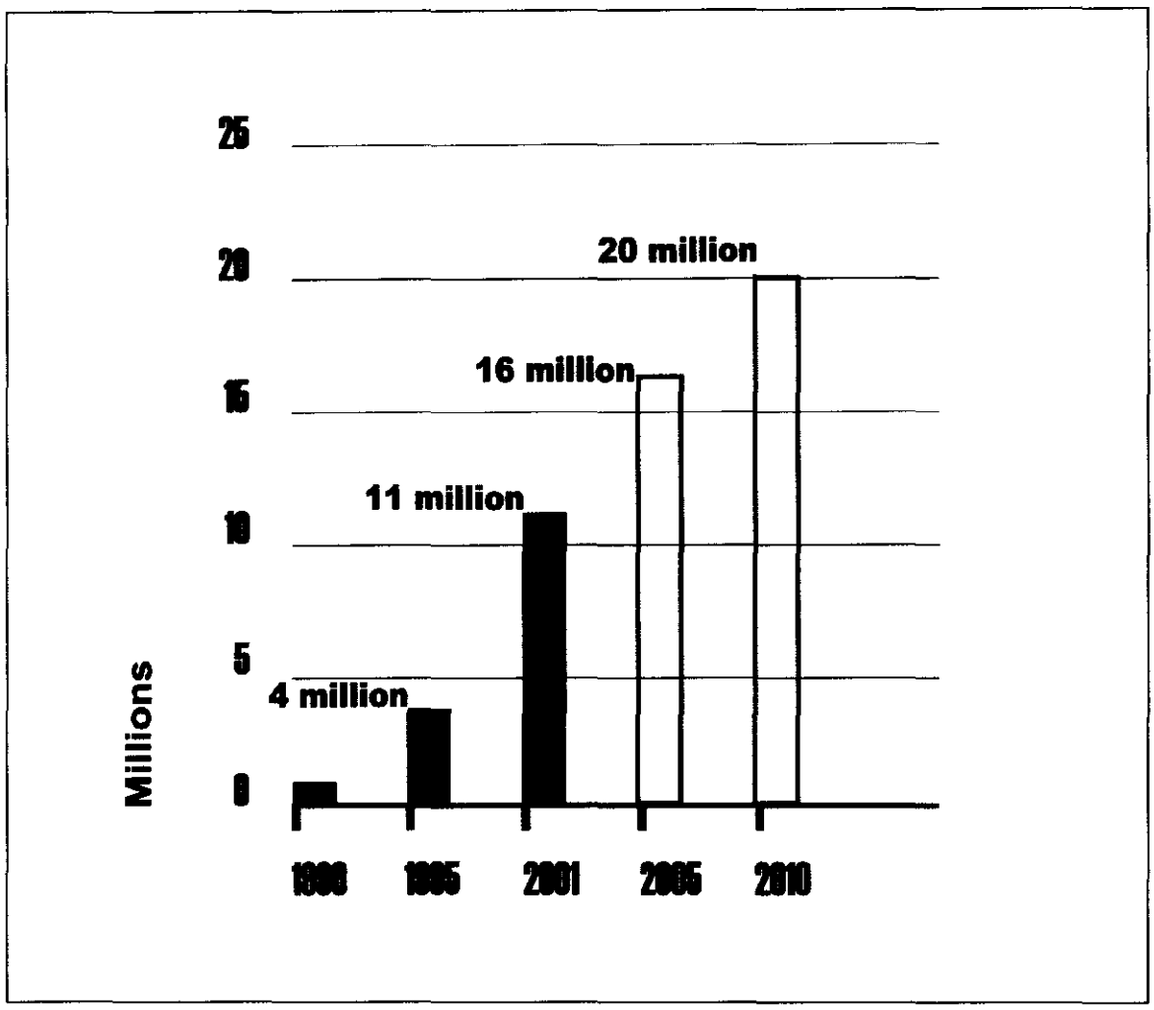
See figure 3.2 "Children who have lost at least one parent to AIDS, 1990-2010". The orphans Ms Bala, is looking after refered to in case study 4, are among 11 million of Africa's children under the age of 15 who have lost their parents to the HIV/AIDS epidemic. The United Nations Children's Fund (UNICEF, 2003) report "Africa's orphaned generation" released in November 2003 estimates that by 2010 the orphan figure in sub-Saharan Africa will soar to 20 million.

UNICEF estimates that AIDS have worldwide orphaned approximately 14 million children by 2003. The report states because of "... HIV/AIDS, the number of orphans is now increasing exponentially rather than declining". UNICEF Executive Director, Carol Bellamy said that AIDS orphans are "... arguably the most neglected crisis spawned by the HIV/AIDS pandemic" and that "... we are facing a development catastrophe that requires an emergency response". Ms Bellamy continued by saying that there "... is no better gauge of its scale and cruelty than the orphan crisis and the shameful inadequacy of the world's response to date" (Russouw, 2003a:4).

More than 13 million children have lost at least one parent to AIDS and approximately 33,3% of them lost both parents to the disease. According to UNAIDS (2003a), children who have lost at least one parent to AIDS in the three Africa countries number as follows: South Africa 662,000; Uganda 884,000; and Botswana 80,000.

Figure 3.1 follows on the next page.

Figure 3.1 Number of children who have lost at least one parent to AIDS, 1990-2010



Source: Africa's orphaned generation (UNICEF, 2003)

3.6.3 Informal support

According to the United Nations Children's Fund (UNICEF, 2003) report 90% of AIDS orphans in sub-Saharan Africa were cared for by their extended families. The UNICEF (2003) report states "but this traditional support system is under severe pressure. Many countries are experiencing large increases in families headed by women and grandparents" due to the impact of HIV/AIDS. Furthermore the report states that African

governments "... had been slow to respond" and found that 65% of governments did not have national policies in place to address the plight of AIDS orphans.

See section 3.5.2. The same argument used for the elderly has been used by some for orphans, namely, that an entity called the extended family will absorb the orphans and destitute created through AIDS-related mortality. This view has been heard from people ranging from senior policy makers in international agencies to politicians in Africa and Asia. It is now heard less as the full effects of the epidemic become apparent. As discussed above, this situation can be described as follows (Eekelaar & Pearl, 1989; UNICEF, 2003):

(i) It is a variable, it is dynamic and can become more or less extended depending on resource availability.

(ii) It is ideological, as it is something people want to believe because it validates their traditions.

(iii) It is ideological because belief in it relieves politicians from responsibility for thinking through the implications of the epidemic and having to provide effective leadership in the administration of the epidemic.

(iv) Reaches a point where it can no longer cope.

In the past, the sense of duty and responsibility among extended families in Africa was almost without limit. Even when a family did not have sufficient resources to care for its existing members, orphans were taken in. This was the basis for the assertion that traditionally "... there is no such thing as an orphan in Africa" (Foster, 2000 in Essex et al., 2002). Africa is home to approximately 90% of the children orphaned by AIDS (UNAIDS & WHO, 1999; UNICEF 2003). Paradoxically, the effectiveness by which African extended families have absorbed millions of vulnerable children has contributed to the complacency of external agencies and governments concerning the emerging orphan crisis (Essex et al., 2002:665; UNICEF, 2003).

Contrary to the traditional belief, as early as 1992, a study in urban South Africa showed that 62% of residents in Soweto felt that AIDS orphans should be the responsibility of the

state (Steinberg et al., 2000 in Barnett and Whiteside, 2002). Thus: the impact of the epidemic on children and families has proven to be particularly hard to quantify, analyse and confront, and even harder to put on the agendas of policy makers, philanthropic agencies, and political leaders.

Families cope with the death of relatives by ensuring that orphans receive care from a substitute caregiver. See section 3.3.2. According to Essex et al., (2002:665) the extended family support network functions through changes in household composition: relatives move into households to care for children who survive their parents, or orphans move into households of one or more relatives in response to the overwhelming demands of the epidemic. The extended family remains the predominant care-giving unit for orphans in communities in Africa with severe epidemics. But the extended family is not a social sponge with an unlimited capacity to soak up orphans. This traditional safety net is becoming saturated, overwhelmed, and weakened by a combination of three factors:

(i) huge increase in the number of orphans;
(ii) significant decrease in the number of prime age caregivers; and
(iii) systemic change to the social structure that underpins the traditional safety net.

This view is also supported by (Hampson, in Eekelaar and Pearl (1989:201) and by the Executive Director of the United Nations Children's Fund (Russouw, 2003a:4) and it's November 2003 report (UNICEF, 2003).

In Barnett and Blaikie (1992) a thorough explanation is given of the change in the social structure that underpins the traditional safety net; therefore the failure to assist in providing care and support for women, orphans and the elderly due to HIV/AIDS in Africa as is described in Eekelaar and Pearl (1989); Essex et al., (2002) and UNICEF (2003), requires urgent attention by political leaders and governments.

The reason for the many orphans that are without care in Buganda, a region in Uganda, is analysed as follows. Firstly, Buganda has undergone enormous changes over the past century as has most regions in Africa. Secondly, even in societies where custom is, or was supposed to dominate, people did not always obey it. Rather, they made their

individual and household decisions in relation to custom, rather than always in accordance with it, as in any human community. Thus, what to do and how to do it always contained an important element of individual choice. The importance of this observation is that in Buganda, in Uganda and in Africa as a whole, traditional custom does not dominate the exclusion of individual, household and familial choice (Barnett & Blaikie, 1992:111).

Responses to abnormal circumstances will undoubtedly increase the extent to which people act in ways that are inconsistent with their customs and values. In the HIV/AIDS-affected communities a feeling prevails that more ought to be done and there are many explanations of what is perceived as a reluctance to take in orphans. These feelings centre on the constraints placed on households by the difficulties of the general economic climate. People are of the opinion that they can barely feed, clothe and send their own children to school, let alone assume additional responsibility for orphans. Furthermore, given the high levels of AIDS-related mortality in this area, salary earners or the wealthy find themselves increasingly requested to care for the children of their dying relatives or friends. Such people may feel that they are unable to provide for any more dependants in their households. In these circumstances, it may once again be concluded that indigenous mechanisms for managing orphans within the kinship and household system have now reached, or are reaching, their absorptive capacity.

There also exist an additional reason why orphans may remain without care. This is due to stigma. In this regard fear exist that the orphans may be infected with AIDS and that they will pass is on to the families who care for them. Although few instances of this concern were reported, there were sufficient reasons for it to be seen as a significant area requiring attention by leadership (Barnett & Blaikie, 1992:111).

Moreover, social welfare systems started to weaken prior to the impact of AIDS as a result of economic mismanagement, corruption, and the imposition of structural adjustment programmes. The largest increases in orphan numbers are occurring in the

countries in southern Africa that had high rates of urbanisation and weakened extended-family safety nets (Essex et al., 2002:666).

3.6.4 Impoverished orphan households

Economic factors are crucial: as it will determine how the extended family will provide care for its orphans. The death of a father within a household often causes the most harmful economic consequences for children because of high costs for medical treatment, the loss of income, funeral costs, and often, the loss of family property as a result of opportunistic seizure. When there are no other sources of income, poor households will be forced to sell off assets that are critical to provide desperately needed revenue: even if the sale thereof will jeopardise the long-term sustainability of the household. In Uganda, per capita income in orphan households was 15% less than in non-orphan households (Konde-Lule et al., 1995).

Mobility is common among adolescents affected by AIDS. In order to generate an income, adolescents leave orphan households to seek work, as agricultural labourers for more prosperous farmers or, in towns, as domestic workers. Some girls become involved in commercial sex work or enter into marriage as girl brides to provide for the needs of younger children in their household. Children who live on the streets are significantly more likely to be orphans. This is found true because of the numbers of street children that have increased as a result of the epidemic. One less obvious economic impact of the epidemic has been an increase in child labour, sometimes involving children as young as five. In fact, within one household, the workload of orphans may be greater than that of the non-orphans, especially true if the orphan is female. Orphans may be co-opted into agricultural activities or may work as virtual slaves for domestic chores (Essex et al., 2002:669).

The following case study provides details of the situation facing children who have become orphaned due to AIDS.

Case study 5

More children are now going hungry than before because the mortality rates of parents (breadwinners) have increased dramatically due to AIDS. "Economies are collapsing and famines are growing in areas that always had food", said Aloys Nyabola Mbori. He heads various committees that are committed to find ways to feed and care for the growing number of orphans in East Kagan, a village in western Kenya. Mbori added that Africa "... has seen poverty, but this will be worse than anything we have ever known" (Wax, 2003a:5).

Families are breaking apart because they cannot feed all the orphaned relatives who come to the door, desperate for help. Gideon Oswago is head public health officer for the African Medical and Research Foundation, an organisation based in Nairobi. Oswago cares for four orphans, along with six of his own children. He said that the situation "... reached the point where if you see an orphan coming, it is a huge burden". There is also concern among health and education workers that a generation growing up without parental guidance will worsen political instability on a continent already struggling to overcome terrorism, civil and ethnic strife (Wax, 2003a:5).

Rebel groups have tapped into this vulnerable orphan population by enticing abandoned children to earn money, food and respect with guns. The United Nations Children's Fund (UNICEF) said the "... implications of this are monstrous. The profound trauma of losing a mother or both parents has devastating long-term implications, not only for a child's well-being and development, but for the stability of communities and ultimately nations themselves". According to UNICEF, by 2003 there were an estimated 892,000 orphans in Kenya (Wax, 2003a:5).

From the above case study the desperate situation facing orphans also impacts upon other areas such as education and legal protection for orphaned children. These impacts will be discussed in the following sections.

3.6.5 Education of orphans

AIDS orphans are at greater risk of malnutrition, illness, abuse and sexual exploitation than children orphaned by other causes. They must grapple with the stigma and discrimination so often associated with AIDS, which often deprive them of basic social services and education (Kelly, 2000 in Barnett & Whiteside, 2002).

A study in Uganda found that affected households were so financially strained that they could not raise funds to send their own children to school. Likewise, the education of children in households with parents weakened by HIV/AIDS may be disrupted if the children take over household and care-giving chores. When families need to generate cash, boys, who have more earning power, may be removed from school. Research have found that among children between the ages of 15 and 19 whose parents had died, only 29% continued their schooling without disruption, 25% lost school time, and 45% dropped out of school altogether. Children of school-going age who had the greatest chance of continuing their education, were those who lived with a surviving parent, while those fostered by grandparents have the least chance. Even where orphans manage to continue schooling, their performance is often poorer than their non-orphaned counterparts (Essex et al., 2002:668).

3.6.6 Legal protection of orphans' properties

In Uganda a number of disputes before local courts involving orphans are recorded. These cases concerned the rights of orphans to inherit the tenure of the farm from their deceased parents. See section 3.6.4 "Impoverished orphan households". Unfortunately, these children are vulnerable to pressures from guardians, relatives and others without moral scruples. Minors are always vulnerable to relatives who may want to cheat them out of their inheritance, or who may divert their wealth to educating their own children. Orphans are no exception. In the Rakai district of Uganda, some landlords have started dispossessing the orphans of their rights of land which their parents had enjoyed and

which are widely treated as heritable in these communities. These are specific problems of policy that need to be addressed. However, the underlying policy issue is the choice between targeted and non-targeted aid. The former may create privileged households and encourage corruption and even orphan-farming by unscrupulous people. The latter may be seen at best as an inefficient use of scarce resources, at worst as a threat to the welfare of these children. In general we are talking about very poor people and very poor communities, their poverty made worse by the past traumas they have suffered and the current trauma due to HIV/AIDS (Barnett & Blaikie, 1992,125).

The impact and the importance of the social groups: individuals, households and communities, women the elderly and orphans enjoy universal recognition as social groupings that are in drastic need of support, policy and leadership action for positive results. Prove of this is the support that is given toward alleviating the dire situations faced by these groupings by prominent international aid agencies such as the World Bank, United Nations, and the Washington, DC based AIDS Action organisation. Furthermore, the issues surrounding these social groupings were formally discussed at both the International AIDS Conferences held in Kampala, Uganda in 1995 and in Durban, South Africa in 2000 to promote their causes for attention by leadership.

3.7 CONCLUSION

In chapter 3 the socio-economic impact due to HIV/AIDS with emphasis on the social groupings: individuals, households and communities, women, the elderly and orphans have been described.

When the HIV/AIDS epidemic was recognised worldwide as an epidemic with serious consequences for every country in the world where it starts to spread and the fact that there exists no cure for it, it was made a major issue in the United Nations (UN) administration. Many years of research, worldwide campaigns and programmes in many countries preceded the document "Declaration of Commitment on HIV/AIDS", signed by

all member countries at the UN General Assembly Special Session on HIV/AIDS, 25-27 June 2001 (UN, 2001).

The heads of State and Government representatives assembled at the United Nations from 25-27 June 2001, for the 26th special session of the General Assembly. The Assembly was convened in accordance with resolution 55/13 of 3 November 2000 as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects, as well as, to secure a global commitment to enhancing co-ordination and intensification of national, regional and international efforts to combat it in a comprehensive manner (UN, 2001).

The Assembly noted with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst affected region. In Africa, HIV/AIDS is considered a crisis: which threatens development, social cohesion, political stability, food security and life expectancy, and imposes a devastating economic burden. Furthermore, the emergency situation on the continent needs urgent and exceptional national, regional and international action (UN, 2001).

Because stigma, silence, discrimination and denial, as well as a lack of confidentiality undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families and communities and nations, it must also be addressed (UN, 2001).

The Assembly stressed that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS (UN, 2001).

The Assembly acknowledged that prevention of HIV infection must be the mainstay of national, regional and international response to the epidemic. Also, that prevention, care, support and treatment for those affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic (UN, 2001).

The Assembly recognised the need to achieve the prevention goals set out in the Declaration in order to stop the spread of the epidemic, and acknowledged that all countries must continue to emphasise widespread and effective prevention, inlcuding awareness-raising campaigns through education, nutrition, information and health-care services (UN, 2001).

Also recognised is the fact that effective prevention, care and treatment strategies will require behavioural changes (UN, 2001).

The Assembly (UN, 2001) welcomed the progress made in some countries to contain the epidemic, particularly through:

(i) strong political commitment and leadership at the highest levels, including community leadership;
(ii) effective use of available resources and traditional medicines;
(iii) successful prevention, care, support and treatment strategies, education and information initiatives;
(iv) working in partnership with communities, civil society, people living with HIV/AIDS and vulnerable groups; and
(v) the active promotion and protection of human rights; and building on collective and diverse experiences, through regional and international co-operation.

The Assembly noted that strong leadership at all levels of society is essential for an effective response to the epidemic. Leadership by governments is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector. They further noted that leadership involves personal commitment and concrete actions.

Three years after the "Dedication to Commitment on HIV/AIDS" was accepted, it formed the basis of both the speeches of the United Nations Secretary-General, Mr Kofi Annan (2004), and of UNAIDS Executive Director, Dr Peter Piot (2004), at the XV International

AIDS Conference, held in Bangkok, Thailand, 11-16 July 2004. They both took stock of the progress made by member countries since the Declaration was accepted.

Dr Piot (2004) stated that most importantly every community needed to change their behaviour in order to rewrite the rules (transformation) of how it deals with those sensitive issues at the heart of the epidemic: sex, homosexuality, commercial sex, drug use, rape, stigma, gender and masculinity. He continued by saying that some of the greatest challenges faced in this century are of peoples own making: " the obstructions of bureaucracy, the injustice of stigma, the rivalry, the lack of coherence, and the failure of political leadership".

According to Dr Piot the tools to change the course of the epidemic are within the reach of all countries. But he questioned if affected countries were committed to transformation; thus willing to change their institutional behaviours in order to be successful (Piot, 2004).

In his opening address to the XV International AIDS Conference on 11 July 2004, Mr Annan (2004) stated that very few countries and leaders had fulfilled their obligations. He said the fight against HIV/AIDS required leadership from all sections of government, and it needed to go right to the top. Further reference is made to the Secretary-General's speech in the conclusions of chapters 5, 6 and 7.

According to both the UNAIDS (2004) report and the findings of the XV International Conference on AIDS held in Bangkok, 11-16 July 2004, the HIV/AIDS epidemic is continuing to increase in numbers of new infections worldwide, and in new areas such as India.

A survey of the theories of leadership, in chapter 4, follows.

CHAPTER 4

LEADERSHIP

4.1 INTRODUCTION

The primary aim of this chapter is to do a survey of the following theories of leadership: transformational leadership; leadership as traits and motives; and the bases of leadership-power. The history of leadership will also be discussed to support the description of the meaning of leadership, in order to define effective leadership.

Leadership as a phenomenon is distinguished from management. Management could be described as more formal and a scientific concept, while leadership is described as an art and a trait. Therefore, the relationship between leadership and management is determined to have a better understanding of leadership as such.

A further aim of this chapter is to find an answer to the question, whether leadership makes a difference, by investigating three arguments that mitigate the value of leadership.

In order to understand the theories of leadership that are discussed in this chapter, it is necessary to provide a background of leadership.

4.2 CONCEPTS OF LEADERSHIP

4.2.1 Beginnings of leadership

The study of leadership is one of the world's oldest preoccupations. The understanding of leadership has figured strongly in the quest for knowledge (Nkomo, 2003:13) throughout the ages.

Leaders such as prophets, priests, chiefs and kings, served as symbols, representatives and models for their people in the Old and New Testaments, in the Greek and Latin classics, and in the Icelandic sagas. The subject of leadership was not limited to the classics of Western literature. It was of much interest to Confucius, Plato and Aristotle. Myths and legends about great leaders were important in the development of civilised societies. The greater the socio-economic injustice in the society, the more distorted the realities of leadership, its powers, morality and effectiveness (Bass, 1990:3). All societies have created myths to provide plausible and acceptable explanations for the dominance of their leaders and the submission of their subordinates (Paige, 1977).

The study of leadership rivals in age the emergence of civilisation, which shaped its leaders as much as leaders shaped civilisation.

From its infancy, the study of history has been the study of leaders: what they did and why they did it. Over the centuries, the effort to formulate principles of leadership spread from the study of history and the philosophy associated with it to all the developing social sciences. In modern research there is still a search for generalisations about leadership, built on the in-depth analysis of the development, motivation and competencies of world leaders, living and dead (Bass, 1990:3).

Written philosophical principles dated B. C. were developed, in and by which guidance could be given to future leaders.

The Egyptian hieroglyphics for leadership (seshemet), leader (seshemu) and the follower (shemsu) were written 5,000 years ago. The Chinese classics, written as early as the 6th century B. C., aimed to exhort advice to leaders of the country about their responsibilities to the people. Confucius urged leaders to set a moral example and to manipulate rewards and punishments for teaching what was right and good. Taoism emphasised the need for the leader to work himself out of his job by making the people believe successes were due to their efforts (Bass, 1990:3) and that the leader is no longer required by the followers.

The heroes in Homer's Iliad exemplified Greek concepts of leadership. Ajax symbolised inspirational leadership and law and order. Other qualities that the Greeks admired and thought were needed in heroic leaders, were: (i) justice and judgement; (ii) wisdom and council; (iii) shrewdness and cunning; (iv) valour and activism (Sarachek, 1968).

Greek philosophers such as Plato, in his Republic, scrutinised the requirements for the ideal leader of the ideal state. The leader was to be the most important element of a good government, educated to rule with order and reason. Aristotle, in his politics, was disturbed by the lack of virtue among those who wanted to be leaders. He pointed to the need to educate youths for such leadership.

A scholarly highlight of the Renaissance was Machiavelli's "The Prince" (1962). Machiavelli's thesis: "... there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things", is still a germane description of the risks of leadership and the resistance to it. He believed leaders needed steadiness, firmness, and concern for the maintenance of authority, power, and order in government. According to Bass (1990:4), Machiavelli is still widely quoted as a guide to effective leadership. At West Point, an elite military training college in the United States, the fundamental principle of Hegel's (1971) "Philosophy of Mind", which argues that by first serving as a follower, a leader subsequently can best understand his followers, is taught. According to Hegel (1971), the understanding of the above principle is a paramount requirement for effective leadership.

Hegel's (1971) "follower" principle is supported by Peter F. Drucker. Drucker states (in Hesselbein, Goldsmith & Beckhard, 1996), that all effective leaders display four commonalties: (i) Leaders have followers, without followers there can be no leaders. (ii) Effective leaders are not necessarily loved or admired, their followers do the right things in order to attain the required results. (iii) Leaders are highly visible, therefore they set examples. (iv) Leadership is not rank, privileges, titles or money: it is about accountability and responsibility.

4.2.2 Phenomenon of leadership

Leadership is a universal phenomenon in humans and in many species of animals.

According to Allee (1945, 1949, 1951) in Bass (1990), all vertebrates that live among and in groups, exhibit social organisation and leadership. This is observed among high-ranking males who feed more freely than do other members of the group and who tend to have more ready access to females. In some cases high status involves guard duty and protection of the herd. Individual animals dominate or submit their local spaces to others in the well-known pecking order. Carpenter (1963), in Bass (1990), studied societies of monkeys and apes. His general findings suggested, that the leader tended to control the group's movements in its search for food and shelter, regulate intragroup status, defended the group, and maintained its integrity in its contacts with other organised groupings. When the dominant male was removed from the group, the territory covered by the group was markedly reduced. Thus: the leader enlarged the freedom of movement and ensured that feeding of the group remained sustainable.

Parenthood is a condition that unarguably cuts across cultural lines and makes for ready-made patterns of leadership to be observed. Nevertheless, the patterns of behaviour that are regarded as acceptable in leaders, differ from time to time and from one culture to another. Citing various anthropological reports on primitive groups in Australia, Fiji, New Guinea, the Congo and elsewhere, H. L. Smith and L. M. Krueger (1933) concluded, that leadership occurs among all people, regardless of culture, be they isolated Indian villagers, nomads of the Eurasian steppes, or Polynesian fisher-folk.

Leaders such as Abraham, Moses, David and Solomon, were singled out in the Old Testament for a detailed exposition of their behaviour and relations with God and their people. God was the supreme leader of His people who clarified, instructed and directed what was to be done through the words of His prophets and arranged for rewards for

compliance and punishment for disobedience to the rules and laws He had handed down to Moses.

Latin authors such as Caesar, Cicero, and Seneca wrote extensively on the subject of leadership and administration. Their influence on Thomas Jefferson and James Madison had an impact on the design of government of the United States of America. Military writings about leadership stretch from the Chinese classics to the present. Among them were the writings of Napoleon. He listed 115 qualities essential for a successful military leader.

4.2.3 Importance of leaders and leadership

Napoleon expressed his feelings about the importance of leadership in his remark that he would rather have an army of rabbits led by a lion than an army of lions led by a rabbit. Leaders can make the difference in whether their organisations succeed or fail. Surveys of job satisfaction from the 1920's onward illustrated the importance of leadership. The outcomes of these surveys uniformly reported, that the favourable attitudes of employees toward their supervisors contributed to the satisfaction and commitment that employees displayed toward their work (Bass, 1990:6).

Leaders affect organisational performance.

Leaders, through their actions and personal influence, bring about change. Individuals who control organisations, mostly senior officials, live by this assumption. A frequent antidote to major organisational problems, is to replace the leader, in the hope that the newly appointed leader will reverse performance problems (DuBrin, 2004:6).

An example of this assumption in action, is the frequent replacement of athletic coaches and the team leadership after one or two losing seasons. The owners, officials, players and spectators assume, that the leadership acumen of the new leadership and coaches will vastly improve the ratio of wins to losses. Duncan Innes (2003:12) wrote that one of the

saddest aspects of the South African campaign in the 2003 Rugby World Cup, had been the pathetic attempt by the rugby leadership to justify their failures and that of the coach in this way to keep their well-paid positions. Innes (2003:12) continued by stating, that if any of the leadership and coaches who where destroying South African rugby, while earning excessive pay cheques and benefits, were allowed to continue in their jobs for longer than one more week, it would be a disgrace to the nation.

Followers expect that people in senior positions act like leaders.

It is expected of leaders to provide their organisations and their people with hope of a better future. The leaders must also show that they command a thorough understanding of what actions are required, give direction and provide opportunities to learn and grow (Manning, 2002:53).

Effective leadership is in high demand. In particular, there is a call for strong ethical leadership.

This interest has resulted in a burgeoning of academic programmes in leadership studies throughout the world. Courses in leadership, ethics and leadership, and community leadership, are being integrated into the academic curricula at all levels (Northouse, 2004). The largest number of leadership positions in the United States are in the non-profit and social sectors. It is becoming increasingly important as more and more of the tasks that government was expected to do during the last 40 years, will have to be taken over by civil organisations and non-profit organisations (Peter F. Drucker in Hesselbein, Goldsmith & Beckhard, 1996). They all require effective leadership.

A good example hereof, is the acceptance of corporate social responsibility as good practice in business. The pursuit of profit is tied to a commensurate moral obligation to support the communities in which an organisation operates. Corporate social responsibility is an area in which an organisation is able to combine business, community and personal reward (Llett, 2004:10).

In the tenuous years that lie ahead, the familiar benchmarks, guidepost and milestones will change as rapidly and explosively as do the times, but one constant at the centre of the vortex, will be the leader.

The modern leader for today and the future, will be focused on how to develop quality, character, mind-set, values, principles and courage (Francis Hesselbein in Hesselbein, Goldsmith & Beckhard, 1996:122). An effective leader will be monitoring the quality of leadership, the work force and relationships.

More and more organisations today are facing adaptive challenges. Changes in societies, markets and technology around the globe are forcing them to clarify their values, develop new strategies, and learn new ways of operating. The most important task for leaders, in the face of such challenges, is mobilising people throughout the organisation to adapt (Heifetz & Laurie, 1998:171).

The following section will address the meaning of leadership.

4.2.4 Meaning of leadership

The word "leadership" is a modern concept that denotes an element of sophistication.

In earlier times, words meaning "head of state", "military commander", "chief" or "king" where more readily used in most societies. These words differentiated the ruler from other members of society (Bass, 1990:11).

The Concise Oxford English Dictionary (COED, 2002:806) describes a leader as "... the person who leads, commands, or precedes a group, organisation, or country"; also "... a member of the government officially responsible for initiating business in parliament".

There exist almost as many definitions of leadership as there are persons who have attempted to define the concept. Moreover, many of the definitions are ambiguous. Nevertheless, there is sufficient similarity among definitions to permit a rough scheme of classification.

Stodgill (1974); Bass (1990); Pierce and Newstrom (2000); DuBrin (2004); and Northouse (2004) mention the following concepts relating to leadership.

(i) The focus of group processes.
(ii) A matter of personality.
(iii) A matter of inducing compliance.
(iv) The exercise of influence.
(v) Particular behaviours.
(vi) A form of persuasion.
(vii) Power relationships.
(viii) An instrument to achieve goals.
(ix) An effect of interaction.
(x) A differentiated role.
(xi) The initiation of structure.
(xii) Many combinations of the above-mentioned definitions.

(i) Leadership as a focus of group processes

In the early definitions of a leader, the tendency existed to look at the leader as the focal agent of group change, activity and processes.

Cooley (1902) maintained, that leaders are always the centre of activities, and that, after close examination, all social movements will be found to consist of tendencies having leaders and leadership activities at its core. Mumford (1909) observed, that "... leadership is the pre-eminence of one or a few individuals in a group in the process of control of societal phenomena". Blackmar (1911) saw leadership as the "... centralisation of effort in one person as an expression of the power of all". According to L. L. Bernard (1927), in

Bass (1990), the needs and wishes of the group members influence leaders; in turn, they focus the attention and release the energies of group members in a desired direction.

As a nation develops, it requires a centralised locus for its operation that can be achieved only by a single leader (Babikan, 1981 in Bass, 1990). The most important decisions and their implementation centre on the beliefs and abilities of the leader even when, as in parliamentary democracies, actual decision-making is not concentrated but spread out. The leader embodies the collective will. The single leader solves the essential problems, offers possible solutions, establishes priorities and launches developmental operations.

Centrality of location in the group can permit a person to control communications, and hence is likely to place him or her in a position of leadership, but centrality in itself, is not leadership (Bass, 1990:12).

(ii) Leadership as personality and its effects

The concept of personality has all along appealed to several early theorists of leadership. They sought to explain why some persons are better able than others to exercise the art of leadership.

Bowden (1926), in Bass (1990), equated leadership with strength of personality, by stating that "... the amount of personality attributed to an individual may not be unfairly estimated by the degree of influence he can exert upon others". W. V. Bingham, in Metcalf (1927), defined a leader as a person who possesses the greatest number of desirable traits of personality and character. At the extreme, in times of crisis, followers endow a highly dominant figure that is empathic to their critical needs with charisma. The personality of the "hero" then makes it possible for him or her to perform enormous feats of leadership (Stark, 1970 in Bass, 1990).

(iii) Leadership as an art of inducing compliance

This set of definitions tends to cast leadership in terms of the moulding of the group around the will, intentions and wishes of the leader.

Munson (1921) defined leadership as "... the ability to handle men so as to achieve the most with the least friction and the greatest co-operation; Leadership is the creative and directive force of morale". According to Allport (1924), "... leadership is personal social control".

It cannot be ignored, that much leadership is authoritarian, directive and even coercive. Bass (1990:13) states, that the effects hereof are seen in public compliance, but not necessarily in private acceptance. Both Bennis (1959) and Bundel (1930) in Bass (1990), define leadership as the art or process of inducing others to perform, according to a desired behaviour, what an agent wants.

(iv) Leadership as the exercise of influence

Here the defining of leadership employs the concept of influence as separate and distinct from dominance, control or the forcing of compliance (Pierce & Newstrom, 2000:7).

J. B. Nash (1929), in Bass (1990), suggested, that leadership is a logical consequence that influences to bring about change in the conduct of people. Stogdill (1950) in Bass (1990) termed this "... the process of influencing the activities of an organised group in its efforts toward goal setting and goal achievement".

Katz and Khan (1966) considered the essence of organisational leadership to be the influential increment over and above mechanical compliance with routine directions of the organisation. They observed, that although all supervisors at the same level of organisation have equal power, they do not use it with equal effectiveness to influence individuals and the organisation.

According to Bass (1990:13), the effort of an individual to change the behaviour of others can be classified as attempted leadership. When the other members actually change, this creation of change in others, is successful leadership. If the others are reinforced or rewarded for changing their behaviour, this evoked achievement is deemed to be effective leadership.

Defining effective leadership as successful influence by the leader that results in the attainment of goals by influenced followers, is defining leadership in terms of goal attainment (Bass, 1990:14).

(v) Leadership as an act of behaviour

Pierce and Newstrom (2000) described this as focussing upon the acts of leadership. What do the leaders do? Shartle (1956) suggested, that the act of leadership is "... one which results in others acting or responding in a shared direction".

By leadership behaviour we generally mean the particular activities in which a leader engages in the course of directing and co-ordinating the work of his or her group members. This may involve such acts as structuring the work relations, praising or criticising group members and showing consideration for their welfare and feelings (Bass, 1990:14).

(vi) Leadership as a form of persuasion

Persuasion is a powerful instrument for shaping expectations and beliefs, particularly in political, social and religious affairs.

Persuasion can be seen as one form or art of leadership. Much of what has been learned from studies of persuasion, can be incorporated into an understanding of leadership (Bass,

1990:15). Certain definitions of leadership reflect the movement of others through strongly held convictions or reason (Pierce and Newstrom, 2000:7).

According to Neustadt (1960), from his study of U. S. presidents, presidential leadership stems from the power to persuade. Schenk (1928) in Bass (1990) suggested, that leadership is the management of men by persuasion and inspiration rather than by the direct or implied threat of coercion. According to Truman (1958:139) "... a leader is a man who has the ability to get other people to do what they don't want to do, and like it". Eisenhower said that "... leadership is the ability to decide what is to be done, and then to get others to want to do it" (Larson, 1968:21).

(vii) Leadership as a relationship of power

Most political theorists such as Machiavelli and Marx, have seen power as the basis of political leadership. Power is regarded as a form of influence relationship.

It can be observed, that some leaders tend to transform any leadership opportunity into an overt power relationship. The frequency of this observation, combined with the often-undesirable consequences for individuals and societies, has induced the rejection of the notion of authoritarian leadership. Nevertheless, many of those who were most committed at one time to trust building, openness and participatory approaches, have faced the world as it is, not as they would like it to be, and have come to acknowledge the importance of power relations in understanding leadership (Bass, 1990:15).

Janda (1960), in Pierce and Newstrom (2000:8), sees leadership in terms of the perception of the members of a group; that another group member has the right to prescribe behaviour patterns for the former regarding his or her activity as a member of a particular group.

(viii) Leadership as an instrument of goal achievement

This set of definitions ascribes an instrumental value to the act of leadership for accomplishing the goals and satisfying the needs of a group.

A leader, according to Cowley (1928), "... is a person who has a programme and is moving toward an objective with his group in a definite manner". The classical organisational theorists defined leadership in terms of achieving objectives of a group. R. C. Davis (1942) referred to leadership as "... the principle dynamic force that motivates and co-ordinates the organisation in the accomplishment of its objectives".

Tucker (1981) observed, that it is most unfortunate that politicians must focus the attention of their constituents on short-term goals and programmes in order to remain popular. But more statesmanlike leaders are required to arouse and direct a democracy toward achieving long-term goals, such as stabilisation of the population, improvement of the environment and arms control.

(ix) Leadership as an emerging effect of interaction

Several theorists have viewed leadership not as a cause or control of group action, but as an effect of it.

Pierce and Newstrom (2000:7) does not see leadership as the cause of group action, but something which emerges as a result of interactions within and among members of the group. Bogardus (1929), in Bass (1990), states, that "... as a social process, leadership is that social inter-stimulation which causes a number of people to set out toward an old goal with new zest or a new goal with hopeful courage – with different persons keeping different places".

(x) Leadership as a differentiated role

According to role theory, each member of a society occupies a position in the community, as well as in various groups, organisations and institutions. In each position, the individual is expected to play a more or less well-defined role.

Different members occupying different positions, play different roles (Bass, 1990:16). Sherif and Sherif (1956) state, that these roles come to be defined in terms of stable expectations that group members develop for themselves and other members of the group.

From this perspective, leadership as a differentiated role might be seen as that function which integrates the other roles to advance the cause of the social system or goals of the group (Bass, 1990:17; Pierce and Newstrom, 2000:7).

(xi) Leadership as the initiation of structure

Several commentators view leadership not as the passive occupancy of a position or as acquisition of a role, but as a process of originating and maintaining the role and structure (Bass, 1990:17). Stogdill (1959) adopted this approach, when he defined leadership as "... the initiation and maintenance of structure in expectation and interaction".

It must be kept in mind, that leadership is more than just the initiation of structure. As Gouldner (1950) noted, we need room for acts of leadership in the completely structured group. Stogdill's (1959) inclusion of maintenance of structure is important. The persons, resources and tasks within the differentiated roles, should also be considered.

(xii) Leadership as a combination of elements

Some scholars and researchers combine definitions of leadership to cover a larger set of meanings.

Bass (1990) employs the following definition of leadership. Leadership is an interaction between two or more members of a group that often involves a structure or restructuring of the situation and the perceptions and expectations of the group members. Leaders are agents of change; persons whose activities affect other people more than the activities of other people affect them. Leadership occurs when one group member modifies the motivation or competencies of others in the group.

Leadership requires eliciting co-operation and teamwork from a large network of people and keeping the key people in that network motivated, using every manner of persuasion (Kotter, 1990).

A clear distinction is made between headship and leadership.

The Concise Oxford English Dictionary describes headship as "the position of leader or chief" (COED, 2002:655). Holloman (1968, 1986), in Bass (1990), conceived headship as being imposed on the group, but leadership as being accorded by the group. In similar fashion, C. A. Gibb (in Lindzey & Aronson, 1969:213), distinguished leadership from headship as follows.

(i) Headship is maintained through an organised system and not by fellow members of the group spontaneously affording recognition of the contribution of an individual to group progress.

(ii) The group goal is chosen by head persons in line with their interests and not internally determined by the group itself.

(iii) In headship, there is little or no sense of shared feeling or joint action in pursuit of the given goal.

(iv) In headship, there is a wide social gap between the group members and the head, which strives to maintain this social distance as an aid in the coercion of the group.

(v) The authority of the leader is spontaneously accorded by fellow members of the group and particularly by followers. The authority of the head derives from some extra-group power that he or she has over the members of the group, who cannot meaningfully be called followers. They accept domination for fear of punishment, rather than elect to follow in anticipation of rewards.

Kochan et al., (1975) agreed with Gibb (in Linzey & Aronson 1969), because they saw that managers, executives and senior officials must be both leaders and heads. Therefore, in its conception, leadership can include headship.

Effective leadership can be defined as the interaction among members of a group that initiates and maintains improved expectations and the competence of the group to solve problems or to attain goals (Bass, 1990:20). Peter F. Drucker (in Hesselbein, Goldsmith & Beckhard, 1996) builds on this definition by describing effective leaders as doers, people who take action, and not preachers.

Judith M. Bardwick (in Hesselbein, Goldsmith & Beckhard, 1996:131) describes six items to be found among effective leaders that seem especially critical to creating a sense of strong leadership and achieving success for organisations facing difficult times. The obligations or duties of leaders should among others, be the following.

(i) Defining the business of the enterprise; determining what the organisation should do and what it should not be concerned with. This is the first step in setting priorities. Without priorities, efforts are splintered and little is achieved.

(ii) Creating a winning strategy; it is the responsibility of the leaders to create a winning strategy that will cause the organisation to succeed, to grow and to prosper. For strategy to succeed, it must anticipate, create, and guide change and create commitment in the organisation's members. It should be so plausible, clever and bold and achievable, that in itself it generates a conviction that even if the journey is hard, it is worthwhile.

(iii) Communicating persuasively; trust is a competitive advantage in a world of adversarial competition. Trust is a matter of predictability. People trust others when they are told that something will happen and it does. Ineffective or non-existent communication, especially in wartime, results in an enormous increase in mistrust, confusion, and cynicism and a huge decline in morale, belief in the organisation and confidence in leadership.

(iv) Behaving with integrity, because without integrity trust is never achieved. The best leaders are transparent: they do what they say. People believe them because they act in line with the values they espouse. They do not play Machiavellian games of manipulation and duplicity.

(v) Respecting others; effective wartime leaders require input from everyone involved. They prefer spirited debate before decisions are made, although the best leaders are often strikingly knowledgeable.

(vi) Acting; in wartime, when conditions are ambiguous and decisions are difficult, leaders must decide, choose and act. If leaders don't act, they are perceived as being indecisive and weak, and this increases people's sense of anxiety, powerlessness and insecurity. When others doubt a leader's ability, confidence, or effectiveness, the mission is sabotaged.

If one is to make extensive use of observation, it will still be important to define effective leadership in terms of acts, behaviour, roles played, its centrality to group processes, and compliance with the observed performance (Bass, 1990:20).

In light of the objective of this thesis, which is to determine the effectiveness of leadership in fighting the HIV/AIDS pandemic, it is important that the role of the most senior leaders in government, who are responsible for results and accountable to the public for their actions, be defined in terms of personality traits, motives and bases of power that underpins transformational leadership (Bass, 1990:20).

In the following sections the relevant theories of leadership, as referred to in the above paragraph, will be discussed, they are: (4.3) traits and motive of leaders; (4.4) power bases; and (4.5) transformational leadership

4.3 TRAITS AND MOTIVES OF LEADERS

The belief that certain personal characteristics and skills contribute to leadership effectiveness in many situations, is referred to as the universal theory of leadership. According to this theory, certain leadership traits are universally important: they apply in all situations. For example, creative thinking, a characteristic, helps a leader to formulate an exciting vision, that in turn, is leadership behaviour (DuBrin, 2004:32).

The trait approach to leadership analysis began in the early 20th century with an emphasis on identifying the prominent qualities of great persons.

Smith and Krueger (1933) completed a survey of this literature up to 1933. During the middle part of the 20th century, provision was made to include the impact of situations on leadership (Stodgill, 1948). Most recently, it has shifted back to re-emphasise the critical role of traits in effective leadership (Zaleznik, 2003). Great companies such as General Electric utilise the identification of effective leadership characteristics, matching them with the performance criteria required of individuals in order to produce results in their Leadership Effectiveness Survey of employees (Ulrich, Zenger & Smallwood, 1999). By taking a closer look, a clearer picture can be obtained of how an individual's traits contribute to the leadership role (Northouse, 2004:16).

Leadership is about character (Bennis & Nanus, 2003). Characteristics associated with leadership, can be classified into four broad categories: (i) personality traits; (ii) motives; (iii) cognitive factors; and (iv) physical and background factors. According to Kirkpatrick

and Locke (1991), no matter how personal characteristics are classified, they point toward the conclusion, that effective leaders are made of the "right stuff".

A full listing of every personal characteristic would consume hundreds of pages. Therefore, included here are the major and most consistently found characteristics that are related to the effectiveness of leadership.

4.3.1 Personality traits of effective leaders

Leaders have certain personality traits. These characteristics contribute to leadership effectiveness in many situations, as long as the style of the leader fits the situation well (Locke & Associates, 1991).

The personality traits of leaders can be divided into two main groups: (4.3.1.1) general personality traits; and (4.3.1.2) task-related traits.

4.3.1.1 General personality traits

General personality traits are defined as traits that are observable both within and outside the context of work. These traits can be further divided into nine subgroups: (i) self-confidence; (ii) honesty, integrity and credibility; (iii) dominance; (iv) extroversion; (v) assertiveness; (vi) emotional stability; (vii) enthusiasm; (viii) sense humour and warmth; and (ix) high tolerance for frustration.

(i) Self-confidence

Individuals with self-confidence see themselves as masters of their own fate, rather than at the mercy of luck, fate or other powerful people. This assists them to cope better with stress and generally make them more effective and satisfying leaders (Bennis & Nanus, 2003).

In virtually every leadership setting, it is important for the leader to be realistically self-confident. A leader who is self-assured without being bombastic or overbearing, instils confidence in team members. In addition to being self-confident, the leader must project that self-confidence to the group (Locke & Associates, 1991). Quite often he or she can do so by using unequivocal wording, maintaining a good posture, and making appropriate gestures, such as pointing an index finger outward. Self-confidence is not only a personality trait; it also refers to the behaviour a person exhibits in a number of situations. Northouse (2004:19), describes it as the ability to be certain about the competencies and skills that one possesses. DuBrin (2004:34) supports this, by equating it to being calm and collected under pressure. Thus it can be concluded that a person is a self-confident leader, when he or she retains composure during a crisis, such as managing a large product recall.

The Pick 'n Pay blackmail incident is a good example hereof.

This incident illustrates how white collar crime can threaten the security of the public and how effective leadership and good corporate governance can protect the consumer and public. A blackmailer disrupted the operations at Pick 'n Pay for two months and forced the chain of supermarket stores to remove five products from their shelves in the interest of consumer protection. No new incidence of poisoning was found. Although Pick 'n Pay should have brought the matter to the attention of the public earlier, the author still maintains, that the company handled the crises well by applying effective leadership and the principles of good corporate management. The blackmailer intimidated the public and is probably guilty of attempted murder. He or she is probably also guilty of blackmail, which is classified by definition as a white-collar crime (Minnaar, 2003).

The seven principles of good corporate management, as laid down by the King Commission in the King II Report (IODSA, 2002) on corporate governance, are: (i) internal discipline; (ii) transparency; (iii) independence; (iv) accountability; (v) responsible leadership; (vi) fairness towards all role players and not only shareholders; and (vii) social responsibility. Furthermore, companies should also comply with a three-

fold requirement of economic and social responsibility as well as a responsibility, towards the environment.

The handling by Pick 'n Pay of the blackmail crisis is an example of effective leadership and good corporate governance, because expert advice was immediately sought and measures taken against the blackmailer. Pick 'n Pay did not meet the demands of the blackmailer (Minnaar, 2003).

The leadership was ethical in taking steps to make public safety a priority and placed it above the threatening financial loss. Information was disseminated in a responsible manner. Pick 'n Pay was transparent at all times about the events and its handling thereof in the interest of the consumer. The company could have suffered financial loss if consumer and investor trust was adversely affected. Ultimately the ethical stance taken by Pick 'n Pay caused the consumers to remain loyal. The share price of the supermarket chain has increased since the announcement of the crisis and the manner in which it was handled (Minnaar, 2003).

The General Electric Leadership Effectiveness Survey (LES), (Ulrich et al., 1999), indicates the following behaviour for leadership effectiveness. The individual has to have sufficient self-confidence to be able to:

(i) share information across traditional boundaries and be open to new ideas.
(ii) encourage and promote shared ownership for the vision and goals of the organisation.
(iii) trust others; encourage an entrepreneurial spirit of risk taking and a no limitation behaviour.
(iv) be open to ideas from any source and a vehicle for others' success.

