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# FAX TRANSMISSION

TO: **Ms Sandra Thurman, US AIDS Policy Director**
FAX:
FROM: Ms Aletta de Villiers

DATE: **27 October 1998**
NUMBER OF PAGES **(including this page) 5**
SUBJECT: AIDS/Health crisis in the Eastern Cape

Dear Sandy,

Press coverage in the last few days has spurred me into sending you this series of clippings. As you can see, AIDS has at last become acknowledged as a truly severe problem. Coupled with the imminent collapse of our health services, I cannot imagine where we are heading in terms of death tolls in the province in the next few years.

You met Rob Shell (quoted in the AIDS stories) at dinner with the Woods one night - he is exceptionally tall and oddly attractive. You also met Trudie Thomas, the Health Minister, who spoke at the meeting we held - a smallish, not-young woman.

Your friend Zuma is going completely mad at the moment. In a country where our police force can't stop people from shooting, raping or robbing each other (or burning or slashing them to death for that matter) in full view of the public, and where corruption is running riot in every aspect of public and private life, she is busy introducing a new crime - that of cigarette smoking in public places. I am dead against smoking in my space, but good heavens, when you refuse AIDS education programmes, yet introduce no-smoking legislation in Parliament, you truly must have a screw loose. Can't we somehow tell your story here?

Do let me know what you are up to, and when you think you could come out here. I've been liaising with Sarah, but with the political shenanigans around Clinton, you must all be busy planning your futures.....

Sarah told me you had been ill - I do hope you are back on track and are not quite such a skeleton as when I saw you in July!

Best wishes,
Sincerely,

ALETTA DE VILLIERS

(1)

Daily Dispatch, Friday October 23, 1998 Pg 1&2

# G'town, PE army bases 'spread Aids'

By Eddie Botha

**EAST LONDON — There is overwhelming evidence that some army bases in the province are instrumental in spreading the deadly Aids epidemic, says Rhodes University population research unit director Robert Shell.**

The army bases in particular were Forest Hill in Port Elizabeth and Grahamstown.

A high and even sensational regional clustering of the deadly epidemic, which is now approaching holocaust numbers in South Africa, is to be found in the poorest and most marginal communities of the Eastern Cape.

Dr Shell presented the alarming findings to the annual meeting of the Demographic Association of SA.

He said three million positive cases of HIV-infected people were reported nationwide, with 750 000 in the Eastern Cape alone. But little attention had been focused on the province until the epidemic had already reached its deadly Aids phase.

An overall projection — based on 1996 estimates by the Department of Health — that 700 people were becoming infected with HIV daily, with the rate of new infections doubling every 15 months, was too modest.

"It will take a number of years before the full impact of the Aids epidemic will be felt, although the socio-economic costs of this epidemic are already quite evident."

Dr Shell said the vectors of the disease in the Eastern Cape were emerging from the north-east of the province. "Hardly any cases come from other provinces," he said.

Referring to army bases as Trojan Horses, Dr Shell said at least some urban HIV vectors might have been internally in South African cities near military installations.

Compared to Cuba, where tests were carried out on military personnel returned from areas in Africa where South African soldiers had also served, South African HIV researchers were seemingly unaware of the incidence in the SANDF.

Returning cadres who had served in Central Africa in the struggle before 1994 possibly contracted HIV there.

"Once they had returned and were incorporated into the SANDF, they were distributed all over the country and became an almost perfectly randomly distributed set of sites for the epidemic."

Forest Hill and Grahamstown were instrumental in spreading the epidemic in its incipient stage.

Culturally it was apparent that HIV was located predominantly in the African sector of the population. The Asian population hardly registered cases and European and coloured populations' proportions were declining.

"The African proportion, however, is increasing and in five years the epidemic will be purely African as the positives in the other ethnic groups will have died."

There was no ethnic explanation for this pattern other than the simple fact "that the poorest and most illiterate members of our society are in the African population".

There was African evidence which suggested that male circumcision reduced a man's susceptibility to HIV.

There was also a dangerous myth, the prevalence of which had to be investigated for the Eastern Cape, that sexual with a virgin would cure HIV and Aids.

In the Eastern Cape a girl in the virgin group (5-14 years) was eight times more likely to be infected than her male counterpart. A UN International Children's Fund study found that African girls aged between 9 and 1[illegible] were five times more likely to be infected with HIV th[illegible] boys of the same age.

**See page 2**

(2)

DAILY DISPATCH, FRIDAY OCTOBER 23, 1998

# Aids threatens SA with another lost generation – expert

**By Eddie Botha**

EAST LONDON — The cost of treating a terminal case of Aids a month is equivalent to placing 19 schoolchildren in primary school a month, says the director of Rhodes University's population research unit, Dr Robert Shell.

Dr Shell, who presented a research paper to the annual meeting of the Demographic Association of SA, said the increasing Aids epidemic would become a heavy burden on national and provincial budgets.

Measurement of the impact of the epidemic on companies and enterprises was more complex. However, productivity would be affected when experienced staff fell ill, were absent or died.

"Absenteeism, lower productivity and loss of experienced staff will add to the direct cost of Aids in the workplace.

"The overall effect of Aids will be to reverse hard-won development gains and make all people in the country worse off," Dr Shell said.

He warned that South Africa, as during the apartheid years, would once again face a lost generation — children growing up without care and role models.

"Few countries have endured such consecutive inter-generational calamities."

Dr Shell suggested that, in the absence of cost-effective medical interventions, medically supervised male circumcision might slow the progression of the Aids epidemic. He also suggested the House of Traditional Leaders might have to take a more effective role in popularising and supervising safe circumcision rituals.

