HIV/AIDS IN SOUTH AFRICA

It is estimated that by the end of 2005 around five and a half million South Africans were living with HIV/AIDS, with around one in five adults aged 15-49 testing positive for HIV. According to UNAIDS, in 2005 nearly 1,000 people in South Africa were dying each day due to AIDS, and the number of children thought to have lost one or both parents to the epidemic had more then doubled in the space of two years to a shocking 1.1 million. A 2004 survey published by the South African Advertising Research Foundation found that South Africans spent more time every month at funerals then they did at barbeques, shopping, or even having their hair cut. When the first national antenatal survey to test for HIV was conducted in 1990, it was found that only 0.8% of pregnant women were infected with HIV. However, by 2000 this had skyrocketed to 22.4%, and by 2004 had reached an alarming 29.5%. It is widely believed that if the South African government had acted quickly and decisively during the 1990s the extent and severity of the current epidemic could have been avoided.

However, the South African government was slow to react to the growing HIV/AIDS epidemic. During the early post-apartheid period they were wrestling with social upheaval and political restructuring and failed to recognise the explosive and devastating impact this epidemic would soon have across the entire country. This was further exacerbated by the ongoing refusal of key government leaders to publicly acknowledge the causal link between HIV and AIDS. When questioned in 2000 on whether HIV causes AIDS, President Mbeki obtusely replied: “Does HIV cause AIDS? AIDS is an acquired immune deficiency syndrome. I don’t believe it is a sensible thing to ask if a virus causes a syndrome. A single virus cannot cause a syndrome. A virus causes a disease. AIDS is a syndrome . . . including 29 different diseases. When you ask the question, does HIV cause AIDS, the question is: does a virus cause a syndrome? It can’t.”

This lack of action led the international community to lambast the new South African government for “its lethargic response to a pandemic that kills close to a thousand people a day.” However, in recent years the government has adopted a much more proactive approach and has shown a serious commitment to getting the epidemic under control. In 2003, an Operational Plan for Comprehensive HIV and AIDS Care, Management, and Treatment, was initiated. Among other things, the plan called for a National Disability Grant designed to provide those who are too ill to work with much needed additional income. It was determined that individuals with AIDS would be eligible for a disability grant if their CD4 count dropped below 200. Along with the National Disability Grant, the government also initiated a long awaited anti-retroviral (ARV) “roll-out” program, which was to provide publicly funded ARVs to a target of 53,000 patients by March 2005.

The operational plan has had some success: by the end of 2004, 20,000 individuals were on ARVs in the public sector, voluntary counselling and testing (VCT) had more than doubled, and social grants for individuals with AIDS had increased by 44%. However, the plan has also had its own share of problems. In most areas the government has fallen short of the...
problems such as gender-based violence (GBV) were never adequately dealt with in the plan, while a number of additional unforeseen problems have surfaced since the plan was implemented. Drawing on observations of HIV/AIDS programming in Grahamstown (also known in Xhosa as Rhini), the remainder of the article will explore in greater detail three major issues that became apparent during our time there: (1) A number of the unanticipated and undesirable outcomes of the new national HIV/AIDS programmes; (2) the pervasiveness of misinformation and mixed messages concerning HIV/AIDS prevention and treatment; and finally (3) the pervasiveness of Gender-based Violence (GBV) and the shortcomings of government health services in addressing HIV/AIDS and Gender Based Violence as co-epidemics.

EMERGING CONTRADICTIONS: DISABILITY GRANTS, THE ARV “ROLL-OUT”, AND POVERTY

While both the National Disability Grant and the publicly funded ARV “roll-out” are much needed social programmes, a number of problems emerged shortly after they were implemented. After arriving in Grahamstown, a worker at the Grahamstown Hospice informed us that a number of people who live in the surrounding townships and face pressing and hopeless poverty have sought to purposely infect themselves with HIV. This was done with the express purpose of eventually developing AIDS and qualifying for a disability grant. Shockingly, we soon found that this was not simply the case of a few isolated incidents. Self-infection as a way of gaining access to government benefits had been reported throughout the country, and by late 2005 became such a significant problem that nationwide advertising campaigns were initiated to urge people not to infect themselves with this life threatening illness.