(ii) Honesty, integrity and credibility

Integrity is the quality of honesty and trustworthiness.

Individuals who adhere to a strong set of principles and take responsibility for their actions, exhibit integrity (Northouse, 2004:20).

Followers and group members consistently believe that leaders must display honesty, integrity and credibility. Leaders themselves believe that honesty makes a difference in their effectiveness. Being trustworthy and honest contributes toward leadership effectiveness.

These views are also shared by researchers and outside observers. Under the umbrella term of trust; competence, caring, reliability, predictability and integrity are included. It is often said, that it drives people crazy when bosses do not "walk their talk". Therefore, effective leaders show consistency between their deeds and words (DuBrin, 2004:34).

The trust factor is the social glue that binds and keeps systems together. Honesty, integrity and credibility are hard to gain and easy to lose.

According to Bennis and Nanus (2003), the ability to generate and sustain trust, is the central ingredient in leadership, they state, that one "... can have the most glorious vision in the world and it won't mean a thing if there's low trust in the organisation".

Leaders with integrity inspire confidence in others, because they can be trusted to do what they say they are going to do. They are loyal, dependable and not deceptive (Northouse, 2004:20).

Leadership is in the eye of the follower.

This is why honesty, integrity and credibility are so important. In a study of more than 7,500 managers from public and private organisations, the 87% who responded, selected honesty as a key leadership characteristic, according to James M. Kouzes and Barry Z. Posner, (in Pierce & Newstrom, 2000:37).

According to research conducted by Kouzes and Posner, leaders are considered honest by their constituents when leaders do what they say they are going to do. Agreements not followed through, cover-ups, and inconsistency between words and deeds are all indicators of a lack of honesty (Crainer, 2003). Yet, if a leader behaves in ways consistent with his or her values and beliefs, then we believe we can entrust that person with our careers, our security, and even with our lives.

Bass (1990:69) notes, that integrity of character represents a trait that is associated with leadership maturity. Effective leaders are credible, have excellent reputations, with high levels of integrity and trust (J. Sampson, 2003:7).

In the General Electric Leadership Effectiveness Survey (LES), (Ulrich et al., 1999), the following performance criteria are required to produce effective leadership. The criteria stem from the basic personal characteristic integrity. The individual has to:

(i) maintain unequivocal commitment to honesty and truth in every facet of his or her behaviour.

(ii) follow through on commitments made and must assume responsibility for his or her actions.

(iii) practice absolute conformance with company policies and embody commitment to ethical conduct.

(iv) be absolutely trustworthy. Therefore, one has to display actions and behaviours that are consistent with one's words.

(iii) Dominance

A dominant person imposes his or her will on others. As a consequence, a dominant leader is often seen as domineering or bossy.

Whereas dominance was considered almost synonymous with leadership in the early research of leadership, the more recent viewpoint recognises, that many other traits such

as assertiveness and factors such as the willing submissiveness of followers, are to be taken into consideration (Bass, 1990:90).

(iv) Extroversion

Extroversion has been recognised for its contribution to leadership effectiveness because it is helpful for leaders to be gregarious and outgoing in most situations. Extroverts are more likely to want to assume a leadership role and to participate in activities comprising of groups of people (Bass, 1990:90).

(v) Assertiveness

In recent years more attention has been paid to assertiveness than to dominance and extroversion as a leadership trait. Assertiveness refers to persons being forthright in expressing demands, opinions, feelings and attitudes. This includes characteristics such as determination, initiative, persistence and drive, that all refer to the desire to get the job completed and to attain the expected results.

Assertiveness assists leaders in performing multiple tasks and the subsequent achievement of goals. Among them are the confronting of group members about their mistakes, demanding higher performance, setting high expectations, and making legitimate demands on higher management. To be assertive, differs significantly from being aggressive or passive. Aggressive people express their demands in an overly pushy, obnoxious and abrasive manner; passive people suppress their own ideas, attitudes, feelings and thoughts as if they were likely to be perceived as controversial (Northouse, 2004:20).

(vi) Emotional Stability

According to the research reported on by Bass (1990:70), leaders were found to be more stable and emotionally controlled than their followers. Furthermore, a number of manuals

that outline the practical techniques for gaining friends and becoming a leader, regard self-control as a very important prerequisite for attaining these goals.

Anyone who has worked for an emotional unstable superior, will attest to the importance of emotional stability as a leadership trait. Emotional stability refers to the ability to control emotions to the point that one's emotional responses are appropriate to the occasion. Emotions associated with low emotional stability, include anxiety, depression, anger, embarrassment, and worry (DuBrin, 2004:36).

Emotional stability is an important leadership trait, because group members expect and need consistency in the way they are treated.

One study found, that executive leaders who are emotionally unstable and lack composure, are more likely to derail; that is, to handle pressure poorly and to give in to moodiness, outbursts of anger, and inconsistent behaviour. Such inconsistency undermines their relationships with followers, group members, peers and superiors. In contrast, effective leaders are generally dependable, calm, confident and predictable during a crisis (Locke & Associates, 1991:55).

(vii) Enthusiasm

In most leadership situations, it is desirable for the leaders to be enthusiastic.

Followers and group members tend to respond positively to enthusiasm, partly because enthusiasm may be perceived as a reward for constructive behaviour. Enthusiasm is also a desirable leadership trait, because it helps build good relationships with team members. A leader can express enthusiasm both verbally ("Great job"; "I love it") and non-verbally (making a "high five" gesture). Even the most enthusiastic employees are loath to show more enthusiasm than their superiors do. If the leader does not project a "gung-ho" or "can do" attitude, everybody else will hold back (DuBrin, 2004:38; Manning, 2002:81).

Cox (1926) found great face-to-face leaders to rate high in excitability. According to C. M. Cox, this trait was to an unusually high degree present in revolutionary statesmen.

According to John Kotter, people who are successful in making a difference in the world, especially in providing leadership, tend to nurture optimism within them and try to neutralise cynicism and pessimism (Crainer, 2003). This is a good example of how a trait contributes to leadership effectiveness.

Bennis and Nanus (2003) from their research of exemplary leaders, describe that these leaders truly believe that they can change the world. True leaders have an uncanny way of enrolling people in their vision through their optimism, even-though it sometimes might be unwarranted optimism.

(viii) Sense of humour and warmth

Humour serves such functions in the workplace as relieving tension and boredom and defusing hostility.

DuBrin (2004:41) contends, that because humour helps the leader dissolve tension and defuse conflict, it helps him or her exert power over the group.

According to Bass (1990:70), a sense of humour is relevant to and contributes toward effective leadership.

Being a warm person and projecting that warmth, underscores leadership effectiveness in several ways. Firstly, warmth facilitates the establishment of rapport with group members. Secondly, the projection of warmth is a key component of charisma. Thirdly, warmth is a trait that facilitates the provision of providing emotional support to group members. Fourthly, in the words of Kogan Page, warmth "... comes with the territory. Cold fish do not make good leaders because they turn people off" (DuBrin, 2004:41).

(ix) High tolerance for frustration

An important observation about effective leaders, is that they are able to "stay the course"; they are courageous and patient (Bennis & Nanus, 2003:49).

Research shows, that high tolerance for frustration or the ability to cope with the blocking of goal attainment, exists among effective leaders. This trait is important because a leader encounters many frustrations. Cox (1926) found, that great leaders were characterised, to an outstanding high degree, by "persistence in the face of obstacles"; "capacity to work with distant objects in view"; "degree of strength of will or perseverance"; and a "tendency not to abandon tasks from mere change-ability".

4.3.1.2 Task-related personality traits

Certain personality traits of effective leaders are closely associated with task accomplishment. Competence is the capability that a person brings to a situation. Task competence and intelligence are important to leadership. Task competence and intelligence result in attempts to lead, that are more likely to result in success for the leader and effectiveness for followers and group members (Bass, 1990:109). Task-related traits are observable within the context of work and are dividable into four subgroups: (i) initiative and responsibility; (ii) flexibility and adaptability; (iii) internal locus of control, courage and resiliency; and (iv) emotional intelligence.

(i) Initiative and responsibility

From the research reports collated in Bass (1990:68), initiative and willingness to assume responsibility are traits related to leadership.

Exercising initiative, or being a self-starter, refers to taking action without support and stimulation from others. Initiative is also related to problem-finding ability: you need to exercise initiative to search for worthwhile problems.

As conceptualised by Kirkpatrick and Locke (1991), initiative refers to the proactive side of leadership. Rather than just reacting to events, effective leaders make choices and take action that leads to change. Effective leaders drive change by inspiring people to do new things in a timely manner (Manning, 2002:68).

The General Electric Leadership Effectiveness Survey (LES), (Ulrich et al., 1999), indicates that effective leaders must demonstrate the traits accountability and initiative. To comply herewith, the individual has to:

(i) set and meet aggressive commitments in order to achieve the organisational objectives.
(ii) demonstrate courage and self-confidence in order to stand firm for one's beliefs, values, ideas and colleagues.
(iii) display fairness and compassion to others and still be able to make difficult decisions.
(iv) demonstrate uncompromising responsibility for preventing unnecessary harm to others.
(v) view change as an opportunity. Create real and positive change;
(vi) anticipate problems and initiate new and improved ways for conducting business.
(vii) hate/avoid/eliminate unnecessary bureaucracy and strive for brevity, simplicity and clarity.
(viii) understand, embrace and utilise speed and technology as a competitive advantage.

(ii) Flexibility and adaptability

A leader is someone who facilitates change. Therefore, a leader must be flexible and adaptable enough to effectively manage change.

Part of the reason these traits have become so important in recent years, is that the business and political world has become more competitive and volatile. Faster technological change, greater international competition, the deregulation of markets, over-

capacity in capital-intensive industries, an unstable oil cartel and the changing demographics of the work force, are among the many factors that have contributed to the continuous necessity for change. Major changes are increasingly necessary for survival and competing in this new environment. More change always demands more leadership (Kotter, 2003).

Flexibility, or the ability to adjust to different situations, has long been recognised as an important leadership characteristic.

Leaders who are flexible, are able to adjust to the demands of different situations. Without the underlying trait of flexibility, a person could be an effective leader only in one or two situations where no requirement for change exist or a necessity for transformation (Manning, 2002).

Leading organisational change effectively, can mitigate risks and even avoid them entirely, such as the unwillingness of managers to allocate time and resources towards important projects and employees becoming distracted and losing interest in their work responsibilities, thereby negatively impacting upon productivity and customers (Hiatt & Creasy, 2003).

(iii) Internal locus of control, courage and resiliency

An internal locus of control, courage and resiliency are task-related traits closely related to all of the characteristics that have been discussed under the general personality trait section (4.3.1.1) above.

People with an internal locus of control, believe that they are the prime movers behind events. Thus, an internal locus of control helps a leader in the role of taking action and responsibility because the leader believes fundamentally in his or her innate capacity to produce results.

An internal locus of control is closely related to self-confidence (DuBrin, 2004:45). In a simulated industrial setting, Goodstadt and Hjelle (1973), in Bass (1990:152), found that supervisors with an external locus of control were more likely to rely on persuasion and those with an internal locus of control, were more likely to rely on personal power to attain results. Mitchell et al., (1975), in Bass (1990:153), obtained similar results from their research. Mitchell et al., noted, that supervisors with an external locus of control were more likely to use coercion and legitimate authority, whereas those with an internal locus of control used rewards, respect and expert power.

Leaders need courage to face the challenges of taking prudent risks, and taking initiative in general. They must also face up to responsibilities, and be willing to put their reputations on the line.

It takes courage for a leader to suggest a new undertaking because if the undertaking fails, the leader is often seen as having failed (DuBrin, 2004:47). Therefore, courage is required to inspire and lead people along a strategy that aims to realise a vision that is cutting edge. Cleveland (1985) emphasised, that executives must be prepared to take risks if they are to take the lead in the perilous, problematic and participatory climate for policy-making of today's information-rich world.

If a leader asks a group of people to follow him or her in a new direction, into an unknown territory or a new way of doing business, the leader has to have confidence in himself or herself that he or she can reach the projected outcome or destination. The researcher, Jim Collins, found that great companies were led by leaders with two important leadership characteristics: (i) professional will; and (ii) humility. During a disastrous mission to the Antarctic, the explorer Ernest Shackleton also displayed these two qualities (Nkomo, 2003:13).

Effective leaders are resilient: they bounce back quickly from setbacks such as budget cuts, demotions, and being fired. An intensive study of executive leaders revealed, that they do not even think about failure: in fact, they do not even use the words. Instead, they

rely on synonyms such as mistake, glitch, bungle and setback (DuBrin, 2004; Manning, 2002). In practice, this means that the leader sets an example for team members by not crumbling when something goes wrong. Instead, the leader tries to conduct business as usual (Bennis & Nanus, 2003).

(iv) Emotional intelligence

Emotional intelligence sets effective leaders apart from leaders.

Effective leaders are similar in one crucial way: they all have a high degree of emotional intelligence. From various analyses conducted by Daniel Goleman (2003) and other researchers, emotional intelligence has proved to be increasingly important at the highest levels of organisations, where differences in technical skills are less relevant. The meaning hereof, is that the higher the position of a person who is considered to be an outstanding performer, the more emotional intelligence capabilities are recognised as part of the reason for their effectiveness.

In a 1996 study of a global food and beverage company, David McClelland found that senior managers who possessed a critical mass of emotional intelligence capabilities, outperformed targets by 20%. On the other hand, division leaders without that critical mass, performed below expectations by almost 20% (Goleman, 2003).

Emotional intelligence refers to qualities such as understanding one's feeling, having empathy for others and the ability to control and regulate emotions. Emotional intelligence is also closely linked to personal traits that in turn assists with effectiveness. Three key factors in emotional intelligence exist, that are linked to leadership effectiveness: (a) self-awareness and self-objectivity; (b) self-management and motivation; and (c) social awareness.

with and influence them. Achieving sensitivity towards others, requires empathy: the ability to place oneself in the position of people.

Leaders who show sociability, are friendly, outgoing, courteous, tactful and diplomatic. They are sensitive to the needs of others and show real concern for their wellbeing. These leaders have good interpersonal skills and create co-operative relationships with their followers (Northouse, 2004:20). Social awareness includes having respect for people as individuals, employees and followers (Dunne, 2003:22).

The General Electric Leadership Effectiveness Survey (LES), (Ulrich et al., 1999), indicates, for the characteristics influencing and communication, the following performance criteria is required for leadership effectiveness.
It is necessary for the individual to communicate in an open, candid, clear, complete and consistent manner, and to be open to response and dissent. The following suggestions are important.

(i) Listening effectively and probe for new ideas.
(ii) Utilising facts and rational arguments to influence and persuade followers.
(iii) Breaking down barriers and developing influential relationships across teams, functions, layers and organisations.
(iv) Fully utilising the diversity of colleagues (cultural, race and gender) to achieve success.
(v) Treating people as you want them to treat you.

4.3.2 Leadership motives

In general, effective leaders have an intense desire to occupy a position of responsibility on behalf of others and to be able to exercise control over resources and people in order to attain goals.

Leaders with motivation and the willingness to use power in their dealings with others, will use their interactions with others more consciously to get what they want and to gain control over situations.

Those with motivation and skills, in the use of power, will embed that power in their communications with others and will use tactics to influence what transpires (Bass, 1990:129).

Six specific leadership motives can be identified that assists with effective leadership, all six can be considered as task-related personality traits. They are discussed in the following sections: (4.3.2.1) power motive; (4.3.2.2) personalised power motive; (4.3.2.3) socialised power motive; (4.3.2.4) drive and achievement motivation; (4.3.2.5) strong work ethic; and (4.3.2.6) tenacity.

4.3.2.1 Power motive

Effective leaders display a strong need to control resources. Leaders with high power motives, have three dominant characteristics: (i) they act with vigour and determination to exert their power; (ii) they invest much time in thinking about ways to alter the behaviour and thinking of people; and (iii) they care about their personal standing with those around them. The power motive is important, because it means that the leader is interested in influencing others. Without power, it is much more difficult to influence followers and people (DuBrin, 2004:47).

Communication competence is required to articulate arguments, advocate positions and persuade followers and other people. These functions are important for acquiring and using power, Parks (1985), (in Bass, 1990:149).

Individuals who base their leadership on power, may create conditions that are unsatisfying to some or all of their followers and subordinates. Despite this, these leaders

still can successfully influence the course of events, which will result in the fulfilment of tasks and the attainment of goals by their group or organisation (Bass, 1990:131).

4.3.2.2 Personalised power motive

Leaders with a personalised power motive, seek power mostly to further their own interests.

According to Dunne (2003:22), a leader with a personalised power motive is also referred to as the mercenary: a leader who focuses on personal success; or the pirate: a leader who unites people by appealing to their common desires and greed. They crave the trappings of power such as status symbols, luxury and money. Some leaders with strong personalised power motives typically enjoy dominating others. Their need for dominance can lead to submissive followers and subordinates who are frequently sycophants and "yes"-persons.

McClelland (1985), in Bass (1990), concluded, that if the motivation for power is low, the potential for leadership is generally absent. If power motivation is high and activity is uninhibited, the individual behaves like a conquistador and has thoughts of personal dominance and winning at the expense of followers and other people.

Leaders need to have emotional intelligence, good self-control and the ability to inhibit their own need for power in order to develop a balanced leadership style to exist, that would not alienate followers and other people.

According to Snyder (1974:529), in Bass (1990), abilities associated with self-monitoring cut across the factors of sensitivity and control and have been found to contribute to leadership effectiveness. Self-monitoring is also concerned with social appropriateness, paying attention to social-comparison information, the ability to control and to modify self-presentation.

4.3.2.3 Socialised power motive

Leaders with socialised power motives, use power primarily to achieve and to realise the goals and visions of the organisation.

Dunne (2003:22) propounds, that leaders with a socialised power motive, are also referred to as the good citizens: leaders who inspire personal trust, hold people accountable and make tough calls; or as the benevolent leader: a leader who stresses team success, inspires trust and motivates others by setting clear, ambitious goals that are mutually shared.

In the above context, the term "socialised" means, that the leader uses power primarily to attain organisational goals or visions. As a result hereof, the leader is likely to provide more effective leadership. Leaders with socialised power motives, in contrast to leaders who solely have personalised power motives, tend to be more emotionally mature. Also, they exercise power more for the benefit of the entire organisation and are less likely to manipulate others through the use of power. Leaders with socialised power motives, are less defensive, and are more willing to accept expert advice from outsiders (DuBrin, 2004:49).

Effective leaders are orientated toward serving their organisations. They generate team spirit among their subordinates, clarity of purpose and a sense of responsibility for their work (Bass, 1990:133).

It is important not to draw a rigid dichotomy between leaders with personalised power motives and those with socialised power motives. The distinction between doing good for others versus doing good for oneself, is often made on the basis of very subjective criteria.

4.3.2.4 Drive and achievement motivation

The importance of drive and achievement motivation is described in Bennis and Nanus (2003). They state, that we "... cannot exaggerate the significance of a strong

determination to achieve a goal or realise a vision", because it becomes a conviction, even a passion, for the effective leader to attain expected results to the satisfaction of all the stakeholders.

Leaders are known for the huge effort they invest in achieving their goals and visions. The importance of strong motivation for leadership, is well-accepted. Drive refers to an ability to focus energy into achieving goals and to persistently applying that energy. Drive also includes achievement motivation and, finding joy in accomplishment for its own sake (DuBrin, 2004:50).

Individuals with a strong achievement motivation, have a consistent desire to: (i) achieve through their own efforts and to take responsibility for success or failure; (ii) take moderate risks that can be handled through their own efforts; (iii) receive feedback on the level of their performance; (iv) introduce novel, innovative or creative solutions; and (v) plan and set stretch goals for themselves, their followers and organisations (DuBrin, 2004:50).

4.3.2.5 Strong work ethic

Effective leaders typically have a strong work ethic, a firm belief in the dignity of work.

People with a strong work ethic, are well-motivated, because they value hard work: not to work hard, clashes with their values. A strong work ethic helps the organisational leader to believe that the group task is worthwhile (Manning, 2002).

Effective leaders have a bias towards action that results in success (Bennis & Nanus, 2003). A strong work ethic assists to develop the capacity to translate vision and purpose into reality. It is not enough for effective leaders just to have vision, trust and optimism. The leader has to manifest concrete, active steps – execution – to bring about results. Leaders make things happen. It is often said, that "... real leaders ship". For effective leaders there exists a continuous focus on the task till the work is completed successfully.

4.3.2.6 Tenacity

A final observation about the motivational characteristics of effective leaders, is that they are tenacious. Leaders with tenacity are better at overcoming obstacles, than they are at being non-leaders. Tenacity multiplies in importance for effective leaders, because it can take a long time to implement a new programme and see the results thereof (DuBrin, 2004:51).

According to Simpson (1938), in Bass (1990), it appears that persons in various types of groups may be valued as leaders, because they know what they want to accomplish and are not likely to be swayed from their convictions. The Bennis study of 150 leaders, reinforces the link between leadership effectiveness and tenacity. All interviewees embodied a strongly developed sense of purpose and a wilful determination to achieve what they wanted. "Without that", said Bennis, "organisations and individuals are not powerful. The central ingredient of power is purpose" (DuBrin, 2004:51).

4.3.3 Cognitive factors and leadership

Mental ability, as well as personality, are important for leadership effectiveness.

To inspire people, bring about constructive changes and solve problems creatively, leaders must be mentally alert. Problem-solving and intellectual skills are referred to collectively as cognitive factors.

The term "cognition" refers to the mental process that gathers knowledge. Cattell (1946), in Bass (1990), reported, that intelligence consists of such character elements as being wise, emotionally mature, persevering, mentally alert, vigorous and conscientious.

The discussion of cognitive factors and leadership will have as a first element (in section 4.3.3.1), a description of mental ability and cognitive resources. Thereafter, the specific

cognitive factors required for effective leadership will be laid-out: (4.3.3.2) knowledge of the business; (4.3.3.3) creativity; (4.3.3.4) insight into people and situations; (4.3.3.5) farsightedness and conceptual thinking; and (4.3.3.6) openness to experience.

4.3.3.1 Mental ability and cognitive resources

Analysis and observation show that effective leaders have good problem-solving abilities and indeed for the following reasons.

(i) Intelligent and competent leaders make more effective plans, decisions and strategies than leaders with less intelligence or competence.

(ii) Effective leaders communicate their plans, decisions, actions and strategies clearly.

Strong problem-solving abilities are assets to leaders, because they must collect, integrate and interpret enormous amounts of data (Kotter, 1990). Leaders also need intelligence to run software and computations. Despite the importance of the problem-solving ability for leadership, an advanced capacity for solving abstract problems and an overly intellectual style, can create problems. A leader with too strong a penchant for gathering and analysing information, may suffer from "analysis paralysis". The leader might keep analysing problems at the expense of taking decisive action and risks becoming ineffective.

Effective leaders are able to communicate clearly and convincingly, disarm conflicts, build strong relationships and interpret the information relevant and important for decision-making from that what is irrelevant and less important (DuBrin, 2004:44).

4.3.3.2 Knowledge of the business

According to Kotter (1990:113), the accumulation of experiences over a decade or two is usually very influential in being effective. This is true in a general sense, but it is especially relevant with respect to leadership.

Intellectual ability is closely related to having a good working knowledge of the business and organisation.

An effective leader has to be technically or professionally competent in some discipline, particularly when leading a group of specialists. It is difficult for the leader to establish rapport with followers and group members when he or she does not know what they are doing and when the group does not respect the technical skills of their leader. At a minimum, the leader of specialists must be "snow-proof": that is, not really bluffed about technical or specialist matters (DuBrin, 2004:52).

The results of 11 studies dealing with leadership and knowledge, imply that persons who are chosen as leaders, tend to be those who knew how to get things done (Bass, 1990:65). Cox (1926) also reported, that great leaders were characterised and differentiated from the average by a greater intensity of application and industry.

Therefore, specialised knowledge and the ability to get things done, are factors that contribute to the effectiveness of leadership.

The importance of knowledge of the business, is increasingly being recognised as an attribute of executive leadership. Knowledge of the business is particularly relevant when formulating and implementing strategy (DuBrin, 2004:52).

The General Electric Leadership Effectiveness Survey (LES), (Ulrich et al., 1999), indicates, that an effective leader must possess the personal traits: knowledge, expertise and intellect. An individual must comply with the following criteria in order for him or her to be an effective leader.

(i) Possess and readily share functional and technical expertise.
(ii) Demonstrate broad business knowledge, together with cross-functional and multicultural awareness.
(iii) Able to apply intellectual abilities to the fullest and make good decisions with the limited data availability.

(iv) Speedily distinguish relevant form irrelevant information; grasp essentials of complex issues and initiate action.

4.3.3.3 Creativity

Many effective leaders are creative, because they arrive at imaginative and original solutions to complex problems (Crainer, 2003).

Creative ability lies on a continuum: some leaders are more creative than are others. At one end of the creative continuum are leaders who think of innovative products and services. At the middle of the creative continuum are those leaders who explore imaginative, but not breakthrough solutions to problems. At the low end of the creative continuum are those leaders who inspire followers and group members to push forward with standard solutions to problems (DuBrin, 2004:52).

Creativity is such an important aspect of the role of leaders in modern times, that the development of creative problem-solving skills receives much attention (DuBrin, 2004:52). This is supported by the research in Cox (1926), who found that great leaders rated unusually high in originality.

4.3.3.4 Insight into people and situations

Another important cognitive characteristic of effective leaders, is insight. Insight can be described as a depth of understanding that requires considerable intuition and common sense.

Insight is related to creativity because of its intuitive characteristic. Insight into people and situations involving people, is an essential characteristic component of effective leaders.

A leader with a keen insight, is able to make wise choices in selecting people for key assignments. Insight enables a leader to make good work of training and developing team members. The reason for this, is that these leaders are able to make a careful assessment of the strengths and weaknesses of team members.

Another major advantage of being insightful, is that leaders can size up the situation and adapt his or her leadership approach accordingly. For example: in a crisis situation fellow group members and followers welcome insightful and decisive leadership. Furthermore, insight also helps a leader to solve complex problems and make observations that others might not recognise (DuBrin, 2004:53).

According to Bass (1990:66), various studies found leadership to be related to aspects of insight, as follows: keenly alive to the environment, alert, ability to evaluate situations, social insight, self-insight and sympathetic understanding.

4.3.3.5 Farsightedness and conceptual thinking

To formulate and implement a vision and strategies, an effective leader requires farsightedness and conceptual thinking; the ability to understand the long-term implications of actions, policies, processes and structures (Kotter, 1990:139).

The research of Bennis and Nanus (2003) indicates, that one of the most important elements of effective leadership, is a clearly articulated vision, or sense of direction, in order to focus the attention of everyone associated with the organisation and leader. The requirement of vision for effective leadership, is widely embraced, not only in the corporate world but among leaders of political and educational institutions, churches, and other non-profit organisations as well. Today it is generally accepted, that all successful organisations need not only have a clear mission or purpose, but also a widely shared vision, and that few leaders can succeed without both.

Tom Peters, business management consultant and author, compiled a list of characteristics future leaders will have, the most important being that of "... a good communicator who overseas a satisfying two-way flow of information". This includes imparting vision and objectives that everyone understands, listening to associates and maintaining an open-door policy (Anon, 2003a:4).

DuBrin (2004:53) describes conceptual thinking as the ability to see the overall perspective or big picture. This in turn, assists with the ability of farsightedness. A conceptual thinker is also a systems thinker, because of his or her fundamental understanding how the environment influences the organisation and how different parts of the organisation influence each other.

The General Electric Leadership Effectiveness Survey (LES), (Ulrich et al., 1999), requires an individual to possess the personal characteristic farsightedness or vision to be an effective leader. In this regard the individual has to:

(i) develop and communicate a clear, simple, stakeholder focussed vision and direction for the organisation;
(ii) be forward-thinking, stretching horizons and challenges current thinking and imaginations; and
(iii) update the vision and direction to reflect constant and accelerating change that has an impact on the organisation and its business.

4.3.3.6 Openness to experience

An important characteristic of effective leaders, is their openness to experience, and this is also described as having a positive attitude toward learning.

Leaders regularly utilise what they have learned form experience in order for them to be effective (Manning, 2002:86). People who have a great deal of openness to experience, have well-developed intellects. Traits commonly associated with this dimension of the

intellect, include being imaginative, cultured, curious, original, broad-minded and intelligent (DuBrin, 2004:54).

4.3.4 Physical and background factors

Many attempts have been made to highlight the physical and intellectual differences that exist between leaders and the general population (Manning, 2002:31). Another perspective on understanding the personal qualities of effective leaders, is to examine their physical characteristics and biological or background factors.

A major limitation to this approach is, that it is based on physical and cultural stereotypes that are changing as more diverse people gain power. The physical and background factors reviewed here, are energy and physical stamina (4.3.4.1); and biographical factors (4.3.4.2).

4.3.4.1 Energy and physical stamina

Being an effective leader, requires considerable energy and physical stamina (Bennis & Nanus, 2003).

The most demanding physical challenges facing leaders, are long working hours, frequent travel, and presentations to various stakeholders. Physical energy is helpful in inspiring followers and group members and in sustaining high levels of productivity. Jeffrey Pfeffer (1992:168) observes about the traits of leaders, "Without endurance and the ability to persevere, other skills and attributes are not worth much".

According to Cox (1926), effective leaders are characterised by a high rate of energy output. But Cox (1926) also found, that various groups of great leaders differ markedly from each other in physique, energy output and athletic prowess; only successful military leaders were outstanding in these traits.

In their article published in the October 2003 edition of Directorship: "Self restoration and self preservation for top achievers", B. Lane and J. Dry (2003:10) describe the importance for leaders to master the art of personal energy management. Because effective leaders burn high levels of energy during goal attainment, better personal energy management will provide an improved ability to sustain high-level performance to assist in effectiveness.

4.3.4.2 Background factors

Seniority, education and social background

Business Week tabulated biographical background factors of the 1,000 most highly placed executives in American-based corporations. One of the major findings is, that the ability to stay with one organisation for a long time, is an asset to becoming a top executive. The average service at the company for a Chief Executive Officer is 22,5 years.

Business Week also found that 916 executives took an undergraduate degree of some kind, whilst the other, 55, attended some college. More than half received a Bachelor of Science degree, the majority of them in business or related fields. More than one-half of the executives attended graduate schools, earning doctorates in physical science degrees in law or business (Wadekar, 1993:64).

According to Bass (1990), the conclusions drawn from research on the importance of education and social background for leadership, were that:

(i) high socio-economic status was an advantage in attaining leadership status;

(ii) leaders who rose to high-level positions in industry tended to come more from the lower socio-economic strata of society than was the case 60 years earlier; and

(iii) leaders tended to be better educated now than leaders formerly were. The rise in the general level of education of the population, is common knowledge. Requirements for managerial and administrative positions, increasingly demand a graduate degree, such as the Master of Business Administration (MBA) degree.

The trend toward reduced emphasis on social status and more emphasis on education, in order to rise to a leadership position, is expected to continue.

Research conducted by Amarach Consulting for the Smurfit School of Business at University College, Dublin, revealed that 60% of women had seen their careers benefit within a year of their having completed the full-time MBA programme (Anderson, 2003:22). Professor Lize Booysen from the UNISA Graduate School of Business Leadership states, that international and local literature shows, that the future leadership style in organisations will overlap more with the female style of leadership, due to more women studying executive programmes and more women being accepted into leadership positions. This will lead to the skills of women being more readily accepted, valued and utilised in the exercise of leadership (Booysen, 2004).

Background factors make their largest contribution toward the understanding of leadership, to the extent that it reflects underlying traits, motives, characteristics and skills. People for example, who received advanced degrees, may have a hunger for knowledge and good problem-solving skills. People who attended well-known schools, may make extensive use of networking (DuBrin, 2004) to attain positions of power.

The trait approach emphasises, that having a leader with a certain set of characteristics, is crucial in ensuring effective leadership.

This approach suggests, that organisations will function better if the people in senior positions have designated leadership profiles. To find the right people, it is common for organisations to utilise personality assessment instruments. Organisations can, therefore, specify the characteristics or traits that are important to them for particular positions and then use personality assessment measures to determine whether or not an individual fits the needs of the enterprise (Northouse, 2004:21).

Now that the traits, motives and characteristics of effective leadership have been established a discussion of heredity, environment and leadership follows.

4.3.5 Heredity, environment and leadership

Do heredity and environment within which individual's functions, contribute toward leadership effectiveness? Are leaders born or made? Do you have to have the right stuff to be a leader? Many people ponder these issues now that the study of leadership is more in vogue than ever. See Kotter (1990:103); Bass (1990); Manning (2002); Harvard Business Review (2003); DuBrin (2004) and Northouse (2004).

A balanced answer to the above questions is, that the traits, motives, and characteristics required for leadership effectiveness are a combination of heredity and environmental factors. Certain inherited pre-dispositions and aptitudes that require the correct opportunity to develop, fully underpin personal traits and cognitive abilities. Cognitive factors of leadership and task-related personality traits are good examples hereof. But individuals need the right opportunity to develop their cognitive factors and task-related personality traits, in order for them to function in a manner that will give rise to their receiving recognition and for them to be appointed to positions of leadership (DuBrin, 2004). This is also supported by Kotter (1990:114) and Manning (2002).

The physical factor of energy also provides insight into the nature-versus-nurture issue. Some people are born with a biological propensity for being more energetic and ambitious than are others (Kotter, 1990:105). Yet, unless their energy is well-directed, it will not assist an individual to become an effective leader.

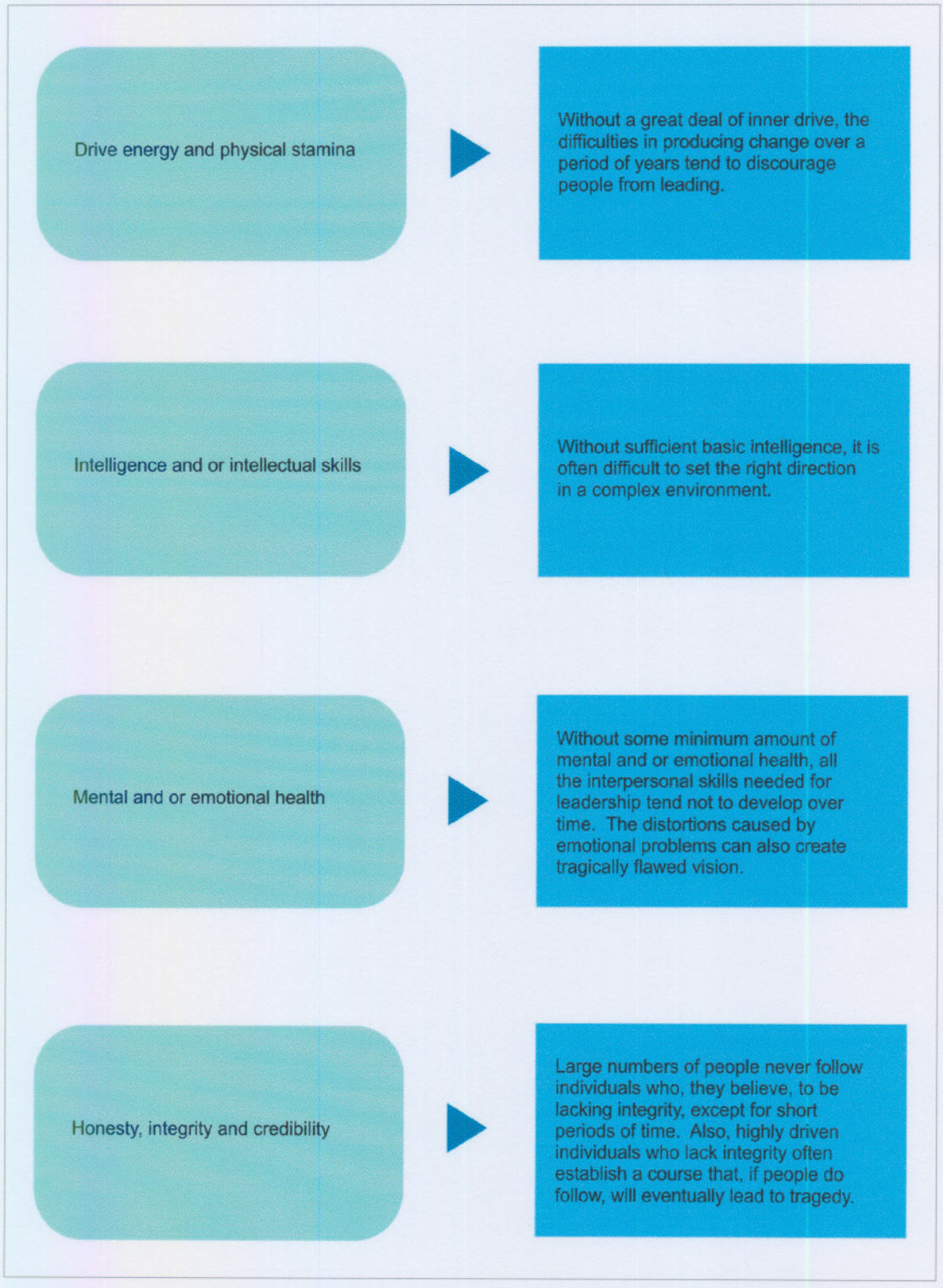
The nature-versus-nurture issue also surfaces in relation to the leadership characteristic of creativity, innovation, mental resources and emotional intelligence. The important genetic contributors to imaginative thinking, include brainpower and emotional expressiveness. Mental or emotional health is important attributes, because this allows leaders to effortlessly interact with organisations and with people (Kotter, 1990:106).

Research regarding emotional intelligence, reinforces the above statements concerning leadership being a combination of inherited and learned factors. An individual therefore, possesses genes that influence the emotional intelligence required for effective leadership. However, experience is also important for emotional intelligence, because this increases with age, and a person usually becomes better at certain activities such as managing relationships the more practice has been undertaken therein (DuBrin, 2004:55).

Figure 4.1 "Heredity, childhood and leadership in big jobs" compares the effects of certain inherited characteristics with the influence they have on individuals who are employed in large organisations.

Figure 4.1 follows on next page.

Figure 4.1 Heredity, childhood and leadership in big jobs



Source: Kotter (1990:108)

4.3.6 The strengths and limitations of the trait approach to leadership

The trait approach has proven value, with a century of research to support it. No other leadership theory can boast of the breadth and depth of studies conducted on the trait approach. From the abundance of research has emerged a body of data that points to the important role of various personality traits in the leadership process (Northouse, 2004:22).

A compelling argument for the trait approach, is that the evidence is convinced that leaders possess personal characteristics that differ from those of non-leaders.

Kirkpatrick and Locke in DuBrin (2004:56) concluded from their research that leaders "... do not have to have to be great men or women by being intellectual geniuses or omniscient prophets to succeed". But they do need to have the "right stuff" and this "... stuff is not equally present in all people".

Understanding the traits of effective leaders, serves as an important guide for leadership selection. If we are confident that honesty, integrity, creativity and imagination are essential leadership traits, then we can concentrate on selecting leaders that possess these characteristics. Another important strength of the trait approach to leadership is that it can help people to prepare for leadership responsibility and can be used for personal awareness and development through personal analysis (DuBrin, 2004; Northouse, 2004).

A limitation to the trait approach is, that it does not tell us which traits are absolutely necessary in which leadership situations. We also do not know how much of a trait, characteristic, or motive is the right amount. Too much focus on the trait approach can breed an elitist conception of leadership. People who are not outstanding on key leadership traits and characteristics, might be discouraged from seeking leadership development and positions (DuBrin, 2004; Northouse, 2004).

Another critique is, that the trait approach has failed to take situations into account. As Stogdill (1948) in Northouse (2004) pointed out, it is difficult to isolate a set of traits that

are characteristic of leaders without factoring situational effects into the equation as well. People who possess certain traits that make them leaders in one situation, may not be leaders in another situation. Thus: the situation influences leadership, and it is, therefore, difficult to identify a universal set of leadership traits in isolation from the context in which the leadership occurs.

The situational approach, on the other hand, denies the influences of individual differences, attributing all variance among persons to the fortuitous demands of the environment (Bass, 1990:87).

A balanced perspective on the trait approach is, that certain traits, motives, and characteristics and skills increase the probability that a leader will be effective. Yet they do not guarantee effectiveness, and the leadership situation often influences which traits will be most important (Kotter, 1990; DuBrin, 2004).

Section 4.4 will explore the meaning of power, the bases of such power, and how such power contributes to leadership effectiveness in societies, communities and formal organisations.

4.4 BASES OF POWER

In the beginning of the 21st century power is conspicuous in its absence. Powerlessness is the ultimate pitfall in the face of crisis and complexity.

In the extreme contradiction and polarisation of thought and action, power has been deliberately obstructed while a certain degree of disorder exists. Institutions have been rigid, slothful or mercurial. Senior officials in supposed leadership positions, seem to be ignorant and out of touch, insensitive, unresponsive toward their constituents and therefore ineffective. Worst of all, solutions have been haphazardly designed or they have not been implemented at all. This has created a managerial mayhem that can be more fully

understood with the examination of power. Power can be defined as the basic energy to initiate and sustain action that translates intention into reality, and power is the quality without which a leader cannot lead (Bennis & Nanus, 2003).

There is no excuse for ineffective leaders and ineffective organisations to hold on to power at the expense of their constituents. Therefore, wishing away calamity, is weak leadership.

To acquire and retain power, a leader must often skilfully use politics. No matter how meritorious the ideas of a leader are to bring about constructive change, without power and political backing, those ideas will not be developed further and become implemented.

To exercise influence, a leader must have power. Power is the potential or ability to influence decisions and to control resources. Effective leaders use power appropriately and understand when and how to be directive and when to delegate (DuBrin, 2004:193).

Power is the force that can be applied to produce a certain activity or performance of work. It is the rate at which energy can be absorbed. Power is the ability to take actions and to initiate interactions. It is a force underlying social exchanges in which the power and the person in the exchange relationship has less power and the person with more power is able to obtain compliance with his or her wishes. The compliant person depends on the more powerful other person for desired outcomes that cannot be obtained from other sources (Emerson, 1964 in Bass, 1990:225).

Power can be viewed as the enhancing agent to assist leadership in being effective and vice versa. Power is intertwined with effective leadership.

Provision must be made for power in the vision that a leader has for the future, otherwise dire consequences could result. Examples hereof, is the possibility for an unnecessary slow implementation process or even the hindering of participation by key constituents in a just future. The hindrance of participation is a consequence of public fear of

confrontation, whether it is between lovers, friends or through crime, local injustices, the media or government. (Bennis & Nanus, 2003).

In the above section the importance of power for effective leadership has been discussed and the following section will explore the various bases from which power can be derived.

4.4.1 Sources and types of power

Power is one of the most widely known forces in the universe. It is the pull-and-push everyone experiences and exercises from birth to death. Power is implicit in every facet of human interaction, whether it is familial, sexual, occupational, national or international (Bennis & Nanus, 2003).

Power begets power.

Power from one base can generate power in another. An example hereof, is individuals whose power is based on the legitimacy of their positions, can acquire additional power by controlling the rewards that accompany the legitimacy of the positions occupied. In a similar method, followers and group members tend to refer to those they perceive to be experts. Perceived expertness, in turn, tends to legitimate the leadership role (Goodstadt & Kipnis, 1970).

The closer a person is to power: the greater the power he or she exerts.

A good example hereof, is the higher a production unit report in the hierarchy of an organisation; the more power the unit possesses. The practical implications are, that a leader in charge of a department reporting to the chief executive officer has more power than a department reporting to a general manager. Leaders in search of more power typically manoeuvre toward a higher-reporting position in the organisation. Many managers of quality assurance now report at a higher organisational level than previously.

Part of this enhanced power can be attributed to the increasing attention organisations are paying to quality as part of their overall strategy to attain a competitive advantage (DuBrin, 2004:199).

Power can be derived from many sources. Although we may be able to identify the different bases of power, in reality they are likely to be intertwined with one another (Bass, 1990).

4.4.2 Position power (power granted by the organisation)

The status associated with the position of an individual gives that individual power to influence those who are lower in status.

Custom, tradition, rules and regulations assign power to incumbents of positions. Leaders and senior officials are mostly viewed by their followers and subordinates as the "purveyors of rewards and punishments" (Krech and Crutchfield, 1948 in Bass, 1990:228).

Power is frequently classified according to whether it stems form the organisation or the individual. Four of these bases of power which stem from the organisation, that is, from the position an individual occupies within the organisation, can be identified: (4.4.2.1) legitimate power; (4.4.2.2) reward power; (4.4.2.3) coercive power; and (4.4.2.4) information power.

4.4.2.1 Legitimate power

Legitimate power is based on norms and expectations that group members hold regarding certain behaviours that are appropriate in a given role or position.

These norms and expectations are the drivers of the legitimation of a specific position. Followers and group members are more likely to accept the position of the leader and his

or her influence as legitimate, when the leader holds attitudes that conform to the norms of the followers, the group or the organisation (Bass, 1990:243).

Power granted by the organisation, is called legitimate power "... the lawful right to make a decision and expect compliance". Individuals at the highest levels in an organisation have more power than people below them. However, organisational culture helps establish the limits of power an individual has. An example hereof, is to be seen in the experiences of newly appointed executives; they are often frustrated with how long it takes to effect major changes within an organisation (DuBrin, 2004:194).

According to Bass (1990), House (1984) provided a rationale for the fact that although people accept leadership based on legitimate power, they do not do so with any special enthusiasm or as readily as they do when leadership is based on expert power.

4.4.2.2 Reward power

Reward power refers to the ability an individual has to facilitate the attainment of desired outcomes by others (Bass, 1990:236). The authority to give employees rewards for compliance, is described as reward power.

If a general manager can directly reward supervisors with cash bonuses for achieving quality targets, this manager will exert considerable power. Therefore, leaders can use reward power effectively only when they have meaningful rewards at their disposal (DuBrin, 2004:194).

Justis (1975), in Bass (1990), examined effective leadership as a function of the extent to which the rewards received by followers are dependent on the competence and performance of their leaders. Justis (1975) found, that the effectiveness and influence of the leaders was greater the more the leader was seen to be competent, and the more the rewards the followers depended on the performance of the leader.

4.4.2.3 Coercive power

The leader who uses coercive power, controls the granting or denying of valued rewards or feared penalties, simultaneous with subordinates private feelings remaining hidden, while pressure on them exist not to express publicly what they really feel.

Coercive power implies the ability to impose penalties for non-compliance (Bass, 1990). The use of coercive power is less popular with leaders and subordinates alike. Leaders tend to employ this form of power to deal with the unacceptable performance of subordinates, primarily when they do not have the power or resources to reward subordinates for such acceptable performance (Kipnis, 1976).

Coercive power is the power to punish for non-compliance and is based on fear. A common coercive tactic is for a senior executive to demote a subordinate manager if he or she does not comply with the plans for change of the executive.

Coercive power is limited, in that punishment and fear achieve mixed results as motivators. The leader who relies heavily on coercive power, runs the constant threat of being ousted from power (DuBrin, 2004:194).

4.4.2.4 Information power

Information power is derived from formal control over information people need to perform their work.

A sales manager who controls the leads from customer inquiries, holds considerable power. As the branch manager of a real estate agency put it, that ever since "... the leads were mailed directly to me, I get oodles of co-operation from my agents. Before that they would treat me as if I were simply the office manager" (DuBrin, 2004:195).

4.4.3 Personal power

Three sources of power are derived from characteristics or behaviours of the power actor: (4.4.3.1) expert power; (4.4.3.2) referent power; and (4.4.3.3) prestige power. All three are classified as personal power, because they are derived from the person and not from an organisation.

4.4.3.1 Expert power

Expert power is the ability to influence others through specialised knowledge, skills, and abilities. A marketing manager who is adept at identifying new markets possesses expert power.

Expert power may be manifested in information, knowledge, and wisdom; in good decisions; in sound judgement; and in accurate perceptions of reality, Watts (1986), (in Bass, 1990:233).

The power of revolutionary or transformational leaders often begins with their perceived power as experts, which they use to define prevailing problems and to develop innovative solutions. Followers are persuaded that the leaders have the right answers to their problems and are organised to provide support, Gjestland (1982), (in Bass, 1990).

According to Podsakoff and Schriesheim (1985), in Bass (1990:233), in comparison with other bases of power, the use of expert power by leaders appears to be most acceptable to and most effective with followers. It most readily gains the compliance of followers and is least likely to provoke their resistance.