Dr Shell recommended a public relations wake-up call for communities in the Eastern Cape and that opportunities be made available for counselling centres and expansion of clinics in remote areas.

"Every highway should have a billboard every 100 kilometres. A school competition might be launched for the design of Aids awareness posters."

Dr Shell also suggested that the newly developed saliva test (which had been rejected by the WHO) should be reinvestigated as it was inexpensive and fast.

Mobile testing units should be deployed, and the province might want to consider a week-long anonymous death scan in certain selected areas where every person who had died within a specific week would be tested for HIV.

Dr Shell said policy makers should plot an algorithm for health providers to use in advising mothers about the relative benefits and risks of breast-feeding their babies.

"A central provincial registry of HIV data needs to be established, data capture clerks need to be trained on site and an archiving policy needs to be established."

Dr Shell said needlestick injuries might also be minimised by the new sheath syringe developed recently.

3

Daily Dispatch, Monday, October 26, 1998

**EDITORIAL OPINION**

# Aids on the march

RHODES University's Population Research Unit director Robert Shell's warning that the level of HIV and Aids infected people in South Africa is approaching holocaust numbers, cannot be ignored.

In five years time, says Shell, the epidemic will be purely African, as the white and coloured proportions of positives are declining. In short, Aids could destroy the soul of the nation.

Meaningful intervention by government — sadly missing according to Shell — is now needed more than ever.

Health Minister Nkosazana Zuma has tried in the past to bring across the message of the road of destruction that will be left behind by the deadly disease.

Unfortunately, the minister and her subordinates wasted valuable taxpayers' money on the Sarafina debacle.

And now, while she is seemingly unable to comprehend the full scope of the socio-economic implications threatened by the epidemic, Zuma occupies herself in using taxpayers' money to fight the tobacco industry over advertising.

Shell cautions that there are several methodological problems with the approach in South Africa where most studies of HIV/Aids rely on antenatal studies to provide comparative indices of incidence for the epidemic.

Rural areas are not serviced by antenatal clinics to the same extent as urban areas, says Shell. This is a particular shortcoming in the Eastern Cape.

Shell says it seems true to claim that a co-ordinated programme of intervention for this most deadly of epidemics has yet to begin in the poorest province of our country.

Until the release of the 1996 census results there were also not reliable denominational data from which to draw meaningful regional incidence figures.

In short, all national comparisons based on antenatal date are suspect, contends Shell.

For the purpose of his study Shell obtained data from a broader spectrum of sources, including results from pre-employment tests, blood donor tests, district surgeons, private doctors, provincial and mental hospitals, insurance companies, the prison and police services and the SA National Defence Force.

It is from these results that Shell was able to issue the further frightening warning that there is overwhelming evidence that there are internal urban sites of infection — dubbed by him as Trojan horses. Army bases especially in Port Elizabeth and Grahamstown are instrumental in spreading the epidemic in its incipient stage.

It will be folly to believe that this situation has been isolated to Eastern Cape military installations.

Returning HIV infected cadres have been incorporated into the SANDF, as a result of which some army bases have become almost perfect distribution sites for the epidemic.

Shell conjectures that such returning veterans (many of them heroes) and all with assured state employment will appear as most desirable suitors to any impressionable young, poor women.

The implications of Shell's research – that every military base is a potential breeding-ground of Aids – demand an urgent, nationwide follow-up by the department of Health and Defence.

EASTERN PROVINCE HERALD, TUESDAY OCTOBER 27, 1998

(4)

## Department in the red and services face total collapse

# Health crisis looms for EC

By NICK WILSON and PATRICK CULL

**BISHO – The Provincial Health Service will collapse by February or March next year unless the Health Department receives money from the Provincial Reserve Fund.**

This warning was given yesterday by Health MEC Dr Trudy Thomas during a sitting of the provincial legislature.

There would be no money for critical posts such as staff for new clinics, security staff at hospitals, pharmacists, financial managers and a media officer.

The transfer costs to ambulance services, local government and primary health care services are also set to run out.

There would also be a cutback in drugs, patients' food, water and electricity and laboratory services.

Dr Thomas said the implications of the R2,8-billion budget were a continued moratorium on clinic building, hospital restoration, on equipment procurement as well as on the replacement of equipment, some of which is obsolete or dangerous.

There could also be no purchases of vehicles or ambulances to extend services to the rural areas.

A total of R115-million was suspended from the already meagre health budget for use in the Provincial Reserve Fund.

The fund is aimed at slashing the estimated R1,8-billion provincial debt from last year.

Dr Thomas said her department had calculated that it would need R3,5-billion for health services for the 1998-99 financial year.

She said this amount would allow the department to keep its present services going.

Dr Thomas said what had to be noted, was that while the national average of the total budget spent per province on Health was 23,8 per cent, the Eastern Cape only received 18,1 per cent of the provincial budget.

Although the National Department of Finance initially agreed that health figures were credible, they came back soon afterwards to say that the country could not afford it and they would only be able to let health have R3,1-billion.

The next blow came when the province said it would not be able to give the department this amount, but only R2,9-billion because of provincial statutory and personnel obligations.

This allocation was much less than the department spent in the previous year.

Implications of the outs included the department running out of money for ambulance services in January next year, as well as reduced transfers to local government and provincial-aided hospitals.

Dr Thomas said the final blow came with the acute crises in education and this resulted in the R115-million being suspended.

She said her department would need the R115-million suspended from their first allocation restored plus another R33-million to keep the department going.

This amount of R150-million did not include some of the debts that had surfaced and whose exact amount had not yet been determined.