Purposeful self-infection is not the only problem that is linked to these new National Disability Grants. Not only is a CD4 count of 200 the level below which patients qualify for the grants, but it is also the level below which individuals (aged 6 and over) become eligible for publicly funded medications under the ARV roll-out programme. However, because the CD4 count of patients who successfully respond to ARV treatment will likely rise above 200, a problematic situation arises whereby many patients risk losing their National Disability Grant if they adhere to ARV treatment. Many patients who are currently living in poverty are finding themselves torn between their immediate health needs and the continued economic security of their families. ARV treatment will improve their immune response, but they will have to forego their disability grant and the much needed additional household income this may provide. A loss of household income also risks exacerbating food insecurity and poor nutrition which may undo many of the positive health outcomes associated with ARV treatments. Furthermore, despite improvements to a patient’s health while taking ARVs, there is no guarantee that, given high unemployment rates and the social stigmas surrounding HIV/AIDS, they will be able to find work.

Other social grant programmes have also had unforeseen and equally undesirable outcomes. For example, families receive a government child allowance of 170 Rand per month for each child. One hospice worker noted that in an environment of desperate poverty, this has become an economic incentive for women to have more children than they might otherwise choose. When it comes to the HIV/AIDS epidemic, as a result of the limited availability of Nevirapine (a treatment that would help prevent vertical transmission of HIV/AIDS to the fetus), the main sources of infection for children in South Africa are currently perinatal and mother’s milk.12 There is concern that the child allowance is encouraging many women with AIDS who do not have access to Nevirapine to continue to have children, even as they become increasingly ill. Not only does this contribute to greater numbers of infants with HIV/AIDS, but many of these women die while their children are very young, and there may or may not be anyone left to raise them.

MISINFORMATION AND MIXED MESSAGES ABOUT HIV/AIDS

Providing the public with clear and accurate information on HIV/AIDS prevention is critical if the epidemic is to be successfully controlled. However, in Grahamstown, mixed and often conflicting information and advice is being communicated to the public concerning HIV/AIDS. This has given rise to confusion within the community which has, among other things, drastically undermined the effectiveness of education efforts aimed at curbing the spread of HIV/AIDS. Nationally run health education and awareness raising programmes, such as the LoveLife and the Khomanani campaigns, along with most civil society organizations working in the area of HIV/AIDS have been vocal in encouraging the use of condoms as a way of reducing the risk of infection. Free condoms are provided at all hospitals and from a number of community organizations, such as the Raphael Centre in Grahamstown.

However, a number of health workers, civil society organizations, and influential local figures have been giving out different and sometimes conflicting advice. A humanitarian group of expatriate catholic nuns, who provide a sex education service for all of the children attending school in the Grahamstown area, promote abstinence and discourage the use of condoms as a form of prevention. Furthermore, numerous physicians interviewed at the local hospital also promoted abstinence to all their patients while actively dissuading them from using condoms as a form of birth control or to prevent the transmission of HIV/AIDS. Both the nuns and a number of physicians felt that condoms are largely ineffective in preventing the spread of the virus as people rarely use them properly, and that even when used properly the virus will “leak through”. Most physicians were strongly of the opinion that a strategy which encouraged monogamy and abstinence would be more effective. Some felt that programs which promoted condom use, such as local street theatre puppet shows aimed at educating people on the proper way to put on a condom, were instead contributing to the spread of HIV through decreasing the social anxiety of individuals when it came to both talking about and having sex.
Further confusion in Grahamstown has arisen as a result of the health advice being given out by local traditional healers, known as Sangomas, some of whom openly argue against the use of condoms. According to one local health worker, a Sangoma in the area was spreading the word that condoms were in fact purposely being coated with the virus and were responsible for spreading HIV/AIDS. Sangomas have also been known to administer traditional herbs and medicines claiming that they can assist in the prevention and treatment of HIV/AIDS. While there may be emotional and nutritional benefits to the care given by these traditional healers, their advice and treatments also risks causing further harm by misleading patients as to the nature and severity of the illness, discouraging the use of both condoms and ARVs and, potentially having detrimental interactions with ARVs. It is crucial to note that these experiences with traditional healers are not necessarily representative of all healers. Several recent case studies in Uganda and Zimbabwe have shown that traditional healers are uniquely positioned to strengthen the response against the epidemic and work together with health professionals trained in western medicine. However, this level of coordination was not demonstrated in Grahamstown.