Expert power also stems from critical problems. A theory has been developed to explain why some organisational divisions are more powerful than are other divisions.

The strategic contingency theory of power suggests, that units best able to cope with the critical problems and uncertainties within an enterprise, acquire relatively large amounts of power. The theory also implies, for example, that when an organisation faces substantial production difficulties, the production division will gain power and influence over organisational decisions. The sudden power and influence of the production division is based on its exclusive ability to handle the particular problems concerning production (DuBrin, 2004:198).

4.4.3.2 Referent power

Referent power is based on the desire of the followers to identify with their leaders and to be accepted by their leaders (Bass, 1990:235). Referent power is the ability to influence others through desirable traits and characteristics (DuBrin, 2004:195).

Podsakoff and Schriesheim (1985), in Bass (1990:235), found that the use of referent power by leaders usually contribute to better performance, greater satisfaction, greater role clarity and fewer excused absences by their subordinates and followers.

4.4.3.3 Prestige power

Prestige power is another important source of personal power. Prestige power stems from the status and reputation an individual possesses.

An example hereof is, that a political leader who has accumulated important political successes, acquires prestige power. Executive recruiters, for example, identify executives who could readily be placed in key executive positions because of their excellent track records (DuBrin, 2004:195). Nelson Mandela is an example of a leader with great prestige power for his transformational successes in politics.

Because personal power is a source of leadership power, and leadership implies a position that is more senior in relation to others within an organisation, the exercise of position and

personal power is, therefore, intertwined. To make effective use of position power, the leader should possess such characteristics as integrity, initiative, the desire to lead, communication skills, emotional security and intelligence.

The theory of transformational leadership will be discussed in the following section.

4.5 TRANSFORMATIONAL LEADERSHIP

This section discusses four authoritative approaches to transformational leadership, its strengths and certain criticisms thereof.

4.5.1 Transformational leadership according to J. M. Burns

The first approach (4.5.1) is taken from the publications of James MacGregor Burns (1978; 2003).

In order to identify transformational leadership, it is important to distinguish between the activity "rule" and "lead".

4.5.1.1 Difference between rule and lead

Questions that can be formulated to assist in this regard are as follows. Are the leaders in question, transforming leaders, who mobilise and respond to followers and create changes that are real, deep, comprehensive, durable, and grounded in values? Or are the leaders instead merely rulers?

A good example, to assist with answering the above questions, is Adolf Hitler. Even in terms of his own Nazi standards he was a failure. If a head failed to create for the people lasting, meaningful opportunities for the pursuit of happiness then he failed to lead but ruled (Burns, 2003:29). Today, the public, measure leaders and their deeds by the full

range of high public values: order, liberty, equality, justice. All of these values, are the conditions necessary for the pursuit of happiness (Burns, 2003, 49).

Now that a distinction between rule and lead has been made, the question that needs to be answered is what the purpose of leadership is.

4.5.1.2 The purpose of leadership

Summoned by human wants, the task of leadership is to accomplish change in the world that responds to peoples needs and wants. The actions and achievements of leadership are measured by the supreme public values that themselves are the profoundest expressions of human wants: order; liberty; equality; justice and opportunity; and the pursuit of happiness (Burns, 2003).

Therefore, the purpose of leadership is to improve the lives of followers and citizens. Great numbers of people exist worldwide in similar circumstances of geography, race, religion, class, illiteracy, ill health and ignorance. These dire conditions create dire wants that in turn create opportunities for political leaders as well as leaders in commerce to mobilise those in need for the cause of transformational change – or, alternatively, to exploit these needs (Burns, 2003).

Unfortunately, since the time of the Enlightenment, as today in modern society, most of the world's people were unable to "eschew misery". It was not only that they lacked happiness as is the case today, but they also lacked the opportunity and means to pursue it. They lacked the most potent agent for change, for unlocking the transformational capacities needed to make the pursuit of happiness more than just a political message (Burns, 2003).

Therefore, Burns argues (2003) that the protection and nourishing of happiness, for extending the opportunity to pursue happiness to all people, is the most important purpose of transformational leadership.

To understand transformational leadership, it has to be distinguished from change.

4.5.1.3 Difference between change and transformation

We must distinguish between the verbs "change" and "transform" using exact definitions. The Concise Oxford English Dictionary (COED, 2002:235) describes the action of changing as an "... instance of becoming different"; and giving something in exchange or replacing it with something similar in value. COED (2002:1523) equates transform with "... undergoing transformation"; and describes transformation as a "... marked change in nature, form, or appearance".

Burns (2003) states that to change is to substitute one thing for another, to give and take, to exchange places, to pass from one place to another. These are the kinds of changes that can be attributed to transactional leadership. But to transform something is much more profound. To transform is to cause a metamorphosis in form or structure, a change into another substance, a radical change in outward form or inner character, as when a frog is transformed into a prince or a carriage maker into an auto factory. It is change of this breadth and depth that is fostered by transformational leadership.

In broad social and political terms, transforming means basic alterations, in entire systems – revolutions that replace one structure of power with another, or the constitutional changes America achieved in the late eighteenth century. Bernard Bass (1990) also distinguished between the "first order of change" or changes of degree, and a higher order of change, constituting alterations in "attitudes, beliefs, values, and needs". Quantitative changes are not enough to be measured as transformation; they must be qualitative too. Therefore, transformation means to change so comprehensively and pervasive, and perhaps accelerated, that new cultures and value systems take the places of the old.

Empowerment plays an important role in the success of transformational leadership.

4.5.1.4 Role of empowerment with regard to transformational leadership

Leaders take the initiative in mobilising people for participation in the process of change, encouraging a sense of collective identity and collective efficacy, which in turn brings stronger feelings of self-worth and self-fulfillment for followers. This process is also described in Bass (1990) as an enhanced feeling for followers, a "... sense of meaningfulness in their work and lives". By pursuing transformational change, people can transform themselves. The word for this process is empowerment. Instead of exercising power over people, transformational leaders champion and inspire followers. Tension can develop in this process. As leaders encourage followers to rise above narrow interests and work together for transcending goals, leaders can come into conflict with the rising sense of efficacy and purpose of followers. Followers might outstrip leaders. They might become leaders themselves. That is what makes transformational leadership effective, participatory and democratic (Burns, 2003).

4.5.1.5 Transformational leadership defined

Transformational leaders define public values that embrace the supreme and enduring principles of a people. These values are the shaping ideas behind constitutions and laws and their interpretation. They are the essence of declarations of independence; revolutionary proclamations; momentous statements by leaders that go to the core meaning of events; that define what is at stake, such as the Gettysburg Address. Such values are not ordinarily part of the daily discourse of the citizenry. But are part of testing times when people confront the possibilities – and threats – of great change. Powerful foundational values are evoked through transformational leadership. They are the inspiration and guides to people that pursue and seek to shape change, and they are the standards by which the realisations of the highest intentions are measured. Transforming values lie at the heart of transformational leadership, determining whether leadership indeed can be successful in the attainment of its results through transformation (Burns, 2003).

4.5.2 Transformational leadership according to P. G. Northouse

The second approach (4.5.2) is based on the leadership theory and practice of Peter Guy Northouse (2004).

One of the current approaches to leadership that has been the focus of much research since the early 1980's is the transformational leadership approach.

As its name implies, transformational leadership is a process that changes and transforms the lives of followers and other individuals. Transformational leadership is concerned with emotions, values, ethics, standards, and long-term goals, and includes assessing motives and satisfying the needs of followers and treating followers with dignity and respect (as human beings). Transformational leadership involves an exceptional form of influence that moves followers to accomplish more than what is usually expected of them (Northouse, 2004). It is a process that requires of leaders the characteristics as discussed earlier in this chapter (see section 4.3).

From an encompassing approach, transformational leadership can be used to describe a wide range of leadership activities, from very specific attempts to influence followers on a one-to-one level to very broad attempts to influence whole organisations and even entire cultures. Although the transformational leader plays a pivotal role in precipitating change, followers and leaders are inextricably bound together in the transformation process (Northouse, 2004).

4.5.2.1 Transformational leadership defined

The term "transformational leadership" was first used by Downton (1973); however, its emergence as an important approach to leadership began with a classic work of the political sociologist James MacGregor Burns tilted Leadership (1978).

Transformational leadership refers to the process whereby an individual engages with others and creates a connection that raises the level of motivation and morality in both the leader and the followers. This type of leader is attentive to the needs and motives of followers and tries to help followers reach their fullest potential. Burns (2003) points to Mohatma Gandhi as a classic example of transformational leadership. Gandhi raised the hopes and demands of millions of his people: transformed the acts of violence into passive resistance against Imperial rule and thereby successfully transformed India into the largest democracy in the world.

Furthermore, transformational leadership motivates followers to do more than to merely support the leadership (Bass, 1985). This motivation includes the following: (a) followers level of consciousness about the importance and value of specified and idealised goals are raised; (b) support followers to transcend their own self-interest for the sake of the organisation or society as a whole; and (c) moving followers to address higher-level needs.

4.5.2.2 Factors of transformational leadership

Transformational leadership is concerned with the performance of followers and also with developing followers to their fullest potential (Avolio, 1999). Individuals who exhibit transformational leadership often have a strong set of values and beliefs, and they are effective at motivating followers to act in ways that support the greater good rather than their own self-interests. Four factors of transformational leadership are identified. They are (i) idealised influence; (ii) inspirational motivation; (iii) intellectual stimulation; and (iv) individualised considerations.

(i) Idealised influence

Idealised influence, describe leaders who act as strong role models for followers; followers identify with these leaders and want very much to emulate them. These leaders usually have very high standards of moral and ethical conduct and can be counted on to

do the right thing. They are deeply respected by followers, who usually place a great deal of trust in them. These leaders provide followers with a clear vision and a sense of purpose (Northhouse, 2004).

(ii) Inspirational motivation

Inspirational motivation, is descriptive of leaders who communicate high expectations to followers, inspiring them through motivation to become committed to and be a part of the shared vision for society or the organisation. In practice, leaders use symbols and emotional appeals to focus the efforts of followers to achieve more than they would if they acted solely in their own self-interest. Camaraderie or "espirit de corps" is greatly enhanced by this type of leadership (Northouse, 2004).

(iii) Intellectual stimulation

Intellectual stimulation includes leadership that stimulates followers to be creative and innovative, and to challenge their own beliefs and values as well as those of the leader and the organisation. This type of leadership supports followers as they try new approaches and develop innovative ways of dealing with organisational issues. Due to this support, followers tend to think things through on their own and engage in careful problem solving before taking action. This promotes the empowerment of followers in order for them to become leaders in their own right (Northouse, 2004).

(iv) Individualised considerations

The factor called individualised consideration, is representative of leaders who provide a supportive climate in which they listen carefully to the individual needs of followers. Leaders act as coaches and advisers while trying to assist individuals in becoming fully actualised (Northouse, 2004).

According to Bass and Avolio (1990), in Northhouse (2004), transformational leadership move followers to accomplish more than what is usually expected of them. They become motivated to transcend their own self-interests for the good of the society or the organisation.

4.5.3 Transformational leadership according to W. G. Bennis and B. Nanus

The third approach (4.5.3) is based on the publication of Warren Bennis and Burt Nanus (2003) "Leaders". Bennis and Nanus (2003) identified four common strategies used by leaders in the transformation of organisations.

First, transformational leaders have a clear vision of the future state of their organisations. It is an image of an attractive, realistic, and believable future. The vision is usually simple, understandable, beneficial, inspiring and creates energy amongst followers or members of the organisation. The compelling nature of the vision touches the experiences of followers and pulls them into supporting the leader and the organisation. When an organisation has a clear vision, it is easier for individuals within the organisation to learn how they fit in with the overall direction of the organisation and even the society in general. It empowers them because they feel they are a significant dimension of a worthwhile enterprise. Bennis and Nanus found that to be successful, the vision needs to grow out of the needs of the entire organisation and be claimed by those within it. Although leaders play a large role in articulating the vision, the emergence of the vision originates from both the leaders and the followers within the organisation (Bennis & Nanus, 2003).

Second, transformational leaders are social architects for their societies or organisations. This means that transforming leaders create a shape or form for the shared meanings individuals maintain within their societies or organisations. These leaders communicate a direction that transforms the values and norms of their followers, societies or organisations. Transformational leaders have the ability to mobilise people to accept a

new group identity or a new philosophy for their societies or organisations (Bennis & Nanus, 2003).

Third, transformational leaders create trust in their organisations by making their own positions clearly known and then standing by them. Trust has to do with being predictable or reliable, even in situations that are uncertain. For organisations, leaders build trust by articulating a direction and then consistently promote the direction even though the vision may involve a high degree of uncertainty. In this regard Bennis and Nanus found that when leaders established trust in an organisation it gives the organisation a sense of integrity analogous to a healthy identity (Bennis & Nanus, 2003).

Fourth, Bennis and Nanus (2003) states that transformational leaders use "...creative deployment of self through positive self-regard". Leaders know their strengths and weaknesses, and they emphasise their strengths rather than exposing their weaknesses. Based on an awareness of their own competence, effective leaders are able to immerse themselves in their tasks and the overarching goals of their organisations. They are able to fuse a sense of self with the work at hand. Furthermore, Bennis and Nanus found that positive self-regard in leaders had a reciprocal impact on followers, creating in them feelings of confidence and high expectations. In addition, transforming leaders are committed to learning and relearning, so in their organisations there is consistent emphasis on education.

4.5.4 Transformational leadership according to A. J. DuBrin

The fourth approach (4.5.4) is based on the research findings and practices of leaders by Andrew J. DuBrin (2004).

DuBrin (2004) states that the focus on transformational leadership is on what the leader accomplishes, rather than on the leader's personal characteristics and his or her relationship with followers. The transformational leader helps bring about major, positive changes. To explain this further: the transformational leader moves followers beyond

their self-interests for the good of the group, organisation or society. In contrast with this, the transactional leader focuses on more routine transactions with an emphasis on rewarding group members for meeting standards (contingent reinforcement).

4.5.4.1 How does transformation take place

Leaders often encounter the need to transform organisations from low performance to acceptable performance, or from acceptable performance to high performance. At other times, a leader is expected to move a firm from a crisis mode to high ground. To accomplish these lofty purposes, the transformational leader attempts to overhaul the organisational culture or subculture. His or her task can be immense.

To focus the discussion specifically on the leader's role, DuBrin (2004) looks at eight ways in which transformations take place. They are the following.

(i) Raising people's awareness

The transformational leader makes group members aware of the importance and values of certain rewards and how to achieve them. He or she might point to the pride followers would experience should they attain a specific goal. At the same time, the leader would point to the rewards accompanying such success (DuBrin, 2004).

(ii) Helping people look beyond self-interest

The transformational leader helps followers and group members to look at the "big picture" for the sake of the society or the organisation as a whole. An example hereof is a executive vice president of a bank who told her staff members she knows that "... most of you dislike doing your own support work. Yet if we hire enough staff to make life more convenient for you, we'll be losing money. Then the government might force us to be taken over by a larger bank. Who knows how many management jobs would then have to be cut" (DuBrin, 2004).

(iii) Helping people search for self-fulfilment

The transformational leader helps people to go beyond a focus on minor satisfactions to a quest for self-fulfilment. The leader might explain as follows "... I know that making sure you take every vacation day owed you is important. Yet if we get this proposal out on time, we might land a contract that will make us the envy of the industry" (DuBrin, 2004).

(iv) Helping people understand the need for change

The transformational leader must help group members understand the need for change both emotionally and intellectually. The problem is that change involves dislocation and discomfort. An effective transformational leader recognises this emotional component to resisting change and deals with it openly. Organisational change is much like a life transition. Endings must be successfully worked through before new beginnings are possible. People must become unhooked from their past (DuBrin, 2004).

Dealing with the emotional conflicts of large numbers of staffers is obviously an immense task. One approach taken by successful leaders is to conduct discussion groups in which managers and workers are free to discuss their feelings about the changes. This approach has been used quite effectively when firms are downsized. Many of the "survivors" feel guilty that they are still employed while many competent co-workers have lost their jobs. Conducting these sessions require considerable listening skill on the manager's part (DuBrin, 2004).

(v) Investing managers with a sense of urgency

To create the transformation, the leader assembles a critical mass of managers, and instil in them the urgency for change. The managers must also share the top leader's vision of

what is both necessary and achievable. To sell this vision of an improved organisation, the transformational leader must capitalise on available opportunities (DuBrin, 2004).

(vi) Committing to greatness

Peter Koestenbaum (1991) argues that business can be an opportunity for individual and organisational greatness. By adopting this greatness attitude, leaders can ennoble human nature and strengthen societies. Greatness encompasses striving for business effectiveness such as profits and high stock value, as well as impeccable ethics. An emphasis on ethical leadership instils a desire for customer service and quality and fosters feelings of proprietorship and involvement (DuBrin, 2004).

(vii) Adopting a long-range perspective and at the same time observing organisational issues from a broad rather than a narrow perspective

Such thinking on the part of the transformational leader encourages many group members to do likewise. Unless many people think broadly and with a future orientation, a society or an organisation cannot be transformed (DuBrin, 2004).

(viii) Building trust

An important process for transforming is to build trust between leaders and followers or group members, particularly because distrust and suspicion are rampant during periods of uncertainty (change). One component of building trust is to impose transparency on the entire organisation. In this way everyone knows what everyone else is doing (DuBrin, 2004).

Now that a survey of the most authoritative sources on transformational leadership is completed, the strength (4.5.5) and critique (4.5.6) of transformational leadership will be discussed.

4.5.5 Strengths of transformational leadership

The transformational approach has several strengths. First, transformational leadership has been widely researched from many different perspectives, including a series of qualitative studies of prominent leaders and CEO's in large, well-known organisations, and has also been the focal point for a large body of leadership research since its introduction in the 1970's. In this regard see Downton (1973); Burns (1978; 2003); Bass (1985; 1990); Avolio (1999); Bennis and Nanus (2003); Northouse (2004); and DuBrin (2004).

Second, transformational leadership has intuitive appeal. The transformational perspective describes how the leader is out front advocating change for others, and this concept is consistent with society's popular notion of what leadership means. People are attracted to transformational leadership because it makes sense to them. It is appealing that a leader will provide a vision for the future and solutions to overcome problems (Northouse, 2004).

Third, transformational leadership treats leadership as a process that occurs between followers and leaders. Because this process incorporates both the followers' and the leaders' needs, leadership is not the sole responsibility of a leader but rather emerges from the interplay between leaders and followers. The needs of others are central to the transformational leader. As a result, followers gain a more prominent position in the leadership process because the attributions of followers are instrumental in the evolving transformational process (Bryman, 1992; Burns, 2003).

Fourth, the transformational leadership approach provides a broader view of leadership that augments other leadership models. Many leadership models focus primarily on how leaders exchange rewards for achieved goals such as the transactional process. The transformational approach provides an expanded picture of leadership that includes not only the exchange of rewards but also the attention leaders provide towards the needs and growth of followers (Avolio, 1999; Bass, 1985).

Fifth, transformational leadership places strong emphasis on the needs, values, and morals of followers. Burns (1978; 2003) suggests that transformational leadership involve attempts by leaders to move individuals to higher standards of moral responsibility. This includes motivating followers to transcend their own self-interests for the good of the team, organisation, or society. Transformational leadership is fundamentally "morally uplifting" (Avolio, 1999). This emphasis sets the transformational approach apart from all other approaches to leadership because it suggests that leadership has a moral dimension. By emphasising this aspect, the coercive uses of power by individuals such as Hitler or Mugabe can be disregarded as models of leadership.

Finally, there is substantial evidence from various empirical research studies that show transformational leadership is an effective form of leadership (Yukl, 1999 in Northouse, 2004).

4.5.6 Critique of transformational leadership

Transformational leadership also has several weaknesses. One critique is that it lacks conceptual clarity. Because it covers such a wide range of functions, such as creating a vision, motivating, being an agent for change, building trust and acting as a social architect, it is difficult to define the parameters of transformational leadership (Northouse, 2004).

A second critique, is that transformational leadership treats leadership as a personality trait or personal predisposition rather than a behaviour in which people can be instructed (Bryman, 1992). If it is a trait, training people in this approach becomes problematic because it is difficult to teach people how to change their traits. There is also a tendency to see transformational leaders as visionaries and as individuals who have special qualities that transform their followers and societies. These images accentuate a trait characterisation of transformational leadership.

A third critique, is that transformational leadership is elitist and antidemocratic (Avolio, 1999). Transformational leaders often play a direct role in creating changes, establishing a vision, and advocating new directions. This gives the strong impression that the leader is acting independently of followers or putting himself or herself above the needs of followers. Although this criticism of elitism has been refuted by Avolio (1999) and Burns (2003), who contend that transformational leaders can be directive and participative as well as democratic and authoritarian, the substance of the criticism raises valid questions about transformational leadership.

A final critique of transformational leadership is that it has the potential to be abused (Burns, 2003). Transformational leadership is concerned with changing people's values and moving them to a new vision. But who is to determine if the new directions are good and more affirming? Who decides that a new vision is a better vision? If the values to which the leader is moving his or her followers are not better, and if the set of human values is not more redeeming, then the leadership must be challenged. However, the dynamics of how followers challenge leaders or respond to their visions is not fully understood (Northouse, 2004).

Now that the surveys on leadership have been completed, the next section will differentiate between leadership and management to assist with a better understanding of effective leadership.

4.6 LEADERSHIP VERSUS MANAGEMENT

Warren Bennis and Burt Nanus (2003), in their widely acclaimed book "Leadership: strategies for taking charge", distinguish leadership from management as follows: "Most of the earlier management books had identified leadership as just one of the functions of managers". They argue that leaders serve a different organisational purpose from managers. Leaders have a unique perspective and set of responsibilities and they require a different set of aptitudes and skills". The observation by Bennis and Nanus that

"managers do things right while leaders do the right thing" has been widely accepted to assist in the differentiation between leadership and management.

The word leadership is used in two very different ways in everyday conversation. Sometimes it refers to a process that helps direct and mobilise people and or their ideas; we say for example that Anthony is providing leadership in such and such project. At other instances it refers to a group of people in formal positions where leadership, in the first sense of the word, is expected; we say that the leadership of the enterprise is made up of 10 people including George, Alice etc.

In this thesis we will use the word leadership almost exclusively in the first sense. The second usage contributes greatly to the confusion surrounding this subject because it subtly suggests that everyone in a leadership position actually provides leadership.

This is obviously not true; some such people lead well, others poorly, and some do not lead at all. Since most of the people who are in positions of leadership today are called managers, the second usage also suggests that leadership and management is the same thing, or at least closely related. They are not (Kotter, 1990).

Leadership has been a topic of research for a very long time. According to Alfred D. Chandler (2002:455) in: "The visible hand: the management revolution in American Business", the development of top management methods and procedures in the early managerial firms marked the culmination of an organisational revolution that had its origin in the 1850's with railroads. Management was observable in the processes of production and distribution, the methods by which they were managed, the enterprises that administered them, and the resulting structure of industries and of the economy itself.

That which we call management is largely the product of the last 100 years. Management was a response to one of the most significant developments of the 20th century: the emergence of large numbers of complex organisations.

Modern management was invented to help the new railroads, steel mills, and auto companies achieve what the legendary entrepreneurs created them for. Without such management, these complex enterprises tended to become chaotic in ways that threatened their very existence. Good management brought a degree of order and consistency to key dimensions such as quality, profitability of products and sustainable growth (Chandler, 2002).

The discipline of management is defined as a science, resting upon clearly defined laws, rules and principles. The fundamental principles of scientific management are applicable to all kinds of human activity, from our simplest individual acts to the work of great corporations and organisations that require the most elaborate form of co-operation (Taylor, 1998).

In the past century, literally thousands of managers, consultants, and management educators have developed and refined the processes, which make up the essence of modern management. According to Jones et al., (2002) the four principal functions of management involves the following activities.

(i) Planning and budgeting – identifying and selecting appropriate targets or goals for the future, typically for the next month or year; establishing detailed steps for achieving those targets, steps that might include timetables and guidelines; and then allocating resources to accomplish those plans.

(ii) Organising and staffing – structuring working relationships in a manner that allows organisational members to work together to achieve organisational goals; establishing an organisational structure and set of jobs for accomplishing planned requirements, staffing the jobs with qualified individuals, communicating the plan to those people, delegating responsibility for carrying out the plan, and establishing systems to monitor implementation.

(iii) Directing – leading, energising and enabling organisational members in order that they understand the parts they play in attaining organisational goals.

(iv) Controlling and problem solving – monitoring actual results versus planned results in some detail, both formally and informally, by means of reports, meetings, etc.; identifying deviations, which are usually called "problems"; and then planning and organising to solve the problems.

The functions and activities, as described above, produce a degree of consistency and order. Unfortunately, as we have witnessed all too frequently in the last half-century, they can produce order on dimensions as meaningless as the size of the typeface on an executive memoranda (Kotter, 1990).

But that was never the intent of the pioneers who invented modern management. They were trying to produce consistent results on key dimensions expected by customers, stockholders, employees, and other organisational constituencies, despite the complexity caused by large size, modern technologies, and geographic dispersion.

The pioneers created management to help keep a complex organisation on time and on budget to secure the maximum prosperity for the employer, employee and all other relevant stakeholders. That has been, and still is, the primary function of management (Taylor, 1998).

Indeed, leadership is very different from management.

According to current thinking, leadership deals with change, inspiration, motivation, influence and coaching. In contrast, management deals more with maintaining the equilibrium and the status quo (DuBrin, 2004:5).

Leadership does not necessarily produce consistency and order, as the word itself implies; it produces movement and change.

Throughout the ages, individuals who have been viewed as leaders have created change, sometimes for the better and sometimes not. Leaders have done so in a variety of ways and often with every manner of persuasion. Though their actions mostly seem to be about establishing where a group of people should go, getting them lined up in that direction and committed to movement, and then energising them to overcome the inevitable obstacles they will encounter along the way, is of primary importance (Kotter, 1990).

Effective leadership, especially within complex situations, achieves forward movement and transformation that produces envisaged results that satisfies the various needs of all relevant stakeholders. This is done through three activities that is described by Kotter (1990) as follows.

(i) Establishing direction – developing a vision of the future, often the distant future, along with strategies for producing the transformation required to attain that vision.

(ii) Aligning people – communicating the direction to those whose co-operation may be needed so as to create coalitions that understand the vision and that are committed to its achievement.

(iii) Motivating and inspiring – keeping people moving in the right direction despite major political, bureaucratic, and resource barriers to transformation by appealing to very basic, but often untapped, human needs, values, and emotions.

Management and leadership, as defined above, are in some ways similar. They both involve deciding what needs to be done, creating networks of people and relationships that can accomplish an agenda, and then trying to ensure that those people actually get the job done. They are both, in this sense, complete action systems; neither is simply one aspect of the other.

People who think of management as being only the implementation part of leadership ignore the fact that leadership has its own implementation processes: aligning people to new directions and then inspiring them to make it happen. Similarly, people who think of

leadership as only part of the implementation aspect of management, the motivational part, ignore the direction-setting aspect of leadership (Northouse, 2004).

But despite some similarities, differences exist which make management and leadership very distinct from one another.

The planning and budget processes of management tend to focus on time frames ranging from a few months to a few years, on details, on eliminating risks, and on instrumental rationality. By contrast, that part of the leadership process which establishes a direction often focuses on longer time frames, the big picture, visions and grand strategies that take calculated risks, and incorporate a transformation in the values of people as well as of that of the organisation (Bennis & Nanus, 2003).

In a similar way, organising and staffing tend to focus on specialisation, getting the right person into or trained for the right job, and compliance; while aligning people tends to focus on integration, getting the whole group lined up in the right direction, and committed. Controlling and problem solving usually focus on containment, control, and predictability; while motivating and inspiration focus on empowerment, expansion, and creating that occasional surprise that energises people (Jones et al., 2000).

Rost (1991) supports the idea of distinguishing between leadership and management. Rost (1991) contends that leadership is a multidirectional influence relationship and management is a unidirectional authority relationship. While leadership is concerned with the process of developing mutual purposes, management is directed toward co-ordinating activities in order to get the work accomplished. Leaders and followers work together to create transformation, whereas managers and subordinates join forces to sell goods and services.

But even more fundamentally, leadership and management differ in terms of their primary function. The first can produce useful change; the second can create orderly results that keep the organisation working efficiently. This does not mean that

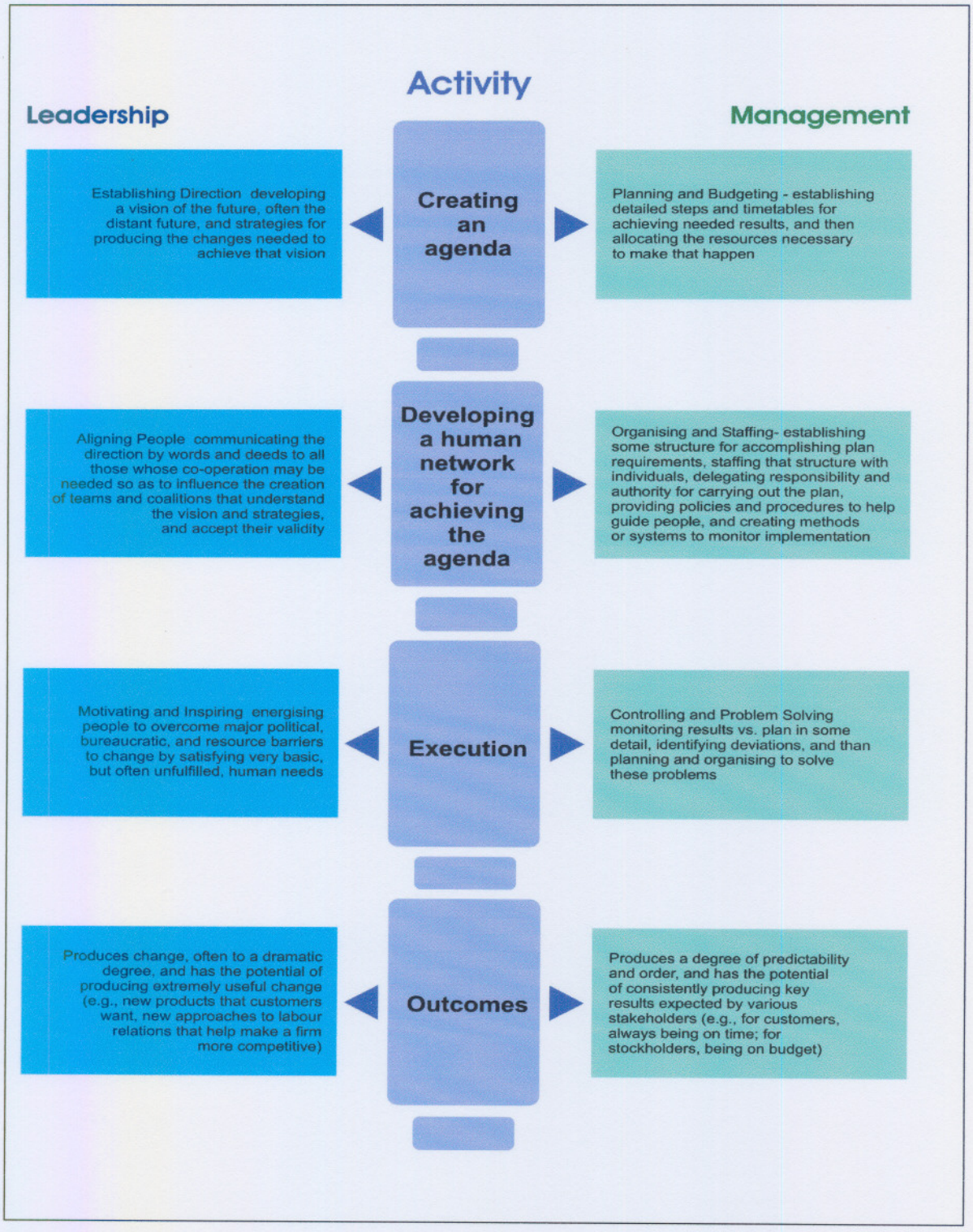
management is never associated with change. In tandem with effective leadership, it can help produce a more orderly change process. Nor does this mean that leadership is never associated with order; to the contrary, in tandem with effective management, an effective leadership process and good communication can help produce the changes necessary to bring a chaotic situation under control (Hiatt & Creasy, 2003). But leadership by itself never keeps an operation on time and on budget year after year, and management by itself never creates significant useful transformation (Kotter, 1990).

According to Abraham Zaleznik (2003), author of the article "Managers and Leaders: are they different?" contended that the most fundamental difference between managers and leaders lies in the conceptions they hold, deep in their psyches, chaos and order. Leaders tolerate chaos and lack of structure and are thus prepared to keep answers in suspense, avoiding premature closure on important issues. Managers seek order and control and are almost compulsively addicted to disposing of problems even before they understand their potential significance. Zaleznik continues by saying in his experience "... seldom do the uncertainties of potential chaos cause problems. Instead, it is the instinctive move to impose order on potential chaos that makes trouble for organisations".

Figure 4.2 "Comparing leadership and management" provides by way of illustration, a comparison of leadership and management by activity.

Figure 4.2 follows on the next page.

Figure 4.2 **Comparing leadership and management**



Source: Adapted from Kotter (1990)

Now that leadership has been differentiated from management, the following section will seek answers to the question whether leadership does make a difference, by examining the arguments against leadership.

4.7 ARGUMENTS MITIGATING LEADERSHIP

The question whether leadership does have an effect on performance and results, requires examination.

Three arguments can be identified that mitigate the importance of leadership. They are the (4.7.1) existence of substitutes for leadership; (4.7.2) irrelevance of leadership; and (4.7.3) complexity theory.

4.7.1 Substitutes for leadership

The substitutes for leadership theory recognises, that during certain circumstances the requirement for leadership is low and ineffective leadership can be counterbalanced by certain factors in the work environment.

Under these circumstances, leadership itself is of little consequence to the performance of group members. This theory states, that many organisations have substitutes for leadership. These substitutes are factors that provide guidance and incentives to perform in the work environment, making the role of the leader almost unnecessary or redundant (DuBrin, 2004:10).

Four substitutes for leadership are recognised under the above-mentioned conditions: (a) closely knit teams of highly trained members; (b) intrinsic satisfaction (c) computer technology; and (d) professional norms.

(a) Closely knit teams of highly trained members

When members of a cohesive, highly trained group are focussed on a goal, they may require almost no leadership to accomplish their tasks. A good example hereof, is air traffic controllers and pilots.

Research indicates, that with these groups; directive, decisive and task-orientated leadership is apparently unimportant. According to Pierce and Newstrom (2000:262), this is particularly evident "... in the white heat of danger, when the whole system threatens to collapse, the stress creates a need for competence among colleagues who by necessity develop close working relationships with each other". All such individuals are trained extensively and daily, regardless of their position in the hierarchy, to redirect operations or bring them to an abrupt halt during crises. Here the experience and continuous training of individuals, along with the close relationship among members of a workforce, is a substitute for the directive leadership of a senior official (Pierce & Newstrom, 2000:262).

(b) Intrinsic satisfaction

Employees engaged in work that is strongly self-motivating, or intrinsically satisfying, require less leadership.

This can be attributed partly to the task itself being performed, that captures the complete attention and energy of a worker. The worker may require a minimum of leadership as long as the task proceeds as planned (DuBrin, 2004:10).

Consultants observed a unique example of this principle at a manufacturer of camping equipment. The enterprise produced sleeping bags of various qualities. At the top of the line were lightweight backpackers filled with down. At the other end were low-cost models filled with floor sweepings from a mattress factory.

Production workers rotated among all the lines so no one group could claim exclusive rights to working on one product. Management contended, that supervisory direction was virtually unnecessary for production employees assigned to the top of the line, yet product quality at this end exceeded expectation. Workers confirmed this fact, that they derived more pride to work on this line and often pulled together in order to solve production problems. On the other hand, the production of bottom-of-the-line sleeping bags were found to consistently lack specified quality standards, and therefore, were also continuously over budget. The consultants concluded, that when assigned to produce the low-quality backpackers, the workers lose intrinsic motivation. As a consequence, they require considerable supervision and leadership (Pierce & Newstrom, 2000:262).

(c) Computer technology

Most organisations in the 21st century utilise computer-aided monitoring and computer networking to take over many of the leadership and directing functions provided by senior officials.

Information systems provide data on productivity and quality, and directions for certain tasks are entered into the information system in order to ensure that the instructions are easily retrievable by co-workers and employees. Error detection and goal setting are incorporated into some interactive systems. These systems are networked to such a degree, that instead of asking a supervisor for assistance, some employees use the computer network to gain assistance from colleagues electronically. However, in this circumstance, it could be argued that the computer equipment is utilised to control instead of to lead workers (DuBrin, 2004:10).

Effective leadership is dependent upon the ability of the leader to supply followers and subordinates with task guidance and incentives to perform to the extent that these are not provided by other sources (Pierce & Newstrom, 2000:263).

(d) Professional norms

Workers who incorporate strong professional norms, often require a minimum of leadership.

Professional employees may be inculcated with so much formal education, that they can perform most work assignments without relying upon technical guidance from their senior officials (Pierce & Newstrom, 2000:263). A good example, is a group of chartered accountants. They do not need visionary leadership to inspire them to perform their auditing tasks (DuBrin, 2004:11). However, when the events of the big corporate scandals in the United States with Enron and Worldcom; in Europe with Parmalat and the actions of governments such as Kenya, to stamp out wide-spread corruption and fraud within the public sector and judiciary; are taken into consideration. It can be argued, that professionals require effective leadership to do an honest job of functions such as auditing the books of a client, or advising against tax fraud.

Although the concept of substitute for leadership has some merit, it reflects a great degree of inexperience about the role of leadership within organisational and political structures (DuBrin, 2004:11).

To a degree, self-managed groups and individuals require considerable delegation by a higher authority. In support of this: higher authority provides examples, guidance, encouragement, support and the burden of ultimate accountability and responsibility for the performance of the organisations and co-workers (Bass, 1990:686).

According to Manz and Sims (1986), in Bass (1990), autonomous self-managed groups require an extra-ordinary leader who is external to the groups. Such an external leader helps the group to become self-monitoring, to set their own goals, criticise and reinforce themselves, and to plan and assign tasks by themselves instead of depending on the super-leader. Furthermore, Bass (1990:686) notes, that with no formally appointed leader in

autonomous groups, members have to be willing and able to take on the leadership task and maintenance functions, as may be required from time to time by the group. Examples of these types of tasks, are accountability and responsibility for performance and actions and the coaching of inexperienced members.

4.7.2 Leader irrelevance argument

According to the anti-leadership argument of leader irrelevance: leadership has a smaller impact on the performance of an organisation than do the forces in the situation the organisation finds itself in at any specific point in time (DuBrin, 2004:11).

The extreme position taken by some critics is that organisational outcomes are determined primarily by other factors, but that leaders are credited with what happened after the fact (Bass, 1990:7; Pfeffer, 1977).

An example of this principle, is the 1993 downturn in the Japanese automobile industry, which occurred even though the five top auto-makers had not changed their leadership. The primary contributors to this decreased demand, were business downturn in Japan and Europe. In addition, Japanese cars had become much more expensive than American cars from the United States. As a consequence, the Japanese share of the American automotive market eroded slightly. Another example is that Jack Welch was the product rather than the producer of the success of General Electric (DuBrin, 2004:11).

Meindl and Ehrlich (1987) argue, that all the effects of leadership are in the eyes of the beholders. Followers attribute effects that are due to historical, economic, or social forces to leadership, which is romantic fiction.

Attribution theorists argue that organisational leaders who are perceived to be exerting leadership on organisational performance, are merely the subjects of misperceptions (Bass, 1990:7). Furthermore, attribution theorists are supported by the argument that high-level leaders have unilateral control only over a few resources. The leader's control of

these resources, is limited by obligations to stakeholders such as consumers and stockholders.

Leadership "neutralisers" are attributes of subordinates, tasks and organisations that interfere with the attempts of the leader to influence subordinates. Unlike leadership substitutes, however, neutralisers do not replace the impact of the leader over subordinates, but rather create and influence a vacuum that can have serious negative consequences (Pierce & Newstrom, 2000: 266).

The leader irrelevance argument would achieve greater practical value if it were positioned to be a leader constraint theory. This would argue, that leaders are constrained in what they can do, but that the leaders are still able to influence people and situations to a certain degree (DuBrin, 2004:11).

4.7.3 Complexity theory

The complexity theory contends that organisations are such complex systems and networks, that the rules of nature cannot account for this complexity.

The complexity theory argues that leaders are unable to effect change in the direction of complex organisational systems and that the fate of an organisation is determined by forces outside the control of a leader. Penultimately, all organisations will cease to exist, because the system dominates over the abilities of leadership (DuBrin, 2004:12).

It has been established, that effective leadership does make a difference in the lives of followers and in organisations, especially when it concerns values and the delivery of promised performance.

4.8 CONCLUSION

In this chapter a review has been undertaken of the most authoritative literature on the subject of leadership and the latest theories of transformational leadership and leaders' traits, motives and power. Literature includes articles and publications of the Harvard Business School Review, the Harvard Business School Press and, among others, James McGregor Burns's (2003) "Transformational Leadership" and Bernard M. Bass's (1990) "Handbook of Leadership".

The most important definitions and theories will now be analysed in order to determine the real meaning of leadership and its value in practice.

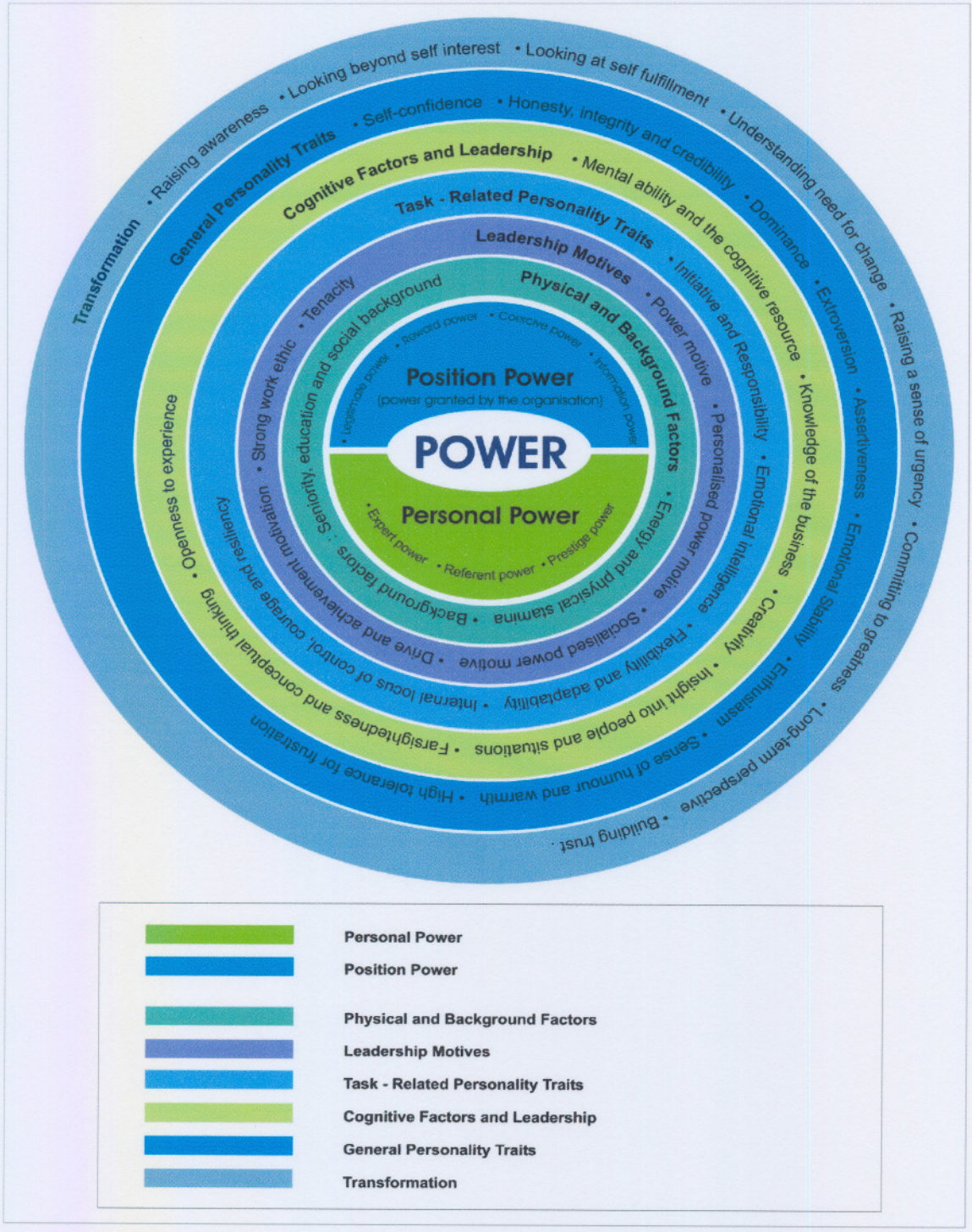
4.8.1 Combining the traits, motives and bases of power of effective leaders in order to attain transformation

Transformational leadership cannot take place on its own, but it is dependent upon the leader demonstrating the traits and motives, and the utilisation of the bases of power, of effective leadership.

Figure 4.3, "Wheel of effective leadership", incorporates general personality traits, task-related personality traits, motives of leadership, cognitive factors, background and physical factors, the bases of power in order for leadership to be effective in bringing about transformation. Cumulatively, this forms a wheel of effective leadership. Figure 4.3 follows on the next page.

The wheel of effective leadership can be described as the engine that drives and assists a person to become effective in order to bring about transformation that can produce results. The core of the wheel is power. Power consists of the two main bases of power, together with their specific sources. Position power is power that is granted by an organisation and is made up of legitimate; reward; coercive; and information power. Personal power is derived from oneself and is made up of expert; referent; and prestige power.

Figure 4.3 **Wheel of effective leadership**



Source: Author's own research

The six rings that surround the core (power), consist of the traits and motives, that in turn, assist with the establishment of effective and transformational leadership. These are as follows.

(i) General personality traits: self-confidence; honesty, integrity and credibility; dominance; extroversion; assertiveness; emotional stability; enthusiasm; sense of humour and warmth; and high tolerance for frustration.

(ii) Task-related personality traits: initiative and responsibility; flexibility and adaptability; internal locus of control, courage and resiliency; and emotional intelligence.

(iii) Leadership motives: power motive; personalised power motive; socialised power motive; drive and achievement motivation; strong work ethic; and tenacity.

(iv) Cognitive factors: mental ability and cognitive resources; knowledge of the business; creativity; insight into people and situations; farsightedness and conceptual thinking; and openness to experience.

(v) Physical and background factors: energy and physical stamina and background factors (seniority, education and social background).

(vi) Actions for transformation: raising awareness among all stakeholders; helping stakeholders to look beyond their self interests; supporting stakeholders to look towards self fulfillment; assisting stakeholders to understand the need for change/transformation; raising a sense of urgency among all stakeholders; committing to greatness; taking a long-term perspective (vision); building trust among all stakeholders.

The rings and their individual factors are set out in no specific order. What is important to notice, is that each ring and individual factor influences the other rings and factors, together with the bases of power, to form effective leadership that can bring about transformation in order to produce the required results.

Effective leadership can be described as the utilisation of personal attributes in combination with power relations as an instrument to formulate exciting visions,

implement strategies and bring about transformation in a successful manner that attain results to the benefit of all the stakeholders.

A specific characteristic of effective leadership that is highly valued and deserves further discussion, is trust. Trust lies within the general personality trait: honesty, integrity and credibility.

4.8.2 Personality traits: trust; drive and motivation to achieve; and emotional intelligence

Trust plays an important and broad role within effective and transformational leadership. Trust incorporates the traits of being predictable and consistent in one's actions, keeping promises and being competent. Competence is the demonstration of sound business sense and professionalism.

Trust is a multifaceted and complex characteristic. A common question about effective leadership is how can leaders build trust with their followers? We understand, from section 4.3 above that there are many traits that leaders can display to build trust. These include: (i) communication – keeping everyone informed; (ii) telling the truth; (iii) being available and approachable; and (iv) respecting others – accepting differences and being an active listener.