These include R18-million owed to Telkom from when the departments of Health and Welfare were joined and the combined former Transkei and Ciskei billing.

Another R103-million was owed for pensions and R27-million was owed to the Western Cape for capital works which were started in previous years and not billed to the department timeously.

They also owed the Department of Justice R43-million from when Health and Welfare were joined.

The preliminary total on debts was R197-million.

However, she said there was new hope with grants from foreign donors and local private companies, missionary societies and service clubs coming in.

Provincial Democratic Party leader Eddie Trent said Dr Thomas should "stop whining".

He said Dr Thomas was part of the decision to suspend the money in order to try and wipe out last year's debt and start the next financial year with a clean slate.

## 'We must all pray that we do not fall ill'

By NICK WILSON

BISHO – The health standing committee report reads "like a horror story on what lies ahead for the citizens of the Eastern Cape", NP chief whip Billy Nel warned yesterday.

Mr Nel cited various points in the report which were matters of "grave concern". According to the report, R115,3-million was suspended from the Health Department's budget and transferred to the Provincial Reserve Fund aimed at clearing the province's debt from the year before.

He said R96-million was suspended from the personnel budget while R19-million was suspended from the equipment budget.

The report said managerial posts were not being filled because of financial cuts, while the training of health professionals under the Provincial Hospital Services Programme was not taking place.

There was a lack of financial management systems and there was no well-planned medical equipment management programme. At most hospitals there was no security.

Mr Nel said: "We must all hope and pray that we do not fall ill. For those in the gravy, the pain is bearable as we can afford private hospitals and care, but for others, good luck."

The health system was "once again in a crisis" and the report highlighted "the fact that the Government cannot run the province". – ECN

# Rhodes University (East London)

# PRU

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POSITIVE OUTCOMES:
The chances of acquiring HIV/AIDS
at primary and secondary schools in the Eastern Cape, 1988-2005
by Dr Robert C.-H. Shell and Rebecca Zeitlin
Population Research Unit, Rhodes University

Abstract: The authors explore the statistical probability of acquiring HIV/AIDS for learners enrolled in SA government schools in the Eastern Cape. Ante Natal Clinic published data and a 10 percent sample of the census of 1996 are used to calibrate the probabilities of becoming infected. While education is glibly assumed to be a key turnaround factor and cultural antidote to the further spread of the pandemic, the authors point out that this earnest and understandably near universal hope is unlikely to translate into reality. Evidently, learners in the new post-1994 schools are being exposed to peer group pressures which are overwhelming HIV awareness programmes the students may be exposed to even via the new government's revolutionary curriculum of 2005. While the number of years at school is correlated with lower STD rates, this does not find an echo in lower HIV rates, nor indeed, lower pregnancy rates. HIV rates among school-going adolescent women in the Eastern Cape are growing extremely rapidly. A young girl who drops out of school in grade two has less chance of acquiring HIV than her sister who stays until matric. The HIV rates among the age group 15-19 in the Eastern Cape are now among the fastest HIV growth rates in the world. Interventions include single sex schools, single sex teaching and significant, interventionist, reproductive health counselling. Clearly, the educational system in and of itself provides no shield of knowledge against the pandemic and should be comprehensively reviewed long before 2005. The authors conclude that sex and death lurk on the playgrounds and in the classrooms as much as they do at truck stops and near military installations.

*The financial assistance of the National Research Foundation (NRF, formerly CSD) towards the research of the PRU is acknowledged. Opinions expressed in this report/ paper/ publication/thesis/script and conclusions arrived at, are those of the author(s) and are not necessarily to be attributed to the NRF*

CONTENTS

Introduction ..... 2

Literature Review ..... 3
- Ghana ..... 3
- Tanzania ..... 3
- Zambia ..... 4
- Zimbabwe ..... 4
- South Africa ..... 5
  - Cape Peninsula ..... 5
  - Cape Town ..... 5
- Conclusion of Review ..... 5

Focus on the Eastern Cape ..... 5
- The age of HIV infection in the Eastern Cape ..... 5
- Virginity and HIV ..... 7
- Correlation between years in school and HIV infection ..... 9

Policy recommendations ..... 11

Literature cited ..... 12

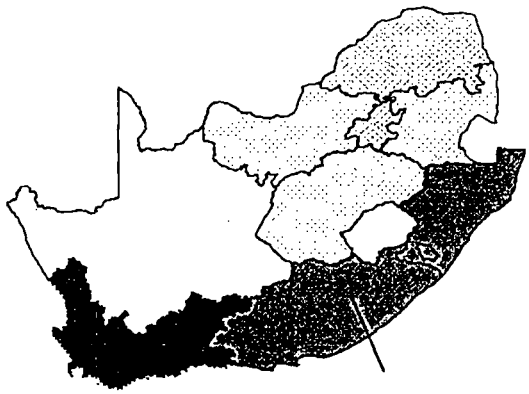
# POSITIVE OUTCOMES:

## The chances of acquiring HIV/AIDS at primary and senior schools in the Eastern Cape, 1988-2005

"We are taught how to live when life has already passed us by.
A hundred schoolboys have caught the pox
before they have studied Aristotle on temperance." Michel Eyquem de Montaigne (1533-1592), *Essais*, 1,26