So while local people are exposed to national campaigns advocating the use of condoms as a form of HIV prevention, they are simultaneously being told that condoms are ineffective by key local health care specialists and religious groups, and that condoms are responsible for the spread of the disease by some influential traditional healers. The lack of coordination, consensus, and consistency among support workers has fostered a climate of confusion and distrust among the local population, shaking the community’s faith in government officials and local health workers and providing fertile ground for the spread of rumours and misinformation. As opposed to having the desired effect of stemming the epidemic, this has arguably been facilitating the spread of HIV.

THE CO-EPIDEMICS OF HIV/AIDS AND GENDER BASED VIOLENCE

According to support workers in Grahamstown, rape is one of the leading vehicles through which HIV is being spread within the community. Indeed, it is now widely recognised that gender based violence, discriminatory gender norms, and unequal sexual relations greatly contribute to the vulnerability of women in both contracting and managing HIV/AIDS. In cases of rape, the physical trauma associated with forced sex has been found to significantly increase the risk of HIV transmission to women. Even when sex is consensual, it is frequently much more difficult for women suffering from abuse at the hands of their partners to negotiate the use of a condom. GBV can also lead to a host of additional acute and chronic physical and mental health problems, which can both directly and indirectly increase women’s risk of contracting HIV. Physical injury, sexually transmitted diseases, gynaecological disorders, depression, self-injurious behaviour, alcohol and drug abuse, fear, anxiety, and low self-esteem, are all problems associated with GBV and an increased risk of contracting HIV/AIDS. It is important to recognize that stemming the spread of HIV/AIDS in South Africa is not simply a medical issue, but depends to a great extent upon our ability to redress existing gender inequalities between men and women.

Unfortunately, this is much easier said than done. On paper, the rights of South African women are officially protected under the 1996 constitution as well as through the 1979 International Convention on the Elimination of all forms of Discrimination against Women, to which South Africa is a signatory. However, in practice, women in South Africa continue to suffer many forms of discrimination. South Africa is thought to have the highest incidence of rape in the world, with one article purporting that a woman is raped every 26 seconds. One local newspaper reported that in the Grahamstown area alone an estimated 4 women were raped every night. For many women living in this small city, gender based violence is an everyday phenomenon. The social worker at the hospital stated that violence and rape within the confines of marriage was “so common, it’s not even strange”. Furthermore, at an educational workshop on rape delivered by a local organization to a group of 24 women with AIDS, the facilitator ended the session by asking whether any of the women present had experienced behaviours defined as rape. Every woman in the room raised their hand and one woman poignantly stated that “sex is something that happens to us”.

It is imperative that rape victims have access to appropriate treatment and services, not only for social, legal, and acute medical reasons, but also for preventing the transmission of HIV/AIDS with post-exposure prophylaxis. The current array of organisations in Grahamstown that offer health, social, and legal support services for GBV survivors is extremely impressive given the city’s small size (including the surrounding townships Grahamstown has a population of approximately 110,000). However, the ability of women to effectively access and use these different services was found to be severely hindered due to a broad range of factors. The remainder of this section will focus on the barriers encountered by rape survivors in their attempts to access treatment and support from one particular type of organisation: public hospitals.

The local hospital in Grahamstown is where the majority of rape victims present in order to receive acute care, post-exposure prophylaxis, and undergo the physical examination required for police reporting purposes. However, there are several significant deterrents which prevent many women from accessing these hospital services. When presenting at the local hospital for treatment, rape survivors complained of a lack of both privacy and anonymity. In particular, the rape examination room is located next to the outpatient department waiting room and women entering the room can be seen by all of those who are seated in the waiting area. For many women who fear being recognized due to the strong social stigmas attached to rape and GBV, this lack of privacy and anonymity may act as a strong deterrent.

Also considered problematic by many interviewees have been the callous or negative attitudes exhibited by some physicians and health care professionals towards survivors of GBV.
and rape. Women were both afraid and uncomfortable recounting the incident to male physicians and some women found the physicians to be unsympathetic to their situation. There was even an account of a physician leaving a rape victim waiting overnight simply because they did not wish to fill out the required paperwork or perform the necessary physical exams. It was remarked by one of the interviewees that voluntary counselling and treatment services for rape victims being tested for HIV/AIDS was often hasty and insensitive. For a woman who has suffered rape or physical abuse and who is unable to shower until the police investigation has been completed, experiences of being poorly treated, poorly counselled, and having to wait in a room for hours on end were described as both painful and inhumane.