Leaders need to prove that they posses the traits: honesty, integrity and credibility, because transformational leaders rely strongly on these values for success. Actions that are synonymous with these values are: do unto others as you want others to do unto you; never deceive or lie for any reason whatsoever; do not let materialism or monetary reward be an enticement to deviate from these principles; rise above accepted norms (compromising) and problems, to seek solutions and to remain motivated; do what they say and say what they do.

Due to the trait: drive and motivation to achieve, effective leaders do not find it difficult to set and attain stretch goals for themselves or their peers and followers. This characteristic assists with and inspires individuals to achieve more and better results. Due to their drive and motivation to achieve, obstacles and difficulties are just that, and not the end of the road for transformational leaders.

Emotional intelligence is regarded as an important aspect of a personality (or leadership). This gives a person the ability to anticipate, discern and to rise above difficulties and facilitate decision-making. Emotional intelligence is also related to the traits of conceptual thinking and farsightedness, which are very important aspects of transformational leadership. Learning and exposure to experience enhance emotional intelligence.

In summary, it can be stated for the purposes of this thesis, that according to the modern theories and concepts of leadership, effective leadership can be defined as the utilisation of personal traits and motives combined with the bases of power as an instrument to formulate exciting visions that inspire followers, implement strategies in order to transform society in a successful manner that achieve expected results to the benefit of all stakeholders.

Since the real meaning and facets of leadership have been described, the following three chapters will investigate policies and leadership pertaining to HIV/AIDS in Botswana, Uganda and South Africa. Chapter 5, Botswana, follows.

CHAPTER 5

AN INVESTIGATION OF POLICIES AND LEADERSHIP RELATING TO HIV/AIDS IN BOTSWANA

5.1 INTRODUCTION

All three of the African countries have been chosen for an investigation of policies and leadership relating to HIV/AIDS due to the uniqueness of their situation. Uganda is poor and situated north of the equator. Botswana is small, landlocked but wealthy in African terms. South Africa is the most developed and advanced in Africa.

The purpose of this chapter is to analyse leadership and policies concerning HIV/AIDS in order to determine the effectiveness of the leaders in the transformation of social conduct in Botswana.

Botswana's experience was that it was suddenly confronted with an alarmingly rapid growth of the HIV/AIDS epidemic. The leadership recognised that they did not take cognisance of the possibility that HIV/AIDS could overrun the country, as it nearly did.

At a stage the prevalence rate rose to 38% of the adult population which was at that time the highest infection rate in the world. The government immediately set about formulating policies with the assistance of international agencies and committed themselves to address the issue in seriousness and in earnest.

5.2 HIV/AIDS STATUS 2003

The HIV/AIDS situation in November 2003 in Botswana is described as follows.

Thirty-five percent, more than one in three, of the adult population of Botswana are infected with the HIV virus, according to government figures. HIV and AIDS have also left up to 80,000 children orphaned in Botswana and dramatically reduced life expectancy to 49 years. President Mogae has pledged to invest much of the country's annual budget in tackling the crisis. His groundbreaking antiretroviral drugs programme has made Botswana the first country in sub-Saharan Africa to provide universal, free access to the medicines (Hearing, 2003).

HIV/AIDS is a disease that has devastated Botswana. Botswana has enormous mineral wealth and a stable democracy, until recently it had the highest income and the highest life expectancy in the region. At present the country has the highest incidence of HIV/AIDS in the world. HIV/AIDS cuts across everything the nation is trying to accomplish as a small nation. Before the advent of the epidemic the country had attained human development indices that were quite impressive; with things like social indicators, life expectancy, and infant mortality, mortality of under fives, mortality and morbidity rates. All of these indicators were very favourable; they were continuously improving, however, now they are being reversed due to the impact of HIV/AIDS (Hearing, 2003).

5.3 HISTORICAL BACKGROUND

The information in this section has been taken from the "Botswana National Policy on HIV/AIDS" (Botswana, 1993).

The first case of AIDS in Botswana was identified in 1985, and it is estimated that the significant spread of HIV in the country started in the mid-1980's. Since then, the spread of the virus in the population has been explosive, starting in urban and peri-urban areas,

and rapidly extending to rural localities. HIV seroprevalence studies among pregnant women in 1992 showed a high prevalence of 12,79% in Maun, 14,9% in Gaborone and 23,7% in Francistown. Results from a similar study in 1993 indicate that more than one in every three pregnant women in Francistown, between one in 10 and one in five at five other urban and rural sites, are now infected with HIV. The national estimate of persons infected countrywide at that time was 92,000. Those results placed Botswana among the worst affected countries in Africa (Botswana, 1993).

Several factors are thought to have contributed to the rapid spread of HIV in Botswana. Among them are the extreme mobility of the population combined with a good communication system, and the high prevalence rate of other sexually transmitted diseases, the presence of which causes a manifold increase in an individual's chance of being infected during sexual contact with an HIV seropositive partner. In addition, sexual behaviour patterns that include having multiple partners, and frequent changes of partner, are accepted as the norm, and common in both urban and rural communities. Rapid urbanisation (approximately 45% of the population now live in urban areas) has led to the breakdown of traditional mechanisms for controlling social and sexual behaviour. Poverty and relative lack of power in sexual and social relations among women are also of significance (Botswana, 1993).

The Medium Term Plan for the Prevention and Control of HIV/AIDS in Botswana, 1989-1993 (MTP), has provided policy and strategic guidance for action since the inception of the National AIDS Control Programme. The MTP outlined the role of the health sector and Ministry of Health, with the support and assistance of other sectors and non-governmental organisations (NGO's), for HIV/AIDS prevention and care (Botswana, 1993).

Research indicate that the HIV/AIDS prevention activities have succeeded in considerably increasing knowledge levels regarding HIV/AIDS, and increasing condom use. In 1993, more than 90% of interviewed youths had correct knowledge about HIV transmission; between 80% and 90% correctly stated two methods of prevention, and 50

to 60% used condoms consistently with casual sexual partners. The distribution of condoms through government outlets also increased from two million per year in 1991 to one million per month in 1993. However, between 15 and 40% of sexually active young men interviewed had an episode of a sexually transmitted disease in the previous year. In addition, 40 to 50% of interviewed young men reported having had more than one sexual partner in the previous 12 months, and multipartner behaviour among males was significantly more frequent than among females. Thus, much still needs to be done to bring about change in patterns of sexual behaviour, and increase levels of consistent condom use, enough to slow down the transmission of sexually transmitted diseases (STD's) and HIV (Botswana, 1993).

As the HIV/AIDS pandemic has evolved, knowledge about the socio-economic factors related to the spread of HIV, and its potential social, economic and development impact, has increased. This has led to emerging recognition that engaging all sectors of society meaningfully in HIV/AIDS prevention will slow down the epidemic (Botswana, 1993).

5.4 REVIEW OF GOVERNMENT POLICY

The information in section 5.4 "Review of government policy" has been taken from the "Botswana National Policy on HIV/AIDS" (Botswana, 1993).

5.4.1 National policy on HIV/AIDS

The National Policy on HIV/AIDS was approved by the government of Botswana on 17 November 1993 and outlines the national response to the epidemic in Botswana. Presidential Directive CAB: 35/93 Dated 17 November 1993, Ministry of Health, Gaborone can be consulted. It describes the role of national leaders, various government ministries, the private sector, non-governmental and community-based organisations, Persons Living With HIV/AIDS, and individual community members, in the national response. The policy forms the basis on which a national strategic plan will be developed.

Within the national strategic plan, different ministries and organisations will formulate their sectoral plans and projects for implementation (Botswana, 1993).

The policy has been used to guide all actors in HIV/AIDS prevention and care, including government ministries at policy-making and operational levels, non-governmental and community organisations, parastatals and private sector organisations and enterprises, and members of the community. External support organisations providing financial and technical assistance for all AIDS-related activities will do so within the framework of the national policy (Botswana, 1993).

The policy and strategic plan also provide mechanisms for resource mobilisation and allocation, and monitoring and co-ordination of AIDS prevention and care activities in the country (Botswana, 1993).

The guiding principles underpinning this policy are based on current scientific, epidemiological and medical knowledge about the distribution and transmission of HIV and other Sexually Transmitted Diseases (STD's), and proven effective interventions in prevention and care. In addition, cognisance is taken of the public health rationale for respecting the human rights, privacy and self-determination of persons living with HIV/AIDS, in line with the country's constitution. At the same time, the responsibility of persons livivng with HIV/AIDS (PLWA's) to protect others from infection, as well as the right of society to that protection, are also taken into account (Botswana, 1993).

The policy has been adopted as a code to be observed by organisations, institutions, employers, etc. Legislation will be developed as the need arises, to support implementation and compliance (Botswana, 1993).

5.4.2 A multisectoral national response

The range and projected magnitude of the socio-economic impact of HIV/AIDS indicate that the epidemic should be regarded as a national crisis, and receive from each

government ministry, and sector of society, the attention that such a crisis deserves (Botswana, 1993).

The incubation of HIV/AIDS is long, so its socio-economic impact will be felt long into the 21st century.

All sectors and the parastatal organisations of ministries, the private sector, and relevant non-governmental and community-based organisations should therefore develop and implement their own HIV/AIDS prevention activities, with initial technical support from the Ministry of Health (Botswana, 1993).

While there is neither a cure nor a vaccine against HIV which are effective; accessible and affordable interventions for changes in social and sexual behaviour which will include the control of Sexually Transmitted Diseases (STD's) remain the mainstay of HIV/AIDS prevention and control (Botswana, 1993).

The overall strategies of the national policy are specified as follows (Botswana, 1993).

(i) The prevention of HIV/STD transmission.
(ii) The reduction of the personal and social impact of HIV/AIDS and STD's.
(iii) The reduction of the socio-economic consequences of HIV/AIDS and STD's.
(iv) The mobilisation of all sectors, and of communities, for HIV/AIDS prevention and care.

Since HIV is mainly sexually transmitted, the prevention of sexual transmission is a key component of strategies for control. It will be achieved through the following means (Botswana, 1993).

(i) Information, Education and Communication, using different media and approaches, and aimed at different target groups, to form the basis for changes of social and sexual norms, values and behaviours which facilitate the spread of HIV in the population.

(ii) The promotion and efficient distribution of condoms to appropriate population subgroups.

(iii) The control of other sexually transmitted diseases through appropriate health-seeking behaviour by the population, and efficient diagnosis and treatment by health-care providers in the formal and traditional sectors.

(iv) Counselling of persons with HIV/AIDS and STD's, and non-infected persons, for the adoption of safer sexual behaviours and practices.

(v) The promotion of gender equality in all spheres of national and community life, to enhance women's social and economic status, and to empower them for more effective participation in decision-making about safer sex.

(vi) Encouraging men to use their authority and power in sexual and family relationships responsibly and positively to protect themselves, their partners and families from infection, through targeted education activities.

(vii) The mobilisation of communities for their active involvement at all stages of HIV/AIDS prevention and care, particularly the problem-definition and intervention design stages.

Prevention of other modes of transmission includes prevention of transmission through blood or blood products, transmission from mother-to-child and transmission via the use of non-sterile instruments in traditional and modern health practices (Botswana, 1993).

Certain ministries, due to their role, expertise and particular advantage, have been identified as key ministries in HIV/AIDS prevention and care. In addition the private sector and non-governmental organisations (NGO's) will play important roles (Botswana, 1993).

The private sector is an important partner in development. The potential impact of HIV/AIDS on productivity and profits in private sector enterprises, through sickness-related absenteeism and premature death of skilled workers is considerable. It has now been recognised world wide that it is in the long-term financial interest of private sector organisations to invest in HIV/AIDS prevention for workers (Botswana, 1993).

The private sector therefore has an important contribution and investment to make to HIV/AIDS and STD prevention, as part of the protection of the skilled workforce (Botswana, 1993).

NGO's and community-based organisations (CBO's) have played leading roles in HIV/AIDS prevention and care in many countries, Botswana included. Their particular advantage of flexibility in response and implementation, closeness to the community and independence make them invaluable partners in HIV/AIDS prevention and care. NGO's and CBO's have also led to the meaningful involvement of persons living with HIV/AIDS (PLWA's) in AIDS prevention and care (Botswana, 1993).

The Ministry of Health and health sector would, because of their experience in this field, be the "lead ministry" in HIV/AIDS prevention and care.

5.4.3 Co-ordination of national HIV/AIDS and STD programmes and activities through the National AIDS Council (NAC)

The coming phase of HIV/AIDS prevention and care in Botswana will be implemented by many sectors within and outside government. Co-ordination of this multisectoral national response will therefore be critical to efficient implementation, and the optimal use of resources (Botswana, 1993).

A National AIDS Council (NAC) was formed to successfully co-ordinate activities implemented by the variety of ministries, sectors and organisations, and to commensurate with the development importance of the HIV/AIDS pandemic. The National AIDS Council has very senior representation from the ministries and organisations involved. The Council was initially chaired by the Ministry of Health and thereafter by the President (Botswana, 1993).

The AIDS/STD Unit of the Ministry of Health serves as the secretariat to the National AIDS Council.

5.4.4 Ethical and legal aspects

HIV/AIDS, through its short- and long-term effects, has serious socio-economic and legal implications for individuals and society. It is therefore necessary to address, in this policy, ethical and legal aspects of living with HIV/AIDS as a society. The guidelines contained in the national policy reflect the principles expressed in the 41st World Health Assembly Resolution WHA42.24 that states, "Avoidance of discrimination in relation to HIV-infected people and people with AIDS". The most important of these principles are the following (Botswana, 1993).

(i) Enable persons with HIV/AIDS to lead productive lives of good quality for as long as possible, making their contribution towards the economic wellbeing and development of their families, communities and the country.

(ii) Observe the public health rationale for the elimination of stigmatisation of, and discrimination against persons with HIV/AIDS, so as to ensure that effective prevention and control measures are implemented with their co-operation.

(iii) Eliminate complacency and denial about the magnitude of the country's HIV/AIDS problem at all levels, through the active and open involvement of persons living with HIV/AIDS in community education, prevention and care programmes.

Where necessary, legislation will be developed to protect the rights of persons with HIV/AIDS, while ensuring that they fulfil their responsibility to protect others from infection (Botswana, 1993).

HIV/AIDS is a dynamic and rapidly changing field, about which new knowledge is constantly emerging. Therefore this policy will be under regular review.

5.4.5 Leadership role of the president

In terms of the National Policy on HIV/AIDS the Office of the President will provide political leadership for the national response to the HIV/AIDS epidemic, and ensure that all sectors are mobilised and become involved as is necessary. The role of the president will include the following (Botswana, 1993).

(i) Mobilise policy-makers at various levels in the different ministries and sectors, with technical support from the Ministry of Health.

(ii) Advocate for the provision of national public and private resources as needed for HIV/AIDS prevention and care.

In addition, the following departments of the Office of the President have key roles.

(i) The Department of Information and Broadcasting will play an active role in information and education on HIV/AIDS and STD's through the development and broadcasting of programmes, spots and advertisements on various aspects of AIDS/STD's. The Department will collaborate with the Ministry of Health, NGO's and CBO's to strengthen capacity for effective public media involvement in HIV/AIDS prevention (Botswana, 1993).

(ii) The Directorate of Public Service Management (DPSM) will ensure that workplace AIDS/STD education/prevention programmes are implemented for all public sector workers. DPSM will also develop policy for the management of Persons Living With HIV/AIDS (PLWA's) in the civil service. Personnel regulations and policies that potentially contribute to the spread of HIV, such as the transferring of people to work in regions that separates spouses and families, will be cancelled, to reach a workable balance between provision of essential services countrywide and the disruption of families (Botswana, 1993).

In addition, DPSM will ensure that projected attrition due to AIDS is adjusted for in human resource development.

(iii) The Botswana Confederation of Commerce and Industry (BOCCIM) and the Botswana Federation of Trade unions (BFTU) will play leading roles in mobilising private sector organisations and workers for HIV/AIDS prevention and care in the country (Botswana, 1993).

(iv) Non-Governmental Organisations (NGO's) and Community Based Organisations (CBO's) will develop and implement innovative HIV/AIDS prevention and care projects and activities, in line with the priorities articulated in the national strategic plan (Botswana, 1993); and

Mobilise communities for HIV/AIDS prevention and care activities that are affordable and sustainable; and

Be advocates for the involvement of various sectors of government, leaders at national, district and community levels, in HIV/AIDS prevention and care; and

Co-ordinate amongst themselves, as well as participating in national co-ordination activities that minimises duplication, and enhances the establishment of complementary programmes, projects and activities.

5.5 ADDRESS BY PRESIDENT FESTUS G. MOGAE AT THE SPECIAL SESSION OF THE UNITED NATIONS GENERAL ASSEMBLY ON HIV/AIDS, 25 JUNE 2001

The information in this section has been taken from the address by the President of Botswana at the Special Session of the United Nations General Assembly on HIV/AIDS, 25 June 2001 in New York (Mogae, 2001).

"The HIV/AIDS pandemic is the most serious global challenge facing humanity at the present time. But if we all act decisively, we can redeem ourselves" (Mogae, 2001).

"HIV/AIDS poses a threat to global security, peace as well as sustained development through reversal of development gains that the world has achieved. If resolute and concerted action is not taken against the spread of HIV/AIDS, the human death toll and suffering that will be inflicted will be catastrophic" (Mogae, 2001).

"Furthermore, if the HIV/AIDS pandemic is not contained, it will accentuate disparities in living standards between developed and developing countries. Developing countries, particularly the poorest, many of which are on the African continent, are also the countries least able to put into effect efficacious strategies to counter the pandemic. This is so because of their lack of human and material resources, under-developed health care systems, lack of health scientific research capability, social security and generally low level of development, which is made worse by low rates of economic growth and declining levels of Official Development Assistance" (Mogae, 2001).

"The HIV/AIDS pandemic is severely limiting development prospects of the affected countries, through loss of skilled human resources, decline in productivity and re-allocation of budgetary and human resources from development activities towards HIV/AIDS related courses. The unchecked spread of the HIV/AIDS pandemic therefore poses a serious threat to the goal of the reduction of global poverty by half by the year 2015. Increased disparities in living standards between developed and developing countries are unacceptable" (Mogae, 2001).

In Botswana, the National HIV/AIDS Strategic Plan embodies a multisectoral approach and a close working relationship among the public and private sector as well as Non-Governmental Organisations. A committed leadership oversees the implementation of the Strategic Plan, across the broad spectrum of their society. Their key prevention strategies include, house to house counselling, behaviour change targeted at the youth and other vulnerable groups, voluntary counselling and testing as well as prevention of mother-to-

child transmission programmes. A combination of hospitalisation and the Community Home Based approach is the cornerstone of care for AIDS patients and support to orphans, vulnerable children and affected families. Treatment strategies include pain management and symptomatic treatment as well as prevention and treatment of opportunistic infections. Antiretroviral treatment was introduced in 2002 in the public health facilities to complement all these activities, as part of the strategy for fighting AIDS (Mogae, 2001).

"The challenge of the millennium is to reverse the effects of the pandemic, not only through prevention and care strategies but through meaningfully addressing the structural determinants such as poverty and gender inequality which exacerbate the spread of HIV/AIDS" (Mogae, 2001).

"What is really required of us is a social revolution, a willingness to commit, to share and to prioritise" (Mogae, 2001).

5.6 IMPLEMENTING THE DRUG TREATMENT POLICY

The information in this section has been provided by the United Nations Africa Recovery (UNAFREC) division (Rollnick, 2002) and by the Ministry of Health (Botswana 2003a; 2003b; 2003c).

5.6.1 Background

In January 2002 Botswana became the first country in Africa to offer expensive, but life-saving, antiretroviral drugs (ARV's) and other medications to all who need them through the public health system (Rollnick; Botswana, 2003c).

It is a costly and ambitious undertaking. A programme that many health care experts say cannot be done in Africa. But for the 330,000 citizens estimated to be HIV-positive,

access to ARV's and to ongoing care, counselling and testing, is a matter of life or death. This vast but sparsely populated territory has the highest HIV infection rate in the world. See table 5.1. Some 26,000 people in this country of less than 1.6 million died from AIDS-related illnesses in 2000/1 alone (Rollnick, 2002). "We are threatened with extinction", President Festus Mogae (2001) told the UN General Assembly on 25 June 2001, "... people are dying in chillingly high numbers. It is a crisis of the first magnitude".

Table 5.1 Botswana's HIV infection rate

Botswana's AIDS epidemic, 2001	
Population	1,6 million
Adult population (15-49)	762,000
Total adults with HIV	300,000
Adult infection rate	38,8 %
Adult women with HIV	170,000
Adult men with HIV	130,000
Children with HIV (0-14)	28,000
Older adults with HIV (50+)	2,000
Total deaths (2001)	26,000
AIDS orphans (0-14)	69,000
Life expectancy (1987)	63
Projected life expectancy (2005)	37

Source: United Nations Africa Recovery (Rollnick, 2002)

Some international health experts, many donor governments and agencies and the pharmaceutical industry, argue that poverty and the absence of infrastructure make it impossible to successfully treat large numbers of HIV-positive people in developing countries with AIDS medications. Rather than waste resources on a failed effort to treat those already ill, they assert, scarce funds should be spent preventing new infections through education and prevention programmes (Rollnick, 2002).

Activists counter that pilot projects have demonstrated the feasibility of treatment programmes in developing countries, and that only a combination of treatment and prevention can turn the tide against the disease (Rollnick, 2002).

Botswana is the first African test case. The Joint UN Programme on HIV/AIDS (UNAIDS), has long maintained that both prevention and treatment are necessary in the campaign against AIDS. Fewer than 30,000 of the almost 29 million Africans infected with the virus have access to the ARV drugs that have dramatically reduced death rates in rich countries (Rollnick, 2002).

5.6.2 Slow but steady progress

If any country in sub-Saharan Africa can implement a comprehensive HIV/AIDS prevention care and treatment programme, it is Botswana. Unlike many of its neighbours, the country has enjoyed an unbroken period of peace and comparative prosperity since independence in 1966. Its government is widely regarded as among the most efficient and capable on the continent, and its annual per capita income of US$ 3,300 is among the highest (Rollnick, 2002).

Still, the obstacles are formidable. Many Batswana are migrant workers, employed in neighbouring South Africa for much of the year, but maintaining farms and families back home. Migrants are at particular risk of infection because of the increased likelihood of contact with prostitutes and other casual sex partners while being away from home. Often

currently undergoing treatment for AIDS-related illnesses. Dr Khan said that the government has "... only opened up pilot sites two years ago. The percentage of mothers enrolled, however, is not desirable. It is low and must be increased. We have problems here, especially the one of stigma". Also, other health officials stated that the enrolment by pregnant mothers had only been in the 11-20% range (Rollnick, 2002).

Dr Khan added that another "... problem is the status of women in relation to men". Many women lack the power to control their decisions about sexuality and remain under the authority of their husbands, parents and in-laws, all their lives. Other problems also mentioned in this regard is "... with those who do enrol, they go home to a remote village with formula milk for their baby and are branded as suspect because they are not breast-feeding; mothers also worry about who will look after their baby if they die. But antiretroviral (ARV) therapy is now available in Botswana for these mothers and their babies" (Rollnick, 2002).

The country currently has 16 voluntary counselling and testing centres specifically for mothers, one in every district. These are stand-alone centres where one can discuss medical problems in privacy. For example "... in the latter part of last year, we had a conference for people living with HIV/AIDS and it drew 500 sufferers", Dr Khan noted, and they "... went back to their homes and formed support groups to reduce stigma" (Rollnick, 2002).

Dr Khan said that NACA urgently needs more trained staff, "... a trained nurse dealing with many people in a rural clinic does not have the time to counsel every HIV patient. We are building a system of lay counsellors, similar to social workers. For this, we do not necessarily need nurses and we have a programme to employ 500 such lay counsellors. We are hoping they will also play a key role in reducing stigma" (Rollnick, 2002).

Dr Khan also mentioned that people living with AIDS, both from the educated urban classes and rural communities, are increasingly aware that the government is providing free lifelong treatment. In this regard she said that these people are "... with us on a

voluntary basis. No one is coerced. We counsel them on positive living, about prevention, about the importance of remaining on the treatment even if they feel better, and they usually go home and spread this positive message" (Rollnick, 2002).

5.6.4 Severe staff shortages

At present, NACA employs 10 doctors working full time on HIV/AIDS at the Princess Marina Hospital in Gaborone, and five at each of the other hospitals. Patients are also seen at the smaller health facilities, some of them are mobile clinics, around the country. Uniquely for an African country, NACA states, almost no one is more than 8 km away from a clinic where they can seek medical help. Even in the remotest areas of the Kalahari, most people are just 15 km away. These clinics decide what sort of treatment people need, and either refer them to a hospital or provide them with ambulance transport if required (Rollnick, 2002).

Ms Catherine Sozi, a British-trained Ugandan doctor based at the UNAIDS office in South Africa, said Botswana can sustain its national health scheme for AIDS patients even though the drugs are required for the duration of a patients life. However, Ms Sozi said, citing a recent UNAIDS assessment, that there exists an "... acute shortage of doctors, nurses and counsellors in Botswana's health care system" (Rollnick, 2002).

The shortage of doctors, pharmacists, nurses and counsellors is compounded by the fact that over 90% of doctors in Botswana are foreigners who do not speak Setswana. Counsellors too are recruited from abroad and need to spend time becoming familiar with the local culture. The government is seeking to recruit up to 200 new doctors from South Africa, Cuba and other nations to assist with administering the drug programme (Rollnick, 2002).

The shortage of pharmacists outside the major hospitals is another problem. The UNAIDS assessment found that the few pharmacy technicians in Botswana are already

stretched and have to manage drug supplies and the distribution thereof in hospitals and surrounding clinics (Rollnick, 2002).

Testing, monitoring and surveillance of the Botswana AIDS plague, as many now call it, is carried out by the new Botswana-Harvard laboratory at the Princess Marina Hospital. The first of its kind anywhere in Africa, the laboratory, with a staff of 50, is equipped with gene sequencers and blood cell sorters, enabling scientists to keep track of the spread of HIV, especially the HIV-1C strain prevalent in Africa. The laboratory will also conduct research for the development of new medicines, including research for a vaccine. Dr Max Essex, Chairman of the Harvard AIDS Institute, said that the "... virus strain in Botswana is different from those in the West", therefore the work conducted through the local laboratory is invaluable (Rollnick, 2002).

5.6.5 Combining treatment and prevention

Botswana is supporting the new drug treatment policy with an expanded and more aggressive education campaign, modelled in part after Uganda, which has successfully reduced new HIV infections through sustained public education and transformation of social conduct. President Mogae is determined that the message of free treatment gets out through any practical means possible like radio, billboard campaigns and by word of mouth (Rollnick, 2002).

The national co-ordinator of the Botswana Network of People Living with HIV/AIDS, Mr Edmund Dladla, welcomed the President Mogae's leadership. Mr Dladla said that any person "... who is of working age, who has a job and some education talks about it, and everyone wonders about the impact AIDS is having, not only on those close to them, but also on the country as a whole. People are scared" (Rollnick, 2002).

Mr Dladla continued, stating that "... for a decade until the end of the 1990's, we were in a state of denial, blaming the crisis on foreigners. Then, as we realised its extent, we started acting. Today, I would say the government is very transparent, pro-active and

accountable. We are the most advanced African nation in this struggle and believe me, I would not have said that just three years ago" (Rollnick, 2002).

5.6.6 Employers get involved

The private sector in Botswana has also become involved in the fight against HIV/AIDS. Three years ago, the biggest employer in the country, the Debswana diamond mining company, realised after testing its 6,000 strong workforce that fully a third of workers aged between 24 and 40 were HIV-positive. With revenues of some US$ 1,8 billion a year, and sufficient supply of skilled miners scarce, the company set up its own HIV/AIDS scheme (Rollnick, 2002).

Dr Clement Chela, of the Botswana Comprehensive HIV/AIDS Partnership, said that this "... collaborative programme is designed to demonstrate the benefits of a comprehensive, multisectoral approach to improving the care of people living with HIV in a country with limited resources". Dr Chela added that the "... fact that ARV's are now freely available has become a motivating factor for people to come forward. The programme we have put in place here can work in other countries in Africa, and with international financial help, it can be sustained" (Rollnick, 2002).

5.6.7 Primary health care department

The Primary Health Care Department aims to improve the health status of all Batswana by providing quality, affordable and accessible preventative, promotive, rehabilitative and curative health services through community and multisectoral participation and involvement by the year 2016 (Botswana, 2003a).

This will be done through the provision of leadership in the implementation of programmes in support of personal, family and community health services, as well as environmental, epidemiological and disease control measures (Botswana, 2003a).

Primary Health Care is comprised of the following divisions: Family Health Division; Community Health Services, AIDS/STD Unit, Dental Health Division, Primary Health Care Support; and the Rehabilitation Services Division (Botswana, 2003a).

The Ipoletse Call Centre for HIV/AIDS and Sexually Transmitted Infections (STI's) is a toll free service that has been established by the Ministry of Health in conjunction with various partners. The Centre operates nationally. The number can be called toll free from any landline and the confidentiality of a caller is guaranteed (Botswana, 2003b).

5.6.8 Criteria for treatment

To manage the demand for antiretroviral therapy (ARV) and some of the accompanying challenges, only patients with a CD4 cell count lower than 200 and /or an AIDS-defining illness will be eligible for the therapy (Botswana, 2003c).

Four priority groups identified as first patients are all (Botswana, 2003c):

(i) pregnant women and with CD4<200 and/or AIDS defining illnesses and qualifying partners who fulfilled the same criteria;
(ii) HIV infected children older than 6 months of age who are inpatients;
(iii) HIV infected TB patients with CD4 <200 and;
(iv) adult inpatients with CD4<200 and or AIDS defining illnesses. By September 2002, approximately 2,200 people enrolled for treatment and about 1,500 are on treatment countrywide.

5.6.9 Testing and monitoring of patients

Testing and monitoring of patients enrolled in the programme is carried out by the new Reference Laboratory at Gaborone's Princess Marina Hospital, and a second station in Francistown is under renovation. The two laboratories will perform the following tests: Viral Load, CD4 count and Drug Resistance. After HIV and CD4 testing, the first step for

potential patients is to meet with the health care provider to assess the patient's readiness before therapy is initiated (Botswana, 2003c).

5.6.10 Programme management

Programme Management consists of officials from the Ministry of Health, Ministry of Local Government, Government Computer Bureau, consultants, and other partners. The dedicated national antiretroviral programme referred to as MASA, has an ARV team that has made tremendous progress in the implementation of the programme and include the following achievements (Botswana, 2003c).

(i) The establishment of systems, policies and guidelines.
(ii) The set-up of drug procurement, storage and distribution facilities.
(iii) They have assisted with the recruitment and training of staff.
(iv) The establishment of IT requirements, networked hospitals and in the procuring of an Integrated Patient Management System.
(v) They have established laboratory and testing infrastructure.
(vi) They have put in place ongoing monitoring, evaluation and research structures.
(vii) Implemented national Information, Education and Communication (IEC) and mobilisation campaigns.

5.6.11 Information, education and communication (IEC)

The Information, Education and Communication (IEC) team produced numerous promotional and education materials, branded with the new MASA logo in support of the programme. These materials include: (i) MASA ARV booklet for the general public titled "What you should know about ARV therapy" in both Setswana and English; (ii) full colour posters with nine key ARV messages for clinics and hospitals in Setswana and English; and (iii) MASA calendars. Forthcoming materials include a booklet on the 100 most frequently asked questions regarding HIV/AIDS and ARV therapy. This is an interactive communication tool that uses the parable of the cattle kraal to illustrate what is HIV/AIDS and how ARV therapy works in the human body. Health workers and NGO's

will be trained on how to use the tool to assist with community mobilisation (Botswana, 2003c).

MASA newsletters, containing up to date information, are being targeted at internal audiences such as service providers, stakeholders and partners. The production of three patient education videos to be aired in waiting rooms at clinics and hospitals is also being produced (Botswana, 2003c).

5.7 FREE ARV DRUGS A MODEL FOR AFRICA

Botswana has one of the highest prevalence rates of HIV/AIDS in the world. For every 10 pregnant adult women, about four are infected with the disease. In this regard, Ernest Darkoh, head of the Botswana AIDS drug programme, warned that it is "... a human catastrophe of unprecedented magnitude", and he added, that, Botswana "... is fighting for its life" (Boroughs, 2003:7).

The nation finally has a reason for hope since the government began offering free antiretrovirals in 2002, more than 6,000 AIDS victims have been spared an imminent death. Tshupo, a plump 31 year-old, feels strong now. In this regard she said: "I can live like anybody else now that there are some medicines", and continued, saying "I am planning positively for the future" (Boroughs, 2003:7).

Only a few years ago, the world saw no way to provide such a future for any HIV-infected African except the elite few. In this regard, Donald de Korte, an assistant to the Botswana government in the AIDS drug programme, said most "... people argued that it was impossible. It was too expensive, too complicated to do in Africa". De Korte recalled that even in 2001, the then United States ambassador in Gaborone asked him not to support the government's drug plans. In the same year, US President George Bush's aid chief warned against widespread use of complicated antiretroviral regimes in Africa,

arguing that many Africans "... do not know what watches or clocks are" (Boroughs, 2003:7).

That those attitudes have changed was greatly in evidence when Bush toured Africa, promoting his Emergency Plan for AIDS Relief. A large part of the US$ 15 billion programme is aimed at providing antiretroviral treatment to two million people in two Caribbean nations and 12 countries in Africa, including Botswana and South Africa. Botswana was far from prepared to launch such an ambitious programme when President Mogae publicly promised free antiretrovirals in 2001. Among other hurdles, the government needed to more than double the number of pharmacists and lab technicians in the country (Boroughs, 2003:7).

The alternatives to this ambitious experiment were much more frightening. Patson Mazonde, Botswana's director of health service, remembers dire discussions with President Mogae in 2000, when Botswana had become the worst-infected nation in the world, with life expectancy projected to fall by half to just 31 years. Furthermore, estimates indicated that by 2016; about 60% of all 10–14 year-olds could be orphaned. Mazonde said that they "... saw this thing as an issue of survival". He continued by saying that is "... how serious it was; we had the fear of a nation simply becoming extinct" (Boroughs, 2003:7).

According to Ernst Darkoh, the highest hope of AIDS experts, is that anitretrovirals will actually slow the spread of HIV by "... breaking the cycle of denial and infection". Antiretrovirals offer Batswana, who have largely avoided voluntary HIV testing in the past, a good reason to get tested. Those who learn that they are HIV-negative have a good reason to stay that way. In this regard, De Korte explains, "People need to know their status before they take responsibility for their lives" (Boroughs, 2003:7).

Early anecdotal evidence suggests that those hopes may be fulfilled. The government is encouraged by the long queues it sees at Gaborone's testing centre everyday, and the AIDS patients on antiretrovirals attest that the drugs are reinforcing the government's

prevention message. In this regard, Tsupo testified that what "... really encouraged me to take the test was that if I had the virus, I was going to be helped". She has subsequently convinced at least five other people to be tested (Boroughs, 2003:7).

The war is far from won. However, the vast majority of AIDS sufferers have not availed themselves of the drugs, because they still have not been tested, and if all of them did at once, in the short term, the government might not be able to accommodate the number of new patients. Even with antiretrovirals donated gratis by Merck and at cost by Bristol-Myers Squibb and GlaxoSmithKline, Botswana is still spending nearly US$ 1,000 per patient per annum to deliver the three-drug cocktail and blood tests (Boroughs, 2003:7).

Can other countries accomplish what Botswana already has? The country was particularly well qualified to launch the first countrywide antiretroviral campaign in Africa. Diamond-rich and sensibly ruled, its per capita income of more than US$ 3,000 places it on par with South Africa, and its public primary-care clinics may be the best in Southern Africa. But, Darkoh believes that two or more Southern African countries have health-care systems that would allow them to adopt Botswana's model in its present form. Accordingly, he stated that even the poorer countries in Southern Africa should adapt Botswana's antiretroviral programme to their own level of development. In this regard Darkoh said that they may "... need to use a radically different model, radical to a point that it may make us uncomfortable". He continued by saying that instead of a doctor "... I am imagining an outreach worker on a bicycle in charge of 10 people and watching them take their pills" (Boroughs, 2003:7).

From the poorest African to the richest AIDS victims in America, no amount of money can change the fact that antiretrovirals merely postpone, for an unknown time-period, the inevitable victory of HIV/AIDS over the body it invades. Mazonde just hopes that these patients can live long enough to raise their children (Boroughs, 2003:7).

5.8 UNITED STATES – BOTSWANA VENTURE

The Botswana Local Government Minister, Gladys Kokorwe, told a United Stats-sponsored medical gathering in Gaborone, on 28 July 2003, that the spread of HIV/AIDS in Botswana is devastating the economy and creating great human suffering (Malema, 2003:6).

She told delegates at a gathering in Gaborone that all present shared a common challenge: overcoming the HIV/AIDS pandemic. The gathering of 67 delegates, including physicians, scientists and laboratory workers from Africa, the Caribbean and the United States (US), are part of the US emergency plan to: combat the spread of HIV/AIDS; treat two million people with antiretroviral medication; and care for 10 million infected people in the region. In this regard, US President George Bush announced a US$ 15 billion HIV/AIDS relief fund for Africa and Caribbean countries over the next five years (Malema, 2003:6).

Peter Kilmarx, the head of BOTUSA, a joint programme between Botswana and the US government, said that their "... mission is to assist in prevention, care and treatment, surveillance and research on HIV/AIDS, tuberculosis and sexually transmitted diseases in Botswana". Botswana, with 40% of its sexually active people in a population of 1,5 million are either HIV-positive or are living with full-blown AIDS, is considered a benchmark state for treatment therapies (Malema, 2003:6).

Trough the assistance of the US administration and US business partners, Botswana was able to set up a state-of-the-art laboratory at the country's biggest hospital, Princess Marina Hospital, in the capital city Gaborone. The Bill and Melinda Gates Foundation, founded by computer tycoon Bill Gates and his wife and the Harvard Institute, are also funding some of the initiatives in Botswana. In addition, US pharmaceuticals giant Bristol Myer Squibb in partnership with the Texas-based Baylor College of medicine opened the Baylor children's clinic at Princess Marina Hospital in June 2003 to provide care for HIV-infected and orphaned children (Malema, 2003:6).

The focus of the meeting was to find a way of upgrading the quality of the regions laboratories to a universally accepted standard. Kokorwe said that diagnostic and research laboratories are an important resource in our diagnostic and care of HIV-infected individuals, however "... we have unfortunately experienced a reversal of the gains that we had hitherto made". She added that with the "... internationalisation of expertise, human resources have become scarce. The movement of health professionals and scientists in search of greener pastures has depleted our scarce human resource" (Malema, 2003:6).

5.9 "MEETING THE GLOBAL CHALLENGE", PRESIDENTS MOGAE'S ADDRESS TO THE BOTSWANA PARLIAMENT, 10 NOVEMBER 2003

The information in section 5.9 has been taken from the State of the Nation Address by the President of Botswana to the First meeting of the 5th session of the 8th Parliament on 10 November 2003 (Mogae, 2003).

5.9.1 Gender equality

Without seeking to minimise the need for additional progress, Botswana can also take pride in their continued progress towards achieving greater gender equality. This is especially manifested in the latest 2003 UN Human Development report in which Botswana was ranked 16th in the world, alongside Canada and Estonia, in terms of its total percentage of females serving as legislators, senior officials and managers. According to this report, the combined figure for women occupying senior leadership positions as of 2002 was 35%, which placed Botswana ahead of the majority of the member nations of the Organisation of Economic Cooperation and Development (OECD), including all of the current member states of the European Union. In the same report, Botswana was also number among the handful of countries, where females are now actually in the majority in the combined category of professional and technical

employment at (52%). These figures demonstrate that the country's society has both the will and capacity to change with the times (Mogae, 2003).

5.9.2 Poverty eradication

After the need to halt the spread of HIV, Botwana's top priority is the elimination of poverty. In this, they have already made some notable progress by reducing their poverty rate from 59% in 1986 to 47% in 1994 and to the latest, 2002, figure of 36%. This has earned them the further accolade (in the 2003 Economic Report on Africa) of being the continent's leader in poverty reduction. But, they still have a long way to go. It is for this reason, that the National Strategy for Poverty Reduction was tabled before Parliament during May 2002. On approval, the government strategy directed the formation of a multisectoral Committee on Poverty Reduction, to help assure implementation (Mogae, 2003).

Their commitment to the wellbeing of the least fortunate has also been manifested in the Poverty Alleviation and Housing Scheme, which since its inauguration has modestly exceeded its targets, in facilitating low-income home ownership (Mogae, 2003).

5.9.3 Combating HIV/AIDS

The President sees the fight against HIV/AIDS as the greatest single challenge to their Nation. "This year too many of us once more found ourselves spending too much of our time burying people whom should otherwise still have been among us. With each premature death we are being diminished as a Nation. Our tragedy is thus not measured by the passing away of so many thousands, so much as the human loss of individual friends and family members, multiplied several thousand times" (Mogae, 2003).

"We have often spoken of the HIV/AIDS pandemic as a war that needs to be won. Yet in this war, we remain our own worst enemies. The continued generosity of international friends, such as the Bill and Melinda Gates Foundation, may assist us. But, it is we, and

we alone, who through behaviour change, must achieve our victory. The stigma surrounding the disease remains one of the greatest barriers to the implementation of various care and prevention strategies. This is why, even with our ability to now offer such interventions as antiretroviral therapy (ARV) to preserve the living and protect the unborn, the majority of our sexually active people still do not know their HIV status" (Mogae, 2003).

On the recommendation of the National AIDS Council (NAC), the Botswana Government has therefore decided that, with effect from January 2004, the detection of HIV should become a regular part of blood tests conducted in government health facilities for medical purposes. Such tests will be routine, but not compulsory. In other words HIV will be tested for unless an individual declines to be so tested (Mogae, 2003).

"We hope to continue to receive generous assistance from international friends in our fight against HIV/AIDS. But, the real onus is on us, to help ourselves by knowing our status and acting responsibly. I need not appeal to parliament to maintain their leadership role in this fight, for I know all of you are painfully aware of the effects this scourge is having in your constituencies" (Mogae, 2003).

5.10 PRESIDENT FESTUS G. MOGAE'S VIEWS AND OPINIONS ON HIV/AIDS: BBC INTERVIEW, 30 NOVEMBER 2003

The information in this section has been taken from an interview conducted by Roger Hearing of the British Broadcasting Corporation (BBC) with President Mogae of Botswana, November 2003 (Hearing, 2003).

5.10.1 The factors causing HIV/AIDS

The question why it is that Botswana has such a high incidence of HIV/AIDS and why it arrived at this crisis situation is, according to the President, due to their open society;

people come and go; and he is of the opinion that HIV did not originate in Botswana. It came to the country and it has stayed (Hearing, 2003).

In the interview President Mogae committed forthrightly on all facets of HIV/AIDS facing Botswana. He said it is not true to say people are infected because they are out of work. "We are losing university students, we are losing high school students and we are losing young professionals in good employment. Of course the level of unemployment is unacceptably high at between 16 and 18% but it's much better than in most African countries" (Hearing, 2003).

The most affected population group is the 15-49 year olds. Most of the affected people are between 15 and 18 and even 20 and up to 22 who are still in secondary and tertiary education institutions at government expense (Hearing, 2003).

Alcohol is seen as a contributory factor, not only in the case of HIV but also in road accidents. In Botswana, many young people own cars; drive fast and die on the roads. These deaths are associated with alcohol. This opinion of President Mogae is supported by Limpet Mpotokwane, a Programme Development Manager for African Comprehensive HIV/AIDS Partnerships in Botswana, who states that alcohol abuse is one of the key factors fuelling the HIV pandemic (Teyise, 2003).

Poverty has always been an issue with HIV/AIDS but not in Botswana. According or the President, there is no correlation between income level and HIV/AIDS (Hearing, 2003).

Many skilled and unskilled workers come into the country illegally, mostly from Zimbabwe. Approximately 1,000 are sent back every week, but they come right back. To the extent that these people are living uncertain lives, they are not seen to help the situation (Hearing, 2003).

"We find HIV in Botswana, in Zimbabwe, and in Zambia so how can I say they are bringing HIV here when there is HIV here and in South Africa? In South Africa the

evidence of the existence of AIDS is apparent for all to see and therefore I would be stating the obvious. It is in the region as a whole. The only difference is that - the only reason why we are different is that we were the first to explain to the rest of the world that we are more seriously affected" (Hearing, 2003).

There are many social problems in Botswana, and whenever a rural urban migration takes place, as happens in all developing countries and all African countries, it tends to breed crime in the urban areas. To the extent that there are illegal immigrants, they would tend to exacerbate, not cause, a problem that already exists. "I hope that the people of Zimbabwe and everybody will understand, illegal immigration tends to exacerbate already existing problems - whether it's crime or whether it's HIV/AIDS or STD's in general" (Hearing, 2003).

The President chairs a multisectoral committee, called the National AIDS Council that has various sub-committees. One sub-committee focuses on men, because the feeling is that the men are responsible for the spread of the disease, and what they should be doing as fathers and as husbands and brothers and just as free agents (Hearing, 2003).

5.10.2 Factors combating HIV/AIDS

The President is of the opinion that everybody should help including and especially African doctors. The Botswana people are dependent on many African doctors from Tanzania, Uganda, Zimbabwe, Zambia and from elsewhere. They would like to hire more doctors, and especially African doctors who are abroad, but find them unaffordable (Hearing, 2003).

"Botswana is a poor country. Our per capita income is US$ 3,000 compared to US$ 40,000 in the United Kingdom, so we cannot be reasonably expected to afford the level of remuneration that these people command as professionals - as medical professionals. But we are, by African standards, paid better than most African countries and that's why we have African doctors here. We are in fact dependent on African doctors" (Hearing, 2003).

"It is interesting that even traditional values, where the young people are not bringing their girlfriends and boyfriends home, is responsible for the spread of HIV/AIDS. A great many people think that the breakdown of our traditional habits and norms is the one that has resulted in the breakdown of family relationships because the young people now can kiss in public and walk hand in hand in front of adults and in front of their parents. There is too much liberalisation rather than too much conservatism and I am inclined to agree that too much liberalisation must be a contributory factor. I am not willing to say any one single factor is responsible but I think it's one of them. I myself have made statements both in general public meetings and in parliament that we should have more discipline, especially in senior secondary schools" (Hearing, 2003).

"In the traditional culture there is a resistance to liberalisation that may be part of the problem. Some people are accusing us of introducing too much liberalism - even churchmen have accused the government of being responsible and encouraging the youth to participate early in sex because we not only preach the use of condoms, we supply them free in all public institutions" (Hearing, 2003).

The Catholic Church, in particular, but some of the other churches and also other traditionalists oppose the use of condoms. The government understands the message that people should abstain, especially young people should postpone their active participation in sex and postpone sexual activity until marriage. They think it is a valid message and that young people should adhere to it. "They are not yet used to sexual activity and if they then have sex, then they should stick to one partner. And in any case if they indulge in sexual activity they should use condoms. So that is why it is called ABC - if you go around Gaborone you will see this message: abstain, stick to one partner or condomise" (Hearing, 2003).

5.10.3 Essence of the prevention campaign in Botswana

The prevention campaign is that people should abstain from sex. They should be faithful or stick to one partner and use condoms. The ideal is to abstain, especially for young people, and the rest should stick to one partner. That is the required behavioural change. The churches have asked to help in this message - to preach it to their congregations. They are not expected to preach the use of condoms, but to preach abstinence, and being faithful to or stick to one partner. Even if they do not like the government advocating the use of condoms, they should at least not speak against it (Hearing, 2003).

"People in Botswana, especially the men have many girlfriends at the same time as having a wife. It is what they seem to accept. Social change or change of attitude, behavioural change, does not come overnight but that's what we have been trying to preach. And in fact we are saying that you can see the consequences and therefore the only thing we should do is to change our behaviour" (Hearing, 2003).

It is seen as the most difficult part - there is stigma and has been for some time - for the last couple of years people were not willing to talk about it - firstly about sexual matters and secondly about the HIV/AIDS pandemic. But, according to the President, that has changed very substantially, because, whenever he makes a public statement or address meetings, these days, - whenever ministers and members of parliament address public meetings, they speak about HIV/AIDS. They never address public meetings without talking about HIV/AIDS; also public officials, not only health officials, as was the case at the beginning. But he acknowledges that stigma persists, and he agrees that it is part of the reason why many people are reluctant to know their HIV status because of the social stigma attached to the disease (Hearing, 2003).