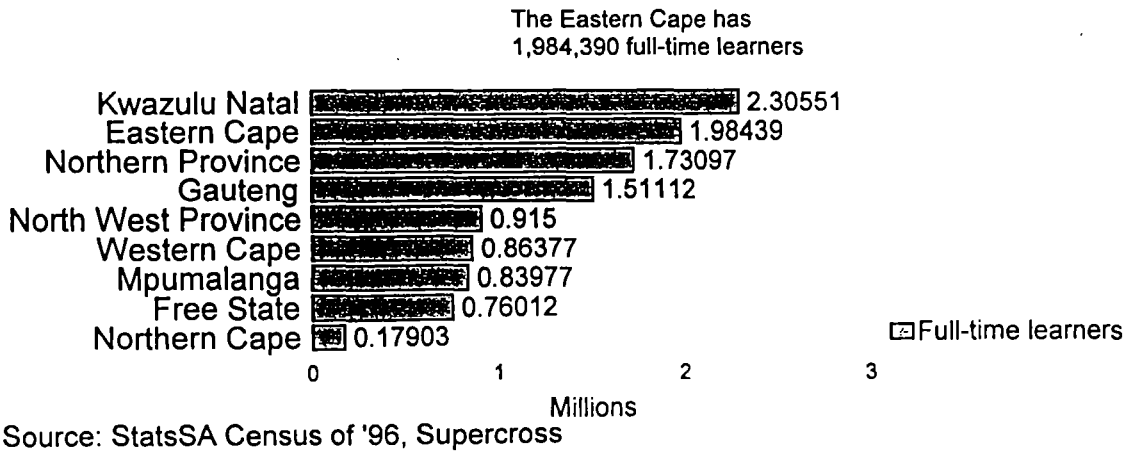
## Introduction

The Eastern Cape is among the most populous of all the provinces (StatsSA 96). The province is a source of out-migration for young males seeking employment. Consequently there are a greater proportion of women and children in the province. The number of children studying at school is very high in proportion to the rest of the population. Only the North West province reports a greater proportion of children studying at school. Only KwaZulu Natal has more full-time learners (see map and table). Education is probably the most powerful weapon against HIV/AIDS. But the education system, by concentrating the population of children together, is also a source of infection.



# A population at risk:

## full-time learners by province, 1996




Source: StatsSA Census of '96, Supercross

Driving casually through the Eastern Cape, one might have the Panglossian impression that all is well in the fields of education. Indeed, there are many newly built schools in the rural areas, their bricks and new roofs still shiny in the sun. Eager African learners, so long denied the chance of proper schooling, now throng the roads in their colourful uniforms to join the queue at the windows of the enlightenment. It is not an unpleasing spectacle for the progressively minded traveller as he or she winds through the hills and dales of the Eastern Cape. But is the picture correct?

Most people share the cherished belief that once the population is made literate or HIV aware, behaviour will automatically change for the better. As one of South Africa's leading researchers put it: "In the absence of a cure or vaccine for the disease, education is the most important strategy in limiting the spread of HIV/AIDS" (Haldenwang 1993: 51). There is however, no evidence that this has happened in the rest of Africa where the pandemic began nor that it will automatically happen in South Africa unless there are dramatic changes in the education system.

## Literature Review

Although HIV prevalence data are not available for many areas outside of South Africa, the following literature review of HIV/AIDS in the education systems of the African continent gives a useful overview of the factors that cause school children—and female students in particular—to be at a high risk of acquiring HIV.

### Ghana

The results of a series of focus groups in Ghana show that adolescents are interested and concerned about AIDS. Yet they do not change their risk behavior. Almost every student in the focus group knew that HIV could be spread through sexual intercourse or through contact with blood. They also cited the key prevention methods: reducing the number of sexual partners, using condoms, abstaining from sex, sterilizing needles and avoiding unnecessary blood transfusions. At the same time, many continued to have unsafe sex. Female students acknowledged that young women were often economically forced to exchange sex for money with older men. Often, these men were their teachers. The girls commented that "instead of teaching the children against sex [the teachers] rather have sex with young girls." Girls also complained about being forced into sex by male schoolmates. Furthermore, girls that used condoms were stigmatized as 'flirts' while it was more socially acceptable for boys to use condoms. While the results were not quantitative, the authors believed that they clearly highlighted the reasons that girls were more susceptible to the virus (Porter 1994).

### Uganda

It is widely believed that the Ugandan government recognized HIV/AIDS as a major problem and reacted aggressively with a multi-sectoral approach well before any African governments. We learn that Uganda is one of the few African countries that has experienced any success in slowing down the HIV/AIDS pandemic. What does the scientific literature say?

A 1996 study confirmed earlier government findings that the youth under 16 years were at high risk and would be suitable intervention targets (Migliori et al. 1996). In response, the government allowed for the implementation of specially designed programmes to change adolescent behavior. In one recent evaluation of a particular program designed by the African Medical and Research Foundation in conjunction with the Soroti District Administration, the percentage of students in their last year of primary school who reported being sexually active dropped from 42.9% to 11.1% after two years of a special, intensive school health education programme. A control group only exposed to the national health education curriculum showed no significant decline after this same period.

Most significantly, Shuey et al. (1999) also found that before this intervention, school children in their study who had a family member with AIDS were *more* likely to be sexually active, a finding which was contrary to near universal expectations of behavioural change following knowledge of AIDS within the family. After the programme, the learners in the intervention group—but not the control group—reversed this trend. This would suggest that we should research much more intensively the impact of HIV on individual families.

It is important to note that the Ugandan national curriculum was not effective in changing sexual behaviour during the surveillance period 1989 to 1992 . Uganda's successes must therefore also be attributed to a dynamic response of the national government and also allowing local initiatives and experimentation. This evaluation also proved that sexual behavior change is possible in a school-going adolescent population. However, that success depends on early, intensive, locally administered education. The authors conclude that "the quality of implementation is probably more important than the detailed design of materials or curricula...efforts should concentrate on improving the quality of actual delivery of school health education, using simple, but effective behaviour change techniques such as experiential learning, peer interaction and supportive supervision"(Shuey et al. 1999: 418).