Free HIV post-exposure prophylaxis is now available to rape survivors through most public hospitals. If a woman presenting at the hospital for rape has a non-reactive test, then one week’s supply of ARV prophylaxis is provided and she is scheduled for follow-up testing to assess if there is any seroconversion. However, instructions regarding the use of ARV prophylaxis are often given in the patient’s second language and as a result women frequently do not fully understand the proper follow-up procedures. Furthermore, while rape survivors are eligible for a full month’s supply of ARV prophylaxis free of charge, they must return to the hospital after one week to receive the remaining doses. However, the public hospital is situated on the outskirts of town at the top of a large hill and transportation, whether in a donkey carriage, bus, or taxi, can be costly for those living in the townships. Many patients cannot easily afford the transportation costs involved in getting to the hospital. Not only does this deter people from returning to the hospital for follow-up testing and their remaining ARV prophylaxis, but transportation costs can even deter people from reporting rape incidents or seeking appropriate care in the first place. There have been reports that in cases where rape victims have required acute medical care but could not afford transportation, informal arrangements have been made whereby the family of a rapist will pay for the victim’s transport to the hospital in exchange for a promise from the victim’s family that they will not formally report the incident to the police.

As mentioned above, the health sector is uniquely positioned as a site where individuals must present in order to receive acute care, HIV counselling and testing, post-exposure prophylaxis, and undergo the physical examination required for police reporting purposes. This makes hospitals an ideal focal point for the coordination of health, legal and social support services for victims of GBV. Furthermore, hospitals are also well situated to coordinate services aimed explicitly at tackling the co-epidemics of HIV/AIDS and GBV. If access to existing hospital services can be improved and linkages between hospitals and other service providers can be better coordinated to eliminate repetition and facilitate a better continuum of care, the quality of treatment for rape and the prevention of the transmission of HIV would be greatly improved.

CONCLUSIONS

Among the myriad of problems currently being faced in the battle against HIV/AIDS, in Grahamstown three simple yet significant challenges stand out. First, the implementation of new policies such as the National Disability Grant and the ARV “roll-out” programme have given rise to conflicting incentives which have proven counterproductive and need to be addressed. Second, mixed educational messages regarding the prevention and spread of HIV from a range of influential actors in key positions of authority have also been both contradictory and counterproductive, giving rise to a sense of distrust and confusion amongst local communities and arguably facilitating the spread of HIV/AIDS. Finally, much more needs to be done in terms of recognizing and addressing GBV as a co-epidemic of HIV/AIDS. In this area, public hospitals appear to be particularly well situated to be coordinating treatment and support services for those who have suffered rape and who are at risk of contracting HIV. However, steps must be taken to remove barriers which may serve to deter women from accessing or optimising the use of hospital services.

Many of the issues and problems discussed in this article are recognized by health and community officials working in Grahamstown. A promising new development has been the recent call for a municipal “AIDS Council”, made up of representatives from health, community, legal and political groups, that could coordinate the response to the epidemic thus reducing duplication of efforts as well as inconsistencies and gaps in existing services. This council is still in the planning stage; however it represents a growing acknowledgement that the effectiveness of one institution working on its own is limited, and that new more innovative and collaborative approaches are needed to tackle the epidemic.

Focusing as it has on the difficulties and deficiencies of organizational responses to HIV/AIDS in South Africa, this article has been relatively critical of current practices and practitioners. However, during our time in Grahamstown it also became clear that the majority of people working in the area of HIV/AIDS have a deep commitment to improving the quality of life of those around them. It should be recognised that it is largely the continued efforts and support of these dedicated groups and individuals that offers hope to the millions who now live with HIV/AIDS in South Africa.

ACKNOWLEDGEMENTS

This article is based on research conducted in 2006 during a five week placement at Settler’s Hospital located in Grahamstown, Eastern Cape, South Africa which was made possible thanks to a scholarship from the International Women’s and Children’s Health Network. We would also like to thank all of the participants who shared their time and stories with us.

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