"I had a test and was clear but it is only part of the effort to try and encourage people to know their status especially as antiretroviral therapy is available. It is very important to know your status, your HIV status, so that if you are negative then you try to remain

negative and if you are positive you can be assisted. Being positive is no longer the death sentence that it used to be and that HIV is just a disease like any other" (Hearing, 2003).

But, he maintains, stigma is very difficult. Even some of the people who want to help, like church people, who used to say that AIDS is a punishment from God because they have sinned and therefore it follows that those who were HIV positive were the sinners. "We have convinced the churches that that is the wrong interpretation. But the stigma persists. Some people say know your status, please come out. There are people who are HIV positive, and are hiding - that's stigmatising. You may have syphilis, it's sexually transmitted, if it is untreated it also can be terminal. But nobody says you may have syphilis come out and get tested. Or you may have hepatitis B, which is also sexually transmitted. They say you may have AIDS, that's sexually transmitted, come out - that's stigmatisation" (Hearing, 2003).

5.10.4 Assistance through testing

The President openly encourages all cabinet ministers to have an HIV test. He has asked them and they obliged - even members of parliament. At the time of this interview, three members of parliament were tested and announced their status. From the 1 January 2004, anybody who visits a government medical facility, unless they refuse, will also be tested for HIV/AIDS. Government officials have, for political reasons, been tested for HIV/AIDS and the idea in mind is that it will have an impact on other people, as it is a good thing for people to test. The President has undergone the test and announced the result, he hopes this will now inspire everybody else to undergo testing (Hearing, 2003).

Voluntary counselling and testing centres are available, but not used to the extent that government would like. That means that many people are still not coming forward. "If they were, if they thought that because there are drugs then they would test and even if they are positive they'd be treated anyway, they would be coming forward. Therefore their present behaviour is not consistent with their believing that there is no punishment. In any case the death toll is not increasing, I have no evidence that it is increasing - it may

be stabilising but it's still very high. The people are not ignorant. The most severely affected population is the 15 to 49 year-old grouping and within that cohort it is the 18 to 24 year-olds. Those people are not ignorant and they understand very well that these antiretroviral therapies are palliatives, they can prolong your life but there is no cure" (Hearing, 2003).

5.10.4.1 Results of testing

When AIDS treatment became widely accessible in Botswana, the government decided to overhaul its approach to HIV testing (Keeton, 2004).

The success of the Botswana treatment programme, in conjunction with efforts to make testing more accessible, resulted in a new willingness among people to know their status. Botswana implemented its new approach to HIV testing in January 2004 - shifting from the voluntary counselling and testing model used in South Africa, to offering routine HIV testing for patients (Keeton, 2004).

Routine testing for patients with symptoms indicating HIV is not compulsory. However, it reverses the traditional approach whereby patients must opt in by giving permission to be tested, in this way patients opt out if they are not ready to be tested. From 1999 to 2003 only 90,000 HIV tests were done of an estimated 300,000 Batswana with HIV/AIDS. Following increased access to testing and the move to routine testing, the number of people opting to have HIV tests has soared (Keeton, 2004).

Testing almost tripled at a treatment clinic in Serowe, north of Gaborone, while at nearby Tutume more than 400 patients were tested during January - nearly half the total of 1,000 tested there last year. Although routine testing is medically appropriate, it is a difficult shift in policy, given the fears and stigma associated with HIV. Access to antiretrovirals has helped in this respect, as AIDS is no longer regarded as an imminent death sentence (Keeton, 2004).

Botswana's Health Minister, Lesego Motsumi, is convinced that the country's decision will save lives through early diagnosis. When Botswana began antiretroviral treatment in January 2002, many of the first patients were being brought in on stretchers. According to Minister Motsumi, routine testing and the efficacy of antiretrovirals is motivating people to get tested before they become very sick. In this regard the minister said that a "... lot of people who were written off have got better on treatment and that has been such an encouragement to the rest" (Keeton, 2004).

HIV testing is becoming more common in Botswana, but the Health Minister admits there is a small percentage who would "... rather die than know their status". While about 14,000 people were on treatment in the public programme by March 2004, this was still way below the estimated 100,000 needing it. This acted as a spur for Botswana's government to adopt routine testing. What it means for patients is more cursory pre-test counselling (which was a bottleneck in the system) and more intensive post-test counselling. But this could be risky as people need proper counselling to accept their status and shortcuts can be disastrous, even ending in suicide (Keeton, 2004).

Many patients and health workers think that routine HIV testing assists with reducing the stigma, by taking away the moral judgement. While routine testing may remove some of the burden from individuals, it raises the responsibility of health workers to make sure that patients are fully informed about their choices and to protect their privacy. In clinics with piles of files and queues of people requiring attention, it is possible to see how patient confidentiality could be eroded (Keeton, 2004).

The most promising new strategy in Africa, is the opt-out approach to testing. In 2004, Botswana, Malawi and Lesotho, with guidance from a group of international scientists in Nairobi, have begun to offer HIV tests regularly in public hospitals and clinics to people exhibiting signs of infection, mothers seeking prenatal care and clients at clinics specialising in sexually transmitted infections (Itano, 2004).

5.10.5 Communicating the message of prevention

The information in this section has been taken from an interview conducted by Roger Hearing of the British Broadcasting Corporation (BBC) with President Mogae of Botswana, 30 November 2003 (Hearing, 2003).

President Mogae stated in his interview on BBC, November 2003, that their best endeavours are made to communicate with everyone but obviously there is no guarantee that the communication is as effective in the more remote areas. In the towns, schools are visited and two institutions for deaf people, with whom are communicated through sign language, are also visited by social workers (Hearing, 2003).

The adverts used, bring exactly the same message - that sex is very dangerous. "Somebody said that President Museveni of Uganda says that they overcame the pandemic in Uganda because they said abstain or have sex and die. So I said well it may not be the style of our language but we are virtually saying that. People are aware that if you contact AIDS you die. If they did not think so there would be no stigma. People are ignoring the dangers of contracting HIV/AIDS" (Hearing, 2003).

President Mogae encourages politicians to make a contribution. One contribution they can make, is to use the state machinery to inform the population about the precarious situation. He maintains that everybody has a role to play, even if it is only to warn the nation of the problem. Church people have a role to play and other people also have roles to play. According to him the majority of people in the world feel that the African leaders have not done enough. They also said these leaders have been silent about the pandemic, and that it may be true, but that it was partly because of the stealthy way by which the virus invaded the people. By the time the African people became aware of their predicament, it was perhaps too late (Hearing, 2003).

The President is convinced that his government can use its best endeavours to help, to inform and to provide assistance, certainly to orphans and certainly with antiretroviral

therapy, to the extent that the budgetary situation permits. It is also important to preach change, even if people do not change, at least they cannot say they do not know (Hearing, 2003).

5.10.6 Research and statistics

Botswana has one of the leading laboratories, built by themselves, that is being operated by the Harvard AIDS Institute. "There is a great deal of research now - there are at least half a dozen institutes who are doing research here in the country. We are being helped in our fight against HIV/AIDS by the international community - UNAIDS, the Gates Foundation, the Merck Campaign Foundation and information is being exchanged freely. However, Botswana is a small country with a very small pool of scientists. But a great number of scientists from abroad are working on the problem here. In fact right now tests for a vaccine are taking place" (Hearing, 2003).

They also have a law and ethics committee. The law and ethics committee subjects everything that is done by government to a debate. Testing for HIV is routine, since January 1, 2004, in medical facilities, but it is not compulsory because the law and ethics committee advised that it would be a violation of the constitution and a violation of human rights (Hearing, 2003).

By November 2003, 41,000 orphans have been registered, 30% of whom are orphaned because of roads accidents. It was decided not to call them AIDS orphans to avoid stigmatisation. Orphans are entitled to support from government - food rations, clothing, everything that they need. Those who are HIV positive are entitled to free antiretroviral therapies. Prevention of mother-to-child transmission (MTCT), are done and therefore expectant mothers who attend the antenatal clinics are tested. And if they agree, they are put on a programme to receive antiretroviral therapies for a few weeks before delivery and a few weeks thereafter. The child is also given AZT and Nevirapine. "In fact, 60% of the children now born of HIV-positive mothers do not have the virus - government support starts there. We provide infant formula and we now encourage the mothers -

depending how advanced their situation is - not to breastfeed, which is a reversal of our policy. We have been encouraging breastfeeding - now we are saying it is better if you do not breastfeed" (Hearing, 2003).

Research is ongoing in Botswana. They rely on surveys. The women are attending antenatal clinics. They are persuaded to test themselves, and from these surveys percentages can be deduced. If other researchers obtain a different figure (percentages), nothing is to be gained by arguing that is not right, whether it is 22% and not 33%. You have the order of magnitude, according to the President (Hearing, 2003).

The national samples from pregnant women give a lower level of HIV infection compared to the estimates of the United Nations (UN). There is consistently a discrepancy, with the UN estimating a figure that is higher. According to President Mogae, the government does not want to argue about the levels because 50%; would be too high, even 25%; would be too high. Therefore, the government of Botswana finds the debate about statistics irrelevant (Hearing, 2003).

5.11 CONCLUSION

5.11.1 Status of the 2002 national response to the UNGASS "Declaration of Commitment on HIV/AIDS"

In his foreword to the report, Festus Mogae, President of Botswana and chairman of the National AIDS Council (NAC), states that the government of Botswana was among the 189 countries that signed the document (UN, 2001) of commitment on the declaration of the United Nations General Assembly Special Session on HIV/AIDS in June, 2001 in New York, USA. Since then the people of Botswana have remained committed in their response and have sustained the momentum of the political commitment to address the epidemic (Botswana, 2002).

According to the President, the HIV prevalence in the country appears to have stabilised over the last five years as revealed by the annual HIV sentinel surveillance efforts. The pattern is evident from data generated from the voluntary counselling and testing centres as well as the prevention of mother-to-child transmission (MTCT) services (Botswana, 2002).

From reported surveys, President Mogae says specific behaviours support the plateau of the epidemic in the country. These include high condom use, reduced number of sexual partners, high awareness level especially among the ages 15-19 years and 20-24 years. Based on these encouraging findings, they are intensifying their local efforts to ensure a complete turn around of the epidemic in the country (Botswana, 2002).

In his preface to the report, the Minister of Health, Joy Phumaphi, states that the United Nations (UN) Declaration (UN, 2001) called for a new type of framework for an expanded global response to the epidemic through setting of goals and targets intended to address all dimensions of the pandemic. Through the submission of this report on Core Indicators to the UN General Assembly in March 2003, Botswana is fulfilling its reporting requirements on its HIV/AIDS national programme outcomes and national impact objectives of the Declaration (Botswana, 2002).

The Minister said this report will inform the United Nations General Assembly Special Session, (UNGASS), secretariat, on the commitment and action of the Republic of Botswana, and will also be utilised locally by all stakeholders in the country aimed at sharing information, identifying duplication of efforts, as well as reinforcing the current level of political commitment to combat the HIV/AIDS epidemic (Botswana, 2002).

According to the report, Botswana's HIV prevalence of 35,4% among women, aged 15-49 years, remain among the highest in the world. The epidemic, at this high prevalence level, is having a major negative impact on Botswana's small population of 1,7 million. As there is no cure for AIDS and no effective vaccine, most of them are likely to die within the next decade (Botswana, 2002).

On adult prevalence, the report stated that in Botswana, the percentage of 15-49 year olds antenatal clinic attendees infected with HIV (prevalence) increased from 13,8% in 1992 to 35,4% in 2002. This represents more than a doubling of the prevalence in 10 years. There is some evidence, however, that in recent years the prevalence may be reaching a plateau, since from 1999 to date it has not significantly increased or decreased (Botswana, 2002).

The age pattern of HIV infection indicates that the 15-19 years age group demonstrated the lowest HIV prevalence in 2002. The 25-29 age group had the highest HIV prevalence at 50% (Botswana, 2002).

Co-ordination of national response stakeholders has been one of the major challenges. Currently, Botswana has adopted a multisectoral approach, co-ordinated by the National AIDS Co-ordinating Agency (NACA). These efforts are beginning to show results. There is beginning to emerge a consistent plateau pattern in the HIV prevalence in some age groups and even a decline in others. Behavioural indicators corroborate these observed patterns (Botswana, 2002).

The report gives a ray of hope: Botswana's youth. Just as there are major differences between the geographic areas of the country, so there are differences between demographic groups. In particular, consistent evidence from sentinel surveillance data indicate that the HIV prevalence in the 15-19 age group is lower than in higher age groups and has been stable or even declining over the recent past. In 1995, prevalence in the 15-19 age group was the same as for the whole 15-49 population (32,4%) In 2002 the 15-19 year olds prevalence had declined to 22%, while that for the entire 15-49 age group had increased to 35,4% (Botswana, 2002).

This "ray of hope", is consistent with information contained in the survey report of Botswana's youth behaviour. The observation is that a high level of awareness exists of HIV and knowledge of how to prevent it. Condom use for sexually active youth (under

the age of 24) is high, reaching between 88,3% (males) and 75,3% (females). Multiple partnering, another high-risk behaviour is lower among sexually active females than among their male counterparts. Given the size and the strategic importance of the youth in the prevention of HIV the youth age-groups present themselves as a good target for achieving Botswana's long term vision of an "AIDS-free generation" (Botswana, 2002).

5.11.2 Moody's report emphasises stability despite AIDS

The information in this section, regarding the report by rating service group Moody's on Botswana, has been provided by I-Net Bridge (2003:14) information service and reported in This Day newspaper.

Moody's Investor Service said Botswana's A2/Prime-1 foreign currency ratings and stable outlook reflect sustained economic growth and a favourable debt and liquidity position. This is despite long-term challenges that include the country's high rate of HIV/AIDS prevalence and weak budget results. According to I-Net Bridge (2003:14) information service, the government's domestic currency rating is A1/stabel.

Moody's report for 2003 emphasise Botswana's enduring social and political stability and the prudent use of its mineral endowment, which has led to sustained growth rates, rapid expansion of infrastructure and a remarkable increase in living standards. These strengths are mitigated in various degrees by a narrow economic base and the devastating socio-economic effects of HIV/AIDS (I-Net Bridge, 2003:14).

5.11.3 AIDS epidemic report, July 2004

See chapter 2, figure 2.4. According to the HIV prevalence rates, the epidemic in Botswana is a "generalised" condition. See table 5.2 "Specific HIV and AIDS estimates and data, Botswana, end 2003" for the state of the epidemic in Botswana. Table 5.2 provides data for adults and children combined, adults (15-49), women (15-49), and children (0-14) at end 2003, and a comparison of these figures as reported at end 2001.

The data in table 5.2 is taken from the UNAIDS "Report on the global HIV/AIDS epidemic", July 2004.

Figures for adults and children combined

See table 5.2. The HIV prevalence rate for adults and children combined has remained stable at 350,000 from end 2001 to end 2003.

Figures for adults (15-49 years of age)

See table 5.2. The HIV prevalence rate for adults has remained stable at 330,000 from end 2001 to end 2003.

Figures for women (15-49 years of age)

See table 5.2. The HIV prevalence rate for women has remained stable at 190,000 from end 2001 to end 2003.

Figures for children (0-14 years of age)

See table 5.2. A small increase is noticed for children (ages 0-14) from 22,000 at end 2001 to 25,000 at end 2003: a 13.64% increase in the number of children infected with HIV.

Table 5.2 follows on the next page.

Table 5.2 Country-specific HIV and AIDS estimates and data, Botswana, end 2003

Estimated number of people living with HIV

Country	Adults and Children end 2003 *Estimate*	Adults and Children end 2001 *Estimate*	Adults (15-49) end 2003 *Estimate*	Adults (15-49) end 2001 *Estimate*	Adult (15-49) rate (%) end 2003 *Estimate*	Adult (15-49) rate (%) end 2001 *Estimate*	Women (15-49) end 2003 *Estimate*	Women (15-49) end 2001 *Estimate*	Children (0-14) end 2003 *Estimate*	Children (0-14) end 2001 *Estimate*
Global Total	37,800,000	34,900,000	35,700,000	32,900,000	1.1	1.0	17,000,000	15,700,000	2,100,000	2,000,000
Sub-Saharar	25,000,000	23,800,000	23,100,000	22,000,000	7.5	7.6	13,100,000	12,500,000	1,900,000	1,800,000
Botswana	350,000	350,000	330,000	330,000	37.3	38.0	190,000	190,000	25,000	22,000

Source: Report on the global AIDS Epidemic (UNAIDS, 2004)

5.11.4 Evaluation

The questions raised in the objectives of the study in chapter 1, together with the impact of Botswana's leadership and policies concerning HIV/AIDS, may be answered with the assistance of the Secretary-General, Kofi Annan's (2004), address to the XV International Conference on AIDS, of 11 July 2004. Mr Annan based his comments on the document: "Declaration of Commitment on HIV/AIDS", accepted at the United Nations General Assembly, Special Session on HIV/AIDS, 25-27 June 2001 (UN, 2001).

The above mentioned issues are best analysed in the form of a list of 14 questions which the author attempted to answer from the data in chapter 5.

Question 1

Have the leaders demonstrated an understanding of their socio-economic responsibilities due to the impact of the HIV/AIDS epidemic? (Author)

Answer

The President, Festus Mogae, has personally and publicly taken up the socio-economic responsibilities that arose due to the impact of the HIV/AIDS epidemic. He demonstrates a clear understanding of the responsibilities.

The government policy is implemented on a decentralised basis. It also addresses the problem of the poor and was later also connected with the programme for the socio-economic development of the country. A sectoral approach was organised to reach all of the affected population. President Mogae clearly understands that the impact reaches individual, household and community levels. Both the employed and unemployed are affected. This has negative long-term economic consequences for the country, and is addressed by the government.

Question 2

Are the leaders clear and unambiguous in their role and pronouncements on HIV/AIDS? (Author)

Answer

President Mogae's pronouncements on HIV/AIDS in his speeches in parliament and in public are clear and unambiguous and stress the seriousness of the epidemic affecting the country. The President is both forthright and consistent in his constructive approach to all the relevant aspects concerning HIV/AIDS.

Question 3

Did the leaders express policies to demonstrate visionary political leadership at an early stage of the epidemic? (Annan, 2004)

Answer

President Mogae indicated that his government did not in the initial stages of the epidemic identify the seriousness of HIV/AIDS. However, after the acceleration of the incidence rate, the seriousness was recognised and addressed immediately. The President also changed the separate classification of orphans who were affected by HIV/AIDS to merely orphans to avoid stigmatisation. A national register was established to render support to all orphans. The government's initial policy concerning testing was the voluntary reporting by individuals. It did not promote acceleration of numbers to be tested and identified for treatment. This system was therefore changed to a policy that allows for HIV/AIDS testing of individuals who report to hospitals for medical assistance, unless they object thereto.

Question 4

Are the leaders taking a strong stand by showing commitment? (Annan, 2004)

Answer

President Mogae shows strong commitment in the implementation of the policies concerning HIV/AIDS. He had himself tested and publicly announced the results to serve as an example for others to overcome the stigma and to do the same. President Mogae has also taken up the chairmanship of the National AIDS Council (NAC) in order to direct and implement the policies of the government. Both President Mogae and his Minister of Health stated in their country's response to the United Nations General Assembly Special Session on HIV/AIDS (Botswana, 2002) that the people of Botswana have sustained the momentum of the political commitment to address the epidemic.

Question 5

Have the leaders led by example by breaking the silence on the disease (Annan, 2004)?

Answer

Botswana, like other African countries, has a homogeneous culture of secrecy regarding sexual activity. President Mogae, however, has been outspoken on the issues and encouraged the entire population to discuss the problem in order to break down the stigma attached to the illness and to encourage testing and treatment. All his Cabinet ministers and senior government officials have been encouraged to mention the AIDS issue in speeches at every public opportunity.

Question 6

Do the leaders lead by example by achieving the cultural shift (behavioural change) needed to fight the epidemic effectively? (Annan, 2004)

Answer

The issue is behaviour change. This concerns the content and qualification of prevention in addressing the epidemic. The President has whole heartedly and outspokenly followed the example of President Museveni of Uganda, by promoting the policy of ABC: abstain, be faithful to one partner, use condoms. He has been propagating the key issue of abstinence through billboard advertising, among others. This is seen at the heart of behavioural change of society. The promiscuous practices of the past had to be stopped for the spread of the disease to be halted. The President acknowledges that society must be transformed to successfully combat the epidemic.

Question 7

Have the leaders led by example by working to scale-up the infrastructure, responses, including the provision of treatment to all those who need it? (Annan, 2004)

Answer

The President and his government have a positive approach to address all the aspects of the epidemic. Their aim is to develop infrastructure within the limitations of the budget, and together with the co-operation of international bodies in rendering assistance. Botswana was the first African country to introduce free anitretroviral therapies to the whole population. In this process the network of centres was extensively developed for effectiveness. The President also recognised the lack of numbers of medical practitioners and is relying on professionals from outside the country to provide the necessary support. The President himself actively advocates testing and counselling.

Question 8

Does the leadership empower all levels of government, civil society, the private sector, communities, households and individuals to actively participate? (Annan, 2004)

Answer

Botswana has the same policy framework as other countries, which is partly a United Nations model. The purpose is to encourage all role players representing society such as business, churches, non-governmental organisations (NGO's), and community based organisations (CBO's), to participate in the policy framework. The implementation of the plans is decentralised through districts and the sectoral approach. Botswana has success in the implementation of the sectoral organisation. Successfull involvement of civil society and the private sector has been achieved, because of successfull motivation. Government accommodates differences in policies in working with the churches in regard to abstinence and condoms and fosters good relations with religious organisations.

Question 9

Do policies exist to ensure that women have access to prevention and care? (Annan, 2004)

Answer

The policy documents are similar to the United Nations documents and identify the plight of women. Because statistics indicate that women are the most vulnerable of all the affected groups, government has committed itself to address the rights of women. Women are encouraged to avail themselves of the facilities for treatment and care. The ABC policy has a direct bearing on women in prevention.

Question 10

Do policies exist that empower women and girls to protect themselves against the virus and to provide them with power and confidence in order to transform relations between women and men at all levels of society? (Annan, 2004)

Answer

The government recognises the shortfalls in the position of women in African culture and endorses the approach in the United Nation's documents of human rights to improve the status of women in society.

Question 11

Is government providing adequate national budget to fight and mitigate the impact of the epidemic? (Annan, 2004)

Answer

Botswana is one of the wealthiest countries in sub-Saharan Africa, after South Africa and is able to provide for a comprehensive prevention and care programme that includes the rollout of antiretroviral therapies. However, it still has limitations in offering everything to everybody. The country's good fortune is to have good relations with international bodies such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Bill and Melinda Gates Foundation, Merck Laboratories, and the United States government which contribute generously to the fight against HIV/AIDS.

Question 12

Is the government on track to reduce the scale and impact of the epidemic by 2005 as promised? (Annan, 2004)

Answer

The latest statistics support the trend of the last few years that the increase in prevalence has been stabilised. Decrease is expected but there is no proof yet. Encouraging signs exist that the increasing numbers of newly infected youth has also stabilised.

The number of adults (15-49 years of age) infected with HIV has stabilised, and remains at 330,000 from end 2001 to end 2003. The number of women (15-49 years of age) infected with HIV has stabilised and remains at 190,000 from end 2001 to end 2003. The number of children (0-14 years of age) infected with HIV slightly increased with 3,000 (13.34%) from end 2001 to end 2003 (UNAIDS, 2004).

Question 13

Are the national prevalence rates of the infected number of people decreasing or increasing? (Author)

Answer

The adult (15-49 years of age) prevalence rate has decreased by 0,71% from 38% at end 2001 to 37,3% at end 2003 (UNAIDS, 2004).

From the latest statistics (UNAIDS, 2004) it is clear that the national prevalence rates of the infected number of people has stabilised.

Question 14

Is the leadership effective in terms of delivering of results? (Author)

Answer

In an interview on 30 November with the BBC, 10 years after the Botswana National Policy on HIV/AIDS was adopted, President Mogae said that the government believed in what they were doing, and that their approach is already making a difference. Maybe not as fast as they would like, but it is thought that it is already making a difference. Here is a leader expressing his belief in his government and that it is succeeding.

President Mogae has displayed great leadership qualities due to his thorough knowledge of the HIV/AIDS epidemic. He addresses it in an honest, open and forthright manner. The crux of the problem lies with the cultural practices of married men having multiple sexual partners amidst the taboo within the culture not to discuss sex and the stigma attached to the disclosure of being HIV-positive.

The President's answer is prevention and that means a change in behaviour namely to practise abstinence, faithfulness to a married partner and the use of condoms. His leadership is demonstrated by the fact that he has tackled the fight against HIV/AIDS head on, publicly and consistently and expects his government, cabinet and the entire population to do the same.

President Mogae leads by example. He declared in public that he had himself tested for HIV and the results were clear. He encourages his government and cabinet and colleagues to follow his example and be tested; and furthermore, encourages the entire population to do the same. He leads the nation by promoting ethical and moral cultural and sexual relations in an endeavour to address the crisis head on to win the battle against the growing number of infections. He is convinced he is making a difference and in so doing is setting the highest standards for leadership and governance.

The office of the President also took on major functions in the implementation of the National Policy in areas such as broadcasting and public seminars. In addition he also took the responsibility of chairing the National AIDS Council (NAC). This demonstrates the active, hands on leadership role he has taken upon himself to save Botswana from a national tragedy.

His empathy for the victims of HIV/AIDS is shown when under his leadership it was decided not to identify the orphans as AIDS orphans, but as orphans, in order to avoid stigmatisation.

The serious commitment of the government to combat HIV/AIDS is reflected in the fact that Botswana is the first country in sub-Saharan Africa to provide antiretroviral drugs free of charge to the entire population. President Mogae's commitment to combat HIV/AIDS is illustrated in his decision to address the problem on every public platform and to have his senior government officials do the same. In fact, he invited every person in the nation to come forward and face the facts about the epidemic.

The conditions concerning HIV/AIDS in Botswana, one of the three African countries to be studied, have been investigated. The next country is Uganda, in chapter 6.

CHAPTER 6

AN INVESTIGATION OF POLICIES AND LEADERSHIP RELATING TO HIV/AIDS IN UGANDA

6.1 INTRODUCTION

All three African countries have been chosen for an investigation of policies and leadership relating to HIV/AIDS due to the uniqueness of their situation. Uganda is poor and situated north of the equator. Botswana is small, landlocked but wealthy in African terms. South Africa is the most developed and advanced in Africa.

The purpose of this chapter is to analyse leadership and policies concerning HIV/AIDS in order to determine the effectiveness of the leaders in the transformation of social conduct in Uganda.

Sub-Saharan Africa, where Uganda is situated, bears the heaviest burden of the HIV/AIDS epidemic. This region accounts for 28,5 million children and adults, this is approximately 71,3% of all people living with HIV/AIDS globally (UAC, 2002a).

The Ugandan AIDS Commission (UAC) states that, in sub-Saharan Africa, HIV is mainly transmitted through heterosexual intercourse. Variances in sexual behaviour across cultures, age groups, and gender is mostly influenced by culture and socio-economic circumstances that in turn influences HIV prevention strategies. As a result, poverty, underdevelopment and illiteracy contribute to the spread of HIV in the developing world, even though HIV/AIDS is also seen to aggravate poverty, further hindering development efforts and eroding gains in these areas of development (UAC, 2002a).

Uganda was among the first countries in the world to be overwhelmed by the epidemic. The Surveillance Unit of the Ministry of Health estimated that approximately 1,050,555 people were living with HIV/AIDS in December 2001, and that approximately 940,000 Ugandans were estimated to have died of HIV/AIDS related illnesses since the onset of the epidemic in the country. The national HIV prevalence rate was estimated to be 6,5% of the total Ugandan population at the end of 2001; following a history of declining trends from a national average of 18%, including 30% in the worst hit areas of the country, in the early 1990's (UAC, 2002a).

6.2 GEOGRAPHICAL, SOCIAL AND ECONOMIC BACKGROUND

Uganda lies in Africa's sub-Saharan region. It is a landlocked country, situated in the eastern part of Africa, bordering with Kenya to the east, Tanzania and Rwanda to the South, the Democratic Republic of Congo to the west and Sudan to the North.

According to the preliminary report of the 2002 national population census, the country's population size is estimated at 24,7 million people and life expectancy at birth was estimated at an average of 43,2 years. Life expectancy without AIDS was estimated at an average of 54 years in 1998 (UAC, 2002b).

Literacy rates were estimated at 77% for males and 51% for females during 1999/2000. The majority of Ugandans, approximately 87%, live in rural areas where subsistence agriculture is the major source of food and income (UAC, 2002b).

Uganda is categorised under the least developed and most resource constrained countries in the world. The 2000 Human Development report, of the United Nations Development Programme (UNDP), estimated the country's Gross Domestic Product (GDP) to be US$ 8,676 million for 2001/2002, with a growth rate of 5,6%, and the real GDP per capita to be 371,300 Ugandan Shillings. The Human Poverty index was estimated at 37,5% in

2001 with a high proportion of the population without access to health care facilities, approximately 51% of the general population (UAC, 2002b).

The country is partitioned into 56 local government authorities also known as districts. The decentralised system of governance adopted in 1995 devolved most functions and powers to districts that shoulder the task of service delivery to grassroots communities. The central government focuses on policy making, standards setting, support, supervision and national security (UAC, 2002b).

6.3 HIV/AIDS STATUS 2003

UNAIDS estimated during 1999, that approximately 1,9 million people were living with HIV/AIDS in Uganda, since the onset of the epidemic. AIDS is responsible for up to 12% of annual deaths and has surpassed malaria and other illnesses as the leading cause of deaths among individuals aged 15–49 years. The World Health Organisation (WHO) estimated, during 1999, that approximately 10% of the adult population where HIV infected (Uganda, 2000a).

The worldwide concerns, particularly Uganda's, regarding the HIV/AIDS epidemic, are primarily due to the unique nature of the epidemic and it's impacts. Firstly, the epidemic's principle route of transmission is through sexual contact, this includes both heterosexual and homosexual intercourse. Owing this feature, the epidemic mainly affects the sexually active population, therefore, sexual activity is the main defining risk factor for the variation of its incidence and prevalence according to sex, geographical location, culture, and socio-economic status (Uganda, 2000a).

The age group most affected (15–50 years) also occupies a very critical position in families and communities as a whole: as head of households, the labour force, and leaders in society. As a result, HIV/AIDS has touched on every aspect of national life and development including individual behaviour, the roles and functions of the family,

communities, the economy, and care and support systems. In the absence of a cure or vaccine, change in sexual behaviour remains the most important approach towards preventing HIV infection (Uganda, 2000a).

One of the most visible and immediate socio-economic impacts is the rapidly growing number of AIDS orphans. UNAIDS estimated, in 1998, that approximately 1,9 million Ugandan children had lost either one or both parents due to AIDS. Given that HIV infected persons will progress to full-blown AIDS and die, the number of orphans, therefore, will increase. Although families have, to a large extent, absorbed the burden of AIDS orphans, surveys suggest that the extended family (caregivers) are over-stretched by the ever-increasing number of orphans. Despite the work of government and other organisations to fight stigmatisation, the children affected by HIV/AIDS are still exposed thereto and neglected. Evidence of this is seen when orphanhood, gender disparities and cultural practices tend to render the girl child particularly exposed to exploitation and heavy responsibilities, especially in areas of housekeeping and agricultural production. Being orphaned and poor further exposes the girl child to a greater risk of HIV infection due to coercion into early marriage, sexual abuse, and prostitution (Uganda, 2000a).

The AIDS epidemic has also adversely affected the economic sector. Unlike other illnesses, HIV/AIDS affects adults in their prime and productive years. Sickness and death due to HIV/AIDS affect places of work through absenteeism and the loss of skilled employees. At the household level treatment cost of AIDS financed from household savings reduce the capital available for investment in agriculture, education and other areas of importance. Furthermore, the time spent by relatives on care of AIDS patients reduces the time they spend on production and income generating activities. This worsens poverty, increases inequality and makes the development goals that have been achieved, void (Uganda, 2000a).

The main observations made in the National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1 – 2005/6, March 2000, with regard to the status of the epidemic, include the following descriptions (Uganda, 2000a).

(i) There has been an overall decline in HIV-positive seroprevalence rates observed at designated sentinel points.

(ii) The decline in HIV-positive seroprevalence rates has led to a convergence of rates between the various categories of the population such as between rural and urban areas, and the geographic regions of the country.

(iii) Surveillance data is mainly based on blood samples taken from women attending antenatal clinics, therefore, the seroprevalence rates for large sections of the population remain estimated such as children, men, and post menopausal women.

(iv) Despite the acknowledged decline in seroprevalence rates, the mechanisms that produced this reduction are not fully understood. Owing to weak monitoring, it is not possible to apportion the observed decline between the three factors of abstaining, being faithful to one's partner, and condom use.

(v) Although HIV seroprevalence declined from 30 to about 10% between 1992 and 1996, it appears to have stagnated since then. A seroprevalence rate of 10% is still high given that HIV/AIDS results in certain death.

(vi) In the past, HIV/AIDS interventions did not fully benefit from reference to a common national programme of action and as a result, a number of agencies and line ministries did not make their due contribution.

(vii) Government has introduced a national decentralisation policy, which has inter alia devolved public service delivery to local governments. This policy has brought HIV/AIDS closer to the grassroots and local governments, therefore, they should play a more active role in the implementation of certain sections of the National Strategic Framework. Local governments are also encouraged to design interventions specific to their jurisdictions and in response to the special nature of their HIV/AIDS situation.

(viii) The HIV/AIDS problem has clear adverse implications for the attainment of national goals for socio-economic development. In some sectors, HIV/AIDS threatens to erode the achievements already made, while at the individual level, the failure to access prompt treatment for opportunistic infections, hinders People Living With AIDS (PLWA's) from full participation in social and economic activities.

(ix) The spread of HIV/AIDS is also influenced by trends in neighbouring countries. For example, civil conflict, which may lead to an influx of refugees, also affects Uganda's ability to control the spread of the disease. Similarly, the lack of access to condoms in neighbouring countries would have a direct bearing on HIV/AIDS trends in Uganda.

6.4 IMPACT OF HIV/AIDS

The information in this section is taken from the National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1–2005/6, March 2000 (Uganda, 2000a).

6.4.1 Risk factors

Since the dominant route for the transmission of HIV infection in Uganda is through sexual contact, the risk factors for infection are closely related with the frequency of unprotected sex with infected partners. The main risk factors for heterosexual HIV infection are the following (Uganda, 2000a).

(i) Unprotected sex with an infected person.
(ii) High number of sexual partners during a lifetime.
(iii) The presence of a STD.
(iv) Sexual contact with a menstruating partner.
(v) Sexual intercourse before sexual organs reached a mature age.

According to the 1999 STD/HIV Surveillance report, young women aged 15–24, are at a higher risk of HIV infection than men, because girls have their first sexual encounter at an earlier age than do boys. This assist with explaining why approximately 54% of the reported AIDS cases are females (Uganda, 2000a).

6.4.2 Predisposing factors

According to the National Strategic Framework (Uganda, 2000a), the predisposing factors include inter alia:

(i) little knowledge of the dynamics of HIV infection and prevention;
(ii) inadequate life and negotiating skills;
(iii) poverty;
(iv) negative cultural practices such as widow inheritance, polygamy and female genital cutting;
(v) consumption of alcohol and other intoxicants leading to irresponsible and /or unprotected sex;
(vi) extensive sexual network; and
(vii) civil strife and armed conflict and war in parts of the country.

It should be noted that the relative importance of each of these factors has been changing over time and across geographical areas.

6.4.3 Incidence and prevalence

Available data suggest that the prevalence of HIV has been declining significantly in Uganda since 1992. During 2000, the overall HIV prevalence rate was thought to have stagnated at about 10%, but the UNAIDS (2004) report shows that the prevalence figure has come down to approximately 6% by end 2003.

Data form sentinel sites since 1989 indicate that the decline is particularly pronounced among urban pregnant women, aged 15–19, followed by women aged 20–24. In one of the sentinel sites in Kampala, the HIV prevalence rate was 29,5% in 1992, but this has declined to 13,4% in 1998 (Uganda, 2000a).

In the beginning of 1989, HIV prevalence was as high as 25%, and only peaked in 1992, before it started a steady decline from 1993 to 1996, and stagnated at approximately 12% for the period thereafter. However, HIV prevalence among antenatal clinic attendees in the Tororo area has shown a small, but consistent, decrease since 1996 (Uganda, 2000a).

Surveys on knowledge, attitudes and practices conducted by the Ministry of Health also indicate an increase in the average age of first sexual encounters, a reduction in number of casual sexual partners, and an increase in general condom use, especially between casual sexual partners. These findings suggest that the decline in HIV prevalence in Uganda is likely to be linked to changes in behaviour (Uganda, 2000a).

6.4.4 HIV prevalence/AIDS cases

The HIV infection rate also varies significantly with age. HIV prevalence is very low between the ages of 0–5 and 5–14, but shows a marked rise in the age group 15–19, particularly among girls. Mother-to-child transmission (MTCT) of HIV is attributed for the HIV prevalence among young children. In September 1999, the World Health Organisation (WHO) together with the United Nations Children's Fund (UNICEF) and UNAIDS, released a statement on policy guidelines in which they estimated that approximately 15% of children fed on breast milk of HIV-infected mothers acquire the virus (Uganda, 2000a)).

In Uganda, the HIV prevalence pattern for gender and age groups is described as follows. HIV is higher for females than for males, aged 15–24, but the gap reduces between ages 24–29. The prevalence rates for males then supersede that of females aged 30 and above (Uganda, 2000a).

6.4.5 HIV/AIDS and culture

Other cultural factors that perpetuate HIV infection include inadequate life skills and education from family, because parents and other adults often avoid talking to young

people about sex. There are also stereotype roles, which encourage submissiveness on the part of girls and aggressiveness on the part of boys. For example, many cultures place a high premium on the virginity in girls while promoting early and active sexual behaviour for boys (Uganda, 2000a).

6.4.6 HIV/AIDS and migration

In the Great Lakes Region, people tend to move mainly due to civil conflict and the search for better job and trading opportunities. Uganda, due to its political stability, is currently host to a large number of refugees and internally displaced persons from this region (Uganda, 2000a).

According to Barton and Mutiti (1998), STD prevalence is high in the northern regions of Uganda, and can be linked to military movements, camp following and prostitution. Early sexual activity among boys and girls and unwanted pregnancies are also high.

6.4.6.1 Freed kids

The Minister of Gender, Labour and Social Development, Zoe Bakoko Bakoru, reported that half of the children rescued from the, Lord's Resistance Army (LRA), rebels in northern Uganda are HIV-positive (Namutebi, 2004).

Minister Bakoru said the LRA leader, Joseph Kony, was abducting and allotting children as young as nine as wives. The minister continued by saying that the children needed psychosocial attention because they get traumatised (Namutebi, 2004).

6.4.7 HIV/AIDS and regional affiliation

Uganda is closely tied to her neighbours through culture, shared ethnic groups, and a common history. As a result there is considerable movement of persons and goods across its borders. Most imports destined for Rwanda, Burundi, South Sudan and Eastern Congo

pass through Uganda. Apart from the railway and road networks, Lake Victoria is shared between Kenya, Uganda and Tanzania and provides another transport link between the countries. Uganda is also a member of the regional economic groupings: for example the East African Community (EAC), the Kagera Basin Authority Preferential Trade Authority (PTA), the Common Market for Eastern Africa (COMESA), and the Inter-Governmental Authority on Drought and Development (IGADD) (Uganda, 2000a).

In recognition of the close association between population movements and the spread of HIV/AIDS, countries of the Great Lakes Region started the Great Lakes Initiative on AIDS (GLIA) in March 1998, with a co-ordinating Secretariat located in Kigali. Through this forum, the member states (Kenya, Uganda, Tanzania, Rwanda and Burundi) share experiences and resources in the combat against HIV/AIDS. GLIA focuses on cross-border issues and other problems of common concern related to HIV/AIDS in the participating countries (Uganda, 2000a).

6.5 HISTORICAL BACKGROUND

Although the AIDS epidemic, locally known as "Slim", began to spread in Uganda on the shores of Lake Victoria during the late 1970's, AIDS was first identified in 1982 (Hooper, 2000).

The first HIV/AIDS case was identified in Uganda in 1982 along the shores of Lake Victoria. Superstitions and witchcraft characterised the initial response from communities amidst the lack of clear government leadership in response to HIV/AIDS. Consequently, the epidemic progressed very fast to a national prevalence of 18,3% with some centres registering prevalence above 30% by the end of 1992. Spontaneous community and health care facilities responses were reinforced in 1986, when the new government lead by the National Resistance Movement (NRM), established the first AIDS Control Programme (ACP) in the Ministry of Health (UAC, 2002b).

In 1986, after Mr Museveni came to power, the government launched the AIDS Control Programme (ACP) to spearhead the struggle against HIV/AIDS. The programme's objectives, according to Dr Joshua Musinguzi, the acting programme manager of ACP, were to prevent further transmission of HIV, create mechanisms to care for the infected and their families and create the capacity to contain the epidemic. Dr Musinguzi said the "... backbone of our programme was information, education and communication. We had to make people aware of the problem and translate this awareness into behavioural change". The core of the ACP's anti-AIDS message was abstinence from sex, faithfulness to one's partner and the use of condoms. In this regard, Dr Musinguzi said that many "... more people are now using condoms and there has been a decline in casual sex" (Kirungi, 2001).

The ACP alone distributed 80 million condoms last year, and the number is expected to rise to 120 million in 2001, compared to only four million in 1990. A June 2000 report shows an increase in condom use across the country. In Kampala, 51% of those surveyed used condoms in 1998 compared to only 42% in 1995. The report also records a slight decline in non-regular sex partners from 14,1% in 1995 to 13,7% in 1998. However, condom use with non-regular partners increased significantly, from 58% to 76% (Kirungi, 2001).

As early as 1987, the government of Uganda recognised that the magnitude and impact of the HIV/AIDS epidemic cut across all sectors of life. Subsequently, the strategy referred to as the Multisectoral Approach to the Control of AIDS (MACA), was developed and adopted in 1992 to ensure a concerted response. This policy and strategy calls for the involvement of everyone, individually or collectively to fight the epidemic within their mandates and capacities at all levels of government, civil society and the private sector (UAC, 2002b).

The Uganda AIDS Commission (UAC) was established, by Statute of Parliament, in 1992 under the Office of the President, to ensure a focused and harmonised response. Due to President Museveni's leadership in the Ugandan response to HIV/AIDS, the

country's response has been marked with high levels of political commitment in all branches of government; an openness about HIV/AIDS that enhanced behaviour change interventions; unprecedented support from international development partners; and action from all sections of government, civil society and the private sector (UAC, 2002b).

The National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1–2005/6 was published in March 2000. The partners included the Government of Uganda, Uganda AIDS Commission (UAC), Joint United Nations Programme on HIV/AIDS (UNAIDS), and other stakeholders in HIV/AIDS (Uganda, 2000a).

This document gives a review of past performance and a statement of the nation's planned response to the HIV/AIDS problem particularly in the period 2000/1-2005/6. The Framework is sequel to and builds upon similar previous documents, namely; the Multisectoral Approach to the Control of AIDS (MACA) concluded in 1993; and the National Operational Plan for HIV/AIDS/STD Prevention, Care and Support 1994-1998. A National Strategic Framework for HIV/AIDS activities was drawn up to cover the period 1998-2002. However, subsequent review of implementation indicated that the document had a number of shortcomings. In particular, there was a need to place the HIV/AIDS problem in the broader context of national development and relate it to other national policies on health and to the poverty eradication programme. The national Strategic Framework 2000/1–2005/6 addresses these shortcomings and updates the 1998-2002 Framework (Uganda, 2000a).

The National Strategic Framework 2000/1–2005/6 builds on the national response to HIV/AIDS since 1982, when the disease was first identified. The government has been consistently vigilant and the response has been characterised by a policy of openness and has benefited from leadership and commitment from the highest level of government. Government has fully recognised that HIV/AIDS has far-reaching consequences, and goes beyond the health sector (Uganda, 2000a).

A structured government response to the HIV/AIDS epidemic dates back to 1986 when an AIDS Control Programme (ACP) was created in the Ministry of Health. This was the result of the work of a committee constituted in 1985 to promote resource mobilisation in order to prevent and mitigate the impact due to the epidemic (Uganda, 2000a).

6.5.1 Government response to HIV/AIDS

Uganda's response to HIV/AIDS has been a collective effort by the government, (non-governmental organisations (NGO's), community based organisations (CBO's), religious groups, individuals, PLWA's, local and international donors. Openness, political leadership and commitment at the highest level of government have characterised the national response to the epidemic. There have also been efforts to mobilise and unify the responses to the epidemic, at international, national, district and community levels, including the establishment of AIDS Control Programmes in government ministries, NGO's and CBO's (Uganda, 2000a).

In 1990/91, government adopted a multisectoral approach to the control of HIV/AIDS (MACA) in dealing with the epidemic. This approach emphasised the notion of collective responsibility of individuals, community groups, different levels of government, and other agencies for the prevention of HIV infection. It also emphasised building and strengthening organisational capacity among government sectors and non-governmental organisations to sustain anti-AIDS activities. The Uganda AIDS Commission (UAC) was therefore established in 1992 by Act of Parliament to address the HIV/AIDS problem in this broad context. The National Operational Plan for HIV/AIDS prevention, care and support (1994–1998) was drawn up to provide guidance for agencies involved in the HIV/AIDS-related work (Uganda, 2000a).

By 1994, UAC prepared a Multisectoral Approach, called MACA, and a National Operations Plan to be used as guidelines for project implementers. In order to strengthen the multisectoral approach, Programmes for AIDS Control (ACP) were created in 12 other line ministries (Uganda, 2000b).

Government response to HIV/AIDS is based on the fact that AIDS affects all strata of the population, and poses a serious threat to the socio-economic life and development of the country. The national response to HIV/AIDS has therefore been characterised by a policy of openness backed by effective political and resource support from the highest level of government (Uganda, 2000b).

The government policy of openness and political commitment to HIV/AIDS control has created high levels of awareness in the population about the dangers of the epidemic and possible means of prevention. The establishment of the UAC and the creation of AIDS control programmes outside the health sector have strengthened the multisectoral response to the epidemic making the overall response to the epidemic more effective (Uganda, 2000b).

6.6 REPORT ON DECLINING RATES OF HIV/AIDS INFECTION

The information in this section has been provided for by the United Nations Africa Recovery (UNAFREC) division (Kirungi, 2001).

Uganda has recorded declining rates of HIV infection since 1993. Although HIV prevalence among pregnant women in certain regions rose from 24% in 1989 to 30% in 1992, by 1999 the national prevalence rate had dropped to 10%, according to the figures from the AIDS Control Programme (ACP) in the Ministry of Health. Among patients suffering from sexually transmitted diseases at Uganda's leading hospital, Mulago, HIV infection rates fell from 44,2% in 1989 to 23% in 1999 (Kirungi, 2001).

This achievement can be attributed to four factors, according to Dr Joshua Musinguzi, the acting programme manager of ACP: the high level of political commitment to the fight against HIV/AIDS, openness about the epidemic, involvement of all sections of society and the government policy of decentralisation. Dr Musinguzi said that President

Museveni immersed himself in work against HIV/AIDS and "... got engaged in the fight early and encouraged other political leaders to do so" (Kirungi, 2001).

Table 6.1 Profile of AIDS in Uganada

People living with HIV/AIDS (1999)	823,000
of which:	
women (15-49 years old)	420,000
men (15-49)	350,000
children	53,000
Adult HIV prevalence rate (%)	8,3
Estimated AIDS deaths to 1999	110,000
Children who have lost one or both parents	1,700,000

Source: United Nations Africa Recovery (Kirungi, 2001)

6.6.1 Local councils

Dr Musinguzi stated that the ACP conducted information campaigns on radio, television and in newspapers, distributed leaflets and posters and is responsible for putting up billboards across the country. However, because of the limited reach of these, especially in the rural areas, the programme also uses existing administrative and social institutions. Dr Musinguzi said that they "... especially used the Local Council (LC) system not only to get out the message to every village but also to ensure that anti-AIDS activities were initiated and implemented at the lowest level" (Kirungi, 2001).

The LC system is a hierarchical administrative structure from the village to the district level. At each level, there is a governing committee composed of nine elected members, including secretaries for health, women and youth. The ACP trained LC officials at the district and in some cases, sub-county levels, and they, in turn, trained their counterparts at the lower levels on AIDS-related issues. In this regard Dr Musinguzi said the ACP "... approach was to encourage them to design and implement their own strategies to cope with the problem" (Kirungi, 2001).