The flexible, multi-tiered but above all dynamic educational programs in Uganda may serve as a model to the rest of Africa and indeed the developing world. However, it must be recognised that Uganda began with an exemplary, dynamic program *early* in the course of their pandemic. The national programme did not work at first. Such responses may no longer be appropriate in a fully blown pandemic such as is sweeping across South Africa.

Tanzania

A study of school children conducted in the Arusha and Kilimanjaro regions of Tanzania by Klepp et al (1996) looked at factors which contributed to decisions to engage in sexual behaviour. This study showed that past behaviour is the strongest predictor of intention to engage in sexual activity. Consequently, the authors logically came to believe that HIV/AIDS prevention programmes must start *before* the students have their first sexual experience. They concluded that educational programs that only disseminate information, without affecting changes in attitudes, will not be successful (Klepp et al. 1996).

Matasha et al. strongly argued in favour of sexual and reproductive health education in

Tanzanian primary schools. 80% of primary school boys and 68% of primary school girls in the Mwanza region were sexually experienced. The median age of first sexual intercourse was 15 for both boys and girls. The ratio of HIV infected young women to HIV infected young men was 4.1: 1.8, over two to one. One quarter of primary school girls reported having sex with an adult—including teachers and relatives—and another 23% with "strangers". 'Forced sex' accounted for one third of all school girl's first sexual experience and nearly half reported 'forced sex' at some point. 52% of primary school girls cited money or presents as a reason for engaging in sexual activity. In contrast, only 12% of primary school boys reported having sex in exchange for money or gifts, less than 10% of boys were forced into sex as their first sexual act, and 76% percent were never forced into sex. About one quarter of the primary school students had 'some' or 'adequate' knowledge of STDs. However, there was no correlation between knowledge of STDs and sexual activity. Although condom use increased with education, sexual health education did not start until secondary school when most students had already been sexually active for some time (Matasha et al. 1998).

Zambia

In Zambia, where premarital sex is generally taboo, 77% of youth (15-19 yrs.) interviewed were sexually active. The median age of first sexual experience was between 14 and 15 for females. According to unpublished results, female secondary students were four times as likely as male secondary students to be infected with HIV. The authors claimed that 'sugar daddies' who exchange money, gifts, and a sense of security for sex, were partly responsible for this discrepancy. These older men have higher rates of HIV and spread it to the young girls. Despite the national AIDS education and awareness campaign that was launched in 1986, more than half the sexually active student population had never used a condom. In the preceding month, only four percent of respondents used a condom with a partner who was not their boyfriend or girlfriend. Over half the respondents agreed that they needed to change their behavior. Yet even after education 59% admitted they had not changed at all. The female drop-outs showed the highest rates of behavioral change. Unlike school girls, drop-outs did not face the same social stigma for using condoms. While school girls would be perceived as 'sluts' for wanting to use condoms, drop-outs were already seen that way (Feldman et al. 1997).

Zimbabwe

Eighteen percent of 1,689 Zimbabwean students (10-19 yrs.) sampled were sexually active. Due in part to the falling age of menarche, girls were becoming sexually active at an increasingly earlier age. The mean age of first intercourse for boys was approximately 12.0, and for girls it was approximately 13.6. These same children knew little about the sexual transmission of HIV/AIDS. Most (83%) knew that HIV/AIDS was not treatable, but only 13.2% knew that HIV was transmitted by having sex with an infected person. However, 69.2% answered that blood transfusions could spread the virus and 52.9% reported that a mother could infect her child at birth. The authors speculated that the falling age of menarche coupled with the lack of proper knowledge about HIV and sexual health that put young women in the educational system at high risk (Kasule et al. 1997).

South Africa

Cape Peninsula

Out of 5, 851 participants, 17.4 percent of high school students in the Cape Peninsula region reported having sexual intercourse. The median age at first intercourse was 14.9 for males and 15.6 for females. The average number of sexual partners over the previous year was 1.5 for males and 1.0 for females. Students were concerned about pregnancy. Sixty percent had done something to prevent pregnancy the last time they had sex. However, their method depended on their first language. While 68.6, 70.7 and 81.9 percent of English, Afrikaans and English and Afrikaans-only speakers used condoms, only 16% of Xhosa speakers used condoms in their last sexual episode. In contrast, 75.5 % of Xhosa speakers used injectable steroids and only 9.3, 14.9, and 4.6 of English, Afrikaans and English and Afrikaans-only speakers reported doing the same. The authors felt that this made Xhosa speakers more susceptible to the HIV virus because injectable steroids do not offer a barrier against STDs (Flisher et al. 1993).

Cape Town

Seventy-five percent of students from township high schools around Cape Town reported having had sexual intercourse. Almost half of the female students under 18 stated they were virgins, but only 9% of female students over 18 stated the same. Less than 15% of all male students reported being virgins and 36% claimed to have had two or more partners in the previous 10 months. 73.9% of students did not know that AIDS is incurable and most did not think they were at risk. While students most commonly chose condoms as the most effective prevention of STDs, they rarely used them. Instead, they most commonly maintained 'one sexual partner at a time' for prevention. 43.4 and 32.5 percent of female students under 18 and over 18, respectively, did not know what a condom was (Mathews et al. 1990).

Eastern Cape, South Africa

A study of 2108 learners in 26 schools in 22 rural districts of the Transkei in the census year of 1996 concluded that "adolescent sexuality in rural Transkei is characterized by early initiation and high level of sexual activity, low contraceptive usage and a high rate of adolescent pregnancies and STDs ... sexual intercourse is the rule rather than the exception." The mean age of first sexual coitus was 14.86 for girls and 13.43 for boys. The average length of time between the first "date" and first coitus was approximately three months for both boys and girls. Of all female sexually active respondents the most commonly reported reason for having sex was 'forced by partner'. The next most common was 'peer pressure'. Together, these responses accounted for almost half of all the responses. Males tended to report 'proof of normality' as the reason for initiating sex. Over three quarters of sexually active girls had never used contraception. Of those that did use protection, most used pills or injectable progestins. A whopping 95% of sexually active girls were not using barrier systems which would protect them from either STDs or HIV/AIDS. Furthermore, over 30%

of the girl respondents had been pregnant. According to the researchers, "adolescent pregnancy is generally accepted, tolerated and even connived at by the society." Half the school boys and almost one quarter of the school girls had a history of STDs, which is known to increase the ease of HIV infection (Schoub 1999: 101-107). The study found a direct positive correlation between initiation of sexual activity and both the age of menarche, which has been falling, and the age at the first date. When combined with the low use of condoms and the significant STD rate, these school children are clearly at a high risk for acquiring HIV. The authors recommend that full health education must start before students are 13 years old (Buga et. al 1996).

## Conclusion of Review

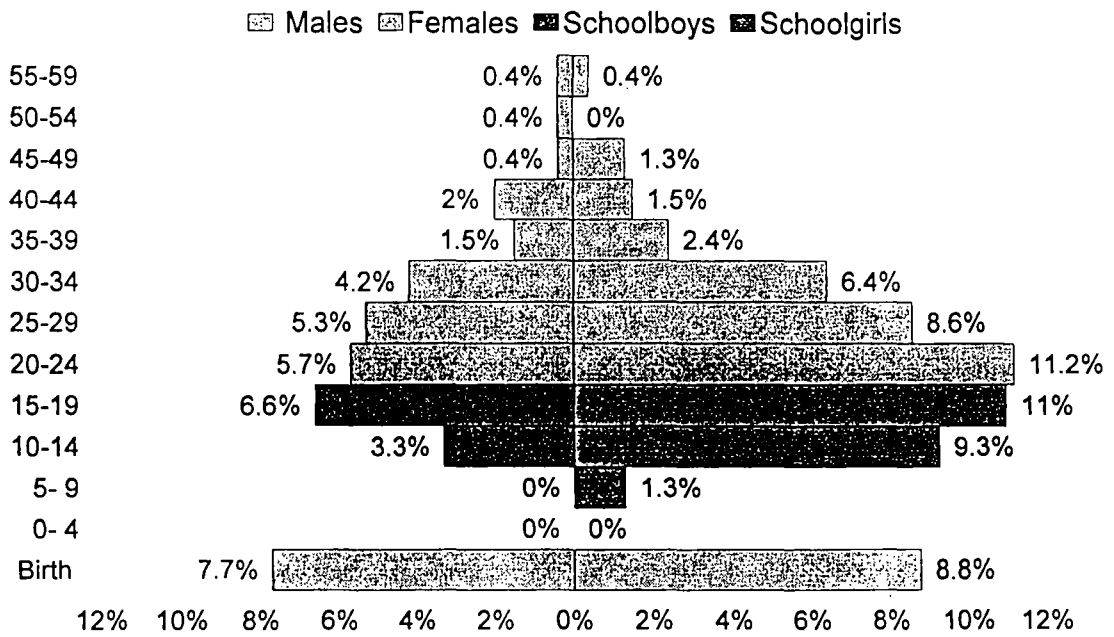
This review shows clearly that the educational systems of Africa and South Africa are not providing nearly enough adequate reproductive health counselling. Even the Ugandan system had flaws. Intervention had to be intensive to work at all. As leading epidemiologists have concluded: "Education does not, of itself, confer protection from HIV infection" (Meidany 1998: 9 and "[c]learly, education on its own in insufficient to affect the transmission of HIV (Schoub 1999, 251). The stronger statement, which nobody seem to have made, is that the educational system is part of the problem, not the solution.

## Focus on the Eastern Cape

### The age of HIV infection in the Eastern Cape

Dr Etienne du Plessis, the director of Health Services at Port Elizabeth, has had his staff collect data on AIDS deaths in Region A of the Eastern Cape. We know the ages of these AIDS deaths from a sample of 454 tested AIDS cases. If we assume that they acquired HIV ten years before, we have a rough and ready population pyramid of the age of infection. As can be seen from the following graphic, 31.3 percent of all AIDS deaths in this group acquired HIV in the age groups 10 to 19. By far the biggest group were female. That is to say almost a third of all HIV is acquired in the teens, in the school years. If we take away the non-behavioural casualties of the pandemic—infants with HIV (17% of all cases)—we are left with a clear intervention target. Almost fifty percent of HIV in Region A is acquired by adolescent girls of school-going age.