Although there was no direct funding from the government for AIDS-related activities in the villages, LC committees were given assistance in the form of information leaflets, condoms and, in some cases, HIV testing services. Since 1996 when the government adopted the policy of decentralisation, 65% of tax revenues remains at the sub-county level and some of it is committed to AIDS activities in villages. In addition, the ACP uses drama groups, schools, churches, mosques and other community-based organisations (CBO's) to help spread the word on AIDS. Dr Musinguzi said that because of the commitment of the leadership there existed an "... openness about it, the challenge of AIDS became the concern of everybody. Churches, mosques, schools, the army, and even private companies initiated their own programmes to handle the problem" (Kirungi, 2001).

6.6.2 Combating stigmatisation

Dr Musinguzi stated that openness about AIDS also helped remove the stigma associated with the scourge and encouraged people infected with HIV to join in the fight (Kirungi, 2001).

Rev Jackson Muteeba, an AIDS control programme manager, said that they "... went to the villages encouraging people to come for HIV testing. We provided our members with home care support and counselling". As the numbers grew, however, his organisation found it difficult to provide these services. In this regard Rev Muteeba said they then "... encouraged them to form local associations so that they could support each other.

Intervention measures are more effective and sustainable if they are applied from the lowest level, right from the home". The group, with over 4,500 registered HIV patients, provides its member associations with training and advisory services. There are now over 1,500 NGO's and CBO's involved in HIV activities in Uganda (Kirungi, 2001).

Dr Musinguzi also mentioned that it was the involvement of different sectors of society that originally led to the formation of the Uganda AIDS Commission (UAC) in 1992 to assist with the co-ordination of all AIDS related activities. The UAC's director of AIDS research and policy development, Dr John Rwomushana, explained that under the multisectoral approach the commission had adopted in 1993, the struggle against AIDS was broadened to include fighting poverty, illiteracy, child abuse and cultural practices like polygamy and wife inheritance, all of which make individuals more vulnerable to HIV infection (Kirungi, 2001).

6.6.3 Cultural sensitivities

Dr Rwomushana said Uganda's "... education campaigns not only addressed AIDS and health-related issues, but also risky cultural practices. HIV control was made an integral part of the country's national education and poverty eradication policies". One of the biggest challenges, according to Dr Rwomushana, was how to campaign against AIDS and risky behaviour without upsetting cultural and religious sensibilities. In this regard he said that they "... adopted a policy of inclusiveness that avoids confrontation with the different social and religious groups". He supported this statement by adding that the "... fact that the chairman of the Uganda AIDS Commission, Halem Imana, is a retired Catholic bishop is a demonstration of this" (Kirungi, 2001).

One policy that posed particular problems was the promotion and distribution of condoms. Many religious groups were opposed to this, prompting the ACP and UAC not to be very forceful in promoting them in the beginning. That obstacle has now been overcome, according to Dr Rwomushana, who said the Ugandan authorities "... encourage groups that preach morality to promote means of HIV avoidance they are

comfortable with, without, however, undermining other agencies that may be promoting methods less acceptable to them" (Kirungi, 2001).

6.6.4 Big challenges

Despite all these achievements, there are serious challenges still to be overcome, not least the growing number of AIDS orphans. According to the UAC, there are 1,9 million Ugandan children who have lost one or both parents to AIDS. Dr Rwomushana, who is in charge of the formulation of national strategy to address the problem of orphans, said the "... challenge is to provide them with housing, food and education" (Kirungi, 2001).

Another big challenge, according to Dr Musinguzi, is reducing the comparatively high prevalence of HIV among girls aged 15-19 years. A March 2001 UAC report noted that girls are six times more likely to be infected with HIV than boys of the same age. Dr Musinguzi attributes this to the "sugar daddy" syndrome, referring to older, relatively wealthy men who engage adolescents in sexual relationships. He said a "... broad approach that involves enrolling and keeping girls in school and equipping them with skills to resist such men is needed" (Kirungi, 2001).

Daunting as these challenges are, Dr Rwomushana has no doubt that they will be overcome. He said that through effective leadership and the "... involvement of everybody, we have managed to bring the infection rates down. There will be no complacency, and the situation can only improve" (Kirungi, 2001).

6.7 UGANDA COUNTRY STATEMENT: AIDS - THE GREATEST LEADERSHIP CHALLENGE, ADDIS ABABA, 3–7 DECEMBER 2000

The information in section 6.7 has been taken from the Uganda Country Statement, "AIDS: the greatest leadership challenge", presented at the Africa Development Forum, Addis Ababa, Ethiopia, 3–7 December 2000 (Uganda, 2000e).

Leadership in Uganda has recorded several successes in fighting the epidemic. The first success recorded by the top leadership, led by the President, was to admit that there existed a problem, in order to tell the country that AIDS was killing people and was spreading rapidly. This initiative by the leadership started in 1988, when it was still taboo for officials to admit to the existence of the epidemic, as most deaths at the time were attributed to various causes including witchcraft (Uganda, 2000e).

The attitude of the top leadership, and the release of statistics showing the extent of the problem and its serious implications for the future, played a crucial role in the process of openness. For instance, President Museveni, stated at the 9th International Conference on AIDS and STD's in Kampala in 1995, that President Castro of Cuba had told him 18 (30%) of the 60 soldiers Uganda had sent to Cuba for training were found to be HIV infected after testing. This interaction made the leadership more aware of the problem, supported a change in attitude, and convinced them to listen to the advice from authoritative institutions such as the United Nations and the World Health Organisation, and other professional advisers (Uganda, 2000e).

The second success is the high level of knowledge and awareness regarding HIV/AIDS that has been instilled among the Ugandan population. The openness of the top leadership was followed by its active participation in educating and sensitising the population about the epidemic. This leadership style opened the door widely for those individuals and agencies ready to engage in preventive campaigns against HIV/AIDS and supported them in intensifying their activities. After a decade of education and sensitisation, it is estimated that almost every person above the age of 10 knows about HIV/AIDS and most of those who know are aware of the most important routes of HIV transmission and how to avoid them (Uganda, 2000e).

Another success of the leadership has been the formulation and implementation of efficient and effective policies that included multisectoral programmes to fight the epidemic (Uganda, 2000e).

The success in the fight against the epidemic is reflected in recent trends of several statistics. Firstly, data from HIV infection sentinel surveillance sites show persistent declining trends in both urban and rural areas. For example, antenatal prevalence rates in Nsambya hospital in the capital city dropped from about 30% in 1992 to 12,4% in 1999 and those in the upcountry Lacor hospital decreased from 27,1% in 1993 to 12,3% in 1999. Secondly, people's sexual behaviour and practices are reported to have improved with increased proportion of the sexually active persons using condoms to prevent HIV infection, reduction of the number of sexual partners and increased median age at first sex. Thirdly, voluntary counselling and testing (VCT) have been expanded to more areas of the country and has been integrated into district health services (Uganda, 2000e).

A shortcoming has been inadequate leadership at local government levels. The leadership provided by the President at the national level has not always been emulated by leadership at the lower levels of government. Another shortcoming in the leadership to fight HIV/AIDS is found in behaviour management. Although almost all Ugandans know the existence of HIV/AIDS and the major routes of transmission, a sizeable proportion of the population are not aware of preventative measures partly due to some conflicting messages from different sources, lack of communication on the subject between parents and children, poverty, civil conflicts and limited counselling and testing facilities at grass root levels. This has resulted in minimum sexual behavioural change among vulnerable groups, such as adolescents, street children and refugees (Uganda, 2000e).

6.7.1 Leadership challenges and obstacles

The leadership in Uganda has met several challenges and obstacles in fighting the epidemic. The first challenge is lack of infrastructure in the country to fight HIV/AIDS (Uganda, 2000e).

The second challenge to leadership is to prioritise the fighting of HIV/AIDS. With many competing demands for scarce resources, the leadership in government had to work hard to prioritise in order to fund the fight against HIV/AIDS (Uganda, 2000e).

A further leadership challenge is about perception. Although great progress has been made, there is still stigmatisation of people living with AIDS (PLWA's) by various levels of leadership (Uganda, 2000e).

A fourth challenge to leadership is inadequate support given to PLWA's. Due to financial constraints, leadership in government cannot afford the provition of palliative drugs to PLWA's (Uganda, 2000e).

Poverty is an additional challenge to the leadership. Low household incomes, which often are below survival level leave nothing for the families to assist PLWA's with (Uganda, 2000e).

6.7.2 Future strategies

The National Strategic Framework 2000/1–2005/6 (Uganda, 2000a) provides the national guideline and serves as a source of inspiration to all sectors of society for planning and implementing strategies to fight HIV/AIDS and emphasises collaboration and co-ordination among all stakeholders working towards prevention and care. The Framework places the HIV/AIDS problem in the broader context of national development and relates it to other national policies, such as Vision 2025, Poverty Eradication Action Plan, National Health Policy and Decentralisation Policy. It seeks active participation of all stakeholders in the management, monitoring and evaluation of the activities to fight HIV/AIDS. The National Strategic Framework also establishes indicators for measuring progress and impact of interventions and forms a basis for costing and mobilisation of the resources for implementation.

The goals of the Framework (Uganda, 2000a) are to reduce HIV/AIDS prevalence rates by 25% in the next five years, to alleviate health and socio-economic effects of HIV/AIDS at individual, household and community levels, and to enhance national capacity to respond effectively to the epidemic.

The HIV/AIDS advocacy matrix, as contemplated in the Framework, analyses the problems faced by the leadership and makes recommendations for the way forward on a number of issues. These issues include problem behaviour, desired behaviour, barriers, key promises, desired actions, communication objectives, message concept, communication channels/settings/opportunities, communication action, communication materials and output indicators (Uganda, 2000a).

After studying the advocacy matrix, a workshop recommended a broad role for leadership, and this is threefold in manner. Firstly, the leadership at all levels should actively participate in HIV/AIDS activities in their areas. Secondly, the leadership should plan and budget for more employment opportunities for the youth in order to reduce poverty. Thirdly, overall resource allocation should be reviewed in order to increase national and local funding of HIV/AIDS activities (Uganda, 2000a).

Although Uganda has achieved much in the fight against the epidemic, much more needs to be done to significantly reduce HIV infection and mitigate socio-economic effects on the society. To achieve this, leadership at all levels must participate.

6.8 STATEMENT BY PRESIDENT YOWERI K. MUSEVENI, AFRICAN DEVELOPMENT FORUM 2000, ADDIS ABABA, 7 DECEMBER 2000

The information in this section has been taken from a statement made by the President of Uganda at the African Development Forum, Addis Ababa, on 7 December 2000 (Museveni, 2000).

HIV/AIDS is the worst misfortune that has befallen Africa in the 20th century. Although the disease has spread throughout the world, sub-Saharan Africa, with only 10% of the world's population, accounts for 24,5 million people or 71% out of the 34,3 million people in the world estimated to be living with HIV. Out of the 18,8 million people who have died of AIDS, 14 million of them have died in sub-Saharan Africa. Out of the 13,2 million children who have been orphaned by AIDS, 12 million are in sub-Saharan Africa. "These grim figures clearly indicate that HIV/AIDS is an overwhelmingly African problem" (Museveni, 2000).

Uganda was, until recently, synonymous with AIDS. By 1993, 1,5 million Ugandans, or 15% of the adult population, were living with HIV/AIDS. By 1998 the number of people infected with AIDS reached 2,000,000, of which 800,000 had died, and one million children had been orphaned due to AIDS. This was the highest rate in the world. "It is very little consolation that, since 1993, we have moved from number one to number 14. However, the decline in the prevalence of HIV in the last seven years in Uganda is a clear indication that, given the will, we can, ultimately, overcome the HIV/AIDS pandemic" (Museveni, 2000).

6.8.1 Creating Awareness

"When the first cases of HIV/AIDS were identified in Uganda in 1983, the people in the affected areas associated the disease with witchcraft and religious workers regarded it as a punishment by God to the wicked. Those who carried the cross of HIV/AIDS and their relatives, given the stigma attached to the disease as a disease of shame, especially when it became clear that it was mainly sexually transmitted, did what they could to conceal and deny their condition. Moreover, in the tyranny and anarchy that reigned in the country at that time, nothing was done to respond to the impact due to the disease. When the National Resistance Movement took power in January 1986, we found a distressing hopelessness and resignation amongst those infected with HIV/AIDS. We had weathered many storms and we saw HIV/AIDS as one more challenge, admittedly a very serious

one, to confront. The immediate task was to bring HIV/AIDS out into the open so that it could be given a face or a common front could be drawn to attack" (Museveni, 2000).

Accordingly, in May 1986, Uganda's Minister of Health, at the World Health Assembly in Geneva, informed the delegates that Uganda had an AIDS problem and needed the support of the International Community to deal with it. This was shocking news to many. "Here we were, owning up to our problem, HIV/AIDS, which was associated with homosexuality and drugs and referred to as a disease of stigma and shame. This revelation did not go down well with some of our African friends. Sadly, however, this was the reality" (Museveni, 2000)..

"At home, we opened up the AIDS problem to public debate and began to develop a broad consensus on how to tackle the problem" (Museveni, 2000).

The Ugandan government took initiative and immediately implemented the following steps (Museveni, 2000):

(i) established an AIDS Control Programme (ACP) in the Ministry of Health, the first of its kind in the world;

(ii) organised an International Conference on AIDS in Kampala to mobilise financial and material support for prevention and care activities; and

(iii) proceeded with setting up the National AIDS Prevention and Control committee, which was composed of government officials and members of civil society. This committee was replaced in 1992 by a statutory body, the Uganda AIDS Commission (UAC), that is permanently based in the Office of the President in order to ensure leadership commitment and effective support for inter-departmental co-ordination.

In addition to the AIDS Control Programme (ACP) in the Ministry of Health, ACP's were set up in other ministries and, by 1993, these programmes had been established in 12 ministries. Leadership also encouraged the private sector to set up ACP's of their own. The governments approach, right from the beginning, has been that of a multisectoral

approach that incorporates and supports all role players in society, to ensure that government, the private sector and civil society have worked as a team to roll back the enemy (Museveni, 2000).

6.8.2 The politics of HIV/AIDS

The political leadership in Uganda is totally committed to the elimination of HIV/AIDS; and they believe, according to President Museveni, that this has been critical to ensure Uganda's successful response to the pandemic (Museveni, 2000).

Once the leadership decided to take HIV/AIDS out of the closet, all levels of leaders, from the president to the village committees, mobilised to create awareness of the dangers of HIV/AIDS among the population. The leadership explained what it was and what it was not; how the infection spreads; and how it can be avoided. The President called it the good disease because it is, largely, an infection of choice. It is a largely sexually transmitted disease and can, therefore, be avoided through proper sexual behaviour (Museveni, 2000).

The democratisation that is on-going in Uganda also helped them greatly in their awareness campaign. The media, both electronic and print, is completely free and largely private. They are encouraged to join the struggle against HIV/AIDS and they carried very important messages from the fearsome ones such as "AIDS KILLS" to the de-stigmatising ones such as "DO NOT POINT FINGERS AT PEOPLE WITH AIDS" (Museveni, 2000).

Most importantly, has been the empowerment of women in Uganda. "Today women participate at all levels of governance; and I am happy to report that they have become very assertive of their rights. This empowerment has liberated them from being merely sexual objects. They are now in full control of their lives and can make their sexual choices without coercion. In my view it is very difficult to confront the AIDS problem without empowering women", according to President Museveni (Museveni, 2000).

As a result of their awareness campaign, close to 100% of Ugandans know what HIV/AIDS is and how it is spread; the risks involved; and how it can be prevented. There are indications that transformation of positive behaviour change has taken place. The prevalence rate has been reduced, from approximately 30% in the early 1990's, to approximately 8% in the late 1990's; the age of first sex among girls increased from 14 to 16 years; and from 14 to 17 among boys between 1995 and 1998; sex with non-regular partners has also been reduced; and condom use increased from 57,6% in 1995 to 76% in 1998. In 2001, Uganda required 80 million condoms. Most importantly, the stigma attached to people living with HIV/AIDS has virtually evaporated (Museveni, 2000).

Since 1990, when the first AIDS Information Centre was opened, 450,000 people have come forward for voluntary testing and counselling. Many people have come out openly to declare their status. HIV/AIDS is now almost regarded like any other chronic disease, albeit incurable. At this stage, the drugs being used have not yet removed AIDS affliction from the list of terminal sicknesses. "However, I can inform you that some of our people who were found with AIDS in 1986 are still moving around, working and raising their families" (Museveni, 2000).

6.8.3 Dealing with people already infected with HIV/AIDS

"People living with AIDS need love, care and understanding like everybody else. Therefore, the first task of leaders is to urge the population to accommodate people living with AIDS (PLWA's) in their communities and to afford PLWA's equal treatment. The infected need to support their families, like everybody else; and for as long as they are capable of working, they should be allowed to continue working. They need to be counselled to better cope with their condition, and here the role of civil society is paramount. They need medical care, especially the treatment of opportunistic diseases; and we should, therefore, increase our health budget to respond adequately to the needs of PLWA's" (Museveni, 2000).

According to President Museveni, poverty compounds the problem of AIDS. "It is not sheer coincidence that sub-Saharan Africa, the poorest region of the world, is also the most severely HIV/AIDS infected region of the world. Poverty has a lot of bearing on the spread of HIV/AIDS. We must, therefore, move simultaneously against both poverty and AIDS. We cannot wait to tackle HIV/AIDS after elimination of poverty; but as long as poverty persists at current levels in Africa, the eradication of HIV/A1DS will be an uphill task" (Museveni, 2000).

The President maintains that Uganda, is too poor to treat some of the opportunistic diseases. People, therefore, die prematurely, not from HIV/AIDS per se, but from conditions that can be treated successfully. Most Ugandans living with AIDS cannot afford the antiretrovirals drugs (ARV's) that have been proven to be effective. In Uganda it costs Shillings 8000,000/= (approximately US$ 450) a month to give one patient a course of ARV drugs and, at the present level of science, the administration of these drugs must go on throughout one's life. ARV drugs can give people living with AIDS prolonged life; but neither governments nor many individuals can afford them in Africa. "We do not manufacture these drugs here. The big pharmaceutical companies have invested in the research and manufacturing of these drugs and they expect to make returns on their investments" (Museveni, 2000).

"Since 24,5 million out of the 34,3 million people living with AIDS are in sub-Saharan Africa, we are, potentially, big customers. The market for ARV drugs is here. I do not agree with those who say that the drug companies should just reduce the costs of these drugs. This would be counter productive as it would discourage further research. Instead, I propose that African countries plus the member nations of the Organisation of Economic Cooperation and Development (OECD) countries should combine efforts and reimburse the money that the successful pharmaceutical companies spent on research and development plus a negotiated profit level. Thereafter, the drug companies should lower the prices of the ARV's" (Museveni, 2000).

"Oftentimes, we in Africa wait and expect solutions to our problems to come from elsewhere. Many of us are waiting for a cure for HIV/AIDS to come from somewhere and we are complaining that no one is coming up with a cure soon enough. We, indeed, sometimes impute sinister motives to the lack of innovativeness in the solution of our problems. Are we, therefore, prepared to remain mere objects of history and not its subject? We, too, have our own scientists; the problem is that they are not properly supported in order to arrive at solutions to our problems. This must change. The leadership of Africa must be committed to research and development (R&D). We should commit more resources to R&D, we must carefully rank our priorities and clearly HIV/AIDS research should rank first; we must pool our resources if, need be, and concentrate on a few problems at a time. If we are resolute, we can solve some of our seemingly in-solvable problems. For instance, if all of us pooled our resources and set up one HIV/AIDS Research Centre, we could perform some of the miracles that the big pharmaceutical companies are now performing. We need to have confidence in our scientists and to put them to work. In Uganda, for many years now, we set up an ultra-modern AIDS laboratory that has made it unnecessary to send patients abroad. Together, we can expend this capacity for greater achievement" (Museveni, 2000).

6.8.4 Reasons for reduction in prevalence rates

"In Uganda, where we were once synonymous with HIV/AIDS, we are now counted as a success story and people are coming from all over the world in order to learn from us, and possible, even to emulate what we have done. We really have nothing to offer in Uganda, neither advanced science nor superior health facilities, but we have commitment, leadership and therefore success. The leadership has political will and therefore, we have successfully transformed society, this has brought about behaviour changes, this has been vital to the reduction of infection rates. It is through leadership and political commitment, thorough knowledge of our country, and compassion for our people, that we gave HIV/AIDS a face and eradicated the stigmatisation of people living with AIDS, that enabled us to have brought down the rate of prevalence" (Museveni, 2000).

6.9 REVIEW OF GOVERNMENT POLICY

Information in this section has been taken from the National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1–2005/6 (Uganda, 2000a).

6.9.1 Purpose of the policy framework

The purpose of the National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1–2005/6 is to be able to take the following actions (Uganda, 2000a).

(i) Relate the fight against HIV/AIDS to the development goals and actions plans particularly the Vision 2025 and Poverty Eradication Action Plan (PEAP).

(ii) Bring to the fore the active involvement of all stakeholders in the planning, management, implementation, monitoring and evaluation of HIV/AIDS intervention programmes over the 2000/1–2005/6 period.

(iii) Establish indicators for measuring the progress and impact of HIV/AIDS intervention programmes in the country in order to support decision-making and future planning.

(iv) Provide a basis for costing and mobilisation of resources for HIV/AIDS intervention programmes in Uganda.

6.9.2 HIV/AIDS in government planning

Given the pervasive effect of HIV/AIDS on the social and economic life of the country, and its implications for implementing poverty eradication strategies, the Framework is to be viewed as subordinate and complimentary to key policy documents and action plans to fight poverty in Uganda. These include the Poverty Eradication Action Plan (PEAP), the National Health Policy and the Local Government's Act of 1997 (Uganda, 2000a).

6.9.3 The Poverty Eradication Action Plan (PEAP) and the Uganda Vision 2025

The PEAP is the principle guide to all developmental activities of the central and local governments in Uganda in the medium term. Vision 2025 outlines the national aspirations in the long term and provides the context in which short term plans are drawn up. The PEAP and Vision 2025 sets out the government's commitment to reduce the incidence of absolute poverty, to 10% and relative poverty to 30% of the total population, by the year 2017. The fact that HIV infection rates are still high, poses a serious threat to what has already been achieved in reducing poverty, and poses an obstacle to the realisation of national development goals. Within the context of PEAP, the fight against HIV/AIDS will therefore require a multisectoral approach, and will form an integral part to efforts aimed at poverty eradication and overall developmental activities in Uganda (Uganda, 2000a).

6.9.4 The Local Government Act of 1997

The primary aim of the Local Government Act of 1997, is the decentralisation of governance and service delivery, by devolving certain powers to the district authorities. The central government is responsible for policy, setting standards, and providing guidelines. As a result, some responsibilities for HIV/AIDS prevention and care have also been transferred to the Districts. Recognising the devolving of powers to the Districts, the National Strategic Framework requires the active participation of the various tiers of local government in the planning and co-ordination of the HIV/AIDS activities. As a consequence, the Framework also recognises the potential for variations across the Districts regarding the intensity and nature of the HIV/AIDS problem, and therefore the preferred interventions (Uganda, 2000a).

6.9.5 Goals of the National Strategic Framework 2000/1–20005/6

Given the adverse impact due to HIV/AIDS on health, life expectancy and the socio-economic development, the epidemic also impacts upon the national policy aiming at poverty eradication by the year 2017, therefore, the primary aim of the National Strategic Framework is to contribute to the attainment of these broader goals. The following three aims have been identified as fundamental in support hereof (Uganda, 2000a).

(i) Reduce HIV prevalence with 25% by the year 2005/6.

(ii) Mitigate the health and socio-economic effects of HIV/AIDS at individual, household and community levels.

(iii) Strengthen the national capacity in order to respond more effectively to the epidemic.

6.9.6 Process of drafting the National Strategic Framework

The work of the Eleven Core Groups of Members (CG11) was originated around the thematic areas of prevention, care, mitigation, and research and drew on experts beyond its membership (Uganda, 2000a).

The Strategic Framework for HIV/AIDS 1998–2002, aimed to provide for the formulation and organisation of prevention and care programmes through the attainment of the following seven goals (Uganda, 2000a).

(i) Stopping the spread of HIV infection.

(ii) Mitigating the adverse health and socio-economic impact due to the HIV/AIDS epidemic.

(iii) Strengthening the national, district and lower level capacity to respond more effectively to the HIV/AIDS epidemic.

(iv) Establishment of the national information base on HIV/AIDS.

(v) Strengthening the national capacity to undertake relevant research into HIV/AIDS;

(vi) Providing care, support and protection of rights of PLWA's.

(vii) Reducing the vulnerability of individuals and communities to HIV/AIDS with specific focus on children, youth and women.

Following a period of implementation, it was observed that the policy for the 1998–2002 period had certain shortcomings that necessitated revision. The current Strategic Framework for HIV/AIDS 2000/1–2005/6 is therefore designed to ensure that the duplication of efforts are minimised, it engenders more focussed intervention programmes and the simplification of the programmes for monitoring and evaluation. The Framework also puts HIV/AIDS into the broader context of socio-economic development in which the epidemic is a significant factor (Uganda, 2000a).

The original seven goals were therefore regrouped, as follows, in the Framework 2000/1 to (Uganda, 2000a):

(i) reduce the rate of HIV infection;
(ii) mitigate the health and socio-economic impact due to HIV/AIDS at individual, household and community levels; and
(iii) strengthen the national capacity to respond more effectively to the epidemic.

6.10 IMPLEMENTATION OF POLICIES AND REVIEW OF PROGRESS

Information in this section has been taken from the National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1–2005/6 (Uganda, 2000a).

6.10.1 Goal I: reduce the rate of HIV infection

The implementation of the strategies that flowed from the Framework was done through: (i) effective information and communication campaigns that supported behaviour change; (ii) expansion of Voluntary Counselling and Testing (VCT); (iii) promotion of syndromic and etiologic management of Sexually Transmitted Infections (STI's); (iv) vaccine trials; (v) promotion of antiretroviral therapy; (vi) the use of universal precautions; (vii) safe

blood transfusion in health care settings; and (viii) the prevention of mother-to-child transmission (PMTCT) (Uganda, 2000a).

6.10.1.1 Information and education campaigns (IEC) to promote behaviour change and reduce vulnerability

The provision of intensive HIV/AIDS information campaigns together with making voluntary counselling and testing (VCT) available at community levels has had, to a great degree, a positive impact on the population. The main effects of the IEC and VCT programmes include the following outcomes (Uganda, 2000a).

(i) Increased knowledge on HIV/AIDS. Two in every three persons are able to cite at least two acceptable ways of protection against HIV.

(ii) Increased the usage of condoms, especially among first sexual contacts, from 7% in 1989 to 42% in 1995, particularly in Kampala.

(iii) Reduced the number of sexual partners an individual had. Approximately 57% of women and 64% of men have reported a change in their sexual behaviour by either remaining faithful to one partner or having fewer partners.

(iv) Increased the median age at first sex in girls, with approximately six months, to 16 years of age, between 1989 and 1995.

(v) Established an effective condom promotion strategy, and co-ordination mechanism within the social marketing groups.

6.10.1.2 Constraints

Despite the achievements that have been made thus far, there are constraints that have been identified in the promotion of effective information and education campaigns (IEC) that supports behaviour change. In this regard, the following three constraints have been identified (Uganda, 2000a).

(i) Despite the high levels of awareness that has been attained among the population, it has not been translated into positive change in behaviour mainly due to the existence of inadequate IEC messages and the failure to address the limited personal

perception of the risk HIV infection poses. Only 62% of women and 83% of men managed to change their sexual behaviours due to the threat posed by HIV/AIDS.

(ii) Condoms are still inaccessible and unaffordable to the majority of people, particularly in rural areas, therefore, the costs for the promotion hereof must be balanced with its affordability.

(iii) Various social and cultural obstacles to behaviour change must be addressed.

6.10.2 Goal II: mitigate the health and socio-economic impact of HIV/AIDS at individual, household and community levels

6.10.2.1 Socio-economic support

At an early stage it was recognised that the HIV/AIDS epidemic would result in serious socio-economic consequences due to a changed pattern of public expenditures and a reduction in private savings. The morbidity and mortality rates of the workforce would increase leading to a serious loss of manpower. Although the earlier National Operational Plan, dated 1993, did not provide solutions to these problems, it provided a starting point for addressing them (Uganda, 2000a).

6.10.2.2 Government to help orphans

The government plans to formulate a policy to provide for families supporting orphans. While closing a workshop in Entebbe, in April 2004, Gender Minister, Zoe Bakoko Bakoru, said the government wanted to discourage the institutionalisation of orphans. Minister Bakoko Bakoru said orphans would be helped to settle with relatives and well wishers who could look after them better (Olupot, 2004).

Minister Bakoko Bakoru said the orphan "... situation in Uganda is alarming. Over two million children are estimated to be orphans, the majority oprhaned by HIV/AIDS". In this regard the Minister stated that the plan was ready for approval by Cabinet, pledging to support it and all related programmes (Olupot, 2004).

Participants from seven countries attended the workshop, which resolved to facilitate the dire situation of parents living with AIDS and to help prevent mother-to-child transmission of HIV. They called for real co-operation between their governments and non-governmental organisations (Olupot, 2004).

6.10.3 Goal III: to strengthen the national capacity to respond to the epidemic

Strengthening the national capacity to respond more effectively to the epidemic is vital to the reduction of infection rates and mitigating the socio-economic impact due to the epidemic. A further aim is to safeguard the achievements that have been attained. Two main areas were identified for the strengthening of the national capacity to respond more effectively to the epidemic (Uganda, 2000a).

(i) Mobilisation of resources in order to support building of institutional capacity for effective implementation, co-ordination, monitoring and evaluation of HIV/AIDS activities.

(ii) Providing for more research and making information regarding HIV/AIDS more readily available.

6.10.4 Summary findings and priorities for the period 2000/1–2005/6

The foregoing analysis points to a number of noteworthy developments since the HIV/AIDS disease was first identified in 1982. These changes have implications for future strategies in dealing with the epidemic and it defines the context in which this Framework is to be implemented. A summary of the major findings are presented (Uganda, 2000a), and based on this, a number of priority areas are proposed in section (6.10.4.1).

(i) There has been an overall decline in the HIV seroprevalence rate between 1992 and 1996. However, these rates have become stagnant since 1996.

(ii) Seroprevalence rates have only been determined for special groups e.g. blood donors, VCT clients, antenatal and STD clinic attendees.

6.10.4.1 Priority areas for 2000/1–2005/6

The following areas have been identified for priority attention, these flow from the summary of the major finding (6.10.4) (Uganda, 2000a).

(i) It is important to recognise that the current seroprevalence rate of approximately 10% is still too high. HIV/AIDS must remain high on the national agenda in order to achieve further reduction in HIV infection. Advocacy, IEC and VCT, shall continue to be important strategies in the prevention of HIV infection and mitigation of its effect.

(ii) As a first step toward achieving further declines in HIV infection, more information is required for the design of interventions. This should include knowledge of seroprevalence rates for the general population (men, children, young people, post-menopausal women). This information should be linked to information on the knowledge, attitude, beliefs and practices regarding HIV/AIDS so as to establish the causal mechanisms that are influencing the seroprevalence trends.

6.10.4.2 To reduce HIV prevalence by 25% by the year 2005/6

The goal to reduce HIV prevalence by a further 25% shall be achieved through the following means (Uganda, 2000a).

(i) Promoting behaviour change (abstinence, faithfulness and safer sex) among sexually active populations particularly young people aged 15 – 24.

(ii) Reducing the current 2–4% risk of HIV-infection through blood transmission by at least 50%, by 2005/6.

(iii) Reducing the prevalence of sexually transmitted infections (STI's) with 25%, by 2005/6.

(iv) Reducing the vulnerability of individuals and communities to HIV/AIDS with special focus on children, youth and women.

(v) Reducing the current 15–25% incidence of mother-to-child transmission (MTCT) with 33%, by 2005/6.

(vi) Promoting therapeutic and preventive HIV vaccine development and trials among all sections and age groups of the population.

(vii) Strengthening the national capacity to respond more effectively to the HIV/AIDS epidemic

The strengthening of the national capacity to respond more effectively to HIV/AIDS shall be ensured through the following measures (Uganda, 2000a).

(i) Mobilising all sections of society: government, civil society, and the private sector to refocus and expand political action, financial commitment and other programmes in order to address HIV/AIDS at all levels of society.

(ii) Strengthening the information base on HIV/AIDS at national, district and lower levels of society.

(iii) Strengthening the capacity to undertake research related to HIV/AIDS among all sections and ages of the population.

6.10.5 Co-ordination

6.10.5.1 Mandate, mission and functions of UAC

The Uganda AIDS Commission (UAC) was established by statute in 1992 to oversee, plan and co-ordinate AIDS prevention and control activities throughout Uganda. Members of the UAC are drawn from government ministries, parliament, non-governmental organisations, religious organisations and individuals active in the field of HIV/AIDS. UAC established a national co-ordination structure, which consists of sector ACP's in 13 ministries, and Technical and Advisory Committees. AIDS Co-ordination Committees were also established to oversee the implementation of HIV/AIDS activities at the district and sub-county levels (Uganda, 2000a).

6.10.5.2 Mandate of UAC

Uganda AIDS Commission is an independent agency established by statute of parliament. The Commission has a secretariat, which is responsible for the day-to-day work. The mandate of UAC is to (Uganda, 2000a):

(i) liaise with the line ministry and other ministries on policy issues;
(ii) provide leadership to all partners in the HIV/AIDS response;
(iii) ensure the fulfilment of national goals; and
(iv) ensure co-ordination, monitoring and evaluation of the progress in implementing the national plan.

6.10.5.3 Mission statement of UAC

The Uganda AIDS Commission exists to provide leadership in co-ordination of HIV/AIDS programmes and activities of all stakeholders in Uganda through advocacy, joint planning, and monitoring in order to eliminate the AIDS scourge in Uganda (Uganda, 2000a).

6.10.5.4 Jinja district fails to implement UAC programme

Jinja is one of the districts where people living with HIV/AIDS have not utilised the government funds for the Community HIV/AIDS Initiative (CHAI) programme (Nampala, 2004:7).

Joy Rujojo, an executive member of the National HIV/AIDS Commission, said it is "... disheartening to disclose that district HIV/AIDS officers, Jinja inclusive, have returned CHAI funds to Kampala, claiming that they could not disburse the money because the beneficiaries did not know how to apply for the money and did not have projects". Ms Rujojo was addressing Jinja leaders during a budget conference at the District Hall on 6 February 2004 (Nampala, 2004:7).

Ms Rujojo indicated her regret that while the government continued to extend the Ugandan Shillings 45 million fund to people living with HIV/AIDS in various districts, the beneficiaries were not accessing it due to the negligence of the leaders. In this regard she said it is the "... duty of the district authority to guide and educate these people on viable projects and how to apply for the funds" (Nampala, 2004:7).

6.11 UGANDA TURNS BACK THE AIDS TIDE

A massive government education programme from the early 1990's made Uganda the first country in sub-Saharan Africa to reverse its own AIDS epidemic (Ross, 2003).

In 1984 the then Minister of Health, Dr Ruhakana Rugunda, had faced harsh criticism from fellow African colleagues when he announced at the World Health Assembly that Uganda is being overwhelmed by HIV and AIDS. Dr Rugunda said that African leaders complained that he was portraying "... Uganda and Africa in a bad light by admitting to such an embarrassing disease" (Ross, 2003).

Since 2001 the statistics show that this early openness by the leadership paid off. A report by the Ministry of Health estimated that only 6,2% of the population are infected with the virus. While doubts have been raised over the accuracy of these figures, there has clearly been a fall in HIV prevalence since the early 1990's, and this is evident in localised changes. For example, figures recorded at an antenatal clinic in central Kampala show a drop from 24,5% being HIV positive in 1989 to 8,5% by 2002 (Ross, 2003).

President Museveni made it government policy to be open about HIV and AIDS and he insisted that the topic be included in sex education in schools. The climate of free debate has led young Ugandans to delay losing their virginity, to have fewer partners, and to use more condoms. Among fifteen-year-old girls, the proportion of teenage girls who reported ever having used a condom tripled. The epidemic has been rolled back. Between

1992 and 2002, HIV prevalence among women attending urban antenatal clinics fell almost 30% to about 5% (Guest, 2004:104).

The President's view on sex education is supported by the State Minister for Primary Education, Namirembe Bitamazire, who advised parents to talk to their children about sex, sexuality, and other life skill practices (Kiwawulo, 2004).

This, the Minister said, would help reduce the spread of HIV/AIDS and other sexually transmitted diseases. Bitamazire said the state of health of Uganda's youth requires more involvement on health and education related issues. In this regard she said there are "... still high rates of teenage pregnancies, abortions and sexually transmitted infections out there" (Kiwawulo, 2004).

6.11.1 Eroding stigma

Prof. Francis Omaswa, the director of health services at Uganda's Ministry of Health, is convinced that the government's warning broadcasts worked. But, it was only when the campaigns began to focus on living positively with HIV/AIDS, that, they began to erode stigma and denial. In this regard, the Ugandan musician, Philly Lutaaya, greatly contributed to the efforts of government, by being one of the first people to publicly announce that he was HIV-positive (Ross, 2003).

6.11.2 Easy as ABC

The Ugandan approach has been dubbed the "ABC" strategy, with the emphasis firstly on abstinence, then on being faithful and thirdly on condoms.

Prof. Omaswa, at the Ministry of Health, points out that condoms have not been the main reason for the drop in the HIV rates. He said condoms have "... a place in the control of HIV/AIDS. But more importantly, the sexual behaviour in Uganda has changed. There is more responsible sex – full stop" (Ross, 2003).

However, at Kitante Hill secondary school, Samual Nangira, a member of a club set up by Straight Talk, stated that few teenagers are abstaining from sex, and that they rather prefer to rely on condoms (Ross, 2003).

Graca Machel, wife of President Nelson Mandela, has urged Ugandan authorities to share the lessons they have learnt in the fight against HIV/AIDS with other African states. Uganda has achieved success against AIDS, reducing the HIV infection rate from 30% in 1990 to 5% in 2003 (Sapa-APF, 2003).

Mrs Janet Museveni, wife of the President of Uganda, said to the South African Church Leadership Assembly (SACLA) in Pretoria the most important strategy in the fight against HIV/AIDS is prevention (Skinner, 2003).

Mrs Museveni maintained that success showed prevention to be best strategy against AIDS. Had Uganda decided that only a piece of rubber, a condom, could stand between life and death of an entire continent, they would have been doomed already. Her county's successful campaign against HIV/AIDS was based on this principle / viewpoint (Skinner, 2003).

More than 90% of Ugandans know what HIV/AIDS is, how it is transmitted and how it is prevented. This is, however, head knowledge and to ensure behavioural change by people, they must become convinced of these facts. Her husband, President Yoweri Museveni, declared in 1992 faithfulness to one's spouse and condemnation of pre and out of marriage sex to be the cornerstone of Uganda's AIDS policy (Skinner, 2003).

Mrs Museveni mainly works with young people. She maintained that it was easier to change the youth's lifestyle than to change the embedded lifestyles of adults. This was done mostly through the school system and the mass media. For these efforts to be successful, they must be based on the principles of the Word of God, she said. They established a forum where young people can discuss their frustrations and aspirations

without fear of condemnation. In this regard, many young people had at that stage signed a pledge not to have sex before marriage (Skinner, 2003).

Uganda's HIV infection dropped from 30% in 1990 to 5% in 2002. Janet Museveni said the most encouraging news was that the biggest decrease in HIV was recorded amongst young people (Skinner, 2003).

State Minister for Health, Dr Alex Kamugisha, has said President Museveni did not campaign against the use of condoms at the 2004 XV International AIDS Conference in Bangkok, Thailand. In support of this, Minister Kamugisha told a press conference on 16 July that Uganda was still using the ABC (abstinence, be faithful, condomise) strategy (Odyek, 2004).

Dr Kamugisha said the President "... did not at any one time, campaign against the use of condoms. On the contrary, he said denying condoms to people who need them would be condemning them to death. Condoms save lives if used correctly and consistently". However, he said the condom has never been the primary focus of Uganda's strategic response to the HIV/AIDS epidemic (Odyek, 2004).

Brother Anatoli Wasswa of Banakalori Catholic Brothers Kiteredde in Rakai district has backed President Yoweri Museveni on the promotion of sexual abstinence as the best solution to fight HIV/AIDS. Wassawa said condom use was unreliable. He continued by saying that more people would "... perish if the pro-condom use campaign over shadows the abstinence approach to HIV/AIDS prevention, and the condom use campaign would promote moral decay" (Buregyeya, 2004).

President Yoweri Museveni criticised AIDS activists who prefer condoms to abstinence and faithfulness. He said these people "... are now pushing that the whole world should be condomised, that all relationships should go through the condom" (Ahimbisibwe & Kulubya, 2004).

In this regard the President said the promotion of condoms, without ABC, encouraged people to have sex, and to recklessly go around "tasting", which in the long run could easily expose them to HIV. He maintained people should use condoms as a last resort if they cannot abstain, or remain faithful to one partner (Ahimbisibwe & Kulubya, 2004).

The President cautioned the youth against pre-marital sex and maintained that abstinence was the safest way to avoid HIV/AIDS (Ahimbisibwe & Kulubya, 2004).

Dr Myers Lugemwa, General Secretary of the Uganda Medical Association, said President Museveni was right on abstinence being a key pillar in the prevention of HIV/AIDS during Museveni's visit to XV International AIDS Conference in Bangkok, Thailand, in July 2004. It is a fundamental law in medicine and nature that prevention is better than cure (Lugemwa, 2004).

In this regard Dr Lugemwa (2004) added that the best way to prevent any disease is to completely avoid the scourge. The condom gives a barrier only to those with high uncontrollable sex urge. It does not keep you away from the scourge of infection.

6.11.3 Antiretroviral drugs

While progress has been made in raising awareness, few people living with HIV and AIDS are able to access life-prolonging antiretroviral drugs, even though prices have fallen. Currently the most common drug combination costs US$ 27 a month. An estimated 15,000 Ugandans are taking the drugs, but over 150,000 desperately need them (Ross, 2003).

The Joint Clinical Research Centre is the main supplier of these drugs. Dr Peter Mugenyi, the director, is concerned that without an effective information campaign, the drugs will not be used properly and will become less effective as the virus mutates. Dr Mugenyi warned that people "... need to know that these drugs are delicate and if not used correctly, resistance will occur. That danger is real" (Ross, 2003).

However, a task force from the Ministry of Health has been addressing this very question, but many health professionals maintain the country is not well prepared for a large scale rollout of antiretroviral drugs (Ross, 2003).

6.11.4 Population statistics

The success that Uganda has attained in combating the HIV/AIDS epidemic has had enormous benefits, as seen inter alia in the population growth figure. The Population Reference Bureau (PRB) sponsored a global study on population growth estimates and their findings thereof were released in East Africa during 2003. This report confirms the projections of decline in the populations of South Africa and Botswana and an increase for Uganda as estimated by the United States Bureau for the Census.

The PRB projected Uganda to become the 20th largest country as the population of South Africa shrinks. The population of Uganda is projected to reach 82,000,000 by 2050. This would make Uganda the 20th most populous nation on the planet. The current population of 25,000,000 is expected to increase 226% by the middle of the 21st century. If current trends hold Uganda will rank as one of the fastest growing countries worldwide (Kelley, 2003:11).

The population growth rate in Uganda is expected to outpace that of Central Africa. The PRB report describes Central Africa as "... the fastest-growing region in the first half of the 21st century". Uganda's success in controlling the HIV/AIDS epidemic appears to be the key reason why the country looks set to become a population superpower. Also, the yearly number of births is more than the number of deaths in Uganda, and these are better than both Kenya's or Tanzania's. In addition, the average number of children born to an Ugandan woman during her lifetime is 6,9. This figure is substantially greater than the fertility rates of both Kenya; 4,4 and that of Tanzania; 5,3, respectively (Kelley, 2003:11).

Uganda's expected growth also contrasts sharply with the demographic outlooks for Southern Africa. This regions total population is forecasted to decrease by 22% due to the unrestrained spread of HIV/AIDS. The PRB commented on this phenomenon by saying that it is a "... decline no one would have predicted in the recent past". The percentage loss will be greatest in Botswana, with its current population of 1,600,000 expected to fall by almost 50% over the next 50 years. The estimated shrinkage of the population of South Africa from 44,000,000 in 2003 to 33,000,000 in 2050 could also hold significant political ramifications for the country. South Africa could experience diminishing political and economic importance in Africa. The PRB study show that Uganda should replace France as the world's 20th largest nation worldwide (Kelley, 2003:11).

This trend in growth has also been confirmed by the Ugandan Population Secretariat on 13 September 2004.

Uganda's population grows by a colossal one million people annually and will by 2025 have hit 54,000,000 with the current growth rate of 3,4%. The Uganda Population Secretariat acting director, Charles Zirarema, said on 13 September 2004 that the multiplication is higher than the ideal rate that should be in tandem with the rate of economic growth (Mukasa, 2004a).

Mr Zirarema was addressing the press ahead of the joint launching of the World and Uganda's Population Report at the International Conference Centre. During the launch, the nation will review the plan of action agreed on in September 1994 at the International Conference on Population and Development held in Cairo, Egypt (Mukasa, 2004a).

Mr Zirarema said while the population increases, the nation is not coping with the provision of services like reproductive health to ensure a quality population. He said the fertility rate remained at seven children for the last 30 years. He said surveys indicate that the poor produce more. In this regard he said his office have bad indicators. "The poor are basically reproducing themselves while rich people who have reached secondary school and above have showed interest in having fewer children" (Mukasa, 2004a).

Uganda has dramatically reduced its number of HIV infections. Both reports of the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2003a; 2004) provide clear evidence hereof. In recognition of the gains made by Uganda, President George Bush, on his trip to Africa during 2003, praised Uganda for its ability to effectively deal with the AIDS pandemic (Democrat & Chronicle, 2003:4).

The HIV/AIDS pandemic continued its assault on sub-Saharan Africa in 2002-2003, taking an estimated 2,300,000 lives, infecting an additional 3,000,000 people, and continuing its spread in all but a very few countries (Fleshman, 2004:9). The findings, in an epidemic update, released on 25 November 2003, by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2003), confirms, Africa is still the epicentre of the global crisis. The continent accounts for almost 80% of 3,000,000 fatalities globally and more than 60% of the five million new infections (Fleshman, 2004:9).

The update report contained better news for Uganda, where years of aggressive education and prevention programmes saw infection rates in the capital Kampala drop to 8% from 30% a decade ago (Fleshman, 2004:9).

6.11.5 Life expectancy increases

The life expectancy of Ugandans has shot up by five years from 42 to 47 years. The shift is attributed mainly to the decline in the HIV prevalence from 18,5% in 1991 to 6,2% in 2004. The statistics were contained in the state of Uganda Population report 2004, which was launched simultaneously with the state of the World Population report on 15 September 2004 (Mukasa, 2004b).

The launch, organised by the Ugandan Population Secretariat and the United Nations Fund for Population Activities (UNFPA), was presided over by the second deputy Prime Minister, Henry Kajura, at the International Conference Centre in Kampala (Mukasa, 2004b).

Head of the Population Sercretariat, Director Charles Zirarema, said although the prevalence of HIV had reduced, Ugandans must guard against complacency for it to reduce further. The life expectancy is also related to the increased use of contraception from 15% in 1995 to 23% in 2003. Life expectancy is, however, still low by African and global standards. Uganda has failed to hit the ideal rating because of the abject poverty among the populace, with the poverty prevalence rate at 38% (Mukasa, 2004b).

Mr Zirarema said this means out of the "... 26,3 million Ugandans, 10 million are living in poverty, on less than one dollar a day". He continued by saying poverty was related to and accounted for all other bad indicators: "If I have less than one dollar per day and I have to buy contraceptives, I weigh whether to buy a packet of three condoms or food" (Mukasa, 2004b).

6.11.6 AIDS epidemic report, July 2004

According to the UNAIDS (2004) "Report on the global AIDS Epidemic", released on 21 July 2004, HIV/AIDS estimates for Uganda have been revised downwards. An estimated 4,1% of Ugandan adults aged 15–49 are living with HIV (Wendo, 2004).

The report states that the number of adults and children estimated to be living with HIV is 530,000. It continued by saying that the precise number could be anything between 350,000 and 880,000 adults living with HIV in Uganda. UNAIDS stated that the figures were revised globally because they are using better methods for estimating HIV prevalence, acknowledging that previous figures could have been somewhat over-estimated (Wendo, 2004).