# The age of infection



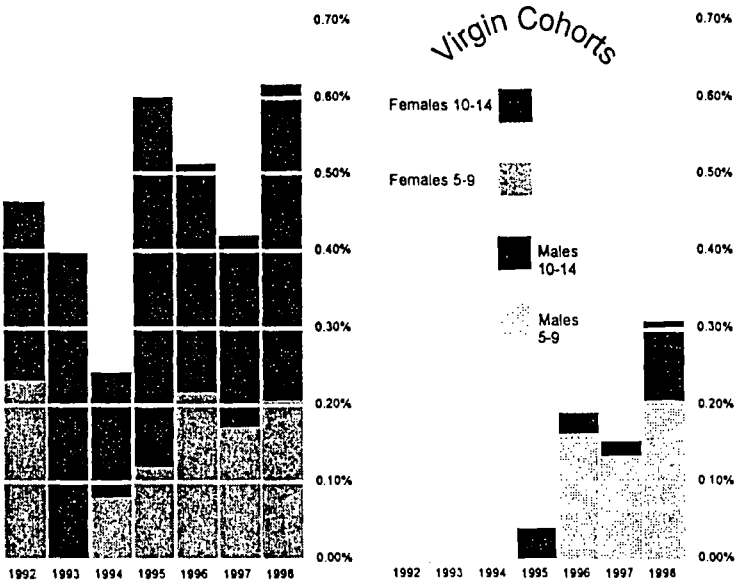

N=454; source: Port Elizabeth: Aids Training, Instruction and Counselling Centre (ATICC), 1998

Virginity and HIV

After the sexual revolution, the loss of virginity used to be a simple *rite de passage*. Today in the era of HIV/AIDS the event must be seen to enhance the chances of acquiring HIV. This is not simply due to the inherent risk of sex. The presence of blood due to the breaking of the hymen and trauma to the vagina from stretching of the vaginal walls allows the virus to infect much more readily. Although small cuts and microscopic lesions are normal during any sexual encounter, they can be guaranteed during sex with a virgin. It may be presumed from the studies done around Africa that the age of first sex is low and almost always in the school going years. Furthermore, it often involves older men—sugar daddies—who have higher HIV and STD rates. Therefore, sex without a condom for a virgin girl is equivalent to sexual Russian Roulette. Nobody seems aware of the obvious danger of the virgin syndrome.

Of course, this process also affects young girls who have been raped by those who believe that sexual intercourse with a virgin will "cure" HIV/AIDS. This dangerous myth, which has been linked to the belief in a virgin cure for venereal disease, dates back to 1949 (Mager, n.d: 20). One can see how this myth evolved. Adults, who fear their peers may be infected with HIV, turn to children who are presumed free of HIV; but some desperate HIV positives have come to believe sleeping with a virgin girl will actually cure them.

It is unclear how widespread this practice has become in the Eastern Cape. However, in the Eastern Cape (Region A), a girl in the virgin age grouping (5-14 years) is more than eight times more likely to be infected than her male counterpart (see following table). Even in the 5-9 year age groups girls are more likely to be infected (ATICC 1998). This is even higher than the much cited United Nations International Children's Fund (UNICEF) study that shows African girls aged between nine and 15 years are five times more likely to be infected with HIV than boys of the same age (Sebunya 1996: 15).




Source: Port Elizabeth: Aids Training, Instruction and Counselling Centre (ATICC). 1998

**Figure 3**: Virgin age groups over time

| | *Females* | *Males* | *Total* |
|---|---|---|---|
| ***5 to 9 years old*** | 26 | 17 | 43 |
| ***10 to 14 years old*** | 50 | 6 | 56 |

Prof. Robert Dorrington, one of the country's actuarial experts on HIV, has observed that this finding might reflect the enhanced perinatal survival of females to HIV infection at birth (personal communication 1998). However, one should note that HIV infection in these age groups has grown from zero percent in 1991 to almost one percent of the total in 1998 (Shell 1998, 8). If this finding were due to perinatal survival availability there should be no increase. The figures should be constant. Moreover, the older age group should be smaller as fewer survive.

It is also possible that the reported increase is a result of more children being tested. Some commentators have pointed out that there has been an increase in reports of child abuse since 1994 possibly as a result of the receptivity of the new ANC government to issues of gender. Race may also be an issue here. Before 1994, it would be unlikely for a black person to complain to a local white authority about child abuse.

Obviously, rape at any point will increase the susceptibility of the woman to HIV because of trauma to the vagina. This risk is enhanced for virgins. Whether school-aged girls are infected with the virus due to rape or unsafe consensual sex, the enhanced susceptibility of the young woman to HIV during her first sex act probably plays a role in the relatively higher HIV rates among young women. It would seem to be imperative to have special counselling on the values of virginity and the potential danger. Every virgin contemplating sex should have a condom.

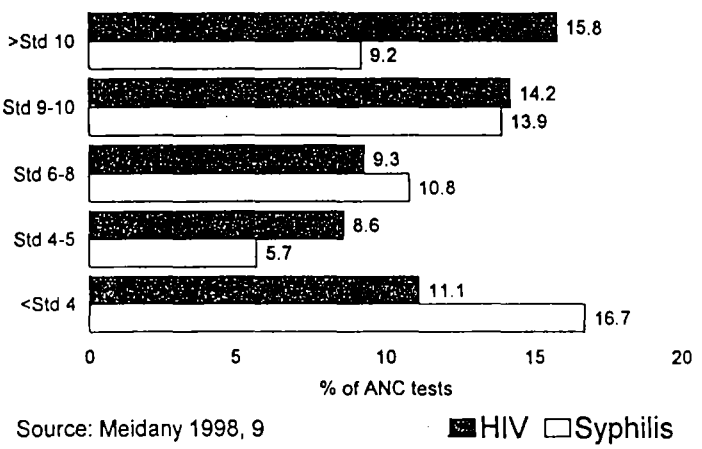
Correlation between years in school and HIV infection

Data from ANC surveys in the poorest province—the Eastern Cape—show that the standard reached in school is positively correlated with HIV status (see following graphic). People with matric have the highest prevalence rate. This might mean that a girl in Standard 5 who drops out of school entirely will be safer from HIV/AIDS than her sister who stays until her matriculation. Education, considered by all to be the great hope for a change in behaviour, therefore might not be the hoped for panacea but instead, have unintended *accelerative* effects on the pandemic.