According to the report, (UNAIDS, 2004), at least 24 countries in sub-Saharan Africa now have higher HIV prevalence than Uganda.

See chapter 2, figure 2.4. The prevalence rate in Uganda is still in a "generalised" condition. See table 6.2 "Specific HIV and AIDS estimates and data, Uganda, end 2003" for the state of the epidemic in Uganda. Table 6.2 provides data for adults and children combined, adults (15-49), women (15-49), and children (0-14) at end 2003, and a comparison of these figures as reported at end 2001. The data in table 6.2 is taken from the UNAIDS "Report on the global AIDS epidemic", July 2004.

Table 6.2 follows on the next page.

Table 6.2 Country-specific HIV and AIDS estimates and data, Uganda, end 2003

Estimated number of people living with HIV

Country	Adults and Children end 2003 *Estimate*	Adults and Children end 2001 *Estimate*	Adults (15-49) end 2003 *Estimate*	Adults (15-49) end 2001 *Estimate*	Adult (15-49) rate (%) end 2003 *Estimate*	Adult (15-49) rate (%) end 2001 *Estimate*	Women (15-49) end 2003 *Estimate*	Women (15-49) end 2001 *Estimate*	Children (0-14) end 2003 *Estimate*	Children (0-14) end 2001 *Estimate*
Global Total	37,800,000	34,900,000	35,700,000	32,900,000	1.1	1.0	17,000,000	15,700,000	2,100,000	2,000,000
Sub-Saharar	25,000,000	23,800,000	23,100,000	22,000,000	7.5	7.6	13,100,000	12,500,000	1,900,000	1,800,000
Uganda	530,000	620,000	450,000	520,000	4.1	5.1	270,000	310,000	84,000	97,000

Source: Report on the global AIDS Epidemic (UNAIDS, 2004)

Figures for adults and children combined

See table 6.2. The HIV prevalence rates for adults and children combined have decreased from 620,000 at end 2001 to 530,000 at end 2003: a 14,52% decline in the number of infected people.

Figures for adults (15-49 years of age)

See table 6.2. The HIV prevalence rate for adults (15-49 years of age) has decreased from 520,000 at end 2001 to 450,000 at end 2003: a 13,46% decrease in the number of infected adults.

Figures for women (15-49 years of age)

See table 6.2. The HIV prevalence rate for women (15-49 years of age) has decreased from 310,000 at end 2001 to 270,000 at end 2003: a 12,90% decrease in the number of women infected.

Figures for children (0-14 years of age)

See table 6.2. A decrease is also noticed for children (ages 0-14) from 97,000 at end 2001 to 84,000 at end 2003: a 13,40% decrease in the number of children infected with HIV.

6.12 CONCLUSION

6.12.1 Evaluation

The questions raised in the objectives of the study in chapter 1, together with the meaning of Uganda's leadership and policies concerning HIV/AIDS, may be answered with the assistance of the Secretary-General, Kofi Annan's (2004), address to the XV International

Conference on AIDS, of 11 July 2004. Mr Annan has connected his comments to the document: "Declaration of Commitment on HIV/AIDS", accepted at the United Nations General Assembly, Special Session on HIV/AIDS, 25-27 June 2001 (UN, 2001).

The foregoing issues are best analysed in the form of a list of 14 questions, which the author attempted to answer from the data in chapter 6.

Question 1

Have the leaders demonstrated an understanding of their socio-economic responsibilities due to the impact of the HIV/AIDS epidemic? (Author)

Answer

Uganda is one of the poorest countries in Africa and in the world. Uganda has enacted its policy on HIV/AIDS into legislation. Thereby, everybody is tied into responsibility by the act. President Museveni was the first to connect the AIDS programme with the eradication of poverty and with socio-economic development in order to address HIV/AIDS in a broader perspective. His policy of decentralising the administration of the programme against HIV/AIDS to the districts, is spreading the responsibilities of government to the communities and villages.

Question 2

Are the leaders clear and unambiguous in their role and pronouncements on HIV/AIDS? (Author)

Answer

President Museveni has accepted leadership responsibilities since the start of his presidency. His immediate task in 1986 was to bring HIV/AIDS out into the open and

create a common front in attacking the epidemic. His policy from the start was transparency, honesty, open discussion and focus on prevention based on the policy of ABC "abstinence (behavioural change), faithfulness to one partner, and the use of condoms". Everyone in the country and in government, at all levels, were to be included. Uganda's leadership was the first in Africa to admit that HIV/AIDS is a crisis affecting the country and that assistance was required. The then Minister of Health, stated that Uganda's announcement of the HIV/AIDS threat to the World Health Assembly in 1986 was criticised by other African leaders for admitting that the country had a problem.

Question 3

Did the leaders express policies to demonstrate visionary political leadership at an early stage of the epidemic? (Annan, 2004)

Answer

The outspokenness of President Museveni that abstinence is the only answer to avoid an early death, shows an early grasp of the fundamental aspect of prevention. This position addresses the immoral sexual, cultural and traditional practices. He has also limited the misleading influence of witch doctors by dissemination of information and education about HIV/AIDS. He tried to persuade radical church leaders, who proclaimed that HIV/AIDS is God's wrath on the people for their sins, to reconsider their views. The framework for assistance in the programme against HIV/AIDS also allows for non-governmental organisations (NGO'S), community based organisations (CBO'S) and faith based organisations (FBO's) to operate with little government restriction. President Museveni's leadership led to the Vision 2025, with main goals to improve socio-economic conditions, eradicate poverty and reduce the incidence of HIV/AIDS.

Question 4

Are the leaders taking a strong stand by showing commitment? (Annan, 2004)

Answer

President Museveni has made himself responsible at all times for leading the fight against HIV/AIDS. His approach is hands on, and the Uganda AIDS Commission (UAC) is based in his office. The President demonstrated strength and commitment to address the issues forthright at all occasions, public and official, even at his daughter's wedding. The political leadership in Uganda is totally committed to the elimination of HIV/AIDS and they believe, according to President Museveni (2000), that this has been critical to ensure Uganda's successful response to the pandemic.

Question 5

Have the leaders led by example by breaking the silence on the disease (Annan, 2004)?

Answer

The leadership explained what HIV/AIDS was and what it was not; how the infection spreads; and how it can be avoided. The President called it the good disease because it is, largely, an infection of choice. It is a largely sexually transmitted disease and can, therefore, be avoided through proper sexual behaviour.

The democratisation that is on-going in Uganda also contributes greatly to their awareness campaign. The media, both electronic and print, is completely free and largely private. They are encouraged to join the struggle against HIV/AIDS and they carried very important messages from the fearsome ones such as "AIDS KILLS" to the de-

stigmatising ones such as "DO NOT POINT FINGERS AT PEOPLE WITH AIDS" (Museveni, 2000).

As a result of their awareness campaign, close to 100% of Ugandans know what HIV/AIDS is and how it is spread; the risks involved; and how it can be prevented. There are indications that transformation of positive behaviour change has taken place.

From day one President Museveni insisted on the public discussion of HIV/AIDS in both public and private spheres. This was also a method, together with advertisements, to break down the stigma attached to the disease. He has taken the lead to address the epidemic at every occasion in all his speeches and insisted that his ministers and senior officials do the same. By 2001 the stigma attached to people living with HIV/AIDS virtually evaporated.

Question 6

Do the leaders lead by example by achieving the cultural shift (behavioural change) needed to fight the epidemic effectively? (Annan, 2004)

Answer

President Museveni leads by example. Prevention is his primary goal. His policy of ABC: abstinence, faithfulness to one partner, and use of condoms, is connected with transforming society by changing behaviour. The drastic reduction in the prevalence rate in Uganda has been attributed to the ABC policy and confirmed by experts. Indeed, the social conduct of society has successfully been transformed by effective leadership.

Question 7

Have the leaders led by example by working to scale-up the infrastructure, responses, including the provision of treatment to all those who need it? (Annan, 2004)

Answer

A limitation has been the lack of resources because Uganda is a poor country. Despite this, the network for prevention and care has been effectively organised from national to district level and the people are encouraged to adopt prevention strategies and treatment where possible. The limited budget made little provision for antiretrovirals and other treatments. A policy of "Scale Up" has been implemented to address the epidemic and in addition Uganda was the first country to connect the campaign against HIV/AIDS with development goals. Everyone is also encouraged to report for testing and counselling. A new policy was also adopted in 2004 to improve the plans of attending to orphans due to HIV/AIDS. A challenge to leadership was to prioritise the many competing demands for scarce resources in the fighting of HIV/AIDS. Therefore, leadership in government had to fund the fight against HIV/AIDS by prioritising its different programmes.

Question 8

Does the leadership empower all levels of government, civil society, the private sector, communities, households and individuals to actively participate? (Annan, 2004)

Answer

In Uganda everyone is openly encouraged to participate, both public and private. The President compels senior officials in the central government and at district levels to publicly take the lead against HIV/AIDS. Uganda has also achieved success with the sectoral organisation of government in combating the HIV/AIDS epidemic. All sectors of

society including NGO's, CBO', FBO's and businesses work well together with government to implement policy.

Question 9

Do policies exist to ensure that women have access to prevention and care? (Annan, 2004)

Answer

Uganda has made the provision of prevention and care for women part of its campaign against HIV/AIDS.

Question 10

Do policies exist that empower women and girls to protect themselves against the virus and to provide them with power and confidence in order to transform relations between women and men at all levels of society? (Annan, 2004)

Answer

Most importantly has been the empowerment of women in Uganda. "Today women participate at all levels of governance; and I am happy to report that they have become very assertive of their rights. This empowerment has liberated them from being merely sexual objects. They are now in full control of their lives and can make their sexual choices without coercion. In my view it is very difficult to confront the AIDS problem without empowering women", according to President Museveni (2000).

The policy of ABC assists with transforming relations between men and women. Despite the limited funds the prevention of mother-to-child transmission (MTCT) has been identified as an important area for prevention and treatment, and is a priority.

Question 11

Is government providing adequate national budget to fight and mitigate the impact of the epidemic? (Annan, 2004)

Answer

Uganda has a small budget, therefore a limited network for treatment exists. In this regard, the country relies mainly on foreign aid for funding the government programme, and non-governmental organisations (NGO's) and faith based organisations (FBO'S). However, despite the limited budget, the leadership is committed to prioritise its expenditure to ensure that areas of priority such as HIV/AIDS are incorporated into the budget annually.

Question 12

Is the government on track to reduce the scale and impact of the epidemic by 2005 as promised? (Annan, 2004)

Answer

The adult (15-49 years of age) prevalence rate decreased by 1% from 5,1% at end 2001 to 4,1% at end 2003 (UNAIDS, 2004).

The latest statistics support the trend of the last couple of years that the decrease in prevalence is continuing and is consistent. The country is encouraging the youth segment to change its behaviour. Uganda is one of the best examples in the world of a successful turnaround with limited funding.

Question 13

Are the national prevalence rates of the infected number of people decreasing or increasing? (Author)

Answer

The numbers of infected people are decreasing and especially in the segments of the youth, women and children.

The latest statistics show that the number of adults (15-49 years of age) infected with HIV decreased with 70,000 (13,46%) from end 2001 to end 2003. The number of women (15-49 years of age) infected with HIV decreased with 40,000 (12,9%) from end 2001 to end 2003. The number of children (0-14 years of age) infected with HIV decreased with 13,000 (13,4%) from end 2001 to end 2003 (UNAIDS, 2004).

Question 14

Is the leadership effective in terms of delivering of results? (Author)

Answer

President Museveni is effective in terms of delivering results. This is evident in the decreasing numbers of the rate of prevalence and in the policies that have been implemented to address the socio-economic impact of the epidemic. President Museveni has been included on the short list of nominations for the Nobel Prize for his role and leadership in combating HIV/AIDS.

The conditions concerning HIV/AIDS in Uganda, the second of the three African countries have been investigated. The third country to be investigated is South Africa in chapter 7.

CHAPTER 7

AN INVESTIGATION OF POLCIES AND LEADERSHIP RELATING TO HIV/AIDS IN SOUTH AFRICA

7.1 INTRODUCTION

All three of the African countries have been chosen for an investigation of policies and leadership relating to HIV/AIDS due to the uniqueness of their situation. Uganda is poor and is situated north of the equator. Botswana is small, landlocked but wealthy in African terms. South Africa is the most developed and advanced in Africa.

The purpose of this chapter is to analyse leadership and policies concerning HIV/AIDS in order to determine the effectiveness of the leadership in the transformation of social conduct, in South Africa.

In South Africa, despite all efforts, the HIV/AIDS infection rate has increased significantly over the five-year period, 1995–2000. Estimates suggest that of all people living with HIV in the world, 6 out of every 10 men, 8 out of every 10 women, and 9 out of every 10 children are in sub-Saharan Africa. These figures provide sufficient evidence to make HIV/AIDS both a regional and a national priority (South Africa, 2000c).

Data from the Department of Health's (DOH) annual National HIV Seroprevalence Surveys of Women attending antenatal clinics for the past 10 years, provides a good estimate of HIV prevalence and trends over time in South Africa (South Africa, 2000c).

According to the DOH, (in South Africa, 2000c), the HIV epidemic in South Africa is one of the fastest growing epidemics in the world. The following two groups bear witness to the statement made by the DOH.

(i) Young women aged 20-30 have the highest prevalence rates.

(ii) Young women under age 20 had the highest percentage increase, compared to other age groups in 1998 and 1999.

These and other data clearly indicate that the HIV epidemic is severely affecting the young, black, and economically poor population of South Africa.

The DOH report (South Africa, 2000c) states that in 2000 approximately 3,5 million South Africans were living with HIV. It is estimated that in 1998 over 1,600 people were being infected with HIV daily, this translates to more than 550,000 people infected each year. It is estimated that by the year 2005, there will be six million South Africans infected with HIV and almost one million children under the age of 15 whose mothers will have died of AIDS.

AIDS is currently not a notifiable disease in South Africa and voluntary reporting seriously undermines the estimates of the number of people with AIDS. It is estimated that there were approximately 165,000 people living with AIDS and 120,000 AIDS deaths in 1998. Projections indicate that by 2002 a quarter of a million South Africans will have died of AIDS annually, and that this figure will rise to more than a million by 2008. Average life expectancy is expected to fall from approximately 60 years to 40 years between 1998 and 2008 (South Africa, 2000c).

7.2 PRESIDENT THABO MBEKI AND HIV/AIDS

7.2.1 Official views 1995-2002

AIDS prevention efforts in South Africa since 1990 have been confused. The government had plenty of warning. AIDS came late to South Africa. In 1990, it was a relatively small problem. Less than 1% of South African women in antenatal clinics tested positive for HIV that year (Guest, 2004:105).

Health Minister Manto Tshabalala-Msimang accused former president F. W. de Klerk and his National Government of not responding adequately to HIV and AIDS when they were in power. The ANC-led government was concerned about the remarks made early in October 2004 by De Klerk about South Africa's programme on HIV/AIDS, she said on 5 October 2004 (Sapa & Reuters, 2004:9).

De Klerk was quoted in the media as saying the ANC-led government lost years in the fight against AIDS by not implementing a plan on the issue drawn up by the former health minister in his government. The former president was quoted telling a group of pharmaceutical wholesalers that the "... action plan, as (with) so many other good action plans and policy documents, was left on the shelf to gather dust because, understandably - let me say understandably - there was a wish on the side of the ANC to reinvent the wheel". De Klerk did not detail what the plan might have been (Sapa & Reuters, 2004:9).

Minister Tshabalala-Msimang said AIDS had been a global challenge since it was discovered in the 1980's. She said De Klerk and the apartheid government "... failed to take meaningful action to respond to this challenge". She added the "... ANC and other organisations outside of government had to lead many efforts in responding to the rapid spread of HIV infection in the early 1990's, with former president Nelson Mandela launching the main programme in 1992" (Sapa & Reuters, 2004:9).

The "limited interventions" made by De Klerk's government were not only ineffective, but contributed to perpetrating negative stereotypes and stigma around HIV and AIDS. The Minister said it was only "... after 1994 that tangible efforts were made by the ANC-led government to curb the spread of HIV infection; provide treatment, care and support for those infected and affected; and address the stigma associated with HIV and AIDS" (Sapa & Reuters, 2004:9).

De Klerk noted that few people in the 1980's had imagined the toll that AIDS would take on the country. He said the disease "... has already reduced life expectation from 63 years in 1990 to only 47 in 2004". He added that an estimated 5,6 million South Africans,

or 28% of the country's sexually active population, were HIV-positive: "Many of these people will die within the next 10 years and will leave behind them more than a million orphans" (Sapa & Reuters, 2004:9).

After years of protests by AIDS activists and warnings by doctors, the government announced in August 2003 that it would drop its long opposition to life-prolonging antiretroviral drugs in the public sector and begin making them available to the sick and the dying. But the rollout of the public drug programme has been slow, with a shortage of drugs and poor infrastructure hampering distribution - leading to fresh charges by activists that the government is still not serious about fighting the epidemic (Sapa & Reuters, 2004: 9).

During its first five years in government, 1994-1999, the ANC government did practically nothing. Nelson Mandela, South Africa's first black president, rarely mentioned the disease (Guest, 2004:105). In 1997, Deputy President Mbeki, along with the then-health Minister, Nkosazana Zuma, endorsed an anti-AIDS drug, Virodene, one of the major constituents of this drug was dry-cleaning solvent. The Medicine's Control Council refused to sanction trials of the drug, raising concerns over the methodology and ethics of the drug (Alfreds & Jacobson, 2003:4).

In 1997, the South African government tried to obtain cheaper versions of the AZT drug that was available in most western countries. It was blocked by the world pharmaceutical industry, which took up a law suite against alleged breach of intellectual property rights. But even after the companies agreed to charge lower prices, the government said it was unable to fund the drugs, even if it was only meant for HIV-positive mothers and rape victims (Alfreds & Jacobson, 2003:4).

In 1998 no anti-AIDS posters were seen at all. The only senior member of Mr Mandela's government who tried to do something about AIDS was the Health Minister, Nkosazana Dlamini-Zuma. The Minister was responsible for sponsoring a costly flop of an anti-AIDS musical, which unfortunately promoted a "cure" based on a toxic industrial

solvent, and for purging members from the South African drug-control agency when its members pointed to her failures (Guest, 2004:105).

According to the Joint United Nations Programme on HIV/AIDS report (UNAIDS, 2003a) by 2002, HIV prevalence had risen fifteenfold, making South Africa the country with the most infected people anywhere in the world. Roughly 4,5 million South Africans carried the virus. By way of comparison, this is more than 200 times the number of people who died in political violence during the decade before liberation.

In June 1999, when Tshabalala-Msimang was appointed Minister of Health, she vowed to put her weight behind stemming the tide of the pandemic and was welcomed by the same people who had been marginalised by her predecessor. Towards the end of the 1999, the Department of Health released a five-year plan with a strategy for preventing mother-to-child transmission, (MTCT). However, President Mbeki then made statements about the toxicity of AZT, and in January 2000 a new version of the five-year plan was released and the objective of reducing MTCT was no longer a priority (Alfreds & Jacobson, 2003:4).

Robert Guest (2004:105) states that many people hoped that Mr Mbeki, who succeeded Mr Mandela as president in 1999, would take the catastrophe more seriously. He did, but not in the way anyone expected. After researching the subject, he began to question whether HIV really caused AIDS. He appointed a panel of experts to look into the matter, including some American AIDS "dissidents" (who denied that HIV caused AIDS) and excluding anyone from African countries that had actually succeeded in tackling the epidemic. His health minister, Manto Tshabalala-Msimang, circulated chapters from a book claiming that HIV was concocted by a secret organisation called the Illuminati as part of a conspiracy to wipe out homosexuals, blacks and Hispanics. This baffled South Africans. Some thought that their president was telling them that AIDS did not exist, and concluded that it was therefore allright not to use condoms.

The following statements, in this section (7.2.1), of President Thabo Mbeki and Health Minister Manto Tshabalala-Msimang respectively, have been printed in the Sunday Times, on 10 August 2003, in an article titled "What the government said in the past" (Anon: 2003c:6).

"It is obvious that whatever lessons we have to and may draw from the West about the grave issue of HIV/AIDS, a simple superimposition of Western experiences on African reality would be absurd and illogical. Such a proceeding would constitute a criminal betrayal of our responsibility to our own people. I am convinced that our urgent task is to respond to the specific threat that faces us as Africans. We will not eschew this obligation in favour of the comfort of the recitation of a catechism that may very well be a correct response to the specific manifestation of AIDS in the West. We will not condemn our own people to death by giving up the search for specific and targeted responses to the specifically African incidence of HIV/AIDS", President Thabo Mbeki in a letter to world leaders, April 3 2000 (Anon: 2003c:6).

"Contrary to the claims you make in the promotion of AZT, all responsible medical authorities repeatedly issue serious warnings about the toxicity of antiretroviral drugs, which include AZT", President Thabo Mbeki in a letter to opposition leader Tony Leon, 1 July 2000 (Anon: 2003c:6).

"A virus cannot cause a syndrome. A virus can cause a disease, and AIDS is not a disease", President Thabo Mbeki responding to questions in Parliament, September 2000 (Anon: 2003c:6).

"Indeed HIV contributes (to the collapse of the immune system), but other things contribute as well", President Thabo Mbeki answering questions in Parliament, September 2000 (Anon: 2003c:6).

"There is, needless to say, growing pressure for the use of antiretrovirals on a much wider scale in SA. Our position on this matter is clear: at current prices we simply cannot afford

to give antiretroviral therapy in the public sector", Health Minister Manto Tshabalala-Msimang addressing a conference in March 2001 (Anon: 2003c:6).

7.2.2 Evaluation by President Mbeki's AIDS panel

Despite protracted discussion among panellists, little emerged to suggest that the HIV/AIDS issue had to be radically re-evaluated. However, the Minister of Health, Manto Tshabalala-Msimang, mentioned concern among local health officials about the accuracy of HIV tests. That came, a week after the release of figures by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2000a) that say, South Africa had the highest number of people in the world infected with HIV, this figure is estimated at 4,2 million. A project to evaluate the reliability of the tests used to diagnose HIV/AIDS, would have been carried out over the following few months by Dr Helene Gayle, of the Centre for Disease Control, Dr William Makgoba, president of the Medical Research Council, and the dissident scientist, Dr Harvey Bialy, of the Autonomous National University of Mexico. The project was to be completed by the end of 2000. But orthodox scientists, including Gayle and Makgoba, said they were in no doubt that HIV tests were accurate. In this regard, the Director-General of the Department of Health, Dr Ayanda Ntsaluba, said after the meeting that the department "... is proceeding with its programmes on the basis that HIV is the cause of AIDS. So far, there is nothing to suggest we should be doing otherwise" (Anon, 2000a).

7.2.3 AIDS report fails to settle debate

The government finally, in April 2001, released and responded to the report of the AIDS panel convened by President Thabo Mbeki in 2000 (Cherry, 2001).

The report contained few surprises and had dual (and dichotomous) sets of recommendations, depending on acceptance of the premise that HIV caused AIDS. The panellists met in May and again in July 2000 to consider the causes of the immune

deficiency leading to AIDS, and the best response to the pandemic in a local context (Cherry, 2001).

But the controversial inclusion on the panel of prominent AIDS "dissidents" who believe that HIV is not the causal agent of AIDS precluded the possibility of consensus. The Minister of Health, Manto Tshabalala-Msimang, conceded this the previous week. The government's response, she said, would be to continue with its AIDS programme based on the premise that HIV is the cause of the disease, while supporting the research programme proposed by the panel. In this regard, the Minister in the Office of the Presidency, Essop Pahad, confirmed that government "... will have to await the outcome of further research before we see whether public policy should be adjusted" (Cherry, 2001).

According to Cherry (2001), the reality is that, after almost a year of paralysis resulting from the President Mbeki's flirtation with the dissident movement, the Department of Health (DOH) decided not to wait for the panel's report. In this regard the, Director-General of the DOH, Ayanda Ntsaluba, declared publicly in October 2000 that he believed HIV caused AIDS, and began with the implementation of a pilot programme using antiretroviral drugs to prevent mother-to-child transmission (MTCT) of the disease.

President Mbeki attracted so much criticism for his attitude to AIDS that he eventually said he would "withdraw" from the debate (Guest, 2004:105).

7.3 HIV/AIDS/STD STRATEGIC PLAN FOR SOUTH-AFRICA 2000-2005, MAY 2000

7.3.1 Development of the strategic plan

The development of the plan, "HIV/AIDS/STD Strategic Plan for South Africa 2000–2005", was initiated by the Minister of Health, Dr Manto Tsabalala-Msimang, in July

1999. This was in response to President Thabo Mbeki's challenge, to all sectors of society, to become actively involved in initiatives designed to address the HIV/AIDS epidemic (South Africa, 2000c).

In October and November 1999 task teams met to further develop their goals and objectives. The task teams reviewed information and data from the following sources (South Africa, 2000c):

(i) the National AIDS Plan for South Africa, 1994;
(ii) the Department of Health White Paper for the Transformation of the Health System, 1997 (South Africa 1997);
(iii) the Annual HIV/AIDS/STD review, 1997;
(iv) reports from the September meeting of the Provincial Members of the Executive Councils (MEC's) for Health; and
(v) the National AIDS meeting.

7.3.2 Purpose of the strategic plan

According to the report (South Africa, 2000c), this document is a broad national strategic plan designed to guide the country's response as a whole to the epidemic. It is not a plan for the health sector specifically, but a statement of intent for the country as a whole, both within and outside government. It is recognised that no single sector, ministry, department or organisation is by itself responsible for addressing the HIV epidemic.

7.3.3 Major causes and determinants of the epidemic in South Africa

The immediate determinants of the epidemic include behavioural factors such as unprotected sexual intercourse and multiple sexual partners, and biological factors such as the high prevalence of sexually transmitted diseases (South Africa, 2000c).

The underlying causes include socio-economic factors such as poverty, migrant labour, commercial sex workers, the low status of women, illiteracy, the lack of formal

education, stigma and discrimination. The national HIV/AIDS/STD Strategic Plan must address all these mediate determinants and underlying causes (South Africa, 2000c).

7.3.3.1 Tuberculosis and HIV/AIDS

Closely linked to the HIV/AIDS epidemic, is a Tuberculosis (TB) epidemic which is fuelled by HIV infection and which is also the most frequent cause of death in people living with HIV. In South Africa, approximately 40-50% of TB patients are infected with HIV. In some hospitals in South Africa, the HIV prevalence in TB patients has been recorded as over 70% (South Africa, 2000c).

7.3.3.2 Sexually transmitted diseases

There is compelling evidence of the importance of Sexually Transmitted Diseases (STD's) as a major determinant of HIV transmission. Approximately 11 million STD episodes are treated annually in South Africa, with approximately five million of these managed by private general practitioners. Even without the HIV epidemic, STD's pose an important public health problem (South Africa, 2000c).

7.3.4 Response analysis

A summary of the key responses and constraints include the following (South Africa, 2000c).

(i) In 1992 the National AIDS Co-ordinating Committee of South Africa (NACOSA) was launched with a mandate to develop a national strategy on HIV/AIDS. Cabinet endorsed this strategy in 1994. The goals of this plan were to (a) prevent HIV transmission; (b) reduce the personal and social impact of HIV infection; and (c) mobilise and unify, provincial, international and local resources.

(ii) A South African National STD/HIV/AIDS Review was conducted in 1997 in respect of the goals outlined in the NACOSA plan. This review indicated the following strengths in South Africa's response to the epidemic.

(a) High level of commitment from the Ministry of Health (MOH).

(b) Collaboration initiated by the Department of Health (DOH) at various levels to ensure an interdepartmental and intersectoral response.

(c) Highly motivated and active non-governmental organisations (NGO's) and community based organisations (CBO's), albeit operating with limited resources.

(d) Adequate drug supply and accessibility for STD management in most clinics.

(e) Improvements in TB services.

Among the constraints the following were noted (South Africa, 2000c).

(i) District structures had not been established.

(ii) Lack of integration of STD/HIV/AIDS and Tuberculosis (TB) care.

(iii) Lack of visible commitment outside the DOH to effective interdepartmental implementation of the programme.

(iv) Continued high levels of discrimination and human rights abuses of people infected and affected with HIV/AIDS.

(v) Lack of provincial policies, guidelines or management protocols for comprehensive care and counselling.

(vi) Health promotion materials were not always available in vernacular and were not client sensitive or user friendly.

Following this review of both the strengths and weaknesses in addressing the HIV/AIDS epidemic, the following recommendations were made (South Africa, 2000c).

(i) To increase the resources and to build capacity at provincial and district levels to manage, organise, and implement the HIV/AIDS/STD Programme. Provincial authorities should designate co-ordinators responsible for HIV/AIDS/STD in every Province and District.

(ii) To secure political leadership from the Deputy President and to increase political commitment and public leadership.

(iii) To strengthen interdepartmental and intersectoral response to the epidemic.

(iv) To develop concerted efforts by all stakeholders to protect human rights, counter discrimination and reduce stigmatisation.

(v) To support and strengthen People Living With AIDS (PLWA) initiatives and increase full involvement of PLWA's in programme design, implementation, and evaluation.

(vi) To increase collaboration between the HIV/AIDS/STD and TB programmes.

Subsequent to the South African National STD/HIV/AIDS Review, 1997, certain elements of the recommendations have been addressed by the following actions (South Africa, 2000c).

(i) Appointing HIV/AIDS Co-ordinators in each province and supporting regular training and meetings to facilitate programme implementation.

(ii) Establishing an Inter-Ministerial Committee on AIDS. This Committee consisted of Ministers and Deputy Ministers and met on a monthly basis to discuss HIV/AIDS and provide political direction and policy guidance to the HIV/AIDS & STD Directorate. Late in 1999, after a Cabinet decision to dissolve all Inter-Ministerial Committees and to take issues into the Governance Cluster meetings. In the case of HIV/AIDS this was also facilitated by the creation of the South African National AIDS Council (SANAC).

(iii) Launching the Partnership against AIDS by the President in 1998 that seeks to broaden and formalise the participation by all sectors in the response to the epidemic.

(iv) Developing an HIV/AIDS policy by the Department of Education for learners and educators. This makes HIV/AIDS education a component in the curricula of all secondary schools. Developing other national policies including, the Syndromic Management of STD's and postexposure prophylaxis (PEP) following occupational exposure to HIV.

(v) Establishing the South African AIDS Vaccine Initiative in 1998. This initiative seeks to develop an effective, affordable preventive vaccine for universal use in South Africa and Southern Africa Development Community (SADC) countries by 2005.

(vi) Establishing SANAC, a multisectoral body that will oversee the national response to the epidemic and the implementation of the Strategic Plan. SANAC will be the point of collaboration between government and all other sectors.

(vii) Establishing a national Interdepartmental HIV/AIDS Committee that has worked to develop HIV/AIDS workplace policies and minimum HIV/AIDS programmes for all government departments.

(viii) Developing a Strategic Framework for a South African AIDS Youth Programme.

(ix) Improving collaboration between HIV/AIDS/STD and TB programmes in the area of policy formulation and advocacy.

This Strategic Plan aims to address those recommendations that have not been adequately attended to since 1997, and provides a strategic framework for the country's response to the HIV/AIDS and STD epidemic.

7.3.5 Current structures in South Africa to address HIV/AIDS

7.3.5.1 Cabinet

The Cabinet is the highest political authority in the country. The Cabinet meets weekly, but HIV/AIDS issues are not regularly discussed at this level, as this has been deferred to the South African National AIDS Council (South Africa, 2000c).

7.3.5.2 South African National AIDS Council

The South African National AIDS Council (SANAC) is the highest body that advises government on all matters relating to HIV/AIDS. Its major functions are to (South Africa, 2000c):

(i) advise government on HIV/AIDS/STD policy;

(ii) advocate for the effective involvement of sectors and organisations in implementing programmes and strategies;

(iii) monitor the implementation of the Strategic Plan in all sectors of society;

(iv) create and strengthen partnerships for an expanded national response among all sectors;

(v) mobilise resources for the implementation of the AIDS programmes; and

(vi) recommend appropriate research.

This body is chaired by the Deputy President, and consists of 16 government representatives and 17 civil society representatives (South Africa, 2000c).

7.3.6 Guiding principles

The principles for HIV/AIDS and STD prevention, treatment and care efforts for South Africa have been previously adopted in the National AIDS Plan for South Africa, 1994–1995, and the Department of Health White Paper for the Transformation of the Health System in South Africa, 1997, and are reaffirmed in the Strategic Plan (South Africa, 2000c).

7.3.7 Goals, objectives, strategies and lead agencies

The primary goals are to reduce the (South Africa, 2000c):

(i) number of new HIV infections (especially among youth); and,

(ii) impact of HIV/AIDS on individuals, families and communities.

The following general strategies are stressed (South Africa, 2000c):

(i) An effective and culturally appropriate information, education and communications (IEC) strategy.

(ii) Increase access and acceptability to voluntary HIV counselling and testing (VCT).

(iii) Improve STD management and the treatment of opportunistic infections and promote increased condom use to reduce STD and HIV transmission.

(iv) Improve the care and treatment of HIV positive persons and of persons living with AIDS, to promote a better quality of life and limit the need for hospital care.

The Strategic Plan is structured according to the following four areas (South Africa, 2000c):

(i) Prevention.

(ii) Treatment, care and support.

(iii) Human and legal rights.

(iv) Monitoring, research and surveillance.

In addition, the youth will be broadly targeted as a priority population group, especially for prevention efforts (South Africa, 2000c).

7.4 MANAGING THE IMPACT OF HIV/AIDS IN SADC, AUGUST 2000

7.4.1 Socio-economic setting

The SADC has a total population of 191 million people, with an average gross national product (GNP) per capita of US$ 1,096. This average GNP figure masks great inequalities within the region, with Botswana, Mauritius and South Africa having a figure of over US$ 3,000; while countries like the Democratic Republic of Congo, Malawi, Mozambique, and Tanzania have less than US$ 200. This gap in GNP per capita for the region, US$ 80-3,380, has major implications on the availability of resources to support development efforts, including the financing of health services and various measures needed to combat the impact of HIV/AIDS (South Africa, 2000d).

7.4.2 Initiatives in SADC countries

During 2000, South Africa was both the chair of and the host of the Health Desk of SADC, which has 14 member states: Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe (South Africa, 2000c).

In December 1999, the Southern Africa Development Community (SADC) HIV/AIDS Task Force, adopted the vision of "A SADC Society with reduced HIV/AIDS" to guide the work of the seven sectors participating in the development and implementation of a multisectoral SADC HIV/AIDS Framework for the period 2000-2004. This vision led to development of the overarching goal of "... decreasing the number of HIV/AIDS infected and affected individuals and families in the SADC Region so that HIV/AIDS is no longer a threat to public health and to the socio-economic development of Member States". This goal provides guidance to all SADC sectors in the formulation of their responses to the epidemic (South Africa, 2000d).

According to the SADC report (South Africa, 2000d), the health sector has over the last two decades provided much of the leadership in the HIV/AIDS response and has advocated a strategy that addresses the HIV/AIDS epidemic through the efforts of the health care system, communities, youth, the private and public sector and other stakeholders in society. This multisectoral HIV/AIDS framework recognises that the wider participation of all sectors and communities (including youth, women and children) in the HIV/AIDS response is likely to lead to enhanced synergism and compliment efforts for achieving greater impact.

The main strategy being pursued in the SADC framework, "Managing the impact of HIV/AIDS in SADC", is to promote the re-allocation of responsibilities for planning, co-ordination, implementation and monitoring and evaluation of the HIV/AIDS response across the social and economic sectors of SADC, consistent with the specific mandates and comparative advantage they enjoy. In this manner, the response will become increasingly multidisciplinary and multisectoral in character, and take on a more regional flavour (South Africa, 2000d).

Overall, the strategic framework is guided by Article 10 of the SADC Health Protocol within which all SADC sectors use their comparative advantage to address the needs of those sectors and communities they serve; Transport, Mining, Tourism, Human Resources, Information, Culture and Sports, Labour and Employment, and Health. The

underlying strategy of this Framework is to assist each sector in building its own capacity, so that it can develop, implement and monitor an effective HIV/AIDS programme – supported by the Health Sector Co-ordinating Unit (South Africa, 2000d).

7.4.3 Situation analysis of HIV/AIDS in the SADC region

The Southern Africa Development Community (SADC) region faces a very severe HIV/AIDS epidemic. The current extent of the pandemic has affected virtually every aspect of the lives of the people in the SADC region and has now reached crisis proportions. Since the mid-1980's when HIV/AIDS was identified in most countries of the region, there has been a rapid increase in the numbers of adults and children infected with, and dying from HIV and AIDS, with a corresponding adverse impact on the socio-economic development of the region. HIV/AIDS is now arresting or even reversing the major socio-economic gains of the past two decades in such areas as health, agriculture and education. Health care systems are overwhelmed with HIV/AIDS patients with the result that health workers are overburdened, health care costs are escalating and acute conditions are being "crowded out". Conditions such as tuberculosis (TB) which were almost being brought under control in the 1970's have re-emerged as a result of the HIV/AIDS epidemic, further straining the over stretched health care systems (South Africa, 2000d).

The demographic impact of HIV/AIDS in the region has also been serious: life expectancy has dropped significantly to approximately 40-50 years, child and adult mortality rates have risen, while the number of orphans continues to increase at an unprecedented rate (South Africa, 2000d).

From the epidemiological surveillance of HIV/AIDS in the region, it is not uncommon to find HIV seroprevalence rates in excess of 20% or more in the adult population in most urban areas of the SADC region. This in essence means, that a large number of productive and skilled men and women will lose their lives prematurely to HIV/AIDS, with dire consequences for the socio-economic development of the region. Yet, the full

impact of HIV/AIDS is still to come, because of the prevailing high levels of HIV infection in the communities, which will ultimately translate into AIDS patients requiring care and social support (South Africa, 2000d).

The characterisation of HIV/AIDS "as a disease of sub-Saharan Africa" is aptly demonstrated by the following facts available from the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2000a).

(i) The region has registered a total of close to four million deaths, which have left behind nearly three million orphans.

(ii) The estimated total number of AIDS cases in the region is four million, leaving another estimated six million who are HIV-positive and likely to develop AIDS.

(iii) There are about 10 million citizens living with HIV/AIDS (5% of the total population) in the region.

According to the UNAIDS (2000a), report it is estimated that the region has an average adult prevalence rate of 12% (which would mean close to 10 million people are affected by HIV/AIDS in this region).

HIV/AIDS is therefore a major burden and challenge to the health, social, and economic development of the region. There can therefore be no meaningful development in the SADC region as long as HIV/AIDS is not addressed on an urgent and emergency basis, and justifiably so, the SADC Ministers have identified HIV/AIDS as a crisis that requires a multidisciplinary and multisectoral approach. This entails forging strategic partnerships and alliances across public and private sectors, and civil society (South Africa, 2000d).

7.4.3.1 Health status in the region

The HIV/AIDS epidemic has begun to adversely affect the health status of people in the SADC region. The health indicators have also begun to deteriorate. While the region has registered a steady improvement in the provision of safe water supplies and sanitation facilities during the last decade, the challenge of high morbidity and mortality rates

remains. Infant mortality rates in the 1980-1997 period only dropped from 109 to 92 deaths per 1,000 live births, while maternal mortality rates in the same period remained at 634 per 100,000 live births. Prevalence of malnutrition among the under-fives was around 25% during the 1990's, and under-fives mortality rate were 146 per 1,000 live births. The population in the region, with a relatively heavy burden of illness and poor health, is now faced with an even more menacing and growing AIDS/TB co-epidemic (South Africa, 2000d).

The prevalence of communicable but preventable diseases is high in the SADC region and the advent of HIV/AIDS has further complicated the prevention efforts of these diseases. Also, of particular importance and significance, is the emergence or re-emergence of tuberculosis as a major public health and socio-economic problem, that threatens the lives of hundreds of thousands of people in the SADC region. Despite efforts by governments in the region over the last decade to address HIV/AIDS and its effects, the pandemic still constitutes the single biggest threat to health within the SADC (South Africa, 2000d).

7.4.4 HIV/AIDS response analysis in the SADC region

Member States in the SADC region have been implementing HIV/AIDS programmes since the mid-1980's in order to (i) prevent or reduce the transmission of HIV and other STD's and (ii) reduce the socio-economic impact of HIV/AIDS among individuals, families and communities (South Africa, 2000d).

In the early stages of the epidemic, many countries were guided in the implementation of HIV/AIDS Programmes by the World Health Organisation's (WHO) Global Programme on HIV/AIDS (GPA) which was later incorporated into the United Nations Joint Programme on HIV/AIDS (UNAIDS), in 1996.

The early HIV/AIDS response was mainly centred on raising awareness of HIV/AIDS through information, education and communication (IEC) campaigns and communication

for behavioural change (abstinence, mutual faithfulness), condom promotion, treatment of STD's as well as clinical and home-based care. These early approaches were predominantly medical and health-focused in nature and largely neglected the participation of other sectors in the response. In addition, it emerged that there was (and there still is) the challenge of narrowing the gap between knowledge and behaviour (South Africa, 2000d).

7.4.5 Sector strategies

7.4.5.1 Culture and information sector

The economic imbalances amongst the member states in the region, as well as improvements in transport and communication infrastructure, have contributed to easy movements of people, who, among other reasons, are in search of better employment and economic opportunities. Within the boarders of the individual member states, evidence is found of rural – urban migration. This is mainly pronounced amongst the youthful generation, which also migrate to urban and/or industrialised places in search of better economic opportunities. Such migrations have resulted in population explosions in urban areas often resulting in squatter settlements. The results of this is poverty, lack of educational opportunities, prostitution, crime, drug and substance abuse which are all predisposing factors to contraction and spread of HIV/AIDS (South Africa, 2000d).

Anecdotal evidence suggests that there are traditional practices that have been associated with facilitating the spread of HIV/AIDS. Most societies have a negative attitude towards people living with HIV/AIDS. There is a big stigma attached to those people infected by the virus and they often suffer from social alienation. However, culture has a key role to play in the development of positive attitudes towards HIV/AIDS infected and affected individuals at any stage of the disease (South Africa, 2000d).

7.4.5.2 Tourism sector

Tourism is a major earner of foreign exchange and provides both direct and indirect employment opportunities. The region has set aside nearly 10% of its land as protected areas – where tourist resorts are found in the form of national parks. The World Bank (2000a), "World Development Report", show figures that each tourist brought US$ 384 to the region, although there are wide variations between countries with low volume and those receiving high volumes of tourists. Of the 10,6 million tourists who came to the region, half went to South Africa and 20% to Zimbabwe. Therefore, nearly 75% of all tourists to the region have South Africa and Zimbabwe as destination (South Africa, 2000d).

In line with evidence from available statistics, the message to tourists and the local population will be "avoid unprotected sexual encounters, and preferably avoid sex altogether". For this reason, the SADC strategy will involve regional tourism bodies in mounting campaigns aimed at (South Africa, 2000d):

(i) educating tourists on the availability of health facilities that are of acceptable standards in the region;

(ii) equipping tour-operating companies with skills and information to promote safe sex among tourists and local populations; and

(iii) promoting safe sex awareness among all workers in this sector.

7.4.5.3 Transport sector

With a region as vast as the SADC and given the historical migration of populations in search of economic opportunities, transport is an important sector for socio-economic development. The importance of railways is for instance even captured in popular music describing the role of trains in bringing people together. With several members of SADC being land-locked, there is a particular importance attached to roads, rail and air travel in the region. For those countries with a coastline, transport has had the added impact of

maritime trade (with sailors and traders from all over the world having used these ports over the last 500 years). Disease and trade have come with travel, and this sector is particularly important in promoting transnational awareness on measures aimed at curbing the spread of HIV/AIDS (South Africa, 2000d).

7.4.5.4 Transit settlements need prevention strategies

Everjoice Win, the international gender co-ordinator for Action Aid, revealed that Southern Africa's notoriously porous borders and the border settlements have increased the regional spread of HIV/AIDS. Speaking at a conference on HIV/AIDS and poverty in Pretoria, she emphasised that women were most at risk of infection and, therefore, continued by saying the rights of women need to be protected. In this regard Ms Win added, that prevention strategies needed stronger messages to empower women to change their lives, "we must create a sense of awareness among women as to their rights regarding HIV" (Venter, 2004a:5).

Lovemore Mhuriyengwe, director of Project Support Group (PSG), a non-governmental organisation specialising in HIV/AIDS research, said regional mobility played a major role in transmission. Mhuriyengwe stated a study by "... PSG has shown that border towns and migrant-labour transit towns have high HIV rates". In this regard he said social conditions in the border towns acted as a catalyst for the spread of the pandemic; "borders often juxtapose rich and poor countries and communities, creating economic inequalities that often attract poor rural communities, particularly women". Mhuriyengwe pointed out that these circumstances created an environment for commercial sex. He said men "... passing through these settlements have money and are surrounded by low-income, largely female communities. These men often seek commercial sex, and the women provide it" (Venter, 2004a:5).

Studies in South Africa have shown that border and migrant community settlements have a high prevalence of HIV/AIDS. The border town of Musina, a major point of exit and entry for Southern Africa in the Limpopo province, has a HIV rate in pregnant women of

more than 20%, compared with the provincial figure of approximately 14%. In this regard Mhuriyengwe said countries "... that share borders with South Africa show a similar pattern, which is a concerning trend in terms of HIV transmission". He added that HIV prevention programmes were urgently required among low-income women in these communities (Venter, 2004a:5).

7.4.6 Employment and labour sector

The HIV/AIDS pandemic has had a tremendous impact on the demand and supply of labour in the Southern African Development Community (SADC) region, and the pandemic has affected the employment and labour sector in several ways, they are as follows (South Africa, 2000d).

(i) Negative trends of employment figures due to the impact of HIV/AIDS.
(ii) Identification of particular labour practices that persists and is considered an obstacle to the tackling of HIV/AIDS pandemic.
(iii) Negative trends in labour productivity in the region due to the impact of HIV/AIDS.
(iv) High costs of managing HIV/AIDS in the workplace (absenteeism, medical costs and funerals).

Regional integration in the context of the global economy is also influenced by the availability of labour, and SADC has a history of large-scale labour migration coupled with the relatively free movement of people. One benefit has been that there are fairly common labour practices in the region, which should make it easier to share strategies, be it in the organisation of labour or in the provision of services to workers. This is the context within which a common HIV/AIDS Code is being approached, and forms an important strategy for the employment and labour sector, which has to effectively implement the Code in all member countries (South Africa, 2000d).

Even before the advent of AIDS, the region had a relatively high proportion of children in the 10-14 age group active in the labour force. According to the World Bank (2000a), "World Development Report 1999/2000", 30% of the population in the 10-14 age group

was part of the labour force in 1980, and this figure has only dropped to 24% by 1998. The proportion of women active in the labour force has over the last two decades remained at 44%. The major change in this region, has been the growth in urbanisation, with the population living in urban areas having risen from 22% in 1980 to 37% in 1998. These changes have had a major impact on the way the HIV/AIDS problem has developed in the region (South Africa, 2000d).

According to the report "Managing the impact of HIV/AIDS in SADC", (South Africa, 2000d), the following impacts is seen on the employment and labour sector due to HIV/AIDS.

(i) Increased use of child labour due to loss of adults.
(ii) High attrition and loss in the labour force.
(iii) Reduced labour productivity.
(iv) Increased costs to employer and government.

7.4.7 Leaders pledge to fight AIDS

At a summit in Dar-es-Salaam in August 2003, the leaders of the Southern African Development Community (SADC) pledged to fight HIV/AIDS and adopted a road map to accelerate the flagging economic integration of their peers (Independent Foreign Service & Sapa-AFP, 2003:14).

According to Tanzanian President Benjamin Mkapa, the leaders approved an HIV/AIDS framework and programme of action for 2003 to 2007, that offers them "... a measurable target against which our efforts, actions and successes, or lack thereof, will be measured (Independent Foreign Service & Sapa-AFP, 2003:14).

Tanzanian President Mkapa said at the summit's opening in Dar-es-Salaam, in August 2003, that AIDS was among the biggest threats to the regional grouping's member states, as about 14 million people are infected with HIV/AIDS. He stated that the "... region is the epicentre of the AIDS scourge" (Independent Foreign Service & Sapa-AFP, 2003:14).

7.5 GOVERNMENT'S RESPONSE TO HIV/AIDS – SINCE FEBRUARY 2003

President Thabo Mbeki said in Cape Town at the opening of Parliament, in February 2003, that the government would continue to implement its "... comprehensive HIV/AIDS strategy". The two sentences the President pronounced about the disease, while more than 10,000 people massed outside the Parliament building to demand treatment for people with HIV/AIDS, did little to convey the impression of a caring government committed to helping the estimated 4,5 million of its citizens living with the disease (Health E-News Service, 2003).

The Treasury and the Health Department were examining the cost of introducing antiretroviral drugs in public health and were expected to report back on this during April/May 2004. But there are still serious shortcomings in the implementation, particularly as regards treatment and care (Health E-News Service, 2003).

Voluntary counselling and testing (VCT) for HIV/AIDS is internationally recognised as being the best method to both prevention and treatment. However, most South Africans taking the test are not motivated by a desire to take control of their own destiny. They are either pregnant, and being offered the anti-AIDS drug Nevirapine, or have been sent by doctors for testing. Yet, voluntary counselling and HIV testing forms the cornerstone of South Africa's national AIDS plan. This is vital if people are to take individual responsibility for their own health and sexual practices (Health E-News Service, 2003).

Dr Olive Shisana, an executive director of the Human Sciences Research Council (HSRC) and former director-general of Health, stated that the gap "...between policy and implementation is at the heart of the problem of the AIDS crisis in the country". In this regard Dr Shisana said if all "... the elements of the (national HIV/AIDS plan) were implemented, South Africa would be well on its way to managing this epidemic". She continued by saying that she found no censure of those departments and provinces that

were failing to implement the plan. Mpumalanga was a perfect example. The province's once-effective HIV/AIDS programme lied in tatters and there was evidence of widespread abuse of funds, while its then Health MEC, Sibongile Manana, consistently obstructed the dispensing of antiretroviral drugs (Health E-News Service, 2003).

In this regard the actions of the Minister of Health is also found lacking. Instead of reprimanding the Health MEC, Manana, Health Minister, Dr Manto Tshabalala-Msimang, recently said she would "... go to prison with her", if Manana were jailed for failing to rollout the provision of Nevirapine to pregnant HIV-positive women and their babies, as ordered by the Constitutional Court (Health E-News Service, 2003).

However, within days of Minister Tshabalala-Msimang's irrational backing of the anti-antiretroviral MEC, the Minister had very positive discussions with three universities about government input into a planned antiretroviral study. In February 2003 the Minister met the vice-chancellors of the universities of Natal, Cape Town and Witwatersrand to discuss whether government concerns could be incorporated into planned research into providing antiretrovirals to people with HIV/AIDS in resource-poor settings (Health E-News Serive, 2003).

The Health Minister further commented on the antiretroviral therapies by saying:

"It's not just antiretrovirals... we've got traditional medicines that we know actually averts AIDS related diseases and one of it comes here from the North West ... we are studying it with the Medical Research Council of South Africa and we are seeing excellent results", Health Minister Manto Tshabalala-Msimang, July 2003 (Anon: 2003c:6).

"We have a responsibility to guide those who implement an antiretroviral therapy programme to ensure that it is done properly and not in a populist manner", Health Minister Manto Tshabalala-Msimang addressing a mining summit on HIV/AIDS, May 2003 (Anon: 2003c:6).

"Yes, there is a casual link between HIV and AIDS, but everybody who tests positive is not necessarily dying of AIDS. Testing HIV-positive is not a death sentence", Health Minister Manto Tshabalala-Msimang on the government's preference for separating HIV from AIDS (Anon: 2003c:6).

The battle lines have been drawn in this country over antiretrovirals, both because of the government's convoluted, secretive and slow approach to treatment issues and because of lobbying by the Treatment Action Campaign (TAC). The TAC has vowed to launch a "... peaceful civil disobedience campaign", unless the government announces a national antiretroviral treatment programme. The organisation has been particularly angered by the breakdown in negotiations between business, government, labour and community organisations over a "... national framework agreement on the prevention and treatment of HIV/AIDS" (Health E-News Service, 2003).

The government has shown clear preference for the South African National AIDS Council (SANAC) to be the clearing-house for HIV/AIDS programmes and even decision-making, rather than or any other body. Despite the fact that the SANAC excludes key stakeholders such as the TAC, it has become the organisation responsible for approving all South African applications to the Global Fund to Fight AIDS, tuberculosis and malaria. Responsibility for the Council lies with Deputy President Jacob Zuma, who had been tied up for months with the Rwanda peace talks. In reality, the Department of Health runs the day-to-day affairs of SANAC. Promises to make the body more representative and to ensure it has dedicated staff, have yet to materialise. Unless a powerful body fills the leadership vacuum on HIV/AIDS, citizens are likely to continue to be bewildered, depressed and angered by leaders who do not know how to drive and co-ordinate policy (Health E-News Service, 2003).

7.5.1 Government's change of heart

The government, lead by President Thabo Mbeki and Health Minister Manto Tshabalala-Msimang, spent five years procrastinating over providing life-saving drugs. The government wavered between declaring drugs like AZT and Nevirapine, used with success to prevent mother-to-child transmission (MTCT), highly toxic and saying it could not afford to make the medicines widely available (Alfreds & Jacobson, 2003:4).

During August 2003, the government stated that antiretrovirals do help improve the quality of life of those suffering from AIDS, and will therefore make them available at public hospitals. Following are some of the government actions in the last five years.

In 2000, President Mbeki started questioning whether HIV caused AIDS, and said discussion on the causes was necessary. The President established an advisory committee/panel of AIDS dissidents and mainstream scientists in 2000. In April 2000, the President wrote to world leaders contrasting the spread of the disease in Africa through heterosexual contact to that in the West, where it first emerged in gay communities in the United States of America. Calling for an "African solution to an African problem", the President said that the South African government would not "... condemn our own people to death by giving up the search for specific and targeted responses to the specifically African incidence of HIV/AIDS". In July 2000, President Mbeki opened the 13th International AIDS Conference in Durban, saying that all South Africa's problems could not be blamed "... on a single virus" (Alfreds & Jacobson, 2003:4).

By the end of 2001, the government announced its decision to appeal against a High Court order that directed state health authorities to make Nevirapine available at all public health facilities. This was after the Treatment Action Campaign had taken the Government to court in August 2001 for its refusal to provide antiretroviral drugs in state hospitals. The Minister of Health, Manto Tshabalala-Msimang, said the decision to appeal against the court order was not because "... we are against protecting babies from

HIV", but because government felt it was wrong that the judiciary was dictating policy (Alfreds & Jacobson, 2003:4).

In April 2002, under immense pressure, the government announced widely applauded plans to extend its provision of the drug beyond 18 existing pilot sites. But, government said that it would continue with its legal fight in order not to provide antiretroviral drugs. In July 2002, the Constitutional Court ordered that Nevirapine had to be provided in State hospitals to reduce the risk of mother-to-child transmission of HIV/AIDS. The government asked the court to rule on the matter after the Pretoria High Court had ruled three times that government must allow for national use of Nevirapine for pregnant mothers (Alfreds & Jacobson, 2003:4).

In January 2003, Finance Minister, Trevor Manual, told the World Economic Forum that South Africa would not be seeking money from the Global AIDS Fund, because the problem was not cash, but the lack of infrastructure to deliver treatment. Also in January 2003, the Anglican Archbishop of Cape Town, Njongonkulu Ndungane, slammed the government for "sinning", by withholding truth and maintaining the "silence of denial" over AIDS. In February 2003, former president Nelson Mandela, entered the debate over the government's AIDS policies by meeting the ruling ANC leadership to press for an end to the delay in provision of antiretrovirals. Mr Mandela told the Sunday Times, that the fight against Aids "... is a war. It has killed more people than has been the case in all the previous wars and in all the previous natural disasters. We must not continue to be debating, to be arguing, when people are dying" (Alfreds & Jacobson, 2003:4).

On 7 August 2003, the government finally put an end to its 18-month delay in signing an agreement with the Global Fund to Fight AIDS, Tuberculosis and Malaria, giving South Africa access to US$ 41 million for the fight against the pandemic. On the same day, the Minister of Health, Tshabalala-Msimang, issued a conciliatory statement acknowledging that antiretrovirals "... can help improve the condition of people living with AIDS". The statement was a major departure from earlier pronouncements in which the Minister indicated that she doubted the efficacy of the drugs (Alfreds & Jacobson, 2003:4).

7.5.2 AIDS drugs approved, 8 August 2003

On 8 August 2003, Cabinet announced it had asked the Department of Health to prepare a plan for the provision of AIDS drugs by September 2003 (Alfreds & Jacobson, 2003:4).

A momentous day in South Africa's history was celebrated with the news that thousands of people affected by the deadly AIDS virus would get life life-prolonging antiretroviral treatment. The long awaited decision, taken at a special Cabinet meeting, 8 August 2003, comes after years of acrimony between the government and activists. This decision signalled an important official change in South Africa's approach to AIDS, which had infected an estimated, 4,7 million people in the country, the highest number in the world (Clarke & Terreblanche: 2003:1).

At that time, more than half-a-million people are believed to have died from AIDS-related opportunistic diseases and approximately 500,000 people require antiretroviral therapy to enhance and prolong their lives (Clarke & Terreblanche: 2003:1).

7.5.3 Massive demand for treatment

The health department faced the task of complying with the Cabinet's instructions to develop a strategy on how the antiretroviral drugs were to be distributed to the HIV-positive people who needed them. That would be the biggest treatment plan in the world, according to Dr Eric Goemare, the South African head of Médecines Sans Frontiéres. Dr Goemare said certain "... provinces, such as KwaZulu-Natal and Gauteng, were years ahead of provinces like the Eastern Cape. The Western Cape ... already has concrete plans for 15 antiretroviral sites for adults and another six or seven for children" (Kahn, 2003b:3).

The financial resources required were immense. A joint health department and treasury task team estimated for providing a comprehensive package of care and treatment to just

50% of the 120,000 people who would be clinically eligible for antiretroviral medicines in 2008, would incur an annual bill of between South African R 9,6 and R 10,5 billion (Kahn, 2003b:3).

Health Minister, Manto Tshabalala-Msimang, promised to meet the September 2003 deadline for a rollout plan of antiretroviral drugs (Altenroxel, 2003c:7).

Dr Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), maintained that the new initiative will make South Africa's fight against AIDS truly comprehensive, with treatment complementing prevention efforts. The decision followed similar moves by Rwanda, Malawi and Mozambique, among others (Altenroxel, 2003d:3).

7.5.4 Ex-president Nelson Mandela's support for treatment

Former President Nelson Mandela joined millions of people around the country in welcoming the government's U-turn on rolling out antiretroviral drugs. Prof. Jakes Gerwel, Chairman of the Nelson Mandela Foundation, said that both the organisation and Mr Mandela, who had criticised the government for delaying providing the drugs, were "overjoyed" by the government's announcement, 8 August 2003, (Bezuidenhout et al., 2003:1).

The government announced that it had given the Minister of Health, Manto Tshabalala-Msimang, until the end of September 2003 to develop a detailed operational plan for rolling out antiretroviral drugs. Prof. Gerwel described the government's directive as great news for the millions of people living with HIV/AIDS. He stated that the Nelson Mandela Foundation had not campaigned vigorously in the previous months for anti-AIDS drugs, because, it had become aware of the government's intention to provide them (Bezuidenhout et al., 2003:1).

Joining Mandela in celebrations were other outspoken critics of the government's AIDS policy, including Constitutional Court Judge Edwin Cameron and activists Gail Johnson and Zackie Achmat. Judge Cameron, who is HIV-positive, said he was "elated and optimistic" at the announcement, which is seen as an "irreversible commitment by government". He thought that it was going to translate within months into many lives being saved. Still, there was a long, hard road ahead and at least South Africa had then embarked on it. Gail Johnson, whose adopted son Nkosi, died of AIDS, said her son "... Nkosi would be over the moon. For him it was imperative that people lasted longer and did not die". Zackie Achmat, of the Treatment Action Campaign, said the announcement represented "... hope for the first time in four years" (Bezuidenhout et al., 2003:1).

The Cabinet's decision to adopt the recommendations of the Joint Health and Treasury Task Team, that antiretroviral drugs be made available at public hospitals to those who need them, came after a period of progress in the fight against AIDS. The Cabinet said, 8 August 2003, it had noted the task team's assertion that the government's primary challenge "... is to ensure that the 40 million South Africans who are not infected with HIV stay that way; and that those who are infected, but have not as yet progressed to an advanced stage of AIDS, lead a normal life through proper nutrition". The report stated that: "The introduction of antiretroviral therapy would have a significant impact on AIDS mortality, reducing considerably the number of deaths from AIDS during the next decade". The report further stated, that providing drugs to everyone who needed them would result in 1,7 million deaths being deferred until 2010 (Bezuidenhout et al., 2003:1).

The Democratic Alliance (DA) and Inkatha Freedom Party (IFP), both vocal critics of the government's AIDS policies, said they "cautiously" welcomed the announcement, but warned that they would monitor the government's actions closely. The DA's health spokesman, Mike Walters, MP, said it is "... unfortunate that it has taken this long to have positive reaction from the government. Their decision has everything to do with elections next year (2004)". However, government spokesman, Joel Netshitenzhe, dismissed the DA's remarks as "nonsensical", saying the decision was a result of "a

logical evaluation" of the government's approach to the epidemic (Bezuidenhout et al., 2003:1).

7.5.5 Comments by X. Mangcu, executive director of the Steve Biko Foundation

Dr X. Mangcu said: "I remember the sense of excitement I felt when President Thabo Mbeki seemed to suggest a shift in government's dilly-dally on HIV/AIDS in his state of the nation address in February 2002. I was lyrical about how President Mbeki had risen to the challenge of taking us out of the quagmire of whether HIV actually causes AIDS" (Mangcu, 2003:12).

"Brilliant, absolutely brilliant", he exclaimed. However, a fortnight later the African National Congress came down like a ton of bricks on Gauteng premier Mbhazima Shilowa for suggesting an expanded HIV/AIDS programme in his province (Mangcu, 2003:12).

No sooner had the cabinet made its decision this time around than Minister of Health, Manto Tshabala-Msimang, seemed to pour cold water on the idea, or at least confuse the issue, by suggesting that government still had to look into the fact it might have to provide 12 combination therapies (Mangcu, 2003:12).

According to Dr Mangcu: "Is it any wonder, then, that I am temted to roll my eyes at the mention of a rollout? How, though, do we get to the point where citizens roll their eyes at public policy announcements? I suppose disappointments accumulate to that point" (Mangcu, 2003:12).

7.6 SECTOR ANALYSIS OF HIV/AIDS

7.6.1 The economy

7.6.1.1 Jobs and the economy

According to Altenroxel (2003e:3), AIDS is reducing South African's chances of getting a job. The grim reality is, that companies are reducing the size of their labour force, in a bid to avert the financial impact of sick and dying staff.

Demographers attending the Joint Population Conference in Potchefstroom in October 2003 were told how companies are adapting to the HIV epidemic by replacing employees with machines to avoid the costs of absenteeism. Professor Carel van Aardt, of the University of South Africa's (UNISA) Bureau for Market Research, said, a survey conducted by his institution, revealed that the majority of South African companies did not see AIDS as a big threat, they simply adjusted their strategies to cope with its impact. This included a shift towards contract labour and spending more on technology, both of which are bad news for job creation (Altenroxel, 2003e:3).

Several studies comparing the household expenditure of families affected by HIV and those who were not have shown that unaffected families have much more money to spend on anything, from electricity to soap. Those with one or more sick or dying relative, diverted funds to pay for medical needs and funerals, and gradually used up their savings to put food on the table (Altenroxel, 2003e:3).

Van Aardt revealed astounding figures extrapolated from these household studies to show how AIDS would reduce spending on basic items such as food, clothing and household appliances. Based on current prices, consumers would spend South African R 6,2 billion less on grain products such as maize meal and R 24,7 billion less on beverages and tobacco in 2012, compared to current trends (Altenroxel, 2003e:3).

7.6.1.2 AIDS drains profits

According to an in-depth survey of 1,006 companies, HIV/AIDS substantially reduced the profits of more than 40% of manufacturers in Gauteng and KwaZulu-Natal. The study was conducted by the South African Business Coalition on HIV/AIDS (SABCOHA) and the Bureau for Economic Research, among respondents were in the manufacturing, retail, wholesale, motor trade, and in the building and construction sectors (Pela, 2004:3).

Leighton McDonald, a board of governors member of the SA Business Coalition on HIV/AIDS, said companies in KwaZulu-Natal and Gauteng had borne the brunt of the pandemic: "... 34% of the companies surveyed reported HIV/AIDS already had a negative impact on their profits". In this regard, McDonald said the SABCOHA survey shows "... the disease is undoubtedly a bottom line issue for business" (Pela, 2004:3).

The retail trade seemed to be the least affected, with only one in four of the retailers reporting that HIV/AIDS has had a negative impact on their profits. In this regard Leighton McDonald, of SABCOHA, stated that previous studies on the impact of HIV/AIDS identified the mining, transport, building and construction, and manufacturing sectors as the most vulnerable to the pandemic "... as a large proportion of their workforce falls within the high-risk semiskilled and unskilled categories" (Pela, 2004:3.

According to McDonald, 39% of the companies surveyed, stated HIV/AIDS had lowered labour productivity or increased absenteeism among employees. The situation was, however, different in the retail trade, with companies reporting that the disease has had a 20% impact on productivity or absenteeism. Furthermore, McDonald indicated that companies based in the Western Cape, had experienced a much smaller impact, with less than 20% AIDS-induced negative impact on production. He said these results "... are consistent with estimates of HIV prevalence among pregnant women visiting antenatal clinics, which suggests that HIV prevalence is the highest in KwaZulu-Natal, followed by Gauteng, and the lowest in the Western Cape (Pela, 2004:3).

The SABCOHA study indicated that manufacturers were better prepared as 42% had implemented an HIV/AIDS policy. Disappointed, McDonald said only "... 9% of retailers and 15% of building and construction companies surveyed, have implemented an HIV/AIDS policy" (Pela, 2004:3).

Information services, Bloomberg (2004:3), reported Lonmin PLC, the world's third largest platinum producer, as saying, in February 2004, that a testing programme in 2003 indicated, that as many as a quarter of Lonmin employees had contracted HIV. Modelling since then suggested infections would peak at approximately 26% in 2006. The London-based company carried out anonymous and voluntary saliva tests on 60% of its workforce. Lonmin started providing infected employees with antiretroviral treatment from 1 December 2003, and is considering extending the programme to include the families of employees.

7.6.1.3 Budget provisions

National Treasury's Deputy Director-General for public finance, Andrew Donaldson, stated that the 2003 budget had allocated South Africa R 3 billion for HIV/AIDS from 2003 to 2006. This money was allocated to the provinces via the equitable share, and was not specifically targeted at providing AIDS drugs (Kahn, 2004a:3).

The treasury then announced an additional South African R 90 million in its adjustment appropriation budget in November 2003. Mr Donaldson said this was money earmarked for the provision of antiretroviral medicines in the remaining half of the financial year, which ended in March 2004. At the same time, Finance Minister Trevor Manual said in his medium-term budget policy statement that another South African R 1,9 billion had been budgeted for the drugs over the following three years, beginning with South African R 300 million for 2004/5, increasing to South African R 600 million for 2005/6, and then rising to South African R 1 billion for 2006/7. This money would go to the provinces as conditional grants (Kahn, 2004a:3).

7.6.1.4 Economic growth rate

A National Treasury study found that as much as 0,5% would be shaved off South Africa's economic growth rate, if government did not implement its comprehensive plan for the treatment of HIV/AIDS. A key part of the HIV/AIDS programme is the rollout of antiretrovirals, which was repeatedly delayed by the Department of Health. There is also a strong preventative element in the plan. National Treasury Director-General, Lesetja Kganyago, said that the econometric study, finalised in January 2004, concluded that the implementation of the programme would lessen the economic effect of the HIV/AIDS epidemic, by reducing its slowdown effect on growth from 0,5% to 0,3%. During February 2004, Finance Minister Trevor Manual, projected growth in gross domestic product (GDP) of 2,9% in 2004. Government plans to spend South African R 12,3 billion on HIV/AIDS over the next three years (Ensor, 2004:1).

National Treasury Director-General, Ms. Lesetja Kganyago, told a joint sitting of Parliament's two finance committees, on 19 February 2004, that the study focussed on the effect of the HIV/AIDS epidemic on the labour market and consumption. Kganyago did not believe a 0,3% slowdown effect would be "drastic". She said a number of studies had been undertaken to assess the economic and social effect of the epidemic, and the national treasury felt it necessary to have its own study done (Ensor, 2004:1).

Research undertaken by Standard Bank in 2002/3, which modified the findings of the International Monetary Fund and World Bank studies, concluded that the effect of HIV/AIDS on GDP growth would be about 0,2%. Industry studies suggested prevalence varied between 3-4% (excluding the mining sector), depending on the industry in question. A significant assumption in the modelling was that most of the HIV prevalence was amongst low and unskilled workers (Ensor, 2004:1).

7.6.1.5 ARV treatment to reduce economic impact

A new study by the national treasury showed that a complete rollout of antiretrorviral (ARV) treatment would reduce the economic impact of HIV/AIDS by half (Dawes, 2004:13).

Finance Minister Trevor Manual told high school pupils in parliament on 17 March 2004 that the disease would trim economic growth by 0,23% a year. This figure is sharply lower than the 0,5% previously quoted in treasury documents and by private sector economists, and it fills an important gap in Budget documentation released during February 2004 (Dawes, 2004:13).

An economist stated that this was based on the existing treasury model which is roughly in line with the work done in 2001 by the Bureau for Economic Research and in 2000 by ING Barings. The model on which the new estimate is based is the first to try to calculate the macroeconomic results of the government's planned antiretroviral rollout. It considers both supply-side factors, notably the differing impact of the epidemic on skilled and unskilled labour, and demand-side factors like changing consumer and government spending patterns and investment decisions. In this regard the economist said the model "... found that people will live four to four-and-a-half years longer, and be more productive and healthy, so there is a substantial improvement, especially at the beginning" (Dawes, 2004:13).

7.6.2 Teachers

7.6.2.1 Teachers in KwaZulu-Natal

According to figures released in February 2003 by the Health Economics and HIV/AIDS Research Division (HEARD) at the University of Natal, over 680 teachers in KwaZulu-Natal, more than 55 per month, died in-service in 2000. Most died from unspecified

illnesses and the average age at the time of death was 36. Between 1999 and 2000, there was a massive 70% increase in deaths of female teachers between the ages of 30 and 34 (Cullinan, 2003).

HEARD research associate, Peter Badcock-Walters, said the "... teachers mortality pattern, in terms of age and gender, is consistent with what we know of the impact of AIDS on the general population". Mr Badcock-Walters warned, that unless the Department of Education trained and recruited large numbers of teachers by the end of the decade, it might not be able to meet the educational needs of KwaZulu-Natal (Cullinan, 2003).

In this regard Mr Badcock-Walters said there is "... already a relatively high teacher attrition rate of about 6% a year, and AIDS is adding to this problem". He said the private sector "... has traditionally recruited teachers for its middle level management. As HIV/AIDS takes its toll on business, this recruitment is likely to increase. We also need to acknowledge that these were in-service deaths and might only present half the picture, as many teachers die soon after leaving the service" (Cullinan, 2003).

AIDS-related deaths, approximately 1% of teachers in 2000, are expected to reach 5% by 2010. If these trends continue, projections suggest that over 60,000 new teachers will be needed by 2010 to fill the vacancies. The total number of provincial teachers at present is 75,000, with around 68,000 of these publicly paid. It has been estimated that it costs around South Afrcan R 100,000 to train a new teacher (Cullinan, 2003).

Mr Badcock-Walters said that unless these trends can be changed, the department may need to consider a number of different strategies to address the looming teacher shortage. These policy options could include shortening the four-year pre-service training of new teachers; increasing the retirement age and incentives to attract teacher's who have left, back into the profession (Cullinan, 2003).

In conclusion, Mr. Badcock-Walters said, "sooner or later, the strategic use of antiretroviral drugs to prolong the careers of teachers living with AIDS may have to be addressed. Most importantly though, teachers, like everyone else, have to reduce the risks they face and provide role models for their learners" (Cullinan, 2003).

7.6.2.2 South African Democratic Teachers Union - findings

In the hope of finding a collective approach to tackling the pandemic, teacher unions and health and education departments from nine African countries came together, in November 2003, at the School Health and HIV/AIDS Prevention conference in Johannesburg.

Thulas Nxesi, secretary general of the South African Democratic Teachers Union (SADTU) and vice president of Education International (EI), said teachers around "... the world are dying like flies because of HIV/AIDS and many teachers are infected and affected by the disease". Thulas Nxesi said by analysing the death rate of SADTU's members, the union had found that a teacher died of AIDS related illnesses every 10 days (P. Govender, 2003:6).

Other research conducted by the union, between May 2000 and June 2001, found that 1,011 teachers had died in that period. Though HIV and AIDS were not mentioned, opportunistic infections were cited as the cause of death on most death certificates. However, Nxesi said the "... figure could be even higher now as we have entered another phase". He continued by saying that previously, "... there was a high infection rate. Now we are at a stage where people are beginning to die. We are burying a lot of our members because of AIDS". Many teachers are still not disclosing their HIV status, therefore, SADTU is basing its statistics on AIDS-related symptoms and the opportunistic infections that sufferers eventually die of (P. Govender, 2003:6).

Teachers need to tell pupils everything they need to know about sex but are too afraid to ask - and do it with confidence. This is the heart of EI's school-based approach to HIV/AIDS education. How does this approach work?

The EI's programmes are decentralised and run by teachers on the ground. While it is the responsibility of all teachers to speak about HIV/AIDS, each school should also appoint one person to run the programme, the idea being that this person can be approached, and relied upon for confidentiality, by any pupil or teacher at their school. This person will thus need to be sympathetic and caring. Unfortunately, there exists no clear message regarding the policy of ABC: abstinence, change behaviour, and alternatively - use a condom, in this "Plan for school-based action" (P. Govender, 2003:6). This plan is discussed below.

According to EI, teachers can do the following in the classroom to educate their pupils regarding HIV/AIDS (P. Govender, 2003:6): "Plan for school-based action".

(i) Make young people aware of safer sexual habits, like the use of condoms or abstaining from sex.
(ii) Teachers must empower pupils so they can make wise choices regarding sex and health issues.
(iii) Serve as a role model to pupils and the community and spread the right attitude towards AIDS.
(iv) Dispel myths and misconceptions regarding HIV/AIDS.
(v) Encourage tolerance and compassion towards people living with HIV.
(vi) Encourage colleagues to be part of the struggle against AIDS.

Also in this regard, teachers can do the following in the community (P. Govender, 2003:6).

(i) Participate in initiatives for the prevention of HIV and other sexually transmitted infections.

(ii) Involve other members of the community, especially parents, in HIV/AIDS/STD prevention programmes.

7.6.3 Religious bodies

Health E-Service News (Van Sickle, 2003) reported many religious organisations have long been silent on the issue of HIV prevention, instead of addressing the pandemic by offering care to those already infected or support for orphans. Those that do tackle prevention tend to promote sexual abstinence and steer clear of condom promotion.

In this regard, Prof. Suzanne Leclerc-Madlala, an anthropologist at the University of Natal, said when "... you compare our faith-based efforts with those of other African countries, that have been more vocal and taken a more proactive approach, I think you can say we have been slow to catch on with faith-based groups and prevention". Many faith-based organisations have come a long way in understanding that they can preach abstinence, but that a lot of women in South Africa are not yet in a position to make informed and healthy lifestyle decisions. People might try and deny it, but the South African youth are sexually active and there are many people, particularly men, who have more than one sexual partner. This type of behaviour is not easily changed (Van Sickle, 2003).

Uganda's successful abstinence campaign is proof that abstinence is an effective way to curb the HIV/AIDS epidemic. Faith-based organisations should not stop people from using condoms, but should not encourage their use. However, these organisations hope many people will choose abstinence because it is 100% effective in prevention (Van Sickle, 2003).

Another powerful faith-based organisation in KwaZulu-Natal, the Church of the Nazareth, or the Shembe Church, has also taken up the fight against HIV/AIDS, however, they advocate traditonal practices to prevent HIV infection. Abstinence is seen as the only answer, and church members are forbidden to use condoms. "We are preventing

AIDS through the Bible", said Enoch Mthembu, a committee member for the Shembe Church. Mtembu said people "... must behave with morality at all times. There should be no difference between your behaviour at a shebeen or at a church" (Van Sickle, 2003).

Although the church has no formal clinics or support groups, Mthembu says the church encourages abstinence by educating members about the risks of sex and benefits of remaining a virgin. Abstinence among men is regulated by traditions that require the men to pay "lobola" after sleeping with a woman. According to the Shembe Church, among women, virginity testing, which is performed by older women, is the most effective technique, to help motivate the youth with abstinence. Mthembu stated that if churches "... were doing the right things, we would not have this problem with HIV". He added that where "... do people get this disease? It all comes back to moral issues and how people behave" (Van Sickle, 2003).

The non-governmental organisation, Choose Life, says their credo is focussed on strict abstinence, no-condom approach to prevention. The organisation also focuses on the alleviation of poverty and malnutrition as this is a crucial aspect for them in order to stop the spread of the disease. In this regard, Towell, a spokesperson for Choose Life, said: "Poverty, unemployment, AIDS, the three are always linked". Towell added, "You have to address all of these in order to make an impact" (Van Sickle, 2003).

Towell says she is relieved that the church has kept its policy on abstinence, because South Africa's attempts to use condoms as a method of effective prevention have failed, and only abstinence is the safe, easily understood way to stop the spread of HIV. However, she accepts that the strategy is not always easy to put into action, as many women depend on men for their food and shelter, and these men do not always agree to abstain or even to use condoms (Van Sickle, 2003).

7.6.4 South African National Defence Force

7.6.4.1 No further recruitment into defence force

The South African National Defence Force (SANDF) will no longer accept HIV-positive people into its ranks. This announcement was made by Defence Minister, Mosiuoa Lekota, at a justice-cluster briefing in Pretoria, on 7 October 2003. The Minister said that any person "... with the condition (HIV) cannot be recruited (into the defence force)". He added that the SANDF cannot "... take in ill people into positions in the army. It is not useful. We need people who would be sent into difficult missions and be able to (withstand the pressures)" (Sefara, 2003:1).

Furthermore, Minister Lekota announced that an estimated 20-22% of members of the defence force were HIV positive (Sefara, 2003:1).

7.6.4.2 HIV infected soldiers should be fired

Official statistics indicate that approximately a quarter of the 75,000-strong South African National Defence Force (SANDF) is HIV-positive. According to General Pieter Oelofse, the director of medicine in the SANDF's military health service, approximately 23% of soldiers were infected with HIV, and this figure would grow if the SANDF did not take steps to "... get rid" of them (Michaels, 2004:2).

However, General Oelofse says hearing loss and obesity pose a more serious threat to the combat readiness of the SANDF, while other health hazards, such as hypertension, dental problems and Hepatitis B, also rank as dangers after HIV. HIV is the third most prevalent health problem among soldiers, after hearing loss and obesity (Michaels, 2004:2).

General Oelofse told the portfolio committee on defence during August 2004 that 17% of soldiers tested positive for HIV in preparation for operation Blue Crane, a training

exercise, in April 1999, involving several Southern African nations. The General said a similar percentage of soldiers have tested positive during routine health assessments in March 2000, and based on an infection rate of 12%, the figures were extrapolated to reach a total estimate of 23%. He added that AIDS-related deaths in the SANDF were put at 2,5% in the official mortality statistics, however, many patients did not want their status revealed (Michaels, 2004:2).

7.6.5 Hospitals

7.6.5.1 Human Sciences Research Council on South African hospitals

A secret report done for the Department of Health has found that nearly half of all patients in state hospitals are HIV-positive. This figure is among the alarming findings in a report entitled "The impact of HIV/AIDS on the health sector", published in 2003 but kept under wraps (Terreblanche, 2004:1).

The report, leaked to Independent Newspapers, was based on an in-depth study during 2002 under the direction of Dr Olive Shisana, executive director of the Human Sciences Research Council's (HSRC) programme on the social aspects of HIV/AIDS. Aspects of the report's findings were discussed at the 2003 national AIDS conference, but the government has so far refused to release the full 175-page report (Terreblanche, 2004:1).

On 4 August 2003, data made public for the first time, at the South African National AIDS conference, raised the alarming possibility that a high risk of HIV transmission exist in hospitals and clinics. In this regard, a shocking picture of poor clinical practice, inadequate sterilisation facilities and a high HIV/AIDS prevalence rate among young healthcare workers has emerged from preliminary findings of a national study of healthcare workers conducted by the HSRC (Kahn, 2003c:3) .

Dr Olive Shisana, executive director of the HSRC's HIV/AIDS research programmes, said: "30% (of the facilities surveyed) never stocked sterilising equipment and only 40%

of professional healthcare workers were trained in universal precautions, (raising) the question of blood-borne infection in healthcare facilities". The HSRC study, which was commissioned by the health department, surveyed 2,000 healthcare workers and 2,000 patients in more than 200 hospitals and clinics across South Africa (Kahn, 2003c:3).

According to the report, only 86% of healthcare workers had access to protective gloves, and 56% had access to protective gowns. Fifty nine percent of the facilities surveyed never stocked HIV testing kits. Just more than 16% of the healthcare workers surveyed were HIV positive, with a higher proportion of HIV infection among young workers; 20% of those aged 18-35 were HIV positive, compared with 16,6% of those aged 36-45. Dr Shisana said this has "... major implications for the future supply of healthcare professionals" (Kahn, 2003c:3).

Dr Shisana referred to findings from, Statistics South Africa, that there were 375,670 AIDS-related deaths in 2000, therefore, she said an estimated 6,000 to 12,000 healthcare workers had died from the disease during 2000. She continued by saying the HIV/AIDS epidemic was exacting a heavy psychological toll on healthcare workers, with more than half of them saying they were exhausted and 39% saying they were suffering from low morale (Kahn, 2003c:3).

One of South Africa's leading epidemiologists, University of Natal researcher Prof. Quarraisha Abdool Karim, told conference delegates that South Africa was experiencing the world's most severe developing HIV epidemic, with 10% of the global burden of HIV infection. South Africa is home to only 1% of the world's people. According to Prof. Karim, the number of deaths would begin to outstrip the number of new infections, resulting in a reduction in the total number of people infected with HIV. However, this should not be interpreted as success in controlling HIV/AIDS (Kahn, 2003c:3).

The HSRC said preliminary findings of an upcoming report on HIV risk factors among children showed that 12,7% of orphans who had lost both parents were HIV positive. In

this regard, previous research showed, that 3% of all households, were headed by children (Kahn, 2003c:3).

7.6.5.2 Fifty percent of child patients in KwaZulu-Natal infected

More than half the children admitted to South Africa's second-largest hospital are HIV-positive or have full-blown AIDS. Professor Jerry Coovadia, a leading AIDS expert who heads the HIV/AIDS research unit at the Nelson Mandela School of Medicine in Durban, said King Edward VIII Hospital, had an HIV infection rate of between 40% and 60% for child patients (S. Govender, 2003:4).

KwaZulu-Natal's Director-General of Health, Professor Ronald Green-Thompson, refused to grant permission to reporters to visit the hospital, saying he did not want to stigmatise it as an AIDS hospital. He stated a similar grim picture was seen at hospitals throughout the province, where 60% of patients were HIV-positive. In this regard he stated the "... epidemic has put pressure on our services because of recurring opportunistic infections". He said the "... health department's budget is also stretched because end-stage patients are brought to our hospitals and clinics" (S. Govender, 2003:4).

Another leading AIDS researcher, Professor Salim Abdool Karim, said one in four patients left King Edward "in a hearse". He stated that the biggest "... impact of the disease has been on King Edward's medical and pediatric wards. Prof. Karim said the female wards "... are the fullest, and there are a number of young people coming in for treatment of serious illnesses. We hardly ever saw young people in the medical wards up to the mid-1990's". Prof. Karim stated that about 50% of the patients at King Edward's medical wards had tuberculosis (TB), which is often AIDS-related, "... these patients have very unusual strains of the disease, including TB of the bones, kidneys and uterus. Pneumonia is another common disease". Prof. Karim added that the "... HIV/AIDS situation has thrown the hospital into despair. The doctors and nurses have to deal with losing patients almost every day" (S. Govender, 2003:4).

Prof. Coovadia said AIDS at King Edward had also affected the training of medical students. The uniformity of patients' problems had stifled the ability of students to analyse diseases critically (S. Govender, 2003:4).

7.6.6 South African women

The information in this section has been provided by Caroline Hooper-Box (2004:7), who covered the London launch of the Global Coalition on Women and AIDS, during January-February 2004, which is supported by UNAIDS, and a article about women and HIV/AIDS by Shadrack Motloung (2004:5) in the Labour Dynamix Journal.

Existing HIV prevention and protection efforts are failing to stem infections among women and girls. Speaking at the London launch of Global Coalition on Women and AIDS, UNAIDS, executive director, Dr Peter Piot, said young women were increasingly becoming infected by husbands and long-term partners. Dr Piot supported this statement by saying, because women "... lack social and economic power, many women and girls are unable to negotiate relationships based on abstinence, faithfulness and use of condoms". He said women and girls are often powerless "... to insist on condom use. They may be coerced into unprotected sex or run the risk of being infected by husbands in societies where it is common or accepted for men to have more than one partner. Women are also biologically more vulnerable to infection; male-to-female HIV transmission is estimated to be twice as likely than female-to-male" (Hooper-Box, 2004:7).

Furthermore, violence also increases the danger of HIV infection among women. In this regard Dr Piot said that "... fear of violence not only prevents women from accessing HIV/AIDS information, it prevents them from getting tested, disclosing their HIV status and receiving treatment and counselling, even when they know they have been infected" (Hooper-Box, 2004:7).

According to the United Nations (UN) 2003 world population report, 30% of young women in South Africa indicated that their first sexual experience was coerced. The UN report also documented a study undertaken in South Africa that found sexual violence and coercion against girls was so wide spread it was referred to as "everyday love". According to UNAIDS, most sexually transmitted HIV infections in females occur either inside marriage or in relationships that women believe to be monogamous (Hooper-Box, 2004:7).

Shadrack Motloug (2004:5), a manager at the United Association of South Africa (UASA) trade union, said it is of the utmost importance that we cultivate a society in which women and their rights are respected and protected. UASA celebrated Women's Day by putting the focus on the effect of violence on all spheres of women's lives. Motloung said that research has shown that more than 5,000,000 South Africas are HIV positive, 50% of whom are women.

Women who are abused run the greatest risk of all groups to be infected with AIDS. When in an abusive situation, these women are defenceless and often raped, with most contracting AIDS as a result. Motloung (2004:5) said it is a real shame that a women can be deprived of her options in life, such as not being free to choose with whom to talk or work or to opt for safe sex.

HIV status can also often be used to manipulate a women who has tested positive, by threatening to expose her to the community. In this regard, Motloung (2004:5) said therefore it is important that society reconsiders its position regarding HIV and becomes more supportive in order to prevent women from exposure to such duress.

7.6.7 Children under nine

Section (7.6.7) is taken from a report by Russouw (2004:3) on the Human Sciences Research Council (HSRC, 2004) report "The national household HIV prevalence and risk survey of South African children", May 2004.

A pioneering study on the incidence of HIV among South Africa's children, released on 12 May 2004, disclosed that almost 7% of the country's children between the ages of 2 and 9 are HIV positive. The national household HIV prevalence and risk survey by the HSRC (2004) to determine the rate of infection among children aged 2–14, is the first of its kind in South Africa. It found that 5,4% of children between the ages of 2–18 were infected with HIV. The report suggested that the higher prevalence rate among children aged 2–9 could be a result of mother-to-child transmission (MTCT) of the virus (Russouw, 2004:3).

According to the 2001 census, South Africa is home to more than 14 million children aged up to 14. The HSRC (2004) report showed that 4,7% of children aged 10–14 were HIV positive. However, the report states that the study of nearly 300 children did not focus on the reasons for the high rate of HIV infection among children, however, it warned that sexual abuse was a critical issue. Many children were living in high-risk environments. In this regard, the survey indicates that children were mostly at risk of contracting HIV/AIDS through MTCT and in early infancy, many faced the risk of sexual abuse within their homes, schools and communities (Russouw, 2004:3).

The chief researcher, Dr Olive Shisana, executive director of the HSRC's social aspects of HIV/AIDS research programme, pointed out that previous studies have focussed on children older than 15. In this regard, she said that they always "... looked at HIV/AIDS transmitted to children from their pregnant mothers. We never really looked at non-traditional modes, such as the possibility that these children have been sexually abused" (Russouw, 2004:3).

The report also found that almost half of children infected with HIV lived in dire poverty and lacked basic necessities, such as food and clothing. It found that black children were the most vulnerable to the disease because half of them lacked basic resources. About 6,4% of the children between the ages of 2–18 who live in informal settlements were infected. Shisana said that they found "... black children were the most infected and affected by AIDS, as black people are predominant in South Africa. We did have white and coloured children who tested positive, but their numbers were too small to measure" (Russouw, 2004:3).

The study showed that 3,3% of children aged between 2 and 18 had lost one or both parents to HIV/AIDS. The report warned that the number of children orphaned by AIDS could mushroom and the full effect had not been felt yet. The survey found that province of KwaZulu-Natal had the highest proportions of children who had lost both parents to the disease (Russouw, 2004:3).

A call is made in the report that more attention be given to research on children, and not only to focus research on women and especially those attending antenatal clinics. Children, especially those in informal settlements, where people around them are selling drugs and alcohol, are at high-risk of infection. Children must be protected and encouraged to learn about HIV/AIDS from an early age (Russouw, 2004:3).

7.6.8 Public servants and school enrolment

A major new study undertaken on behalf of the government has found that South Africa is in the midst of an HIV/AIDS crisis even more devastating than feared. More than 100,000 civil servants are infected with HIV/AIDS, and the disease has so devastated the population that the national enrolment of grade one pupils at schools has plummeted (Naidu, 2004:1).

The authors of the population study, released in April 2004, queried how government "... can be maintained and function effectively when many of its officials become ill with HIV and die of AIDS". Anton Lourens, the general manager of the Public Servants Association, said the study, which was undertaken by the University of Pretoria's Centre for the Study of AIDS on behalf of the Department of Social Development, supports the findings of a similar survey handed to the Minister of Public Service and Administration, Geraldine Fraser-Moleketi, during 2002 (Naidu, 2004:1).

Lourens said that the Association is of the "... view that the government has kept the first report a secret because it is unable to act upon it". He said that they are "... extremely worried about how HIV/AIDS is affecting our members but there is a limit to what we can do because the government, as the biggest employer in the country, has not shown a willingness to co-operate in dealing with the pandemic" (Naidu, 2004:1).

Fazila Fayers, a member of the Health and Other Services Personnel Trade Union of South Africa, stated that the public service would be severely affected by the pandemic. Fayers said that there have been "... numerous reports which show clearly the impact HIV/AIDS is having on the civil service, yet the difficulty is convincing the government as an employer, which is in denial, that it is going to affect the operations of government" (Naidu, 2004:1).

The study predicts that the rate of infection among managerial and supervisory staff will reach 10% by 2005. She states that if the "... general forecast of AIDS deaths is reliable, it might be that up to a quarter-of-a-million public servants may die of the disease by 2012", and will include many teachers, who make up almost 40% of employees in the public service. In this regard, both the South African Democratic Teachers Union (SADTU) and the National Organisation of Professional Teachers Association of South Africa (NAPTOSA) said HIV/AIDS was taking its toll on teachers who were forced to take sick leave. Dave Bolt, NAPTOSA president, said the "... number of teachers employed by the state is down, primarily because of the impact of HIV/AIDS" (Naidu, 2004:1).

The study also predicts that there will be an estimated five million to seven million deaths due to HIV/AIDS between 2000 and 2010. The public service has more than one million employees. The majority of those infected with HIV/AIDS are in the 25–34 age group, with the highest number in the province of KwaZulu-Natal (Naidu, 2004:1).

School enrolment figures paint an equally bleak picture. The study shows that there will be fewer pupils in future than earlier population forecasts. The average rate of increase in school enrolments between 1980 and 1984 was 3,63%. Between 1985 and 1989 it was 3,78% and between 1990 and 1995 it was 4,21%. But, between 1995 and 2000 it had collapsed to 0,5%. The study states that the "... drop in overall enrolments over this period can be attributed to declining fertility rates and to rising infant mortality, mainly as a result of HV/AIDS" (Naidu, 2004:1).

According to the study, a substantial number of secondary school pupils, possibly as many as 500,000 will be living with HIV and are likely to die before the age of 30. The report states that the "... impact of the epidemic is already being experienced by children as a result of the deaths of their parents and relatives" (Naidu, 2004:1).

Responding to the findings of the study, Duncan Hindle, Deputy Director-General in the National Department of Education, said that HIV/AIDS was not a notifiable disease and that the department did not conduct tests on children to determine their HIV status. The study states that HIV/AIDS should become the singular focal point that society needs mobilising around, but, in "... mobilising against HIV/AIDS there is also a need to provide direction as to what it is that we are fighting for". The study continues by saying that if "... interventions aim to prevent a generalised AIDS epidemic, then we are too late in epidemiological terms, given the levels of HIV infection in South Africa. The epidemic is here and in full blood and we are being buffeted around it" (Naidu, 2004:1).

7.6.9 Agriculture

The United Nations (UN), at a conference on HIV/AIDS and poverty, in Pretoria, on 19 May 2004, predicted that Southern Africa might lose 16 million agricultural workers due to HIV/AIDS by 2020. This dire mortality rate is set to have a significant impact on the region's capacity to sustain agricultural production, increasing poverty and resulting in severe food shortages (Venter, 2004b:5).

Also, the World Health Organisation (WHO) estimated that between 60% and 80% of AIDS-related deaths in the region were due to malnutrition. WHO said that the region's economically active population, people between the ages of 15-49 years, is being eroded by the AIDS pandemic (Venter, 2004b:5).

According to James Morris, UN envoy for Humanitarian Needs in Southern Africa, this will drastically affect the region's food-production capability and further fuel already critical food shortages. James Morris said the HIV/AIDS "... pandemic is threatening the very future of nations and a bold approach is needed to address the crisis of devastating illness and drought-afflicted agriculture". Morris said the crisis in Africa had not been fully grasped by the international community and warned that an "... exceptional effort is urgently needed if a major catastrophe is to be averted" (Venter, 2004b:5).

Scott Drimie, of the Human Sciences Research Council (HSRC), stated that the "business as usual" approach to food security must be replaced by directly involving the communities concerned. In this regard Drimie said the challenge is "... to develop food-security interventions and farming practices that adapt to the reality of middle - and late-stage HIV/AIDS affected environments and maintain productivity" (Venter, 2004b:5).

7.6.10 The labour force

According to a new study of the impact of HIV/AIDS in the global labour force, released in July 2004, by the International Labour Organisation (ILO, 2004), "HIV/AIDS and Work: Global Estimates, Impact and Response", the number of infected workers and the consequent loss of productivity will climb sharply. The report predicts, by 2005, the cumulative loss of workers, worldwide, from the epidemic will reach 28 million. That figure could climb to 48 million by 2010, and 74 million by 2015, respectively. Worldwide, an estimated 36,5 million people engaged in some form of economic activity, are HIV-positive, resulting in an annual loss of US$ 25 billion in productivity, this figure is twice the yearly gross domestic product of Kenya (ILO, 2004).

Already the worst affected continent, Africa, is home to 70% of the world's labour force infected with HIV. According to the ILO (2004) report, the loss "... of human resources due to HIV/AIDS, will especially damage the capacity of the state to supply essential goods and services, with far-reaching effects on the rest of the economy".

Some African countries have staggering figures of HIV-positive economically active people. The ILO (2004) report estimates the following figures: South Africa has 3,7 million; Nigeria 2,4 million; Tanzania 1,4 million; Ethiopia and Zimbabwe 1,1 million each; and Kenya one million.

The ILO (2004) report concludes by stating that HIV/AIDS "... destroys human capital built up over years and weakens the capacity of workers to produce goods and services for the economy. This loss of skilled labour, together with the increase in care and treatment costs, tends to depress production, hamper savings and impede investment in the long run". "At the same time, reduced economic growth due to HIV/AIDS affects the public revenue base, reducing public expenditure on education, as well as on other sectors such as health that help build and sustain human capital".