The data show that education does seem to work in relation to syphilis prevalence figures. The ANC blood sample is split and the donors are tested anonymously for both STDs and HIV. The higher the standard reached the lower are the syphilis prevalence figures (see figure). This simply shows that syphilis is curable and that students with higher standards seek treatment.

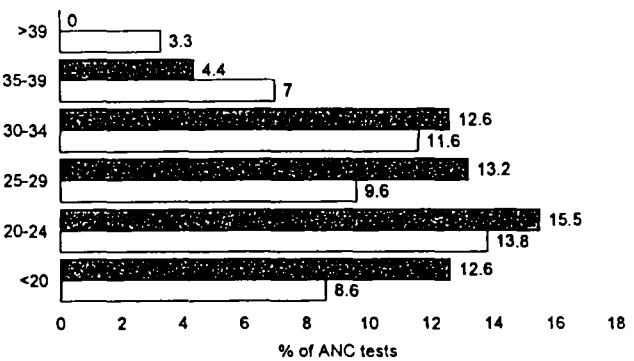
HIV however is irreversible and therefore the older age cohorts simply reflect the cumulative acquisition of the incurable and deadly virus acquired at younger ages.

1997 Ante Natal Clinic results:
HIV and Syphilis by educational standard




Source: Meidany 1998, 9

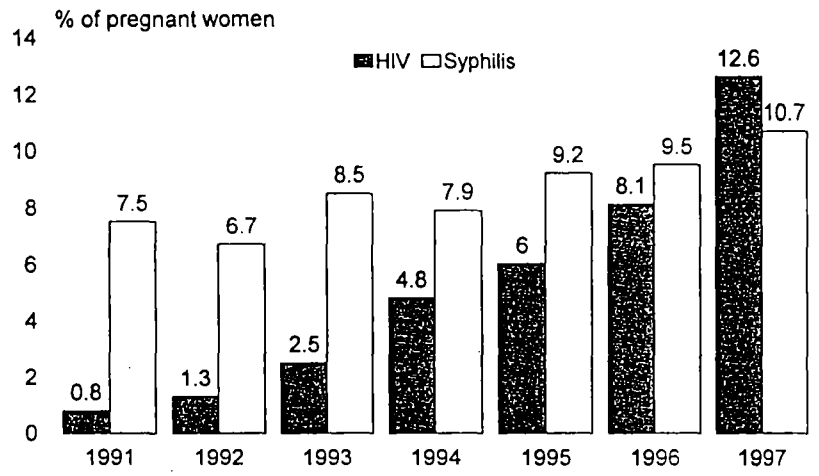
1997 Ante Natal Clinic results:
HIV and Syphilis by age group




Source: Meidany 1997, 8

While syphilis is curable, it is still growing (Meidany 1998, 7). This can be seen in the following graphic:

HIV and syphylis prevalence in the Eastern Cape over time




Source: Meidany 1998, 7

In this context of infection, while schools might well act as formal disseminators of HIV awareness, they are simultaneously—and more importantly—arenas of peer group pressure and sexual contact. Children are being warehoused in government-sponsored institutions which currently present a mortal danger to them. The massive changes to the educational system such as outcomes-based education (OBE), right-sizing and regional redeployment of teachers have helped to destabilize the one profession that is going to be critical in the fight against AIDS. It is clear that the new education system is woefully unprepared and ineffective in combatting the HIV/AIDS pandemic.

Until there is a stabilization of the profession and a revision of Curriculum 2005, which would include appropriate reproductive health education, the virus will continue to haunt the playground. However, it could be argued that such curriculum reform will itself promote precocious sexual activity as safe sex practises become known and popular. The following letter to the Daily Dispatch on the 9th March 2000 from Gilbert Daley, an experienced school teacher of rural African learners makes our point far more poignantly and effectively than anything we could write:

> It is very disheartening to read your article on schools being "breeding grounds for AIDS". Many children of the rural schools come from abject poverty. This does not mean that they are immoral or necessarily involved in sexual activities. The permissive society contributes to the fall of adolescent girls to a great extent. Those guys after the initiation school take it for granted that they can do anything they want. There is no mechanism to curtail the male chauvinism in schools. More condoms than text books were distributed in rural schools last year, thereby transforming "learning culture" into "condom culture". One cannot help feeling that those who took the decision to contribute condoms lacked vision and wisdom. In my decades of teaching rural African children, it was shocking and morally repulsive to have learners fiddling with condoms while serious teaching was going on. It violates all

> bounds of decorum when you have to pick up used and unused condoms to clean up the classroom. The age-old values – like marriage is a sacred institution; pre-marital sex is abominable; and there are worthier pursuits than sex – should be inculcated in our learners. Above all, the dignity of the teacher and the teaching profession should be brought back rather than making the teacher a cog in a machine that woks seven hours a day without sentiments and sincerity (page 12, editorial page).

This sincere letter highlights on an anecdotal level the perceived disrespect of learners for their teachers. It also implies that simple condom distribution is not enough to inform students and change underlying attitudes. Rather, free condom distribution without appropriate reproductive health counselling might well further empower male chauvinism.

Policy recommendations

1. The introduction of single sex schools
2. The introduction of single sex teaching
3. The reduction of the age range within individual classrooms
4. The routine anonymous testing of teachers and learners for HIV/AIDS
5. The development of a special curriculum by the Department of Education for reproductive health
6. The public should be made aware of the dangers of girls losing their virginity while having unprotected sex.

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